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CHAPTER 5: CLIENTS ACCOUNTING FOR THE RESPONSIBLE SELF IN INTERVIEWS

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Introduction

Nowadays, lively political and academic discussions revolve around the issue of personal and social responsibilities (e.g. Passini 2011; Snelling 2012; Pearl and Lebowitz 2014). For example, the discussions consider in what sense and to what extent (ill)-health and (bad) wellbeing are personal choices and accomplishments (Giddens 1999; Wikler 2002; Brownell *et al.* 2010; Scott and Wilson 2011; Wiley *et al.* 2013). A common view is that individuals are primarily responsible for their health and well-being and thus at least partly causing their adversities and problems (Robert *et al.* 2008; Lundell *et al.* 2013). Although public perceptions are not monolithic and this view of the responsible self is widely criticised, it can still be said to represent a dominant cultural expectation of agency in the Western world (Lyon-Callo 2000; Pearl and Lebowitz 2014).

The clients utilising employment, health, social and housing services and benefits are culturally expected to account for being responsible and as "trying" despite the need of subsidies and support services. However, individuals experiencing social exclusion are often in a difficult position due to attempting to live up to the idea of a responsible self. Social exclusion erases and narrows capabilities, resources and choices in life and can be defined as "what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, unfair discrimination, poor housing, high crime, bad health, and family breakdown" (Social Exclusion Unit 2004: 4; Cole *et al.* 2011: 13). These features are also well-known social determinations of (mental) health problems (SDH) (Lundell *et al.* 2013: 1116; May *et al.* 2013).

One root of the responsibility discussion is advanced liberalism that emphasises that people are to help themselves and find ways to strengthen their capabilities to be self-governing individuals. Personal responsibility and self-management are widely discussed in the govermentality literature (Rose 1996; Scott and Wilson 2011; Solberg 2011; Chapter 2). Interestingly, self-management, which implies empowerment and recovery, is at present strongly promoted in the (margins of) welfare services (Davidson 2005; Scott and Wilson 2011; Chapter 3). For instance, self-management has become a common approach in mental health work (Sterling *et al*. 2010) such as where the client interview data examples of this chapter are located. Often, welfare workers support the client's responsibility and ability to manage his/her difficulties in life by conducting self-management techniques such as making weekly programmes and schedules with the clients. Self-management can be understood as the ability of individuals to get along with the symptoms as well as the physical, psychosocial and lifestyle changes inherent in living with severe conditions (e.g. by leaning to utilise different techniques and welfare services) (Johnston *et al.* 2008). Thus, it first and foremost puts forward the notions of personal responsibility in line with advanced liberalism.

Our aim in this chapter is to reflect on issues related to personal and social responsibilities by applying the concept of self-management, which we understand as being a mediator between macro level discussions on responsibilities, professionals' ideas of good recovery and grass-roots level practices at the margins of the welfare services. The question addressed is as follows: how do clients manage personal and social responsibilities in the process of recovery at the time of rising expectations of self-management and the responsible self (self-responsibilisation)?

We begin by introducing discussions related to responsibility and self-management. Discourses of responsibility can roughly be divided into two: those that emphasise personal responsibility as essential in one's agency and well-being (Brownell *et al*. 2010), and those that concentrate on social responsibility i.e. that emphasise that others, institutions and collectives are crucial for ensuring an individual's wellbeing in society. Personal responsibility can especially be seen as a crucial element of becoming the subject of one's life (see Giddens 1999; McNamee and Gergen 1999; Kelty 2008; Ballet *et al.* 2007), whilst social responsibility emphasises the subjects' interconnected relations and obligations: "the importance of connections between people, through their social commitments and their embedding in social institutions" (Ballet *et al.* 2007: 186). Accordingly, personal and social responsibility intersect with one another as a responsible self is not only expected to manage one's

own life but also to be socially enlightened and to take care of the well-being of others too (Rose 1996; Lister 2015).

Then we continue by demonstrating via interview data examples how on the one hand clients at the margins of welfare services account for (trying to) taking responsibility for themselves and others and on the other hand resist this cultural expectation as impossible to live up to (in a current situation). There exists a gap between cultural expectations and the resources and capabilities of individuals (Scott and Lyman 1968). This gap is present in the interview talk as excuses, justifications and explanations in regard to expectations to restore things back to "normal" in a responsible way (see Chapter 4). In the analysis section we illustrate how clients reflect on the discourses of responsibility and self-management. These discourses set norms for good and respected individuals, and thus they offer "yardsticks" for the clients to assess their self-management abilities and stages of recovery.

Discourses constructing the responsible self

Discourses of responsibility

> As it is used today, 'responsibility' is an interestingly ambiguous or multi-layered term. In one sense, someone who is responsible for an event can be said to be the author of that event. This is the original sense of 'responsible', which links it with causality or agency. Another meaning of responsibility is where we speak of someone being responsible if he or she acts in an ethical or accountable manner. Responsibility also however means obligation, or liability, and this is the most interesting sense to counterpose with risk. (Giddens 1999: 8)

In line with the above quotation, Snelling's (2012: 162) definition demonstrates the multi-faced nature of responsibility. He represents three dimensional definition of responsibility: "(i) a responsible agent; (ii) having obligations (responsibilities); and (iii) being susceptible to being held responsible (that is blamed if he fails to meet them)". Responsibilities can, as in this chapter, be approached as discursive accomplishments that are constantly redefined and revised in particular contexts and social situations. This is what we mean by the term "discourses of responsibility".

Responsibilities are expressed in relation to authorities and governance, and thus they imply existing power relations, obligations and rules related to prefer behaviour and actions in current society. Individuals possess rights and responsibilities with respect to each other, communities, social institutions and authorities (Dean 2002; Flynn 2005; Ballet *et al.* 2007; Kelty 2008; Passini 2011: 282). As Trnka and Trundle (2014: 136) argue, "responsibility is a multivalent concept and practice that is central to contemporary social life. Notions of responsibility are pervasive, visible in forms of governance, emerging and enduring subjectivities, and collective relations in a wide range of settings". For example, being a welfare client implies particular responsibilities set by the welfare professionals and institutions. Also, the status of being a human being in Western society distributes responsibilities and rights to individuals according to human rights, religion and democracy. All in all, discourses of responsibility govern and direct individual conduct. However, they comprise a dispersed and conflicting totality that makes it possible for the individual to act upon the idea of the responsible self in various ways in different personal, societal and interactional contexts. Discourses of responsibility therefore enable and prompt agency in many ways, yet also restrict it.

Doheny (2007) deals with discourses of responsibility by presenting a liberal, republican, communitarian and deliberative democratic version of responsibility. Liberal responsibility is mostly about personal rights and responsibilities. It emphasises the importance of not abusing or misusing the rights of a free individual, whereas republican and communitarian versions have more to say about social responsibilities as civic virtues (see also Lister 2015). From a critical point of view it can be argued that although republican and communitarian versions of responsibility "explain that the citizen must internalize certain virtues if s/he is to behave responsibly, there is an absence of detail on how the responsible citizen grapples with their actual responsibilities" (Doheny 2007: 408). The deliberative democratic version of responsibility, which is introduced as an alternative and preferred version of responsibility, highlights that a fair distribution of responsibilities requires ethical sensitiveness, reflective thinking and negotiations. It is also seen to offer a relevant theoretical background to understand how people tackle responsibility issues in their everyday life. Following the idea of responsibilities being negotiated and managed at the grass-roots level, it has been for example studied how patient responsibility is constructed and negotiated in hospital settings and "how these practices draw on discourses of medicine, care and neo-liberalism" (Holen and Ahrenkiel 2011: 299). Similarly Beckmann (2013) studies lived experiences of people living with HIV/AIDS in Tanzania, and how they account for acting responsibly according to their condition, even though the biomedical authorities often see this action as irresponsible.

As discussed in this book, Miller and Rose (e.g. 2008) have approached personal responsibility as a representation of an advanced liberal form of governance that is known for relying on and enabling individual independence, empowerment and self-management (Rose 1996; Dean 2002; Chapter 2). In other words, advanced liberal governance values self-disciplined, multi-skilled, entrepreneurial and resilient individuals (Stasiulis and Bakan 2003: 22; Ilcan 2009: 211; Solberg 2011). As Hazleden (2014: 422) sees it: "Contemporary understandings and classification of the self are bound up with (neo)liberal political ideology and the rhetoric of choice, self-responsibility and individual aspiration". The advanced liberal understanding of personal responsibility is often referred to as self-responsibilisation. This stresses personal choice and autonomy as the means through which personal responsibility is accomplished – the responsibilities of the state are reduced, and it is up to the individual to make the best out of the opportunities and to reach for the best possible well-being. As Michailakis and Schirmer (2010: 931) put it, we have witnessed a "shift from a collective responsibility of the welfare state towards individual responsibility". Self-responsibilisation focuses on the phenomenon of enfolding political expectations and aims at personal subjectivities (Hazleden 2014: 433). Accordingly, individual agency is directed by ongoing (self-)responsibilisation accounting processes (Clarke 2005).

Client responsibility and self-management

Personal responsibility is strongly addressed in client responsibility and self-management approaches. Holding individuals accountable for their lifestyle choices and health is at the moment both a general and topical, yet controversial, discussion in today's society, which has a growing awareness of health risks, the importance of prevention and the growing demands for more and better treatments for less costs (Cappelen and Norheim 2005; Cayton 2006; Jallinoja *et al.* 2007; Share and Strain 2008; Civaner and Arda 2008: 267; Michailakis and Schirmer 2010; Scott and Wilson 2011). Civaner and Arda (2008: 264) have come up with the following list of patient responsibilities: "promoting self-health, respect for the health and well-being of others, the appropriate use of health care resources in the public sector, sharing relevant health information with health care workers, considering carefully any advice offered by the health care worker, and adhering to agreed treatment plans". They classify patient responsibilities into four categories that are "technical requirements, consumer obligations, responsibility for one's own health, and responsibilities to society at large (social responsibility)" (Civaner and Arda 2008: 264). Holen and Ahrenkiel's (2011) study shows that patient responsibility comprises aspects such as to have

morality, to possess proper will, to be compliant, display control and controllability, to be active and, most importantly, to strive for self-sufficiency.

Self-management resonates with and has been incorporated into patient/client responsibility discussions (Jallinoja *et al.* 2007: 244), and it was first applied in the welfare work context in the medical rehabilitation and chronic disease literature (Sterling *et al.* 2010: 133). The approach is based on and promotes the idea of a health consumer that is a responsible, choosing, life planning and self-efficient actor (Scott and Wilson 2011: 43). Within this approach, the ideal client is one who monitors and governs his/her condition with the help of appropriate expert knowledge and support. It expects the client to perform responsibly also by pursuing healthy living and reducing risks, following chosen care plans and medication and being a co-operative and active actor in the health and social services (Lorig and Holman 2003; Sterling *et al.* 2010: 134). The expertise of welfare workers is directed particularly to "individuals who lack the cognitive, emotional, practical and ethical skills to take the personal responsibility for rational self-management" (Rose 1996: 348).

In the governmentality literature self-management programmes are named as "responsibility projects" (see Chapter 2). Self-management can been interpreted to focus on "inquire about the self", which is also a bedrock of advanced liberalism governance, as the majority of its techniques for tackling social problems "fall under the rubric of self-help and governing of the self" (Lyon-Callo 2000: 335; see also Broom *et al*. 2014). Rose (1990) calls techniques that focus on the transformation of subjectivity from powerlessness to active participation as "technologies of citizenship" (Hazleden 2014: 423; see Chapter 6). Accordingly, the self-management approach is said to be "social revolution, not against capitalism, racism, and gender inequality, but against the order of the self and the way we govern ourselves" (Cruikshank 1996: 231 ref. Lyon-Callo 2000: 335).

In addition, the self-management approach implies empowerment and recovery (Davidson 2005; Johnston *et al.* 2008; Sterling *et al.* 2010; Pulvirenti *et al.* 2014; Chapter 3). It is enhanced by stating that when clients are actively involved in managing their conditions, better outcomes are achieved. It is also seen as the client's right to have an active role in finding solutions to health and well-being problems. In other words, self-management permits clients to become participants in the recovery process (Davidson 2005; Sterling *et al.* 2010; Chapter 3). The approach is applied as a professional care ideology, as programmes and specific techniques to strengthen and empower

clients to overcome difficulties and improve their quality of life despite possible lifelong conditions. In long-term conditions self-management is seen as a lifelong learning process and task that can be accomplished and strengthened by mutual co-operation between clients and welfare workers. Johnson *et al.* (2008: 5) state that "at the heart of each self-management approach is an empowered patient with the skills and confidence to better manage chronic diseases and interact with the primary health care system". They also provide an enlightening definition of self-management that emphasises empowerment and reciprocal relationship between clients and welfare workers:

> Self-management refers to an individual's ability to manage the symptoms, treatment, physical, psychosocial, and lifestyle changes inherent in living with a chronic condition. Self-management programmes seek to empower individuals to cope with disease and live better quality lives with fewer restrictions from their illness by developing self-efficacy, which is the level of confidence that an individual has in his or her ability to succeed in dealing with their own chronic disease. It is important to note the distinction between initiatives to build patient self-management and self-management support. Self-management support requires a provider or health care team to perform a certain set of tasks to create the self-efficacy necessary for a patient to deal confidently with their own range of emotional, physical, and physiological symptoms of their chronic disease. Self-management does not replace a health care team, but rather, encourages a reciprocal relationship between patient and physician, where self-management skills can be built and used at home, as well as in routine health care system interactions. (Johnston *et al.* 2008: 5)

This definition links together personal and social responsibility as workers are constructed as the ones enabling via reciprocal relationship a client to be self-efficient in the community. To grasp how clients manage severe conditions in everyday bases, it is important to understand their everyday challenges, ways of making sense of health, ill-health and their agency, as well as the structural barriers that hinder their access to resources. Clients often are in a position where they have no other alternatives than to balance the demands of the condition against those of everyday life and to manage in one way or another with or without the support of welfare workers (see van Houtum *et al.* 2015). Clients thus display personal responsibility, agency and means to manage difficulties and risks, even though their actions might not always be approved by welfare workers. The self-management approach is based on three presumptions that need to be addressed cautiously. Firstly, individuals are seen as disempowered per se. Secondly, it is assumed that all individuals

want or have the resources to be empowered, to make life changes or self-manage their conditions in a professionally preferred way (Pulvirenti *et al.* 2014). Thirdly, it is an individual client that is worked on and targeted for interventions. A critical stance towards the self-management approach and its presumptions makes it possible to resist the cultural expectation of the responsible self and to recognise its limits and risks, such as victim blaming (see Chapter 2) - without denying the positive consequences of the approach for clients' agency and well-being.

Clients taking part in the life management programmes and techniques

Self-management programmes and specific techniques are at present commonly conducted in welfare services to enhance the self-efficacy and personal skills of clients to govern health and welfare difficulties in everyday settings (Lorig *et al.* 1994; Lorig and Holman 2003; Sterling *et al.* 2010; Cramm *et al.* 2015). It can be argued that the self-management approach currently represents a preferred way to do mental health work and to understand client participation. In the following we introduce shortly a few self-management programmes to demonstrate how they construct the client as a responsible and active participant in service delivery and thus promote the cultural expectation of the responsible self.

Different self-management programmes – for instance Care Programme Approach (CPA) (see Chapter 7), Wellness Recovery Action Planning (WRAP) and Recovery Star – comprise techniques such as education, care plans, time tables, advice-giving and directing, agreements, self-assessments and follow ups to achieve recovery and better ability to function. WRAP is one of the mental health self-management techniques developed by service users and rooted in the recovery movement. It is widely applied especially in English speaking countries (Davidson 2005; Doughty *et al.* 2008; Scott and Wilson 2011). Scott and Wilson (2011: 40) take a critical stance toward it and note: "The WRAP is noteworthy for its construction of a health identity which is individualised, responsibilised, and grounded in an 'at risk' subjectivity; success with this programme requires development of an intensely focused health lifestyle".

Recovery Star is a holistic and personalised outcome measurement tool. It is based on the idea that both the worker and the client assess, rate and discuss the client's progress in self-management and recovery. The tool directs clients to plan, quantify and reflect on their progress, as well as welfare professionals and organisations to capture performance and outcome results (Onifade 2011; Tickle *et al.* 2013). Ten dimensions (see Dickens *et al.* 2012) are assessed: "managing mental health;

physical health and self-care, living skills, social networks, work, relationships, addictive behavior, responsibilities, identity and self-esteem and trust and hope" (Tickle *et al.* 2013: 195). Furthermore, Recovery Star is based on the idea of a "ladder of change" that demonstrates steps in the recovery journey from "being stuck to accepting help, then on to believing that things can change, thereafter to learning new skills/approaches to maintain recovery and finally to self-reliance" (Onifade 2011). As WRAP, Recovery Star aims to construct and facilitate transformation from a passive self driven by external forces to a reflexive self that is proactively and responsibly managing the circumstances and difficulties in life.

The clients, whose interview talk we analyse in this chapter, have participated in a variety of more or less strict self-management programmes. They have been clients of several health and social services, having lived in supported housing and rehabilitation course settings or independently with the support of floating support services. Accordingly, our presumption is that they have confronted and experienced a range of "re-responsibilisation" techniques such as monitoring pre-symptoms and well-being, making weekly schedules, taking part in self-care groups, practicing social and everyday living skills and receiving advice concerning healthy living, medication and preferred behaviour. Thus, it is important to scrutinise how such "re-responsibilized", and in many ways socially excluded, individuals account for personal and social responsibility.

Clients accounting for causes and responsibilities in interview talk

> To live a life at all is to confront conditions that are nettlesome, disappointing, irritating, and downright devastating. The problem then is not that we confront the problematic but, rather, how we respond. Perhaps the chief riposte is to seek restoration: We strive ascertain cause and with cause in place, gain rationale for action. With responsibility assign, we sense responsibilities for admonishment, correction, coercion, punishment, and so on (McNamee and Gergen 1999: 3).

Responsibility is a central concept within human life and thus also for an ethnomethodologically informed research approach (see Chapter 4) where it is seen as linked to accountability in social interaction. Following this approach, the subsequent analysis examines negotiations of responsibilities "in action". We ask, to what extent and in what ways do the clients (and interviewers) orient to the discourses of responsibility and self-management approach in interview interaction.

The illustrative examples are chosen from a data corpus of 44 (32 Finnish and 12 English) client interviews which have been conducted in four different settings: 1) a supported housing and floating support service for people with mental health and substance abuse problems (Finland); 2) a floating support service for people with mental health problems (UK); 3) a project offering housing and social skills training for young adults with diagnosed schizophrenia (Finland); and 4) an outpatient clinic for people with severe drug abuse problems (Finland). All these services are run by non-governmental organisations (NGOs) (see Chapter 4). The services deploy a variety of self-management programmes and techniques to promote individual recovery and coping in everyday life. For example, the clients commonly practice travelling by public transportation and everyday living skills such as cooking and cleaning. An essential activity is also giving information about mental difficulties and substance abuse problems and advising how to manage them.

The structure of the thematic interview was the same in England and Finland. The interview proceeded temporarily: the themes addressed the past, present and future hopes of clients. The themes covered the clients' background, previous and present accommodation and contacts with the social and health services. In addition, direct questions were asked about agency, personal and social responsibility and client-centredness.

Responsibilities are often touched upon by both participants in the interviews: by the interviewer when putting forwards questions in a frame of responsibility and self-management and thus inviting the client to account their own responsibilities and those of others. As seen from the examples, the interviewer directs interviews by asking questions that imply particular presumptions concerning the client roles and responsibilities in the recovery process. However, the main emphasis in the analysis is on the responses and accounting practices of clients (not on the expressions of the interviewers).

In the analysis we apply analytical concepts such as causal accounting and resistance (see Chapter 4). In a broad sense, accounts are seen to be present in all everyday communication (e.g. Buttny 1993; Antaki 1994). In accounting, speakers address issues of agency and responsibility (Edwards and Potter 1993: 25). As Garfinkel (1967: 33) notes, speakers routinely build into their talk accounts rebuttals to potential criticisms (see Raitakari *et al.* 2013). For example, in interview talk clients often explain their action and answer questions in a way that implies that they are aware that

they are potentially judged as “not responsible” and “not trying”. As Matarese and Caswell (2014: 46) state, “accounts are common responses to questions prompting an explanation”.

When we apply a narrower sub-concept of accounting – causal accounting – the interest lies in how individuals account for causes and construct cause-and-effect relations when making sense of their actions and the situation at hand (Bull and Shaw 1992; Juhila *et al.* 2010). By “cause-and-effect relation”, we do not refer to mechanistic causality, as in experimental methods, but to individuals’ everyday rhetorical claims of cause-and-effect (Bull and Shaw 1992; Raitakari *et al.* 2013). Applying Bull and Shaw’s (1992) ideas on causal accounting we scrutinise the clients’ “theories of cause” and how they construct relations between causes, agency and responsibilities regarding their own situations and behaviour. In a variety of ways, the clients claim causal relations between the following issues: What is causing their conditions and difficulties? What can be done to ease the suffering? Who ought to be active and responsible in solving problems?

By giving causes, justifications and explanations – for example, by referring to factors that are out of one’s reach, control or are unchangeable – individuals define the scope of their responsibilities and account for not being able to be the expected responsible self. In the client interview talk causal accounts are often built in a manner that creates an image of a good client who is trying his/her best in a demanding situation to live according to self-management expectations. However, the clients construct also causal accounts that imply resistance towards and resigning from the self-management approach.

The analysis section proceeds in the following way: in the first part, we analyse data examples that illustrate accounts for trying to be the responsible self. We notice that the clients express a lot their wish to be more self-sufficient, independent and active in life, but at the same time there are things that make it impossible for them. We refer to this kind of talk when using the term “trying to be the responsible self”. We chose, named and organised the data examples according to different factors that the clients construct as mainly their responsibility. In the second part, we examine such data examples that illustrate resistance towards personal responsibility. This resisting talk produces causal accounts for not being able to be responsible for one’s life (for now) or act responsibly (in a particular situation). It also makes it possible for the client to question the profound justification of (re)-responsibilisation. Accordingly, we have named the last data examples according to the reasons constructed as explanations and justifications of why the client is not capable of taking the position

of the responsible self. Hence, the analysis in a general sense demonstrates how discourses of responsibility and self-management are reflected among clients at the margins of welfare services.

Responsible self: Accounting for trying

Responsible for…

Our first impression of the data was that it comprises a large amount of professional self-management vocabularies, as well as causal accounts that explain why it is difficult for the clients to live up to the expectation of the responsible self as much as they would like to. These causal accounts also imply attributes of responsibility and blame. The clients describe their struggles with ordinary everyday matters and limited resources, yet also their abilities to manage symptoms and to estimate their shifting ability to function. Whilst doing this, they simultaneously allocate responsibilities to themselves and others; for example, welfare workers.

... managing care contacts, monitoring oneself and seeking help

The first example is client interview data from England. The client is living in her own flat with the support of a floating support service. She is in her fifties and has special needs related to substance abuse and severe psychotic level mental health problems. The interview is held in a supporting housing and floating support service's office. The data excerpt is from an interview section concerning support services and professional networks taking part in the client's treatment.

Extract 1

1. INTERVIEWER: What is important for your own wellbeing?
2. CLIENT: Making sure that I'm drug free and alcohol free, that's the most important one. Making sure that I have three teams, Support Service, my advocate and my psychiatrist and my social worker is. Making sure they're there so I can trust them. So, that if I do start to feel unwell I have somebody that I can phone up, you know, and get in touch with. Instead of leaving it and leaving it, and getting worse, you know, to the point where I want to hurt myself. I don't want to have to get to that point any more.

At the beginning of the extract, the interviewer asks what is important for the client in sustaining her wellbeing (turn 1). In the response the client constructs herself personally responsible for "*making sure that I'm drug free and alcohol free being*". Her duty is "*making sure*" about a variety of things: a substance-free life, support services, a trustworthy worker and her ability to act if things

are "*getting worse, you know, to the point where I want to hurt myself*". In her response the client portrays herself as a strong and empowered agent in the sense that she manages her condition and professional network, monitors wellbeing, makes requests for support and allocates appropriate responsibility to the welfare workers. Causal accounts are presented when the client argues that she is required to be active in order to sustain good condition and support relations. Conversely, she constructs her possible passivity as a cause that leads to a worsening of things. The client wants to be the responsible self that takes care and does not hurt herself. However, success in this is bound to her ability to be proactive and keeping the welfare workers committed to helping her. In her response, the client displays herself as an active actor who is responsible for arranging her own care. She positions herself as the central person whose role is to inform, coordinate and make demands on welfare workers concerning her health and safety. The responsibility to manage the condition is constructed as shared between the client and welfare workers; responsibilities are based on reciprocal client-workers relationship. In order for the client to act responsibly, the welfare workers carry an obligation to be available and responsive to the client's needs.

In general, such client talk reflects the ideals of the personal responsibility and self-management approach. The self is constructed as active, reflexive, monitoring and responsible for the condition getting better or worse. Accordingly, the client associates with personal responsibility and self-management vocabularies, and this makes it possible for her to display strong and empowered agency. However, the client's ability to be personally responsible is bound to the welfare workers' social responsibility to be liable and available to care for the client.

… being an independent and well-functioning client

The following data example is from a client interview conducted in the Finnish project offering housing and social skills training for young adults with diagnosed schizophrenia. The client is in his thirties and has a severe mental health problem, which make coping in everyday life demanding. The interview is held in the project's office. The excerpt is from the end of the interview where the client's wishes for the future are being discussed.

Extract 2

1. INTERVIEWER: Well. You can choose yourself. Thinking about something so extensive as the future. What would you?
2. CLIENT: Hope for?

3. INTERVIEWER: Hope for?
4. CLIENT: Well. Functional capacity, to be able to do those things that I used to do, which I was interested in. Difficult.
5. INTERVIEWER: Functional capacity is a fairly broad too and it comprises so many issues.
6. CLIENT: Yeah, and I also want this, what would I call it? It's a bit difficult to describe. Functional capacity and what else. This kind of, like having a tolerable life somehow. So I wouldn't have to suffer so damn much. That kind of thing.
7. INTERVIEWER: Well. That's something already.
8. CLIENT: Well. Anyway, functional capacity and coping in life. I could get started with that. And managing symptoms. I mean, they're mostly the same things as here ((project's name)).
9. INTERVIEWER: Indeed. Yeah, you do have plenty to hope for there.
10. CLIENT: To be able to finally become independent despite everything. Not be so dependent on so many things just because you're so broken.
11. INTERVIEWER: Do you think that becoming independent would be about having less contact with these treatment places, or?
12. CLIENT: I mean just in general, to have enough money, the apartment would be in decent shape, financial issues would be handled on time and accurately without any changes to payment terms or due dates and things like that. It also requires that I should get this chaos out of my head somehow.

The extract begins with the interviewer's inquiry concerning the client's future expectations (turn 1). The client first clarifies that the question is really about his wishes (turn 2). Then he responds by using professional self-management language: "*functional capacity and coping in life. I could get started with that. And managing symptoms. I mean, they're mostly the same things as here ((project's name))*" (turn 8). In this turn the client explicitly makes a reference to the project that is underway that can be regarded as a specific self-management programme. The client hopes for the same things that have been discussed in the project. He uses causal accounting when arguing that the limited ability to function is restricting him from doing things that he has previously done and that would interest him (turn 4). Poor ability to function is thus constructed as a cause and a justification of a passive self.

The client continues by constructing himself as trying to be eventually more independent and less dependent "*despite everything*" (turn 10). The client justifies his current dependency by defining himself as incomplete "*you're so broken*". An "incomplete" self cannot be independent and thus is constructed as the cause of the client being dependent. The client expresses dependency negatively: he values independency and wants to abandon dependency although he has restrictions. Independence is culturally a highly appreciated attribute of the responsible self, and it is also for the client, too. The interviewer presents a clarifying question concerning what independency actually means for the client, and suggests that it might mean having less intense relations with the treatment institutions (in this way aligning with the idea of independence being a valued attribute, turn 11).

However, the client talks into being a more overall self-management based understanding of independency. He stresses the following issues: "*to have enough money, the apartment would be in decent shape, financial issues would be handled on time and accurately without any changes to payment terms or due dates and things like that*". These resonate with the expectations related to the responsible self (turn 12). The client thus recognises improved self-management as his future recovery aim, yet also constructs a major obstacle in achieving it: "*It also requires that I should get this chaos out of my head somehow*". The client utilises the passive tense. Hence, from the utterance, it is possible to read what the client is displaying as his aim and what the difficulty is in reaching it, but it is not possible to read how and who would be able to undo the difficulty; the chaos. The utterance is constructed as a causal account: the mental chaos is seen as causing the dependency, and consequently to achieve independency, the chaos first needs to be solved. The client talk is unclear about allocating personal and social responsibility: someone needs to act on the chaos, but it is unclear who and by what means.

In sum, the "wish talk" reflects and uses personal responsibility and self-management vocabularies to set recovery aims and visions for the future. The client would want in the future to be self-sufficient and a more active agent, and thus he allies himself with the responsible self at the ideal level. The self-management approach provides a "yardstick" for the client for preferred agency and a vision of a better, more independent future. However, in this example, it does not give means to construct an empowered self that would know how to overcome the barriers in the way of a preferred agency, or who could be helpful in the struggles against dependency. Accordingly, the (mental) chaos is constructed as a force and agent on its own, not managed by the client's endeavours, and it is thus not a question of personal or social responsibility.

Resisting self: Accounting for limited responsibility

Limited responsibility due to …

Next we examine how the clients resist the expectations of personal responsibility and self-management. When the clients formulate resisting accounts, they display their limited abilities and strengths as causes and explanations of why they cannot (try to) live independently without support. The examples illustrate the resistance towards the expectation of personal and social responsibility, the responsible self.

... severe conditions and limited strengths

This example demonstrates a resisting self in a situation where the client's energy and ability to function are limited. The client is from the Finnish floating support service for people with mental health problems. The client is in his twenties. He suffers from severe mental health problems and ADHD. The interview is conducted in the client's apartment. The extract is from an interview section where client-centreness is discussed.

Extract 3

1. INTERVIEWER: If you think about, do you have some wishes that you would like to present to the physician, for example, or, what should they take into consideration in your treatment or. How should they change their actions?
2. CLIENT: I haven't come up with anything new. Sometimes I feel like there has been too much happening here. I should be doing things all the time, like sorting out and taking care of things and vocational rehabilitation activities and everything. I don't seem to have enough strength for it.
3. INTERVIEWER: What is your role in rehabilitation? What should you do in order to maintain your condition?
4. CLIENT: Well, to live as regularly as possible, regularly, and have a healthy life style. I haven't come up with ((anything else)). I'm just trying to make things work in every way I can, to avoid having excessive stress which would make my condition worse.

The extract begins with the interviewer's question concerning the client's wishes for treatment. The question is also formulated to find out the client's view on the welfare workers' roles, possibilities and responsibilities to aid him in managing his condition: is there anything that welfare workers should change in their conduct to be more supportive for the client (turn 1). The client does not come up with any straightforward requests for the welfare workers despite "*sometimes I feel like there has been too much happening here.*" The client's response can be interpreted to mean that the welfare workers are considered partly responsible for arranging too many things for the client to do. However, the client does not explicitly blame them but his limited resources: "*I don't seem to have enough strength for it*." (turn 2). The client interprets his limited strength as a main problem and the one to be blamed. He constructs a cause-and-effect relationship between the feeling of "too much" and a lack of energy. If he had more strength, things would be easier to conduct. Hence, the lack of energy works as an explanation and justification for the client's difficulties to fulfil the tasks related to a responsible self operating in society and "doing recovery". The client explains that he is

struggling to perform the expected tasks at the margins of welfare services, and thus there is the risk that the responsible self is too great a demand in his current situation (turn 2).

The interviewer's second question explicitly addresses personal responsibility and self-management in recovery. It also puts forward a presumption that managing mental health requires one to actively do things (turn 3). This may trigger the clients to respond by using vocabularies of self-management and by constructing recovery as a matter of a particular way of living. He contends that he ought "*to live as regularly as possible, regularly, and have a healthy life style*." In addition, the client explains that he has discovered the importance of avoiding too much stress. In the causal account the stress is perceived as a cause of the possible worsening of the condition. In other words, sustaining good condition would require circumstances favourable for a life without stress.

In this example, personal responsibility and self-management have been displayed as demanding activities that would require strong agency and strengths from the client. The client outlines a balance between trying to fulfil the tasks (of the welfare services) and the risk of becoming too stressed. Personal responsibility and self-management does not appear as empowering "I talk" or hopeful "wish talk" but as "pressing talk" of things being understood as "too much" and possibly worsening the client's condition. Instead of reaching for more self-management techniques, things to do to manage everyday life, the client tries to avoid increasing activities in life. In this sense, the client talk formulates a critical stance towards the ever growing demands of personal responsibility and self-management, and it emphasises that they can in some situations work against the liberating aim of becoming an empowered and healthy individual.

... illegitimate/ unrealistic expectations

The fourth example is from the supported housing service for people with mental health problems. The client is in his thirties and has severe mental health problems. The interview was held in the client's apartment. The data excerpt is from an interview section concerning the client's arrival at the supported housing services.

Extract 4

1. INTERVIEWER: So, if we just talk a bit about your present life here in ((supported housing services for people with mental health problems)). So, what do you do with the staff, do you have conversations?
2. CLIENT: Now that I'm moving out not so much.

3. INTERVIEWER: Oh that's right.
4. CLIENT: When I first moved in, yeah.
5. INTERVIEWER: You had then.
6. CLIENT: Yeah. When I moved in yeah, and it's only because I was getting better, better I should say, that it lessened off a little bit I should say. Check up on me. See if my room was tidy and that. My room's never tidy. My kitchen is. I'll wash the pots right, and I'll do that, and I actually quite enjoy doing that right. But my front room is just, it's like a bomb's gone off and I don't know why.
7. INTERVIEWER: So, they come and say to you could you please?
8. CLIENT: Yeah. And I don't do anything. Eventually I'll look at it and think I need to go in the bed now.
9. INTERVIEWER: So, how about discussions then?
10. CLIENT: Telling a depressed person to do something is really a bad idea.

The extract begins with the interviewer's question that implies the presumption that using the service comprises encounters and discussions with the workers (turn 1). The client's response constructs the intensity of the client-worker interaction to be bound to the client's well-being and progress in recovery: "*it's only because I was getting better, better I should say, that it lessened off a little bit*" (turn 6). The phrase is a causal account in the sense that "getting better" is seen as a cause for a lessening of the support relationship. It also constructs what the welfare workers do (are responsible for) as part of the support relationship: "*Check up on me. See if my room was tidy*" (turn 6). These activities can be interpreted as worker-led management techniques that have elements of control, ensuring and taking responsibility for the client's coping. The next question-answer sequence (turns 7 and 8) reveals the assumption that the client is directed to eventually internalise the importance of having a tidy room and work for it by himself. The client expresses how he is not acting accordingly with this expectation of self-managing and personally responsible client: "*My room's never tidy.*" (turn 6), "*I don't do anything. Eventually I'll look at it and think I need to go in the bed now*" (turn 8). The account is a factual statement: it does not indicate that untidiness is a problem for the client or that he would try to change his behaviour in the future. It can be interpreted as resistance towards higher cleanness standards, more active agency and self-management requirements.

The interviewer goes back to the assumption that a support relationship should include conversations (turn 9). The client responds in an ambiguous way by saying that "*Telling a depressed person to do something is really a bad idea*", which implies that telling someone what to do is not an appropriate technique to approach a person that lacks energy and is depressed (turn 10). The account can thus be read as resistance towards such a support relationship that is based on "telling" or advice giving. The turn creates a potential causal account: because the client is "a

depressed person", the room is never tidy. Being a depressed person is then put forward as an explanation and justification for the client's passive behaviour. The causal account is constructed in a way that the situation appears as self-evident, fixed and unchangeable. The account proposes a "fatalistic talk" that there is no means to change a depressed person, and consequently no one is to blame for or seen as being accountable for the passive self. It is just a common fact.

… *discriminating society*

The last example examines social responsibility and society as a context where socially excluded individuals try to manage their lives. The interview interaction does not follow the ordinary pattern of question-answer sequences as the client both asks the questions and answers them. He uses the question sheet that the interviewer gives to him. In this way, it is easier for the client to stay focused and handle the interview situation. The client was in his thirties and had many special needs related to drug abuse, homelessness, severe mental health conditions and ADHD. The interview was conducted in a Finnish outpatient clinic for people with severe drug abuse problems.

Extract 5

1. CLIENT: Yeah. Yes. Who is responsible for your well-being and recovery? I am, and probably the party treating me. At least on some level. They're responsible for what the treatment is. They're responsible for that at least. I can't really say. How do you see the responsibility or impact of the society regarding your coping or the fact that things haven't always been easy? The society sucks, it tries to put all people into the same category. But when this one person, I'm a Lego piece and I don't belong to that big Lego series. So, I'm flawed and I'm thrown away into the trash can. I'm just a mere nuisance from an elitist point of view.
2. INTERVIEWER: That was a really great analysis. One of the greatest I've ever heard.

The extract begins with the question that the client reads from the question sheet "*Who is responsible for your well-being and recovery?*" (turn 1), which triggers the client to distribute responsibility between himself and those involved in his care. The client recognises himself personally responsible "*Ì am*" and welfare workers as partly responsible for the content of the treatment: "*what the treatment is*" is defined as the scope of the welfare workers' responsibility. The utterance reflects the thought that it is the welfare workers that decide the quantity and quality of treatment services. The client goes on to the next interview question that addresses society's impact on the client's recovery (turn 1). The question gets the client to describe critically how in society it is attempted to put everyone into the same category and thus not allowing unfitting "Lego pieces" that do not belong to the "big Lego series". This metaphor can be understood to mean that

individuals are grouped into those who are fit for society and those who are not; the outcasts. In addition, it refers to stigmatising, blaming and discriminating societal powers which are beyond the client's control but which do have an influence on his wellbeing. The client displays how he does not have influence or personal responsibility in society; he is just thrown away by others. The metaphor portrays the client as being "faulty" and "waste" that society does not care for: "*I'm flawed and I'm thrown away into the trash can. I'm just a mere nuisance from an elitist point of view*" (turn 1).

In sum, the data example demonstrates a "drifting talk". It is a description of circumstances that oppress and exploit the self and make self-managing thus difficult. The self is oppressed by powers out of its control and given a degrading position in society. The self is faced with external forces that it is not capable of (or responsible for) taming or turning for the better. The client constructs himself without an entitlement to agency and thus is at the mercy of others' (discriminating) action. In turn, welfare workers are seen as being only responsible for treatment services. In the example, no-one is seen as capable of making a totally inclusive "Lego series" or of taking wider social responsibility: the socially excluded individual's personal responsibility is narrowed to "drifting" and to being an object of the actions of others.

Conclusion and discussions

Today much is talked about self-responsibility. Individuals are expected to actively manage their own health and make responsible lifestyle decisions (Roberts 2006; Broom *et al.* 2014). They are supposed to work on themselves and seek expertise knowledge in order to learn skills and self-management techniques for better well-being and health (Scott and Wilson 2011; MacGregor and Wathen 2014; Chapter 2). In this chapter, we have scrutinised how the clients talk about personal and social responsibility in the process of recovery at the time of rising expectation of self-management and the responsible self (self-responsibilisation). We have illustrated how "theories of causes" are influential and essential in how people construct and distribute responsibility, blame and agency – and thus important matters to examine. Cause construction points to the ones responsible for (exceptional) occasions and life situations (e.g. Pearl and Lebowitz 2014).

We have demonstrated how the clients at the margins of welfare services on the one hand (try to) live up to the ideal of the responsible self and on the other hand resist this cultural expectation as impossible or unreasonable. They (and interviewers) reflect responsibilities by utilising client

responsibility and the self-management vocabularies. Then they use professional concepts that resonate with the management of health, well-being and life. Self-management vocabularies allow empowering “I talk” and future-oriented, hopeful “wish talk”. Clients construct their agency frequently in a way that reflects the ideal individual presented in the era of advanced liberal governance. In other words, they express that they try to be self-sufficient, independent and active in life despite barriers, and it is the “I” that needs to be, and can be, the one that makes the required life changes (see also Chapter 6).

Self-management vocabularies point to the deficiencies of individuals that are to be worked on. Thus, it can be interpreted that they trigger “pressing talk” in which recovery activities become constructed as “too much” and a burden according to the client’s present strengths and abilities. The self becomes constructed as “insufficient” and “faulty”. The way of talk can be seen as the client’s linguistic device to resist personal responsibility by stating that limited resources are causing passive agency and a need for the support of others. The self-responsibility is a too demanding expectation in a powerless situation and if “*you're so broken*”.

However, the clients also detach themselves from the self-management approach and personal responsibility by producing resisting “fatalistic talk” that displays their situation as such that there is no means (and no sense) to try to change things for the better or to ease their troubles. Similarly, “drifting talk” positions the client as powerless and oppressed and thus without the ability to be a personally responsible actor. We conclude that for the clients at the margins of welfare services managing responsibilities “in action” is a demanding, context-bound and multi-dimensional accomplishment. They are struggling to both be the responsible self with limited resources and to detach themselves from this expectation.

Although self-management techniques support clients to manage their everyday lives and offer objectives for more active agency in health and illness, they do not necessarily eliminate the clients’ need for support. Personal responsibility is talked into being and reflected in relation to social responsibility. In other words, the clients bring forward that in order to take responsibility from themselves they need to have sufficient resources and others such as welfare workers to support and value them. This underscores the relevance to examine further the causal relation constructed between supportive relationships and self-management as has been already done by previous research (Dashiff 2003; Cramm *et al.* 2015).

Many scholars have claimed that personal and social responsibility are intertwined, related and relational concepts (McNamee and Gergen 1999; Brownell *et al*. 2010; Naumova 2014; Trnka and Trundle 2014). Personal responsibility requires social responsibility: social recourses, social support, genuine options in life and reciprocal relations in the community (Brownell *et al.* 2010). Trnka and Trundle (2014:137) approach the distinction between personal and social responsibility by arguing that responsibilisation contains multiple meanings and needs to be approached not only within an individual neoliberal discourse, but "through the lenses of care relations and social contract ideologies". Similarly, Passini (2011: 284) argues that "the claiming of rights and a sense of duty should always involve the recognition of a responsibility – to oneself as well as to others". Our individual agency is dependent on the actions of others and on our status in the community. There are times that we are able to care for ourselves and others, whilst at other times we might be powerless, helpless and without means to live a meaningful life due to long-term illnesses and adversities.

The clients' talk about recovery and self-responsibility reflects the cultural and moral understanding of what a valued citizen and lifestyle means (Broom *et al.* 2014; Keddie 2016). We agree with Broom *et al.* (2014: 527), that a cultural norm of duty is to be taken as the core morality implicated in the drive for good health, and that it is also present in advanced liberal governing of the self (see also Brownell *et al*. 2010). Without denying that self-management may promote empowered selves, it can also turn out to be "cruel optimism" for those who do not have the resources or possibilities to achieve positive recovery outcomes by setting them in the position of the ones that fail. MacGregor and Wathen (2014) stress the risk that social determinants are ignored at the political level and "those who cannot manage their own health may fall further behind".

At the time of rising expectations of self-management clients both try to fulfil the criteria of the responsible self and detach themselves from it. They identify the risk of failures in recovery and the assumed gaps in their life between expectations and actions. Hence, it is critical to not only work on individual conduct but also on the cause-and-effect relation in play and "relational re-responsibilisation". The relevant questions are: how is valued and "sufficiently" responsible agency culturally constructed? Whose responsibility it is to promote and support this agency? The responsible self is a reciprocal, social, relational and negotiable construction and is thus a collective accomplishment.

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