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

Dr Wendy Sims-Schouten, Associate Professor in Childhood Studies, University of Portsmouth, UK
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).
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).

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*. 
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’
References


