Journal of Undergraduate Research at NTU

Williams, B. (2018) The journey to self-stigma and its impact on 'recovery' in people experiencing mental distress: Fighting back with stigma resistance. *Journal of Undergraduate Research at NTU*, Volume 1, Issue 1, p. 283 – 303.

ISSN: 2516-2861

The journey to self-stigma and its impact on ‘recovery’ in people experiencing mental distress: Fighting back with stigma resistance

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Abstract

Research into the recovery model of mental health is providing more evidence of how people who are experiencing mental distress can live a life that they can define as fulfilling. It offers alternatives to the dominant biomedical approach. Through Personal, Cultural and Structural (PCS) oppression analysis this paper argues that self-stigma filters down through structural means, such as the Mental Health Act 1983 and psychiatric institutions. In addition, the media influences the cultural domain, with sensational headlines and poor representation of people who experience mental distress. This is then internalised by the personal experiencing mental distress.

Through an analysis of the literature, stigma resistance is explored as an antidote to self-stigma and the processes preceding it. Evidence suggests macro and micron changes to the way society views mental distress is necessary to facilitating recovery. For example, anti-stigma campaigning can raise awareness and give a voice to those who experience mental distress.

A conceptual framework was utilised to navigate through the evidence; empowerment, personal and social identities, and connectedness. The evidence for each domain provided further argument for the importance of the role social work can play in these recovery processes.

Critics of the recovery model suggest the term ‘recovery’ has been hijacked by policymakers. The conceptual framework has been criticised for becoming too rigid. However, the counterargument suggests that social work can remedy this by applying both art and science paradigms, maintaining creativity to supplement the rigour of evidence.

With social work values and ethics aligning with the idea of the recovery model, this paper argues that social workers are in the best position to support people in facilitating recovery.

Keywords

Mental health; Recovery; Stigma; Empowerment; Social inclusion; Identity

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Introduction

"Why treat people and send them back to the conditions that made them sick?" (Marmot 2015, p.6). In the UK, a quarter of the population experience mental distress, with serious mental illness (SMI), such as paranoid schizophrenia and bipolar disorder, affecting 2-6% (McManus 2009; McManus 2016; Mind 2013a). There is an ever-growing body of research that is looking past the dominant biomedical treatment of symptoms and is focusing on how people can live fuller lives despite mental distress. The recovery model of mental health has its roots in the survivor movement – where survivors of mental illness formed collectives to express their views against what they perceived as a highly oppressive psychiatric system (Beresford 2005). The main concept to the recovery model is for the person experiencing mental distress to be able to define their own journey to a more fulfilling life with valued social roles (Tew *et al* 2012). The recovery model rejects the notion that a person should be symptom free before they can become active citizens. Rather, they oversee a reclamation of a lifestyle that has meaning for them (Tew 2011). Using PCS analysis – analysing how personal, cultural and structural oppression effect people - this paper will look at how people experiencing mental distress may come to self-stigmatise and the impact this has on recovery. It will then look at how social work can combat self-stigma with stigma resistance through its own value base, anti-stigma campaigning, empowerment, positive identity, and connectedness.

Thornton and Lucas (2011) have argued that the recovery model is at risk of becoming so broad that it may no longer be identifiable as a model that can challenge the strong biomedical stance. Leamy *et al* (2011) similarly agreed that the concept of recovery is becoming conceptualised as a philosophy or attitude. This leaves a certain level of chaos that can leave the waters of recovery muddied. Therefore, Leamy *et al* (2011) proposed a conceptual framework for a recovery model that is theoretically sound and incorporates a clear synthesis of people's lived experiences of mental distress. The conceptual framework suggests five interlinking recovery processes. They include empowerment and control; positive personal and social identities; connectedness; hope and optimism; and, meaning and purpose. Tew *et al* (2012) argues that the first three are, by their nature, more social and, therefore, should be the focus of social work intervention. While conceptualising the recovery model of mental health may seem counterproductive, the recovery processes have a broad scope in which they can be utilised. Therefore, social workers have an important role to play in helping people who experience mental distress define their recovery. To do this means to find a way past the barrier that is self-stigma.

Literature review

The hierarchy of evidence is widely recognised as a sound way of highlighting reliable research (McNeece and Thyer 2008). Despite suggestions that the hierarchy is misunderstood (Taylor, Killick and McGlade 2015), there are calls for it to be ignored when researching issues around mental health. Instead, efforts should be focused on qualitative and emancipatory research (Gould 2006). This can tap into the vast quantity of service user knowledge and consider the complexity of their lives (Beresford 2005; Cooper 2003). Therefore, when researching for this paper, the voice of people who

have experienced mental distress has been sought. The literature reviewed for this paper are mostly peer reviewed journals and academic texts. However, newspaper articles, legislation, government policy and appropriate websites were also included to give cultural and structural perspectives.

The journey to self-stigma

Kondrat and Teater (2009) suggest that self-stigma is when a person holds prejudicial beliefs about themselves and expect discrimination against them. There are wide ranging effects of self-stigma on an individual. Livingstone and Boyd's (2010) systematic review suggested a positive correlation between self-stigma and increased symptomology. Lysaker *et al* (2007) highlighted the complex relationship between self-stigma and positive symptoms in relation to people with a diagnosis of schizophrenia. They found that not only did higher levels of self-stigma result in an increase in positive symptoms, but positive symptoms can in turn make a person more vulnerable to self-stigma. There is also evidence to suggest that self-stigma has a negative effect on empowerment, identity and connectedness (Laughrane *et al* 2011; Danzer and Wilkus-Stone 2015; Perry 2014). This all has a significant impact on recovery. Understanding how someone comes to self-stigmatise is important, especially as the role of a mental health social worker is to promote recovery and social inclusion (BASW 2014a).

Structural oppression

Thompson's (2012) PCS model can be used to explore how discrimination manifests through structural, cultural and personal oppression, despite Dominelli's (2002) suggestion that the shifting nature of society and social divisions aren't considered. It can be argued that a journey to self-stigma begins with the foundations upon which society is built: the law. The Mental Health Act 1983 offers a statutory framework in which practitioners can work with people experiencing mental distress. It defines a mental disorder as "any disorder or disability of the mind". Compulsory powers under the act state that, under section 2, someone can be detained in hospital for 28 days for assessment. Section 3 requires a mental disorder of nature and degree that the person requires medical treatment in hospital and detention is necessary for health or safety of patient or protection of others (Legislation.gov.uk 1983, n.p.). This is despite little evidence suggesting people need protecting (Pilgrim and Rogers 2014).

For someone to be detained under the Mental Health Act, an application must be made by an Approved Mental Health Professional (AMHP) once they - along with the medical recommendations of one or two doctors, depending on the section of the Act - determine that the individual meets the detention criteria (Legislation.gov.uk 2007). The majority of AMHPs are social workers. This role can be counter-productive to the recovery model, as stigmatising labels are used to determine what service a person can get (Bailey and Liyanage 2012). It can also fail to see people who experience mental distress holistically (Morriss 2016). However, Gregor (2010) found that one of the motivating factors behind social workers becoming AMHPs is that they feel they are the best placed profession to exercise the power that the Mental Health Act carries and apply the five guiding principles of the Code of Practice. Thich are: using the least restrictive option and maximising independence;

empowerment and involvement; respect and dignity; purpose and effectiveness; and, efficiency and equity (Department of Health 2015).

In the UK, a mental disorder is a condition of the mind that is recognised in the American Psychiatric Association's (2013) DSM-5 and the World Health Organisation's (1992) ICD-10. These two publications are influenced by Kraepelinian theorising of genetic factors and tainted gene pools – Emil Kraepelin was a German Psychiatrist from the late 19th early 20th Century who believed mental illness to be a biological malfunction (Pilgrim and Rogers 2014). Sheppard (1995) and Jablensky (2007) argue that the two diagnostic manuals ensure that psychiatry continues to research biomedical causes of mental distress despite little emerging evidence that this is the case. It is argued that classifying behaviours and symptoms can help predict whether a mental health condition will improve or not with treatment (Kennard 2013). However, contrary to many physical illnesses, mental health conditions have much higher levels of uncertainty and psychiatry is described as not being an exact science (Hedenrud, Svensson and Wallerstedt 2013).

Despite one of the five core principles of the Mental Health Act 1983: Code of Practice being empowerment and involvement (Department of Health 2015), involuntary hospital admission is disempowering. One person who was involuntarily admitted to hospital believes that "if there is any discrepancy about what the patient wants and what the doctors want, I think the doctors should come first" (Laughrane et al 2011, p500). This demonstrates a significant power imbalance, which drives stigma and thwarts recovery (Sayce 2016). This learned powerlessness strengthens the inferiority felt by people experiencing mental distress (Tew 2005). Despite policies - such as No Health without Mental Health - that commits to aiding recovery and ending discrimination (Department of Health 2011), the legal framework and psychiatric practice that dominates mental health creates a power imbalance that outmuscles the recovery model (Sayce 2016).

The dominant approach lead by law and psychiatry has increased negative effects on BME groups as they face dual discrimination (O'Hara 2014). Fernando (1988) highlighted that black people were more likely than white people to be diagnosed with paranoid schizophrenia; detained under the Mental Health Act 1983; admitted as offender patients; held by the police under Section 136 of the Mental Health Act 1983; and given high doses of medication. Essentially, this points towards the fact black people are over represented in inpatient settings (Pilgrim and Rogers 2014). 49% of participants in a study conducted by Time to Change (2014) said that they faced racial discrimination from mental health staff when in hospital. This is counterproductive to recovery as race, culture and ethnicity are very much a part of peoples' identities (Thompson 2012). This leads Fernando (2003) to conclude that psychiatry is a racist institution, built upon traditions of Western culture and Kraepelinian theories (Sheppard 1995; Jablensky 2007; Garner 2010).

Cultural oppression

Media representations are one of the main drivers of social stigma on a cultural level. 1% of violent crime is believed to be perpetrated by people experiencing mental distress, while accounting for 11%

of homicides (Time to Change 2017; Campbell 2016a). Despite these low numbers, violent crime involving people who experience mental distress appears to claim more than its fair share of column inches (Potok 2002). For example, in the case of Jonathon Zito, there was a dearth of interest when he was murdered by Christopher Clunis. But, two months into the trial, it was revealed that Clunis had a diagnosis of paranoid schizophrenia. Media attention on the case increased dramatically (Tummey and Turner 2008). Despite some media outlets attempting to readdress the balance (Watts 2017; Marsden 2017), media portrayals do nothing to help people experiencing mental distress with mostly negative stories as they fuel societal perceptions that are stigmatising and inaccurate (Murphy, Fatoye and Wibberley 2013; Patterson 2006).

Personal oppression

Stereotypes created by structural and cultural oppression feeds into the psyche of the individual. Cognition is affected; beliefs that people experiencing mental distress are unwell and dangerous fester. This prejudice then leads to discrimination (Corrigan and Watson 2002). Discrimination is then internalised by the person experiencing mental distress and they begin to self-stigmatise (Moses 2009). One person recalled how they felt after being told they were 'psychotic'. That term conjured up images of "serial killers" and "fictitious villains". "This added weight to my own delusional and self-loathing narrative" (Anon 2017, n.p.).

Stigma resistance

Social work, values, and ethics

The first line of the international definition of social work reads, "social work is a practice-based profession and academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people" (BASW 2014b, n.p.). It could be argued that this definition captures the very essence of the recovery model. Therefore, social workers have a critical role to play in promoting these recovery processes when working with individuals, families and wider communities.

Further parallels can be made between the recovery model and social work values and ethics. The Code of Ethics for Social Workers highlights human rights as a core value. Its ethical principles, such as upholding and promoting human dignity and wellbeing; respecting the right to self-determination; promoting the right to participation; treating each person as a whole; and identifying and developing strengths align themselves with recovery concepts. This being defined by the person and working with that person, rather than a diagnosis (BASW 2014c; Tew et al 2012).

Macro changes

For the recovery model of mental health to be successful, there needs to be macro and micro changes to society. Anti-stigma campaigners have worked tirelessly in raising awareness of discrimination. They are the front line of stigma-resistance. They seek to challenge behaviours and attitudes towards people who experience mental distress that discriminate and stigmatise, and look to create narratives that will overturn stereotypes (Sayce 2016). Campaigners such as Mad Pride would

campaign and protest government austerity measures (Abraham 2016). Recovery in the Bin (2017a) protest what they believe are neoliberal agendas hijacking the term recovery and shaping it to fit political discourse. For real changes to be made to how society views mental distress, and changes to mental health legislation and practice, more awareness raising is required (Sayce 2016). Not only could this reduce the levels of stigma, and therefore self-stigma, it could boost recovery opportunities. Social workers can empower their service users, and themselves, to take part in such demonstrations. In times of austerity and government cuts leaving local authorities strapped for cash (Butler 2015; Campbell 2016b), the voice of the service user has never been more important (Sayce 2016; Beresford 2005). With the help of social workers, that voice can become louder. This is in line with the social work value of social justice with ethical principles of challenging discrimination; recognising diversity, and; challenging unjust policies and procedure (BASW 2014b; Kondrat and Teater 2009).

Biopsychosocial model

Another macro change would be to readdress the imbalance of the biopsychosocial approach. Mental health practitioners, whether they be social workers, community psychiatric nurses, psychologists or psychiatrists, will claim that the most beneficial model to practice mental health is the biopsychosocial model (Watts 2017). This looks to bring together practitioners from different professions and create multidisciplinary teams. It gives a more holistic approach to mental health care, looking at biological, psychological and social aspects of mental distress (Webber and Nathan 2012). However, the biological side to the biopsychosocial model dominates.

Tew (2005) argues that biomedical approaches to mental illness fails to promote recovery and offers little evidence of scientific progress during the last 50 years. The course of psychosis is unpredictable (Bentall 2003), yet medical treatment dominates mental health care. Healy (2015) argues this is helped, in part, by pharmaceutical companies driving myths about how psychiatric medication works. Tew (2011) suggests mental distress is a natural reaction to life experiences. Evidence that draws correlations between poverty, child abuse, social class, employment with mental distress continue to emerge (Santos and Ribero 2011; Felitti et al 1998; Evans-Lacko 2011). Yet the UK government fund research that only focusses on the biological makeup of mental illness (Knapton 2016). An argument behind their motivation suggests that it is easier to deal with an individual that is ill and placing responsibility on them, rather than intrinsic societal failings (Rose 1999; Pilgrim and Rogers 2014).

This is not an argument against medication. Despite a lack of knowledge as to how psychiatric medication works (Healy 2015), it must be acknowledged that it can and does aid recovery. However - as demonstrated in a study conducted by Williams, Almeida and Knyahnytska (2015) – medication can be supplementary to a more holistic approach to recovery. One participant in their study said, “When my meds weren’t working, I wasn’t always taking them. But now that my meds work, I take them every day” (p.18). The study went on to suggest that a person’s insight into their mental distress and a demonstration of the effectiveness of the medication was necessary for them to be concordant with medication. Perivoliotos, Grant and Beck (2009) demonstrated, in a case study of a young

woman known as Kate, how their goal orientated cognitive therapy focussed on Kate's social withdrawal and inactivity. Kate lacked insight into her psychosis, but by the end of her therapy, she had supported employment and started to display insight. Therefore, it could be argued that medication can be supplementary to a more psychosocial approach. Social work is key to readdressing this balance as practitioners are experts in identifying social detriments and social solutions for people experiencing mental distress (Department of Health 2016).

Micro changes

Empowerment

Although a contested term, empowerment can be defined as a creative process whereby a person's resources are utilised to gain power and control of their life (Banks 2012; Browne 1995; Green, Lee and Hoffpauir 2005). Empowerment can be the gateway to recovery from mental distress. Sibitz *et al* (2011) suggest that empowerment results in higher levels of stigma resistance. Kondrat and Teater (2009) argue that empowerment is key to ensuring people who are experiencing mental distress are in control. They demonstrated, through an understanding of social constructivism, that narrative therapy can help redefine an experience of mental distress from one of an objectified and stigmatised illness to a journey that is solely owned by an individual. This promotes empowerment which brings a sense of personal agency, increases self-esteem and self-determination. This equates to a reduction of self-stigma. Tew (2012) argues that, despite power being constructed by the individual, social work practitioners can facilitate this construction. One way of doing this is to adopt a strengths based approach. Hepworth *et al* (2009) highlights the importance of including a person's strengths when working with then. This approach helps maintain anti-oppressive practice and removes the social worker as the expert, thus placing the power in the hands of people experiencing mental distress (Parker and Bradley 2014). The strengths based approach is naturally pro-recovery as it removes focus from people's deficits - i.e. psychiatric symptoms - broadens horizons and offers a resistance to the more conventional biomedical approach (Fawcett and Reynolds 2010; Sparks 2012).

A strengths based approach can be complimented with self-directed support. The latest in a long line of developments surrounding the personalisation agenda, the Care Act 2014's Care and Support Statutory Guidance looks to place the service user in control of their own care and support through self-directed support (Department of Health 2017). A survey conducted in 2009 evidenced that in only 22% of cases were service users' and/or their carers involved in the setting up of their care and support (Department of Health 2010). This is despite evidence suggesting that if individuals participate in their own care and support, they gain a greater sense of power and control (Rabiee, Moran and Glendinning 2009). Despite an argument suggesting that the personalisation agenda is neoliberalism creeping into social care and an attempt to reduce welfare expenditure (Lymbery 2012; Cunningham and Cunningham 2012; HM Treasury 2015), self-directed support offers social workers the opportunity to promote empowerment and work with, rather than for, people who are experiencing mental distress and are eligible for care and support (Bamber et al 2012). This collaborative effort enables people to be the experts in their own situation. This is fundamental to the recovery model of

mental health (Beresford 2005). As one man put it, "[professionals] have looked at me and they have considered that I've got enough knowledge and experience to be able to have an input" (Laughrane et al 2011, p. 500).

Positive personal and social identities

People who experience mental distress can become dislocated from a sense of identity they once maintained (Tew et al 2012). This is the result of social stigma and self-stigma. "I felt like I wasn't worth much as a person" (Cruwys and Gunaseelan 2016, p.38). Postmes, Haslam and Jans's (2012) study found many people identifying as a depressed person, saw themselves as ill and, therefore, different to other people. Sayce (2016) argues that people become "partial citizens" (p.18).

Use of language is one way in which social workers can help people experiencing mental distress develop more positive personal and social identities. Mullay (2002) suggests that language is a powerful instrument for oppression. Tew (2011) points out that language relating to mental health issues is more contested than any other field of social care. As discussed earlier, oppression and discrimination filters down from the top. It can be argued that it is down to social workers to challenge language used by professionals. The dominant biomedical approach, with its pathologizing lexicon that puts people experiencing mental distress in less powerful positions (Pervoliotos 2009), should be challenged. Instead of terms such as 'patient' or diagnostic categories, people should be asked how they would like to be referred to. Social workers can apply anti-oppressive practice and actively educate others in the damaging effects language can cause and propose more appropriate alternatives (Larson 2008). Social workers can also refrain from using language such as 'mental illness' and 'mental disorder' and instead focus on the individual person and their experiences (Tew 2005; Tew 2011). Reclamation of language in a mental health context is also a positive move forward in helping people form positive identities. Organisations such as Mad Pride and Carnival Mad look to reclaim ownership of terms such as 'mad', 'nutter' and 'psycho', and promote their appropriate use (Abraham 2016; Openfuturevision 2016; Nunn, G. 2014).

Employment is another way in which people who are experiencing mental distress can reclaim a sense of identity. The Equality Act 2010 defines a disability as physical or mental impairment that has a "substantial" and "long-term" negative effect on your ability to partake in day-to-day living (Legislation.go.uk 2010, n.p.). With this definition, it can be argued that people who experience mental distress have a disability and should be protected from discrimination under the Act. However, discrimination in the work place is still common place (Landau 2014). One person reported that "my employers said my sickness was becoming a nuisance, affecting team productivity and giving the company a bad name". Under pressure from management, this person resigned from their job. This caused further loss of confidence and self-esteem (Mind 2013b, n.p.). This demonstrates the damaging effects of social stigma and self-stigma. A result of this, there is low employment rates for people who have experienced mental distress, lower than any other disadvantaged groups (Sayce 2016; Booth et al 2014). All of this is despite of the fact that high numbers of people from this group want employment (Grove 1999; Mental Health Network 2016). Evidence suggests that supported

employment can have a positive effect on peoples' personal and social identities, boost stigma resistance and improve chances of recovery (Shankar, Barlow and Khalema 2011; Drake and Whitley 2014). Despite a programme of austerity imposed by the UK government focussed on deficit reduction (HM Treasury 2015), Booth et al (2014) argues that investing in supported employment would convey profits for the Exchequer, with £1.04 coming in for every £1 spent. Employment for people who experience mental distress also eases the burden on already stretched mental health services as it can result in symptom reduction (Bush et al 2009; Boffey 2016). Just like employment, supported education is also beneficial for recovery. Rinaudo and Ennals's (2012) case study demonstrates a young man whose education was disrupted due to him experiencing mental distress. Leaving education had a profound effect on the young man, but through support he was able to return to education. This experience proved to be empowering and helped him regain a sense of identity.

Social workers are in a unique position to be able to help people reform their own identities to facilitate recovery. Empowering people who experience mental distress to find social roles is as important as using positive language. One way in which social workers can do this, is to work with the Equality Act 2010. Informing service users of their rights and protections under the Act could encourage more people to enter employment (Moriarty 2013). Social workers can also work with employers to ensure that reasonable adjustments are made to facilitate full participation in the selection process for the job and then within the job role itself (Legislation.go.uk 2010; Mind 2013c).

Connectedness

Experiencing mental distress can have a negative and profound effect on a person's social networks as social isolation is a common side effect of mental distress (Tew et al 2012; Moses 2008). The Office for Disability Issues (2013) report that 26% of people who experience mental distress have no, or only one or two close contacts, compared to 14% of people with other disabilities and 8% of people with no impairment. Perry (2014) explains this through the concept of secondary social disruption. Perry suggests that people have a constant turnover of people in their social networks. For example, starting a new job means leaving current colleagues and obtaining new ones. But, as discussed earlier, people who experience mental distress are also highly likely to experience discrimination. The British Social Attitudes Survey 2015 highlights some of this discrimination. The Survey revealed that 45% of the respondents would be willing to live next door to someone with a diagnosis of paranoid schizophrenia. Only 27% of the respondents would be happy for an individual with a diagnosis of paranoid schizophrenia to be married into their family (Public Health England 2015). This means that when someone who is experiencing mental distress is also faced with discrimination, secondary social disruption occurs and gaps in social networks do not get refilled (Perry 2014).

Secondary social disruption highlights the need, and expectation, for social workers to work alongside people to empower them to develop new personal relationships (Tew et al 2012; Huxley et al 2009). Research suggests that peer support can boost stigma resistance (Jensen and Wadkins 2007; Verharghe, Bracke and Bruynooghe 2008). Peer support can also create safe environments for people who experience mental distress. Whitely and Campbell (2014) highlight how effective peer

support can be. In their study, they found conversations about mental distress became normative. One participant said, “I am able to talk to people who are going through the same thing, without being judged” (p.5). Webber (2005) argues that involvement from mental health services can increase stigma and therefor damage outcomes for people who experience mental distress. He goes on to suggest that social workers should always be looking to the community to help build social capital.

Maintaining current relationships is also an important factor in aiding connectedness. One way social workers can achieve this is by working alongside family members of people who experience mental distress. With the biomedical model dominating mental health care, it is clear to see why people might not fully understand the experience of someone’s mental distress. Social workers can educate families and friends about the recovery model of mental health. This can help the recovery process as it creates environments that are stigma and discrimination free, boosting stigma-resistance (Evans-Lacko 2011; Perivoliotis Grant and Beck 2009). Bronfenbrenner’s (1979) ecological systems theory explains the world around a person who is experiencing mental distress by highlighting different levels of human interaction: micro level (individual); meso level (interpersonal); and, macro level (systemic). Using Bronfenbrenner’s theory, Mizock, Russinaova and Millner (2014) argue that for a person to reduce their own self-stigma (micro), acceptance from family members (meso) and wider communities (macro) is important to achieving this. Research has highlighted that caring for someone who experiences mental distress can be a confusing and frustrating time that can cause emotional strain on the relationship (Forchuk 2000). Forchuk (2000, p.133) went on to suggest that once a carer realised they could not control or fix the “disease”, they accept it and gain a new respect and admiration for the person who is experiencing the mental distress. Combining these ideas, that a person who is experiencing mental distress requires those around them to understand and accept their experience and that carers feel more at ease when they understand they can’t ‘fix’ their loved one, highlights how social workers need to work with families as well as individuals. This, in time, can aid recovery.

Criticisms of the recovery model

One of the biggest critics of the recovery model of mental health is Recovery in the Bin – a user led organisation who are “fed up with the way colonised ‘recovery’ is being used to discipline and control those who are trying to find a place in the world” (Recovery in the Bin 2017b, n.p.). The term ‘recovery’ appears in many government policies (Department of Health 1999; Department of Health 2011; Department for Work and Pensions/Department of Health 2006), suggesting an adoption of the recovery model. However, UK mental health policy and law is criticised for being risk averse and not promoting the recovery it professes to (Burgess 2016). This, in turn, creates a culture of risk-averse social work practice as practitioners fear being held responsible for any major incidents (Webber and Nathan 2012). For example, according to the Mental Health Act 1983: Code of Practice (Department of Health 2015), a community treatment order’s intention is to promote stable mental health and recovery outside the hospital. However, evidence suggests that community treatment orders have no significant effect on peoples’ recovery (Dawson 2016). This suggests that their introduction was

motivated by concern for risk and public safety (Webber and Nathan 2012), supporting Recovery in the Bin's (2017a) concern that 'recovery' has been colonised by mental health services, commissioners and policy makers.

The conceptual framework looked to tackle perceived weaknesses in the concept of recovery (Thornton and Lucas 2011; Leamy et al 2011). However, there is a danger that it could become too robust. There is a lot of research into indicators of stigma resistance and recovery in areas such as housing and employment (Booth et al 2014; Rinaudo and Ennals 2012; Tew et al 2012). But this doesn't mean everyone's recovery will be defined by these areas. For example, Paul Checkley (2017, n.p.) talks of his experience of sexual abuse, depression, suicide attempts and psychosis. His mental distress spanned over many decades. He had been in and out of hospital and subjected to many interventions. However, he eventually found happiness, identity, and purpose when he started looking after chickens. "They made me smile. I hadn't smiled properly in 40 years". One of the main principles of the recovery model is that it is defined by the individual (Tew et al 2012). Therefore, remaining person centred and willing to take positive risks ensures that the wishes and feelings of the individual will be listened to (Wallcraft 2012; Titterton 2005). This highlights the importance of using art – creativity and love - as well as science in social work (Pincus and Minahan 1983).

Conclusion

Social stigma and self-stigma are highly complex processes. However, PCS analysis highlights some of the key facilitators. The initial arguments made in this paper suggests that the current processes in place for people who experience mental distress are highly stigmatising and can perpetuate their distress. Legal frameworks in the guise of the Mental Health Act 1983 and the dominant biomedical approach to mental health care form the structural element of the PCS. This ensures that power is always in the hands of the professionals. It increases self-stigma felt by the person experiencing mental distress and reduces opportunities for recovery. The cultural element then colludes with structure. The media portray those experiencing mental distress - particularly those with diagnoses such as paranoid schizophrenia – as dangerous. Sensational headlines and disproportionate column inches help prejudicial beliefs form in the minds of individuals, creating fear and distrust of people experiencing mental distress. This is quantified in the British Social Attitudes Survey, overwhelmingly stating people with a diagnosis of paranoid schizophrenia are not welcome in peoples' networks. All of this comes together and is internalised by the person experiencing mental distress. The prejudice they feel feeds into their self-narrative and they begin to lose self-worth and see themselves only as partial citizens.

This paper explored how social workers can work with the recovery model of mental health to offer alternative methods for people experiencing mental distress. One argument suggests that the biomedical approach shouldn't be forsaken, but a more balanced biopsychosocial model can give weight to a person's social needs. The conceptual framework put forth by Leamy *et al* (2011) highlighted five recovery processes. The first three - empowerment, personal and social identities, and connectedness – were explored. The literature highlights that empowerment can be activated

through social constructivism and narrative change, and a strengths based approaches. Personal and social identities can be boosted through promoting positive use of language. Employment and education also has beneficial effects on identity. Research also brings to light the importance of connectedness with utilisation of peer support groups providing opportunities for people to form relationships. Systems theory can be used to ensure families can play their part in someone's recovery.

A limitation to the recovery model is that the term 'recovery' is overused in mental health policy and law. They imply that recovery should be at the heart of mental health care. But the reality is a system that many believe oppresses and stigmatises those who experience mental distress. A limitation to the conceptual framework is that it could become too rigid and forget social work's art paradigm.

Despite these criticisms, the conceptual framework highlights how adopting the recovery model can be more beneficial to the wellbeing of a person experiencing mental distress, than the more commonly used biomedical approach. Furthermore, it places social workers in the best position to be able to facilitate the recovery model as it aligns well with the profession's values and ethics. Also, basic social work models and theories such as the strengths based approach and ecological systems theory enable recovery. The oppressive and stigmatising effects of current mental health care can have a significant impact on someone experiencing mental distress. However, by working with social workers and implementing the recovery model of mental health, they can resist stigma and fight back, claiming a life that they can define as fulfilling.

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