

The negative effects of oppression in the recovery process

Ann-Charlott Timander^a, Anders Möller^b and Larry Davidson^c

^aDepartment of Social Work, Gothenburg University, Gothenburg, Sweden; ^bDepartment of Social Science, Ersta Sköndal University College, Gothenburg, Sweden; ^cSchool of Medicine and Institution for Social and Policy Studies, Yale University, New Haven, Connecticut, USA

ABSTRACT

The aim of this project was to study if and how experiences of oppression on the grounds of mental distress and gender affect the reclaiming and (re)construction of identities in the recovery process. In this study 33 narratives were analysed using framework analysis. The analysis showed that the experience of oppression affected the participants negatively along emotional and psychological pathways and affected their life activities, that is, their recovery process was negatively affected. By using a British disability studies perspective on oppression [Thomas, C. 2010. "Medical Sociology and Disability Theory." In *New Directions in the Sociology of Chronic and Disabling Conditions. Assaults on the Lifeworld*, edited by G. Scambler, and S Scambler, 37–56. Palgrave Macmillan] the understanding of experiences of mental distress and recovery was argued to be deepened. The process of recovery was in the light of the findings argued to be a highly social and not just an individualistic process, where social factors like experiences of oppression could become a barrier in the recovery process.

ARTICLE HISTORY


Received 22 July 2015
Accepted 16 May 2016

KEYWORDS

Recovery; oppression;
identity; mental distress; (re)
construction

Introduction

For many people experiencing mental distress crisis, their sense of who they are and how they are perceived by others may be transformed (Estroff et al. 1991; Pettie and Triolo 1999). For example, Wisdom et al. (2008) found that persons with experience of mental distress may face severe challenges managing their sense of identity following the onset of mental distress. Such challenges to identity can be that of being diagnosed with a stigmatized 'mental illness' such as 'schizophrenia', together with the societal responses to that diagnosis (Estroff et al. 1991). It has been argued, therefore, that the reclaiming and (re)construction of a positive identity is a core component of the recovery process (Davidson et al. 2005; Davidson and Strauss 1992; Estroff 1989; Pettie and Triolo 1999). Some researchers have mapped the stages/phases through which people with experience of mental distress typically pass, when they are reclaiming and (re)constructing positive identities (Andresen, Oades, and Caputi 2003; Davidson and Strauss 1992; Pettie and Triolo 1999; Skea 2009). However, some critics argue that in those models the impact of experiences of oppression and power are not sufficiently highlighted (Davidson et al. 2010). This study investigates whether social factors such as discrimination and oppression are of importance in the study of the process of recovery. For example, Topor and colleagues (2011), suggest that the process of recovery unfolds within a social and interpersonal context. If this context is an important factor in promoting or impeding recovery, stage of change models will be rather limiting and would not be able to fully illuminate the social, structural, and political aspects of the reclaiming and (re)construction of a

CONTACT Ann-Charlott Timander ✉ ann-charlott.timander@socwork.gu.se  Department of Social Work, Gothenburg University, Sprängkullsgatan 23, Box 720, SE-405 30 Gothenburg, Sweden

positive identity in the recovery process. Thus, the aim of this article is to study if and how experiences of discrimination and oppression on the grounds of mental distress and gender affect the reclaiming and (re)construction process of identities in the recovery process. To adopt a social structural and interpersonal perspective of recovery processes in this article is indeed a rather novel and original approach, and therefore an important contribution to develop thinking about theory, policy, politics, and practice in relation to experiences of recovery and mental distress.

Theory and methods

Recovery

Both individual aspects and social aspects of the recovery process were highlighted in this study. Recovery is thus seen as a social-existential state, achieved by service users/survivors themselves and/or with the support of the mental health service and others, and sometimes in spite of psychiatric services (Pilgrim and Rogers 2009). We are inclined to view recovery from the perspective of recovery in rather than recovery from long-term mental distress (Davidson and Roe 2007), and we are inspired by the service user/survivor movement's conceptualization of recovery, where '... everyone is considered capable of recovery ...' (Davidson 2003, 50). Recovery in this study is viewed as the '... successful survival of social invalidation' (Pilgrim and Rogers 2009, 951). That is, the survival of the invalidation from the psychosocial forces that was the source of the mental distress, as well as the survival of the discrimination and oppression from the psychiatric services and the wider society (Pilgrim and Rogers 2009). The goal of recovery is thus not to become 'normal'. The goal is of becoming more deeply, more fully human (Deegan 1996).

The following definition of recovery has been guiding this study:

Mental health recovery is a journey of healing and transformation for a person with a mental health disability to be able to live a meaningful life in communities of his or her choice while striving to achieve full *human potential or personhood*. (SAMHSA, the US Substance Abuse, Mental Health Services Administration 2004 cited in Bellack and Drapalsky 2012, 156) (Our emphasis)

Disability and disablism

It is common in the field of mental health to use the concept of stigma, and the legacy of Goffman's work (1990) has been strong. However, we believe that a theoretical framework drawn from British disability studies and the use of the terms oppression and discrimination is more fruitful in contrast to stigma theory which are often applied to mental distress. In line with Sayce (1998) we argue that the concept of stigma can render the act of oppressive treatments invisible, that is, that the individual's experiences become decontextualized. Furthermore, as Thomas maintains (2012), Goffman (1990) examined how deviance was bestowed by social actors invested with power at the micro-level, and by so doing he located the normal/deviant dualism at the interactional core, so using a social deviance perspective on those who were labelled as 'deviant'. Consistent with this view we have studied the impacts of oppression on the grounds of mental distress and gender in the recovery process and when so doing we have used a British disability studies perspective, as it is outlined by Thomas. Thomas proposes an extended social relational definition of disablism:

Disablism: refers to the *social* imposition of *avoidable restrictions* on the life activities, aspirations and psycho-emotional wellbeing of people categorized as 'impaired' by those deemed 'normal'. Disablism is *social-relational* in character and constitutes a form of *social oppression* in contemporary society –alongside sexism, racism, ageism and homophobia. In addition to being enacted in person-to-person interactions, disablism may manifest itself in institutionalized and other socio-structural forms. (Thomas 2010, 37). (Emphasis in original)

Furthermore, according to Thomas the forms and impacts of disablism are also refracted in some ways through the prism of gender relations and gendered locations. She calls this form of disablism, 'gendered disablism' (Thomas 1999). However, we have in this study also focused on the individual's

internalization of oppression, what we have considered ‘internalized disablism’ (Timander 2015; Timander, Grinyer, and Möller 2015). Based on our research we see internalized oppression, ‘internalized disablism’ as an internalized effect, affecting the psycho-emotional well-being of people categorized as ‘impaired’, which may for the individual lead to restricted life activities. However, ‘internalized disablism’ starts out with social disablism, and then becomes internalized oppression within the individual.

Methodology and methods

Since our aim in this paper is to understand and describe an experiential social process, a quantitative approach would not be suitable for this particular study. Thus this is a piece of qualitative research; a qualitative methodology has been used.

Different organizations for mental health service users/consumers/survivors and traditional mental health organizations in Gothenburg, Sweden, and Oxford, the UK were approached in order to recruit participants. The findings presented here are based on qualitative in-depth interviews that the first author conducted in Gothenburg, Sweden, and Oxford, UK, during the year 2012–2013. The first author transcribed the interviews recordings verbatim, and also carried out the translation from Swedish to English. The interviews were recorded with the permission by the participants and written informed consent was obtained. However, the informed consent was viewed as an ongoing process, and research participants could withdraw at any time up until publication of results. Each research participant was given a cinema gift card of a value of £ 20, for each interview. The names of the participants in this presentation have been changed, and personal characteristics have been de-identified. Before the study began, ethical approval from relevant authorities in the UK and Sweden was obtained.

The ‘sample’ of 33 research participants cannot claim to be representative of men and women with experience of long-term mental distress in a statistical sense. However, it is important to note that the findings are based on 17 women and 16 men, whose ages were fairly evenly distributed through the 20s, 30s, 40s, 50s, and 60s and from a variety of socio-economic, family, and educational background. Furthermore, they all self-defined as having experience of long-term mental distress and recovery. A couple of participants had experiences of living in a different country before moving to the UK or Sweden, thus we had some participants who had experienced being in an ethnic minority. When it came to sexual preference one woman openly identified as lesbian. Not many of the participants were in the forefront of the service user/consumer/survivor movements in England or Sweden and/or political activists in the movements. However, most of the participants were active and non-active members of the mental health service user/consumer/survivor organizations or traditional mental health organizations in Sweden and England. Thus this ‘sample’ is quite varied, drawn from a cross-section of men and women in the wider population.

The analytical method used in this study was framework analysis. The framework approach is a matrix-based method. It involves constructing thematic categories into which the data can be coded (Ritchie and Spencer, 1994). Unlike some other qualitative methods it:

... allows themes or concepts identified *a priori* to be specified as coding categories from the outset, and to be combined with other themes or concepts that emerge *de novo* by subjecting the data to inductive analysis. (Dixon-Woods 2011, 1). (Emphasis in original)

The benefit of doing so is that it enables issues and questions identified in advance to be explicitly and systematically considered in the analysis. But it also allows enough flexibility to detect and characterize issues that emerge from the data (Dixon-Woods 2011). This method might be classified as an abductive approach, a kind of oscillating between deductive and inductive approaches. This analytical method is an established and rigorous five-stage method for analysing qualitative data. First the researcher must immerse in the data, and making notes of for example recurrent themes and issues. Once the selected material has been reviewed, the researcher returns to the notes, and

attempts to identify key issues, concepts, and themes. Thus, the analyst sets up a draft thematic framework within which the material can be sifted and sorted (Ritchie and Spencer, 1994). In the next stage, the indexing stage, the thematic framework is systematically applied to the data. In stage four the data are summarized in thematic charts and they are devised with headings and subheadings. In the final stage, mapping and interpretation stage, or synthesizing the data, the analyst maps, interprets and synthesizes the data through reviewing the charted data, comparing themes, and sub-themes with each other (Ritchie and Spencer, 1994).

The main themes were created by drawing on earlier research and theories. Main themes were, for example 'disablism' and 'affected negatively by oppression'. The subheadings to the main themes were inductively constructed in order to gain as much new data as possible and still being able to be rooted in the original data. Examples of subheadings were, 'structural disablism', 'non-structural disablism', 'gendered disablism', 'feeling not normal', and 'feeling not rational'. The reason why a theoretical framework from British disability studies was used, was because sociologists in disability studies in the UK use a social oppression paradigm, in contrast to medical sociologists who usually theorize 'chronic illness and disability' through the social deviance lens (Thomas 2007).

Findings: the negative effects of oppression

All 33 participants gave accounts of what we would interpret as experiences of disablism (Timander 2015). In line with others, we argue that the individual biomedical model understanding of experiences of mental distress is dominant in our contemporary Western societies and that 'ordinary' people and professionals are to a greater or lesser extent, socialized to view experiences of mental distress from a biomedical perspective (Pilgrim 2014). The issue here is the essentially medicalized nature of mental health policy and practice (Beresford 2005). Thus, the biomedical model is dominant conception and materialized to a lesser or greater extent in institutions (Watermeyer and Görgens 2014) such as for example the mental health services and the social services. We argue that at work is the sedimented reality of a medicalized culture, in which repeated messaging often disqualifies those with experience of 'mental difference' from a legitimate claim to full citizenship. In Western contemporary societies, the hegemony of the 'rational and sane' ideal commonly denigrates any and all variations (Spandler and Anderson 2015). Thus, the inherent problem with a medicalized perspective on experiences of mental distress is that it is based on a pathologizing construct: there is something 'wrong' with the person (Beresford 2005) because the individual is perceived to be 'irrational and insane' (Spandler and Anderson 2015) and 'deviant' (Beresford 2013). We argue that the notion of unreason, irrationality, and deviance which relates to experiences of mental distress and the active pathologization and criminalization of people with experience of mental distress in contemporary Western societies impacts the life of people who experience mental distress.

We will now show by using some narratives that the participants in this study were affected negatively by experiences of oppression, disablism. There were no dominant themes, rather the women and the men internalized different kinds of devalued beliefs/identities and displayed a range of emotional responses due to experiences of oppression on the grounds of mental distress and gender. Some of these powerful narratives will now be displayed and described below.

'Week and defective'

Some of the participants felt that they were 'week and defective' because they had experienced mental distress. Judith, in her late 60s, 'struggled' her first few years after her first mental health crisis, because she felt she was 'not normal' and needed to 'become normal again'.

In those first few years, I kept thinking: 'I need to get back to normal. I must get back to the mainstream. I must get back to the main track. And to do that I need to get back to work'.

During those initial years of ‘struggle’ when she felt an urge to ‘become normal again’ and start working again she saw herself as also ‘weak and defective’ and ‘not good enough’.

Judith: Well, you know, you are a manic person, you, you are not quite up to scratch. Possible, possible you are weak. You are somehow defective. You know what I mean? You should, you should not got ill in the first place: ‘It is your fault really, is it not?’ Do you see what I mean? You kind of absorb all that. ... I always wanted to be open, you know, I wanted it to be out there. I wanted it to be known. But perhaps in the past, it was more: ‘I am not very good, you see I am a service user’. It was a more negative thing. I was sort of telling people about my negative bits, if you like: ‘So I am really not good. I am only a service user’.

Judith had an urge to ‘become normal’ again and get a job, and work regularly between nine and five as everybody else. She saw herself as ‘weak and defective’ and not ‘good enough’ because she had experienced mental health problems. Thus to experience mental distress was a sign of ‘weakness’ and ‘not being up to scratch’. Judith felt it was her ‘fault’ that she experienced mental health problems, something was ‘wrong with her’.

‘Not being able to recover’

Some of the participants believed they would never recover. Peter, in his 60s, believed too that he would never recover.

Peter: I do not think I ever will recover. As I said to you, things are different than years ago, than it is today. There is no recovery, it is something that, that is with you for the rest of your life. There is no, there is no, what is the word. There is no light in the end of the tunnel. There is not one. ... You cannot get a recovery. I have known people to be depressed for 20 odd years, 30 years. There is no recovery, there is nothing like that. That is why I said to you, you got to take day by day. Just to consider taking your tablets. ... So there is, there is no. ... There is no end to it.

According to Peter life was a tough struggle, and life was especially a tough struggle when experiencing mental distress. He believed that recovery was about being ‘cured’ from one’s symptoms and one’s experience of mental distress, and based on his experiences, he thought he would never recover. For Peter, life was hard and he felt he had to adjust his way of living according to the fact that he never knows what is around the corner and to the ‘never ending story’ and the ‘hardship of experiencing mental distress’.

‘Sick’

Martina and Sven saw themselves as ‘sick’. In the following account, Martina tells about her experience of recovery, and how seeing herself as ‘sick’ was a barrier in her recovery process.

Martina: Yes it actually started with me deciding that I should act like I was cured. As I mentioned earlier, this with normal humans have reactions to certain experiences. I started to understand that I was not so sick that I believed I was. It became, it was like a self fulfilling prophecy to believe that I was so weird and strange, sort of sick. ... And even if people told me that I was good, I still: ‘No, because I know that I am absolutely the worst. What you are saying does not matter, you are just saying it because you want to ease your conscience. But I know that you are wrong.’ ... Yes, very much and it is still a barrier. It is the same thing. I really have to get my act together, and: ‘Get real, this is an old habit of your old identity, you know. This is not, it is not relevant for the situation, it is nothing. It is just some’. Yes, like that. Like a small piece of old thoughts, but it is tough. Because sometimes I get insecure as everybody else. And then I easily fall back on: ‘Yes, of course, it was me who is so bad. How could I forgot it?’ To say instead like this: ‘I can do that’.

Arguably, Martina had internalized a view of herself as ‘sick’ and perceiving herself as ‘sick’ shaped her identity in a negative way, and sometimes still do when she has ‘bad days’ and she feels insecure. Seeing herself as ‘sick’ and ‘mentally ill’ erected ‘restrictions’ within herself, and became, according to her, a barrier in her recovery process.

Like Martina, Sven saw himself as ‘sick’. During many years in his life he just saw himself as ‘sick’ and he was during those years given very heavy medication that affected him and detached him from his thoughts and emotions and his belief in his capabilities.

Sven: Yes, during many years then, I was just sick. It was, the illness dominated and I just saw myself as sick, and nothing else, and not as someone without it. During that time I was given heavy medication of (mentions a medication). ... And, I have been rebuilding myself to, to, a view of myself that is comprehensive and which includes knowledge, studies, capabilities, everything which I thought I did not possess any longer when I was so heavily medicated. In a way, you know one forgot everything one had done and one had knowledge about, and all of one's capabilities. It was just, yes life was, I would say, just a grey sludge. I have gradually returned after this treatment, and to start to believe in myself more.

The medication affected Sven so much, and he felt that he lost his identity and he felt his life was like a 'grey sludge', Sven believed he was a 'sick' person. He interpreted the negative side effects of the medication in a very sinister way, by seeing them as signs of 'mental illness'. Arguably, he felt hopeless because of his sinister interpretation of the side effects and because of the negative subjective side effects which made him lose touch with his emotions and thoughts and lose his belief in himself and his capabilities.

Feeling like a 'criminal'

Whenever Andrew had been detained and sectioned when he had experienced mental distress crises, and on these occasions he had been picked up by the police. Being detained and sectioned, with police involvement made him feel like a 'criminal'.

Andrew: Whenever I have been detained under section 136, I have always been picked up by police officers. So you know I end up in hand cuffs; I end up going in to a police car. Not because I have committed any crime, I am being detained for my own safety, and for the safety of others. So, I have actually not committed any crime. But I go through a criminal process. So, you know I am detained by police officers, I am hand cuffed, and I end up in a police car, taken to a police cell and kept in a police cell, my shoes are taken, my laces are taken, my belt is taken. You know, so by the time, invariably I am in there over the night, and mostly the next day. Then somebody will come and assess you. And then I will be taken to a psychiatric hospital. So by the time I get to the hospital, I am already feeling (inaudible), I am already feeling a lot worse. My mental health has gotten a lot worse, because I have been detained by police officers and I have been kept in a police cell, you know. And I really, sometimes I can take it on. The nurses. So at the time I get to the psychiatric hospital, because I already have had 48 hours of custody, I am feeling even more obliterated and worse, than when I was picked up, if that makes sense? ... Yeah, because you are treated as a criminal. ... And actually where you are, you are in there with the muggers, and the rapists and buglers, you know. So by association you are seen as that. You know, somebody is walking around and looking in to the cells, and they are looking at criminals. Because they are in cells, you know. So, you are treated like on and you begin to feel like one.

Andrew felt he was being treated as a criminal when he was detained by the police and sectioned by the mental health services. However, he had not committed any crime, rather he was experiencing mental distress. Andrew felt he was treated like a criminal and he started to feel like a 'criminal' as well, and his experience of mental distress was exacerbated as a result.

Feeling ashamed

Some of the participants felt ashamed of their experience of mental distress and their ascribed diagnosis and they concealed their experiences. In the following account, Harry in his 40s, tells about the fact that he was ashamed of his ascribed diagnosis and his experience of mental distress when he was younger, and that he did not want to talk about his ascribed diagnosis or mental distress with his friends and others. He tried to 'conceal' his experiences of mental distress. He compared himself to his friends, who had to his knowledge not experienced any mental distress, and who he thought of as being 'normal', which he felt he was not. It was very important for Harry to be 'normal', looking 'normal', acting 'normal' and doing what 'normal' people do.

Ann-Charlott: What do you feel about this diagnosis?

Harry: You know, it has been tough. There were some times ... When I was younger it was hard. Because then you compared yourself with everyone else, you compared oneself. One created one's own. You know it felt, one was

ashamed of, partly because of this illness. It was mostly then. Then you could for example, when you were sitting in a cafe talking and stuff like that. Then you did not want to say that, did not want to say that. You did not want to talk about yourself. My sickness or my diagnosis or like that, you know. I did not want people to talk about that with me.

Feeling frightened

The issue of being prescribed medication was a topic the participants spoke about. Ben, in his 50s, experienced physical life-threatening side effects of the prescribed medication, and he felt frightened and stressed due to that.

Ben: It frightened me at all. And I was given, another drug. A similar period of time to that, when I was still young. They gave me a drug and then sent me home. And I was almost paralysed down on my left side. And they Yes, medication. My parents rang in and said: 'He is not the same. He is really, very, very poorly.' And he described over the phone. And they said: 'Well get him in fast'. And that really, that was, that was one occasion. Just, just that one really and I. They gave me the antidote to this thing and I just collapsed on the floor in a heap. And I thought: 'God, you know, that was not really good nursing or really very good consultation'. ... I thought, you know. Because my left side was completely different to my right. It, it was that bad. ... Yes, yes, it was. It did make me very stressed and very frightened. ... Then they just said: 'We must put you on', what was it? You know: '24 hour looking at you'. And they said to my parents, you know, that there was not anything that they could do at the moment. They went home, and I, I just had to, had to stay in the ward. But in the section where they would be watching me night and day.

Ben had been prescribed medication and when taking the tablets he experienced life-threatening side effects. Experiencing the side effects made him very frightened and stressed. He had put his faith in the doctors and took the prescribed medication. When he experienced the paralysis he was rushed to the psychiatric ward, and he was sectioned, and they gave him an antidote. However, despite the seriousness of his condition he was not rushed to the general hospital, but rather the psychiatric ward and he was sectioned, and he was given an antidote. The life-threatening side effects and the treatment on the psychiatric ward made Ben feeling very frightened and stressed, and fearing for his life. However, he did not complain or reflect about being treated in a psychiatric ward rather than in a general hospital.

'Not a proper man' and 'not a good mother'

The men and the women gave also examples of emotional and psychological responses to gendered disablism. Ymmot, in his 60s felt that he was not a 'man' when facing a series of complicated life problems and a stressful work. He used alcohol to handle the situation, and when the alcohol consumption spiralled out of control and his life situation too he tried to take his life.

Ymmot: I think it was that I completely 'stumbled' when I had my last divorce. Because I just went in to the wall. It was too much at work, go through a divorce, and find a new relationship, and then there was another divorce again. At the same time there were problems with my partner's children and my son got in to drugs. And he ended up in jail and in a treatment home, and all this. It was many factors during few years, which, which totally knocked me.

Ann-Charlott: So, and did you feel self-contempt because you did not have the ability to handle all, this whole, this big situation?

Ymmot: Yes, yes, I am the big brother, and I have always been the Big Brother, and have had great positions in my career. And have been travelling around in Sweden and have (mentions his duties) for (mentions a company). With own ideas and so. So when everything around me collapsed, then I collapsed too.

Ymmot feels that he was not a 'proper man'. He felt he could not face and handle his complicated life situation as a man is 'supposed to do'. Ymmot did not feel as such, so he felt self-contempt and started to increase his usage of alcohol to handle his feelings. His life situation eventually collapsed and he did not seek and/or got any help. The life situation of his led him to try to end his life.

Christine, in her 60s, felt guilty for not being a 'good mother' because she had experienced mental distress.

Christine: I am talking about it know because I had my children talking about their misery with me. And I think the best part that happened was when one of my daughters, also the middle one, she, she worked. ... One day she offered me a holiday weekend away. She took me to a nice place in the countryside. Because she knows that I love the countryside. The atmosphere was very good and the environment was really right. The situation was good, and everything was good, and we were only two. And she had massive big room for the two of us only. And she brought things that she knows about me out. How I was with them, the children. How I accused them. How I made life difficult. Without accusing me, but she brought it in such a way like a counsellor would do. And for some reason, because of the environment, the circumstance, the circumstance. And everything was so good and normal. My eyes were being open, bit by bit and I could see clearly, where I was wrong. I could see clearly were I judged my children, accused them. Where I was so hard. Where I thought they fought me. That concave mirror, was from my side. And, and she would stand, sit there and comfortable. Not accusing, not raising, and that opened my understanding. And I do not, I do not think I have ever cried that much and that guilt of what I put others through. Thinking it was the other person, while it was actually me.

Christine felt that she was not a 'good mother' because of her experience of mental distress. Christine had to flee her country and seek asylum for her and her children in England and start a new life. In addition, her husband and her oldest son were killed in the civil war and she has never been allowed to see and visit where they are buried. Thus, it is understandable that Christine responded to these traumatic life experiences by experiencing mental distress. However, Christine felt that she was not a 'normal' mother, and she sometimes referred to herself as 'monster mum'.

Discussion

Challenges to identity

In this research and article we asked if and how the process of being identified with a social category, being identified as experiencing mental distress and being identified as a man or a woman, affected the recovery process. In other words, did the experience of oppression on the grounds of mental distress and gender affect the process of recovery, and if so, how? The men and women gave many examples that the experience of disablism and gendered disablism affected them negatively, and were working along emotional and psychological pathways. For example the participants felt powerless, of lesser value, ashamed, and frightened. They also internalized denigrating beliefs about themselves, they were internalizing a devalued ascribed identity. For example, they thought they were a 'criminal', a 'bad mother', and a 'sick person'. The participants' senses of who they were and how they were perceived by others were transformed when experiencing a mental distress crisis (Estroff et al. 1991; Pettie and Triolo 1999). The continual subjection to negative stereotyping, social responses of being ascribed with a 'mental illness', and 'normal' people's and practitioners' and professionals' understanding of experiences of mental distress from an individual biomedical perspective, might lead to shifts in identity, to a lesser or a greater, extent with a loss or distortion of any positively valued sense of self, and affect the person along psychological and emotional pathways. Thus, the experience of social oppression can become a barrier in the reclaiming and (re)construction of a positive identity in the recovery process. The reclaiming and (re)definition of one's self as a person is probably the essence of the recovery process (Davidson 2003). The pathologization and criminalization of experiences of mental distress and the hegemonic ideal of the 'sane and the rational' in contemporary Western societies, 'denigrates and social invalidates' people who experience mental distress, and these experiences of oppression might affect people who experience mental distress psychologically and emotionally and their life activities, that is, their recovery process. The same conclusion can be drawn in regards to gender; experience of gendered disablism affected the participants negatively by affecting their emotional well-being and they internalized an ascribed negative identity, for example seeing oneself as a 'monster mum'. In addition, experiences of oppression sometimes fed into the very experiences of traumatization and victimization and/or exclusion that might have contributed

to the women and men's original experience of mental distress, thereby instigating a potentially vicious cycle of increasing distress, powerlessness, victimization and traumatization (Tew 2005). Thus, the experience of disablism and gendered disablism was embodied as pain and 'suffering' for the participants. For example, they displayed a range of negative emotional and psychological responses, and/or their experience of mental distress was exacerbated when experiencing social oppression. Disablism, experiences of oppression, should be thought about as fully embodied (Thomas 2007). Thus, on the basis of our findings and in line with others (Tew et al. 2012) we argue that when one is studying processes of recovery one should indeed deal with the possible impact of discrimination and oppression. A way forward is by using a theoretical framework drawn from British disability studies – a framework which focuses on experiences of social oppression, rather than the 'deviant' individual. The recovery process should be seen as not just an individual journey of 'healing', but also as a process that unfolds within a social and interpersonal context (Topor et al. 2011), which can facilitate or become a barrier in the recovery process (Timander 2015). Thus, by using a social structural and interpersonal perspective on recovery processes in this study, novel findings were revealed. This piece of research adds to the call for Western societies to learn to validate and celebrate 'social difference', and to begin to explore innovative and creative ways of thinking about experiences of mental distress and recovery. Furthermore, we have advanced a disability studies perspective by studying experiences of mental distress and recovery from a social structural point of view and exposed the systemic and symbolic violence that lie at the core of the psychiatric system and the oppression by the wider society, and validated and celebrated service users/survivors lived experiences.

Conclusion

The experience of oppression affected the participants negatively along emotional and psychological pathways and affected their life activities and, they, for example, internalized devaluing beliefs/identities about themselves. Thus, using a British disability studies perspective on oppression has deepened the understanding of experiences of mental distress and recovery. The process of recovery was, in the light of the findings, argued to be a highly social and not just an individualistic process, where social factors like experiences of oppression could become a barrier in the recovery process. The impact of experiences of power and oppression is currently not sufficiently highlighted in the stage models of recovery (Davidson et al. 2010). Thus in line with Topor et al. (2011), and on the basis of our research, we argue that when studying processes of recovery, researchers have to become more explicit about if and how issues of power and social structures in society shape the reclaiming and (re) building of identities, because it seems like recovery unfolds within a social context.

Acknowledgements

The authors would like to thank all of the participants who agreed to take part in this study – without their willingness and their trust with their stories, this research would not have been possible.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributors

Ann-Charlott Timander, PhD. Senior lecturer at the Department of Social Work, Gothenburg University.

Anders Möller, PhD. Professor Emeritus in Public Health at the Department of Social Sciences, Ersta Sköndal University College.

Larry Davidson, PhD. Professor of School of Medicine and Institution for Social and Policy Studies, Yale University.

References

- Andresen, R., L. Oades, and P. Caputi. 2003. "The Experience of Recovery from Schizophrenia: Towards an Empirically Validated Stage Model." *Australian and New Zealand Journal of Psychiatry* 37: 586–594.
- Bellack, A. S., and A. Drapalsky. 2012. "Issues and Development on the Consumer Recovery Construct." *World Psychiatry* 11: 156–160.
- Beresford, P. 2005. "Social Approaches to Madness and Distress. User Perspectives and User Knowledges." In *Social Perspectives in Mental Health. Developing Social Models to Understand and Work with Mental Distress*, edited by J. Tew, 32–52. London: Jessica Kingsley.
- Beresford, P. 2013. "Foreword." In *Mad Matters: A Critical Reader in Canadian Mad Studies*, edited by B.A. LeFrancois, R. Menzies, and G. Reaume, ix–xii. Toronto: Canadian Scholars' Press.
- Davidson, L. 2003. *Living Outside of Mental Illness. Qualitative Studies of Recovery in Schizophrenia*. New York: New York University Press.
- Davidson, L., J. O'Connell, J. Tondora, M. Lawless, and A. C. Evans. 2005. "Recovery in Serious Mental Illness: A New Wine or Just a New Bottle?" *Professional Psychology: Research and Practice* 36 (5): 480–487.
- Davidson, L., and D. Roe. 2007. "Recovery from Versus Recovery in Serious Mental Illness: One Strategy for Lessing Confusion Plaguigng Recovery." *Journal of Mental Health* 16 (4): 459–470.
- Davidson, L., D. Roe, R. Andres-Hyman, and P. Ridgway. 2010. "Applying Stages of Change Models to Recovery from Serious Mental Illness: Contributions and Limitations." *Israel Journal of Psychiatry and Related Sciences* 47 (3): 213–221.
- Davidson, L., and J. S. Strauss. 1992. "Sense of Self in Recovery from Severe Mental Illness." *British Journal of Medical Psychology* 65: 131–145.
- Deegan, P. 1996. "Recovery as a Journey of the Heart." *Psychiatric Rehabilitation Journal* 19: 91–97.
- Dixon-Woods, M. 2011. "Using Framework-based Synthesis for Conducting Reviews of Qualitative Studies." *BMC Medicine* 9 (39): 1–2.
- Estroff, S. E. 1989. "Self, Identity, and Subjective Experiences of Schizophrenia: In Search of the Subject." *Schizophrenia Bulletin* 15: 189–196.
- Estroff, S. E., W. S. Lachiotte, L. C. Illingworth, and A. Johnston. 1991. "Everybody's Got a Little Mental Illness: Accounts of Illness and Self Among People with Severe, Persistent Mental Illness." *Medical Anthropology Quarterly* 5: 331–369.
- Goffman, E. [1963] 1990. *Notes on the Management of Spoiled Identity*. London: Penguin Books.
- Pettie, D., and A. M. Triolo. 1999. "Illness as Evolution: The Search for Identity and Meaning in the Recovery Process." *Psychiatric Rehabilitation Journal* 22 (3): 255–262.
- Pilgrim, D. 2014. *Understanding Mental Health: A Critical Realist Exploration*. Abingdon: Routledge.
- Pilgrim, D., and A. Rogers. 2009. "Survival and Its Discontents: The Case of British Psychiatry." *Sociology of Health and Illness* 31 (7): 947–961.
- Ritchie, J., and L. Spencer. 1994 "Qualitative Data Analysis for Applied Policy Research." In *Analyzing Qualitative Data*, edited by A. Bryman and R. G. Burgess, 173–194. London: Routledge.
- SAMHSA. *The U.S. Substance Abuse*. Mental Health Services Administration, 2004.
- Sayce, L. 1998. "Stigma, Discrimination and Social Exclusion: What's in a Word?" *Journal of Mental Health* 7 (4): 331–344.
- Schea, J. M. 2009. "Coming Back Normal: The Process of Self-recovery in Those with Schizophrenia." *Journal of the American Psychiatric Nurses Association* 16 (1): 43–51.
- Spandler, H., and J. Anderson. 2015. "Unreasonable Adjustments? Applying Disability Policy to Madness and Distress." In *Madness, Distress and the Politics of Disablement*, edited by H. Spandler, J. Anderson, and B. Sapey, 13–26. Bristol: Policy Press.
- Tew, J. 2005. "Core Themes of Social Perspectives." In *Social Perspectives in Mental Health. Developing Social Models to Understand and Work with Mental Distress*, edited by J. Tew, 13–31. London: Jessica Kingsley.
- Tew, J., S. Ramon, M. Slade, V. Bird, J. Melton, and C. Le Boutilier. 2012. "Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence." *British Journal of Social Work* 42: 443–460.
- Timander, A-C. 2015. *The Reclaiming and (Re)construction of Positive Identities in the Recovery Process by Women and Men with Experience of Long Term Mental Distress. A Comparative Study: Gothenburg, Sweden and Oxford, England*. Lancaster, the UK: PhD-thesis, Lancaster University.
- Timander, A-C, A. Grinyer, and A. Möller. 2015. "The Study of Mental Distress and the (Re)construction of Identities in Men and Women with Experience of Long Term Mental Distress." *Disability and Society* 3 (3): 327–339.
- Thomas, C. 1999. *Female Forms: Experiencing and Understanding Disability*. Buckingham: Open University Press.
- Thomas, C. 2007. *Sociologies of Disability and Illness. Contested Ideas in Disability Studies and Medical Sociology*. Basingstoke: Palgrave Macmillan.
- Thomas, C. 2010. "Medical Sociology and Disability Theory." In *New Directions in the Sociology of Chronic and Disabling Conditions. Assaults on the Lifeworld*, edited by G. Scambler, and S Scambler, 37–56. Houndmills: Palgrave Macmillan.
- Thomas, C. 2012. "Theorising Disability and Chronic Illness: Where Next for Perspectives in Medical Sociology?" *Social Theory and Health* 10 (3): 209–228.

- Topor, A., M. Borg, S. Girolamo Di, and L. Davidson. 2011. "Not Just an Individual Journey: Social Aspects of Recovery." *International Journal of Social Psychiatry* 57 (1): 90–99.
- Watermeyer, B., and T. Görgens. 2014. "Disability and Internalized Oppression." In *Internalised Oppression. The Psychology of Marginalized Groups*, edited by E.J.R. David, 253–280. New York: Springer Publishing Company, LCC.
- Wisdom, J. P., K. Bruce, Auzeen G. Saedi, T. Weis, and C. A. Green. 2008. "Stealing Me from Myself: Identity and Recovery in Personal Accounts of Mental Illness." *Australian and New Zealand Journal of Psychiatry* 42: 489–495.