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Why do people with mental distress have poor social outcomes? Four lessons from the capabilities approach

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A B S T R A C T

Macro level data indicate that people experiencing mental distress experience poor health, social and economic outcomes. The sociology of mental health has a series of dominant competing explanations of the mechanisms at personal, social and structural levels that generate these poor outcomes. This article explains the limitations of these approaches and takes up the challenge of Hopper (2007) who in this journal proposed the capabilities approach as a means of normatively reconceptualising the experiences of people with mental distress, with a renewed focus on agency, equality and genuine opportunity. Using an innovative methodology to operationalise the capabilities approach, findings from an in-depth qualitative study exploring the lived experiences of twenty-two people with recent inpatient experience of psychiatric units in Scotland are presented. The paper demonstrates that the capabilities approach can be applied to reconceptualise how unjust social outcomes happen for this social group. It distinguishes how the results of using a capabilities approach to analysis are distinct from established dominant analytical frameworks through four added features: a focus on actual lived outcomes; the role of capabilities as well as functionings; being normative; and incorporating agency. The capabilities approach is found to be an operationalisable framework; the findings have implications for professionals and systems in the specific context of mental health; and the capabilities approach offers a fertile basis for normative studies in wider aspects of health and wellbeing.

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1. Introduction

Evidence indicates that social outcomes for people with mental distress are persistently poor. They experience lower life expectancy (Thornicroft, 2011, p.441), are more likely than most people to live in relative poverty (Rethink, 2003), be victims of violence (ODPM, 2004, p.25), live in disadvantaged areas (Tew, 2011, p.37), live alone (ODPM, 2004, p.86), have financial problems (ODPM, 2004, p.85), and have less access to employment (ODPM, 2004, p.1). They tend to experience stigma and discrimination (ODPM, 2004, p.24) including at work (e.g. Coppock and Dunn, 2010, pp.111–112). Life for many can become ongoing “predicament” (Barham and Hayward, 1991) or “trap” (Estroff, 1981) caught between living freely and being at risk of having freedom constrained by state actors, including, for example, having their ability to parent questioned (Read and Baker, 1996).

Macro-level research has also contributed to understanding social determinants of mental distress. Income and relative poverty, unemployment and poor quality employment are associated with risk of mental disorders (WHO and Calouste Gulbenkian Foundation, 2014, p.24). Evidence suggests that “social injustice is killing people on a grand scale” (WHO Commission on Social Determinants of Health 2008, p.26), especially so for people with mental distress (2008, p.98, Table 9.1), determined by socioeconomic context and position, exposure, vulnerability and health care access.

The capabilities approach (CA), developed by Sen (e.g. 1980, 1999) and Nussbaum (e.g. 2006), has been operationalised for other social groups experiencing poor outcomes (e.g. Dean et al., 2005; Wolff and De-Shalit, 2007; Burchardt and Vizard, 2011). Hopper (2007) has argued that in principle the CA offers a framework for analysis of agency/structure relations, diversity, personal experience, normativity and the role of resources which interact to shape social outcomes for people with mental distress. Arguing that capabilities speaks “to citizenship as well as health” (2007, p.875), and enables accounting of “vital contextual features – the enabling resources, rules and connections that make prized

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prospects like a decent job feasible" (2007, p.871), he suggests that this merits empirical work (2007, p.876).

The aim of this paper is to explore the analytical advantages of using a capabilities approach to conceptualise social outcomes experienced by people with mental distress. It applies data from an in-depth qualitative study exploring the lives of people with recent experience of being in psychiatric hospital in Scotland, UK. The paper first outlines the dominant analytical frameworks used to interpret the experiences of people with mental distress. Concepts from the CA are then discussed and the study design described. The paper then highlights empirical findings which demonstrate contributions to analysis activated by applying the CA, namely: maintaining a focus on actual lived outcomes; taking into account what people could alternatively do (capabilities) as well as what people are doing (functionings); highlighting the role of agency; and using a normative framework. These demonstrate the promise of capabilities, as suggested by Hopper (2007), in providing an original explanation of how differential social outcomes happen for people with mental distress.

2. Social perspectives of mental distress and explanation of poor social outcomes

The dominant western interpretation of certain emotional experiences as 'mental illness', and the contingent model of treatment as being through a part-coercive psychiatric system of asylums, hospitals, diagnoses and physical, chemical and psychological interventions, was based on a number of dominant post-Enlightenment influences, including notions of rationality and irrationality (Foucault, 1967) and the power of the medical profession (Scull, 1975; Foucault, 1967). There is an underpinning assumption "that there is some underlying pathological process" (Busfield, 2011, pp.17–18) explaining these emotional expressions, subsequently contextualised by evidence on social determinants. The power of the state and psychiatric professionals in classifying people as mentally disordered is maintained through national mental health laws that include elements of compulsion, and also in more subtle forms incorporating community care and notions of "recovery" (Anthony, 1993; Harper and Speed, 2012).

The medically-dominated approach has provided some benefits for people with mental distress, evidence suggesting that medication may for some reduce 'psychotic' experiences at least in the short-term (Bentall, 2009, pp.219–221) and reduce repeated experiences in the longer term (Bentall, 2003, p.499); and that diagnosis can provide subjectively helpful explanations for confusing emotional experiences (e.g. Stalker et al., 2005). People with mental distress now spend less time living in physically segregated institutions (Bentall, 2009, pp.42–44; Busfield, 2011, p.178). However, the transformative promise of recovery is institutionally weak in practice (Hopper, 2007; Davidson et al., 2009) whilst arguably more insidious in terms of social control (Davidson, 2003, p.36).

It is against this medical conceptualisation and the persistent evidence of people with mental distress experiencing poor social outcomes, that the sociology of mental distress has been positioned. Whilst these perspectives cross-cut, producing "sedimented layers of knowledge" (Rogers and Pilgrim, 2010, p.11), epistemological 'waves' can be distinguished.

Conflict theory-based structuralism uncovered the dominant social norms and professional powers that maintained social injustice for people with mental distress (e.g. Foucault, 1967; Scull, 1975). Symbolic interactionist and social constructivist studies demonstrated the impacts of these power-inflected social relations at a micro-level, including stigmatisation and labelling (e.g. Szasz, 1960; Goffman, 1961; Scheff, 1966). Whilst the former approach minimised the agency and diversity of people with mental distress, the latter underplayed analysis of wider structural influences on micro-level interactions. Both types of study influenced a third wave of literature foregrounding 'survivor' experience of the psychiatric system, with an increasing role for user-led research into experiences of mental health services (e.g. Tew et al., 2006; Reynolds et al., 2009). Survivor-influenced approaches have reinforced the centrality of oppression of people with mental distress, arguing that the psychiatric system both denies meaningful choice and has not improved social outcomes (e.g. Plumb, 1993; Beresford, 2012). However, survivor-influenced research is opaque about diversity of user experiences beyond those which are oppressive (e.g. Reynolds et al., 2009) which holds the risk of leaving the analysis of material experiences of mental distress to medicalised epistemologies, and, as Tew et al. argue (2006, pp.11–13), is in conflict with taking user accounts seriously. These collective limitations have led to a fourth critical realist 'turn' (e.g. Rogers and Pilgrim, 2003) which seeks to incorporate all perspectives, including medicalised epistemologies and influences on social outcomes beyond the mental health system itself, whilst maintaining a normative stance (Watson, 2012, p.102). However, in the context of mental distress, this has been applied for the purposes of critique of the medical model (e.g. Rogers and Pilgrim, 2003; Pilgrim and Bentall, 1999) rather than to conduct primary research.

So, whilst successfully highlighting the power of dominant social norms and the oppressive role of professional powers within the psychiatric system (c.f. Bracken et al., 2012), these social perspectives leave analytical gaps. They can diminish normativity, for example in terms of the potential significance of the mental health system in preserving life. The focus on critique of the medical model means that sociological analyses tend to essentialise the agent and neglect diversity in distress trajectories (Bolton, 2008, pp.83–91). The focus on the dominant psychiatric model and system can diminish the role of multiple wider influences on social outcomes (Rogers and Pilgrim, 2003) whilst fuller analyses operate only at the level of critique.

Although the principle in survivor-influenced studies of acting as a "countervailing force to experts' control and production of knowledge" (Rogers and Pilgrim, 2003, p.186) remains powerful, a gap remains for a theoretically-informed model to conceptualise the experiences of people with mental distress which can normatively draw these sedimented layers of research together, respecting concepts of diversity, agency, social relations and structure. Beresford (2012, p.159) notes that social understandings still lack a model with the power to explain disadvantage and with the potential to transform the way in which people with mental distress are socially perceived. Hopper (2007) suggests that the CA offers such a model.

3. The capabilities approach and mental distress

The CA has the potential to shed light on the social outcomes of people with mental distress in a way which is not restricted to use of services or compliance with treatment regimens because it focuses on whether all people have the freedom to live a valued life. Capabilities is analytically significant in the context of social understandings of mental distress as it does not assume oppression or social injustice, but offers a framework to explain how oppression may or may not occur in the context of the psychiatric system and wider social structures whilst maintaining a normative stance. So, it offers the possibility of bringing together both the biomedical and the social in the study of mental health, expanding the analysis.

The CA utilises a range of interlinking concepts to understand how people achieve social outcomes (see, for example, Robeyns, 2005; Nussbaum, 2011; Venkatapuram, 2011). From this range,

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