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Article Title: “It’s Recovery United for Me”: Promises and Pitfalls of Football as Part of Mental Health Recovery

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“It’s Recovery United for me”:

Promises and pitfalls of football as part of mental health recovery

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Abstract

This paper builds on the concept of mental health recovery to critically examine three football projects in the United Kingdom and their effects on the recovery process. Drawing on qualitative research on the lived experiences of mental health clients and service providers across the three projects, we explore the role of football in relation to three components of recovery: engagement, stigma, and social isolation. The findings indicate how the projects facilitated increased client engagement, peer supports, and the transformation of self-stigma. The perception of football as an alternative setting away from the clinical environment was an important factor in this regard. Yet, the results also reveal major limitations, including the narrow, individualistic conceptualization of both recovery and stigma within the projects, the reliance on a biomedical model of mental illness, and the potentially adverse consequences of using football in mental health interventions.

Introduction

Mental health is a global priority with numerous policies and services intending to support individuals to realize their abilities and lead meaningful and purposeful lives. The World Health Organization (WHO, 2014) considers mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” What constitutes mental illness is not straightforward and remains controversial (Thompson, 2007). The biomedical model, which underpins most psychiatric and health services, views mental illness as an objectively diagnosable and measurable condition. In contrast, sociological perspectives stress that the definition of mental illness reflects subjective social judgments more than objective scientific measurements of biological problems, and that the biomedical model is too individually focused and generally ignores the social origins of illness and its treatment (Weitz, 2013).

During the past two decades, there has been a growing interest in the role that sport and physical activity can play in mental health promotion and treatment (e.g., Fox, 1999; Jones, 2009; Penedo & Dahn, 2005; Faulkner & Carless, 2006; Carless & Douglas, 2010). Consequently, sport and physical activity are now well accepted by both individuals with mental illness and mental health professionals as making a key contribution to the treatment and recovery process, especially when they are integrated into psychiatric rehabilitation services (Richardson, Faulkner, McDevitt, Skrinar, Hutchinson, & Piette, 2005). In the UK, football has become increasingly popular in broader health and welfare programs (Bingham, Parnell, Curran, Jones, & Richardson, 2014; Darongkamas, Scott, & Taylor, 2011; Pringle, Parnell, Zwolinsky, Hargreaves, & McKenna, 2014). Football has been incorporated into mental health initiatives within the Department of Health, while the Football Association has

been partnering with agencies such as Mental Health Trusts, Primary Care Trusts, the Professional Footballers’ Association, and the Football Foundation to establish football and mental health projects (Pringle, 2009). Mental health projects that incorporate football in their delivery are currently implemented by a range of organizations, including mainstream health agencies, football authorities, professional football clubs, and charities.

Correspondingly, there has been a growth in academic research exploring football and mental health interventions (e.g., Parnell, Stratton, Drust, & Richardson, 2013; Pringle, 2009; Pringle & Sayers, 2006; Robertson, Zwolinsky, Pringle, Hargreaves, Lozano, McKenna, & Zwolinsky, 2014, Pringle, McKenna, Daly-Smith, & White, 2013). Core to this research base is how football can engage disenfranchised men in mental health projects (Carless & Douglas, 2008; Steckley, 2005), as both a motive and method (Pringle & Sayers, 2004). Thus, Spandler and McKeown (2012) view football as “an important medium to engage men who are seen as reluctant or unwilling to access services” (p. 388). Beyond engagement, Pringle and Seyers (2006) and Spandler and colleagues (Spandler & McKeown, 2012; Spandler, Roy, & McKeown, 2014a, 2014b; Spandler, McKeown, Roy, & Hurley, 2013) identify the therapeutic value of football, while Time to Change (2011) notes the potential of football to contribute to the reduction of stigma. Further, Spandler and McKeown (2012) pay specific attention to the implications of using football to engage men in mental health programs for prevailing gender relations.

This paper aims to progress this research base by providing new and critical insights into processes of engagement, stigma change, and the interaction between playing sport and more formal therapeutic intervention. We do so by critically examining three football projects, operated by a mental health trust and two charity organizations in the UK, that were designed to assist mental health recovery. Our focus is on three key components of mental health recovery: service user engagement; stigma; and social isolation. The next section provides the

framework for the paper by focusing on the recovery paradigm and its critique. We then present the research methods used to elicit the experiences of clients and service providers within the three projects. The paper next provides a discussion of the above three key components of mental health recovery in the narratives of clients and service providers. Finally, we identify the critical pitfalls and limitations of using football as a vehicle for mental health recovery.

Conceptualizing recovery in the context of mental illness

The overarching framework for this paper is provided by the notion of recovery. Recovery has become a prominent paradigm in mental health in the last three decades (Anthony, 1993; Ramon, Healy, & Renouf, 2007). Whereas previous mental health paradigms suggested that people with serious mental illness needed to accept that “normal” life was impossible and that dreams of independence were unattainable (Corrigan & Ralph, 2005), the emergence of the recovery movement (Davidson & Roe, 2007) drew greater attention to how individuals with mental illness can and do recover (Carpenter, 2002). However, there are competing interpretations of recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Most definitions of recovery involve some consideration of acceptance of illness, having a sense of hope about the future, and finding a renewed sense of self (Deegan, 1998; Davidson, O’Connell, Tondora, Lawless, & Evans, 2005; Corrigan, 2006). Repper and Perkins (2003, p. ix) posit that recovery is essentially about “seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering the social roles and relationships that give life value and meaning.” This interpretation of recovery stresses that recovery does not require remission or absence of symptoms. Instead, it regards mental illness as “only one aspect of an otherwise whole person” and recognizes that people may consider themselves to be in recovery while continuing to be affected by mental

illness (Davidson & Roe, 2007, p. 461-2). Recovery, then, is “a lived experience of moving through and beyond the limitations of one’s disorder” (White, Boyle, & Loveland, 2005, p. 234).

Recovery is generally considered an ongoing and personal journey that can involve multiple pathways (e.g., Markowitz, Angell, & Greenberg, 2011). Some scholars explicitly distinguish recovery from treatment, arguing that while treatment “encompasses the way professionals intervene to stabilize or alter the course of an illness,” recovery can “occur within or without the context of professionally directed treatment” and “be claimed only by the person in recovery” (White et al., 2005, p. 235). This distinction allows for a more critical understanding of recovery as a guiding framework for mental health care. From a sociological perspective, a fundamental critique of the recovery paradigm is that it fails to problematize the biomedical model of mental health. Not only does recovery continue to be “implicitly reliant on a model of deficit” (Harper & Speed, 2012, p. 14) through its emphasis on the need to “fix” or transform a “disorder,” it also places the onus for recovery on the individual, whereby that individual is urged to change their personal outlook. In so doing, the recovery paradigm tends to individualize what are social problems and obscures the potential for recovery to be used to explore the collective, structural experiences and causes of emotional distress (Harper & Speed, 2012; Howell & Voronka, 2012). Critics further assert that recovery has been appropriated by psychiatry and community public health in ways that actually exacerbate issues of stigma, isolation, and low policy priority, and that it has become code for cutting services and funding for those most in need of it (LeFrancois, Menzies, & Reaume, 2013; Dickerson, 2006).

This critique has inspired attempts to reclaim recovery from its increasing professionalization within community mental health by putting front and centre the lived experiences and personal narratives of psychiatric survivors. For example, the Mental Health

“Recovery” Study Working Group (2009) explores what effects recovery is really having on psychiatric survivors and their significant others, situating recovery not only as a personal journey, but also as a social process in which people address the need for tangible resources such as employment, income, housing, safety, and education. Moreover, the Working Group gives voice to recovery as critique targeted at a range of institutions (e.g., medicine/psychiatry, health care, medication/drugs) that are implicated in the labeling, mistreatment, and marginalization of those who have been characterized as in need of recovery.

The concept of recovery and its critique provide the overarching framework for this paper. We pay specific attention to three key components within recovery. Firstly, client disengagement is a significant barrier in the delivery of mental health services (Baydar, Reid, & Webster-Stratto, 2003; Kim, Munson, & McKay, 2012). Recent research shows that service providers struggle with the challenges of maintaining client engagement, and that developing so-called “therapeutic alliance” is a key component of client engagement in mental health recovery (Kim et al., 2012). Therapeutic alliance can be defined as “the quality of the helping relationship, an emotional bond between the two parties on the therapeutic tasks, and/or the agreement between the two parties on the expectations and goals of therapy” (Kim et al., 2012, p. 245).

Client engagement is heavily influenced by how stigma, the second component of recovery, may impede people from using mental health services. People living with mental illness experience stigmatizing attitudes toward them on a daily basis (e.g., Horsfall, Cleary, & Hunt, 2010). According to Corrigan (2004), stigma can be divided into public stigma (attitudes and beliefs of the public toward those with mental illness) and self-stigma (attitudes and beliefs of the individual toward themselves), yet their effects interact and often reinforce each other. It has been argued that developing resilience to stigma and actively combating it

are key to recovery (Davidson et al., 2005). Stigma attached to mental illness is a major obstacle to the provision of care (Sartorius, 2007; Corrigan, 2004) and can lead to discrimination in physical health services (Sartorius, 2007). Stigmatization and discrimination by health care professionals have been identified as a major concern that denies service users their basic human rights (Pelligrini, 2014; Horsfall et al., 2010; Mental Health “Recovery” Study Working Group, 2009). Power differences are essential to the social production of mental illness stigma; yet, the role of power is frequently overlooked because of the tendency to focus on the attributes associated with mental distress rather than on power relations between people who have these attributes and people who do not (Link & Phelan, 2001). As Link and Phelan (2001) argue, the problem with this approach is that it leaves the wider context untouched: the attitudes and beliefs of powerful groups that lead to labeling and discriminating, and the power of such groups to act on their attitudes and beliefs.

Lastly, social isolation is the third component of mental health recovery the paper features and involves a “sense of being alone, being alienated from the world around you” (Ralph, 2005, p. 134). Feelings of isolation are influenced by how “stereotype, prejudice, and discrimination can rob people labelled mentally ill of important life opportunities that are essential for achieving life goal” (Corrigan, 2004, p. 616). Recovery plays a key role in the reduction of social isolation, and vice versa (Ralph, 2005). Support and relationships with friends, peers, family, and service providers are critical elements in the recovery journey. Indeed, the Mental Health “Recovery” Study Working Group (2009) found that many psychiatric survivors consider community (that is, social relationships and a sense of belonging) as vital for recovery, as well as the receiving and giving of peer support.

Methods

While research into mental health recovery has accelerated in the last three decades, sociologists have given it relatively limited attention (Watson, 2012; Davidson, Sells, Sangster, & O’Connell, 2005). Watson (2012) contends that this lack of attention is problematic because qualitative sociological methods are particularly well suited for developing person-centred understandings of recovery; that is, “individuals’ personal experiences of recovery and the meanings they associate with it” (p. 298). A similar argument has been made by scholars and activists who stress the need for personal and collective stories of recovery and stigma to counteract the hegemony of biomedicalism (e.g., LeFrancois, Menzies, & Reaume, 2013). Building on these arguments, this study used a qualitative research approach that gave participants the opportunity to articulate their lived experiences of football within the recovery process. We have sought to provide what Davidson et al. (2005) call “first-person accounts of recovery” (p. 149), and to situate this lived experience “within the social,” that is, in relation to the social dimensions of mental illness and recovery and how they are framed and experienced within the projects.

We purposively sampled clients and service providers across three UK-based projects that were designed to engage individuals with mental illness in the treatment and recovery process. The projects were delivered as part of a multi-service agency approach that used sport, in this case football, as a catalyst to engage participants who have experienced limited success in more mainstream treatment and recovery settings. The projects were organized and delivered by a mental health unit of the National Health Service (NHS) Mental Health Trust (Project 1) and charity organizations (Projects 2 and 3), respectively. The projects were awarded funding to operate sessions twice a week in ten-week blocks over a three-year period.

The projects had the same structure, with three elements consistent to each. The first was a Football Program that delivered activity sessions of a recreational and fun nature for all participants as well as academy sessions for those participants with greater football ability who preferred a more competitive activity. Project 1 employed a qualified head coach and assistant coach to deliver this component, whereas the Director of Project 2 was herself a qualified football coach and delivered all football sessions. Both projects entered teams into a competitive league established for football projects, like these, comprised solely of people with mental illness. In contrast, Project 3 used qualified coaches from a local Premier League football club, and offered activity sessions only.

The second element was a Healthcare Treatment Program delivered by professional medical staff, such as clinical psychologists, clinical nurse specialists and clinical psychiatrists, who were based at the mental health unit. The treatment program involved informal meetings at the project venue as well as formal meetings held at the mental health unit. The nature of the meetings was adapted to suit individual needs, depending on the progress of the participant, their feelings on the day and any subsequent needs or assistance they required. Group meetings also occurred at the request of both the participants and the medical staff. Participants voluntarily agreed to attend meetings and decided the direction and focus of each. The program offered flexibility so that meetings could take place before the football activity, during it, instead of it or at the end of it, depending on the specific needs and situation of the participants.

The final element of the projects was a Support Workshops Program provided by external partner agencies, which focused on educational, vocational and lifestyle/health related issues. Workshops were scheduled after the football activity and attended by those not in a meeting in the Healthcare Treatment Program. A range of external partners offered expertise specific to, for example, employability skills, education courses, housing and

accommodation, drug, alcohol and sexual awareness, financial management and planning, and diet and nutrition.

Participant recruitment to each project was similar as participants were referred from a range of agencies, such as drug and alcohol services, youth offending and probation services, and in-patient and out-patient NHS departments. Further, some participants were self-referrals who had learned of the project through a friend or colleague who was in attendance. Upon referral to the project, the project director met with each participant and conducted an initial assessment of the participant and their individual case history, with particular attention to the state of mind and any previous or ongoing mental illness. The participant was then allocated to a relevant staff member from the mental health unit and a meeting was arranged between both at the participant’s first session as part of the Healthcare Treatment Program. Participants attended the project for a maximum period of ten weeks.

The research process

One of the co-authors made regular visits to each project and conducted semi-structured interviews with project participants, project staff and associated professional medical staff and partner agency staff. In total, we interviewed 38 people including 20 participants, five coaches and assistant coaches (two of whom were former professional football players), three project directors, three clinical psychiatrists, three clinical psychologists, two clinical nurse specialists, one National Health Service (NHS) Borough Director, and one NHS Borough Assistant Operation Director. Interviewees were selected using a purposive sampling method. Individuals were selected on the basis of their personal involvement in and experience of the project. All participant interviewees were project participants, albeit with varying degrees of regularity. We further sought to achieve maximum variation by sampling participants with varying levels of engagement with sport

both within and outside mental health services. Recognizing that further research is needed to explore the ways in which women with mental illness experience sport (Carless & Douglas, 2008), we sought to achieve a gender-diverse sample. However, during the research it became evident that all project participants were males, between the ages of 18 and 40, and this is reflected in the all-male research sample. In contrast, four of the staff interviewees and two project directors were females.

Ethics approval for the research was granted by the university where two co-authors were employed at the time. A key issue raised during the approval process concerned the position of the researcher in the interview process, with the possibility that participant interviewees might be in a “fragile” state of mind and relay sensitive information about themselves or place the researcher in physical danger. It was agreed that informed consent should be sought in advance with the project director consulting with relevant NHS medical staff before seeking informed consent with the participants. This process was successfully completed and informed consent was provided by a number of relevant participants. It was also considered that as the research team had no prior relationship with the participants, the presence of the project director at interview would safeguard the interests of both participants and the interviewer. We recognize that this brought a degree of paternalism to the interviews that had the potential to influence the experiences and responses of the participants, especially where a participant wished to share information not intended for the project director. Therefore the presence of the project director can be considered a limitation to the research data.

The interviews were conducted within the familiar setting of the project venue and focused on the following themes: the content and implementation of the project; the interviewee’s personal or professional experiences of the project; perceived impacts and limitations of the project and related experiences. However, as each set of interviewees

engaged differently with the project the interview schedules were formulated accordingly to take into account the different levels of engagement and experience. The interviews were audio-recorded and transcribed in full.

Data analysis

Once the qualitative interview data had been collected, the interview transcripts were entered into NVivo and coded for data analysis using thematic analysis techniques. We examined the data to identify the common issues and themes that recurred. This process was not necessarily sequential; as new themes and sub-themes emerged, the observations were compared and the data were re-examined. Data from each project were first sought to be understood individually and in as much depth as possible. The findings from each project were then compared to those of the others in order to identify commonalities and differences, and to make the interpretations and inferences more robust.

Findings

Client engagement

The personal narratives of clients provided critical insight into how the football projects sought to engage them in the recovery process. Matthew (all names are pseudonyms), for example, explained:

I was told of the project up at [hospital] and I should go to it, deal with my depression. I was thinking ‘nay, not for me’ but then I was told it was a football project with coaches from [Premier League club] who I am daft about and I was there straight away. I met [the project director] and got stuck in with the lads and then met [the psychologist] and it was not like getting treatment.

This participant, like several others, had disengaged from mental health services. They came to this project because of the primary attraction of football and, once there, embarked upon a treatment program. In this case, football was used as a *practice* to engage

disengaged individuals (Evans, McElroy, & Pringle, 2008) as well as a “hook” for a mental health intervention (Spandler & McKeown, 2012; Spandler et al., 2013).

The use of football as a hook was based upon a combination of factors which made it appealing to potential participants. Firstly, football is a valued cultural practice in the UK, especially for males, and as such male participants with an already established interest in or affinity with football self-selected the project because of the positive symbolism offered by football. Secondly, as shown in detail below, football provided a non-clinical environment in which participants did not feel stigmatized, out of place or uneasy in the way they might have in a clinical setting. Football, with its specific language and banter, created an atmosphere of enjoyment, relaxation, familiarity and normality which allowed (male) social bonding and emotional support to be established. Furthermore football, which is based upon teamwork and interpersonal contact in a competitive environment, provided a space and opportunity for masculine practices to be played out. The relational dynamics of football were paramount to the establishment of emotional and social support for participants who experienced therapeutic group work as part of the wider recovery process (Spandler et al., 2014b).

What can thus be unpacked is that attendance through the forum of football was only the first step in the engagement process. For many participants, football was critical to offering a different surrounding than a typical clinical environment (Spandler et al., 2013, 2014a). The pedagogies of the coaching staff deliberately focused on the use of football in creating a positive atmosphere, as explained by one coach: “The participants come to me and I know how I have to be up-beat and positive. The way I look at it we have a setting here where we get the lads to have fun, make sure they enjoy it but they respect each other in the group.” A project director who also delivered football sessions agreed with the coach’s statement:

I know from personal experience how uplifting football is and how it can bring joy, happiness and success and I have had some right down-in-mouth sorts be referred here and you would not believe the transformation in them through football as the games we play, we get them all involved and that is vital for lifting self-confidence.

These remarks from service providers involved in the projects highlight not only the “feel good effect” (Fox, 1999, p. 414) of playing football, but the recognition that football can provide fun and enjoyment which breeds a shared setting of comfort and familiarity. The pedagogies of the coaches were central to providing a relaxing and comfortable environment and the use of football “banter” for ice-breaking and humour purposes was regularly observed (Spandler et al., 2014b).

A further dimension to engagement through the positive atmosphere created through football sessions was the potential value it had toward recovery, as summarized by Paul:

I was drifting before I came here. Got quite a few problems going on and was quite down. The football gave me a real boost. I loved it. I loved coming here. It got me fitter. I was feeling better about myself but the thing for me was how much fun it was here and how it made me feel just so much better. [Coach] is so positive, he is friendly and fun and the football is great. It helped me to turn things around and the [medical] staff being here as well has really helped.

As the projects were held at a football facility rather than a specialized, clinical medical facility, their capacity as an alternative venue (Spandler et al., 2013, 2014b) helped participants connect with medical staff in ways that strengthened their bond and developed therapeutic alliance between participants and staff. In this context, a clinical psychologist stated that “the way this program is developed with football and medical elements and support workshops together the staff can develop therapeutic alliances and client-patient trust, and this is essential in individual mental health treatment.” This was further supported by senior management:

The therapy through football is not possible to recreate in the classroom. A classroom cannot recreate the group dynamics the way this program can

through football. The program works as it prevents the condition from getting worse and someone going into relapse. This engages users in a way other forms of treatment cannot (NHS Borough Assistant Operation Director).

The importance of this alliance was aided by the alternative setting provided by the project that brought with it a more relaxed and informal approach to mental health recovery, indicative is Roman’s comment that:

Even though [the Clinical Nurse Specialist] treats us, we see her here, she is always coming up, asking how things are, what do I need, how is it going? She is almost like a mate rather than someone helping me with my depression and we can talk about things here I would not talk back at the unit. If we need though, and there is stuff we want to talk about in private, or I am struggling with something, we can go back to the unit and talk there. It really works for me.

Roman’s experience was not unique. Some participants who engaged with the project were already within the NHS system but were not actually engaging with their treatment; however, they started to do so after joining the project. Luke was one of a number of clients who experienced this kind of change:

I was used to being treated in [a mental health] unit at the hospital and it was one-on-one [with the psychiatrist] and I found it useless. It did nothing for me. My psychiatrist suggested I come here and [he] came with me. I saw this was different so I played the football and then had my sessions after and I really opened up to my psychiatrist and we got going on things.

For Luke and some of the other participants, the project offered an alternative setting in which to re-engage with mental health services. In some cases, their experiences inspired other clients to also join the project. For example, Daniel explained how he “was happy to stay” as a permanent resident in the mental health unit and “be looked after” but then “I came on the project and saw other players had got themselves into their own places. After a while I thought I’d fancy that so I worked with the staff to set that in place.” Daniel believed that the project “has helped me to be able to look after myself and without it I do not know what I would have done or where I would be.” As football is a team sport, the project placed Daniel

in an environment with other clients and was able to use this shared setting to develop personal agency that helped change things in his life.

Overall, these comments indicate broad support for the use of football as an engagement tool, which reflects previous research (Pringle, 2006; Pringle et al., 2014; Robertson et al., 2014; Spandler & McKeown, 2012; Spandler et al., 2013, 2014b). Of particular note is how football acted as a hook for individuals to engage with recovery-oriented mental health services through the project. It is important to recognize that the project, while using mental health professionals, was separate from mainstream services, which added a different appeal to potential service users who viewed it, initially at least, as a football project rather than a mental health intervention. Participants’ narratives recognize and support the alternative setting of such projects away from the clinical environment (cf. Spandler et al., 2013, 2014a).

The reduction of stigma

Stigma was a prominent theme in the narratives of both clients and service providers. A project director explained that “whilst treatment and recovery was important so too was the removal of stigma, both personal and societal, as the issue of stigma is the biggest thing we face.” Many participants indicated the difficulties of having a stigma attached to them due to their mental illness. John, for example, expressed how “this [stigma] was a real problem for me coming to the project as getting over that is really hard and admitting I have a mental problem that others will think badly about me because of and worrying about what others think was a big issue for me.”

Project staff centralized stigma with the overall aim to “seek participants to accept they have a mental illness and not feel it is a stigma” (clinical nurse specialist). As a coach put it:

[The] key thing we do is get participants accepting they have an ailment, that is why they are at [the project] though that is something we always fight with as participants feel stigmatized before they get to us but we have been successful at changing their mindset.... One thing about mental illness is, it is very courageous admitting you have it. I can relate to the lads I get here that way and respect them for their courage.

In a similar vein, a clinical psychologist explained how:

[I]n the company of each other...they see that actually they are not alone and what they are experiencing is in fact normal here and nothing to feel shame about.... This program is normalizing the issue of mental health in a group setting which are both very important issues and everyone then is placed together and is willing to talk about their illness. A key strength of this intervention is the project is a big family; it is normalizing the issue of mental health so that it is not an issue and everyone is willing to talk about the issue or issues they have.

The significance of this normalizing process is highlighted in the narratives of clients.

Matthew, for example, confessed that, at the project, “I saw other people like myself, we sort of were the same and I felt normal, and my psychologist said that I was just normal in the group.” Paul further commented that at the project he “was able to accept my illness and not think of it as some sort of a stigma where people looked down at me. With the football it helped me to do other things and I started to look after myself, and I see that with others too and we feel we are the normal ones.” Normalizing mental illness for each participant was thus pivotal:

Before I had been getting treatment but felt very alone, but here you have your mates. We do the football, we have the sessions after it on things like looking after yourself, managing money, and after that we hang around together. I have met some good mates through this and no longer feel alone with a problem as we are just normal around here. I don’t feel the shame I used to. (Roman)

The features of football as a team sport which emphasizes teamwork, unity, and responsibility was capitalized upon by service providers as an alternative setting which created positive feelings amongst participants. The significance of this cannot be discounted as to how the project provided a “non-stigmatising environment” (Spandler et al., 2014b, p.232) for clients to attach to and seek to work toward the transformation of self-stigma.

Further, by normalizing mental illness in the project in this way everyday discrimination and disparities experienced by the clients were diminished at least for the time spent at the project.

Even though clients were engaging in a treatment program, the football component was important in creating a *different* self-identity and outward appearance than the one established through mental illness labeling. Even though one of the projects was held at a sports venue located in the grounds of the hospital, the football component was critical, as described by Peter: “I have my kit bag and tell my mates I am off to my football club, which it is here. Others don’t need to know I get treatment here as they see me with a football bag and know I play football rather than [being] some nut-job getting treatment.” This comment is revealing with regard to stigma change.

Firstly, we see evidence here of the social origins of the men’s mental illness: while they may have a mental impairment or problems of living, the most important element is often society’s response to their impairment in that it stigmatizes and labels them as “mentally ill” and fails to include them regardless of their individual differences. Rather than locating difficulties in individual deficit or what is wrong with people, this shifts the focus to the discrimination and exclusion the men face in their daily lives. Secondly, in terms of self-stigma, both clients redefined their identity as a football player rather than merely a mental health service user, even though both recognized they were indeed one and the same. Additionally, both used this identity to resist, alter, or downplay public stigma as a mental health client as by carrying a football bag they considered themselves to be viewed differently and performed that football player identity.

A more critical reading of the way stigma is addressed in the projects, however, is also warranted. While the language used by service providers was generally not experienced as being explicitly pejorative or stereotyping, the dominant understanding of stigma that emerged from the client and service provider narratives has both an individualistic focus and

relies on a deficit model through its emphasis on the need to accept, and deal with, the participant’s mental problems. This is evident, for instance, in the aforementioned comments by project staff and participants with regard to “accepting they have an ailment,” “changing their mindset,” “accept they have a mental illness,” “admitting I have a mental problem,” and so on. In these descriptions, the onus for stigma change is primarily on the individual client. From a sociological perspective, this emphasis is problematic because while it may address to some degree the issue of self-stigma (Corrigan, 2004), it fails to address the broader question of who does the discriminating. The mental illness stigma is primarily seen as “something *in the person* rather than a designation or tag that others affix to the person” (Link & Phelan, 2001, p. 366), or as something that is best addressed within the person by changing their “mindset.” Fundamentally, then, it overlooks the “mindset” of powerful groups that leads to labeling and discriminating and, in so doing, only addresses a few mechanisms that can lead to stigma, most notably, as shown above, around redefining one’s identity and normalizing one’s experience. We will return to this critical issue in the discussion.

Countering social isolation

The final key component of mental health recovery we shall focus on is social isolation. Participants’ narratives indicated the importance of reducing feelings of social isolation by bringing together people with similar mental illness. Many reported that they had previously felt alone and socially excluded but once at the project valued the opportunity to spend time and space with people “like me.” Timothy, for example, confessed:

The funny thing I found by coming here is that before I got referred here, I felt very alone. I felt lost and abandoned. I was working with [a psychologist] but was not getting anywhere. I came here and the first thing was that the people here were like me. We had all the same issues, the same things, and that said to me I was not alone. This is a normal situation for us where we can be mates. It gives us a friendship network where we all support each other and make sure no one slips back into the bad ways of drinking or smoking or drugs and pull each other through; we are all the same really.

Timothy, like Luke previously, was a NHS client who was struggling with recovery but the project reduced his feelings of isolation and loneliness by establishing connections and relationships with other service users who were also in recovery.

The professional medical staff acknowledged this experience of social isolation. A clinical nurse specialist explained how:

...one of the bigger battles is getting the client to understand they are not alone. We are here to support, but bringing them to the project and showing them people like themselves, being around similar people, being able to discuss their problems together, that is a real benefit of the way the project is.

A clinical psychologist indicated how embedding football in the project had particular benefits in this regard: “Football is a family thing where you are part of the team and make friends, and for me medically that gives structure to the recovery process as participants are in a better frame of mind.” The team sport setting, he argued, cannot be underestimated in countering social isolation among people with mental illness. Many participants shared the view that countering feelings of social isolation through the sense of belonging to the “football family” was significant as “football is a team game and we have to rely on each other in the games and we become mates that way” (Matthew). These views echo sentiments expressed by Spandler and McKeown (2012, p. 390) as to how football is well placed to serve to prevent social isolation “due to its uniting effect...football is seen as giving individuals meaning and common purpose, bringing people together who may be isolated especially those who find social interaction and intimacy difficult.” The team ethic behind football cannot be discounted or downplayed here (Spandler et al., 2014b).

Furthermore, the three projects sought to capitalize on this sense of belonging to the group or team by offering group therapy alongside individual therapy for clients who were dealing with similar issues, such as depression or alcoholism. Service providers argued that what was “unique and vital for the mental health recovery we are trying to deliver” was the

project’s ability to “bring a group together and they can play football but we can then work beyond that as a group or individually in the treatment sessions” (clinical psychiatrist). In order to facilitate this, they adopted a group therapy approach: “As we had the football family so to speak developing friendships among individuals as part of a group, the application of [a] group therapy [approach] suited the treatment we provided as we could tackle the same issues through the group dynamic setting.” (clinical psychiatrist). It could be argued that this approach to therapy may be influenced by how “football is believed to allow the safe expression of emotion” (Spandler & McKeown, 2012, p. 390) and if so this created a positive sense of belonging and sharing which benefited recovery.

The group therapy sessions presented both opportunities and challenges for participants. Earlier Luke spoke about the difficulties he experienced with previous one-on-one treatment and how the project had improved his relationship with his psychiatrist. Another participant, Peter, experienced a similar process:

I was shy and did not speak much to my therapist so was sent here and seeing the group work and hearing people I felt better to share my things. At the start I did not speak in front of my group but spoke much more to my psychiatrist and really opened up and after a while I talked to the group.

Peter’s comments illustrate how involvement in the football sessions and in the different types of therapy on offer can provide shared experiences to talk about, combined with opportunities to discuss those experiences (Carless & Douglas, 2008).

Discussion: Limitations and pitfalls of football and mental health recovery

The projects examined in this paper present an approach to mental health recovery that clients considered both meaningful and beneficial. However, their experiences also suggest major limitations and pitfalls to the use of football in mental health recovery.

At one level, the competitive nature of football complicates its uses in the context of mental health recovery. Clients and service providers highlighted not only the capacity of

football to stimulate recovery, but also how football can potentially exacerbate mental illness.

In the projects in question, some interviewees considered the competitive nature of football problematic or at least a challenge. One coach noted:

As much as I like to get the lads going and put on challenging drills to increase self-confidence, I have to be careful and keep a close eye as there are boundaries and some (participants) cross them. I have had to stop sessions and do something else as they were getting out of hand, I have had to step in and stop people from coming to blows, and I have even had to ban a couple who simply could not control their anger and unfortunately got a bit violent.

While over-aggression and violence are unwarranted and unwelcome aspects of the project, it has to be stressed that such behaviour is clearly not confined to projects that use football for mental health recovery. Instead, it is experienced at all levels of the game.

Another coach explained how the competitive nature of the football activities could potentially have a negative impact on participants’ self-esteem and thereby exacerbate mental illness:

As much as football is about winning and that is good and all that, it goes the other way. We have seen it here with some of the less-skilled getting the piss taken out of them and it’s not good. It’s hard to coach them out of that as they just accept they are no good and in some cases some of them we don’t see again.

Service providers had to walk a fine line in this regard. The challenges this poses were evident in the story relayed to the authors by staff on one of the projects. This project was aware of a league that was operated specifically for people with mental illness. Staff and participants agreed that the participants should enter and compete in the league. However, after the initial games the dynamics of the group began to change: “When we got back to our own project the next week the players in that team if you like, they started wanted to go off and work on tactics and they got too feisty in the games and it created tensions as all they wanted was to practice for the next league games” (project director). As a consequence, some clients’ expectations of the project also began to change:

We would get new participants come along and all they wanted was the football. They thought we were a club so the other stuff we do, the treatment, the workshops, they would not go to that and we asked around and people came to us because they thought we were a football club in a league. Which we were but not in that way. (Project director)

The project made a decision to pull out of the competition. While the project continued to organize tournament days, these were held in-house and embedded within the wider project, rather than as a stand-alone competitive activity.

These findings resonate with previous research that shows that the use of football for health purposes is double-edged due to it being based on a power/performance model of winners and losers, aggressive bodily contact, territory attack and defence, which can result in stress and performance anxiety particularly for the low skilled whose self-esteem and motivation may well be affected (Andrews & Andrews, 2003; Rookwood & Palmer, 2011; Spandler et al., 2014a). While for some participants who are at least semi-skilled football players the addition of competition may increase enjoyment and self-esteem, for others such competitive activity can be an alienating experience that can “lead many of the people who attend projects like these to feel excluded, [and] marginalised” (Spandler et al., 2014a, p. 141).

At a deeper level, we can draw on the critique of narrow conceptualizations of recovery and stigma to identify some key pitfalls of the projects examined in this paper. In some respects, the projects seek to move beyond the view of recovery as a highly personal journey to consider it as a more social process, one embedded in community and supports. This is evident, for example, in the focus on engagement and countering social isolation and, more specifically, on facilitating the kinds of community and peer support that participants consider critical to recovery. Yet, our findings also show that the projects operate mainly within a biomedical model of mental illness, one that is individually focused through an emphasis on the adjustment of the individual to social forces by “recovering” (Poole, 2007).

By individualizing mental health recovery, the broader social and structural contexts of mental illness, and the power relations inherent in attempts to engage mental health service users, are largely sidelined in the projects.

As shown earlier, this is particularly evident in the way the projects address stigma. The onus is put on participants to transform self-stigma, but the broader power relations that shape stigma are not responded to in the projects. Such a narrowly conceived intervention is limiting because it fails to address the fundamental cause of stigma, that is, the attitudes and beliefs of powerful groups that lead to labeling and discriminating, and the power of such groups to make their cognitions the dominant ones (Link & Phelan, 2001). An effective response to stigma should “either produce fundamental changes in attitudes and beliefs or change the power relations that underlie the ability of dominant groups to act on their attitudes and beliefs” (Link & Phelan, 2001, p. 381). The effectiveness of the projects’ approach to stigma change is inherently limited because this broader context is left untouched.

A significant issue in this regard is how the projects were designed to accommodate in a football setting people with similar experiences of mental illness. As such, they did not actively promote social interaction between clients and those who did not have mental illness, nor did they provide participants with access to mainstream football clubs or facilities. While the project setting assisted the recovery process by reducing self-stigma and social isolation, it did not systematically address the wider stigmatization that clients face in many mainstream settings. This is problematic because social integration is a key component of recovery (Repper & Perkins, 2003; Leff & Warner, 2006). The projects did little to encourage such social integration and may be questioned for possessing a limited capacity to address the aforementioned mechanisms of stigma. The task of educating the wider community about mental illness understandably lies outside the scope of the project, however it is clear that

without such broader collective action, the gains made in the project may not fully transfer back, or be sustained, in clients’ social lives.

Conclusion

This paper has sought to provide new and critical insights into how participation in football can affect recovery in the context of mental illness. Our findings corroborate previous research that found that sport and physical activity can provide the opportunity for positive social interaction, a sense of safety and social connectedness, and the development of a sense of meaning, purpose, and achievement (Carless & Douglas, 2008, 2010; Mason & Holt, 2012). In particular, our research indicates the significant role that the football activities played in enabling clients to be and share time and space with others “like me.” This sense of safety, social connectedness, and peer support was enhanced by the informal nature of the social interaction, which extended to the therapeutic alliance between clients and mental health professionals, who were considered to be more approachable and responsive to the needs of participants within the sport setting. Moreover, our findings highlight the role of football participation in counteracting the stigma the clients experienced and, in so doing, the opportunity it provided for participants to work with professional staff on a recovery program, especially those who had either withdrawn from or become disengaged with the recovery process. The appeal of the project beyond what was on offer through mainstream services was noted as one of the key attractions while, as stated, the significance of its non-clinical setting cannot be downplayed (Spandler et al., 2013, 2014b).

However, our findings also highlight major limitations and pitfalls, most notably with regard to the competitive nature of football and the way recovery and stigma are understood and addressed in the projects. With regard to the latter, key concerns are the individualistic focus of both recovery and stigma within the projects, and the reliance on a recovery model

based on an implicit notion of deficit that seeks to “fix,” “heal,” or “adjust” participants. While a focus on recovery as a personal journey is helpful, it downplays the crucial link between individual experiences and wider social, political, and economic struggles (Harper & Speed, 2012). If football projects are to genuinely contribute to mental health recovery beyond the benefits discussed in this paper, it is critical that they recognize the flaws of the dominant recovery paradigm in mental health and develop approaches to recovery and stigma that address the broader social and structural issues that affect the capacity of people with mental illness to lead meaningful and purposeful lives.

Football clubs, especially at the elite end, possess significant community capital – not to mention finance – and have potential to play a meaningful role in the lives of people with mental illness. A key step in this regard would be the inclusion of mental health promotion in their activities, for example through the establishment of partnerships with NHS Mental Health Trusts to jointly work toward designing, funding and implementing football projects. The non-stigmatizing environment provided by football (at least for male participants) could be built by clubs hosting and opening up their facilities for use by mental health projects. This could be regarded as a football club within a football club where individuals with mental illness feel welcome, safe, included and valued by attending football activities at their local professional club. Doing so could also create a synergy and joined-up approach between mental health professionals and football communities who could work together to enhance the value of football as part of mental health recovery.

A critical challenge in this regard is the need to build awareness of, and respond to, the social dimensions of mental illness including stigma, social isolation, and social exclusion and discrimination. In addition to the interpersonal contact that the football projects may promote and its potential positive effects on stigma change, a suggested approach would be to educate and raise awareness within football communities of the social origins of mental

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illness, possibly with the assistance of (former) professional footballers who are psychiatric survivors. This could assist in challenging inaccurate stereotypes and misconceptions about mental illness and the recovery process.

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