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Perceptions and Experiences of Personal Recovery for Ethnic Minority People with Severe Mental Illness: A UK-informed Qualitative Systematic Review

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Abstract

Research has shown that ethnic minority people living with severe mental illness (SMI) experience poor mental healthcare and outcomes. Mental health services are increasingly embedding recovery-focused approaches, informed by personal recovery models. Personal recovery focuses on creating social connections, building hope, establishing an identity, finding meaning and feeling empowered while living with SMI. However, how personal recovery is defined from the perspective of ethnic minority people with SMI is not well understood across the literature. To address this gap in knowledge, we conducted a qualitative systematic review to investigate how ethnic minority people with SMI perceive and experience personal recovery. Searches were completed through three databases (MEDLINE Ultimate, APA PsycINFO and CINAHL Ultimate). Studies that met the inclusion criteria were analysed using narrative synthesis. Twenty studies were included in the review, from which three themes were generated: i) The Family as a Supportive and Obstructive System; ii) Faith as the Foundation for Hopefulness and iii) Discovering Identity through Agency and Social Interactions. Across the three themes, facilitators and barriers of personal recovery were identified. The findings indicate the need for mental health professionals' to focus on minimising specific barriers to recovery for ethnic minority people with SMI. This review provides a robust account of personal recovery, that will serve to enhance healthcare professionals' knowledge regarding care initiatives and additional considerations for ethnic minority populations.

Keywords Ethnic Minority · Severe Mental Illness · Personal Recovery · Health Inequities

Early conceptualisations of recovery from mental illness, often stemming from Western regions of the world, have tended to focus on the stabilisation or decrease in clinical symptoms and treatment adherence (Jacob, 2015). These are often determined through validated psychometric outcome measures. However, the trajectory of clinical recovery is rarely linear and encompasses a wealth of challenges individuals may experience along the way (Slade & Longden, 2015). Indicators of recovery may include symptom reduction; however, it has been argued that individuals, their supportive network, as well as healthcare professionals, should look beyond clinical recovery only (Damsgaard & Angel, 2021) and instead consider personal recovery approaches.

Whilst clinical recovery usually symbolises the efficacy of treatment outcomes, personal recovery approaches seek to view the individual holistically. Anthony (1993) is often cited as a fundamental contributor to the emergence of personal recovery approaches within Western contexts, which focus on the individual experience of restoring personal attributes, reclaiming purpose and meaning in one's life despite the challenges of their illness. Further insights from Slade (2009) argued that healthcare services should make personal recovery an integral part of care provision to promote overall well-being, as this will, in effect, facilitate

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clinical recovery. Therefore, personal recovery from mental illness can be thought of as shifting the focus from symptom reduction to creating a broader sense of hope, identity, and empowerment in one's life.

A more theoretically contemporary definition of personal recovery is outlined in a seminal systematic review that investigated personal recovery in relation to mental illness (Leamy et al., 2011). Leamy and colleagues developed a conceptual model outlining 13 components of personal recovery processes, summarised across five themes collectively called the CHIME (Connectedness, Hope, Identity, Meaning, and Empowerment) framework. *Connectedness* refers to interactions with others, such as family and peers; *hope* includes being future orientated; *identity* reflects making sense of themselves; *meaning* encourages individuals to find purpose; and *empowerment* offers the opportunity for individuals to feel autonomous throughout their walk in life. Despite there only being six out of 97 studies included within the model that identified findings related to ethnic minority people, such as the role spirituality and stigma play in determining personal recovery outcomes, there has been a growing number of cross-cultural reviews that have explored cultural understandings of personal recovery in mental health in non-Western contexts, that replicate findings from the CHIME framework (Kuek et al.,2020; Murwasuminar et al., 2023; Panadevo et al., 2025; Sofouli, 2020). Given these findings, it is plausible to suggest that the CHIME framework supports some understandings of personal recovery outcomes in ethnically diverse populations.

In the Global North, it has been widely reported that ethnic minority people are more likely to receive a diagnosis of a severe mental illness (SMI) such as schizophrenia-spectrum disorders (NHS England, 2024). Ethnic minority people may face individual and systemic barriers to accessing mental healthcare, such as stigma and a mistrust of mental health services, resulting in negative help-seeking attitudes (Ahad et al., 2023). As such, ethnic minority people may experience challenges in their pathway into care and experience poorer health outcomes compared with other majority ethnic groups (Bansal et al., 2022).

Underlying this, there is an emerging field of research about the importance of ethnic identity and the role this plays in experiences and concepts of mental health. In one example, Moore et al. (2022) found strong associations between a person's ethnic identity and personal recovery. The authors' findings suggest promoting ethnic identity enhances social connections with others from a similar ethnic background. These findings reinforce the importance of identity and connectedness in supporting personal recovery. Given the widely reported poor mental healthcare experiences among ethnic minority people living with SMI (Anthony, 1993), and the important role of personal identity in personal recovery models, understanding concepts of ethnic identity is warranted in recovery-focused treatments and care.

Currently, there is a paucity in the literature to understand how personal recovery is experienced or perceived qualitatively by ethnic minority people with SMI and the role that ethnic identity, hope, and empowerment may play in regaining a meaningful life. Therefore, a systematic review approach was selected to conduct an in-depth analysis of existing qualitative research, focused on personal recovery in ethnic minority people with SMI. The primary research question for this systematic review was, "How do ethnic minority people with SMI perceive and experience personal recovery?" Furthermore, the secondary research question was "What are the facilitators and barriers of personal recovery, and what strategies (if any) were used by the ethnic minority people and/or healthcare professionals to resolve such barriers?" The review will potentially support recovery-focused approaches within mental health services when supporting ethnic minority people with SMI and provide strategies for promoting personal recovery.

Methods

The systematic review protocol was submitted to the International prospective register of systematic reviews (PROSPERO) (Registration number: CRD42024572389) (Linton et al., 2024). The conduct of the review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 checklist (Page et al., 2021). The research team consisted of a Doctorate in Clinical Psychology researcher (primary reviewer) and two supervisors (second and third reviewers).

Search Strategy

The primary reviewer completed preliminary hand searches related to the topic of interest to understand the scope of the literature, which subsequently informed the research questions developed. Following this, systematic searches were completed using three databases: MEDLINE Ultimate, APA PsycINFO, and CINAHL Ultimate. These databases were selected due to their strong catalogue of psychological and health-related research literature. Initial searches were completed on 29 October 2024. In addition, grey literature searches through library and university repositories, hand searches, and citation chaining were completed on 11 November 2024. An updated search was completed on 21 November 2025. An exhaustive list of search terms was developed and used across the databases (Table 1). The reviewers selected primarily UK-based definitions to

Table 1 Search Terms Used for Systematic Review

Search Terms			
Perceptions OR Perspectives OR Experiences OR Beliefs OR Attitudes OR "Lived Experience" OR Views OR Interview* OR "Focus Group"	Recovery OR "Personal Recovery" OR "Mental Health Recovery" OR Rehabilitation	Ethnic minorit*" OR "Ethnic* diverse" OR Ethnic OR Black OR Caribbean OR Africa* OR Afro-Caribbean OR Asian OR BME OR BAME OR Pakistani OR Bangladeshi OR Arab OR Indian OR Chinese OR "East Asian" OR "Middle East" OR Multiracial OR Biracial OR "Mixed-race" OR Hispanic OR "People of Colo? r" OR "African-American" OR Indigenous OR Maori OR Latin* OR "Roman Gypsy" OR "Other Ethnic"	"Severe Mental Illness" OR "Serious Mental Illness" OR "Psychiatric Disorder" OR "Mental Disorder" OR Schizo* OR "Bipolar Disorder" OR "Severe Mood Disorder" OR Psycho* OR "Personality Disorder" OR "Complex Emotional Needs" OR "Complex Needs" OR "Major Depressive Disorder" OR "Eating Disorder" OR "Emotionally Unstable Personality Disorder"

determine the ethnicity and SMI search terms (NHS England, 2024; GOV.UK, 2021). Additional global ethnicity search terms were included but used more broadly to capture non-UK defined ethnic minority groups.

Eligibility Criteria

The inclusion and exclusion criteria were developed collaboratively across the research team. Studies met the inclusion criteria if they were (a) qualitative or included a qualitative component; (b) peer-reviewed studies or studies reported outside of traditional commercial publishing (i.e. grey literature) that included the perspectives and/or experiences of personal recovery for ethnic minority people with SMI (c) studies conducted in high-income countries, defined by the World Bank income groups whose population is majority white (Hamadeh et al., 2024), and (d) studies that included data from participants categorised as an ethnic minority in the country the study was conducted in. The exclusion criteria were (a) quantitative studies; (b) studies that included common mental health conditions (e.g., mild depression and anxiety-specific conditions); and (c) studies that included trauma-based conditions (e.g., Post-traumatic Stress Disorder (PTSD) and Complex Post-traumatic Stress Disorder (CPTSD).

Study Selection

The initial database search identified 1,998, and the updated search identified 240 new studies. Overall, the database searches yielded 2,238 results. Search results from each research database were exported to EndNote, a reference management software. After duplicates were removed, this left a total of 1,389 papers. Following this, the results were amalgamated and exported to Rayyan, a software used for screening papers used in systematic reviews (Ouzzani et al., 2016). After title and abstract screening, 37 papers remained for full-text screening. To ensure rigour, 20% of the selected full-text papers were independently screened by a second reviewer. There were no discrepancies identified between the reviewers; therefore, the inter-rater agreement was 100%. Four papers were identified through hand searches, with two additional papers identified through citation chaining. The search results and selection process are outlined in Fig. 1. In total, 20 papers were included within the systematic review. These included five papers identified through grey literature searches and 15 papers identified through the research databases.

Data Extraction and Synthesis

Data were extracted from the included studies using a standardised data extraction sheet. These included study characteristics (e.g., author, country, study aims, study design, methods, analysis), study outcomes, and author recommendations. In order to synthesise the data, first-order interpretations (key themes), direct quotes, and second-order interpretations (authors' explanations) were analysed following the narrative synthesis approach (Popay et al., 2006). The narrative synthesis method is a four-stage process beginning with (i) the development of a theory (ii) synthesising the data, (iii) comparison within and between the studies, and (iv) critically evaluating the strength of the synthesis. Thematic analysis was used within the narrative synthesis framework to support stage two of the analysis in synthesising the data (Braun & Clarke, 2006). Data were organised and analysed in the software application NVivo 14 (Lumivero, 2023). The primary reviewer led stage two of the analysis by using line-by-line open coding to develop codes and to generate themes. Codes and themes were discussed and confirmed with a second reviewer to minimise the potential for bias. The themes were then compared in stage three of narrative synthesis using framework analysis (Gale et al., 2013). The reviewers were from ethnically diverse backgrounds; this included White British, Black Caribbean, and Black African. They acknowledged the importance of being reflexive throughout the analysis process.

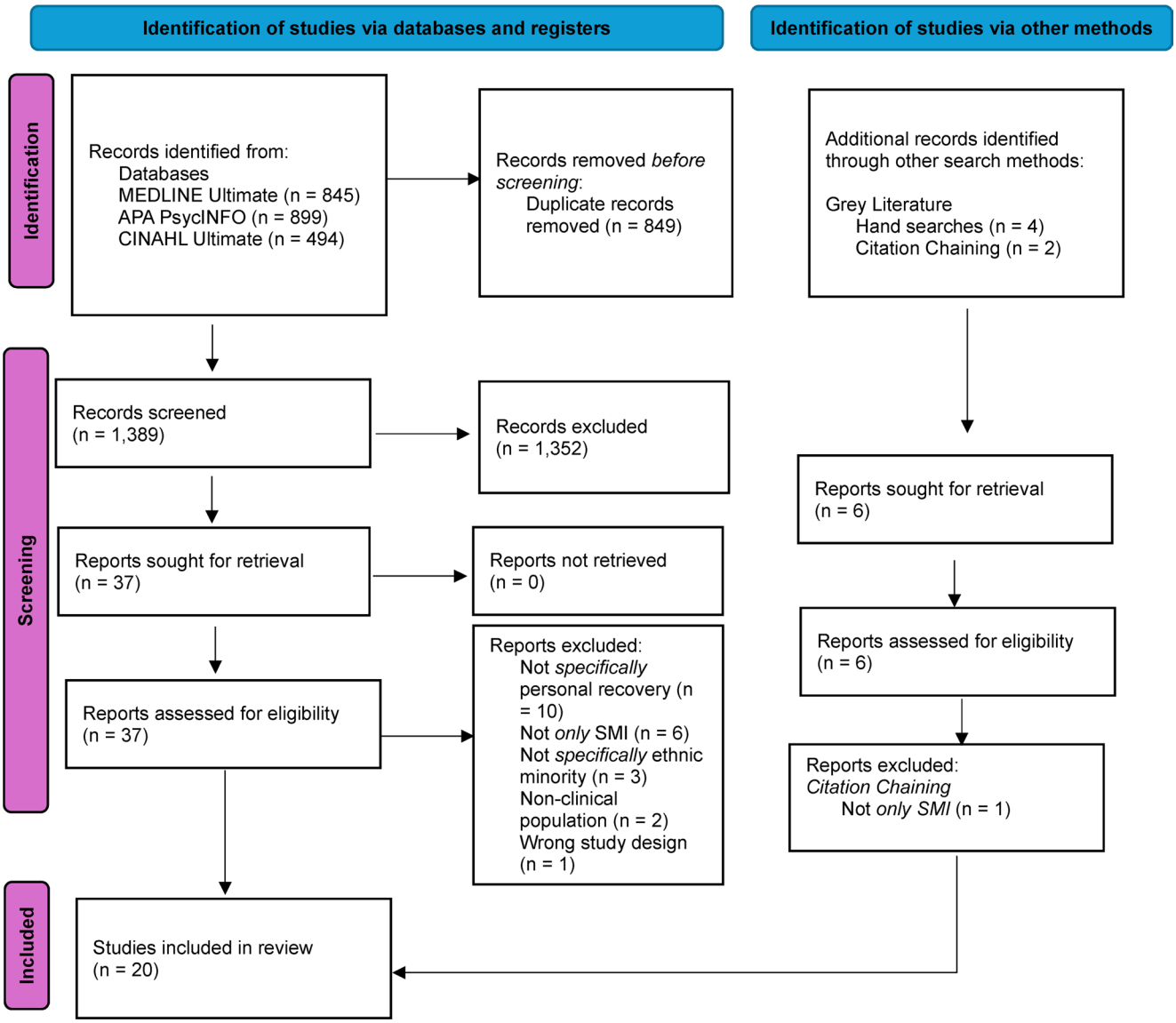

Fig. 1 PRISMA Flowchart of studies found through searches

Quality Assessment

The included papers were critically appraised by one reviewer using the Specialist Unit for Review Evidence (SURE) quality assessment tool (Specialist Unit for Review Evidence [SURE], 2018). The SURE quality assessment tool is robust and ensures a rigorous evaluation of methodological quality for qualitative research papers. At least 20% of the included papers were independently critically appraised by a second reviewer. Any discrepancies between reviewers were resolved through further discussion in supervision. Papers were not excluded by the outcome of their quality assessment; therefore, they remained included in the systematic review (Table 2).

Results

Study Characteristics

A summary of the characteristics for each study is outlined in Table 3. Thirteen studies were conducted in the United States (Armour et al., 2009; Habhab, 2016; Jankowski et al., 2023; Lee, 2012; Lee et al., 2015; Misra et al., 2020; Mohsin et al., 2024; Moore et al., 2024; Myers & Ziv, 2016; Pahwa et al., 2018; Saunders et al., 2023; Whitley, 2011; Whitley, 2012), three studies were conducted in the United Kingdom (Lawrence et al., 2021; Tuffour et al., 2019; Tuffour, 2020) two were conducted in New Zealand (Clark et al., 2023; Wang & Henning, 2012) and two were conducted in Canada

Table 2 Summary of the Included Studies Quality Appraisal using the SURE Quality Assessment Tool

Questions to assist with the critical appraisal of qualitative studies	Armour et al. (2009)	Clark et al. (2023)	Habhab (2016)	Jankowski et al. (2023)	Lawrence et al. (2021)	Lee (2012)	Lee et al. (2015)	Misra et al. (2020)	Mohsin et al. (2024)	Moore et al. (2024)	Myers et al. (2016)	Pahwa et al. (2018)	Saunders et al. (2023)	(Tuffour 2020)	(Tuffour et al. 2019)	(Virdee et al. 2017)	Wang et al. (2012)	Whitley (2012)	Whitley (2011)	Whitley (2016)
Does the study address a clearly focused question/ hypothesis?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the choice of qualitative method appropriate?	Y	Y	Y	Y	Y	Y	Y*	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the sampling strategy clearly described and justified?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the method of data collection well described?	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the relationship between the researcher(s) and participants explored?	Y	Y*	N	N	Y	N	N	N	N	Y	Y*	Y	Y	Y	Y	N	N	Y	Y	N
Are ethical issues explicitly discussed?	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y*	Y*	Y	Y	Y
Is the data analysis/ interpretation process described and justified?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y
Are the findings credible?	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is any sponsorship/ conflict of interest reported?	?	N	?	N	?	N	?	N	N	N	?	N	N	?	N	?	N	?	?	N
Did the authors identify any limitations?	Y	Y	Y	Y	Y	Y	Y*	Y	Y	Y*	N	Y	Y	Y*	Y	Y	Y	Y	N	Y
Are the conclusions the same in the abstract and the full text?	?	Y	Y	Y	Y	Y	Y*	Y	Y	Y	Y	Y	Y	Y	Y	?	?	Y	Y	Y

Y= Yes, N= No, ?= Can't tell, *= reported poorly

Table 3 Summary of Study Characteristics of Included Studies and Key Findings

Author(s), year	Country	Aims	Study Design	Participants				Key Findings
				N	Age	Gender male(m), female (f)	Diagnoses	
Armour et al. (2009)	USA	Understanding African American's experiences of living with severe mental illness	Qualitative (interviews), Hermeneutic phenomenological, secondary data analysis	9	25–54	M (4), F (5)	Schizophrenia (5), Bipolar 1), Schizoaffective (1), Major Depression (2)	- Participants were eager to pursue normalcy. - Through this process it involved overcoming obstacles, taking responsibility for their illness and utilising external systems for support.
Clark et al. (2023)	New Zealand	Experiences of recovery for Māori with eating disorders	Qualitative (interviews), Kaupapa Māori design, Thematic analysis	15	16+	Not reported	Anorexia Nervosa, Bulimia Nervosa or Binge Eating Disorder	- Recovery was perceived to enhance empowerment and participants looked beyond their illness and towards a brighter future.
Habhab (2016)	USA	Explored social factors that influence recovery in Arab Americans accessing a clubhouse	Qualitative (interviews), outcome measures (Recovery Assessment Scale), Grounded Theory	15	26–72	M (7), F (8)	Major Depressive Disorder (7), Schizoaffective Disorder (3), Anxiety Disorder (2), Bipolar Disorder (2), Post Traumatic Stress Disorder (1)	- Psychosocial factors such as culture, family, treatment adherence, gender differences were found to influence recovery outcomes and experiences
Jankowski et al. (2023)	USA	Exploration of the impact of stigma and racial discrimination on young Black people	Qualitative (focus groups), Thematic content analysis	7	18–27	M (4), F (3)	Psychosis	- Recovery included taking ownership of one's life, and resisting the negative stereotypes associated with having psychosis.
Lawrence et al. (2021)	UK	Understanding experiences of using services and living with psychosis	Qualitative (interviews, experience-centred research, Thematic Narrative analysis	35 Black Caribbean (17), White British (15), Non-British White (3)	21–50	M (17), F (18)	Primary Diagnosis Schizophrenia (22), Mania (8), Depression (5)	- Recovery was harder because of participants experiences with the services, which limited their ability to seek personal recovery
Lee (2012)	USA	Understanding social relationships in the context of living with severe mental illness as an Asian American	Qualitative (interviews), Phenomenological data analysis	12	21–64	Not reported	Schizophrenia or Schizoaffective Disorder	- Family relationships served to advance recovery, but they could also hinder recovery at times. - The importance of culture greatly impacted participants perspectives regarding their role within the family unit and how their illness shouldn't affect it
Lee et al. (2015)	USA	Exploring Asian Americans experiences of family included in their recovery	Qualitative (interviews), secondary data analysis	8	28–60	M (4), F (4)	Schizophrenia	- Family played an important role in offering emotional and instrumental support. - Sometimes family struggled to understand medical interventions.

Table 3 (continued)

Author(s), year	Country	Aims	Study Design	Participants				Key Findings
				N	Age	Gender male(m), female (f)	Diagnoses	
Misra et al. (2020)	USA	How has childhood adversity influenced the perception of family support through recovery	Qualitative (interviews), Modified, Grounded Theory Approach	20 White (9), Black (6), Asian (4), Multiracial (1)	23–69	M (10), F (9), Transgender (1)	Schizophrenia (16), Schizoaffective Disorder (4)	- Participants with limited adversity reported feeling connected and supported by their family through recovery - Participants who experienced adversity reported having limited family support, as well as being rejected by their family because of their illness
Mohsin et al. (2024)	USA	Investigating the perception of different systemic factors influencing South Asians experiences of recovery	Qualitative (interviews), deductive and inductive Thematic analysis	36 Patients (21), Family (11), Clinicians (4)	20–72	Patients M (6), F (14), Non-Binary (1)	Bipolar disorder (4), Complex Post-Traumatic Stress Disorder and Severe Major Depressive Disorder (3), Severe Major Depressive Disorder (7), Schizophrenia (5) Delusional disorder (1), Schizoaffective disorder (1)	- Family involvement was necessary to facilitate recovery, however family also prohibited autonomy. - Participating in activities that allowed for personal development and connecting with others were an important indicator to personal recovery
Moore et al. (2024)	USA	Exploring the relationship between ethnicity and recovery experiences	Mixed-methods (outcome measures and interviews, Explanatory sequential design, Directed content analysis	44 Hispanic/Latine (18), Black, Non-Hispanic/Latine (15), Multiracial (11)	19–29	M (28), F (16)	Schizophrenia Spectrum (25), Depressive (15), Bipolar (4)	- Being aligned with their ethnicity helped to empower participants despite their illness - Participants were conscious of the stigma that prevailed through their ethnicity, making it harder to rely on systems (e.g., family), to assist with recovery - Participants reported negative experiences using services
Myers et al. (2016)	USA	Understanding African American with psychiatric disorders experiences of recovery	Qualitative (Ethnographic observations and interviews), Analysis unspecified	Observations (65), Interviewed (20)	18–60	M (53), F (12)	Psychotic Disorder (59), not reported (6)	- Authors reported two case studies that outlined experiences of social defeat and powerlessness in the face of illness, which was discouraging to their recovery

Table 3 (continued)

Author(s), year	Country	Aims	Study Design	Participants				Key Findings
				N	Age	Gender male(m), female (f)	Diagnoses	
Pahwa et al. (2018)	USA	Exploring formerly homeless individuals with severe mental illness and substance misuse experiences of social re-integration	Qualitative (interviews), Grounded Theory and Case Study analysis	34 Black (22), White (5), Hispanic (3), Native American (2), Asian American (1), Native American/ Cuban (1)	29–73	M (26), F (8)	Severe Mental Ilness (unspecified), Substance Use Disorder	- Connections to others, especially family and the local community, were imperative in facilitating recovery. - Limited connection to others, perspectives around illness including stigma hindered successful recovery and the ability to re-integrate back into society
Saunders et al. (2023)	USA	Understanding Latina/Hispanic women with eating disorders experiences of recovery in relation to cultural influences	Qualitative (Participatory action research framework of Photo-Voice and interviews-SHOWeD method), Secondary data analysis, Thematic analysis	17 White Hispanic (12) Brown Hispanic (4) Black Hispanic (1)	18–25	F (17)	Anorexia Nervosa (11), Bulimia nervosa (4), Binge Eating Disorder (1), Other specified feeding and ED (1)	- The prevalence of stigma internally and externally made it harder to recovery - The family system acted as a facilitator to recovery - Societal gender roles, were perceived as a barrier to pursuing aspects of life beyond what was expected in the culture
Tuffour et al. (2019)	UK	What are Black African service users, perceptions of recovery from mental illness	Qualitative (interviews), Interpretative Phenomenological Analysis	12 Sierra Leone (5), Zimbabwe (3) Zambia (2) Ghana (2)	19–57	M (3), F (9)	Schizophrenia (7), Paranoid Schizophrenia (4), Organic delusional (schizophrenia-like) disorder (N 1)	- Participants reported that finding purpose, religiosity, adherence with medication and integrating into society were important for enabling recovery, however internal struggles sometimes prohibited participants from implementing them into their life
Tuffour (2020)	UK	Exploring the role of religion in facilitating recovery in Black African service users with mental illness	Qualitative (interviews), Interpretative Phenomenological Analysis	12 Sierra Leone (5), Zimbabwe (4) Zambia (1) Ghana (1), Ghanaian parents (1)	19–57	M (3), F (9)	Schizophrenia (6), Paranoid Schizophrenia (4), Organic delusional (schizophrenia-like) disorder (N 1), severe depressive episodes (1)	- Participants discussed how their relationship with God provided them with reassurance and comfort whilst experiencing their illness - Engaging in religious activities, provided opportunities to connect with others - Sometimes religion made their symptoms worse

Table 3 (continued)

Author(s), year	Country	Aims	Study Design	Participants				Key Findings
				N	Age	Gender male(m), female (f)	Diagnoses	
Virdee et al. (2017)	Canada	Exploring South Asians experiences of living with Schizophrenia	Longitudinal, Mixed methods (interviews and ethnographic), Charmaz's coding strategy and Grounded Theory	7	30–62	M (4), F (3)	Schizophrenia spectrum	- Factors related to immigration such as assimilation and exclusion, influenced experiences of recovery, specifically relating to identity - Experiences of family involvement and religion varied amongst participants
Wang and Henning (2012)	New Zealand	Understanding the relationship between Chinese people with Bipolar Disorder and their family	Qualitative (interviews), Content and Thematic analysis	9	20–56	M (4), F (5)	Bipolar Disorder	- Family support was vital for positive recovery outcomes - Support was emotional and instrumental - Support sometimes limited participants interests'
Whitley (2011)	USA	How does living in high crime environments impact recovery for African American women with severe mental illness	Longitudinal, qualitative (focus groups and ethnographic), Thematic analysis	50 African American (45), Unspecified (5)	Not reported	M (10), F (40)	Schizophrenia, schizoaffective Disorder, Bipolar Disorder, and Major Depression	- Living in social deprivation was perceived as a barrier to personal recovery, however the participants sought to resist this defeat and persevered by overcoming hardships so that they can achieve recovery
Whitley (2012)	USA	What role does religion play in recovery for African Americans with dual diagnosis	Longitudinal, qualitative (focus groups and ethnographic), Thematic analysis	50 African American (45), Unspecified (5)	Not reported	M (10), F (40)	Schizophrenia, schizoaffective Disorder, Bipolar Disorder, Major Depression and Substance Use Disorder	- Participants emphasised God's role in the process of their recovery - Engaging in religious activities, acted to encourage fellowship and connectedness
Whitley (2016)	Canada	Comparing perceptions of recovery across different ethnicities with severe mental illness	Purpose-driven comparative study, qualitative (interviews), Thematic analysis	47 Euro-Canadian (28) Caribbean-Canadian (19)	Euro-Canadian (20–69) Caribbean-Canadian (22–62)	M (24), F (23)	Schizophrenia, Major Depression, Schizoaffective Disorder, Bipolar Disorder	- Recovery meant being able to engage in daily activities as usual - Barriers included stigma, low socioeconomics and hospitalisation - Facilitators included having belief in a higher power and being proactive

(Virdee et al., 2017; Whitley, 2016). All studies were qualitative except for two which used mixed methodology (Moore et al., 2024; Virdee et al., 2017). The participants' age ranged from 16 to 73 years however, two studies did not report participant ages (Whitley, 2011, 2012). In total 504 participants were sampled across the included studies and were diagnosed with either Schizophrenia Spectrum Disorders, Bipolar Disorder, Major Depressive Disorder, Mania and/or Eating Disorders. Four studies (Habhab, 2016; Mohsin et al., 2024; Pahwa et al., 2018; Whitley, 2012), included participants with co-morbidities but only the SMI-related findings are reported here. One of the studies (Moore et al., 2024) included mixed methods, however, only the qualitative data were analysed in this review. The ethnic minority groups included African American, Black, Black Caribbean, Black African, Caribbean-Canadian, Māori, Arab American, Asian American, Chinese, South Asian, Hispanic, Native American, Non-British White and Multiracial.

Narrative Synthesis

Following the narrative synthesis approach, three themes were generated from the included papers (i) The Family as a Supportive and Obstructive System, (ii) Faith as the Foundation for Hopefulness, and (iii) Discovering Identity through Agency and Social Interactions. Underpinning each of these themes were specific cultural influences, facilitators, and barriers to personal recovery. Figure 2 outlines the emerging themes and subthemes.

The Family as a Supportive and Obstructive System

Family played a large role in shaping participants personal recovery experiences. Almost all the studies discussed how family acted as a facilitator, specifically how they offered emotional and instrumental support (Clark et al., 2023; Habhab, 2016; Jankowski et al., 2023; Lee, 2012; Lee et al., 2015; Misra et al., 2020; Mohsin et al., 2024; Moore et al., 2024; Myers & Ziv, 2016; Pahwa et al., 2018; Saunders et al., 2023; Tuffour et al., 2019; Virdee et al., 2017; Wang & Henning, 2012; Whitley, 2012; Whitley, 2016). However, 11 studies discussed how distant family relationships presented as an obstacle towards personal recovery (Habhab, 2016; Lee, 2012; Lee et al., 2015; Misra et al., 2020; Mohsin et al., 2024; Pahwa et al., 2018; Saunders et al., 2023; Tuffour et al., 2019; Tuffour, 2020; Virdee et al., 2017; Whitley, 2012).

Family Connectedness

Participants highlighted the benefits of receiving care from their family. The presence of emotional support improved many participants' well-being.

> "My parents are my biggest support throughout all of it. They've known everything, and they've never said like the wrong things. They've always just been trying to help me…" [Saunders et al., 2023, p.343].

There was a clear emphasis on the value of instrumental support, which sometimes surpassed the presence of emotional support, which involved practical support to the participants such as financial help, goods, accommodation and transportation. However, culture seems to play a role,

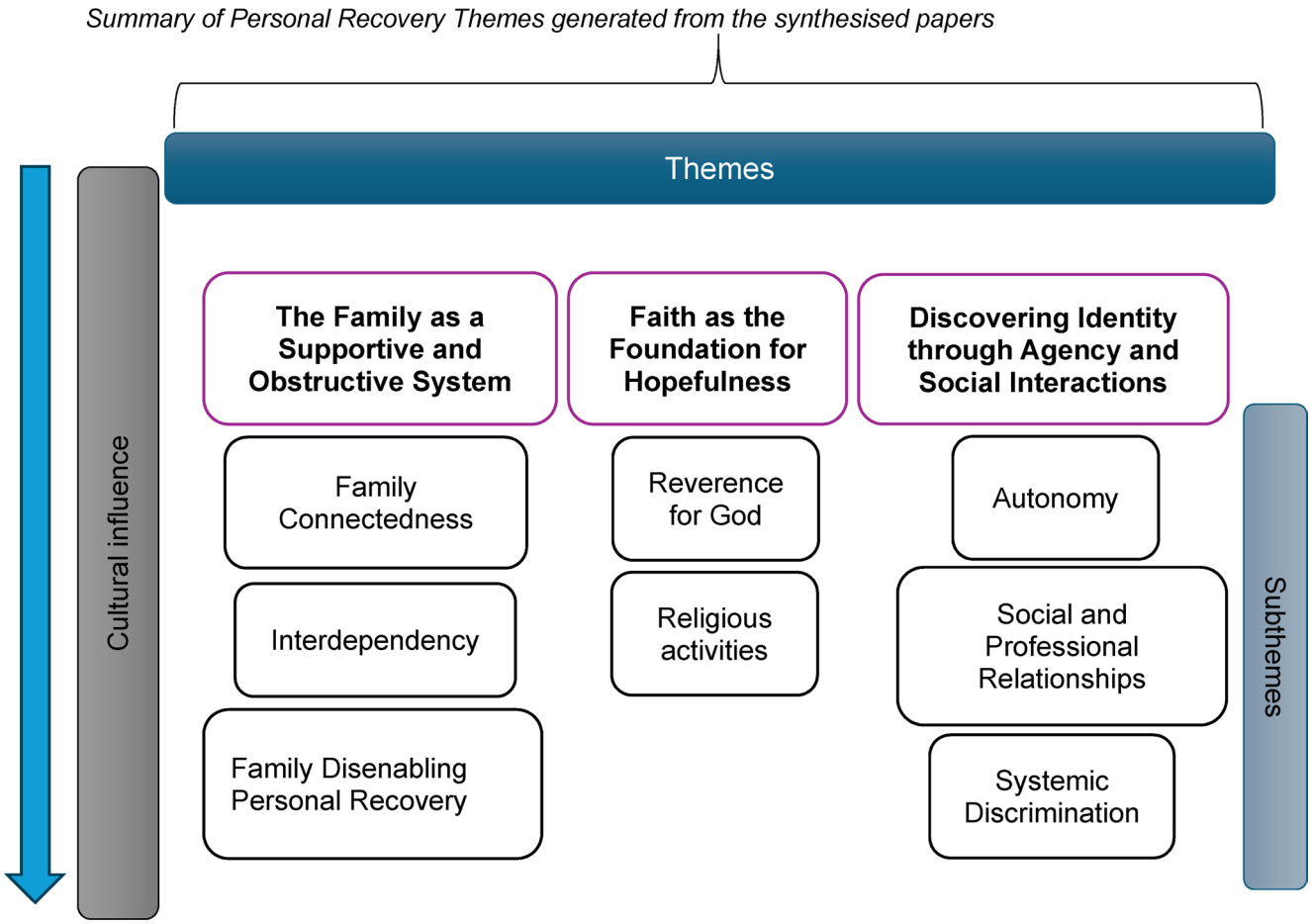

Fig. 2 Summary of Personal Recovery Themes generated from the synthesised papers

whereby families from some ethnic or country backgrounds hold a cultural responsibility to take care of each other. This is demonstrated here by an Asian American participant:

> "My mom helps me with that; she says, 'I'll pay you,'" and "They come and visit me at [the hospital], and they brought me money and goodies to relax me." [Lee et al., 2015, p.274].

The participants valued the support they received from their family, making them feel less isolated and more connected throughout their personal recovery journey.

Interdependency

Whilst reliance on family was imperative for personal recovery, several studies highlighted reciprocal roles within the family unit and how participants found this valuable [Armour et al., 2009; Clark et al., 2023; Habhab, 2016; Lee, 2012; Pahwa et al., 2018). Cultural traditions, such as responsibility for taking care of elders, was viewed as positive and helped with personal recovery. For example, an Asian American participant reflected on their perspective of cultural values within the family:

> When people grow old, like, parents….you can't just put them in a, like um, a hospital, nothing like that in our country. It's a duty or, it's, um, responsibility to take care of parents when they get old. It's like, mostly it's like a heart thing, conviction. [Lee, 2012, p.63]

Interdependency appeared to provide a mutual benefit between them and their family members. This included offering practical and social support to their families, which only enhanced their ability to see beyond their illness and find purpose in their life. In turn, this helped build stronger bonds between the family, increasing a sense of connectedness between the participant and family members.

Family Disenabling Personal Recovery

Sometimes family were perceived as a barrier to personal recovery. Ten studies discussed how a family's lack of understanding about the severity of SMI and subsequent limited family support, could make the process of personal recovery much harder [Habhab, 2016; Lee, 2012; Lee et al., 2015; Misra et al., 2020; Mohsin et al., 2024; Pahwa et al., 2018; Saunders et al., 2023; Tuffour et al., 2019; Tuffour, 2020; Virdee et al., 2017; Whitley, 2012). Cultural bias about mental health, influenced families' responses to participants, which often left participants feeling rejected and misunderstood by their family, leading to increased isolation. For example, a South Asian participant describes how their family responded to their illness:

> "My siblings [and] my parents know [about my mental condition]…All my family members knew that I have this disease…But they were not cooperative. Not encouraging people." [Mohsin et al., 2024, p.6].

Some participants were neglected by their family and left to manage their health on their own, again creating an isolating experience. Furthermore, some studies discussed the significance of family expectation and the negative consequences of this. For example, a South Asian participant discussed how she was struggling with her mental health, but she was pressured to comply with the expected role of a woman in her culture:

> "… I did all the cooking and cleaning of the house when I lived with my family… I had no support… They just accused, accused, accused." [Virdee et al., 2017, p.154].

Similarly, several studies highlighted perceived stigma around SMI from family members. For example, an Anglo-Caribbean woman described how her daughter distanced herself and kept contact to a minimum:

> "My daughter views mental illness as something she should keep away from and avoid… She is ashamed… so when she sees me, she will see me in places that are very, very remote places…" [Whitley, 2016, p.344].

In contrast, other studies discussed how stigma around SMI was ingrained within some cultures, which could drive self-stigma. For example, a Hispanic participant shared how the cultural beliefs in her family prevented her from seeking help:

> "…Cause in Hispanic families that is just not… believable. Like, no one is really mentally ill, or anorexia doesn't really exist when you're Latina. I didn't seek treatment…" [Saunders et al., 2023, p.342].

Faith as the Foundation for Hopefulness

Thirteen studies discussed how participants connecting with their faith and religion facilitated their personal recovery (Armour et al., 2009; Habhab, 2016; Lawrence et al., 2021; Lee, 2012; Mohsin et al., 2024; Moore et al., 2024; Pahwa et al., 2018; Tuffour et al., 2019; Tuffour, 2020; Virdee et al., 2017; Whitley, 2011, 2012, 2016).

Reverence for God

Across the studies, two religions: Christianity and Islam were reported by participants. Consistently, participants reflected on their relationship with a higher power, and this was exampled through the act of prayers and worship. Through these actions, participants felt a sense of healing, support and hope regarding their illness. This was demonstrated by an African American participant expressing their love for God:

> "… You know. I can talk to God. I can pray, and can feel so comforted. You know, and I calm down. But, I have to pray. I pray and cry…" [Whitley, 2012, pp. 93–94].

In contrast, some participants described it as a spiritual experience that assisted with their recovery, rather than referring to a specific God:

> "For me it was a spiritual journey, it was a massive spiritual journey" (Paula, Black Caribbean). [Lawrence et al., 2021, p.6].

Religious Activities

Several studies discussed how the presence of God was palpable by attending places of worship. Through fellowship with other believers, participants received prayers from others, which signified a form of encouragement and connectedness through the recovery process. For example, a Black African participant reflected on their relationship with the church congregation:

> "…I received a lot of support from others…The church people came to pray for me…" [Tuffour, 2020, p.356].

Evidently, belief in a God was highly regarded amongst participants as a method of restoring hope and connection.

Discovering Identity through Agency and Social Interactions

Almost all the studies discussed the importance of achieving agency and building social connections as a process in personal recovery (Armour et al., 2009; Clark et al., 2023; Habhab, 2016; Jankowski et al., 2023; Lawrence et al., 2021; Lee, 2012; Lee et al., 2015; Misra et al., 2020; Mohsin et al., 2024; Moore et al., 2024; Myers & Ziv, 2016; Pahwa et al., 2018; Saunders et al., 2023; Tuffour et al., 2019; Virdee et al., 2017; Whitley, 2011; Whitley, 2012; Whitley, 2016). However, disempowerment, social exclusion and discrimination experienced by ethnic minority people particularly in the Global North context, impeded personal recovery (Armour et al., 2009; Lee, 2012; Moore et al., 2024; Myers & Ziv, 2016; Tuffour et al., 2019; Virdee et al., 2017; Whitley, 2016).

Autonomy

Having choice was important to the participants. Several of the studies perceived clinical symptom management as an integral part of achieving personal recovery. Symptom management was described as adherence to medication, as well as developing strategies to cope with their illness. For example, an African American participant explained a technique they use, when they recognise the onset of their illness:

> "If I feel depression coming on, I'll start thinking very positive things and I'll just keep saying it over and over in my mind until it really sinks in." [Armour et al., 2009, p.609].

Learning how to manage their mental illness symptoms provided freedom, but it also reflected a sense of resilience. Across fourteen studies participants reported a sense of enduring adversity, but felt their perseverance and self-determination supported their recovery (Armour et al., 2009; Clark et al., 2023; Habhab, 2016; Jankowski et al., 2023; Lee, 2012; Moore et al., 2024; Myers & Ziv, 2016; Lawrence et al., 2021;Saunders et al., 2023; Tuffour et al., 2019; Virdee et al., 2017; Whitley, 2011; Whitley, 2012; Whitley, 2016). Some participants tried to view their SMI as empowering rather than impeding on their life. For example, a young Black person, described how an alternative perspective about their illness, changed their life:

> "Once I realized that I have an illness but I'm not the illness…things started getting better" [Jankowski et al., 2023, p.5].

This redirected their attention to begin developing a sense of identity.

Social and Professional Relationships

Developing connections with peers, the wider community, and healthcare professionals was crucial for many participants. For example, an Arab American summarised the benefits of attending a clubhouse, which enabled them to build supportive networks with other people with SMI:

> "I feel like my condition has become much better since attending the clubhouse –the changes have been positive" [Habhab, 2016, p.56].

Contrastingly, some participants sought to build connections with people who did not have a mental illness to support with social reintegration:

> "So like I'm trying to make friends that are like more, like normal, and where I can learn from them." [Lee, 2012, p.62].

Here the participant was striving to integrate themselves back into society by associating themselves with people external to their mental health community. They perceived this opportunity to cultivate an identity external to their SMI. This was further evidenced by a Black African participant who found value in not discussing his mental illness in his voluntary football role:

> "…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." [Tuffour et al., 2019, pp.108–109].

Similarly, there was a desire from the participants to give back to the SMI community, by volunteering to support other service users. A Native American/Cuban women described the positive elements of her peer supporter role:

> "I share, I listen, which is key for me, and I uh, I give back, I give back, just being who I am." [Pahwa et al., 2018, p.1317].

Many participants described having empathy for others with SMI and felt that their purpose in life was to help them in whatever capacity they could.

There were diverse perspectives regarding relationships with healthcare professionals. Several studies discussed the invaluable support participants received from healthcare services and professionals (Armour et al., 2009; Clark et al., 2023; Habhab, 2016; Jankowski et al., 2023; Lawrence et al., 2021; Pahwa et al., 2018; Virdee et al., 2017; Whitley, 2011, 2016). In one example an African American participant expressed their appreciation for their care coordinator which provided a sense of hope and connection:

> "[She] wanted the change. She wanted to see you get better and her support and her being there.. She never forgot my birthday." [Pahwa et al., 2018, p.1317].

However, several studies found contradictory experiences with healthcare professionals (Armour et al., 2009; Lawrence et al., 2021; Lee, 2012; Moore et al., 2024; Myers & Ziv, 2016; Tuffour et al., 2019; Virdee et al., 2017; Whitley, 2016). Some participants felt that healthcare professionals solely focusing on clinical recovery, undervalued the importance of personal recovery. For example, a Black Caribbean participant described being disappointed by the psychiatrist's lack of curiosity regarding her background and identity:

> One of the things I need to do which is one of the things the psychiatrist never actually clocked on to, which is quite bizarre, is that I'm adopted, so that is like a very large segment of my life. [Lawrence et al., 2021, p.6]

There was a noticeable lack of cultural sensitivity reported by ethnic minority groups from professionals from other ethnicities, which made it harder to build rapport and be vulnerable. For example, a participant shared the exhaustion they experienced whilst searching for a suitable therapist:

> "…the way that I dealt with it was finding a therapist that had the same cultural background, but that is not at all easy to find…" [Moore et al., 2024, p.8].

Systemic Discrimination

Systemic discrimination and stigma in relation to socioeconomic barriers (e.g., housing, employment, finances) were expressed as barriers to social connectedness, hope and impacted ethnic identity (Armour et al., 2009; Lee, 2012; Moore et al., 2024; Virdee et al., 2017; Whitley, 2016). For example, an Anglo-Caribbean participant described their perspective on the absence of finances in the Black community:

> "There ain't no black person from the Caribbean who has money here. With money you would get shit done!…" [Whitley, 2016, p.344].

Illustrating a widely-held belief across participants that because of their ethnicity they do not experience equal access to financial resources. Feelings of disempowerment and hopelessness were also amplified when participants associated their SMI with no future prospects. Participants felt that their SMI diagnosis limited them, and they were often viewed by society and systems as incapable. An account from a Black participant highlighted how they were often judged because of their illness:

> "…I was not included within what was going down in family court. To me I didn't' have a voice. I was seen immediately as incompetent because I had a mental illness." [Myers & Ziv, 2016, p.1318).

Discussion

Overall, our findings complement personal recovery outcomes associated with the CHIME framework of personal recovery (Leamy et al., 2011). Family involvement, including emotional and instrumental support, provided social connections and mitigated feelings of loneliness. This finding supports previous reports that have qualitatively explored the role family plays in assisting personal recovery (Aldersey & Whitley, 2015; Piat et al., 2011; Waller et al., 2019). In addition to this, mutual reciprocity was valued within the family system, meaning ethnic minority people felt a sense of empowerment when they were able to help their family. Whilst this finding highlights the importance of interdependency in contributing to positive personal recovery outcomes for ethnic minority people with SMI (Pernice-Duca, 2010), there is little existing research that addresses the significance of ethnocultural influences and traditions that may have encouraged reciprocity (Hickey et al., 2019), which was a key driving factor found in the studies included in this review.

Such ethnocultural influences may derive from collectivistic ways of thinking (Yousaf et al., 2022). This is the cultural idea that interdependency is more favourable and more of a valued societal norm than individuality and independence (Mazzula, 2011). Other family-related findings from this review, likely associated with shared cultural attitudes, include shame and stigma towards SMI (Eylem et al., 2020; NHS England, 2024), which made the ethnic minority people feel rejected and socially isolated (Aldersey & Whitley, 2015). This consequently hindered their personal recovery. Whilst this cultural orientation could explain these findings, there seems to be variability in how collectivism is expressed across and within generations, as second- and third-generation immigrants appear to be assimilating to individualistic characteristics whilst living in Western contexts (Schwartz et al., 2013). A common byproduct of assimilation may include experiences of acculturative stress. This is the negative impact on mental health when adjusting to a new country and culture (Kirbride et al., 2024). Experiences of acculturative stress have the potential to inhibit ethnic identity (Aggarwal & Smith, 2024; Torres et al., 2025), but, surprisingly, this theme did not emerge from the papers included within this review.

Faith and engaging in fellowship with other believers provided reassurance, hope and connectedness. These findings replicate outcomes from previous systematic reviews (Ibrahim & Whitley, 2021; NHS England, 2024; Sawab et al., 2024), that specifically identified positive faith-based experiences facilitating personal recovery. One interesting finding highlighted by Whitley (2016), was that faith-based activities were an important process for ethnic minority people in achieving personal recovery. Similar reports have suggested ethnic minority people rely on their faith as it promotes resilience through challenges and offers connections with others, hence it generates a sense of belonging and shape's ethnic identity (Nguyen, 2020).

The findings from the review also suggest that when ethnic minority people with SMI focus on developing attributes such as self-determination and stigma resistance, it facilitates empowerment and courage to express individual identity (Dubreucq et al., 2022), a similar finding across the broader personal recovery literature (Chan & Tsui, 2025; Thomas et al., 2019). Such attitude modifications led to an alternative outlook towards life and promoted autonomy and goal-directed behaviours, such as pursuing personal hobbies which further increased social connections (Linde et al.,2022). However, whilst stigma towards SMI appears to be a universal problem (Whitley, 2016), ethnic minority people are faced with the intersectional complexities such as systemic discrimination, socioeconomic status and ethnicity that further promote social injustices within the context of healthcare systems (Holman et al., 2021; Karadzhov, 2023). Empirical evidence from recovery-orientated approaches that are community-based such as peer support, individual work placements, supported accommodation and wellness activities has been found to be effective at reducing stigma, creating purpose and strengthening personal identity (Mousavizadeh & Jandaghian Bidgoli, 2023; Slade et al., 2014). It is possible that implementing such interventions into clinical practice may close the gap in health disparities experienced by ethnic minority people with SMI. However, it is the role of healthcare professionals to develop recovery-orientated attitudes to help facilitate this (Green et al., 2008), otherwise the consequences could lead to poorer recovery outcomes (Moore et al., 2022).

Clinical Implications and Future Research

Our findings highlight the need to integrate and adapt personal recovery approaches into clinical practice for ethnic minority groups with SMI. Specifically, focusing on cultural aspects that hinder personal recovery will be crucial, so their experiences can be validated. To address the variability in familial support, it will be imperative to provide psychoeducation to families and ethnic minority communities to help unlearn and challenge potential biases towards SMI, in the hopes it would reduce social stigma and discrimination (Aldersey & Whitley, 2015; Ong et al., 2021). Additionally, it was noted within the review that healthcare professionals will need to develop greater cultural competence by increasing their awareness and sensitivity to cultural elements that contribute positively to personal recovery processes, such as fostering a sense of ethnic identity. This is crucial, given the structural injustices

prevalent within mental health care, which may generate barriers to culturally responsive care and prevent personal recovery, reflecting wider systems of structural violence that disproportionately impact marginalised populations (Farmer et al., 2006). Finally, given the focus on faith and religion facilitating social connectedness and hope in personal recovery for ethnic minority people, future research may focus on the integration of faith-based approaches or interventions both in the community and clinical settings.

Strengths and Limitations

One noticeable strength of the review is that it included multiple studies that provided consistent findings, enhancing its reliability and transferability to ethnic minority populations situated within Western contexts. Additionally, it showcased the voices from various ethnic minority groups with SMI. One limitation would be that the review did not seek to highlight the nuances in experiences and identity between and within the different ethnic groups. The drawback of this is that ethnic minority groups may be viewed as homogenous, rather than considering the cultural and ethnic identity-based differences that influence personal recovery outcomes (Rotenberg, 2019). Furthermore, within this review, the term *severe mental illness* was defined using the UK National Health Service (NHS) criteria; however, there is no universally agreed definition for SMI and many studies included in the review were conducted outside the UK, particularly the USA and Canada, where definitions of SMI operationally differ (Zumstein & Riese, 2020). This discrepancy could limit the review's clinical comparability and transferability to other Western countries, where the severity of mental illness is conceptually determined by whether it generates significant functional impairment, rather than being diagnostic-dependent (National Institute of Mental Health [NIMH], 2024). Finally, there was a large age range among the participants included in the studies, and it is unclear whether perceptions and experiences of personal recovery vary across the lifespan and across intersecting identities such as gender and sex.

Conclusion

This systematic review synthesised a variety of perceptions and experiences from ethnic minority people with SMI, which offered an understanding of what health inequities need to be addressed or considered by healthcare professionals, in order to reduce the disparities in personal recovery outcomes. It is recommended for researchers interested in personal recovery to continue investigating strategies to improve mental health outcomes in the ethnic minority population.

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Data Availability The systematic review analysed and synthesised previously published data. The studies were the data was extracted from are cited throughout the text and are referenced at the end of the systematic review.

Declarations

Competing interests The authors declare no competing interests.

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