MORAL AGENCY AND MENTAL ILLNESS

Margarita Mooney, Yale University, Department of Sociology

*A previous version of this paper was presented at the 2015 Meetings of the International Association of Critical Realism, Notre Dame, Indiana

December 31, 2015
Abstract

How might critical realism provide a better metatheoretical framework to understand the complex causality behind experiences of mental illness? How do we understand the agency of people suffering from mental illness? Prior work on critical realism and disability has argued that critical realism helps move past one or another form of reductionist explanations for illness, whether that be biological, environmental or psychological. But using a critical realist framework to study mental illness also raises issues about the agency of people whose rational capacities are thought to be diminished. In this paper, I present the life history of one of 26 young adults I interviewed as part of a project on resilience. Because interviews reveal the complex causal forces in any person’s life, they remind us that scientific explanations should not be reductionistic. A critical realist framework further allows me to analyze people’s experiences of mental illness as expressing a form of moral agency, albeit one that is constrained by biological illness, structures of power in psychiatry, and cultural categories of mental illness diagnoses.
Introduction

As the diagnosis of mental health disorders rises in the U.S., debates rage about the causes of mental illness and about the effectiveness of various treatments.¹ This paper draws on interviews conducted with young adults in the US who have experienced trauma to demonstrate how critical realism goes beyond most current debates about the causes and treatments of mental health. Similar to other critical realists (Bhaskar and Danermark 2006, Pilgrim 2015b), I argue that critical realism’s emphasis on complex, contingent causality provides a better framework to understand illness than explanations that focus primarily on a single cause, whether that cause be biological, psychological or environmental. Contrary to some who argue that interviews only reveal interpretive stories without any necessary connection to facts (Jerolmack and Kahn 2014),² I argue that interviews reveal the complex interplay of various causal powers influencing mental illness. Because my interviews elicited narratives that connect events and emotions across time, these narratives illustrate the complex, contingent and conjunctural nature of causality that is often overlooked in many approaches to mental illness. Similar to Bhaskar and Danermark (Bhaskar and Danermark 2006), I

¹ The rise of mental health diagnoses, and ensuing debates about causes and treatments, is not unique to the US. For greater detail on similar debates in the UK, see Pilgrim, David. 2015b. Understanding Mental Health: A Critical Realist Exploration. New York: Routledge, Taylor & Francis Group.

² For an analysis of recent debates on interview methods among American sociologists, see Douglas Porpora’s article also being considered for the special issue of JCR. Because his paper is focused specifically on those debates, I do not spend a lot of time here summarizing those debates.
argue that interviews reveal both unique conglomerations of causes as well as illustrate demi-regularities seen in survey data.

A diagnosis of mental illness often places the patient into a power relationship that constrains their agency. Numerous critical realists have argued that human persons as not just bureaucratic role players or passive internalizers of culture or structure, but as persons with centers of consciousness who reflect on the moral purpose of their lives (Archer 2003, Sayer 2011, Smith 2010). How does critical realism help understand the agency of people struggling with mental illness? I argue that, even when patients’ agency is diminished due to psychiatric authority of their treatment, and even if cultural categories of illness mediate their ability to seek treatment, people struggling with mental illness still exercise a form of agency in which they reflect on the moral purpose guiding their lives.³

In the conclusions, I raise two issues for further exploration. Given the complex causality of mental illness, and given the ethical issues regarding mental illness, how does a critical realist approach to mental illness lead to a practical course of action? For example, which cause of mental illness should be given priority? Further, I ask: are pain and vulnerability the opposite of resilience and flourishing?

As Frederic Vandenberghe has argued, because sociology theory and research rests on a utilitarian

framework, human agency is often understood as strategic rather than moral (Vandenberghe In Progress). Due to this utilitarian underpinning of sociological theory and its consequent instrumental view of agency, many sociologists see vulnerability—including our biological weaknesses—as a limitation to be overcome. But if our biological dependence on others is an enduring part of the human condition (MacIntyre 1999), then human agency also should be understood as moral. Because critical realism allows us to how moral purpose can be causally efficacious even in constrained circumstances, I argue that critical realism provides a framework to move beyond the duality according to which to be resilient one must overcome all vulnerabilities. Future research on critical realism and a variety of health questions thus need not presume that health and illness exist on opposite ends of a binary spectrum. Rather, critical realist approaches to health can help highlight the moral purpose and life projects people develop even under constrained biological, environmental and psychological circumstances. It is important to understand moral purpose not just because human beings are interpretive animals, but also because that sense of moral purpose can at times be causally efficacious as a means of healing from illness.

4 In Dependent, Rational Animals, MacIntyre argues that moral philosophers have over-emphasized rationality and independence to the detriment of understanding humans as dependent and vulnerable. MacIntyre argues that we need to understand not only human capacities that promote agency, control and mastery, but also the capacities that help us deal with the human condition of vulnerability and dependency.
Laura: When the Lights Go Out

Are mental health disorders primarily rooted in biology? Or are mental health disorders the result of a lack of structural resources needed for humane flourishing? Or are mental health disorders simply one more social classification we make, subject ultimately to culturally relativist ideas of illness and health? Although critical realists often uphold the importance of how people experience the world as a starting point in explanation, the voices of people themselves often follow meta-theoretical analysis or simply get lost behind the author’s voice. As part of a project on resilience spoke two times with 26 young adults across the United States who had experienced traumatic life events. I chose one case, Laura, to illustrate the theoretical and practical points I wish to make for this article. Rather than just treating each case as data or text, I attempt to recreate for readers the dynamic, emotional interaction in which Laura revealed to me the complex sequence of events, emotions and experiences that caused her misery.

Laura was bullied for being obese as a child, became pregnant at age 15, and dropped out of high school. Her baby brought her happiness she had never known. Until one day an unexpected event

---

5 Ethnographers who use critical realism, such as Claire Decoteau, often given a primary place to participants’ voices in their theorizing. See her paper in the Journal for the Theory of Social Behaviour. But the word limits on journal articles often make it difficult to both present ethnographic work and reviewing competing meta-theories.

6 Laura was one of 26 people I interviewed who had responded to the National Study of Youth and Religion (NSYR) who reported high levels of trauma. NSYR was designed to be a nationally representative sample of 3,370 youth who were recruited for the survey via a random-digit-dialing telephone survey method. The first survey was conducted in 2002, when youth were aged 13-17. NSYR conducted a second round of phone interviews when the youth were 16-21 and again when they were 18-23. Following each telephone survey, NSYR researchers selected a few hundred
changed threw her into a deep depression. She received a phone call telling her to rush home from work. Her baby had walked into the backyard of her house and fallen into a small pond. When Laura reached home, police and paramedics had surrounded her house and her baby was clinging to life. Laura prayed incessantly to God to save her baby’s life, even if her baby would end up brain-damaged. When her baby died a few hours later, even the doctors cried and asked, “Why?”

Although Laura was no newcomer to hardship, this particular event led her to question everything, even God’s providence. How could God have abandoned her at this moment, she wondered? I shivered as Laura described, “I felt like I was left in the dark, like there’s no light at the end of the

---

youth for in-person interviews as well. A fourth and final wave of follow-up surveys of all respondents began in January 2013, when the respondents were in their mid to late 20s. For more information on NSYR research design, see: http://www.youthandreligion.org/research. In July 2013, my collaborators and I obtained a preliminary dataset of 1800 respondents to Wave 4 of NSYR in order to select people who said they had high levels of stressful life events for in-person interviews. Because I was interested in placing people’s life stories in social and cultural context, I interviewed young adults in three regions—the South, the Northeast and the West—that vary in terms of economic opportunities, culture and religion. I contacted 30 people, of whom 26 agreed to be interviewed. I traveled to each of their 26 hometowns in 10 different states. About 1.5 years later, I conducted a follow-up interview with 25 of the initial 26 respondents. Prior to starting the interview, my colleagues and I drafted a nine-page interview protocol covering three main areas: stressful life events, close relationships, and religious experiences and beliefs. Each question/topic had several probes. Some of the important questions I asked during the interviews were not on my questionnaire word for word, but the wording of questions and order of questions emerged through the interaction in each interview. I developed a new questionnaire for the second round of interviews that included more questions on mental health medications, purpose, and emotions. Interviews were recorded and transcribed. During my second visit to each person, I asked if I could visit their homes, churches, or places of work and took notes on what I observed and what we talked about.
tunnel.” Laura’s interior light was extinguished. She experienced a darkness so profound that most people would hope and pray to never end up in her situation.

Not only did this traumatic event effect Laura’s belief in God, it also impacted all of her close relationships. Laura’s mom, dad, brother, and the baby’s father, Robby, all experienced guilt and anguish over the baby’s death, driving wedges in between their already fragile relationships. I met Laura, who is white and lives in the American South, five years after her baby died when she was 26. Laura gave birth to two more children, one with the father of her first child and one with another man she dated during her many breakups with Robby. Robby was also deeply affected by their baby’s death. He started abusing drugs and alcohol, and abused Laura emotionally, physically, and sexually. But she still let him live with her because she wanted her child to be around his father.

Laura certainly believes supernatural forces act in her life, but she can’t predict if those forces will act for good or for bad. She feared Robby so much that she searched for supernatural help to change his behavior and protect her. She learned Wicca to try to expel the demons in Robby’s soul, demons she heard speaking to her while he sleeps. Laura definitely believes in some kind of higher power that is good, not evil, but the problem is that he is not “100 percent there.” In some situations, such as when another one of Laura’s boyfriends took her with him to get drugs, Laura

---

7 When quoting directly from interview transcripts, I use double quotation marks.

8 Work for this study was supported by the John Templeton Foundation through two grants, “A Virtue Ethics Perspective on Stress and Human Flourishing” (Grant #34495) and “Human Flourishing and Critical Realism in the Social Sciences” (Grant #54282). I would like to thank Nicolette Manglos-Weber, Ken Bollen, Micah Roos, Samantha Jaroszewski, Douglas Porpora, Philip Gorski, Timothy Rutzou, and Claire Decoteau for their feedback on various aspects of this project.
asked God to keep her safe, and he protected her. Laura’s experience of God abandoning her at her darkest moment—when her baby was dying—made her doubt whether God really looks out for her.

Not even supernatural powers are deterministic, according to Laura. In Laura’s view, the same cause can be positive or negative at different times. Even supernatural forces—strong as they can be—inhibit interact with our human agency. For example, Robby could choose not to let demons inside of him, just as she chose to only let good spirits inside of her.

Is there a finish line to pain?

To ease her emotional pain, to calm her nerves, and to not cry all the time, Laura used to smoke marijuana two or three times daily. After being arrested for drug possession, however, she stopped smoking marijuana. Instead, Laura began taking four mental health medications to calm her nerves, balance out her moods, and simply enable her to function. When I met her at a coffee shop in the South, her voice was quiet, her diction slurred, and her eyes glassed over. ‘She’s not all there,’ I scribbled in my notes. I could feel in my body that Laura’s pain was so deep and her medication so heavy that she had to work extremely hard to connect to her own inner self.

In the midst of all her pain, Laura emphasized the aspects of her life in which she feels she has some self-direction. Despite her many traumas, Laura worked full-time at a low-wage job. Her hopes focused on taking care of her two children. “I’m stuck,” Laura said. But she believes that she can help her children avoid the same pain she experienced. Sometimes when her children see her crying, they ask, “Mommy, you okay?” Her voice shook when she looked at me and told me that she replies, “Mommy loves you forever no matter what.” For the sake of her kids, Laura wants to “get

---

9 I use single quotation marks when quoting from my field notes or from memory about dialogue that was not recorded.
on track and do good.” Although she couldn’t see exactly what to do next to improve her situation, she prays there will be “a finish line to my pain.” Laura’s dedication to her children is a large part of her life project. The sense of moral purpose she derives from being a mother motivates her to keep struggling, even in very difficult circumstances.

Biological, Social, and Individual Explanations of Mental Illness

Laura’s story raises many theoretical, practical and ethical questions echoed in larger debates about mental illness in the U.S. If so many Americans suffer from mental health disorders, wouldn’t treating mental health disorders similar to diseases like diabetes—as rooted in biology rather than personal failings—also relieve the stigma of talking about mental illness? If we now have medications to treat mental illness, why not better diagnosis those disorders and treat the symptoms with medication? The American Psychiatric Association takes the position that mental health disorders are primarily rooted in biology and thus best treated with medication.

Seeing mental illness as a biological disease has led to an increase in the numbers of Americans taking mental illness medications. According to the Center for Disease Control, one in 10 Americans over the age of 12 takes at least one anti-depressant medication. Similar to Laura and others I interviewed, 14% of those who take one anti-depressant also take a second anti-depressant, or even three or four. Furthermore, data from the National Health and Nutrition Examination Surveys (NHANES), which asks the same questions to a national sample across time, revealed between the 1998-1994 survey and the 2005-2008 survey, the number of Americans taking at least one anti-depressant increased by 400%. NHANES data found that less than one-third of people taking one anti-depressant and less than one-half of those taking more than one anti-depressant had seen a
mental health professional in the previous year.\textsuperscript{10} Medco Health Solutions issued a report in 2011 comparing the use of anti-depressants among Americans with health insurance, finding that more than one in five adults over the age of 20 are taking at least one anti-depressant, a 22\% increase over 10 years earlier. Like Laura and others I interviewed, Medco further found that one-third of patients did not fulfill their prescriptions regularly, indicating they were not taking their recommended medications.\textsuperscript{11}

But this increase in medical treatments of mental illness has met with vociferous critiques. In his book \textit{Medicalization of Society}, Peter Conrad argues that calling things a medical disorder rooted in biology shifts our attention away from the social context or personal pathology behind mental health problems.\textsuperscript{12} Like Conrad, Kutchins and Kirk argue that Diagnostic and Statistical Manual of Mental Health has changed the definition of mental health disorders so many times that we have to learn to see the influence of “social values, political compromise, scientific evidence, and material for insurance claims forms” on the DSM.\textsuperscript{13} Because most Americans are unaware of the non-scientific

\textsuperscript{10} \url{http://www.cdc.gov/nchs/data/databriefs/db76.htm}. Accessed June 2, 2015.

\textsuperscript{11} \url{http://apps.who.int/medicinedocs/en/d/Js19032en/}. Accessed June 2, 2015.


influences on the mental health profession, they are thereby “vulnerable to the misuse of psychiatric diagnosis and authority.”

A further critique of the rise in medicalization of mental illness is that not all sadness should be treated as a disorder. In *Loss of Sadness*, Horwitz and Wakefield argues that the mental health profession mistakenly no longer distinguishes between sadness in response to an event anyone would regard as sad—like the death of a child—and clinical depression, which was thought of as an abnormal response to some event or circumstance. They contend that the rise in treating depression with prescription drugs is a mistake because medication can’t replace other forms of treating depression, such as social support.

A further critique of the medicalization of mental illness is that not everyone who experiences adversity falls into chronic dysfunction. Research on post-traumatic growth has found that people who have strong relationships or have faith in a supernatural being can find positive meaning in

---

14 Ibid., p. xi.


negative events. Studies of resilience and post-traumatic growth show that people can find positive meaning in negative life events, what Dan McAdams calls the redemptive self. The literature on resilience questions the assumption that the best we can hope for after experiencing a traumatic event is to return our state before that event rather than exploring new capacities that are developed as a response to that adversity.

But how well do these three perspectives—the biomedical model of mental health, the social construction of mental health, and the post-traumatic growth literature—help us understand Laura’s experience, and that of others I interviewed? Is the problem at root biological: Laura was mis-diagnosed or did not complete her medical treatments, thus she should get better medical treatment? Or will greater social support and finding meaning in suffering alleviate her symptoms of mental illness? Should Laura be guided to find positive meaning in her baby’s death that will help her grow as a person?


What did Laura herself say that might shed light on each of these perspectives? Laura acknowledged the complex interplay of various factors in her mental illness. Even though she was extremely critical of the side effects of the medications she was prescribed for mental illness, Laura admitted that, working in a pharmacy, she knows that people really do need medications sometimes to get better. The problem Laura sees is that people take too many medications and “their facial expressions look lost.” The generic drug for Zoloft [Fluoxetine] helped her, although she doesn’t take it anymore. But she does take melatonin sometimes to help her sleep. She admitted that there is something true about her diagnosis as bipolar. But rather than only taking medications, she wants to learn to “control” her emotions better and learn to “live with” her ups and downs.

Laura may be vulnerable to psychiatric authority, but she’s also vulnerable to people she has chosen to let into her personal life—especially Robby. Do the changing definitions of mental disorders and the difficulty in establishing what is a normal versus and abnormal reaction to a sad event mean that mental illness is nothing more than a social categorization with no basis in biology? Even though she questioned her diagnoses and treatments, Laura didn’t deny that she is vulnerable to certain bodily chemical mechanisms or imbalances.

Given her low levels of income and education, is Laura particularly vulnerable to the abuse of psychiatry authority? Laura, and others I spoke with, had struggled to understand their diagnoses, especially when confronting the authority of doctors. As Laura put it, her agency was limited in defining her treatment. The doctor “has the license.” He “went to school for blah, blah, blah. He told me what I was [bipolar].” But Laura didn’t seem to just accept medical authority without question; in fact, she eventually discontinued the treatment recommended to her by medical authorities.
Would strengthening Laura’s social support network help her overcome her sadness? Laura’s story certainly contained some elements of narratives of the redemptive self—how their traumas led them to learn to love more, forgive, and strengthen their most important relationships. But she emphasized that her pain over her baby’s death will never fully go away.

Although Laura’s experiences might seem extreme, her case should be considered both for its unique elements and for how it illustrates the complex causal forces likely behind the rising incidence of mental illness in the US. Although the death of a baby may be a rare event and Laura’s ensuing relationship turmoil may seem extreme, similar types of interacting causes are likely behind the rise in mental illness in the U.S. Although I do not have space to present more case studies that emerged from my interviews, the overall pattern of complex causes interacting and then being affected by a single traumatic event was common across my interviews with people who had suffered mental illness.

Nothing on the elaborate questionnaire I used during the first round of interviews even contained a question about mental health medications. Yet many people told me stories like Laura’s: they experienced something traumatic in their teen years, like sexual abuse, death or severe illness of a parent, or life-threatening health issues, that caused them to feel depressed. It really struck me when others I interviewed used the exact same words as Laura to describe their experiences with mental health medications as making them feel like a “zombie” or feel “numb.” Because of the severe side effects of medications, they looked for other ways to deal with their emotions, most often stopping taking medication and ceasing any kind of formal mental health counseling, often because they felt counselors also pressured them to take medications. The people I met had experienced their own
mental illness as the result of a complex set of underlying factors exacerbated by particular events or troublesome relationships.

As Bhaskar and Danermark have argued (Bhaskar and Danermark 2006), rather than using one or another reductionist explanation for disability or other health issues, health is better understood as a laminated system in which generative mechanisms operate simultaneously at various levels (biological, social and psychological). Further, they argue that the importance of any particular factor varies from case to case. It is only by talking to people, I argue, that we can understand the temporal order and relative weight of various factors influencing mental illness. We can generalize about the factors involved in disability but need not construct a theory that specifies the interaction of variables across all or many cases.

Similar to other critical realists who have studied disability and mental illness, improving our approach to people like Laura who suffer from mental illness requires a different understanding of science and of causality. Like Bhaskar and Danermark, I agree that we need a view of science that goes beyond the positivist, reductionist metaphor of the body as an assembly of mechanisms governed by laws that we can discover if we apply the right tool. But the post-modernism critique of positivism too often leads to skepticism or indifference about our ability to know anything meaningful about reality at all, including about how our bodies work. The claim that the lack of universal laws should lead us to abandon the search for causality, even with regards to health and illness, and instead offer socially constructed interpretations of experiences of mental illness fails to capture that causal powers can be real but are activated in a variety of ways across time, even for the same person. We need a view of science that embraces the causal power of meaning-making on bodies without assuming a so-called mind-over-matter attitude that presumes our minds can be
trained to fully control our bodies. As Bhaskar and Danermark argue, a proper diagnosis, and a proper medication (if available) is an important component of treating health disorders.

The strictly biomedical model of mental illness is based on positivist assumptions about science, such as that we can discover universal laws regulating the interaction among various parts of our bodies. In reaction to this naïve biological reductionism, post-modern theories challenge positivism by arguing that universal laws about people and the social world simply don’t exist. Given that medical treatments for mental illness have irregular rather than constant, universal effects, a particular post-modern skepticism sets in that about whether a biological basis of mental illness even exists, and if it does, whether this is even important. Discursivity and performativity become the critical categories that define the normal and the pathological. Pointing to the social and cultural influences on diagnoses of mental health is used to undermine their scientific legitimacy by suggesting that diagnoses are simply discursive formations at the beck and call of particular power structures. A third viewpoint says that our bodies don’t define us as a person as much as our powerful capacity for meaning making, so our response to sad events should be to help people find their unique meaning.20

Without listening to people like Laura, social scientific accounts collapse our understanding of mental health and addiction into questions of biological or sociological variables in the case of positivism, or linguistic, cultural and social narratives and power games in the case of

postmodernism. In both cases the subject’s lived experience of interacting causes is undercut by the imposition of a model which assumes a crude form of determinism and sees the subject as a passive carrier of structures and causes operating inside them but to which they have no access. Although post-modernism may see subjects’ experiences as expressing important meanings, critical realism provides a metatheoretical framework which allows us to see how lived experiences such as Laura’s challenge various reductionist accounts of causation. Critical realism thereby better allows us to understand the complex and contextual causes behind lived experiences of mental health disorders. Critical realism’s viewpoint that causality is always complex, contingent and conjunctural seems like a better explanation of Laura’s mental illness as biologically rooted but also triggered by context (her child’s death) and personal choices (staying in an abusive relationship).

Yet, in many analyses of mental illness, the voice of the patient is downplayed or ignored, often because their rationality is questioned. As Pilgrim (Pilgrim 2015a) has argued, even the biopsychosocial model of health research is just a more complex medial diagnosis tool that does not necessarily give importance to lay people’s (i.e., patients’) own experiences of their conditions. Pointing to the complex generative mechanisms behind health conditions is not the only way critical realists can contribute to health research, he argues. The fact that people really do suffer misery—as Laura’s example clearly shows—also raises important ethical questions, including questions about the agency of people who are in misery. As Pilgrim argues, a complex understanding of the various generative mechanisms operating at multiple ontological levels is a step forward in developing a critical realist approach to health. But critical realism can also help directly engage moral and ethical questions, not just questions of causality, raised by mental illness and other forms of health problems.
Mental Illness and Moral Agency

All of these questions point to a further question about mental illness I wish to now address: If being diagnosed with mental illness implies subjugation to authority, and the very fact of being mentally ill implies some limited psychological capacity, how do people suffering from mental illness exercise agency? Before turning to theoretical debates about, let us first listen to Laura’s own words about her experience of being a person struggling with the mental illness. I agree with Pilgrim people’s accounts of mental illness do not alone provide a full understanding of mental illness, as we are not aware of all the causal processes that operate external to us. However, as he points out, people’s experience of the events that led to their mental illness is a crucial part of any treatment for mental illness. In many cases, the actual event that triggered the mental illness can’t be changed, but people do have the agency to change the meaning of that event, or even to impact the memory of that event (Pilgrim, 2015, pp. 131-133). Because my purpose in this section of this article is to establish that persons with mental illness can exercise moral agency, my in-depth interviews are the best method to understand how people like Laura themselves understand the numerous causes of their distress and attempt to transform those causes they think they can impact. Although I do not deny that there are many psychological processes at work in Laura, some of which may be unconscious, listening to her we see clearly that Laura describes herself as a moral agent navigating the very complex terrain of biological, social and psychological causes of her distress.

I want to be a person, not a zombie

The second time I met Laura, a year and a half after our first interview, I almost didn’t recognize her when she walked into the same coffee shop to meet me again. I was pleasantly surprised to see that
she was walking upright and had a smile on her face. As she described to me the key events that had finally pushed her past the finish line of her pain, her eye contact and her diction were both normal. Most importantly, her court-appointed drug counselor turned into an advocate that helped her evict her boyfriend from her house. Because he refused to leave, Laura first issued him an eviction notice. Then she waited a couple of months and called the police to actually force him out. Without his negative influences in her daily life, she stopped going to the doctor for mental health treatment and slowly started weaning herself off mental health medications.

Now that she was feeling better, she complained how the doctors had put her on so many different mental health medications. Laura’s own ethical critique of her treatment for mental illness really struck me. She repeatedly said that she wants to be a “person” not a “zombie” or a “rat.”\(^2\) The medications took away the sharpness of her sad emotions, but she described how the medications made her “feel like you’re a not person. You just sit there like you’re a zombie…You don’t have no feeling. You don’t really care. You’re okay, but you have no emotions…just like everything is blah.”

During the interview, Laura did not just report her own story, but probed to see if I had ever felt such deep sadness myself. I told her that I cried so much at my father’s funeral that I had no feelings at all the next day, even though I woke up to the tragic events of 9/11. She slowed down her speech, looked at me passionately with her pretty green eyes, and added that when she was on medications, she felt empty inside “all the time.” Someone might crack a joke and she would just feel “whatever” like “there’s nothing there.”

\(^2\) Although I do not have space to present other interviews, I was struck by how others I spoke with who had taken medication for mental illness used the same word—zombie—to describe how they felt.
The medications blocked “all of the bad stuff” and stopped her mind from focusing on her problems, which allowed her to stop crying, look okay, not have swollen eyes, and go to work, and eventually get the strength to evict Robby. Even if she wasn’t crying, she was “still hurt” and “felt broken inside.” She thought maybe that’s just the way she would be forever. But as soon as Robby was gone, she slowly stopped taking the medications and didn’t go back to the doctor. Even with her agency diminished by medical authority and her real experience of distress, Laura decided to change her medication regime on her own.

She still experiences sadness and mood swings, but not as severely as when Robby was around. “I’ll live with myself,” she said. She thinks she has crossed the finish line of her pain, and her life is back on track. She’s trying to be a good mom and keep her job as a receptionist at a pharmacy.

Laura’s life story doesn’t stop at trying to live with her mood swings, improve her social context, or even find meaning in her baby’s death. She struggled throughout all of those events with normative questions about right and wrong, good and evil. For example, Laura repeatedly criticized Robby for not handling well their baby’s death. “I told him he needs to, you know, get his life together. Like me, I work. I work all the time. And I work, and I go home, and I take care of my kids. I do what I gotta do.” Although it still hurts her everyday that her baby died, she has faced her pain. “I think I kind of found myself. I’m peaceful where I am right now as a person,” she said. She contrasted herself to Robby, whose life is hectic, especially when he uses drugs. Robby still laments that so many bad things have happened to him that it holds him back.

Laura sees her struggles with Robby as part of a larger cosmological struggle. She explained how she still does Wicca to try to protect herself from Robby, but she won’t do bad stuff with Wicca because
she believes in karma—if you do bad things, they come back to you. She believes in evil spirits, but she believes that we need to protect ourselves from them, not put evil spells on others. You are particularly vulnerable to demons “when inside you’re weak.” When you “hit rock bottom,” a demon can “feed on the soul.” She called Robby a “smart psychopath” and “manipulative.”

Although she has learned to live with the pain of her baby’s death, “Robby broke himself, and everything went down around it… nothing helped because he didn’t want the help.” Laura’s beliefs in good and evil spirits extend to what happens after this life. When we die, we go to the spirit world, but only those who were good in this life “cross over” to heaven. She went to a medium who has contact with the spirit world, who told her baby crossed over to heaven. Although Laura believes she has passed the finish line of her pain, when she talked about her future, she knows “there’s always the bad with the good.” Although “every day gets easier”, she explained, you can’t change events from the past, and the past still hurts, albeit less as time goes by. All you can do is try to do better in the future, but what happened that was bad may still affect you.

We might be tempted to say that moral questions about right and wrong, good and evil spirits are at best left to theology, not sociology. But to do so would be to ignore that human beings have both a biological and a moral nature that interact with each other. Although Laura’s experiences of the supernatural or moral judgments of herself and others may be flawed, her actions are shaped by those views. Although I initially thought of Laura’s life story as a drama of struggling with mental health, the death of her baby, and an abusive boyfriend, yet another part of her story is about a good life compared to a bad life, being a person not a zombie, and about not letting evil spirits get in us or affect us through others. Laura tried to understand how she should use mental health medications alongside her struggles to understand why God abandoned her, her questions about why she
experiences so much pain, and her desires to build a meaningful life for herself and her children. In our rush to treat the symptoms of mental illness, build social support for those suffering, or even find a positive meaning in suffering, or do all of the above, it’s easy to overlook how pain raises moral and existential. Like questions about biology, social structure and psychology, morals and existential questions also are ontological questions. And Laura’s moral agency can be causally efficacious. But, as she admits, her ability to change her mood swings, social circumstances and biology is limited and her efforts are not always successful.

Conclusions

As a philosophy of science, critical realism clearly provides a metatheoretical grounding for understanding the complex causality of mental illness and the contingency of any particular treatment plan. In the midst of important debates about the biomedical, environmental and cultural causes and treatments of mental health disorders, I have argued that it’s also important to listen to struggles people face, such as the struggle between good and evil, and the struggle to come understand of what is right, true and good and live one’s life in accordance with that truth. Although I agree with Pilgrim (2015) that reducing childhood trauma is a good starting point to reduce the incidence of mental illness, our approach to mental illness should not stop at impacting environmental events that negatively impact people. We need an understanding of human persons that encompasses our need for a moral language to make sense of suffering and vulnerability.

Although I initially intended to use my interviews to compare those who successfully adapt to adversity to those who exhibit chronic dysfunctions, my interviews with led me to question my assumption that resilience means overcoming vulnerability. A tendency in sociology, and indeed in
much of secular modernity, is to try to solve the unsolvable problem of human vulnerability, to find a justificatory meaning for suffering. Laura’s own lay understanding of her mental illness is that her life can’t be free of pain. But her interior reflection on her pain, and her ability to link her pain to a larger cosmological order, gave her a sense of peace in the midst of ongoing suffering.

Not only are interviews and case studies important to see the complex causal forces operating in the world, doing interviews reveals our own vulnerability. When we are sitting face to face with another human being probing about meaning, pain, hope, and faith, we feel emotions that reveal the depth of a human person. When we see how any simple solution to someone like Laura’s situation would not be sufficient to remove her pain, we can still have ethical response and show compassion for her suffering.

Although many sociologists still adhere in discourse to the fact-value distinction, the interviews I conducted were inter-personal interactions with clear ethical dimensions. For example, I felt so empathetic with Laura that after the interview interview, I leaned over, hugged her small frame, and blabbered five times, “I’m so sorry for your pain. I really hope there is a finish line soon.” Although generally I did not offer advice during my interviews for this project, I feared for Laura’s safety. So I pointed out to Laura that she repeatedly identified Robby as the biggest hurdle to her moving forward. I gently told her I agreed with her that she would be better off without him.

---

In addition to Laura, I was repeatedly struck by profound sense of human vulnerability in my interviews. One man had overdosed twice from heroin and been resuscitated. One young woman had a troubling heart condition and had been resuscitated in the emergency room of a hospital multiple times. Others had lost a parent at a young age to cancer. Another young man nursed his mother as she died from her heroin addiction. Another woman nursed her mother for years until she died from overdosing on painkillers. Numerous people I talked to thought about and even attempted suicide—one man was even vociferously encouraged by his mother to take his own life. Having been to the edge and survived, the people I talked to had an even deeper awareness that there is no quick fix to misery. I heard stories of sex, drugs and rock and roll, but eventually realizing those things don’t bring lasting happiness, people turned to their desires to God, to steady romantic partners, and/or to marriage and family. The commonality across interviews was a desire for stability, intimacy and trust even in the midst human vulnerability.

When reflecting my experience doing interviews for this project, I learned how social science is not just about understanding causal powers but that social science also inescapably moral and ethical.23 A better understanding of mental health, and a better understanding of human persons as both vulnerability and potentially resilient, would benefit from not only a critical realist approach to science that avoids reducing the complexity of causality to a single factor or set of variables. Our understanding of mental health would benefit from a moral and practical social science that

23 See Frederic Vandenberghe for how sociology could recover its roots as a moral, practical science. Vandenberghe, Frédéric. In Progress. "Sociology as Practical and Moral Philosophy (and Vice Versa)."
acknowledges that interviews are both science and art, and that scientific knowing and experiential (or lay person’s) knowing are both needed to move us closer to reality.

But what is a person? What is a flourishing life? Recently, numerous critical realists have argued that sociology needs a better concept of the person. Social scientists are often more comfortable discussing properties of culture or structure than what it is to be a person but our understanding of what it is to be a person has profound implications for how we understand a flourishing life.

Although important work has been done by critical realists on the capacities of persons, another important task is to apply general theoretical understandings of personhood to practical and moral questions in particular domains, such as health.

References


Vandenberghe, Frédéric. In Progress. "Sociology as Practical and Moral Philosophy (and Vice Versa)."
