

THE STIGMA OF MENTAL ILLNESS AND RECOVERY

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SUMMARY

Stigma and recovery “from” and “in” mental illness are associated in many various ways. While recovery gives opportunities, makes person stronger, gives purpose and meaning to their lives and leads to social inclusion, in the same time stigma reduces opportunities, reduces self-esteem and self-efficacy, reduces the belief in own abilities and contributes to social exclusion through discrimination. The recovery of a person with mental illness means to get and keep hope, to understand their own possibilities and impossibilities, active living, to be autonomous, to have a social identity and to give meaning and purpose of our own lives. The care system, recovery-oriented, provides help and support to people with mental disorders in his/her recovery, which contributes to reduction of self-stigma, to the elimination of stigmatizing attitudes and beliefs in mental health services which consequently may have a positive reflection in reducing the stigma of mental illness in the community. It is important to look at the stigma and recovery from the perspective of individual experience of each person with a mental illness in the process of recovery. A support to the recovery concept and the development of a recovery-oriented system of care should be one of the key segments of any strategy to combat the stigma of mental illness. Also, the cultural and the social stigma aspects of stigma would be taken into account in the developing of the recovery concept and on the recovery-oriented care system.

Key words: stigma - mental illness – recovery - recovery-oriented services

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Introduction

„The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become the unique, awesome, never to be repeated human being that we are called to be“ (Deegan 1996).

In recent decades of the 20th and in the 21st century the numerous studies on the stigma of people with mental disorders have been carried out, the results of a number of campaigns and other activities related to the reduction of stigma have been published, the guidelines and written recommendations from professional and non-professional organizations for the promotion of mental health have been done, the global action in raising of public awareness about the mental illness stigma in order to change public attitudes and to increase knowledge about this problem have been undertaken. (Flanagan et al. 2017, Stuart et al. 2012, Beldie et al. 2012). But, despite the all taken activities and the recommendations, the stigma of mental illness is still a general public health and social problem and is present in all countries, regardless of the economic and other development (Parcesepe & Cabassa 2014, Rössler & Lauber 2007). Overall, in the sector of mental health and treatment of people with mental disorders considerably less funds is allocated, compared to all other health sectors, but in the same time the mental health problems represent a huge socio-economic burden (Joint Action on Mental Health and Wellbeing 2016; McDaid, Knapp & Raja 2008; World Health Organization, 2003). The development of services of the mental health protection and its preservation is of

unequal even today, more than ever, the gap between developed and developing countries is visible. While in developed countries there is a wide range of different services with very different available programs, together with developed multidisciplinary teams and with accessible overall range of psychopharmacological drugs in the developing and underdeveloped countries it becomes an elusive goal (World Health Organization 2014, Patel 2007). The stigma of mental illness is reflected both on the organization and accessibility of services, on the allocation of funds for the development of mental health services, requests for help, and on the course of treatment and outcome. The public stigma, stigmatizing beliefs among health workers as well as professionals in the mental health is well documented in the literature (Corrigan et al. 2012; Ugar, Knaak & Szeto 2016; Corbiere et al. 2012). Stigmatizing beliefs of mental health professionals are associated with the stigmatizing actions and attitudes toward treatment. Also, the assessment of mental illness and its treatment is associated with attitudes about treatment (Parcesepe & Cabassa 2013). Lower quality of life of patients with schizophrenia in comparisons with with physical disabilities and psoriasis, which indicates that it is necessary, not only to make the treatment of schizophrenia more successful, but also to improve the process of rehabilitation and social reintegration in order to increase the quality of life of people with schizophrenia (Palijan et al. 2017). On the other hand, self-stigma is another important factor that is associated with the diagnosis and treatment of mental illness. In several ways, together with the stigma of mental illnesses the recovery from mental illnesses is closely related to.

The stigma of mental illness

The stigma of mental illness is widespread and significant problem around the world (Parcesepe & Cabassa 2014, Rössler & Lauber 2007, Couture & Penn 2003), and it is debilitating for people with mental illness. It has an impact on their options for life, their beliefs about themselves, and even the course of their illnesses (Overton & Medina 2008). Stigma and effects of stigma are distinguished into two forms, public and self-stigma. Public stigma has been described in terms of stereotypes, prejudice, and discrimination. It is the process by which individuals in the general population first endorse the stereotypes of mental illness and then act in a discriminatory manner (Corrigan & Bink 2016). Self-stigma is the negative self-appraisal stigmatized persons engage in as a result of being a member of a stigmatized group (Corrigan et al. 2006). Stigmatized individuals face public discrimination and are targets of negative stereotypes. They often agree with these stereotypes and apply them to themselves, resulting in low self-esteem and self-efficacy. Diminished self-esteem leads to a sense of being less worthy of opportunities that undermine efforts at independence (Corrigan & Watson 2002, Link et al. 2001). Public and self-stigma decrease the quality of life for individuals with mental health disorders and also interferes with seeking treatment (Vogel et al. 2007). Stigma has become a marker for adverse experiences such as shame, blame, secrecy, the „black sheep of the family“ role, isolation, social exclusion, stereotypes, discrimination and etc. (Byrne 2000).

The effects of stigma are often subtle and spread through many areas of a person's life. Also, there are more direct effects of stigma such as discrimination in the workplace and restriction of housing options. Link & Phelan (2001) noted that stigmatizing processes can affect multiple domains of people's lives and that stigmatization has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health, and life itself. Due to stigma's devastating effects, studies worldwide have recently aimed to raise awareness and understanding about the most effective strategies to combat stigma and discrimination (Corbiere et al. 2012). Strategies aimed at reducing stigma vary in their approaches, content and empirical support. Often, the strategies employed to reduce stigma fall short of their objective, or worse, they exacerbate the problem (Corrigan & Bink 2016). Three main strategies have been found effective in reducing the public stigma of mental illness: protest, education, and contact (Corrigan & Penn 1999). Evidence from a meta-analysis of 34 studies (Griffith et al. 2014) revealed that educational interventions alone or when combined with other interventions are effective in reducing personal stigma for different types of mental disorder. In the same meta-analysis interventions with a user contact element were associated with a reduction in stigma associated with "mental illness". Also, evidence

from a meta-analysis of 72 studies (Corrigan et al. 2012) indicated that education strategies are effective means for positive stigma change. According to Corrigan & Bink (2016), both education and contact are effective for eliciting change, contact brought about a greater reduction in stigma. Moreover, face-to-face contacts with a person with lived experience have the most compelling impact on attitudes and behaviour. Perceptions of public stigma contributed to the experience of self-stigma, which, in turn, influenced help-seeking attitudes and eventually help-seeking willingness (Vogel et al. 2007). Schreiber & Hartrick (2002) suggests that people may feel less self-stigma if their symptoms are normalized and if they are given an explanation for their symptoms. People tend to view their problems with less shame and guilt when given information that suggests that their problems are not their fault, and that are reversible or will improve through treatment (Rosen, Walter, Casey & Hocking 2000; Mann & Himelein 2004). Abiri et al. (2016) found that factors generally thought to reduce stigma internalized as self-stigmatizing beliefs, such as improved insight, increased self-awareness, and psycho-education to improve stigma coping skills, do not appear to improve self-esteem. Evidence from a systematic review of 14 studies (Mittal et al. 2012) revealed that are two prominent approaches for self-stigma reduction. The first approach included interventions that attempt to alter the stigmatizing beliefs and attitudes of the individual and the second, interventions that enhance skills for coping with self-stigma through improvements in self-esteem, empowerment, and help-seeking behaviour. Hence, how individuals experience their illness and its consequences as well as whether they use health services have central role in their life. Accordingly, well-designed interventions aimed to reduction of stigma will help to diminish the impact of mental illness stigma. Reducing the stigma and discrimination associated with mental illness is becoming an increasingly important focus for policy, programming, and intervention work.

Recovery from mental illness and being „in recovery“

There is no single description or definition of recovery. The term 'recovery' has been variously used to mean an approach, a model, a philosophy, a paradigm, a movement, a vision and, sceptically, a myth (Roberts & Wolfson 2004). In the literature there are numerous definitions of what recovery means. One of the frequently used definitions of recovery is from Anthony (1993). Recovery is unique to each person and it is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Also, according to him recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. In this conceptualization of recovery people can recover from mental illness although the illness is not cured, and that

the process of recovery can proceed in the presence of continuing symptoms (Roberts & Wolfson 2004). This is reflect meaning of recovery from user's perspective which call as „personal recovery“ (Davidson & Roe 2007) or being „in recovery“ (Slade & Davidson 2011). Andresen and colleagues (2003) proposed definition that recovery involves the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination. Recovery is often referred to as a process, outlook, vision, and conceptual framework or guiding principle (Jacob 2015). Hope remains the main guiding principle of the recovery process. Hope can be defined as a primarily future-oriented expectation of attaining personally valued goals that will give or restore meaning to one's own experiences (Schrank et al. 2012). The process of personal recovery involves having the courage to step out of one's comfort zone and to take risk, and thus to try, to fail and to try again in the process of correcting and transforming (Slade 2009). This process involves reclaiming a positive identity in two ways: by identity-enhancing relationships and promotion of well-being which push the mental illness into being a smaller component of identity, and by framing and self-managing which pull the mental illness part. These processes take place in a social context which provides support for the development of an identity as a person in recovery (Slade 2009). Group psychoeducation decreased the level of self stigma. This intervention can assist in recovery from schizophrenia (Ivezić et al. 2017). Slade & Davidson (2011) argues that the recovery approach is based on personal recovery, and that personal recovery emerges from outside the dominant scientific paradigm. They noted that our understanding of recovery emerges from people who have experienced mental illness, not from mental health professionals. Patricia Deegan was one of the first people who described how she and other people with the experience of psychosis have moved beyond a patient role and have lived in recovery (Amering & Schmolke 2009). For Deegan (1997) recovery is possible and that is a journey rather than a destination or "cure". She emphasized that one must recover not only from mental illness, but also from internalized stigma, low expectations and dehumanizing clinical practices. According to Amering & Schmolke (2009), recovery is a development of personal growth and overcoming the often negative personal and societal implications of receiving a diagnosis, especially the traditionally attached prognosis, which can hinder this process and the full use of coping strategies and resilience. It does not necessarily imply a return to premorbid level of functioning and asymptomatic phase of the person's life. Nor does it suggest a linear progression to recovery but one, which may happen in "fits and starts" and, like life, have many ups and downs (Jacob 2015). Consistent with above listed understanding of recovery is the working definition proposed by Substance Abuse and Mental Health Service Administration (SAMHSA) (2012). Recovery defines as a

process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Bellack & Drapalski (2012) suggest that recovery is not a simple by-product of traditional outcome domains, such as symptoms, and is not a proxy for quality of life. Rather, it seems to be a distinct construct that may have important implications for understanding users with serious mental illness and for evaluating the outcomes of treatment programs. Also, recovery can be understood from the clinical perspective. Clinical recovery is an idea that has emerged from the expertise of mental health professionals, and involves getting rid of symptoms, restoring social functioning, and in other ways 'getting back to normal' (Slade 2009). In the scientific literature recovery is generally considered from the perspective of the definition of the disease and involves the elimination or reduction of symptoms and return to premorbid levels of function (Bellack 2006). But, as Anthony (1993), notes recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams (Anthony 1993).

Recovery model and the stigma of mental illness

As pointed out by Warner (2009), the recovery model refers to subjective experiences of optimism, empowerment and interpersonal support, and to a focus on collaborative treatment approaches, finding productive roles for user, peer support and reducing stigma. The recovery model is influencing service development around the world. He notes that are key principles of the recovery model: optimism about recovery, the importance of access to employment and the value of empowerment of user in the recovery process. Attempts to reduce the internalized stigma of mental illness should enhance the recovery process. There are a number of publications (Repper & Perkins 2003, Slade 2009, Amering & Schmolke 2009, Bouras & Ikkos 2013, Jacob 2015) which emphasize that the recovery model aims to help people with mental health problems to look beyond mere survival and existence, and that it encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning. Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives. Recovery is not about 'getting rid' of problems. It is about seeing beyond a person's mental health problems, recognising and fostering their abilities, interests and dreams. Recovery can be a voyage of self-discovery and personal growth (Mental Health Foundation 2017). Experiences of mental illness can provide opportunities for change, reflection and discovery of new values, skills and

interests. A basic requirement is a well-organized system of support from family, friends and/or professionals. It also requires services to embrace new and innovative ways of working. There are different models for helping staff to understand personal recovery processes and how they might enable and support personal recovery (Australian Health Ministers' Advisory Council 2013). In Australian's national framework for recovery-oriented mental health services noted several highlighted models. The model developed by Andresen, Oedes & Caputi (2011) underlines four processes involved with personal recovery: finding and maintaining hope, re-establishment of positive identity, building a meaningful life and taking responsibility and control. The model developed by Glover (2012) emphasizes personal responsibility and personal control and reflects the efforts that people undertake in their personal recovery through a set of five processes: from passive to active sense of self; from hopelessness and despair to hope; from others' control to personal control and responsibility; from alienation to discovery, and from disconnectedness to connectedness. Jacobson & Greenley (2001) model's of recovery refers both to internal conditions - the attitudes, experiences, and processes of change of individuals who are recovering - and external conditions - the circumstances, events, policies, and practices that may facilitate recovery. These conditions have a reciprocal effect, and the process of recovery, once realized, can itself become a factor that further transforms both internal and external conditions. According to Corbiere and colleagues (2012) the concept of recovery is based on the hopefulness of a better life, both inside and outside the network of mental health. They also noted that by paying attention to the whole person, beyond the diagnosis and symptoms, as implied by a recovery-based approach, a health care professional could avoid falling into the trap of diagnostic overshadowing, which has adverse consequences for people with a mental disorder. Amering & Schmolcke (2009) in their publication about recovery in mental health, noted that the patient self-determination, individual choice of flexible ways of support and opportunities, interventions aimed at promoting empowerment and hope, and assistance in situations of calculated risk are the new indicators of the quality of services. A recovery-orientation model of mental illness includes a focus on health promotion, individual strengths, and resilience. It is requires specific skills and new forms of co-operation between practitioners and service users, between mental health workers of different backgrounds, and between psychiatry and the public. Also, they point out that co-operation between people with and without lived experience of mental health services has been successful but needs more support. Support is also needed for those who work on the development of alternatives outside the traditional system. As Amering & Schmolcke (2009) emphasized, recovery is a concrete and practical process that involves activities shared with several providers,

whereby the individual can regain and maintain control over his/her own life and can develop and experiment with competencies and new information. Recovery is seen as an active process by the users, and not as something that is being done by the professionals for a "passive and sick" person. The task of professional helpers is to discover the capacities for recovery in each person who is seeking help, to provide support and encouragement, and to stand by them along the way. Also, they noted, that a treatment in the context of the recovery-model consists of a user-driven change process, in which clinicians can serve as consultants and facilitators. It involves mutual-help and self-help interventions that can encourage growth and consider possibilities, hopes, and dreams. Service providers must be prepared to learn alongside service users and to be open to new experiences. And they need to believe in the potential of the users to achieve a meaningful life in place of the patient role. This requires a focus on wellness instead of illness and a shift from patient role to meaningful life roles (Amering & Schmolcke 2009). Recovery-oriented mental health practice refers to application of sets of capabilities that support people to recognised and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations (Australian Health Ministers' Advisory Council 2013). In recovery-oriented practice need to create an enabling environments in which mental health staff and setting serve as agents for promoting recovery from mental illness.

Conclusion

The process of stigma is producing prejudicial behavior which results in prejudice against people with mental illness, which has an impact on many areas of their lives. In the last decades a number of activities toward the stigma of mental illness have been undertaken and this work produced evidence about the effectiveness of the interventions that had been proposed as means to prevent or reduce stigmatization. Also, in recent years, attention is paid increasingly to the concept of recovery from mental illness, not only by users and their relatives but also by researchers, clinicians and practitioners in mental health services. The concept of recovery was conceptualized by, and for people with mental health problems to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnosis. Recovery commonly describes as a unique, nonlinear and personal journey which rarely taken alone, and as a normal human process, and an ongoing experiences and not the same as an end point or cure. Recovery and stigma give different perspectives in relation to individual experiences of persons with mental health issues, and it is should be taken into account in the field of mental health care and recovery-oriented practice, the strategies to cope with stigma, and in the field of stigma and recovery research.

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Esmina Avdibegović: design of the article, drafting the article, review of literature, revising it critically for important intellectual content;

Mevludin Hasanović: drafting the final version of article and revising it critically for important intellectual content, analysis and interpretation of data.

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