PATIENTS AS EXPERTS, PARTICIPATORY SENSE-MAKING, AND RELATIONAL AUTONOMY

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SUMMARY: Although mental health professionals traditionally have been viewed as sole experts and decision-makers, there is increasing awareness that the experiential knowledge of former patients can make an important contribution to mental health practices. I argue that current patients likewise possess a kind of expertise, and that including them as active participants in diagnosis and treatment can strengthen their autonomy and allow them to build up important habits and skills. To make sense of these agential benefits and describe how patients might act as co-regulators of a therapeutic encounter, I look to the enactivist notion of "participatory sense-making".

KEY WORDS: affordance, enactivism, habit, person-centered care, psychotherapy

RESUMEN: Aunque tradicionalmente se ha considerado a los profesionales de la salud mental como los únicos expertos y responsables de las tomas de decisiones, cada vez hay más conciencia de que el conocimiento experiencial de los expacientes puede contribuir a las prácticas de salud mental. Sostengo que los pacientes actuales también poseen un tipo de experticia, y que incluirlos activamente en el diagnóstico y el tratamiento puede fortalecer su autonomía y permitirles desarrollar hábitos y habilidades importantes. Para dar sentido a estos beneficios y describir cómo los pacientes podrían actuar como correguladores del encuentro terapéutico, recurro a la noción enactivista de "hacer sentido participativamente".

PALABRAS CLAVE: *affordance*, enactivismo, hábito, atención centrada en la persona, psicoterapia

1. Introduction

Although mental health professionals traditionally have been viewed as sole experts and decision-makers, there is increasing awareness that people who live with mental illness have a unique set of lived experiences that render them epistemically privileged in certain respects. Some theorists have gone so far as to suggest that just as professionals are a source of expertise, former patients "have special technical expertise in virtue of experience that is not recognized by

degrees or other certificates" (Collins and Evans 2002, p. 238). Their experiential knowledge can make an important epistemic contribution to research, treatment practices, and the development of diagnostic criteria (Tekin 2022). But do *current* patients likewise have a kind of expertise? I will suggest that such expertise consists partly in an epistemic dimension: current patients have knowledge about how various symptoms impact their lives and relationships, what sorts of treatments have proved to be effective in the past, and what it's like to utilize mental health services. In addition, their expertise involves an agential dimension that centers around a kind of responsiveness and attunement to available action possibilities. I argue that regarding patients as experts and including them as active participants in diagnosis and treatment can have important agential benefits insofar as it allows them to build up important habits and skills.

To make sense of these agential benefits and describe how patients might act as co-regulators of a therapeutic encounter, I look to the enactivist notion of "participatory sense-making". As first described by De Jaegher and Di Paolo (2007), "participatory sense-making" is a process of collaborative meaning-making in which new understandings can be generated that were not available to the individuals on their own. While the participants involved do remain autonomous, separate agents, the relationship that arises between them has its own properties that constrain and modulate their behavior. Through the coordination of intentional activity, each agent's understanding is mediated and modified via the meaning-making activities of the other participant(s). Rather than being unidirectional, regulating processes are reciprocal and flow back and forth between the agents; there is a mutual recognition of each other's subjecthood and agency (Brancazio 2020).

Effective talk therapy sometimes counts as a striking example of participatory sense-making: by way of bodily resonance and interactive engagement, therapist and client jointly regulate their interaction and engage in a collaborative interpretation of the patient's experiences. A myriad of shared, complicit, disputed, and rebutted significances and meanings can emerge in a constantly shifting way over the course of the interpersonal encounter. In my view, the enactivist notion of participatory sense-making can help to deepen our understanding of how shared, reciprocal involvement between patient and health care professional "empower[s] and encourage[s] the [patient's] autonomy, self-confidence, dignity, and self-determination" (Toro and Martiny 2020, p. 632). Indeed, regarding current patients as experts, and as co-regulators of participatory sense-making, is

one powerful way to strengthen their epistemic agency (i.e., their capacity to produce and share knowledge) and moral agency (i.e., their capacity to act and make choices). Specifically, it has potential to strengthen habits and skills (competencies) that undergird autonomous agency. My proposed account highlights the important sense in which autonomy is *relational*: individuals can develop and sustain their capacity for autonomy only insofar as they are embedded in a network of social relationships that scaffold and support their agency (Barclay 2000).

2. Patient Expertise, "Person-Centered" Care, and Reciprocity

The relationship between mental health care professionals and patients sometimes is understood in a relatively unidirectional or paternalistic way (Sandhu et al. 2015): professionals diagnose and make treatment decision, and the patient complies. The guiding idea is that professionals have specialized knowledge, training, and skills they can use to serve the best interests of patients. At the extreme, unilateral decision-making can lead to nonconsensual modes of treatment, such as involuntary hospitalization or forced medication. Whereas some view non-consensual treatment as morally permissible in cases where it preserves the best interests of patients and restores their autonomy, others emphasize that such treatment is likely to be ineffective and has the potential to undermine people's trust in mental health care. As a result, patients may under-report symptoms or avoid seeking treatment to avoid further restrictions on their freedom (Cherry 2010, p. 791).

Some theorists also have expressed concern that treatment decisions that don't take the patient's specific needs and preferences into account may violate their dignity (Pelto-Piri et al. 2013). Along these lines, Potter (2019) notes that the testimony of mentally ill persons may be discounted, dismissed, or utterly silenced; "testimonial quieting" occurs when a speaker's credibility as a knower is undervalued due to negative stereotypes or controlling images associated with mental illness. This counts as a form of "epistemic violence" insofar as it undermines individuals' ability to speak and be heard. If patients begin to doubt their own worth as well as their ability to make appropriate choices, their sense of themselves as capable, efficacious, and in control may begin to diminish (Houlders et al. 2021). Such considerations suggest that unilateral decision-making is not only a missed opportunity to gain a better understanding of patients' needs, but also can erode their sense of agency.

I aim to examine how incorporating patients' experiential expertise into decision-making processes can function as one important way to avoid such harms and promote their autonomy. But what do I mean by "expertise"? Dings and Tekin (2023) rightly note that the Expertise-by-Experience movement is complex, with a wide range of goals and orientations, and that experts-by-experience can contribute to mental health care at various levels (p. 3). At the macro level, they are involved in co-design of policy; at the meso level, they contribute to clinical guidelines; and at the micro level, they assist other patients with recovery and offer practical and emotional support (Castro et al. 2019). Here, I speak of the patient as an expert at the micro level and in a narrowly defined context, namely that of their own treatment. I will argue that viewing the lived experience of current patients as a form of expertise resonates with key aspects of so-called "person-centered care", yet places even greater emphasis on patient involvement and reciprocity. Again, note that this focus on current patients is at odds with the usual way of approaching things: theorists typically argue that *former* patients (those who have recovered from any epistemic or agential impairments associated with their mental illness) should be regarded as experts. In the concluding section, I address the concern that many current patients are ill-equipped to engage in participatory-sense-making because their capacities are impaired.

2.1. Experiential Knowledge and Responsiveness to Affordances

As noted already, my focus is on the agential benefits associated with patient involvement. Still, to support my claim that patients ought to serve as co-regulators of the interactions that take place in psychotherapy settings, I need to say more about the sort of special expertise that they possess. Such expertise consists partly in experiential knowledge: patients have (a) daily lived experience of living with a mental illness and managing associated difficulties, (b) experience in dealing with health care providers and health care institutions, and (c) experience in dealing with stigma or marginalization (Castro et al. 2019). They also are aware of how their illness impacts other aspects of their lives, such as their interpersonal relationships, how they are treated within the community, and others' reactions to their illness (Tekin et al. 2020). What is more, they understand how the scientific framing of their illness (e.g., their DSM diagnosis) affects the kinds of accommodations they receive in their jobs or in educational settings. Finally, those who have been successful in maintaining a good

quality of life and navigating their symptoms have a strong grasp of what sorts of material resources or social scaffolds they need to cope with their illness.

One important way that a patient's experiential knowledge differs from the professional knowledge of a mental health practitioner is that it is holistic: it encompasses the full phenomenon in the way that it is experienced by the person (Borkman 1976, p. 448). Mental disorder is a "psychobiological phenomenon" that involves phenomenological, behavioral, social, cultural, genetic, and neurophysiological aspects (Flanagan 2013, p. 866). Paying attention to the perspectives of patients is crucial to gain an understanding of these different aspects and their interplay (Tekin et al. 2020, p. 90). Whereas the professional is more theoretically and medically oriented and focused on symptoms commonly associated with a particular condition, the patient has a more immediate understanding of how these symptoms impact their daily life, relationships, and self-image. Experiential knowledge includes what Borkman labels the cathetic dimension, i.e., an individual's feelings about, and evaluation of, themselves and various aspects of their situation (1976, p. 448). These feelings and evaluations are an important part of what it means, for them, to be mentally ill, which may differ from the meanings commonly ascribed to their symptoms.

In addition to these more straightforwardly epistemic insights, patient expertise has an integral agential dimension. To make sense this, it is fruitful to adopt an affordance-based approach (Dings and Tekin 2023). Affordances are possibilities for action offered by the environment: chairs afford sitting, and knives afford cutting. Whereas the *landscape* of affordances is comprised of the entire set of affordances that are available to a particular agent in a given environment at a specific time, the field of affordances is the smaller subset of affordances offered by the environment that stand out as relevant for a particular agent in a specific situation (Rietveld and Kiverstein 2014). An agent's field of affordances is integral to how they experience the world and what they find meaningful. Which of the environment's available action possibilities take on relevance for an agent and become part of their affordance field has much to do with their specific interests, concerns, and desires. An agent's field of affordances changes in the context of disorder or treatment, as they navigate symptoms or move toward recovery.

Dings and Tekin (2023) maintain that the expertise that patients possess often is not a matter of knowledge in a propositional sense

(knowing-that), but instead consists in responsiveness to affordances, or a skill of navigating alterations in affordances, e.g., finding one's way in a world where one's field of affordances has become constricted due to symptoms or social stigma (Dings 2023). Coping skills then can be understood as a kind of know-how. Building on these ideas, it is reasonable to suppose that patients are directly acquainted with how their field of affordances is contoured and how this field contracts or expands depending on whether they are depressed or manic, for example. They are attuned to the way in which some affordances become especially inviting or salient, whereas others seem closed off or uninviting. What is more, they have past acquaintance with how some of the treatment methods that they have tried impact their ability to engage effectively with action possibilities, including those associated with work-related and social demands. This includes awareness of how the side effects of psychotropic medications impact their action possibilities. They also have a sense of what sorts of treatment interventions work well for them, in the sense that they expand their field of affordances, help them to gain a better "grip" on available affordances, or increase their sense that the affordances that solicit action truly reflect who they are (Dings 2018, p. 691).

One important benefit of this affordance-based approach is that it emphasizes a patient's lived experience of action possibilities and acknowledges that such experience can be highly variable across individuals with the very same diagnosis. After all, which of the many affordances a subject is responsive to in a particular situation (i.e., what invites or repels action) depends partly on their unique goals, concerns, needs, interests, and preferences. The affordances that take on relevance entail a degree of self-referentiality (Dings 2020, p. 60) in the sense that they relate to that specific individual. What is more, alterations to an affordance field that occur due to symptoms can impact different patients in different ways. There is not a singular or universal way in which depression, for example, disrupts a patient's engagement with affordances; and if someone has difficulty writing due to their symptoms, this will be far more disruptive for them if writing tasks are central to their career. Thus, what counts as an inability to gain a grip on affordances will be somewhat idiosyncratic. Likewise, what counts as an effective treatment or coping skill, one which facilitates engagement with relevant affordances, will differ somewhat across patients. Whether or not this sort of variability makes it difficult to attain objective knowledge in the context of scientific research or the development of diagnostic criteria (Tekin

2022), it is integral to devising an effective treatment approach for a particular patient.

2.2. Personalistic Care and Asymmetric Reciprocity

So-called "person-centered care" aims to create space for the expression of this sort of expertise. Rather than adopting a functional, disease-focused, biomedical approach that focuses simply on a diseased organ (i.e., the brain), it strives for a more holistic approach that acknowledges other biological, psychological, and social aspects. Central goals are to acknowledge, understand, and respect the perspective, abilities, desires, values, and complex life situations of individual patients. There also is recognition that individual health care professionals have a unique perspective that influences the provision of care. Person-centered care is relational and participatory rather than something that can be delivered unilaterally, from one person to another. Petterson and Hem (2011) note that "those who are absolutely sure what is the right thing to do, for themselves or others, have no reason to listen to others or bother to re-examine their own opinion" (p. 226). They may simply begin from a pre-established view of what they believe is in the patient's best interest. Person-centered care, in contrast, approaches care as something that arises in the specific interaction that takes place between persons in a particular sort of relationship; thus, those providing care need to pay attention and listen to the responses of patients, in part to know whether their care is well-received or effective.

Similarly, in their discussion of person-centered care, Toro and Martiny (2020) distinguish between a *functionalistic attitude* toward health care provision and a *personalistic attitude*. Someone who adopts a functionalistic attitude views a person's condition (e.g., the fact that they have depression) in functional terms, as a limitation, impairment, or disorder. The focus may be on a particular part of the body, such as the brain, which is not carrying out its proper function. Interaction between patient and professional becomes more transactional and scripted, with the professional carrying out tasks according to preconceived notions of how things should be done. What is more, professionals may be guided by stereotypes, preconceptions about illness and disease, and customary ideas about diagnosis and treatment. They may even think of the patient as a token of a general type, i.e., a generic person with condition x. When a mental health care practitioner adopts a personalistic attitude, in contrast, the extent and nature of the patient's involvement shifts. Practitioners view

the patient as a unique individual, take the time to read a patient's bodily cues, and are willing to improvise and shift course in response to patient input.

One central aspiration of person-centered care is reciprocity (rather than monologue and unilateralism). When there is reciprocal engagement, "interactors acknowledge that they both personally contribute with parts that are necessary for deciding how to accomplish the goal of the interaction" (Toro and Martiny 2020, p. 639), e.g., arriving at a treatment decision. This "implies moving from a perspective where only one person, either the professional or the patient, is the focus, to a dyadic relationship in which the focus is on the interaction" between them (Pelto-Piri et al. 2013, p. 7). In my view, viewing patients as experts helps to emphasize the unique contribution they can make to collaborative meaning-making, one which is just as important as the expertise of professionals. In the next section, I will argue that the notion of participatory sense-making helps to conceptualize what Toro and Martiny (2020) describe as "a dynamical and emergent process" of joint decision-making (p. 639).

However, to suppose that the patient has expertise is not to say that power differences can (or should) always be eliminated completely nor that professional boundaries should disappear in these encounters. Patients and mental health professionals do have different roles to play, and different contributions to make. Especially during phases when patients are severely impacted by symptoms or lacking in self-insight, the expertise of the professional may play more of a guiding role in decision-making. This has led some theorists to speak of reciprocity as *asymmetric* rather than symmetric. In cases of symmetrical reciprocity, there is a relation of reversibility: we adopt the perspective of the other person by "imaginatively representing their perspective to ourselves" (Young 1997, p. 342). However, some have argued that it's not possible to reverse positions, and that the attempt to do so may obscure the lived experience of difference. Rather than putting themselves in others' position, individuals tend to put themselves (with their own unique experiences and privileges) into the positions that they perceive others occupying. Too often, these imaginative projections involve the assumptions and solipsistic meanings of privileged groups. In the context of mental health care, such projections may end up reinforcing harmful stereotypes and preconceptions about what mental illness is and how it impacts people's lives (Molas 2018).

Asymmetric reciprocity, in contrast, aims to understand other persons across differences without identifying with the other or imag-

inatively occupying their position (Molas 2018). This approach emphasizes the importance of appreciating diversity and engaging with others on their own terms. Asking questions and listening attentively are important ways of admitting that one does not already know the other person's perspective and that one is curious and eager to understand them better. Professionals adopt a stance of humility, acknowledge the limits of their own understanding, and avoid speaking on their patients' behalf (Molas 2018). The notion of asymmetric reciprocity allows us to acknowledge that even though parties in the interaction are not epistemic equals, patients still make a distinctive and invaluable contribution. Actively involving patients in diagnosis and treatment decisions does not require a "like for like" exchange in terms of the resources provided or received, but instead, mutual recognition and respect for both persons' epistemic competencies and insights. This can allow for an *informed collaborative alliance* in which the patient acts as an active-informed contributor to their own care, and the professional acts as a facilitator (Badcott 2005, p. 177). Where there is shared deliberation, information is not simply an action from professional to patient, and consent is not simply an act from the patient toward the health care professional. Care provision is professionally-guided (rather than professionally-dictated) and dynamic (rather than static). In such exchanges, "care appears as tinkering, dealing with the messiness and quirkiness of everyday life, in our relationships with the world, others, and self, over time" (Baklien and Bongaardt 2014, p. 630).

3. *Sense-Making and Autonomy*

One theme that emerges from existing work on "person-centered" care is an emphasis on asymmetric reciprocity and the importance of forming a collaborative alliance. In the next section, I will argue that the enactivist notion of participatory sense-making can help us to make sense of the dynamics of these reciprocal interactions.

But first, to explain the enactivist notion of participatory sense-making, I need to unpack associated notions of sense-making and autonomy. While standard approaches in cognitive science conceptualize cognition as computational information processing that is carried out by the brain, enactivism characterizes cognition (sense-making) as fundamentally relational, environmentally situated, and intricately bound up with the dynamics of living organisms. An enactive agent does not passively receive information and then form an internal representation of things in their surroundings, but rather plays an

active role in gauging the meaning and importance of environmental stimuli. In a basic biological sense, the enaction of meaning has to do with survival and adaptivity; and among humans, adaptive sense-making also concerns "faring well" in a particular socio-cultural setting. What an agent perceives, and which action possibilities are disclosed, is partly a matter of what exists in the world, and partly a function of their bodily structure, capacities, and interests.

The notion of biological autonomy, understood in terms of self-production and self-maintenance, is integral to the enactivist approach. Di Paolo (2009) defines an autonomous system as "a system composed of several processes that actively generate and sustain an identity under precarious circumstances" (p. 15). It has the capacity to regulate and control both its own internal, self-constructive processes, as well as its processes of exchange with the environment. A living organism is autonomous in the sense that is self-organized and self-sustaining; it is "constituted as a network of interdependent processes, where the behavior of the whole emerges from the interaction dynamics of its component parts in a self-organized [. . .] manner" (Barandiaran 2017, p. 411). Autonomous agency occurs when this living system regulates its coupling with its environment according to norms of adaptivity, to ensure its continued existence and well-being.

3.1. Sensorimotor Autonomy and Habit

Some enactivists have proposed that self-production and self-maintenance also are operative at a higher level of organization that involves sensorimotor patterns. So-called *sensorimotor autonomy* centrally involves the nervous system and can be understood in terms of the formation of dynamic neurobiological and sensorimotor patterns (i.e., *habits*). Repeated enactments of a particular movement result in neurobiological and sensorimotor patterns that are self-sustaining and self-reinforcing: the more frequently a pattern of behavior is performed, the more likely it will be repeated in the future (Egbert and Barandiaran 2014, p. 3). The exercise of a habit reinforces its durability and causes it to become more sedimented in the body. Elements that support a habit, such as muscular dispositions and neural connectivity patterns, become more ingrained via repeated enactment. However, habits also are precarious in the sense that their supporting elements become unstable if they are not exercised frequently enough. Elsewhere, I have argued that habits encompass not just sensorimotor patterns and overt movement, but also coordi-

nated *patterns of attention* (Maiese 2022b). Such patterns comprise
an individual's characteristic cognitive-affective orientation and their
customary tendencies to interpret themselves, others, and the world
in specific ways.

Over the course of learning and ongoing interaction with their
social world, human agents become selectively attuned to specific as-
pects of their surroundings and begin to exhibit recurring patterns of
bodily expressivity, engagement, and response. These "nested com-
plexes of sensorimotor coordination patterns, entrained by a history
of subtle self-reinforcement" (Egbert and Barandiaran 2014, p. 1)
comprise sets of structured habits that allow agents to engage fluidly
and meaningfully with their environment, often without the need for
high-level deliberation or reflection. Once these structured behaviors
become integrated with other sensorimotor structures and are enacted
repeatedly for the sake of achieving goals, we can begin to speak of
skills.

It is important to highlight that enactivists conceptualize habits
in an organic way, as self-sustaining, highly integrated configurations
that are also quite dynamic. Habits inherently oscillate between sed-
imentation and spontaneity —between stability and plasticity. On
the one hand, habits are stable in the sense that they involve built-
up, engrained patterns of behavior and response. Stabilized habits
and skills operate as methods for guiding and controlling the agent's
interactions and allow for synergies of meaningful movement and
bodily know-how. On the other hand, habits are flexible in the sense
that they are susceptible to ongoing development and change.

Elsewhere, I have argued that this dual stability and plasticity of
habit is central to the autonomy of human agents (Maiese 2022a).
While the term "autonomy" has taken on many different meanings
in the philosophical literature on action and agency, these various
accounts of what it means to be self-determining share some com-
mon themes. First, autonomy is widely understood in terms of a
capacity to guide one's life from one's own perspective, and to act
in ways that genuinely express one's cares and concerns (Frankfurt
1988). Second, many accounts emphasize that autonomous agency in-
volves responsiveness to changing circumstances; to exercise control,
an agent must be able to shift course and modify behavior (Weimer
2013). In my view, the notion of habit helps to make sense of the way
in which autonomy involves both stability (in the sense that an agent
maintains their neurobiological organization or structure), and plas-
ticity (in the sense that associated patterns can be extended, modified,

or developed). First, the stability of habit allows for *authenticity* and
the formation of *character*, making it possible for agents to com-
mit themselves to long-term activities and direct the course of their
lives in accordance with relatively stable concerns and commitments.
Second, the flexibility of habit allows for *reasons-responsiveness* and
effective control. Rather than being a mere triggered response to
stimuli, autonomous action is *guided*, *selectively targeted*, and re-
sponsive to relevant considerations and environmental contingencies.

Social-relational factors are central to habit formation and
meaning-making, which always are situated within a particular so-
ciocultural environment and depend on social interaction. As indi-
viduals learn how to use various tools and develop linguistic sen-
sitivities well-suited for particular social contexts, neurobiological
configurations and coordinated behavioral patterns form and take
root. Thus, just as biological processes of self-maintenance depend
on energetic resources, the formation and maintenance of habits de-
pends on social resources. To make sense of the dynamics that occur
when two or more human agents jointly engage in meaning-making,
De Jaegher and Di Paolo (2007) introduced the term "participatory
sense-making"; it involves "the coordination of intentional activity in
interaction, whereby individual sense-making processes are affected
and new domains of social sense-making can be generated that were
not available to each individual on her own" (p. 497). This "co-
ordination" involves the non-accidental correlation between two or
more agents, so that their behavior matches to a degree far beyond
what is expected given what those agents can do. Once two or more
interactors are part of a coupled system, their expressions, behaviors,
and bodily dynamics modulate those of the other person(s) and their
habits and patterns of bodily attunement may begin to resonate.
Instances of coordination include synchronization, mirroring, antic-
ipation, and complementary movement. For example, consider the
infant who reduces their smiling and gazing, and then attempts to
re-engage their social partner via smiling and vocalizing (Striano and
Reid 2006).

This sort of reciprocal bodily attunement and mutual modulation
grows more complex over time as human agents develop a range of
projects that require them to communicate with others and exchange
information. Through this coordination of activity and the mutual
modulation of sense-making, participants sometimes can develop new
insights (De Jaegher and Di Paolo 2007). Processes of joint cognition
such as group brainstorming sessions, for example, involve highly co-
ordinated interaction in which many actors participate and there are

fluid patterns of communication and response. As a result of this intertwining of sense-making, participants sometimes gain a completely new vantage point on a problem or interpret results in novel ways. As we will see, participatory sense-making in psychotherapeutic settings can help participants to cultivate important habits and skills that undergird the exercise of autonomy.

3.2. Individual Autonomy v. Interactional Autonomy

To see how this sort of habit development occurs, we need to examine the interplay between individual autonomy and interactional autonomy that takes place during participatory sense-making. Whereas individual autonomy involves organic autonomy and sensorimotor autonomy (i.e., the habits of each participant), interactional autonomy results from the enduring patterns that self-organize and sustain the interactive encounter (Di Paolo, Cuffari, and De Jaegher 2018, p. 180). Colombetti and Torrance (2009) note that social interactions have their own complex dynamics, norms, and momentum. The way that an interaction unfolds both affects, and is affected by, the autonomous behavior of each of the individual participants as well as the behavioral patterns that characterize the interactive encounter. There is one sort of "interactive order" associated with family interactions, another associated with workplace interactions, and yet another associated with therapeutic settings. While the participants do remain autonomous, separate agents, the interaction process as a whole has its own properties that constrain and modulate each person's patterns of behavior and attention (De Jaegher and Di Paolo 2007, p. 493). On the one hand, now that they are "components" of a larger system, individual participants are extremely unlikely to do certain things (such as abruptly disengage without explanation). On the other hand, because the relational whole has a qualitatively different repertoire of states and behaviors, it has greater potential than the previously uncoordinated "parts".

For example, consider how, during a game of charades, all the participants must adjust their sense-making so that it converges towards the "right" gesture and the "right" interpretation. They jointly regulate their mutual coupling and follow interactive norms that pertain to that specific interactive situation (Di Paolo et al. 2018, p. 188); and they are sensitive to breakdowns and jointly attempt to recover them. Via the perception-action loops of the various players, the meaning of gestures is collaboratively constructed over the course of the game. Still, it remains possible to individuate each of the

participants and differentiate them from the social interaction that is unfolding. Participatory sense-making presupposes and requires autonomous interactors who can opt to partake in the interaction process in accordance with social norms, defy these expectations, or even disengage from the social interaction altogether. In the case of charades, for example, it must remain possible for each individual participant to leave the room, break the rules, or even refuse to continue playing the game.

However, if one of the participants does refuse to play, this signifies a breakdown in interactional autonomy and puts an end to that participatory interaction. This reveals the "primordial tension" at the core of participatory sense-making, which Di Paolo, Cuffari, and De Jaegher (2018) describe as a tension between an individual order and an interactive order. Whereas an individual agent acts and makes sense in accordance with their embodied habits of behavior and attention, an enactment of specific habits and behaviors may be in tension with the autonomous relational dynamics of the encounter. For example, an action, utterance, or gesture that unilaterally advances the goal of one agent might frustrate the interactive dynamics. Alternatively, one agent may orchestrate the social encounter so that it moves along a pre-defined track (Di Paolo et al. 2018, p. 187). This might involve one agent taking complete control of the way that the interaction unfolds, without giving the other agent an opportunity to act as a co-regulator. Balancing interactional and individual autonomy, in contrast, is a matter of co-regulating the interaction, and requires that each agent regulate their own participation. We can speak of a truly participatory interaction only if (i) there is co-regulation at the level of interaction dynamics that takes on an autonomous organization, and (ii) the autonomy of each individual participating in the interaction is not destroyed in the process (De Jaegher et al. 2016).

In some cases, participants enjoy a kind of synergy. Each agent's actions, utterances, gestures, etc., are in line with their intentions, skills, and sensitivities and expressive of their habits (thereby preserving their individual autonomy), and also aligned with those of the other participant. What is more, the autonomy of the interaction is preserved, so that it continues to modulate the sense-making of each participant. Although interaction processes do involve asymmetries due to the ebbs and flows of mutual regulation, these regulating processes continue to flow back and forth between the agents. For example, in some cases, one participant may take on the role of storyteller, while another participant is regulated as a listener. However,

so long as there is mutual recognition of one another's subjecthood and agency, participants can "jointly ratify one another as authorized co-sustainers of a single, albeit moving, focus of visual and cognitive attention" (Goffman 1964, p. 134). Participants' behaviors become coordinated through this mutual immersion in the interaction, and no single participant has total, isolated control over their own behavior, the other's behavior, nor the unfolding interaction.

However, dissonance is an inevitable feature of interpersonal interaction; this is directly connected to (i) the primordial tension between individual autonomy and interactional autonomy, and (ii) the fact that dyadic interaction involves two "centres of gravity" that continually oscillate between activity and receptivity, or "dominance" and "submission" (Fuchs and De Jaegher 2009). Such tensions can lead to awkward or convoluted behavior on the part of individual agents or a lack of behavioral coordination. In some cases, dissonance or breakdown occurs due to *over-determination*. For example, one participant may attempt to force the other into a particular epistemic frame, by applying a label or operating with a stereotype. Along these lines Fourlas and Cuffari (2022) note that "at the level of direct interpersonal encounter, participants sometimes, even habitually, interact with objectifications, mythologies, and projections rather than actual, contradictory, idiosyncratic others" (p. 356). As a result, meaningful social interaction is replaced by "a stubborn maintaining of solipsistic meanings" (p. 361). One participant occupies the role of regulator in a sustained way and effectively takes control over the sense-making involved in the encounter. However, dissonance can occur even in cases where the intentions and sensitivities of both agents are aligned, but the interactive patterns at play frustrate those intentions (Di Paolo et al. 2018, p. 184). For example, two people may have a recurring argument even when each of them resolves not to let that happen again. In some cases, interactive dissonance is experienced as discomfort or difficulty in the flow of sensorimotor engagements rather than major frustration. Nonetheless, if such dissonance is sustained, interactions eventually break down. Utterances, gestures, or other actions that restore synergy and allow the participants to overcome dissonance effectively assert both individual agency and interactive engagement.

It is precisely via the process of overcoming dissonance and navigating potential breakdowns that the participatory labor of "(re)creating sense" takes place (Di Paolo et al. 2018, p. 184). By way of clarification, accommodation, and the reorienting of attention, participants can generate shared forms of meaning-making, knowing, and

relating. Fourlas and Cuffari (2022) describe linguistic interaction as a matter of *becoming* and emphasize that the autonomy of human agents is open, unfinished, and inherently oriented toward acting in relation to others (addressing others, getting into conflict with others, or collaborating with others). These theorists suggest that interaction participants must be themselves, and yet also be ready to be changed by the interaction. I propose that the "becoming" that occurs in the context of social interaction and dialogue should be understood as a matter of habit development, modification, and transformation. In section 5, I will say more about how engaging in participatory sense-making facilitates habit formation and allows interactors to develop new skills, sensitivities, and know-how that are central to the exercise of autonomy.

4. *Participatory Sense-Making in Therapeutic Settings*

How can the interactive dynamics involved in (a) participatory sense-making, and (b) negotiating the tension between individual autonomy and interactional autonomy, help to shed light on what occurs during constructive therapeutic encounters? I argue that these enactivist ideas help to conceptualize key elements of "person-centered care" and what some theorists have described as "tinkering". What is more, these ideas shed light on the "over-determination" that can occur when treatment decisions are made more unilaterally or imposed in a paternalistic fashion.

   My proposed account builds on the work of Gallagher and Payne (2015), who describe the dialogue between therapist and patient as "a joint action that requires coordination, i.e., where the activity evolves in sequences of turn-taking and perception-action loops" (p. 75); this means that clinical reasoning is not just in the head of the therapist, but instead involves both patient and professional. In many cases, this will involve spoken words and back-and-forth verbal dialogue. However, this sort of joint reasoning does not necessarily require that the patient make explicit suggestions or recommendations; rather, the patient's embodied responses and emotional expressions can contribute to the reasoning process. These nonverbal cues help to communicate patients' awareness of changes to their affordance space that have occurred due to symptoms or stigma, or in response to particular treatment methods. Decision-making occurs partly via a meeting of eye gaze and gesture as the therapist interacts with the patient and feels resistance or accommodation; via "mutual enactive coupling" that involves joint attention and joint action, they

engage (together) in clinical reasoning and sense-making (Gallagher and Payne 2015, p. 73).

Here, I aim to take a closer look at the dyadic interaction between therapist and patient whereby they jointly regulate their mutual coupling, sustain the dialogue, and engage in collaborative interpretation. They often do so by taking "dialogic turns": the person taking a turn regulates the sense-making and orients the attention of the other participant, and their verbal utterance or gesture "creates and projects a space of meaningful responses, reactions, and rejoinders" for the other agent to take up (Di Paolo et al. 2018, p. 223). This is followed by responses, follow-ups, contradictions, requests for clarification, or attempts at interpretation. For example, one participant may repeat an utterance and thereby bring it to shared attention as a possible object of regulatory action. Reported utterances often are refractions of the original phrase or statement and take the shape of a commentary. They include simple repetitions as well as modified, abbreviated, or extended repetitions that seek to aid the interpretive process (Di Paolo et al. 2018, p. 240). For example, a therapist might ask the patient, "earlier you said that you don't think that cognitive-behavioral therapy will work for you; why not?" Or, a patient might ask, "you say that medication has helped me in the past; but have you considered that because SSRIs cause me to gain weight, they are worsening some of my symptoms?" Repeating an utterance brings it to shared awareness and thereby makes it a possible focus for interrogation. The participant who authored the reported utterance may attempt to return to their previous statement by repeating a point they made previously, clarifying what they said, or modifying it (Di Paolo et al. 2018, p. 242). This give and take also encompasses reciprocity at the bodily level, in the form of gaze direction, gestures, and facial expressions (Gallagher and Payne 2015).

Just as a patient's habits of behavior and attention may shift in response to the therapist's comments, questions, facial expressions, or gestures, the therapist's outlook on diagnosis or treatment may shift over the course of the dialogue. As the interpersonal encounter unfolds, a myriad of new understandings can emerge and take shape. In some cases, there may even be questioning of the normative structure that frames the interactive encounter. Di Paolo, Cuffari, and De Jaegher (2018) note that dialogues are always potentially *meta-dialogues*; participants can question and critique the norms and expectations that structure social interaction (p. 243). When a medical framing of mental illness is adopted uncritically in psychiatric settings, this can reinforce accepted "truths" about what it means to

be mentally ill. However, recent developments in neurodiversity and
Mad Pride suggest that many individuals with psychiatric diagnoses
do not understand their condition in medical terms. As active par-
ticipants in dialogues with professionals, patients can question this
medical framing of mental illness and thereby put pressure on the
norms that structure the "interactive order" of many mental health
care settings.

In my view, the notion of participatory sense-making helps to
unpack the interpersonal dynamics associated with what Toro and
Martiny (2020) describe as a "personalistic" mode of care. Recall
that such care acknowledges the need for holistic treatment and
emphasizes that the patient's experiential perspective needs to be
incorporated into the decision-making process. Likewise, it recog-
nizes that the therapist has a particular life history and a unique
perspective that influences the provision of health care. Truly par-
ticipatory sense-making is reciprocal rather than being a scripted,
unidirectional activity or something that simply can be transferred
from mental health practitioner to patient. Key elements are reci-
procity and mutual recognition, with each participant (both patient
and professional) being modulated by the contributions of the other
person. This allows for a kind of interactive "dance" to occur.

What Gibson and colleagues (2020) call "tinkering" is a flexible,
experimental approach to health care that centers around uncertainty
and humility and involves a continuous questioning of what to do
and how to do it. It involves reading others' body language, reading
situations, listening to what others say (and don't say), and inter-
preting expressions of doubt. For example, a therapist might invite
a patient to reflect on their past experience with a particular inter-
vention (e.g., journaling) or try out a particular treatment method
(e.g., exposure therapy) but sense resistance or defensiveness via the
patient's spoken utterances, intonation, facial expressions, posture,
or other aspects of bodily expressiveness. These sorts of bodily cues
may indicate a need to take an alternative approach or adjust the
treatment plan. What is more, because the effectiveness of a particu-
lar treatment approach may vary over time, goals and priorities need
to be negotiated and renegotiated. During the early part of an acute
episode, the mental health practitioner may need to take on more of
a regulator role and assume more control in guiding the interaction.
However, as clients are increasingly enabled, the balance of control
and decision-making can and should shift toward a greater degree of
patient involvement. In some cases, the best thing to do will be to
allow patients to pursue a mode of treatment that, in the opinion of

the mental health practitioner, is not in their best interest. However, trying out a particular treatment strategy that ultimately proves to be ineffective is part of the tinkering process. Once a decision has been implemented, the patient and professional evaluate it together after some time has passed and shift course if needed. This sort of "tinkering" allows for dynamic, improvisational participatory sense-making to unfold.

Crucially, such encounters involve a balance between individual autonomy and interaction autonomy. Because participants cannot communicate with each other unless there is space differentiating them and across which they communicate (Young 1997, p. 352), the autonomy of the individual agents needs to be preserved and there needs to be a recognition of each participant's distinct perspective and expertise. When there is reciprocity, participants take turns adopting the regulator role; they both recognize the other person and experience being recognized by them. Again, reciprocity does not require that each participant contribute equally, whether in degree or in terms of the kinds of knowledge provided. However, it does require that the patient be viewed as a co-contributor and a co-regulator. Reciprocal recognition allows the participants to become aware that their acts may conflict or be aligned with the intentions or point of view of the other person. Such recognition also involves a sensitivity to the sort of dynamics that might lead the interaction to break down. When therapist and patient jointly regulate their mutual coupling, are sensitive to dissonances and potential breakdowns, and jointly attempt to overcome them to sustain the encounter, this preserves interactional autonomy. During therapeutic encounters where there is "critical participation" (Di Paolo et al. 2018), neither professional nor patient assumes complete control over how the encounter unfolds. Instead, there is "an enhancement of inclusive and reflexively engaged participation for all participants and on their own terms" (Fourlas and Cuffari 2022, p. 357). In the next section, I will say more about how such encounters have the potential to promote autonomy.

5. *Relational Autonomy and Social Scaffolds for Self-Determination*

There is evidence that the quality of a therapeutic relationship is linked to mental health outcomes (Martin et al. 2000), and various theorists have outlined the harms associated with lack of recognition and denial of agency in mental health care settings. In a study

conducted by Bacha and colleagues (2020), for example, patients reported that when they felt that knowledge about their condition and treatment was withheld from them, they experienced the mental health system as disempowering and dehumanizing. One participant reported that her experience in hospital was like reliving the loss of control she felt when she was abused as a child (Bacha et al. 2020, p. 376). When a patient or their symptoms are viewed as objects for medical investigation, or a professional dominates an encounter and gives little or no "uptake" to a patient's experiential knowledge, the interaction that takes place is more like someone interacting with an object rather than another subject (Di Paolo et al. 2018, p. 102). Examples of domination that sometimes occur in mental health settings include surveillance, micro-management, and authoritarian coercion to ensure patient compliance. Alternatively, a professional may simply fail to listen to a patient's input or perspective. As a result of being repeatedly dismissed or silenced, patients may begin to doubt their ability to make appropriate choices and their sense of self-efficacy may be diminished. This is connected to the fact that a person's socially recognized self-image, and their sense of themselves as a competent agent, depend significantly on interactional recognition and validation (De Jaegher et al. 2016).

Along these lines, Di Paolo, Cuffari, and De Jaegher (2018) note that if someone adopts the regulator role in an ongoing and sustained way, this can diminish the autonomy of their interaction partner. They describe a "strongly normative act" as one that dictates the sense-making of another participant and limits their options rather than achieving consensual coregulation. For example, if someone shouts, "Don't do that!" there is a kind of temporary high-jacking of another person's sense-making. This command orients the other agent's attention and can be understood as an attempt to put a social interaction under the control of a single agent. In my view, the unilateral imposition of diagnostic labels or treatment decisions by health care professionals likewise can be understood as strongly normative acts. In effect, the professional forcefully regulates the encounter and issues a proclamation ("You have borderline personality disorder") or a command ("take this medication"). Or, if a patient's input does not have very much impact or solicit much attention, this can contribute to less extreme regulation role imbalances. Being dismissed, silenced, or otherwise excluded from decision-making can contribute to "harms of recognition" (Brancazio 2020) and erode a patient's sense of agency.

Conversely, available evidence suggests that patients who share in decision-making have a heightened sense of responsibility and commitment regarding treatment and better therapeutic compliance (Badcott 2005, p. 177). McCann and Clark (2004) found that one crucial element that increases self-determination among young adults with schizophrenia is participatory involvement in decision-making about their care. Similarly, Nelson (2003) proposes that empowerment and gaining control over one's life encompasses decision-making power, access to information and resources, a range of options from which to make choices (not just yes/no, either/or), and the development of confidence and optimism regarding the possibility of recovery (p. 188).

Building on these ideas, I argue that treating a patient's experiential insights as a form of expertise, and as crucial inputs to the process of participatory sense-making in therapeutic settings, is one powerful way to help them to develop competencies that undergird autonomy. By way of participatory sense-making, subjects can develop know-how that enables "more sophisticated ways of being and thinking that are indeed liberty-inducing" (Matthews 2017, p. 404) and expand their affordance field. This discussion reveals the fundamental *relational* dimension of autonomy. Insofar as "our ongoing success as an autonomous agent is affected by our ability to share our ideas, our aspirations, and our beliefs in conversation with others", autonomy competency is a debt that we owe to other people (Barclay 2000, p. 57). A focus on relational autonomy moves us away from a one-sided approach that views either the mental health professional or the patient as an independent decision-maker.

The notion that autonomy is relational builds on the idea that human sense-makers are *co-constituted* via their participation and engagement and that there is a tension between individual autonomy and interactional autonomy. However, if this tension is navigated and negotiated in a constructive way, the autonomy of both the individual agents and the interaction can be preserved and they can develop new habits, skills, and know-how. Thus, the practices associated with participatory sense-making are at the same time practices of identity building (Di Paolo et al. 2018) that help participants to develop various autonomy competencies. Although the autonomy of both professional and patient can be strengthened, I focus here on the benefits for patients.

First, participatory sense-making cultivates habits of *grounded reasoning*. Whereas a person who is intuitively related to their values,

feelings, and beliefs has a habit of reacting immediately and with-
out self-reflection, grounded reasoning centrally involves reflecting
upon one's values, feelings, and evaluative beliefs and examining
whether these attitudes are warranted. This demands that the agent
acknowledge and consider external forms of information that may
challenge or undermine their existing beliefs and values. When a
therapist asks a question, this orients the patient's attention toward
self-interrogation. To respond, they need to make their feelings, atti-
tudes, and beliefs more explicit. For example, a clinician might urge
a patient to express why they think a particular treatment would
not work well for them, given their specific symptoms or unique life
situation.

Second, participatory sense-making can help patients to develop
thinking habits that are more integrative. People who exhibit in-
tegrative thinking recognize complexity, revise their evaluative as-
sessments in response to new evidence, and see interrelationships
between different aspects of their lives. Along these lines, Tekin
(2014) characterizes self-insight as a patient's understanding of four
components of their lived experience: (i) personal identity, (ii) puz-
zling mental states/symptoms, (iii) interpersonal relationships, and
(iv) the relationship between these three components. By way of in-
tegrative reasoning, patients may come to understand, for example,
how the distress they are experiencing is caused partly by workplace
stressors or aspects of their partner's personality and behavior. Such
understanding can contribute to self-insight and help them gain a
sense of what "getting better" means for them. In contrast, someone
who approaches their illness in a more fragmented way might focus
entirely on symptoms and find it difficult to discern how they relate
to other facets of their lives.

Third, participatory sense-making cultivates habits of perspective-
taking. Rather than using their position of privilege to create further
distance between themselves and their patients, the professional en-
deavors to understand the patient's perspective. This involves asking
questions, listening, and taking a genuine interest in patients' life ex-
periences and concerns. The patient, in turn, tries to understand the
perspectives of mental health care professionals and considers their
specialized knowledge and expertise, including what they know about
the efficacy of available modes of treatment. As the professional and
patient each take their "dialogic turn", they orient the other agent's
attention toward an alternative way of viewing the situation. Viewing
things from the perspective of another provides an opportunity for

someone to re-examine their own outlook, allow the viewpoints of others to shape their understanding, and possibly question their image of reality. Petterson and Hem (2011) describe a patient named Tor, who is willing to listen to input from his psychiatrist, consider their outlook on treatment, and modify his own perspective in response (p. 223). This allows for a kind of intersubjective responsiveness that Westlund (2009) suggests is crucial for autonomy. Listening and perspective-taking can allow participants to engage in critical investigation of each other's point of view and become more responsive and attuned to relevant considerations.

Relatedly, participatory sense-making cultivates habits and skills associated with self-regulation. The recognition of another person's autonomy that occurs in reciprocal engagement "involves not only a sensitivity toward others, but a new kind of sensitivity to one's own effect on the interaction dynamics; the incorporation of a new interactive skill of taking others into account" (Di Paolo et al. 2018, p. 220). To sustain the dialogic encounter and address any misunderstandings that arise, the patient will need to adopt an interpretive stance on what they are saying, how they are behaving, and what sorts of feelings they are expressing. This sort of active interpretation will invite reasons-responsive changes to their own utterances, expressions, and feelings, i.e., efforts to self-regulate. Insofar as modifying how they behave and contribute to the interaction requires that they regulate their own thoughts and feelings, there is an important connection between self-regulation and interactive regulation (De Jaegher et al. 2016).

In addition, participatory sense-making allows for the development of self-narration skills, which encompass linguistic habits and habits of introspection. Via participatory sense-making and ongoing co-regulation of dissonance, a patient and therapist can co-construct a narrative that makes sense of the interrelationships between their symptoms, experiences, and interpersonal relationships. In addition to promoting self-insight and honest self-assessment, this co-constructed autobiographical narrative has the potential to expand their sense of agency. For example, if they can construct a narrative that highlights how they have overcome adversity in the past, they may begin to see themselves as resilient, as capable of navigating their mental illness. Or, if the narrative reveals how various hobbies or personal relationships have contributed to their well-being, this can make action-possibilities associated with those pursuits seem more salient. In some cases, patients begin to tell a story about themselves that focuses on their future and involves them moving forward and

gaining more control over their lives. This can help them develop a sense of what they want and what "getting better" means for them.

Part of recognizing a wide array of options is the ability to imagine things otherwise and to envision a possible future that differs in important ways from the past. Exercising autonomy is partly a matter of being "able to adapt to changing environments, to imagine alternative possibilities, to take necessary steps to change (unlucky) situations" (Baumann 2008, p. 460). Participatory sense-making potentially creates opportunities for this sort of imaginative endeavor. For example, when a therapist asks, "have you considered the possibility that...?" this orients the patient's attention toward options they may not have considered. To respond to the therapist's question, they will need to consider this possibility and imagine what that possible future might look like. When done repeatedly, this can allow patients to build up habits and skills associated with openness, cognitive flexibility, and imagination.

Lastly, just as lack of involvement may make patients feel that their contributions are worthless or lack credibility, being an active participant in the conversation can make them feel that their contributions have importance. When a patient's experiential knowledge is regarded as a source of expertise, this can help them to build a sense of self-efficacy and self-trust. Specifically, engaging in participatory sense-making has potential to strengthen a client's confidence in their beliefs, their sense of their own competence as an epistemic agent, and their ability to engage in truthful conversation. And because the exercise of autonomy depends partly on an agent's ability to trust their capacity to make choices, act on their decisions, and assess the values and motivations that drive these decisions (McLeod and Sherwin 2000 p. 262), these feelings of confidence and self-trust can promote autonomous agency.

6. *Conclusion*

I have argued that involving current patients in decision-making and treating their experiential knowledge as a source of expertise can allow for collaborative meaning-making —a form of *participatory sense-making*— to occur. In my view, enactivist conceptions of reciprocal engagement, autonomy, and habit shed light on why being an active participant in diagnosis and treatment decisions helps to advance self-determination and promote the development of autonomy competencies among patients. Because collaborative dialogue allows for the stabilization of new habits and skills, it can

foster self-reflection and self-insight, promote integrative reasoning and perspective-taking, and cultivate self-efficacy. Indeed, emphasizing the involvement of patients and treating them as a source of expertise is one powerful way to make mental health practices more empowering.

One obvious and important objection to my argument is that because people with severe mental illness often exhibit impaired rational abilities, they lack the ability to engage in participatory sense-making and it makes little sense to include them in decision-making. At the extreme, if a patient wishes to decline life-saving care, respecting their autonomous choice may have terrible consequences, i.e., result in death. Thus, if a patient's autonomy is seriously impaired, the best thing to do may be to impose treatment unilaterally, to safeguard their well-being and restore their capacity for autonomous decision-making. However, the biological grounding of autonomy under enactivism may go some way in addressing this objection. After all, since biological autonomy is one key value, efforts to preserve patients' lives and basic well-being may be warranted even if these measures override their wishes. What is more, it is important to highlight that this objection rests on a highly individualistic understanding of autonomy, according to which respect for autonomy requires granting a patient the opportunity to decide for themselves, even if this decision goes against what professionals believe is in their best interest. Upholding autonomy, on this view, demands that health care professionals respect a competent and well-informed patient's right to accept or refuse treatment (Pelto-Piri et al. 2013).

However, once we conceptualize autonomy in relational terms, we see that it should not be understood as a matter of making decisions and executing action plans entirely on one's own. Instead, the guiding idea is that patients contribute to the collaborative process whereby decisions are made. Although they may not possess all the features associated with fully autonomous, self-governing rational agency, they usually do possess features that render them capable of some forms of meaningful communication (Lillehammer 2020). Even though patients do encounter cognitive and affective difficulties, most are still able to appreciate the benefits, risks, and discomforts that can reasonably be expected from various modes of treatment (Cherry 2010, p. 793). Rationality and decision-making competency come in degrees, and local failures of rationality may not have implications for someone's overall capacity for rational decision-making (Houlders et al. 2021). What is more, the capacities that agents do possess can be scaffolded and supported by a clinician. Some theorists conducting

research studies involving subjects with mental illness have found
that with careful implementation of procedures to provide critical in-
formation, even psychotic patients are able to comprehend and retain
information needed for informed consent (Wirshing et al. 1998). If
such procedures can enable those with mental illness to participate
in research studies, couldn't similar efforts be made to support their
role as active co-regulators of participatory sense-making?

It is true that whereas health care professionals have undergone
formal, supervised training and examination before being licensed
to practice, most patients do not possess sufficient physiological and
pharmacological knowledge to fully appreciate the biological nature
of their illness. However, even if professionals have more to con-
tribute than patients who are severely lacking in self-insight, "more"
does not mean "all". Even in emergency situations where coercive
measures are called for (to save the life of a patient), it remains
important to talk to the patient and involve them in participatory
sense-making to whatever extent possible. Such involvement offers
a powerful way to promote their self-insight and strengthen their
ability to exercise autonomy.

REFERENCES

Bacha, Karin, Terry Hanley, and Laura Anne Winter, 2020, " 'Like a
    Human Being, I Was an Equal, I Wasn't Just a Patient': Service Users'
    Perspectives on Their Experiences of Relationships with Staff in Mental
    Health Services", *Psychology and Psychotherapy: Theory, Research and
    Practice*, vol. 93, no. 2, pp. 367–386.

Badcott, David, 2005, "The Expert Patient: Valid Recognition or False
    Hope?", *Medicine, Health Care Philosophy*, vol. 8, no. 2, pp. 173–178.

Baklien, Børge, and Rob Bongaardt, 2014, "The Quest for Choice and the
    Need for Relational Care in Mental Health Work", *Medicine, Health
    Care, and Philosophy*, vol. 17, no. 4, pp. 625–632.

Barandiaran, Xabier, 2017, "Autonomy and Enactivism: Towards a Theory
    of Sensorimotor Autonomous Agency", *Topoi*, vol. 36, no. 3, pp. 409–
    430.

Barclay, Linda, 2000, "Autonomy and the Social Self", in Catriona Macken-
    zie and Natalie Stoljar (eds.), *Relational Autonomy: Feminist Perspec-
    tives on Autonomy, Agency, and the Social Self*, Oxford University
    Press, New York, pp. 52–71.

Baumann, Holger, 2008, "Reconsidering Relational Autonomy: Personal
    Autonomy for Socially Embedded and Temporally Extended Selves",
    Analyse & Kritik, vol. 30, pp. 445–468.

Borkman, Thomasina, 1976, "Experiential Knowledge: A New Concept for the Analysis of Self-Help Groups", *The Social Service Review*, vol. 50, no. 3, pp. 445–456.

Brancazio, Nick, 2020, "Being Perceived and Being 'Seen': Interpersonal Affordances, Agency, and Selfhood", *Frontiers in Psychology*, vol. 11, 1750.

Castro, Eva Marie, Tine Van Regenmortel, Walter Sermeus, and Kris Vanhaecht, 2019, "Patients' Experiential Knowledge and Expertise in Health Care: A Hybrid Concept Analysis", *Social Theory & Health*, vol. 17, pp. 307–330.

Cherry, Mark J., 2010, "Non-Consensual Treatment is (Nearly Always) Morally Impermissible. Conundrums and Controversies in Mental Health and Illness", *Journal of Law, Medicine, and Ethics*, vol. 38, no. 4, pp. 789–798.

Collins, Harris M., and Robert Evans, 2002, "The Third Wave of Science Studies: Studies of Expertise and Experience", *Social Studies of Science*, vol. 32, no. 2, pp. 235–296.

Colombetti, Giovanna, and Steve Torrance, 2009, "Emotion and Ethics: An Inter-(En)Active Approach", *Phenomenology and the Cognitive Sciences*, vol. 8, no. 4, pp. 505–526.

De Jaegher, Hanne, Anssi Peräkylä, and Melisa Stevanovic, 2016, "The Co-Creation of Meaningful Action: Bridging Enaction and Interactional Sociology", *Philosophical Transactions of the Royal Society B: Biological Sciences*, vol. 371, no. 1693, 20150378.

De Jaegher, Hanne, and Ezequiel Di Paolo, 2007, "Participatory Sense-Making: An Enactive Approach to Social Cognition", *Phenomenology and the Cognitive Sciences*, vol. 6, no. 4, pp. 485–507.

Di Paolo, Ezequiel, 2009, "Extended Life", *Topoi*, vol. 28, pp. 9–21.

Di Paolo, Ezequiel, Elena Clare Cuffari, and Hanne De Jaegher, 2018, *Linguistic Bodies: The Continuity Between Life and Language*, The MIT Press, Cambridge, MA.

Dings, Roy, 2023, "Experiential Knowledge: From Philosophical Debate to Health Care Practice?", *Journal of Evaluation in Clinical Practice*, vol. 29, no. 7, pp. 1119–1126.

Dings, Roy, 2020, "Psychopathology, Phenomenology and Affordances", *Phenomenology and Mind*, vol. 18, pp. 56–66.

Dings, Roy, 2018, "Understanding Phenomenological Differences in How Affordances Solicit Action. An Exploration", *Phenomenology and the Cognitive Sciences*, vol. 17, no. 4, pp. 681–699.

Dings, Roy, and Şerife Tekin, 2023, "A Philosophical Exploration of Experience-Based Expertise in Mental Health Care", *Philosophical Psychology*, vol. 36, no. 7, pp. 1415–1434.

Egbert, Matthew D., and Xabier E. Barandiaran, 2014, "Modeling Habits as Self-Sustaining Patterns of Sensorimotor Behavior", *Frontiers in Human Neuroscience*, vol. 8, 590.

Flanagan, Owen, 2013, "Identity and Addiction: What Alcoholic Memoirs Teach", in K.W.M. Fulford et al. (eds), *The Oxford Handbook of Philosophy and Psychiatry*, Oxford University Press, pp. 865–888.

Fourlas, George N., and Elena Cuffari, 2022, "Enacting Ought: Ethics, Anti-Racism, and Interactional Possibilities", *Topoi*, vol. 41, no. 2, pp. 355–371.

Frankfurt, Harry, 1988, *The Importance of What We Care about*, Cambridge University Press, Cambridge.

Fuchs, Thomas, and Hanne De Jaegher, 2009, "Enactive Intersubjectivity: Participatory Sense-Making and Mutual Incorporation", *Phenomenology and the Cognitive Sciences*, vol. 8, no. 4, pp. 465–486.

Gallagher, Shaun, and Helen Payne, 2015, "The Role of Embodiment And Intersubjectivity in Clinical Reasoning", *Body, Movement and Dance in Psychotherapy*, vol. 10, no. 1, pp. 68–78.

Gibson, Barbara E., Gareth Terry, Jenny Setchell, Felicity A. Bright, Christine Cummins, and Nicola M. Kayes, 2020, "The Micro-Politics of Caring: Tinkering with Person-Centered Rehabilitation", *Disability and Rehabilitation*, vol. 42, no. 11, pp. 1529–1538.

Goffman, Erving, 1964, "The Neglected Situation", *American Anthropologist*, vol. 66, no. 6, pp. 133–136.

Houlders, Joseph, Lisa Bortolotti, and Matthew R. Broome, 2021, "Threats to Epistemic Agency in Young People with Unusual Experiences and Beliefs", *Synthese*, vol. 199, no. 3/4, pp. 7689–7704.

Lillehammer, Hallvard, 2020, "Autonomy, Consent, and the 'Nonideal' Case", *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, vol. 45, no. 3, pp. 297–311.

Maiese, Michelle, 2022a, *Autonomy, Enactivism, and Mental Disorder*, Routledge, New York.

Maiese, Michelle, 2022b, "Mindshaping, Enactivism, and Ideological Oppression", *Topoi*, vol. 41, no. 2, pp. 341–354.

Martin, Daniel J., John P. Garske, and M. Katherine Davis, 2000, "Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review", *Journal of Consulting and Clinical Psychology*, vol. 68, no. 3, pp. 438–450.

Matthews, Steve, 2017, "The Significance of Habit", *Journal of Moral Philosophy*, vol. 14, no. 4, pp. 394–415.

McCann, Terence V., and Eileen Clark, 2004, "Advancing Self-Determination with Young Adults Who Have Schizophrenia", *Journal of Psychiatric and Mental Health Nursing*, vol. 11, no. 1, pp. 12–20.

McLeod, Carolyn, and Susan Sherwin, 2000, "Relational Autonomy, Self-Trust, and Health Care for Patients Who Are Oppressed", in Catriona Mackenzie and Natalie Stoljar (eds.), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and The Social Self*, Oxford University Press, New York, pp. 259–279.

Molas, Andrew, 2018, "Empathy, Asymmetrical Reciprocity, and The Ethics of Mental Health Care", *Practical Ethics: Issues and Perspectives*, CSSPE/SCEEA, vol. 2, pp. 52–78.

Nelson, Janet R., 2003, "Bioethics and the Marginalization of Mental Illness", *Journal of the Society of Christian Ethics*, vol. 23, no. 2, pp. 179–197.

Pelto-Piri, Veikko, Karin Engström, and Ingemar Engström, 2013, "Paternalism, Autonomy and Reciprocity: Ethical Perspectives in Encounters with Patients in Psychiatric in-Patient Care", *BMC Medical Ethics*, vol. 14, pp. 1–8.

Pettersen, Tove, and Marit Helene Hem, 2011, "Mature Care and Reciprocity: Two Cases from Acute Psychiatry", *Nursing Ethics*, vol. 18, no. 2, pp. 217–231.

Potter, Nancy Nyquist, 2019, "Voice, Silencing, and Listening Well: Socially Located Patients, Oppressive Structures, and an Invitation to Shift The Epistemic Terrain", in Şerife Tekin and Robyn Bluhm (eds.), *The Bloomsbury Companion to Philosophy of Psychiatry*, Bloomsbury Publishing, London, pp. 305–324.

Rietveld, Erik, and Julian Kiverstein, 2014, "A Rich Landscape of Affordances", *Ecological Psychology*, vol. 26, pp. 325–352.

Sandhu, Sima, Eleonora Arcidiacono, Eugenio Aguglia, and Stefan Priebe, 2015, "Reciprocity in Therapeutic Relationships: A Conceptual Review", *International Journal of Mental Health Nursing*, vol. 24, no. 6, pp. 460–470.

Striano, Tricia, and Vincent M. Reid, 2006, "Social Cognition in the First Year", *Trends in Cognitive Sciences*, vol. 10, no. 10, pp. 471–476.

Tekin, Şerife, 2022, "Participatory Interactive Objectivity in Psychiatry", *Philosophy of Science*, vol. 89, no. 5, pp. 1166–1175.

Tekin, Şerife, 2014, "Self-Insight in the Time of Mood Disorders: After the Diagnosis, beyond the Treatment", *Philosophy, Psychiatry, & Psychology*, vol. 21, no. 2, pp. 139–155.

Tekin, Şerife, Eddy Nahmias, Thomas W. Polger, and Wenqing Zhao, 2020, "Patients as Experience-Based Experts in Psychiatry: Insights from the Natural Method", in Eddy Nahmias, Thomas W. Polger, and Wenqing Zhao (eds.), *The Natural Method: Essays on Mind, Ethics, and Self in Honor of Owen Flanagan*, MIT Press, pp. 79–97.

Toro, Juan, and Kristian Martiny, 2020, "New Perspectives on Person-Centered Care: An Affordance-Based Account", *Medicine, Health Care and Philosophy*, vol. 23, pp. 631–644.

Weimer, Steven, 2013, "Evidence-Responsiveness and Autonomy", *Ethical Theory and Moral Practice*, vol. 16, no. 3, pp. 621–642.

Westlund, Andrea C., 2009, "Rethinking Relational Autonomy", *Hypatia*, vol. 24, no. 4, pp. 26–49.

Wirshing, Donna A., William C. Wirshing, Stephen R. Marder, Robert P. Liberman, and Jim Mintz, 1998, "Informed Consent: Assessment

of Comprehension", *American Journal of Psychiatry*, vol. 155, no. 11, pp. 1508–1511.

Young, Iris Marion, 1997, "Asymmetrical Reciprocity: On Moral Respect, Wonder, and Enlarged Thought", *Constellations*, vol. 3, no. 3, pp. 340–363.