

Rethinking social recovery in schizophrenia: What a capabilities approach might offer

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Available online 17 May 2007

Abstract

Resurgent hopes for recovery from schizophrenia in the late 1980s had less to do with fresh empirical evidence than with focused political agitation. Recovery's promise was transformative: reworking traditional power relationships, conferring distinctive expertise on service users, rewriting the mandate of public mental health systems. Its institutional imprint has been considerably weaker. This article takes sympathetic measure of that outcome and provides an alternative framework for what recovery might mean, one drawn from disability studies and Sen's capabilities approach. By re-enfranchising agency, redressing material and symbolic disadvantage, raising the bar on fundamental entitlements and claiming institutional support for complex competencies, a capabilities approach could convert flaccid doctrine into useful guidelines and tools for public mental health.

Published by Elsevier Ltd.

Keywords: Recovery; Schizophrenia; Capabilities; Disability; Public mental health; USA

Introduction

Ambiguity about core values, operational principles, and organizational goals has its strategic uses, among them the formation of unlikely coalitions in pursuit of structural change. Such amalgams have figured critically in the annals of mental health reform, though the roles of specific groups or external constraints remain disputed and the verdict of history mixed (compare Scull, 1976, with Grob, 1991). Institutional reform inevitably involves a reckoning, a sorting out of competing versions of allegedly shared assumptions, and their selective translation into practice and policy. “Working

misunderstandings” can carry a merry band of reformers only so far before political realities step in to call the question and tally the bill.

This article takes stock of the institutional imprint of “recovery” from severe psychiatric disability in US public mental health, and does so from an applied anthropological stance. This may surprise some. Anthropologists are best known for bringing a spoiler's sensibility to their reading of psychiatric procedure, dusting for cultural fingerprints on the suspect premises of clinical practice—like discerning traces of “governmentality” where others see therapy or empowerment (Joseph, 2002; Rose, 1999). A second, lesser-known tradition claims the same ancestry but applies a rather different sensibility. Its proponents (initially Estroff, 1981) tend to portray contemporary community

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psychiatry as unusually hard repair work in socially suspect precincts (Hopper, 2006; Luhrmann, 2000; Rhodes, 1991, 2004; Robins, 2001; Ware, Lachicotte, Kirschner, Cortes, & Good, 2000), work that has pointedly moral overtones. This inquiry hails from that latter school. It accepts the reality of schizophrenia as ethnographic fact—local, consequential, contested—and asks how its social fortunes may have shifted in response to what looked like an ideological uprising.

Social recovery in schizophrenia

The empirical record

The enigma of recovery in schizophrenia is partly a confusion of tongues. From the earliest days of clinical tracking, the orthodox view of progressive deterioration was harried by reports (sometimes bewildered) of apparent recovery. Its chief proponent, Emil Kraepelin, was widely cited as documenting a “real improvement” rate of 26%, half of whom showed complete recovery (Hinsie, 1931). Early in 20th century, Eugen Bleuler cautioned that most “end-states” escaped clinical inspection; still, he thought “improvement” to be the modal outcome and favored Kraepelin’s phrase “cure with defect” (or “healing with scarring”). Such people could be considered “healthy,” if eccentric or moody; but they had purchased provisional stability by “lower[ing] the level of aspirations with regard to their accomplishments and claims on the world” (Bleuler, 1911, p. 163). In the US, Strecker and Willey reported 20% recovery in patients treated in a private hospital. Queried by colleagues about “scarring,” they clarified: this rate referred to “adjustment at a social level ... [patients were] getting along quite well in simple life situations.” They stressed the capacity of those patients—all of whom were women—to do “important work,” child-rearing and household management, in un-protected environments (Strecker & Willey, 1928, pp. 428–430).

Those results were soon favorably cited by a research psychiatrist wryly noting the “established fact” that recovery occurred among patients in “large, over-crowded State hospitals ... [where] no therapeutic measures have been applied, at least wittingly” (Hinsie, 1931, p. 216). Echoing Bleuler, he admitted how little psychiatry knew about recovery outside hospitals; to call it “spontaneous” was simply a “shield” for ignorance. Hinsie’s honest

appraisal of long-term evaluation was an admission of hitting a brick wall. Fortuitously, field studies of mental illness were just then getting under way in Europe (Hammer & Leacock, 1961). Better understanding of this tantalizing, if still mysterious, prospect of restored functioning would await their results, as well as those of long-term clinical research.

Social recovery’s most prominent champion would prove to be Bleuler’s son, Manfred, whose magisterial account of the natural history of schizophrenia appeared in 1974. His research took him outside the hospital walls, engaging him in the daily lives of those he treated. In his view, the course of schizophrenia usually tended upwards after 5 years, and potential for improvement was stubbornly apparent in even “very chronic” patients decades after onset. Most did well *without* ongoing medication or social assistance. Still, the therapist was hardly a disinterested bystander: “an open heart and an alert mind,” Bleuler counseled, could counter the “resignation and despair” that so often seemed to attend prolonged work with such patients (Bleuler, 1974, p. 253).

Bleuler’s enthusiasm was unusual, but his results were not. “Social recovery” proved common enough outside the hospital, when measured by independent living and gainful employment (e.g., Walker and Frost’s “social restoration score,” 1969). In the 1970s, Strauss and Carpenter’s findings from the WHO International Pilot Study of Schizophrenia (Strauss & Carpenter, 1972, 1974, 1977) put the relative autonomy of distinct domains of functioning on firm empirical footing. Subsequent studies have reinforced the point: whatever their reciprocal interplay might be, the clinical and social courses of schizophrenia need not proceed in lockstep. “Premorbid” competencies are reasonable guides to post-illness performance.

Time, too, has healing power, as Bleuler had shown. Arguably the most persuasive evidence for the long-term prospects of recovery was Harding and colleagues’ study of state hospital patients in Vermont (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b). After 36 years in the community, outcome for between one-half and two-thirds of these subjects was “neither downward nor marginal, but an evolution into various degrees of productivity, social involvement, wellness, and competent functioning” (Harding et al., 1987b, p. 730). Even that scrupulous qualifier (“various degrees”) can’t mask the optimism. And while the

yield of later studies has been mixed, by no means have these bracing results—with their promise of “slow, uphill returns to health” (Harding, Zubin, & Strauss, 1992, p. 34)—been overturned.

Such findings resonate with lessons from cross-cultural psychiatric epidemiology (Hopper, 1991, 2003; Kleinman, 1988). Warner’s exhaustive appraisal of political economy’s role (Warner, 1994) is instructive. The under-appreciated key to this sprawling literature, he argues, is the degree to which social demand accommodates the returning patient and facilitates recovery. Where locally valued positions are available to members impaired by psychiatric disorder, re-integration is assured and the subsequent course of illness more favorable. Scarcity makes collaborative social arrangements likely and these, in turn, can reap therapeutic benefits; chronic sick roles, by contrast, can inadvertently cripple. Opportunities for “appropriate levels of functioning” occur both as a matter of course in traditional subsistence economies and, erratically, in tight labor markets (rebuilding postwar Europe, harvest times in agricultural communities). Where they do, “disability and deterioration” are averted (Warner, 1994, p. 158).

This brief review cannot do justice to the full range of contemporary inquiry or the increasingly sophisticated instruments used to assess disability’s impact in everyday life. (Questions of identity, the drag of indwelling stigma, struggles to rebuild a functional self, for example, have not been touched upon.) But it suffices to identify a persisting tension in the enigma of social recovery. On the one hand, psychiatric observers have long noted those adaptive responses, the lowered aspirations and muted claims, which can serve to reconcile the wounded patient to a life of flattened prospects, colorless routine and modest achievement. On the other, the slow crawl of empirical research has underscored the striking difference that social demand, accommodating surrounds, and time can make for enhanced capacity and demonstrated competence. *Some of the confusion surrounding social recovery stems from the fact that both versions of reintegration—“good enough” under ordinary conditions, effectively normal in reach and performance where unusual circumstances obtain—have been marketed as reason for hope.*

The one pays tribute to human resilience; the other, to targeted investments that can substantially enhance such resilience—to undertaking the neces-

sary social work of accommodation to expand real opportunities.

Recovery as therapeutic project

“Healing with scarring” has proven a durable trope. Present-day arguments and commentaries have unfolded in a recovery literature of unwieldy breadth (existential dispatch, case history, field report, empirical study), bearing the urgency of an idea whose time has come, the imprint of storied accounts of ordeal, and well-earned skepticism of mental health systems. If a provisional consensus may be hazarded, it would read something like this: recovery is difficult, idiosyncratic, and requires faith—but it is possible (e.g., Deegan, 1988, 2003; Mueser et al., 2002; Ralph, 2000). In making such a case, four themes prevail. Tracing them out yields—if not a formal definition of recovery—then something approximating its meaning in use.

1. *Renewing a sense of possibility*: Serious illness disrupts and unsettles, leaching hope from the future, and installing foreboding in its stead. Stigma, internalized and reinforced by an array of subtle cultural cues, compounds this uncertainty with shame, coupled with fears of distancing and rejection. A first task, then, would seem to be countering that stock of attitudes and beliefs about “craziness” that has been unobtrusively threaded throughout the scaffolding of common sense and conduct of everyday life. A second, hard on its heels, is to take stock of the awful indeterminacy of psychiatric diagnosis, and all that it leaves unsaid. Cure may not apply, but an unordinary life limned with possibility is a reasonable hope. Embodied representatives lend credibility to the claim: people who have themselves gone into maw of psychosis and emerged intact, if not unscathed.¹
2. *Regaining competencies*: Lingering symptoms or disabilities notwithstanding, effective engagement in culturally valued (or normalized) activities is essential. Chronic sick roles disable by definition and design, encouraging one to find a place in the segregated company of like-damaged others. Contesting membership there, aspiring to more than “programmatic citizenship” (Rowe, 1999), means demonstrating the social skills and

¹See the website of National Empowerment Center: <http://www.power2u.org/recovery>.

presence that mark one as “mainstream” (or fitting in somewhere socially reputable). These involve symptom management, social interaction, remedial schooling or higher education and work in some fashion. For some, acquiring the requisite skills will mean redressing a developmental gap in their biographies, typically at the transition to adulthood, when the tracks of mature social competence are laid down (later onset of schizophrenia tends to be associated with better outcome, attesting in part to being able to build upon established competencies when wrestling with post-illness identity issues).

3. *Reconnecting and finding a place in society*: Social integration may be an elusive target in research and evaluation, but its centrality to recovery is clear. Reconnecting can be tentative and halting; it can be collective and advocacy-oriented; it can be the quiet work of fitting in and getting it together. It may mean taking part in organized efforts to build contrived communities, or setting oneself to the still poorly understood tasks of building family and household. However actualized, it means constructing ways of belonging and reclaiming moral agency (Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007).
4. *Reconciliation work*: The disruptions occasioned by severe disorder wreak havoc with sense of self and career. Repairing this damage requires a good deal of identity work (Snow & Anderson, 1987). This ranges from the delicate, sometimes achingly slow work of rebuilding a functional self—a person apart from the reality of illness—to determined action to deny stigma a destructive power in one’s own life. For some, a persisting sense of casualty does daily battle with a struggling one of agency. For others, the transformation is spiritual. Like Jacob, having wrestled nightlong with the angel, the sufferer emerges marked (Jacob limped henceforth) but remade in the process (Clay, 1994).

Equally telling is what’s missing from such accounts—structure, first and foremost. Race, gender and class tend to fade away into unexamined background realities, underscoring (intentionally? inadvertently?) the defining centrality of psychiatric disability in these lives. Material deprivation is largely ignored, though poverty and shabby housing bulk large in the lives of many persons with severe mental illness. Vital contextual features—the enabling resources, rules and connections that make

prized prospects like a decent job feasible—are either disregarded or casually remarked, as though their provision were unproblematic or of lesser concern to individual reclamation projects.² The formal service system comes in for mixed review—maligned by some, thanked by others, with insufficient attention to what (other than attitude) needs to change. Community living is taken as a given, despite the continuing presence of institutional equivalents—great hulking arks of the segregated dispossessed—that have yet to be dismantled. Reformist tools central to the cause of social justice in other walks of American life—litigation³ and civil rights—are curiously absent here, as though the relevant politics were personal and an organized adversarial posture unnecessary. Nor is there much talk of the moral economy of care, that stock of founding commitments and once-inviolable norms that is easily eroded or remade in an era when “the movements of patients ... have become the stuff of which markets are made” (Lewis, Shadish, & Lurigio, 1989, p. 178).

To speak of a “model” of recovery is thus misleading. Movements are not peer-reviewed. Mobilizing committed forces means hoisting rallying cries at odds with one another, tamping down potentially divisive demands, and capitalizing on working misunderstandings. In making the case against therapeutic nihilism, rethinking services, and embracing patients as active agents in their own recuperation, this inclusive approach served well, making common cause of potentially discordant constituencies. But the same medley of affirmation, reckless hope and wide appeal made for later difficulties when converting emancipating creed into actionable policy.

Paradigm lost? Recovery’s institutional career to date

It is not too much to say that in the late 1980s and early 1990s, a nascent social insurrection seemed in

²The “few essentials” [sic] listed with brisk efficiency in the recent report of the President’s *New Freedom Commission on Mental Health* (2003, p. 9)—access to health care, work opportunities, affordable housing, and freedom from unjust confinement—appear as mere sidebars, customary provisions to picked up along the way, even as the public system charged with ensuring them is characterized as “in shambles” (Hogan, 2002).

³The ADA has not figured prominently in this story. When it does, substantial “justice disparities” appear in its enforcement of claims filed for psychiatric disability (Swanson, Burris, Moss, Ullman, & Ranney, 2006).

the works. Its manifesto—that something resembling a full life after severe mental illness was possible and that public mental health systems should be held accountable to that high standard—fired the imagination of discontented and excluded users (and once-were-users) of public mental health systems. Retribution and reformation seemed credibly in the offing. Those were giddy times, as the welter of what passed for “evidence” in support of the cause of recovery well attests. Case study, demonstration project, empirical research, practice guidelines, memoir and broadsheet—all were pressed into service as claims-making vehicles (Spector & Kitsuse, 1987), circulated as founding texts. So long as the demand was to be taken seriously as a legitimate alternative to business-as-usual, such diversity was welcome; the genre-spanning rhetoric seemed emblematic of a new regime of inclusion.

But the ground shifts and the game changes when prototype goes up against the demands of mass production. The prospect of institutional uptake forced up all those awkward questions of specification, fidelity criteria, costs, accountability and regulation that a moral campaign is free to ignore. In the event, a few brave and vital exceptions notwithstanding, system transformation faltered. The hybrid vigor that had sustained a movement failed in substantial measure to inform a program. What had begun variously as a “guiding vision” (Anthony, 1993), an empirical corrective to the “clinician’s illusion” of inevitable decline (Harding et al., 1992), a cry of protest (Chamberlin, 1979) and a plea for a “positive culture of healing” (Fisher, 1993), too often devolved in practice into a grab-bag of “assumptions, principles and goals, a set of ideas that were differently interpretable” (Jacobson, 2004). Recovery had become a floating signifier: it all depended, Jacobson shrewdly observed, on the specific problems its various proponents expect it to solve. Wisconsin’s (unfinished) story is a case in point.

Recovery and bureaucracy: one state’s story

In Jacobson’s scrupulously detailed account (Jacobson, 2004), Wisconsin committed itself to restructuring its mental health system on what were then vague but enticing principles of recovery in 1996. A remarkable train of events followed: endless rounds of deliberation, argument, planning, design; workgroups, facilitated discussions, draft upon

draft of models and guidelines, community meetings and retreats—all pursued in a spirit of inclusiveness and respect. If the recovery movement insisted that experience with the system conferred its own expertise, then a recovery-premised planning process would recognize and build upon that proficiency. This meant that the process would have to rework traditional power relationships that system users had long complained about. Disputes over meaning notwithstanding, participants agreed that recovery had to be installed and tracked at three levels—individual, system and societal.

So what, 8 years and counting, has been the impact on everyday lives and practices? Jacobson’s closing field dispatch suggests that progress has been uneven. A “Recovery Workgroup” was reconstituted as a standing advisory board and its hard-won expertise extended. A homegrown model of recovery has been adopted as the official premise of the mental health system. Tools and resources to promote consciousness-raising and self-directed change have been widely disseminated, including a superb workbook and a “guided reflection” exercise that enables agencies to take stock of their own recovery-informed progress. Statewide user advocacy for system-change is thriving and weary champions of recovery now invoke the endorsement of a Presidential Commission. But the “work of specification” (*which* meaning of recovery, geared to what problems, at what levels?), so tricky in the planning phase, has proven harder still in implementation. Demonstration programs are under way in several locales, but their impact will be difficult to assess absent well-positioned research. Financing and reimbursement have been largely shuttered from the contentious recovery debates and “experience as expertise” has had no voice there. The upshot: after nearly a decade of work, wholesale system transformation is still pending. While “change is happening ... most of it is still dependent on the work of committed individuals.” Recovery remains a cadre enterprise, not yet “institutionalized [as] part of the warp and woof of everyday practice and policy” (Jacobson, 2004, pp. 129–130).

Least well reckoned were the barriers to implementing recovery statewide. Simple inertia translated into routine delay rather than outright opposition. Some providers proclaimed recovery old news and themselves seasoned converts, only to prove holdouts instead, deaf to all the new regime implied about radically restructured treatment relationships. (Local agents of change took this in

stride and redeployed to focus on practice and guideline, rather than “attitude change.”) Routine policy changes made in other sectors, without knowledge of or concern for principles of recovery, continue to rock settled assumptions and mundane realities mental health partisans. In a world in which services are increasingly provided on a de facto basis—involving venues, actors, rules and considerations unfamiliar with recovery and beholden to other interests—such uncontrolled externalities multiply, introducing further uncertainty. Structurally this means that the pragmatics of reform are inescapably bound up with developments elsewhere. The mental health system’s warrant for attending to, let alone orchestrating, such developments is unclear. What was true of recovery narratives (avoidance of rude quotidian realities) is no less true of state plans.

The politics of recovery

Reform is hard and the story far from over. Too harsh a judgment of recovery’s prospects may be premature. Wisconsin’s unfinished project, and other smaller efforts in social experimentation, not only exemplify what can be done but also serve as standing reminders to mental health authorities of just how low their sights are set. Even skeptics are hard put to ignore the real if limited change afoot in some mental health systems and the difference it can make for care options (Floersch, 2002; Jacobson & Curtis, 2000). User-run alternatives and technical assistance, affirmative enterprises, research-based claims of drug-free recovery, quasi-legal measures (advance directives) for safeguarding autonomy in anticipation of future breakdown, gutsy forays into the messy particulars of negotiated treatment, and supported employment should all be inventoried. Weedy thickets of protest, mutual aid, misinformation and solidarity thrive in the still largely unsurveyed provinces of the Internet.

That said, any tour of public mental health services finds much that feels familiar. In well-advertised quarters of system reform, places of business once infiltrated by unruly advocates of a democratized community-based care, the absence of change (or its channeling into safer avenues) is unmistakable (Stocks, 1995). Where confrontation was once recognized as a necessary part of continuing the dialog (Blanch, Fisher, Tucker, Walsh, & Chassman, 1993), a blasé been-there-done-that now prevails. Some states opt for the simulacra of

reform: “renaming” old programs suffices to forestall more fundamental questions of power-sharing and responsibility (Jacobson & Curtis 2000, p. 335). Recovery may be the new vernacular, self-help embraced as its “empowering” lay practice, and the message of hope communicated with the anonymous economy of a Hallmark card, but for many (the majority?) persons served by public mental health systems, it remains an irrelevancy. If years of arduous collective work have culminated in a newfound appreciation for self-help, a patchwork of provisional demonstrations, and a slew of promissory slogans, then what, one may be moved to wonder, was all the fuss about? Surely proponents of that long-sought “positive culture of healing” had something more substantial, however inchoate, in mind.

It is difficult to escape the conclusion that operational specificity was unwisely sacrificed in the interest of more efficiently spreading the good news. The movement’s watchwords—voice, authenticity, process, settling old scores and filing fresh grievances—proved ill-matched to the grind of institutional sway and regulatory reform. Recovery had merit, morals and the tempered weight of science behind it ... and so it sashayed into political battle unarmed. An argument for cost-savings was never joined because (one suspects) it could not competently be made. (If the whole point of individualized, needs-and-aspirations-based care is to ratchet up demands as fresh competencies are acquired, it is far from clear that this will be cheaper in the bargain.) Dealing with barriers at street-level bureaucracies was an afterthought (Corrigan et al., 2003). Political timeframes are rudely unaccommodating: state politics are played within close temporal horizons, and the structural reforms implicit in any serious recovery project are substantial and far-reaching. Elections remove critical personnel, realign priorities and leave half-measures to wilt. One administration’s bold stroke proves the next one’s unwanted legacy. In the process, recovery is easily orphaned.

To say what recovery could mean practically requires an approach that can inform social demands, not dismiss them as foregone accomplishments. It will need to be alert to shaping pressures and possibilities of context even as it recognizes the critical role of advocates. It will have to attend not only to loud requests for “evidence-based” practices but to quiet signs of the demoralizing impact of persistent poverty. It will have to balance claims for

agency-enhancing empowerment with demands for system-level reforms. And it should equip us to critically assess that durable tension in recovery's legacy—as evident in patch-worked clinical histories as in rigorous research—the tension between what seemed obscurely possible for the few and what patently sufficed for the many.

Taking agency seriously: the capabilities approach

An unavoidably moral enterprise, distrustful of experts, concerned with human flourishing, invested in choice but suspicious of plainly self-limiting ones, deeply social in outlook, political by default: these same concerns have driven a parallel movement in global development studies—the capabilities approach. This approach not only ratifies the idea that impairment's standing and impact are socially brokered, but also heeds advocates' calls for respect.

Capabilities emerged as an alternative to utilitarian (resource- or income-based) approaches to human welfare, chiefly through the work of Amartya Sen (Nussbaum, 2000, 2004, 2006; Nussbaum & Sen, 1993; Sen, 1980, 1985, 1992, 1993, 2000). Its originality lies in how it redefines “necessities” and sets the standard by which we measure quality of life or well-being. Instead of satisfaction or utility or some package of “primary goods,” Sen proposes that we consider *not* resources but rather *the valued things people are able to do or to be* as a result of having them—the *capabilities* they command. Actual welfare depends less on what I own or have access to than the real opportunities open to me as a result. Because circumstance and need complicate the conversion of goods into opportunities, what people can actually achieve with resources at their disposal will vary with socially recognized diversity, including disability. The nutritional needs of a pregnant woman, like the transportation needs of someone crippled, demand different inputs if equivalent ends (healthy pregnancy, mobility) are to be obtained. Custom complicates matters further: to be a literate woman where there are libraries is of little use if gender confines you to the home; casual ridicule on the job can so poison the workplace that even a capable (but visibly “disabled”) employee may settle for a disability check instead.

Like poverty, disability can be recast as capabilities deprivation because it interferes with a person's ability to make valued choices and participate fully in society. Social judgments determine whether that deprivation is thought fair, necessary or remediable.

Following WHO's lead, interference may be conceived as occurring in two stages (Burchardt, 2004; Mitra, 2006): at the level of the original impairment (here, psychiatric disorder) and at the level of disability (its social reception and consequences). Fully corrective measures must tackle both. Assistive technologies (drugs, rehabilitation, illness management skills—e.g., cognitive techniques to handle voices) can upgrade ability and lower impairment. But success in addressing disability depends upon whether enhanced capacity can then be converted to valued social roles and activities. Training may make someone work-ready, but to convert that into employment requires jobs and willing employers. Social technologies (supported employment, job coaching, affirmative enterprises) can modify environments and ease that opportunity gradient.

Capabilities are substantive freedoms, the potential to do or to be something that is social valued. In practice, they should be distinguished from how they are actually exercised or realized in specific “functionings.” This agent-centered approach places a premium on the deliberative process. *What one chooses is less important than the range of valued options actually entertained, developmentally available and socially sanctioned.* In assessing whether capability has expanded, evidence that one can realistically engage in informed and competent consideration of locally valued alternatives is more important than any particular path selected. Such a posture, meant to ensure respect for both cultural context and moral agency, contains an instructive tension. Eying custom critically, it seeks out suppressed discontent and invites people to question received roles and life courses. It prizes choice but makes unexamined commitments problematic.

Taking capabilities seriously means creating imaginative space where other-than-conventionally prescribed possibilities might be glimpsed. Disability offers a test case.

Social response to disabling difference

Disabilities studies (Albrecht, Seelman, & Bury, 2001) begin from the premise that the social meanings and practical impact of “disorders” are selective local readings of and responses to perceived *differences*—differences that are without social import until they are ranked and responded to. (Consider what passes for prized possessions and enviable traits across cultures, classes and castes.)

Disability is one demarcation among many that embodies this social logic. Impairment is converted into (its social phenotype) disability in the same way and with the same apparent “naturalness” (and, in some cases, stigma), as other culturally recognized differences become distinctions of consequence. We may speak of accidents of birth, quirks of fate, or mishaps of nature; but those accidents, quirks and mishaps become real for us only as they are converted into social markers of esteem or disrepute. *Inquiry into the logic of such transformations, the suppressed assumptions about moral worth and limited capacity at stake, links disability studies to the capabilities approach.* Both see this undeclared social conversion process, which transforms injuries of body and mind into locally salient distinctions, as having practical consequences (discrimination) and emotional impact (shame). For both, the indeterminacies of that process hold the key to social change.

If disability’s social reality—the viable identities and real prospects available to afflicted persons—is determined as much by the rules and resources applied to difference as by any underlying impairment, then restoration and repair become social projects not merely treatment regimens. They require interventions into common meaning-making as well as material provisions of housing and work. Such socio-cultural accommodations enlarge the realm of the possible and transform the meaning of injury.

A capabilities-informed “social recovery” will speak to citizenship as well as health. It will worry about what enables people to thrive, not simply survive. It will explore the tensions between evidence-based prescriptions for restoring well-being and the untidy ambiguities of self-directedness, with its halting, trial-and-error ways. It will critically review past experiences and unexamined assumptions that set the invisible standards against which subjective and objective measures of quality of life are taken. In seeking to come to terms with their own history, ex-patients working together can make recovery a collective project as well as existential ordeal. Institutionally, that project becomes seeing putatively damaged people as pre-emptively constrained moral agents. The terms and conditions of their release, restoration and livelihood—and the resources needed to assist in that effort—become newly contestable. Recovery asks not what such people should be content with but what they should be capable of, and how that might be best achieved and sustained.

The capabilities approach (CA) provides a robust and dynamic framework for undertaking such rethinking. It supplies a model of human flourishing that encompasses primary goods (material and cultural necessities) as well as more complex competencies (the exercise of practical reason and social connectedness) and representations of worth. Asking how disabling differences translate into durable inequities, it bridges material and socio-cultural registers of disadvantage (Olson, 2001; Robeyns, 2003).

Towards a capabilities-informed agenda

Capabilities rework recovery not from within (where it remains hostage to a rhetoric of suffering), but from without (informed by an idiom of opportunity). *Not healing but equality becomes the operant trope.* This has both participatory and substantive meaning. *How* essential goods and services are distributed can be as consequential as their approximation of equity (Anderson, 1999; Hopper, 2006). This arms us to address both immediate grievances—experiences of humiliation and shame that are central aspects of patienthood’s stigma and hierarchy—and long-term prospects for growth and development. Rawls’ “social bases of self-respect” is an essential capability, not because people ought to behave decently toward one another but because cultural equivalents of Adam Smith’s “linen shirt” (accessories that allow one to appear “creditably” in public without shame) are vital to the social self.⁴ Institutionalized disrespect compounds the suffering of those already reeling from psychosis and needs addressing. But for distress to be quelled, capacity instilled, aspiration fueled, real opportunities expanded and the floor of social expectation lifted, more than kindly attitude and respectful posture will be needed. Targeted resources and orchestrated support will necessitate active state involvement.

CA reaches beyond basic needs in prizing agency and deliberation as formative goods. Real opportunities for exercising self-determination and making informed life-changing commitments become paramount. Politically, especially with respect to

⁴Technically, as Nussbaum has recently noted (Nussbaum, 2006, p. 172), this would seem to make them functionings in principle: we do not want to leave open the choice of trading the social bases of self-respect for some other good—of voluntarily enslaving oneself, for example, in exchange for material security. But see comments regarding “dignity of risk” in text.

socially excluded persons, this translates as: “how the realm of the possible is created and how it shapes public decisions about what is desirable” (Weir 1992, p. xiii). How might CA transform our sense of what’s possible and re-configure public mental health services?

Linking capabilities to recovery

Like recovery, CA is radically underspecified, but not for want of trying. CA is incomplete for reasons of basic principle (Sen, 2004) as well as technical difficulties of operationalizing it in practice (Robeyns, 2006). Any application of capabilities must therefore first define/defend a (full or partial) list of valued functionings (e.g., Nussbaum, 2000), or specify a process for identifying/weighting them (Alkire, 2002), and then devise provisional means for assessing real opportunities for achieving them (capabilities proper). For some purposes, measuring achieved functionings rather than capabilities suffices. (The UN’s Human Development Index combines school enrollment, adult literacy, life expectancy and per capita GDP.) With respect to persons recovering from psychosis, this incompleteness is both telling and liberating. Because “outcome” expands to include what really matters to people, we need to undertake explorations of the (distinctive?) value palettes of excluded people. At the same time, at least for basic capabilities and using the imperfect tools at our disposal, we need to inventory what actual “valued beings and doings” are open to them. Constructive work of adding fresh voice and perspective proceeds along with documentation of day-to-day realities of disadvantage. Because the lifeways of these people are littered with “programs,” we also need to assess the capabilities-enhancing potential of existing interventions.

Social participation is so central to the capabilities enterprise—for setting local priorities and, in the rough-and-tumble dialectic of public discussion, for clarifying valued commitments—that some define core capabilities as those required for responsible citizenship (Anderson, 1999). This is serviceable enough as a starting point for an *inventory of disadvantage* among persons recovering from psychosis. Set aside for the moment the always-arresting condition of “appearing in public without shame” and all that it betokens. We know little enough about the social texture of their everyday lives. How widespread are deficiencies in such elemental competencies and opportunities as

functional literacy, access to information, mobility, engagement with others and debate? How often are their faculties of practical reason, for planning a life and making commitments, challenged by something other than a prescription or a program mandate? How commonplace the depredations of ordinary poverty and social isolation?

Exploring the possibly *distinctive value sets* of persons with heavy psychiatric histories is bound to be fraught. The recovery literature bristles with demands for redress of past injuries, injustices and neglect; reparation is a frequent theme. Beyond that, what stands out is the commonplace prayer for home, health, companionship, decent work and the regard of others—with two exceptions. The first is a fierce desire to restructure the contingencies of care for persons in psychiatric treatment; existing initiatives offer some venues for meaningful reform. The second, broached by intimations of the “spiritual,” is the transformative power of psychosis itself; this is still largely uncharted territory of unknown promise. Likely a more common complication is the cumulative impact of confinement, steady regimens of surveillance, discrimination and exclusion. This can cripple imagination, investing collective action with like-historied others with potentially redemptive significance.

If persons with histories of psychosis are to participate in public deliberations, undertake the transformative labor of reworking cultural templates of disability, they will need *practice in voice and standing*. (Present-day advocates with their own histories are both exemplary and exceptional in this regard.) Some may require tailored interventions to deal with cognitive impairments. Ex-patients are painfully aware that the real markers of social competence are moral not technical—being recognized as someone who is trustworthy, accountable for her actions, tuned to reciprocity, a person of judgment and good character (Ware et al., 2007). To attain this, both common accoutrements (a job or schooling, decent dwelling, regular interaction, appropriate attire and bearing) and uncommon abilities (the whole repertoire of coping skills and illness-management rehearsed in the recovery literature) are needed. Routine services address few of these well, others unevenly, still others poorly or not at all. Shifting from structured programs to flexibly configured assistance in making a meaningful life that build on extramural collaborations (e.g., supported employment) will require major shifts in approach.

For ex-patients to take the further step, to speak out publicly about the casual slights and unthinking dismissals that veterans of psychosis endure, will require grace and courage—to say nothing of facility with language, self-confidence, humor and presence. Acquiring these will take collective action, training, rehearsal and organization, all of which have been nurtured (often against formidable odds) by organizations of ex-patients. Critical to such efforts is the exemplary power of “others-like-me” who have gone on to well-tempered lives. They should be affirmatively supported.

With respect to formal interventions, a capabilities-informed approach to recovery would stress *enhanced agency*—not public safety, stable placements or reliable program-participation. This means asking under what circumstances exercising reasoned choice should be prized over foreseeable bad consequences in one’s life. Can a poor choice, assessed in terms of compromised well-being, be preferred if the foregone benefit could have been won only if imposed? Take social regard. CA endorses Smith’s “linen shirt” principle because the esteem of others is essential to achieving self-respect. But so is freedom to put that security at risk (subjecting oneself, say, to ridicule or pity) in pursuit of demanding, potentially destabilizing endeavors. Symptom management is highly valued and avoiding stress is good coping strategy. But electing to try paid work, at risk of upsetting proven routine and established habits, may make sense if potential gains are thought sufficient. (Service-users sometimes call this being accorded “the dignity of risk.”) Similarly, court-ordered treatment may circumvent the vicissitudes and uncertainties of negotiated care, but its uneven results are obtained by foreclosing other options. Alternatives to mandated treatment have been shown to be feasible, but require different institutional commitments. Shared decision-making and advance directives can be effective vehicles for enlisting practical reason to manage medications and psychiatric crises (Amering, Stastny, & Hopper, 2005; Hamann, Leucht, & Kissling, 2003), but their practical utility will hinge on coupling formal system endorsement with the necessary front-line resources of time, trained personnel, and logistical support (Thomas, 2003).

Three problems with applying CA should be mentioned. Choice remains problematic—both axiomatic and suspect. Deprivation and disgrace can so corrode one’s self worth that aspiration can be distorted, initiative undercut and preferences

deformed. Sensitive work will be needed to recover that suppressed sense of injustice and reclaim lost possibility. Second, CA-informed initiatives will not be free-standing or categorically funded. Because they compete with other social investments, what counts as “good enough” in this domain will raise contentious issues of equity. And last, power is both omnipresent and quiet throughout this discussion. CA explicitly avows direct participation in public deliberations about symbolic representations of and material support for excluded people. Abrasive relations with traditional decision-making processes are likely.

Conclusion

Seriously espoused, CA could reclaim recovery’s checkered clinical history, reopen old puzzles, and milk their implications for contemporary practice. This means taking on the orphaned “work of specification” and transforming what is now a co-opted, near-toothless gospel of hope into workable guidelines and tools. Affirming human flourishing as the orienting aim of public mental health is foremost. Our metric of progress should be those locally valued commitments people are actually able to make in their everyday lives. A capabilities-informed mental health program endorses reflective deliberation while applying hard-won skepticism to the shibboleth of choice, especially when options are few and the heavy hand of past failure restricts them further. It rejects therapeutic individualism in favor of understanding persons as social beings embedded in networks of distinction and entitlement that reproduce broader material inequities and ratify rank orders of regard. It welcomes procedural fairness, but refuses to allow it to supplant the substantive freedoms available only through the exercise of agency. And it complements the rediscovery of patient power with a durable memory of how critical appropriate rules and resources are to its effective exercise.

In a word, it calls the system’s bluff. If recovery is really the watchword of the new public mental health, it will need to contend with unconventional ways and means—both within the system and outside its usual bounds—needed to make it a practical reality. The political-economic task (resources) is difficult enough; the cultural one (real participation), plainly daunting. Implementing CA in practice will mean a willingness to follow the recursive lessons of capabilities through to

completion. Recovery on *their* part presumes openness to re-inclusion on *ours*. And that, it seems safe to say, will require not only that we re-evaluate damaged selves but re-examine what it means to hold onto provisionally undamaged ones as well.

Acknowledgments

For critical comments on earlier drafts, I would like to thank Mary Jane Alexander, Barbara Dickey, Dan Fisher, Kris Jones, Sophie Mitra, Beth Shinn, Carole Siegel, Susanna Sussman, Toni Tugenberg, and Norma Ware. This work was supported by NIMH grants MH51359 and MH065247. In memory of Rob Barrett: psychiatrist, anthropologist, stalwart.

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