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Mental illness and recovery: An interpretative phenomenological analysis of the experiences of Black African service users in England

Abstract

Background: Research conceptualising recovery is predominantly Eurocentric. In this article the Black African Service Users' conceptualisation of recovery is developed.

Aims: To explore Black African Service Users' experiences of recovery from mental illness and to understand how they conceptualise recovery.

Methods: Using qualitative research approach and Interpretative Phenomenological Analysis (IPA), semi-structured interviews were conducted with 12 Black African Service Users recovering from mental illness in England.

Results: Participants conceptualised recovery as a pragmatic and subjective concept distributed across a continuum of clinical, functional, spiritual, resilience, identity, and their social and cultural backgrounds

Conclusions: It seems critical for all stakeholders to ensure that these components are embedded in recovery-oriented services for Black African Service Users.

Keywords: Interpretative Phenomenological Analysis (IPA), mental illness, Black Africans, service users, recovery.

Introduction

This paper is a report on one set of findings from the study exploring the experiences of Black African Service Users (BASUs) recovering from mental illness in England. Whilst extensive work has been carried out on conceptualisation of recovery, they are predominantly Eurocentric (Tuffour, 2017a). Moreover, the previous small number of non-Eurocentric studies on recovery including Kalathil (2011) in England; Lapsley, Waimarie and Black (2002) in New Zealand; Armour, Bradshaw and Roseborough (2009) in the USA; and Jacobson and Farah (2012) in Canada clustered experiences together irrespective of the participants racial and cultural

backgrounds. The existing studies have not treated the meanings BASUs assign to their recovery in much detail. This is problematic because studies examining concepts of mental illness in many African cultures suggest that mystical or supernatural powers are often cited as the causes of mental illness (Abbo et al., 2008; McCabe and Priebe, 2004; Mzimkulu and Simbayi, 2006; Olugbile et al. 2009; Muga and Jenkins, 2008; Patel, 1995; Ventevogel et al., 2013). Therefore, the phenomenological meanings that the BASUs assign to their recovery are likely to be different from other groups. Thus, the aim of this article is to explore BASUs experiences of mental illness as well as to understand how they conceptualise recovery using Interpretative Phenomenological Analysis (IPA).

We use the term 'service user' as a general description of the people who use mental health services.

Concepts of recovery

The literature on mental health recovery broadly describes it as a complex and idiosyncratic process that is difficult to conceptualise (Onken et al., 2007; Roe, Rudnick and Gill, 2007). The ambiguity and lack of consensus surrounding the meaning of recovery have made attempts to conceptualise the concept a terminological minefield, though it is possible to identify many of the broad characteristics of it (Tuffour, 2017a). Some authors have conceptualised recovery as multidimensional comprising of clinical, existential, functional, social and physical (Whitley and Drake, 2010). The relevance of this conceptualisation is that different forms of recovery may simultaneously exist in the minds of some service users (Davidson and Roe,

2007 Piat, Sabetti and Bloom, 2009).

Moreover, some accounts conceptualise two-part theorem of recovery: medical and personal (Davidson and Roe, 2007; Silverstein and Bellack, 2008). The medical definitions originate from the perspective of disease, cure and medication (LeBoutillier et al., 2015). The consumer-oriented definitions are regarded as personal and non-linear process of overcoming one's difficulties over time (Tuffour, 2017a). Some key features of personal recovery are hope, self-control, empowerment, choice and spirituality (Leamy et al. 2011; Slade et al. 2012), social inclusion (Tew, 2013) and resilience (Deegan, 2005; Edward, Welch and Charter, 2009). Studies have concluded that interpersonal and relational factors can influence hope after episode of mental illness (Sagan, 2015). Equally, experiences of mental illness can also lead to hopelessness (Waynor et al., 2012). The antidote to this is to empower service users to identify and pursue what is important in their lives (McEvoy et al., 2012). This could be tapping into their religious and spiritual beliefs (Dein and Cook, 2015).

The individual nature of the recovery journey suggests that there is no coherent and generally accepted blueprint for the concept (Perkins and Slade, 2012). Yet despite its intrinsic individualised meaning, recovery has been adopted and operationalised by many mental health service providers in England (Shepherd, Boardman and Slade, 2014). But a recent cross-national study in England and Wales, found wide discrepancies between recovery policy and practice (Simpson et al., 2016). This possibly suggests that the ideals of recovery-oriented approaches have been dampened by

the mental health services.

Methodology

Interpretative Phenomenological Analysis (IPA) is chosen because it is a methodology designed to both examine and interpret how people make sense of their major life experiences (Smith, Flower and Larkin, 2009). IPA is particularly attractive for this study because it is double hermeneutic and data analysis is fluid, intuitive, and open to interpretation and reinterpretation. Moreover, unlike the Husserlian phenomenology, the researcher's interpretations cannot be bracketed off (Henriksson and Friesen, 2012; Smith et al., 2009).

The study had ethical approval of the City, University of London Research Senate Committee and an NHS Local Research Ethics Committee (LREC). 12 participants comprising of three males and nine females were eventually interviewed (Table 1). The participants' 'self-concept' or perception of identity, experiences, and interpretations of their worldview (Rosenberg, 1979) were important in determining the eligibility criteria. Therefore, participants were expected to identify themselves as first or second generation Black Africans and belonging to the geographical region of Sub-Saharan Africa.

Data collection

The first author (IT) recruited participants from an NHS Foundation Trust providing specialist mental health and community health services within the south-central region of England (Tuffour, 2017b). Research data was

collected from purposively selected participants (Table 1). Names of participants have been changed to safeguard confidentiality and anonymity of data.

Table 1: Characteristics of participants

Pseudonym	Country of Origin	Age	Gender	Diagnosis	Type of service
Aisha	Sierra Leone	44	Female	Paranoid schizophrenia	Community
Bobby	Zimbabwe	27	Male	Schizophrenia	Community
Mariam	Sierra Leone	44	Female	Paranoid schizophrenia	Community
Sheku	Sierra Leone	19	Male	Paranoid schizophrenia	Community
Zena	Zambia	24	Female	Schizophrenia	Community
Jane	Sierra Leone	29	Female	Schizophrenia	Inpatient facility
Sheena	Sierra Leone	57	Female	Schizophrenia	Community
Kofi	Ghana	25	Male	Schizophrenia	Community
Asana	Zimbabwe	42	Female	Organic delusional (schizophrenia-like) disorder	Inpatient facility
Eva	Zambia	23	Female	Schizophrenia	Inpatient facility
Ama	Ghana	31	Female	Schizophrenia	Community
Tina	Zimbabwe	34	Female	Paranoid schizophrenia	Inpatient facility

Careful consideration was given before the commencement of all the

interviews. Participants were required to have the capacity to give informed consent and adequately understand written or verbal information in English language as there was no budget to provide necessary translation of written information and interpretation. Participants agreed for the interviews to be tape-recorded. They were also given the choice to withdraw from the interview at any time without any explanation.

Semi-structured interviews were used for data collection. Interview schedule evolving from the pilot interviews (see below) was used as guidance throughout the interviews. The interview schedule was flexibly used to enable emergent interesting ideas to be followed up. Open-ended questions such as: Can you tell me how you first came into contact with the mental health services in England? and follow-up questions such as: What happened after you became unwell? were asked to capture detailed narrations of the participants' experiences. The interviews lasted between 35 and 60 minutes. This was largely dependent on the fluency of the participants.

Given that this study seeks to explore the lived experiences of the participants recovering from mental illness, service users were actively involved in the research design. The draft interview schedule was piloted with City, University of London's service users and carers group advising research (SUGAR) (Simpson et al., 2014). A service user from the research site was also recruited for a pilot interview. Interviews were conducted individually and audio-recorded by the first author.

Reflexivity

The race symmetry (Rollock 2013, Vass 2017) with the participants made IT susceptible to various entanglements and dilemmas. For example, many related to him as 'a brother; a compatriot; a sympathiser; and a helper' with inside knowledge of their experiences (Tuffour, 2017b, 2018). However, IT's shared identity with the participants was beneficial in helping him to understand the cultural nuances of their narrations as well as grounding the interpretation of the data in the participants' cultural worldview (Tuffour, 2018). Raitoharju et al. (2009) argue that without insider help, culture-bound expressions or references can be difficult to understand. Similarly, Tajfel and Turner (1979) argue from the Social Identity Theory (SIT) that emotional connection can be enhanced when members from the same social group, social consensus, and cultural background interact based on their shared identities.

Data analysis

All interviews were transcribed and analysed manually by IT in accordance with IPA ideals of looking for shared, unique, and idiosyncratic themes across the transcripts (Smith et al., 2009). IT kept a reflective diary to record initial thoughts and comments during transcription of interviews. This proved useful during data interpretations.

Results

Five superordinate themes with subordinate themes emerged from the analysis (table 1). The first theme covered the participants' migration trails to England. The second theme *focused* on the meanings the participants

assigned to their mental illness, as well as experiences leading to first contact with the mental health services. The third theme *focused* on the participants' sense of devastation at being diagnosed with mental illness. The fourth theme explored the participants' subjective experiences with the mental health services in England. The final superordinate theme concentrated on the personal meanings that the participants assigned to their recovery.

Table 2: List of superordinate and subordinate themes

Superordinate themes	Subordinate themes
It is different in Africa	Why I came to England
	The way they care about them is different' – I am lucky I am here
	They all act crazy, mad, or different
	'Africa is different'
It all started in England	I didn't know it was a mental illness
	This is where the problem started
	Sectioned
Shattered	Sense of underachievement and burden
	'It has got some drastic connotations'
	I was not like this
	'Black people like to talk a lot'
	'It just completely freaked me out'
	'An adopted-child or a step-child'
'Freaked out'	Support from professionals
	Support from family and friends

Focus on recovery	Resourcefulness and self-awareness
	'There is anointing everywhere'
	Medication
	Social belongingness

Focus on recovery

This superordinate theme offers interpretations grounded in the participants' experiences and perceptions of the meaning of personal recovery. Four subordinate themes come under this superordinate theme: the participants' coping strategies in recovery, the participants' accounts of the relationship between their spirituality and recovery, insights into links between medication and recovery and the participants' unique meanings that they ascribe to their personal recovery. We are focusing on this last superordinate theme to give space for a comprehensive rich analysis. This theme has been chosen because it specifically explores the meanings BASUs assign to their personal recovery. We hasten to add that different interpretations of the data are possible.

Resourcefulness and self-awareness

Nearly all the participants spoke about their resourcefulness in the context of participation in social activities. Others showed their self-awareness in the context of exploring their diagnosis. For example, describing his resourcefulness, Kofi spoke about his extracurricular activities:

I volunteer in football and sport that we have at the moment for social opportunities. We organise football session on Tuesdays and Thursdays which I attend almost every week. I don't talk

about mental health with them and I think that's a positive thing because it's a separate thing away from my health [Kofi].

Here, Kofi is demonstrating that despite his ongoing mental illness, he is resourceful and can give something back to his community. This also gives him the opportunity to socialise and integrate into his community. It is interesting that he deliberately avoids talking about his mental illness when attending such activities. This suggests that perhaps, he uses the community activities as a strategy or even an opportunity to reinvent himself and to overcome the incurred social liabilities of mental illness. Likewise, Tina described her resourcefulness in the context of helping others suffering with mental illnesses:

In the coming months or coming years I see myself as a woman that is successful ..., determined and supportive in a way. Because I feel like it's something that touches my heart that it happens to people...they need the best care that they can get and they need the best support as well, so probably be an advocate [Tina].

Different readings could be ascribed to Tina's narrative. First, it can be assumed from the first sentence that she is indicating her resolve to recover and to regain her self-esteem. Second, she shows her intention to help others who she perceives as being marginalised because of mental illness. Third, Tina appears to highlight feelings of dissatisfaction with the mental health services, therefore it is not surprising that she has a sense of duty to extend acts of real kindness and sensitivity to those she perceives as disaffected by the mental health services.

Sheku expressed his self-awareness in the context of his mother's mental illness and his own diagnosis:

I've got a good understanding of mental illness because when I found out my mother was mentally unwell she was in a hospital...and so... I kind of had mental health experiences with my mum really. So I kind of at a younger age, I kind of watched out for symptoms for myself...but I...never quite know what symptoms to watch out for. I watched out if I started getting unwell...I started watching out for myself...or doing certain things. I wasn't quite successful at that really, as I myself wasn't too well, I wasn't too well [Sheku 6.200-207].

Several readings could be taken from Sheku's account. He portrays that his mother's predicament provided an insight into mental illness. There is a hint of emotions in his account, but the irony is that Sheku did not show any emotions when talking about his mother's mental illness. This is odd given that many people would perhaps show emotions when talking about upsetting past events. Perhaps, such childhood experiences have desensitized his feelings, and he has come to regard mental illness as something familiar in his life. On the other hand, he shows remarkable resilience. He is not ashamed of his mother's mental illness, neither does it dissipate his spirits, rather it invokes the motivation to closely monitor himself for signs and symptoms of mental illness. His lived-experience is poignant, but equally courageous. His account is also suggestive that self-awareness does preclude one from mental illness. However, his experiences somewhat suggest that becoming self-aware can lead to the pathway of recovery.

'There is Anointing Everywhere'

Spirituality and belief systems were acknowledged by almost all the participants as very important in their recovery. Although the participants

did not mention any specific religious affiliation, it was apparent in their narratives that most were conveying deep faith in the Christian philosophy and Pentecostalism. Many professed that God and their spirituality provided hope for recovery and comfort. For example,

Zena also reported that spirituality was having positive effects on her recovery:

When I was diagnosed with schizophrenia, mum would take me to different churches. Before I was diagnosed she would be confined to the Catholic church but now she's open to any churches like the Pentecostal churches... There is anointing everywhere...I've learned to pray more...and have faith in God [Zena].

Here, Zena recounts how she and her mother identified spirituality and religion as one of the main sources of treatment that they really trusted, shortly after she was diagnosed with mental illness. Though her pursuance of multi-denominational spiritual deliverance stands out from the rest of the participants, they all had a common characteristic of seeking God's intervention in their recovery. There were indications that religious beliefs were exacerbating some of the participants' mental illness. For example, Asana narrated how God told her to throw away all her belongings:

I was thinking maybe it was God who was telling me [Asana].

This is significant because the ability to communicate with God or supernatural beings is culturally and religiously powerful for many Africans (Mbiti, 1990; Turaki, 2006). But it is apparent that religious belief was having negative influence on Asana's insight into her mental illness.

Medication

All the participants expressed their desire to get better and seemed to construct their recovery within the context of taking medication. However, the narratives revealed varied and complex views about medication. This was expressed as a continuum, where at one end some participants reported positive experiences with medication, whilst at the other end some reported bad side-effects from medication. Some of the many narratives that spoke positively about their medication included the following:

I like my medication because it makes me feel better [Eva].

My medication, yes it really helps especially the antidepressant medication. Depression is one thing I know I haven't beaten yes so it really helps...It takes my mind off things as well and the hearing voices the medication has helped with that as well [Bobby].

The narratives above suggest that medication is playing a key role in the participants' recovery from mental illness. There is an impression from their narratives that medication is not only reducing symptoms, but it has inherently inspired optimism and triggered insight into the participants' mental illness. Kofi also described his initial reluctance in taking medications because of his own and his brother's preconceived fears:

Initially I found it very difficult taking medication because I think everyone has certain ideas about antidepressants and anti-psychotic medication. I just assumed that it will make me crazier or get hooked...Initially I was completely against it because my brother was quite negative and told me not to take them [Kofi].

Kofi's negative preconceptions about medication were self-instigated and then strengthened by his brother. His narrative is evocative that close

family relatives can be influential in reinforcing negative or unsubstantiated beliefs about issues relating to mental illness.

Some participants reported that they were being coerced into taking medication. For example, Jane reported that getting a depot injection on the ward is something she has 'to go along' with:

Sometimes when you're here and you don't want the injection you feel as if you just have got to go along [Jane].

Jane's account suggests that she feels trapped into taking her medication. The impression is that she feels trapped on the ward, and that she must act as an obedient hostage by complying with her depot injection, something she fundamentally disdains, to secure her freedom. However, one participant pragmatically explained that she could only be coerced to take medication when she was on the ward:

The doctor can only force me when I am in the hospital, but when I go home no one will force me to take the medication [Mariam].

Mariam makes a direct reference to 'the doctor' and 'hospital' as symbols of coercion and dictatorial elements in the mental health system. Her narrative is also suggestive that true autonomy is only guaranteed in one's home environment and not in hospital.

Some participants also spoke about the disabling side-effects of medication, such as weight gain, tiredness, loss of interest, memory loss, perceived loss of intelligence and speech difficulties. For Tina, the side-effects and prospect of being forced to take medication for the rest of her life compelled

her to threaten to leave England for her native country for good:

Well when I looked at the side-effects I was a bit sceptical about what was going to happen because in view of the fact I don't have any children...I wouldn't want my body tampered with and affect the future of my kids...I would absolutely say I don't think I want that because if I'm supposed to take the depot injection for a long time why do I have to be in this country, I don't have to be here...I would go back to my country which is Zimbabwe...why do I have to suffer in this country? I don't have to go through all of this [Tina].

Tina's narrative is complex and requires unravelling. It appears that not only is she preoccupied with the terrible side-effects of the medication, but she is also afraid that the medication might influence her fertility and that she might not be able to have children. This predictably persuades her to doubt or have reservations about the psychotropic medication being prescribed to her. Moreover, the negative social and cultural consequences of becoming childless perhaps contribute to her scepticism about psychotropic medication.

One participant was philosophical about the side-effects of medication:

There is nothing I can do about the side-effects. I think all medications have got side-effects. There is nothing I can do [Asana].

There is an indication of resignation and pragmatism in the comment above. It appears that Asana has given up and there is nothing she can do to stop the side-effects that come with her medication.

Social belongingness

Participants framed the unique meanings of recovery in the context of social

belongingness. For example, one participant framed the meaning of her recovery in the context of finding suitable accommodation:

To find a job and better housing...to improve my status and accommodation [Eva].

Others framed the perception of recovery in the context of living a fulfilled family life:

I mean it's just living a much more fulfilled life, able to work and start my business and able to have children, a family and a husband [Tina].

Tina's account is expressive that, for her, recovery is about finding contentment in life. Importantly, Tina draws on her culturally available stock of meaning to frame her perspective of recovery, because most traditional African societies are pro-family and pro-natal (Gyekye, 1997).

Some participants expressed the meaning of their recovery in the context of their social circles and relationships. This was evidenced when Jane said:

Well I know for one thing that my family's attitudes haven't changed and those are the people that matter the most...they have been very understanding and very supportive [Jane].

Mariam spoke about support from her neighbours:

In Africa we live as a family...your neighbours are a good family...when something happens to you they are the first people to look after you...My neighbours are the most important people [Mariam].

The communal life in Africa is embedded in the memory of Mariam and she romanticises that as important for her recovery. But some reported

that the stigma and negative stereotypes that mental illness attracts within the black African community are detrimental to their recovery.

The thing is...black people like to talk a lot. When he sees that person has a mental illness that person might start talking, talking, talking [Sheku].

They gossip 'you have mental health problems', and that's a bad tag on my name [Jane].

In this section, factors impacting the participants' recovery were contextualised. Analysis provided rich descriptions of the subjective perceptions and conceptualisations of recovery.

Discussion

In this section we situate the findings in the context of the existing theory and literature. A conceptual framework (figure 1) emerging from the analysis of the present study is presented. The participants' explanatory models of mental illness are first considered. This is followed by how they conceptualised recovery.

BASUs explanatory models of mental illness

Participants' explanatory models of mental illness included the complexities of migration, African-centred worldviews and negative life experiences (Tuffour, 2017b). Bhugra et al. (2010) have suggested that problems with acculturation can expose some immigrants to vulnerabilities, especially when confronted with the need to integrate into the dominant culture. The participants' African-derived cultures or worldviews of mental illness is consistent with findings that many Africans often cite mystical or

supernatural powers as the causes of mental illness (McCabe and Priebe, 2004; Patel, 1995). Moreover, the post-migration negative life experiences some participants endured echoes research findings that marginalisation, social oppression, and discrimination can lead to mental illness among immigrants (Fine and YPi, 2016).

The conceptual framework of recovery for BASUs

The results of the present IPA analysis captured the participants' conceptualisation of recovery in the context of their social and cultural backgrounds, remission or eradication of symptoms, spirituality, usefulness in society, ability to bounce back, and unique personal identities. These aspects of reality for the participants informed the abstraction of the recovery model illustrated in Figure 1. Here, recovery is depicted as encapsulating six closely linked dimensions: clinical, spiritual, functional, resilience, identity and social belongingness. The complex process of contextualising recovery by the participants meant that some of the components such as identity and socio-centric/collectivist was closely linked and overlapped with one another, whilst clinical emerged as continuum.

Components of BASUs conceptual framework for recovery

Clinical recovery

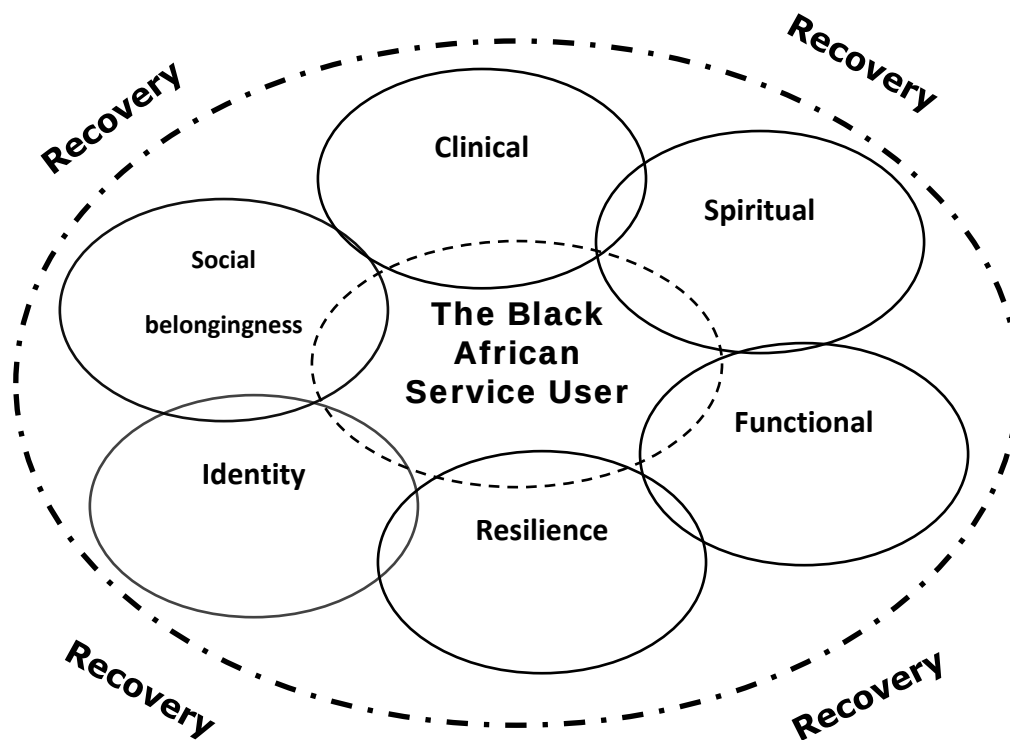
The first dimension of the conceptual framework is clinical where recovery was conceptualised as a clinical outcome and expressed as a continuum, where on the one hand some participants spoke about the concept in

relation to reduction of symptoms or return to a former self, as illuminated by, for example, Bellack (2006); Davidson and Roe (2007); Liberman et al. (2002); Slade (2009); Silverstein and Bellack (2008); and Whitley and Drake (2010). On the other hand, many of the participants conceptualised clinical recovery in the context of finding effective medication. A similar outcome has been reported by Piat et al., 2009; and Whitley and Drake (2010). However, consonant with the literature (i.e. Piat et al., 2009), many participants reported mixed feelings about medication.

Spiritual Recovery

The second dimension of the conceptual framework is spiritual. Here, the participants collectively acknowledged that their religion and spirituality could inspire positive effects and general wellbeing. Substantial empirical evidence has shown the positive impacts of spirituality on mental health (Dein and Cook, 2015; Dein and Littlewood, 2007; Huguelet et al., 2016; Ho et al., 2016). The study echoes the suggestion that people of Black descent relate spirituality to recovery (Leamy et al., 2011). It also confirms the suggestion that the African belief systems are pragmatic, existential and experiential (Mbiti, 1990; Turaki, 2006). However, there were indications that participants' religious beliefs were having negative effects on recovery. This is consistent with Dein and Cook (2015) who argue that spirituality and religion can exacerbate mental illness.

Figure 1: The conceptual framework of recovery for Black African Service Users



Functional Recovery

The findings revealed that participants perceived employment, personal achievement, and education as important stimuli for their recovery. This informed the third dimension of the conceptual framework. Studies have shown that employment opportunities (Biringer et al., 2016; Doroud, Fossey and Fortune, 2015; Gilbert et al., 2013; Markowitz, 2015), education and employment (Mowbray et al., 2005; Rudnick et al., 2013) are important impetuses for recovery.

Resilience

Although many participants expressed devastation at the onset of their

mental illness, but they demonstrated resilience by accepting their fates and moving on with their lives. Thus, resilience formed the fourth dimension of the conceptual framework. Studies have established that resilience can lead to adaptation, self-awareness, hope and optimism, understanding, change in attitude, growth and a new sense of identity (Edward, 2005; Edward, Welch and Chater, 2009). Participants demonstrated in their narratives that their resilience had paved the way to acceptance of their diagnosis and eventual recovery. Studies have shown that learning to accept mental illness and the concomitant difficulties are key precursors to recovery (Ajayi et al., 2009; Bowyer et al., 2010).

Identity

The contextualisation of the participants' accounts resulted to identity as the fifth dimension of the conceptual framework. Here, participants revealed that their identities as Sub-Saharan Africans, communal and tribal belongingness were critical to their recovery journeys. The participants' overwhelming dependence on their culturally available stock of meaning to make sense of mental illness and recovery was particularly notable. This is consistent with many developmental and social psychologists who have suggested that ethnic identity is one of the most important facets of people's self-concept and identity (Sellers et al., 1998; Yip, Seaton and Sellers, 2006).

Social belongingness

The sixth dimension of the conceptual framework is social belongingness.

Many of the participants felt that their recovery would not be possible without their families and social circles. Thus, many contextualised their recovery in the context of their connections with families and neighbours. This is consistent with studies that have reported that recovery unfolds in the context of social connectedness and belongingness (Naslund et al., 2016; Tew, 2013). The participants' deep sense of strong mutual interdependence is consistent with the writings of prominent African philosophers who have championed the idea that personhood and communalism are embedded in the African conceptualisation of well-being and selfhood (Gyekye, 1997; Mbiti, 1990; Menkiti, 1984; Wiredu, 1996). Yet, some reported that their communal belongingness is detrimental to their recovery.

The conceptual framework of recovery presented here captures the dynamic and subtle shades of deeper understanding of recovery for BASUs. The findings add to the awareness that there are additional elements of recovery for BME/BAME that need to be considered. Leamy et al. (2011) acknowledged in their CHIME (connectedness, hope and optimism, Identity, meaning in life and empowerment), conceptual framework for supporting recovery that there are additional specific cultural factors for those from BME/BAME backgrounds that need further understanding. Despite this, the CHIME conceptual framework has been criticised for its failure to consider the burdens that can encumber recovery (Bradstreet, 2016). Stuart, Tansey, and Quayle (2016) have particularly criticised CHIME for failing to adequately account for social determinants of mental

illness, which this study has shown, are more likely to be faced by people from BME/BAME backgrounds.

Conclusion

This study set out to explore the BASUs experiences of mental illness and how they conceptualise recovery. The findings clearly indicate that the meanings BASUs assign to their mental illness and how they conceptualise recovery are imbued with socio-cultural backgrounds. Moreover, the BASUs conceptualisation of recovery is just as complex and multi-dimensional as those from the Eurocentric perspectives (Whitley and Drake, 2010). From the outset of this article, we advocated for a conceptualisation of recovery that sufficiently takes the unique socio-cultural contexts of other cultures into consideration. However, a notable criticism is the use of IPA, which belongs to the Western philosophical ideals, and is arguably alien and incompatible with African worldview. Unlike the African worldview, the philosophical ideals of IPA do not consider the supernatural dimensions of a phenomenon. IPA is a good methodology for inquiring how people make sense of their experiences, but it lacks the emotional accessibility of the African worldview, which is more personal, expressive, and sentimental (Thabede, 2008; Van der Walt, 1997). Nevertheless, we are encouraged by the fact that IPA research is said to be about inquiry into the socio-cultural meanings of individuals (Smith et al., 2009), and this study intrinsically considers the socio-cultural contexts of the participants. Using IPA has for example, helped to identify how participants of the present study make

sense of mental illness and recovery. This represents a breakthrough that mental illness and recovery are suffused with socio-cultural contexts. Moreover, this study could be a blueprint for mental health professionals and service providers to enhance recovery for BASUs. The challenge is for future researchers to use methodologies that reflect the African heritage and cultural worldviews to explore BASUs experiences.

Key points for practice and/or research

- The meanings BASUs assign to their mental illness and how they conceptualise recovery are complex and imbued with socio-cultural contexts.
- Nursing and healthcare policies that grasp how the complexities of BME/BAME socio-cultural contexts fit the recovery-oriented services are needed.
- Reflections embedded in IPA makes it the most suitable methodology for approaching research when there is a race symmetry between the researcher and the researched.
- The double hermeneutic in IPA means that the researcher's interpretations become part of the research and cannot be bracketed in the same way as they might be in an Husserlian phenomenology.
- There is a need for further exploration of BASUs' experiences of recovery using methodologies reflecting their own cultural worldviews and heritage of the African culture.

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