Applied Critical Realism as a Tool for Making Sense of Service Users accounts of their Mental Health

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Mental Health & Mental Health problems as a Concept

- Defining/conceptualising MH and wellbeing is complex
- Influenced by a range of (potentially conflicting) ideologies, from medical naturalism or biomedical approaches to social constructionist approaches (see Kenwood, 1999; Pilgrim, 1999).
- The first is limited by its *one-sided focus on diagnosis and deficits*, whereas the epistemological assumption of latter *is that we can only know the world via the ways we represent it* , thereby ignoring non-discursive factors – e.g. trauma, material issues, neoliberalism, funding cuts etc.

Critical Realism

- In line with Bhaskar's (1989; 2014) critical realist ontology, we adopt a form of reasoning called **retroduction**, which involves *moving from the level of observation and lived experiences to making (non-linear) inferences about underlying structures and mechanisms that may account for the phenomena involved.*
- Personal and societal constraints upon people's actions can be divided into several categories, namely *embodiment, the power of institutions and materiality* (see also Cromby & Harper, 2009).

CR as a middle way

Uses element from both positivism and social constructionism.

Example in relation to MH issues:

- The 'real' level (exploring causal mechanisms, such as hormonal imbalance, trauma and cuts to services to name a few, that generate events),
- The 'empirical' level (experienced events, namely how mental health issues are experienced by people)
- The 'actual' level (events and processes in relation to mental health support).

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Focus on (new) mothers and young care leavers with (diagnosed) mental health issues.

Explores people make sense of their mental health and well-being within the context of the complex material and discursive contexts in which they find themselves.

Incorporates discursive (stigma, accountability, support) and non-discursive influences (emotional response to trauma, domestic violence, cuts to funding, material context), as factors that scaffold people's talk regarding their mental health.

Implications for Practice

A tool that generates insight into both non-discursive and discursive factors that impact on conceptualizations of mental health and well-being, including how service users make sense of resources and support entitlement, and what Bhaskar (2014) refers to as absence (what is missing in a social context or institution/organization) in relation to service provision.

Doing justice:

- To offer a method of making sense of people's accounts in relation to MH that *includes a wide range of factors, including discursive and non-discursive.*
- Making sense of our participants' narratives in relation to MH in the light of embodied, material and social/institutional contexts.
- Our focus is on *how people account for themselves,* the interactional effects of these accounts (e.g. avoiding blame and stigma) and how the logic of these accounts can be made sense of *through an analysis of discursive and non-discursive conditions.*

Note

- For us the non-discursive does not cause a participant to draw on one discourse and not another – instead, we see this as creating a kind of scaffolding milieu.
- We do not claim that our method can identify direct causal relationships between one factor and another; instead our model for CRDA is one in which *discourse, embodiment, materiality and social structures interact in complex iterative ways, creating the conditions of possibility for sense-making*.

A new framework for researching global mental health and wellbeing?

MACRO Tool

Mental Health
and
Applied Critical
Realism
Operational
Tool

Conclusion

- CRDA as a way of ‘doing justice to people’
- People as agents.
- Contextualising talk around MH issues.
- Taking account of the conditions that shape a person’s experiences.
- But also linking this to context, time and place.
- Criticism: ‘pick and choose’ – ‘need a systematic method’

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