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Reframing Early Psychiatric Crises: a Capabilities-Informed Approach

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Article abstract

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Reframing Early Psychiatric Crises : a Capabilities-Informed Approach[1]

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Abstract

Spurred by a working conference convened in the fall of 2009 by the Center to Study Recovery in Social Contexts and INTAR (the International Network Towards Alternatives and Recovery), this paper first develops a serviceable version of Sen's capabilities approach for use in public mental health and then explores how its conceptual toolkit might aid us in rethinking about we approach "first breaks" and early crises. This will be exploratory labor.[2] Provisional efforts have been made to use the capabilities approach to rethink recovery and social integration as outcomes, to support self-determination, and to make a case for peer participation in research. This paper shifts the focus from the remedial work of treatment and social re-entry to the preventive work of crisis management and biographical continuity. After sorting through Sen's approach for grounding principles and heuristic guides – which is here compiled into a sort of primer or toolkit, distilled into 8 key ideas and an anthropological coda on adolescent trial/error – I go on to identify three alternative ways that a capabilities approach might usefully reframe disability and impairment. That done, I make the case for applying the third (or radical) version to the social reception of early crises and try to envision what that might look like in practice.

Keywords : capability approach, recovery, mental health, disability, early psychiatric crises, self-determination

Résumé

Stimulé par une conférence de travail tenue à l'automne 2009 par *Center to Study Recovery in Social Contexts and INTAR (the International Network Towards Alternatives and Recovery)*, cet article développe d'abord une version adaptée de l'approche des capabilités développée par Sen pour l'utilisation en santé publique, plus particulièrement dans le champ de la santé mentale, et explore ensuite comment ces outils conceptuels peuvent nous aider en repensant l'approche de « premières ruptures » et des crises précoces. Ce travail sera exploratoire[3]. Des efforts ont déjà été faits pour employer l'approche des capabilités afin de repenser le rétablissement et l'intégration sociale en tant que résultats, pour soutenir l'autodétermination, et comme argument venant appuyer la participation des pairs à la recherche. Ce document déplace la question de celle de la réadaptation et de la réintégration sociale vers celle du travail préventif de la gestion des crises et de la continuité biographique. Après avoir abordé l'approche de Sen pour fonder des principes et des guides heuristiques - qui sont compilés ici dans une sorte d'esquisse ou de trousse à outils, divisés en huit idées principales et un coda anthropologique sur l'essai/erreur adolescent – l'article poursuit en identifiant trois manières alternatives par lesquelles une approche fondée sur les capabilités peut être utile dans la reformulation du handicap et des incapacités. Cela fait, l'article présente un argument en faveur de l'application de la troisième (ou radicale) version à la réception sociale des crises précoces et tente d'envisager ce à quoi cela pourrait ressembler dans la pratique.

Mots-clés : approche des capabilités, rétablissement, santé mentale, handicap, premières crises psychotiques, autodétermination

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[1] Background paper prepared for Rethinking Psychiatric Crisis: Alternative Responses to "First Breaks." Conference sponsored by INTAR and Center to Study Recovery in Social Contexts, New York University, Nov. 23, 2009. ● Cet article est tiré d'un article préparé pour Rethinking Psychiatric Crisis : Alternative Responses to "First Breaks », un colloque organisé par INTAR et Center to Study Recovery in Social Contexts, Université de New York, le 23 novembre 2009.

[2] As will be soon apparent, applied work in capabilities that deals with physical and mental states of distinction, limitation and exclusion – difference, "impairment," and "disability" – is still in its formative stages; its linguistic house is far from being put into working order. So, a forewarning: In making the argument, this paper will necessarily raid and pillage a number of literatures for concepts, distinctions and applications that will then be put to provisional use, found wanting or misleading, and revised accordingly or thrown out. Initial or trial adoption of terms should not be mistaken for final endorsement – and, indeed, one of this paper's major points will be the need to interrogate the conceptual frameworks we routinely take for granted in discussing public mental health, to question our well-worn equipment of everyday thinking.

[3] Tel qu'il sera donné de voir, les applications pratiques usant de la perspective des capabilités et préoccupées par la distinction entre les états physiques et mentaux, des limitations et de l'exclusion – différence, « déficiences » et « incapacité » - demeure dans des stades de formation; son ancrage linguistique est loin d'être opérationnel. Ainsi, à titre préventif : En formulant l'argument, cet article puise dans un bon nombre de littératures des concepts, des distinctions et des applications qui seront utilisés provisoirement, qu'ils soient pertinents ou non, pour être révisés ou écartés. Une adoption initiale ou expérimentale ne doit pas être confondue pour une approbation finale – en effet, une des contributions majeures de cet article sera de questionner le cadre conceptuel que l'on tient pour acquis lorsque l'on discute de questions relatives à la santé publique en santé mentale, ou que l'on discute de nos outils conceptuels dans leur usage régulier.

Prologue

Transcript excerpt, BBC "Yesteryear" 2030

BBC Interviewer: "So, let me see if I have this right. You're telling us that the practice of removing persons in distress from familiar surrounds and keeping them locked up, often in restraints and under heavy medication, watched closely – a reinvention of the medieval practice of quarantine, really – was actually commonplace 3 decades ago?"

Emeritus. Prof. Psychiatry: "I would say so, yes."

BBC: "The whole thing? The organized conspiracy to admit to hospital, the casual resort to restraints, the routine use of medications, and the non-negotiated, no-appeal, medically sanctioned nature of the process?

EPP: "It was what we knew, how we had been taught."

BBC: "But even then – I was just reading an old (2009) *Lancet* – there were calls for actually listening to the patient and providing (I'm quoting now) 'companionship, respect, practical support, and gainful activity.' What about that?"

EPP: "I can only report that such activities were not part of the evidence base."

The Awful Rowing of Early Psychiatric Crises

Momentum has been building in clinical circles for rethinking conventional practice with respect to "first breaks." In the main this amounts to urgent calls for "early intervention," more rapid referrals from primary care and informed gatekeepers, and reduction in the "duration of untreated psychosis." The tacit assumption is that the main problem lies on the demand/detection side, since promising "evidence-based" psychiatric treatments exist (Boydell & Ferguson, 2011). Accordingly, the usual array of actually existing alternatives assessed in the research literature tends to be combinations of early detection, referral to "specialist first episode psychosis" teams, low-dose second-generation antipsychotic medications, and established psychosocial interventions (e.g., cognitive-behavioral therapy, family psychoeducation, supportive counseling) (Álvarez-Jiménez et al., 2011). The existing literature is virtually silent on two issues that figure prominently in user-survivor discussions (e.g., Beresford et al., 2010): the role of peers and the search for meaning. (Those subjects arise later, in "recovery" discussions.) The argument taking shape in peer literature draws heavily on inventive practice and reflective first-person reports. Its evidence-base is experience, ratified in unplanned comparative assessments.

This paper, by an applied anthropologist not a clinician, is meant as a contribution to that latter argument. Prodded by the ever-cumulating record of service user grievances and occasional glimpses of real alternatives, and drawn by the promise of reframing early crises that a capabilities perspective seems to offer (Hopper, 2007), it sets out to query what might be called the "social imaginary" of first breaks (Taylor, 2004) – the set of background assumptions and unexamined premises behind the medical response to "psychiatric crisis." In a word, it seeks to *reframe* that discussion (Schon, 1995), to open the door to fresh ways of "making the person and cultural meanings malleable" (Luborsky, 1994) in these early, and often recurring, crises.

As with other illness-instigated "biographical disruptions" (Bury, 1982), the experience of a "first break" typically figures as a threshold event in a young person's life, with psychiatric hospitalization marking a first (and often irreversible) step on the road to durable patienthood (Birchwood et al., 1998; McGorry et al., 2008). Hospitalization sets in train a series of adjustments that can easily, insidiously, develop its own self-perpetuating momentum. An alternative "tracking" is dimly laid out, a life plan rescored, a forced and unwelcomed reckoning undertaken. Expectations are ratcheted back, everyday routines are re-orchestrated (undermining old social networks, substituting new and narrower ones), once hope-filled futures are rethought. The gaze of familiars undergoes subtle adjustments; a hovering unease, an unmistakable if elusive tentativeness, comes to haunt everyday interactions. You find, in effect, that you've been socially redefined: from now on, you occupy a distinctive (for some, a defining) "heterogeneity" in social life. In exchange for the promise of help and support, you find yourself party to a tacit compact to be effectively sidelined from the usual life trajectories.

Whatever succor one finds in the therapeutic oasis of a clinic – and users differ on the availability, quality and consistency of the help available – it's the social impact of finding membership *there*, while seeing it slip away in more normative settings, that sets the limits and possibilities of re-integration (Rosenfield, 1997). The pervasive reach of stigma, structural and interactive, makes recovery (no less than its refusal) an extended social project as much as it is an arduous individual journey. The requisite rules and resources implicate systems far afield of the formal mental health system and necessitate ongoing (if muted and sidelined) disputes over the representation and integration of putatively discredited selves.

For many who undertake the ordeal, it marks the end of a familiar way of life and the beginning of an opaque alternative. Lear's meditation on a remark by a late 19th/early 20th century Crow chief, Plenty Coups, may be relevant here. His biographer had been unable to elicit anything about life after forced settlement, life on the "reservation," despite the chief's well-documented activities for more than two decades thereafter. One remark in particular haunts Lear: "…when the buffalo went away, the hearts of my people fell to the ground, and they could not lift them up again. *After this, nothing happened*" (2008: 2, ital. added). Lear insists that we take the statement at face value and try to understand what it could possibly mean. After much reflective work, he arrives at this: with the destruction of a way of life, *history* itself became a co-casualty because one's point of purchase in that project was lost. It no longer *made sense to act* as if one's actions had meaning and consequence. A similar sense of radical disorientation and displacement may be found in some user accounts of their lives post-psychosis.

So Why Turn to Sen?

Amartya Sen's capabilities approach (citations: Sen, 1992; 1999; Nussbaum, 2000; 2011; Alkire, 2002; Robeyns, 2006-2011; Crocker, 2007; Comin et al., 2008; Morris, 2009) was itself invented as an alternative to conventional measures of poverty and well-being in developing countries. Its chief impact to date has been to lift the floor under discussions of human development and to enrich efforts to rethink poverty and well-being (cf. Gough & McGregor, 2007). It was Sen's signal insight that the usual economistic approach (per capita income) ignored both distributional issues and fundamental "heterogeneities" – things that mark or make people different in ways that determine what they can actually do with a given level of income or basket of goods. Income alone cannot tell us what people can actually make of their lives. Real or (substantive) "freedoms," Sen proposed, are what we should be concerned with. These are the locally valued "beings and doings" that people are actually able to achieve or to commit themselves to pursuing. Where people seek purpose, satisfaction of needs, affiliation with others, and the wellsprings of self-respect – here, Sen argued, is where we might find the necessary material out of which to fashion a measure of well-being (or "flourishing") adequate to the complexities of human aspiration. In the shorthand the Center to Study Recovery in Social Contexts has adopted to speak of recovery in mental health, people become "authors of lives worth living."

In identifying the determinants of such flourishing, both resources (private and public, household and civil society) and rules (formal and informal, law and custom) figure critically. Fundamental, too, are the *means* by which locally valued ends ("beings and doings") are defined. For Sen, it's not just that people are able, by dint of someone's effort, to lead more fulfilling lives; rather, it matters crucially that they become active agents themselves in deciding *what counts as a fulfilling life.* Their *agency* (or exercise of self-determination) is as important as – and may be at odds with – their *well-being.* This introduces a crucial tension of particular import to service user accounts of recovery. Agency is triply prized in Sen: it has *intrinsic* value (as a participatory imperative); it has *instrumental* import as means to valued ends; and – intriguingly for our purposes – it has *constructive* power, as action + consequences can clarify, even reveal, underlying values or commitments (1999). By the same token, as a developmental faculty, agency can be wounded, its growth thwarted or stymied, and its exercise neglected altogether by those with authority and power to prescribe a given regimen of well-being. Process-oriented as well as product-conscious, the capabilities approach (CA) places a distinct premium on active social participation in the ongoing cultural conversation (not always articulated as such) about what constitutes a good life and what it means to be recognized as "one of us" in good standing.

Disadvantage, and the social devaluation and "degradation" that so often accompany it, can harm in ways that are both lasting and tricky to discuss. Because it restricts access to positional goods[4] and/or opportunities to achieve, its effects are ultimately moral as well as material, going to the heart of how we assess a person's worth and the recognition we extend to her (Nussbaum, 2004, p. 285; Sayer, 2005; Fraser & Olson, 2008).[5] In poverty studies, one may read about dreams never dared or aspirations foregone; in consumer/survivor/ex-patient circles, the conversation may be about "internalized stigma;" in social science, some refer to "symbolic violence," others to "diminished moral agency," or self-distrust (DeParle, 2004; Corrigan, 1998; Sayer, 2005; MacLeod, 1992; Bourdieu & Wacquant, 1992; Nussbaum, 2000; Moody-Adams, 1992-93, p. 253; Blacksher, 2002). In all of these constructions, the tacit underlying mechanism is a developmental dynamic of early influence and ongoing constraint that instills an internal sense of limited prospects and bequeaths a world in which "justice" is riddled with pre-ordained distinctions. For some analysts, this provides exactly the sort of appropriately hedged hopes that well-adjusted membership in stratified societies requires (Warner et al., 1949, p. 5).

Plainly, there is real value in taking built-in limitations into account when mapping out a career path; the timid and slight of stature are wise not to shoot for the National Hockey League (NHL). For other scholars, though, the dynamic at work serves the deeper ideological purpose of ratifying existing inequalities as natural or "given." Differently positioned social selves, convinced of the justice of the arrangement and of their own inferiority, make for a more tractable citizenry; they conspire in their own governance. By the same token, that process can involve some atrophy, diminishment or scuttling of imaginative capacity, the ability to see beyond what is merely given to the beckoning horizons of what might be possible – that men and women, for example, *both* might justly aspire to equality of stature in marriage, business, property ownership and citizenship. In taking the measure of "entrenched deprivation" Sen prefers the dry idiom of "adaptive preferences" – a self-initiated "prudential" process of tamping down or re-calibrating what one wants or *allows* oneself to hope for, especially "those capabilities which the chronically deprived dare not covet" (Sen, 1992, p. 54; 1999, p. 63).

Admittedly, this can lead dangerously to free-wheeling discussions of "damage," irreversible and otherwise, as the checkered history of the "culture of poverty" in American studies of ghetto life so aptly illustrates (Rigdon, 1988; O'Connor, 2002). It also too easy ignores or dismisses the useful, even redemptive, reassessments of "what really matters" that can follow upon such disruptive events as loss or

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[4] Positional goods can include such cultural capital assets as higher education, for example, especially in prestigious institutions that, in turn, enrich one's stock of social capital – or beneficial networked connections that open access to further contacts and opportunities. See Bourdieu's discussion of the forms of capital (1986).

[5] For a striking demonstration of how moral conclusions about worth – in this case, motivation to cooperate with disease-management efforts – can be drawn from evidence shaped by an intricate interlocking set of circumstances, not character, see Lutfey & Freese's (2005) analysis of two diabetes clinics, one a county clinic.

disabling injury (Albrecht & Devliger, 1999; Wasserman et al. 2005). But by the same token, the notion that people may conspire as agents of their own captivity selves is important. That the long arm of deprivation can quietly hobble the deliberating self alerts us to the possibility that "expressed preferences" (or interview-elicited degrees of "satisfaction") can be very poor indicators of actual states of needs or interests. Faced with repeated denial and disappointment desire may rein itself in, recalibrating what's possible and thus "legitimate" to hope for.[6] Subjective judgment may be affected in other ways as well. The subtle play of influence, history and contingency can make it difficult to identify as "perceived coercion" the ordinary run-of-the-mill constraints that one has learned to expect as inevitable. What to an outsider plainly registers as a "leveraging" apparatus has simply melted into the landscape of everyday life (Monahan et al., 2005). Writ large, the repeated experience of being found wanting or not quite measuring up or belonging ("social defeat") has been implicated by some analysts in both elevated rates of psychosis among migrants of color and poor prognosis in the west more generally (Morgan & Fearon, 2008; Luhrmann, 2008).

We can now put three CA- informed conceptual tools on the table:

- a substantive freedoms approach to human flourishing that places a huge emphasis on *agency* (the exercise of self-determination) and, in consequence, casts a critical eye on developmental or assistance programs that target well-being but ignore or impair agency;
- coupled with the emphasis on agency is sustained concern with *context*: the social machinery that enables people to *convert* resources and rules into real opportunities;
- a working hypothesis that among the lasting effects of deprivation is the toll it take on one's "moral self" or soul, the slowly acquired conviction that limitations are fated if not just, and that adjustment downward is the better part of aspiration ventured.

But what difference might it make to reason this way? What makes this distinctive analytic equipment "good to think with" when confronting the issue of personal crises of the sort that can find themselves classified as "first breaks"?

Both CA-informed social recovery and "alternatives" to early psychiatric crises share a commitment to mobilizing resources and rewriting rules to minimize the social disadvantage – the lasting harm hidden in that "package deal" of offered help and exacted handicap – that resort to emergency psychiatric assistance so often entails. But they do so in markedly different ways, especially marked when *unorthodox* alternatives are considered. (Timing, pace and resource deployment – how family members, for example, may be enlisted as countervailing allies – can figure quite differently in alternative approaches.) As originally conceived, this paper posed two questions: can the crisis of first break be turned to advantage – be *reframed* – as potentially *productive* ordeal, an unsought opportunity to undertake the difficult labor of "value clarification" that CA so highly prizes? Second: is it possible to *interrupt the disablement process itself* at the point of initial reception (whether viewed as trained care, safe haven, guided passage or protected ordeal and "crisis support"), such that the disruptive impact and negative social consequences of seeking help are muted?

That these are *first* breaks distinguishes the present effort from provisional attempts to apply capabilities to social recovery (Hopper, 2007) and alters the nature of the inquiry. *Timing* changes everything. First, certain capabilities may be developmentally staged, such that a critical period exists during which some basic

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[6] This obviously complicates the task of gathering subjective accounts of the experience of treatment – and not only because of the influence that time and perspective can have on reflective accounts of one's past. Methodologists may worry about "retrospective bias;" but the passage of time can illuminate as well as warp readings of the past, even one's own. It's the reader's relationship to the past – reframed, re-appropriated, revisited and re-understood, as the case may be – that matters in this argument, not some pristine version of what really happened. Meaning and moral, rather than event and chronology.

skills or proficiencies[7] must (or should optimally) be acquired. As noted earlier, if missed or delayed strong corrective efforts may be needed to compensate for the lapse or repair the deficit. Even if desired and effective, participating in programs to acquire these skills at a later date can be occasions for shame and may be avoided in consequence. (Consider adult literacy programs.) Minimizing delay and damage to the acquisition of certain core competencies would seem a far better course than mobilizing the resources to fix the damage later. Second, even when well-marked and expected, routine life transitions can be stressful. In late modern societies, this stress is compounded as “transitions” have become less well marked and culturally scripted. Difficulties in negotiating age-graded changes are not uncommon (Newman, 1999). When psychiatric crises coincide with the ordinary work of negotiating such transitions, the potential damage to “normal progress” is amplified. And third, the developmental sequencing of capability acquisition is a social as well individual achievement. Alternative responses to crises that minimize biographical disruptions could prevent the cascading sequence of ever-more isolating moves that so often follows upon the decision to hospitalize. They could, in principle, pre-empt social exclusion.

From Poverty to “psychiatric crisis”

Developed over the course of several decades, Sen’s “capabilities” framework is foremost an argument for recapturing agency in the strong sense of setting one’s own course in life. By placing a premium on *how* decisions are made as well as what they consist in, the capabilities approach has revolutionized the way we think of poverty and “well-being,” especially with respect to international “assisted development” programs. By valorizing the symbolic as well as material dimensions of poverty, it ratifies recognition as well as redistribution on the human rights agenda, which further alerts us to the importance of equipping the socially excluded with the tools (and providing occasions) for them to make their own case.

“Capabilities” is Sen’s term for socially ensured and practically provided opportunities that make it possible for people to undertake those culturally recognized engagements that make for a good life. Income and commodities alone do not suffice to capture the substance of well-being. “Resources,” even when publicly provided, also fall short as an adequate index. Instead, Sen urges us to take stock of the valued things people are actually able to do or to be as a result of having the requisite income, goods and abilities, along with locally enabling social sanctions. In this way, he builds a case for capabilities as *substantive freedoms*: real, actionable options that are open to someone as the combined result of external resources, internal capacities, experience, and a supportive socio-cultural environment. “Heterogeneities” enter the picture here as critical moderators of conversion: how difficult it is to assemble such combinations or to transform them into real opportunities will reflect the enabling/constraining force of such social distinctions as gender, race, class or disability. Social inequalities should be construed/coded as capability deprivations, Sen argues, which must be justified by appeal to reason or scarcity. This can put CA at odds with tradition – what custom bars for women that it freely sanctions for men; or what it denies same-sex couples that it grants to mixed ones. At the same time, CA acknowledges the need to trace out the origins of apparent privations; a life of poverty, chastity and obedience may signal a commitment freely undertaken when entering a religious community, but it is something else entirely when imposed by accident of birth.

“Functionings” refer to the actual choices made, conditions enjoyed, or practices undertaken in a given context. These ranges from life expectancy and everyday securities to more complex “social functionings” like those involved in exercising the duties of citizenship. The basic registers of poverty’s impact (ill

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[7] What Nussbaum (2000, p. 84-85) calls “internal” capabilities will prove crucial to the “navigational capacity” that Appadurai (2004) sees as the crucial developmental acquisition of late adolescence/early adulthood and what we may be most concerned about with preserving (even enriching) through the crisis situations at issue here.

health, premature mortality, inadequate shelter and nutrition, limited literacy, etc.) can usually be tallied as limits on functionings. But Sen insists upon poverty as “capability deprivation” to underscore the deeper forms of disadvantage, the threats to freedom, which the term is meant to capture. To be able to appear in public, apply for a job, send one’s children to school, or pursue marriage “without shame” is one such capability that seems universally applicable (cf. Jacobson et al., 2009). His basic point is the one repeatedly encountered in analyses of the “stigma” attached to mental illness: like the long shadow of psychiatric diagnosis, poverty not only erodes purchasing power but also poisons social regard and cramps participation in civic life. Truly corrective/preventive interventions, then, will need to deal not only with material resources but also with symbolic representations, social practice and everyday engagements – to say nothing of one’s own developing self-understanding.

How well anti-poverty measures enlarge the local field of actually available and valued options in a life is Sen’s proposed metric of development in any social group. Quality of life becomes a textured matter of ensuring both basic securities and the cultivation of more complex capabilities, especially those dealing with “practical reason” and “social affiliation.” The first refers to the arduous business of reflective assessment, good judgment, wide-ranging imagination and courage that goes into *planning a life of one’s own authorship*. The second takes in both opportunities for connectedness and citizenship as well as what Rawls calls “the social bases of self-respect:” those elemental institutional provisions/safeguards that must be in place “if citizens are to have [or develop] a lively sense of their own worth as persons and to be able to advance their ends with self-confidence” (Rawls, 2001, p. 59). For our purposes here, both livelihood prospects (paid work vs. disability benefits) and status devaluation are implicated: social recognition is what stigma, as structural fact and social practice, undermines.

Planning a life and sustained social participation are jeopardized by the biographical disruptions of “first breaks.” More important here, it isn’t simply the bewilderment and rupture of the crisis but *conventional means of responding to it* that compounds and extends the damage to life projects. What alternative responses to first breaks must provide, then, are feasible ways to undercut the iatrogenic consequences of psychiatric treatment (Beals, 1984; Tarrier et al., 2007) – or, more radical still, viable alternatives for negotiating extreme states *without* resort to conventional treatment – while offering guidance and safe haven for the duration of the crisis.

CA has one final provision that will prove of particular interest to us here. It explicitly allows for – in fact, it affirmatively *builds in* – a tension between well-being (being well provided for) and agency (pursuing one’s own life projects and cultivating self-respect). As participants in public mental health systems understand only too well, that tension may complicate even the most fundamental acts of care and custody. To put it bluntly: *agency* is not only the wounded faculty ostensibly being treated; it also conditions – that is, enables, constrains and shapes – how effective care and basic securities are provided at all. Even when delivered with the best of intentions, as Sen reminds us, “cunning development [*or treatment*] programs” may come to grief if they ignore this fact. (One sees this regularly in those desperate tableaux of assistance refused, as in street outreach to the homeless poor [Hopper, 2006]). But the lesson goes deeper than mere stubborn pride – it bores to the heart of elemental protections of dignity. Provision of needs-meeting goods may be stymied, and their intended purposes negated, if the terms of receiving them violate locally/culturally prized aspects of persons. If being a “beneficiary” of some program exacts a diminished sense of oneself as active agent in return, offers of assistance may be refused even if one suffers degraded well-being as a result.

So central an affirmation of agency makes for heightened sensitivity to its denial. For public mental health, one implication is that the adoption of coercive techniques should be subjected to close scrutiny for evidence of feasible options refused. Routine appeals to efficiency and public safety will require argument not just articulation. Nor will it suffice simply to invoke risk management.[8] When we interrogate alternatives, we will be seeking provisions of care or responses to crisis that minimize implicit assaults on dignity and self-determination. (For those already in the mental health system, this is the purpose of advanced directives or crisis plans [Amering et al., 2004].) Recalling that psychiatric crises rarely occur in isolation, we will also want to know how alternatives inventory and engage interested/implicated others, especially families. For both, non-coercive approaches would seem to honor agency and reduce shame.

To the list of three tools compiled earlier, then, we can add five more:

- social wrongs and harms – and thus the local ledger of injustice – must include both material and symbolic forms of deprivation and devaluation;
- assisted development schemes should be judged by how well they enlarge the actual field of valued options in an ordinary life – and the process by which they accomplish this;
- planning a life and social participation – including the "social bases of self-respect" that enable underwrite one's commitment to both of these – make up two core capabilities;
- there is a tension between an assured but other-defined well-being and the riskier road to fulfillment that one maps oneself if but haltingly, through mishaps and instructive failures; and, implicitly;
- a distinction between a weak sense of agency (intentional action) and a strong sense that includes a *reflective* component – or what might be called "critical agency."

A final piece of conceptual apparatus will help clarify the importance of the last two ingredients.

Capabilities and capacity to aspire

What one picks up and internalizes, through existential trial and error, and learns to use reflectively can be recast as improvised rite of passage, as Appadurai (2004) has suggested. For him, culture is not simply a storehouse of tradition or mere repository of the past, but a living program for equipping its members to face a future. Like Sen, Appadurai is acutely conscious of structurally-imposed differences that determine how readily members are called upon to exercise, and thus develop, what he sees as a life-planning (or "navigational") capability. Young people learn about real possibilities in life by trial and error. Locally valued "beings and doings" become real options in one's own life by trying them out and seeing how well they fit. (In the process, the first traces of what Sen calls "commitments" may be laid down, and a life-long interest piqued and cultivated.) The trick is to minimize the long-term costs of what prove to be poor fits or bad choices. Sometimes the buffers are temporal: horrific summer jobs teach as urgently as they do precisely because one knows they won't last; the risks run are time-limited and subject to self-initiated renewal (after a 9-month period of thinking it over and weighing other options). In contrast: dropping out of high school is difficult to compensate for precisely because the passage is normative and so tightly bound with age-mates and adolescent routine. Household resources and social capital may also be critical in salvaging some mistakes; a wasted semester is much tougher to justify when family resources (or financial aid) are in scarce supply. Appadurai's vision of a productive adolescent passage combines hard knocks and soft landings. Short-term apprenticeships with bail-out clauses, they function as rehearsals for the real thing that leave other options open and equip one to explore them in a more informed manner.

That last point is worth underscoring. It's not just that such trial runs or test drives teach one something about how the world works and one's provisional place in it; they also inform choice. Over time, the accumulation of experience from such exercises equips one with "the

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[8] As the competing practices of the U.S. and U.K. illustrate – see Elyn Saks' memoir where the contrasts are brightly drawn (2007: p. 60ff + p. 79ff, vs. p. 124ff).

kind of judgment that arises only from experience; hunches rather than rules" (Crawford, 2009, p. 29). A sense of what's "out there" and what really matters informs "capacity to aspire," shaped by ruling out options and glimpsing possibilities to further explore. In ways both unexpected and brusque, even lousy summer jobs can enrich a developmental project of "values clarification."

To see how this toolkit might aid us in understanding alternative approaches to crises, we need first to review the largely contrived conversation between capabilities and disability to date.

Capabilities / Disability / Impairment: Three Versions

Apart from indexing diversity, unmet need and invisible informal support, disability has not figured prominently in development literature or (until recently) the capabilities framework.

- Original version

Disabilities belong to that miscellany of "personal heterogeneities" that condition how easily resources can be *converted* into opportunities. Illustrative examples – assistive technology and environmental accommodations that correct what would otherwise be the "comparative deprivation" of the disabled – are present in CA from the start (Sen 1992, p. 28). Culture adds complication: to be a literate woman where there are libraries is of no account if women are confined to the home; casual ridicule can lead a capable but visibly "handicapped" employee to settle for disability benefits. The close affinity of CA's "conversion" problem to Word Health Organization's (WHO) original "consequences of disease" schema[9] readily aligned it with the social model of disability. But the impetus to do so arose, not because capabilities scholars thought long and hard about disability, but because practitioners elsewhere turned to Sen's framework for fresh tools to address difficult problems in disability theory – calculations of "disability-adjusted" poverty rates, assessments of disability in development, and modest social-justice applications such as the World Bank's. (e.g., Burkhardt, 2004; Mitra, 2006; Qizilbash, 2006; Zaidi & Burchardt, 2003; Kuklys, 2005; Braithwaite & Mont, 2008; WHO & World Bank, 2011).

CA's distinctive contribution is to argue that, *like other forms of difference,* uncorrected or uncompensated disability amounts to capabilities deprivation because it interferes with one's ability to make a valued life and participate fully in society. Larger social and political considerations (as well as resource availability) determine whether that interference is considered fair, necessary or changeable. As with the WHO scheme, deprivation occurs at two stages: at the level of the original *impairment* (here, "psychiatric disorder") and at the level of *disability* (its social reception and everyday consequences). One's achievement potential in any local environment is a function of the resources at one's command and one's (native or learned) personal capacity. Law, custom (e.g., gender roles), and policy affect how easily that potential can be converted into real opportunity. By definition, impairment limits one's personal capacity in some non-normative way. But to see how that translates into disability in practice, we need to ask whether, in a given setting, customized resources are available to counter what would otherwise be the loss of substantive freedoms. Capabilities are all those valued ends that fall within one's (adjusted) range of real opportunity. Uncorrected disability becomes capability deficit, recognizable both in the diminished range of choices available (because some options are simply foreclosed) and in actual choices made (because that's what "people like me" are expected to do). It is impact, not interference per se, that matters.

Fully corrective measures must target both the fit between personal capacity + targeted re-

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[9] Which distinguished impairment (at the clinical diagnostic level) from disability (or personal functioning) and from handicap (interference with social roles). The recent revision moves from a "consequences of disease" framework to one that lays out "components of health." Medical terminology no longer presides, a new emphasis on activity and participation can be discerned, and the overall shift is one of perspective not merely semantics – it might even be characterized as moving from compensation to aspiration (WHO 1980; 2001).

sources *and* the conversion of adjusted impairment into real opportunity. Assistive technologies (medication, illness management skills, rehabilitation) might enhance personal capacity and lower impairment, but their success in addressing disability depends upon converting the fruits of that assistance into valued social roles and activities. Accommodating culture complements enhanced capacity to produce capability. Training may make you work-ready; converting that into employment requires jobs and willing employers. And even then, social technologies (supported employment, job coaching, affirmative enterprises) may also be needed to modify workplace environments and ease the opportunity gradient. For "treatment" to be a viable option attending to symbolic costs (long-voiced user complaints about lack of respect in clinical settings) may be necessary. And if "recovery" is to be more than rhetorical flourish, substantial "specification" work and targeted resources are needed – not only within public mental health system proper but outside it as well. Nor, finally, can the terms of a reclaimed life be defined simply in terms of "conformity to some pre-defined notion of normality." What really matters – reasoned commitments that trump expert readings of well-being – are what persons living with disabilities themselves decide (Burchardt, 2004, p. 742ff).

That said, much remained unplumbed in this original version. "Values clarification" rarely went beyond what had already been capably argued by others: a determination to minimize the multiple social disadvantages so often entailed by resort to emergency psychiatric assistance. Even as it grappled with the consequences of disability, the capabilities literature showed little interest in its determinants or distribution. Potentially fruitful affinities between capabilities and the social model of disability were rarely explored beyond patented instances of wheelchairs and curb-cuts. Discussions of "agency" never addressed temporary lapses of reason or issues of disputed competency. Unqualified references to "the mentally disabled," marred otherwise bold calls to expand the reach of social justice (Sen, 1993, p. 44) On some accounts, lists of core capabilities could even be read to exclude people whose intrinsic limitations were such as to classify them as not "truly human" or bar them from certain requirements of a good life (Baylies, 2002; Wasserman, 2001).

More to the point here, what counts as "intrinsic" was not closely examined. That impairment itself could be materially shaped by the clinical/social response to the crises that announce its arrival, that it *becomes disabling in part because of the way in which it is received*, was not generally appreciated. The emphasis was on damage control, not prevention. Impairment was taken as given and medically certified. It was what the social machinery of recognition and integration had to work with, not something already shaped and stamped by a largely backstage and unexamined crisis management and difference containment process.

- Revised version

More recently, both the social model of disability and the explicit standard of "human flourishing" in some versions of CA have come under critical scrutiny. Feminist theorists have found it useful (and more faithful to their own experience) to address "impairment effects" – those lingering and/or episodic "disruptive" effects that chronic ailments can exact. Thomas, for example, has argued that in addition to those "restrictions of activity" that are "entirely socially caused" (the contested field of disability claims), there are *also* limitations that are more properly considered as "properties" of the condition itself (Thomas, 2007; cf. Terzi, 2004). And these are likely to matter for one's well-being and life projects no matter how accommodating the social response or individual adaptation.

Nussbaum has rethought earlier comments about core capabilities essential to be fully human, while still arguing for the heuristic value of a "species norm" for flourishing (2006, p. 166ff, 285f). How people afflicted with severe congenital cognitive deficits are ensured "the social bases of self-respect and non-humiliation [and are] able to be treated as a dignified human being whose worth is equal to that of others" remains problematic. Skilled advocacy in well-endowed school systems may secure inclusive policies "focused on recognition of individuality" But this assumes parents with substantial social and cultural capital as well as an unproblematic process of inclusion as the de facto answer to stigma and shame. Intriguingly, too, the bright line drawn between impairment and disability in the WHO *International Classification of Impairments, Disabilities, and Handicaps (ICIDH)* schema is now acknowledged to be "difficult to draw, particularly when the social context is not fixed and is up for debate" (Nussbaum, 2006, p. 426). As before, however, impairment is taken as an unanalyzed given. How the clinical response (to crisis, injury, inheritance, disease) defines the moment, directs the social response and predicts a course – as in the designation "*first* break" – remains unexamined.

It seems fair, then, to characterize the revised version as less a repudiation of the social model of disability than a redress or refinement of the "corrective" originally offered. Social and cultural accommodations to difference are firmly endorsed, while warning of the unintended consequences of "the denial of difference" even when done in service of "an attempt to overcome discrimination" (Terzi, 2004: 154f; cf. Mulvany, 2000). At the same time, the logic of *care* is readmitted to deliberations on policy, softening and extending the law of inclusion. Care requires judgment and discretion if it is to ease the work of suffering and improve quality of life, while avoiding the snare of paternalism (Mol, 2008). By the same token, the work of caretaking is revalued, especially the invisible and largely unacknowledged labor of kin.

- *Radical version*

At the same time, within disability studies a lively debate was shaping up about the norm of "normal" – and the sleight-of-hand involved in presenting it as value-free (e.g., Wasserman et al., 2005; Terzi, 2004). This goes to the heart of the working distinction between individual and collective assumed in the social model of disability. In a Foucault-inspired critique of the social model, Tremain (2005) argues that it remains wedded to a repressive (or "juridical") conception of power; hence, *both* the uncontested object "impairment" *and* overtly rights-based arguments for "inclusion." Impairment offers leverage and legitimacy (courtesy of medicalization) but at unrecognized cost. A subtle form of power acts *antecedently* to the politicized moment of the disabled state. The original act of repair, of arresting a crisis and salvaging a self, is invariably conservative (or "normalizing") no matter how caring or "empowering" the intended intervention (Joseph, 2002; Cruikshank, 1999; Rose, 1999). (To use Foucault's formula, we need to attend to the *productive* forms of power, not simply its repressive variant.) Unexamined "normality" is put to the question. And so it isn't simply (as in the social model) that fresh restraints on freedom are imposed from without on persons with a pre-existing impairment. Rather, it's that the original response *constitutes their freedom* in ways that are defined and circumscribed as "impaired." More akin to gender or caste than it is to policing, medicalization is less an instrument of "social control" than it is a technique for producing special kinds of citizens under the rubric of treatment (Tremain, 2005, p. 11).

What is most insidious about the exercise of "biopower" in this view is the subtlety with which regimes of governance and division take up residence in the deliberating self. This species of power, Tremain argues, "actually governs… by guiding, influencing, and limiting their conduct *in ways that accord with their exercise of freedom*" (2005, p. 10, ital. added). It so, then the domain what, in the CA lexicon, is known as "adaptive preferences" has effectively been extended to cover instances of misrecognized agency as well.

On the user/survivor front, an allied set of concerns is taking shape (Beresford & Wallcraft, 1997; Beresford, 2002; 2004; Beresford et al., 2010). While acknowledging the strategic utility of a rights-based disability movement, some remain skeptical of a membership predicated upon acceptance of an uncontested category of impairment. Rather than acceding to diagnostic or administrative categories, they urge inspection of them as "othering" classifications and segregating practices. In this, they are guided by the reflections of users who have had direct experience with the caustic clemencies of such programs. At the same time, they urge concerted work to develop “alternative understandings and interpretations of madness and distress” (Wilson & Beresford, 2002, p. 143). These variant framings of difficulties and extreme states would seek to establish kinship – *not* by expanding disability’s bounds – but by recognizing humanity’s range. But if this is to go beyond critique and, defying both professional expertise and colonized common sense, seek to *theorize* madness and distress in unorthodox ways, it will need an alternative evidentiary base.

This version takes us deeper into the nature of the reconstructed self that emerges from the ordeal of “first breaks.” It recognizes the clinical experience is baptismal, durably altering, in ways both visible and concealed, those who have endured it and marking their entry to a special category of membership. To repeat: this is not simply a matter of deprivation. Rather, their altered sense of self is less a *deficient* product of denied opportunity (as in CA) than a *shaped* construction of self-understanding.

To the set of tools provisionally assembled, can now be added a reworked social model of disability that (although still a work-in-progress) subjects the category of impairment itself to critical scrutiny. In this way, both the bounds of the normal and the unacknowledged productive power of diagnosis and treatment are reclaimed for analysis.

Applied Capabilities and “First Breaks”

To date, the application of capabilities to the “assisted development” enterprise of public mental health has been *post facto*. A (series of) crises having already occurred and its history already opaque, a capabilities-informed approach addresses the social machinery that freights patienthood and conditions provision of care and livelihood aid in such odious ways. A host of corrective actions follow: confronting stigma, restoring agency, instituting regimens of shared decision-making, providing occasions for exercising voice, contesting coercion, advocating for structural “accommodations” in the mainstream of social life. The aim, *belatedly,* is to enlarge the realm of the possible and transform the meaning of injured selves. Hence the reach of studies cited earlier: rethinking recovery as restored agency, reclaimed citizenship and unbarred social participation. CA helps to frame and justify a restorative agenda: to reduce or contain the collateral damage, in clinical and civil settings, stemming from the ordeal of diagnosis/treatment, and to expand the range of self-determination even in those officially designated “patients.”

Reform proposals that follow are essentially salvage operations, geared to minimizing the consequences of a troublesome identity newly conferred and likely to last. If specific programmatic counterparts remain scarce and difficult to specify, the overriding concerns are familiar – in part because many were originally articulated by voices of discontent among users of services themselves. These include: contesting compromised citizenship as well as impaired health; exploring prospects for people to flourish, not merely be free of constraints; identifying (and working through?) real tensions that may exist between even evidence-based prescriptions for restoring well-being and the messier ambiguities of self-directedness (often operating in halting, trial-and-error mode); opening conventionally closed options in social life (like parenting); rethinking the moral dimensions of full social participation; questioning past experiences that set the invisible standards against which measures of quality of life are taken, and seeking ways of raising that standard by drawing upon the embodied evidence of others with similar experiences differently processed; reframing recovery as collective project as well as existential ordeal.

But the more ambitious and demanding route – and the one at issue here – would be to *disrupt the disablement process itself*, to reconfigure conventional responses to psychiatric crisis in ways that take hold of troubled selves and turn them into patients. It is to intervene in what is currently, if inadvertently, an identity transformation experience, such that the transformative process that psychosis begins and the clinical passage completes is redefined and re-orchestrated (Barrett, 1996). Extending the conversation between capabilities and the social model of disability may yet prove adequate to rethinking recovery. But rethinking "first breaks" raises the ante and complicates the task. The agenda of the "belated" project described above is different from the "preemptive" one at stake here, and for that we need the more thoroughgoing critique offered by the "radical version."

By intervening at the original moment of reception, at the redefined clinic (or its functional equivalent), the arduous, necessary and *later* work of social restoration and identity reclamation may be greatly reduced. There would be less damage to undo, fewer disruptions to repair. In effect, *alternatives* seek to circumvent the social costs of stigma – not by defeating it (the larger, still pending, social project) – but by robbing it of its igniting occasion, the threshold moment of becoming "a mental patient." No clinical harm, no befouled soul.

The radical version takes us back to the roots, to the original staging encounter, and invites us to re-write the script. Hypothetically, then, here is how it might work: Alternative responses to what would otherwise be diagnosed as "first breaks" enable the person in crisis to elude the self-staining encounter that initiates a career of patienthood – embraced, resigned to, contested or refused, as the case may be. Alternatives de-medicalize the moment, reframing the disruption as an unexpected developmental crisis, extreme and un-ordinary perhaps, but still expected to be transient. The moment is expressly recognized – and communicated to both troubled self and engaged collaterals – as *liminal*: those who undertake this difficult passage are suspended, for the duration and dangerously, between an untenable "prior" and an unforeseeable "subsequent." But the logic is one of passage and the operative trope is more boot camp/monastery/trekking pilgrimage than emergency room or hospital bed: a severe and painful transit, aided by experienced guides, justly confident of their skills and your return. (The sufferer finds herself in safe hands: "you'll get through this; we've been here before.") The attendant personnel, rituals of reassurance, techniques of support, interpretive frames and physical location all serve to stage the experience in non-clinical terms. Mobile crisis teams may reconfigure and re-deploy their clinical skills in ways that subvert traditional associations with hospital environs. Instead, much as classic myth and some accounts of user/survivors themselves attest, *the crisis becomes a trial not a breakdown* – not something to escape or suppress or contain, but an ordeal to be endured and learned from. In CA's lexicon, concerns of immediate well-being are temporarily suspended – the quest itself can be difficult and painful, the developmental break fearsome and dislocating – but the unruly agency of the self-in-crisis is unfailingly supported.

We have some evidence that so thorough a re-imagining of the script directing "first responders" to developmental crises may have some real-world resonance. User memoirs are emphatic about the hard work necessary to wrest the unique "meanings of madness" that may apply in a given instance. Correspondingly, clinical sensibilities in the Open Dialogue approach are acutely tuned to the first "tiny signs of the patient's reflection," the earliest stirrings of critical agency in the wounded self, else the "possibility for dialogue might be lost, leading to poor treatment outcome." In the course of that dialogue, "patients and family increase their sense of agency in their own lives" (Seikkula & Olson, 2003; Seikkula et al., 2006). Even within these fraught confines, it seems, the "agony of recognized agency" (Nussbaum, 1999) is no mere mythic allusion, but an existential responsibility slowly and provisionally taken on.

But at the moment, we seem faced with two uncommunicative literatures: the one, wresting redemptive possibility out of a refusal to believe and participate in a clinical enterprise designed to manage chronic disease and its sequelae; the other, a nascent and still largely clinic-based movement departing from standard practice, one whose evidentiary record to date (comparative "outcome" measures) has been assembled as an argument for medical legitimacy (Bola, 2006; Bola et al., 2006). The usual array of outcome measures tend to suffice, while questions of meaning, of reclaiming a life otherwise "written off", are shelved.

The brief as much mutinous chorus as it is documentary record, builds such a powerful case for the centrality of reclaiming the self – existentially, discursively, defiantly, as person not patient – that any case for alternatives would seem bound to address the question: *how do people who have experienced unorthodox responses to crises come to understand the ordeal they have endured, the passage they have completed?* Are these even the appropriate images or names for what they have been through? What explanatory models, interpretive accounts, practical skills, or reframing of this "biographical disruption" do they (or their families) fashion? With whose help? Using what tools? To what end? How do such accounts change, mature or persist over time? Stastny and colleagues' review of (largely European) efforts (2009) suggests that the literature on alternatives has yet to address (or, more precisely, report on) such issues. So we are left, for the time being, with unanswered grievances on the one hand, and tantalizing hints (fleeting mention of a family's linguistic capability for reflection, for example) on the other.[10]

Querying actually existing alternatives

We can, however, formulate some capabilities-provoked questions about the architecture and practice of alternative approaches to crises:

- *Framing the crisis*: How are customary, medicalized (if still nonspecific) anxieties about what is happening – everything the person in crisis (and distraught family) comes pre-programmed to fear – thwarted or redefined? What language(s) of ordeal or extreme states are actually used? Is there a distinctive logic of care (Mol, 2006) at work here? How does it construe the individuality of the passage, the "uniqueness of each person's path"? How do veterans of such alternatives describe themselves afterwards – what images do they use to describe their ordeal? How is their self-understanding changed? What do they tell their friends? How would they advise others in trouble?
- *Guidance, embodied evidence of possibility*: Who make up the crisis-attendant personnel and from whence comes their expertise? Is their support the sort that can be salaried and formalized? If not, how is it provisioned and secured? What assurances can be offered that such resources will be available if needed in the future?
- *Agents and sufferers*: How is the sense of "being in safe hands" communicated? What techniques/gestures/practices (or familiarity of surrounds?) are used to reassure both sufferer and engaged collaterals? How is each (separately? together?) enlisted as an active player in the crisis resolution process? How are they equipped to identify and managed such crises in the future?[11]
- *Outposts of self-respect*: Are such alternatives distinctive enough from conventional responses to convincingly redefine – to *de-pathologize* – the biographical disruption at stake? Can they do so in ways powerful enough to elude the assault on self-respect that medical management so often entails? What staging areas are used? How are they chosen, equipped, dismantled or reframed in ways that distinguish them from hospitals? Is the architecture of alternatives – a program of conditional exemption from ordinary life that transforms one's sense of what it means to belong and make a go of it there – such that survivors can describe what they've been though in ways which enable others to consider such options? (Are they distinctive enough to appeal to those who ask to be made "safe from psychiatric treatment"?)

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[10] A decade ago, Beresford and Wallcraft (1997) described progress in survivor-led inquiries into eating disorders and self-harm. To my knowledge, none has addressed "first breaks."

[11] Is there any linkage with, or reliance on, conventional mental health services? If so, how is that understood?

By Way of Conclusion

Both capabilities-informed correctives reviewed here, the belated and the pre-emptive, ask not what people should be content with but what they should be capable of, and how that might be best achieved and sustained. Each encourages thinking about human flourishing in ways that include both "primary goods" (Rawls' material and cultural necessities), as well as more complex competencies (the exercise of practical reason and social connectedness) and representations of worth. Each bridges material and social registers of disadvantage. Each, that is, opens inquiry into social justice – the first by asking how impairment translates into durable inequities (material goods and, a slipperier quarry, cultural disrespect); the second, by contesting the impairment designation from the start and seeking social resources for unconventional crisis resolution and support. Each ventures beyond demands for reallocating goods or providing special services. Each attends (but in very different ways) to long-festering concerns with stigma and identity (symbolic violence and social representations). The difference, to say it again (a large and consequential one), lies in the timing of the corrective mounted.

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