UPCYCLING RECOVERY
Potential alliances of recovery, inequality and Mad Studies

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Introduction
Originating in the US in the late 1980s and early 1990s, the recovery movement started as a progressive grassroots movement in which we, as survivors, assert our right to control our own lives in the face of dominant psychiatric power. Contrary to the notion of chronicity and deficit often found in Western bio-medical models, recovery-oriented mental health services emphasise the hope of living a valued and decent life with or without the limitations caused by distress and ill-health (Anthony, 1993). Over the years, recovery as a concept has become a frequent discursive feature in mental health policies in various Anglophone countries such as the UK, New Zealand and Australia. In other places, such as Hong Kong and mainland China, where there is a lack of national mental health policy, the recovery approach is often perceived as a welcomed and relevant concept which requires local adaptation (Tse et al., 2013a; Tse et al., 2013b).

Despite the seeming ‘success’ of the mainstreaming of recovery, its implementation has been criticised (Spandler and Calton, 2009; Morrow, 2013; Slade et al., 2014; McWade, 2016). Some service-user groups even argue for jettisoning the concept altogether. They see it as being co-opted into the current mental health system and becoming a disciplinary force that limits users’ autonomy rather than championing it (Recovery in the Bin, 2016). Mad studies has been one of the important spaces in which the recovery concept has been critiqued (Morrow, 2013; McWade, 2016). In this chapter, I will discuss whether we should reclaim the concept of recovery and the possibility of reconceptualising it as a project of community that puts social justice at the core and tackles multi-levelled inequalities. Drawing on my research and observation in the UK, as well as in Chinese-speaking worlds, I will discuss the controversies of recovery and argue for reclaiming rather than jettisoning it. Then I will illustrate how, by throwing light on inequalities and oppression, including those within the psychiatric system, can reveal what can limits service-users’ life chances and constrain their pursuit of valued lives (Tang, 2017). I argue that seeing recovery as a project of community would require challenging these inequalities collectively with cross-sectional movements. Following this I propose Göran Therborn’s (2013) conceptualisation of three killing fields of inequality, namely, vital, existential and resource inequalities, as a means of envisioning potential alliances of recovery, inequality and mad studies.
Shall we jettison recovery?

In its original emphasis, the recovery movement foregrounds lived experience and the experiential knowledge of service-users as well as advocating a shift of power from professional dominance to users’ self-determination. It proposes a change from a notion of deficit in illness model to therapeutic optimism. Patricia Deegan, a disability-rights advocate with lived experience, wrote in the early days of the recovery movement that recovery is not a linear process. In her work ‘Recovery as a Journey of the Heart’ (1996), she wrote that the goal of recovery is not for individuals to get mainstreamed or become ‘normal’. Rather, the aim is to transform the mainstream so that there are rooms for everyone to be themselves and to pursue a life they want. What Deegan conveyed is the agency for us to exist and grow with full potential as human beings. The recovery movement gained momentum and mental health professionals, often co-producing with service-users, have built on research from the recovery movement to produce knowledge on how to change the mental health system itself. For example, Slade (2009) delineates the difference between ‘clinical recovery’ and ‘personal recovery’ and argues for the mental health system to change its focus from the former to latter. ‘Clinical recovery’ is understood as professionals prescribing what recovery is and such prescription is often pre-occupied with symptom remission and the use of medication to eliminate symptoms, while ‘personal recovery’ goes beyond a narrow medicalised understanding of mental distress and respects recovery goals and processes defined and valued by individual service-users. Elements that promote personal recovery, such as connectedness, hope, positive sense of identity, finding meanings in life and empowerment, are also articulated (Leamy et al., 2011).

The uptake of recovery discourse in policy in Anglophone countries can be due to the fact that recovery is a polyvalent and ambiguous concept that can mean recovery from illness which resonates with the traditional bio-medical model, or recovery from the invalidation of lived experience which service-user movements strive for (Pilgrim, 2008). Thus no one will disagree with ‘recovery’. Yet, once mainstreamed, despite the efforts of proponents to propose a paradigm shift in understanding recovery, it lost its original progressiveness as a liberatory discourse in challenging bio-medical dominance. The dominant ideas about what people have recovery from are left unchallenged (Spandler and Calton, 2009). Societies remain intolerant of differences and thus only permit recovery goals that are aligned with socially sanctioned definitions of what a ‘normal’ functioning person should do (Rose, 2014). Morrow (2013) and McWade (2016) argue that neoliberal discourses shape mental health policies which absorb but also co-opt the recovery movement. Drawing on Foucault’s concept of ‘bio-power’ (1980), Morrow (2013) argue that neoliberalism prompts us to take charge of and manage our individual bodies and minds. Policies under neoliberalism favour welfare entrenchment and individual responsibilities. Biopsychiatry, she argues, is tied to neoliberalism through promoting an individualistic understanding and solutions to collective social problems that cause distress in the first place. Public issues become medicalised personal troubles and individual ‘health’ issues that require biomedical intervention. In this context, recovery is co-opted to promote self-management that emphasises individual responsibility to ‘recover’ in a way sanctioned by the neoliberal society.

Morrow’s critique can be exemplified by McWade (2016)’s detailed account of the New Labour government’s reform of the NHS during the 2000s in the UK. On the one hand the government promoted ‘recovery’ as policy vision. On the other hand it increased coercion through introducing community treatment orders and reducing welfare support to service-users. McWade (2016) argues that the mental health promotion discourse that ‘mental illness is like other physical illness’ shifted attention from social problems that cause suffering to medicalising suffering that legitimises bio-medical intervention. Individuals are to be self-responsible for
their success or failure in recovering into an employable ‘functioning’ citizen. Thus some service-user groups argue for jettisoning recovery as it turns against them and becomes a disciplining discourse that puts the blame on people who ‘don’t recover’, denies them the disability benefits they need for survival and pushes people out of services (Recovery in the Bin, 2016). Recovery, originated as a ‘protest’ narrative that challenges bio-medical dominance and paternalism, which became a ‘role model’ narrative against individuals who do not live up to societal expectations. The neoliberal policy context outlined above reduces well-intended efforts to transform the mental health system ‘from within’ into limited changes as the unequal power within the mental health system remains intact. Similar observation can be seen in the peer support movement. In the US, Penney and Prescott (2016) observed that peer workers are encouraged to acculturate into, rather than transform, the existing culture of the institutions they work in. Both recovery and peer support movements share a similar fate of co-option. It is in this context that mad studies emerges as a potential space for protecting and asserting the distinctiveness of experiential knowledge in enlightening our understandings of mental health and madness, as well as ways to alleviate people’s suffering (LeFrançois et al., 2013; Ingram, 2016; Russo and Sweeney, 2016).

Shall we jettison recovery or reclaim it? I would argue for the latter. First, critiques that argue for jettisoning recovery emerge in countries where recovery is incorporated in national policy and operating as an oppressive discourse. In places like Hong Kong where there is a lack of national mental health policy and recovery discourse remains marginal, recovery does not have the same powerful disciplining effect as in the UK. In Hong Kong, while the mainstream discourse is blatantly based on the Western bio-medical model and paternalism that asks service-users to obey professional knowledge also prevails, in the non-profit sector the recovery movement seems to open up space for alternatives. In one major mental health non-governmental organisation (NGO) that promotes recovery-oriented services, a hearing voices group was founded by a survivor social worker. Such alternatives are still important in impacting cultural changes albeit in small ways. Second, the notions of recovery still resonate with the experiences of many service-users. For example, people suffering from acute anxiety, depression, suicidal ideation, penalising voices do want to recover from the torment of their mental distress and regain a sense of control in their lives. I concur with Morrow’s (2013) view that dialogues about recovery in which individuals share their lived experience of negotiating or resisting psychiatry and exploring ways to regain control from sufferings have transformative potential.

In sum, rather than seeing the recovery concept as in itself problematic, I see recovery approaches and the way proponents are attempting to change the system ‘from within’ as insufficient in changing the status quo of the mental health system. Mad studies’ positioning as an in/discipline ‘from outside’ the knowledge production of the mainstream psy-professions, is crucial in retaining the critical edge of grassroots mad politics and survivor movements (LeFrançois et al., 2016). The current development of mad studies seems to focus on articulating and establishing its epistemological and methodological differences to protect and reinvigorate the production of experiential knowledge as protest narratives. Yet it is less clear about how advocates of mad studies would want to influence the system. In this regard, I see recovery as a concept/approach that needs to be critically interrogated and its meaning reclaimed rather than leaving professionals inside the system to define it.

**Upcycling recovery into a project of communities**

The above critiques of recovery point to the need to not just change mental health services but for the wider society to respect and assert the rights of individuals in order for meaningful
recovery to take place. I suggest ‘upcycling’ recovery – a shift from seeing recovery as a project of individuals to one of communities in order to create the social conditions conducive to recovery. My research project in UK was one that identified such social conditions for Chinese people who lived in the UK, having received a psychiatric diagnosis (Tang, 2017). I took a bottom-up approach and asked what recovery means for individuals in this minority ethnic group. As this group is subjected to an intersection of different inequalities such as ethnicity, class and gender, this study illustrates how recovery as a project of communities should tackle multi-level inequalities.

To discover arenas that recovery as a community project should work on, I used the capabilities approach to explore the enabling and deleterious social conditions Chinese service-users faced. Similar to the spirit of recovery approach, the capabilities approach is not concerned with what a person ultimately chooses to do, but whether they have the substantive freedom to be and do what they value (Sen, 1999; Nussbaum, 2000; Hopper, 2007). Capabilities here refers to substantive freedom rather than the abilities they possess. Substantive freedom has two dimensions. One is the process of exercising choice. The other is the opportunities available to an individual, for choice is not real choice if there are no real opportunities, such as a variety of treatment options or employment opportunities, available. Another useful concept in the capabilities approach is adaptive preference. Individuals’ preferences and aspirational for life choices can be unknowingly shaped and conditioned by the barriers and disadvantages they face. The capabilities approach has been adapted in recovery research in various ways to explore and define what capabilities service-user value (Ware et al., 2007) and their experiences in different capabilities domains, such as living in physical security and engaging in productive and valued activities (Brunner, 2017). Wallcraft (2011) used adaptive preference to explain why service-users tend to underrate decreases in their quality of life as they might have minimised how good their life can be. I used the capabilities approach as a heuristic framework to explore what enables and constrains the capability development of Chinese service-users along their recovery journey.

The findings provide pointers for what recovery as a collective project could work on for this group. I found that the inequalities that contributed to their distress and ill-health in the first place shaped the extent they could recover or redevelop the capabilities. Their marginalisation in the labour market, the harsh working conditions in Chinese catering businesses, the pressure of parental expectation of high educational achievement on young people, as well as the isolation faced by overseas brides and the elderly are common issues faced in this group (Tang and Pilgrim, 2017). Language difficulties, stigma and disempowerment related to diagnosis and treatment, as well as grievances during involuntary hospitalisations were also found in the experience of service users. For some, this constrained their ability to use services to their full benefit. Others, felt acute power inequality with professionals and hesitated to seek help from services again. This results in further isolation, especially as they did not have other alternative sources of help available (Tang, 2017). Self-determination in living arrangements, community participation and economic participation were found to be crucial capabilities for building a life they valued after crisis. Yet disempowering attitudes of frontline practitioners, insufficient opportunities for them to participate in the community due to cuts in services and lack of employment opportunities due to racial and disability discrimination limited their life chances to realise their potentials (Tang, 2018a). My point about putting social inequalities into focus is more apparent if we consider how hope is experienced. Hope, an important element in recovery, but can be problematic in some circumstances. The ideology of achieving a perfect life and body image through consumerism can perpetuate a false hope that creates more anxiety in an unequal society and is thus capability diminishing. The diminished opportunities
some face due to discrimination, ageism and racism can also dampen hope. This results in some people not wanting to embrace hope as it can bring vulnerability and disappointment when encountering barriers in the community (Tang, 2018b).

Recovery as a project of community means identifying and challenging multi-level inequalities and oppressions that limit people’s life chances, make them ill in the first place and hinder recovery later on. The above discussion highlights the collective capabilities we need to recover and develop at the community level in order for Chinese people in the UK to thrive and feel hopeful. Individuals’ recovery progress can’t be forced, but we can create favourable social conditions for recovery and capability development to take place.

The need for broad and cross-sectional movements

What is the implication of upcycling recovery as a project of community? For Chinese communities, there is a need to open up a space to facilitate experiential knowledge production to challenge dominant recovery discourses. In my fieldwork, I found that some participants would present ‘standard scripts’ of bio-medical models on the necessity to take medicines when asked what advice they would give to other service-users, even though in the same interview they reported grievances and ambivalence about the usefulness of medicine. This discrepancy reflects the need to empower service-users to reflect and articulate experiences that may be dissonant with mainstream discourses (Tang, 2017). Yet, recovery as a project of community wouldn’t necessarily entail collaborations beyond a particular community. The class, gender, ethnic and other inequalities mentioned above do not just adversely affect UK Chinese service users. The various inequalities may intersect in a particular way to shape the social conditions that this minority ethnic group live in, but inequalities have a deleterious effect on health across the whole population. Take income inequality as an example. Wilkinson and Pickett (2018) provide evidence to show that countries with larger income disparities have higher rates of people with psychological suffering such as stress, anxiety and depression. They argue that the link is evaluation anxiety, as judging each other’s social position and status exacerbates fear and sense of insecurity. Thus I agree with Ferguson’s proposal to build ‘a broad, rather than a narrow, movement to challenge the causes of mental distress, defend existing services and put forward alternative visions of the kind of mental health services we need’ (2017:117).

The political strategy against neoliberal mental health and welfare policy in the UK suggested by Moth and McKeown (2016) provides an example of what such broad movement can be. Two dimensions of the neoliberal political project are restructuring the welfare state and intensification of work. Policies which cut welfare provision and push people to move away from mental health services and ‘return to work’ (often in the name of ‘recovery’) create stress for mentally distressed welfare claimants. What they are asked to reengage in is toxic working conditions characterised by an intensification of work which is common nowadays. Thus Moth and McKeown (2016) point out that a shared insecurity towards income and job stability can be found across welfare claimants, temporary workers and those in more stable employment. Solidarity across these groups, they argue, can be built not just because of their shared material interest, but the potential for a new consciousness of collectivities against neoliberal policies. They show that such possibility of broad cross-sectional movement is evidenced in anti-austerity activism. For example, service-user activists and mental health workers working together to campaign against pathologising unemployed individuals, as well as service-user activists and trade unionists joining forces in campaigns against service closures.

Such broad cross-sectional movements need to acknowledge the internal diversities and tensions. The potential for solidarity requires ‘a fundamentally democratic ethos to ensure that
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unequal and oppressive social relations are not reproduced within cross-sectional mobilisations’ (Moth and McKeown, 2016:385). Unequal social relations within a movement should be addressed. This can be illustrated with the story of a participant in my study. Young, with his English-speaking skills, was able to find a job in the mainstream labour market and disclosed his mental health history to his employer. Yet, rather than having reasonable adjustments in his work tasks, his disclosure seemed to work against him as his colleagues often blamed him for being slow. He admitted that because of his mental health conditions sometimes he might feel that his body had stopped moving and he did not know how long he had stopped. But often he felt that his colleagues exaggerated the length of time he had stopped and he did not receive help when this happened. Eventually he was fired being told that he was ‘lazy’. I asked if he had ever considered seeking help from a trade union so that there could be a third party assessing whether he was unfairly treated. Yet, he had no idea how to approach a trade union representative and also assumed that they could not help. (Tang, 2017). Young’s perception revealed possible barriers for minority ethnic groups and disabled people in seeking help from the trade union. Chinese people are under-represented in union membership (TUC, 2014). This under-representation raises questions about whether trade unions proactively reach out to this group, the consciousness of labour rights among Chinese communities and whether Chinese people anticipate discrimination in the trade union. Young also felt that the trade union would only act on a worker’s behalf if a strong case could be put together. This suggests that trade unions need to proactively provide information and support to under-represented groups and address diversity and equality among their members. The story of Young may also suggest that Chinese communities in the UK are inward looking and rarely join mainstream movements to address issues such as labour rights, which is a shared concern of both mainstream and minority ethnic groups (Tang, 2018c). Thus this story illustrates the need for cross-sectional movements that address inequalities and diversities within them.

Recovery, inequality and mad studies: potential alliances

As for cross-sectional movements among recovery, inequality and mad studies, I propose that Göran Therborn’s (2013) conceptualisation of the three kinds of inequality may be able to provide a framework to envision potential alliances. These three kinds of inequality, namely vital inequality, existential inequality and resource inequality, also impact upon each other. Among the three, existential inequality is of particular relevance to this edited book on mad studies. Investigation of vital and resource inequalities can be found in conventional studies of health inequity, social determinants of health and social inequalities. Vital inequality refers to the ‘socially constructed unequal life chances of human organisms’, such as morbidity rates, mortality rates and life expectancies (Therborn, 2013:49). Therborn links psychosomatic consequences of the class and status system as one reason for vital inequality which is evidenced by Wilkinson and Pickett (2018). People who have received a psychiatric diagnosis have a mortality rate and life expectancy notoriously lower than that of the general population (Brown, 1997; Laursen, 2011). Resource inequality refers to resources for human action, such as income, intergenerational mobility, educational opportunities, social network, and power (Therborn, 2013). Discrimination faced by service-users in the workplace and the community limits their opportunities for earning a decent income and connecting with other members in the community. Robust equal opportunity legislation (for example, the inclusion and proper implementation of reasonable accommodation in disability discrimination ordinance) has the potential to rectify this inequality and increase employment opportunities for people with psychosocial disabilities.
Therborn defines existential inequality, as ‘the unequal allocation of personhood, i.e., of autonomy, dignity, degrees of freedom, and of rights to respect and self-development’ (2013:49). Examples he quotes include sexism, racism and caste system. The concept of existential inequality can be linked to our advocacy of experiential knowledge in the recovery movement and mad studies, for its emphasis on ‘personal autonomy, recognition and respect’ (ibid:50). Newbigging and Ridley’s (2018) application of Fricker’s concept of ‘epistemic injustice’ (2007) in evaluating the effectiveness of independent mental health advocacy services in the UK can help us further elaborate the existential inequality experienced by service users and how this can be challenged. Epistemic injustice takes place when a person is ‘wronged specifically in her capacity as a knower’ (Fricker, 2007:18, in Newbigging and Ridley, 2018:37). This prevents certain groups of people from contesting distorted understandings of their lived experience. There are two forms of epistemic injustice. Firstly, testimonial injustice happens when one’s account is considered less credible or invalidated. Secondly, hermeneutic injustice arises when a marginalised group lacks shared conceptual resources to make sense of their experiences in ways that feel are comfortable or appropriate. In Newbigging and Ridley’s study (2018), testimonial injustice was found as participants felt that their voices were not respected by the doctors and their concerns were dismissed as irrelevant. Their findings show that independent advocates can in some way promote testimonial justice by acting as an epistemic witness to balance the power asymmetry between the service-user and the professionals in the context of detention under the mental health legislation. Hermeneutic injustice was also found as bio-medical discourse was dominant over other possible ways of framing such as trauma or other social perspectives. Yet, this seems to be more difficult to challenge. This, as Newbigging and Ridley argue, was possibly due to the fact that in face of compulsion, advocates focus on safeguarding rights rather than negotiating alternative understandings (2018). The potentials and limitations of statutory independent advocacy service in rectifying existential inequality illustrated in this study can be a learning point for places where the problems of compulsory detention are less discussed, such as Hong Kong.

These three kinds of inequality impact on each other. This can be illustrated by the tragic story of the suicide of a young novelist in Taiwan (BBC, 2018). Lin Yi-han published a novel on sexual assaults which was later revealed to be drawn from her own experience. Before her death, she was open about her experience of mental health problems and had pledged to fight for destigmatisation of mental illness. It was after her suicide that her parents revealed the causes of her suffering was rape by a private tutor when she was a young girl. Rape as an existential inequality, i.e. sexual assault as a violation of personhood predominately imposed by men against women, results in vital inequality (e.g. the high rate of sexual assault and harassment survivors receiving a diagnosis of post-traumatic stress disorder). According to the news report, Lin, because of depressive symptoms and several suicide attempts, could not finish the university degrees that she had started. This shows how vital inequality results in resource inequality as incompletion of university degree adversely impacted on her further education and employment inequality.

Two learning points can be taken from this sad story as an example of possible cross-fertilisation of recovery, inequality and mad studies/movements. First, tackling mental health symptoms and stigma faced by people receiving a psychiatric diagnosis are not enough to recover one’s personhood. Therapies, be it in the form of medicine or psychological intervention to heal from the trauma, could help, but we need to collectively challenge the patriarchy so that no one will experience sexual assault and harassment in the first place. Also, rectifying existential injustice can bring healing and empowerment at a collective level. The tragedy of Lin and the subsequent #metoo movement originating from the West have fostered
the development of #metoo movement in Greater China. In the mainland China, with the use of social media, the large volume of testimonial accounts revealed by women is unprecedented, making these long suppressed experiences visible and pressure from the movement has resulted in a series of changes in sexual harassment-related policies and legislation (Huang, 2019). The second learning point is that when sharing their accounts and understandings of their lived experiences both women and mental health service users could face gaslighting with accusations of unreliable memory, emotionality and irrationality. Thus epistemic injustice as one of the existential inequalities that invalidate our experience because of our ascribed identities is a common challenge for both feminism, recovery and mad studies movements.

Conclusion

From its inception, the recovery movement has attempted to challenge power inequalities within the mental health system and, in so doing, to assert the validity and significance of experiential knowledge. Yet, the mainstreaming of recovery in mental health policies and services in Anglophone countries, where neoliberalism prevails, has been criticised for being co-opted and becoming a disciplinary discourse that can turn against service users. In this chapter, I have argued that while it is crucial to preserve a space for the production of experiential knowledge outside the psy-professions, dialogue and engagement with the recovery movement is still important – we should reclaim its meaning rather than leaving it to the professionals to define recovery for us. Upcycling recovery into a project of communities could provide a way of reclaiming its progressiveness, placing the focus on changing communities and challenging inequalities, rather than on changing and blaming individuals. Such a project requires cross-sectional movements to challenge systemic and multi-level inequalities with joint efforts.

For potential alliances among recovery, inequality and mad studies, the conceptualisation of vital, existential and resource inequality may offer insights when envisioning synergies for future research and activism. Mad studies challenges the failures of recovery and attempts to create and protect a space of ‘in/discipline’ for the production of experiential knowledge and protest narratives that celebrate madness and diverse forms of human existence (Ingram, 2016). When recovery is viewed as a community project to tackle inequalities, epistemic injustice offers a possible entry point for understanding the different kinds of invalidations and oppressions experienced by individuals within that community. This is where upcycled recovery as a project of communities could have shared interests with mad studies. Moreover, charting a new territory of mad studies outside the system to prevent co-option may inadvertently reproduce its marginalised position in knowledge production but maintaining dialogue with upcycled recovery may extend the reach of mad studies. Finally, for people who may not identify with ‘mad’ identity and politics, upcycled recovery may broaden the space for reflecting on their lived experience and producing experiential knowledge; knowledge which may work towards the same goal of challenging power inequality in the mental health system and beyond.

References


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