Introduction

Arabic culture in the Gulf region (i.e., Qatar, Kuwait, Saudi Arabia, Bahrain, Oman) is characterized by traditional values and beliefs. Islam guides nearly every aspect of life for the majority Muslim population. At the same time, development and globalization in the Gulf region is occurring at such a rapid pace that traditional values are under threat (Teller, 2014). This situation sometimes creates a tension between various stakeholders regarding what is understood to be good practice (Al-Subaiey, 2010).

One example where the potential for tension exists can be found in the concept of personal recovery in mental illness. During the last three decades the concept of personal recovery in mental illness has become generally understood as an ongoing process that emphasizes hope, identity, meaning and personal responsibility. However, this understanding has been developed primarily in Western countries, and it is likely that it has inherent Western values that may not be appropriate in non-Western settings.

This is important because non-Western countries have begun to incorporate recovery concepts into mental health service planning and development (See, for example Supreme Council of Health, 2013). However, very little research exists to inform our understanding of what recovery looks like in an Arabic context. This article debates and critiques the concept of personal recovery using an Arabic contextual lens and argues that recovery concepts should not be transplanted into non-Western contexts without careful contextual adaptation and evaluation.

Background

Clinical recovery from mental illness refers to a return to normal function after an illness (Davidson *et al.*, 2005). However, while full recovery is possible in many cases, there are those whose symptoms will persist throughout their lives (Chapman & Horne, 2013; Lacro *et al.*, 2002; McEvoy *et al.*, 2006). Thus, a goal of clinical recovery is neither adequate nor appropriate for many people with a diagnosis of mental illness (Slade, 2009).

Pioneering accounts from service users in English-speaking countries have resulted in an alternate conception of recovery in mental illness, that of *personal recovery* (Deegan, 1988; Houghton, 1982; Leete, 1987; Lovejoy, 1982; Unzicker, 1989). These accounts describe the ongoing impact of mental illness outside of the hospital setting and share insights on how to overcome or mitigate day-to-day challenges.

During the last three decades personal recovery has become generally understood as an ongoing process that emphasizes hope, identity, meaning and personal responsibility (Andresen *et al.*, 2003; Ralph *et al.*, 2002; Spaniol *et al.*, 2002). The goal of personal recovery is for the individual to learn to live well within the limitations of symptoms, rather than trying to eliminate the symptoms (Anthony, 1993). However, despite a general consensus on the potential value of a recovery approach to services, considerable debate exists as to the nature and universality of the concept of personal recovery.

In the following sections, we discuss definitions of personal recovery, examine selected Western and non-Western recovery models, and debate the potential fit of recovery-oriented services in a traditional Arabic context.

It should be noted that the evidence available to support our discussion is generally low level and based mainly on authors' descriptions and opinions of recovery. Moreover, since the authors are Western health professionals, the viewpoint on Arabic culture is from an outsider looking in (Merton, 1972).

Empirical concepts and models of personal recovery

Anthony (1993) developed one of the first models of personal recovery in mental illness. He based this model on a recovery vision: "any person with severe mental illness can grow beyond the limits imposed by his or her illness" (Anthony, 1993, p. 9). At that time, Anthony (1993) suggested a potential framework, but also put forward a call to develop empirically based models of personal recovery.

This call has been taken up by many in the field, resulting in the development of numerous concepts, models, and frameworks over the ensuing decades. Some of these are outlined in the following paragraphs. We do not attempt a comprehensive review of recovery models. This information can be found elsewhere (Leamy *et al.*, 2011; see Slade *et al.*, 2012). Instead we will discuss select exemplars to highlight the similarities and differences between the models as well as the strengths and weaknesses across the models.

Western models. Jacobson and Greenley (2001) describe a conceptual model of recovery from the United States. The main concepts, decided upon in consultation with a diverse stakeholder group, include: hope, healing, empowerment and connections. These concepts were drawn from "an analysis of numerous accounts…" (Jacobson & Greenley, 2001, p. 482). However, the reader is given no further information about these accounts. Thus, it is difficult to make judgements about for whom this model might fit.

Repper and Perkins (2003) describe six concepts of personal recovery. They also recognize the hazards in promoting a universal model, which would ultimately set many people up for failure (Deegan, 1988). The concepts include: restoring hope; the importance of relationships; spirituality, philosophy, understanding; taking back control; coping with loss; and, the quest for meaning and value. Instead of recovery from illness, Repper and Perkins emphasize the recovery of a meaningful and valuable life.

Andresen, Oades and Caputi (2003) developed a set of concepts based on a literature review of 50 articles containing the personal narratives of people with schizophrenia. The concepts include: finding hope, re-establishment of identity, finding meaning in life, and taking responsibility for recovery. While the model's simplicity is helpful for guiding professional care, it also suggests that the process itself should be simple (Larson, 1999). However, recovery is a complex process that is different for everyone and not easy to achieve (Drake & Whitley, 2014).

Slade (2009) offers a personal recovery *framework*, which confusingly, is based on a slightly modified version of Andresen et al.'s (2003) model. The concepts that form the

foundation of his recovery framework are hope, identity, meaning, and personal responsibility. These have been modified from Andresen et al.'s (2003) original model based on a report published by the National Institute for Mental Health in England (National Institute for Mental Health in England, 2004). However, they remain so similar to those identified by Andresen that it creates a question about the generalizability of Slade's (2009) framework to service users with a diagnosis other than schizophrenia.

One of the main limitations of our current knowledge is that recovery models are based on a relatively uniform population, mainly Western Anglophones. Even within Anglophone populations, differences in personal recovery are emerging: Australian models tend to emphasize personal strengths, models from the UK and USA emphasize community integration and participation, and the importance placed on meaning in life is higher in Canada and the UK (Slade *et al.*, 2012).

If differences exist in these relatively similar Anglophone populations, what should be expected in contexts that are socially and culturally dissimilar? A small body of literature that documents recovery in diverse populations has emerged in recent years. We will now turn to this body of work to examine the fit of the recovery model from a more diverse perspective.

Non-Western models. Song and Shih (2009) examined the factors and processes associated with recovery in a sample of 15 Taiwanese participants with a diagnosis of mental illness. The authors identify three cornerstones for recovery. First is 'symptom remission or gaining control'. This first component is somewhat in contrast to Western

models. For example, Taiwanese participants discuss being 'cured' and the importance of medication in this process. In the West, medications are acknowledged as being important for many but they are more often viewed as a necessary evil rather than as a foundation (Slade, 2009).

Self-reliance, hardiness and resilience is the second foundation identified by Song and Shih (2009). Taiwanese participants often referred to having the courage to face challenges and never giving up. This foundation aligns well with the concept of hope from Western models.

The third foundation was family support, which provided both motivation and a sense of duty to overcome the challenges imposed by mental illness (Song & Shih, 2009).

Sung et al. (2006) investigated recovery among eight Korean university students with a diagnosis of schizophrenia. Similar to some Western models, successful social engagement was a key factor in for recovery. However, it seems that social engagement in this Korean sample is not so much about being successfully engaged in meaningful activity and relationships, as it is about the quality of relationships with others and how high quality relationships provide a sense of inclusion.

A final, hybrid example is a narrative study conducted in New Zealand of 20 Maori (indigenous) and 20 non-Maori individuals with a diagnosis of mental illness (Lapsley *et al.*, 2002). While non-Maori participants would be considered 'Western', the Maori people are an indigenous population with unique culture, language and customs (New Zealand

Ministry for Culture and Heritage, n.d.). The authors of this study identified several aspects of Maori's recovery experiences that differed from their Western counterparts.

First, the extended family played a major supportive role for Maori's with mental illness. Second, Maori's cultural interpretations influenced how they perceived the cause of current signs and symptoms, and also whether or not a psychiatric diagnosis was accepted. Finally, the majority of Maori participants reported using traditional healing practices.

Recovery-oriented mental health services

Despite the confusion, debate, and potential risks, Anthony's (1993) original vision remains strong, and in fact, it is been increasingly incorporated into international practices and policies (Gagne *et al.*, 2007). However, it is often unclear how these services should be organized. This is likely due to the lack of evidence available to support recovery-oriented services.

To our knowledge, only one experimental study has examined the effectiveness of a recovery-approach. Slade et al. (2015) conducted a cluster, randomized, controlled trial to evaluate the effectiveness of a standard care plus a recovery-oriented intervention versus standard care alone. Findings indicated that there was no difference between the control and experimental groups on a primary outcome measure (Questionnaire about the Process of Recovery). Lack of significant findings in this study markedly contrast with the rising popularity of recovery-oriented services over the past 20 years.

At least one Arabic country has begun to incorporate concepts of personal recovery into service development. Qatar's National Mental Health Strategy outlines a vison for the redevelopment of services based on people's potential to lead meaningful lives despite their illness (Supreme Council of Health, 2013). It does not rely solely on recovery as a model but does incorporate several key concepts. The report also acknowledges that the lack of local knowledge creates a barrier to efficient service development. The following sections outline several contextual factors in Arabic countries that may be incongruent with Western concepts of personal recovery.

Autonomy vs. community. Islamic ethical principles highlight the importance of the collective over the individual. For example, benefit to society can supersede autonomy in Arabic countries (Abdur Rab *et al.*, 2008; Fadel, 2010). The guiding ethical principles of Islam place the community before the individual in order of importance. One could hypothesize from this position that recovery-oriented services in an Arabic society might emphasize the long term needs of the community as well as, or even ahead of, the individual.

Similarly, group membership is valued above individualism in traditional Arabic countries, such as Saudi Arabia, Kuwait and the United Arab Emirates (Hofstede, 2001; Hofstede *et al.*, 2010). In these collectivist countries, groups (e.g., the extended family) assume caregiving responsibility in return for loyalty. While many Western recovery models do emphasize the importance of social connections and support, the individual is seen to have primary responsibility for their recovery (Deegan, 1988; Mind, 2008).

Emphasizing individual responsibility alone would not be appropriate in a collectivist society.

However, limited evidence suggests that group membership in Gulf countries can be both a source of support and tension. Extended families can facilitate social contact, improved treatment outcomes, and better coping (Bilal *et al.*, 1987; El-Islam, 1982). Conversely, tension in the extended family has also been cited as a precipitating factor for substance abuse, attempted suicide and increased disease severity (Al-Nahedh, 1999; Suleiman *et al.*, 1986; Zahid & Ohaeri, 2010). Additionally, anecdotal evidence suggests that family members are often reluctant to participate in the care of a relative with mental illness. Any Arabic recovery model must take this complex social support mechanism into account. However, there is limited evidence available to guide service development in this area.

Doctor-patient relationship. The doctor-patient relationship is another area where a recovery model may not fit well with mental health services in Arabic countries. Within a recovery model, professional expertise is seen a resource that may or may not be used, or helpful to, all patients. Patients decide what is helpful and what is not and are considered experts by experience. Rahsad (2004) describes a health care system in Egypt where the doctor is the authority and the patient does, or is supposed to do, what the doctor instructs. While Rashad (2004) seems somewhat critical of the system, El-Islam (2008) suggests that Arabic patients prefer an authoritative approach. He describes how patients want their psychiatrists to remove (i.e., cure) their illness, and will accept little personal

responsibility for their treatment. Rather, it is the Arabic family who often works with the psychiatrist to enable treatment (El-Islam, 2008). It is worth noting that paternalism is not unique to the Arabic health care system and has been well documented worldwide (Cody, 2003). However, there has been a slow shift in developed countries to a more collaborative approach over the past several decades (Nys, 2008).

Supernatural beliefs. The majority of Arabic people believe that many mental illnesses occur as the result of *jinn* (demons), black magic and the evil eye (Al-Solaim & Loewenthal, 2011; Salem *et al.*, 2009). Like indigenous new Zealanders (Lapsley *et al.*, 2002), this belief system influences treatment seeking practices of people with psychiatric symptomology. Many Arabs first seek treatment from a traditional (faith) healer prior to seeking psychiatric care (Al Sughayir, 2005; Al-Subaie, 1994). Those who do seek psychiatric treatment often continue to see the faith healer while concurrently receiving psychiatric treatment. Health professionals with a Western orientation to psychiatric treatment might try to convince these service users that supernatural attribution is incorrect and that the actual causative factors relate to brain chemistry. This biomedical understanding may be helpful for some, but for others, it is an instance where tension between Western and non-Western beliefs can be created. This tension also creates potential for a collaboration or partnership between biomedical and traditional healing that is rarely seen. Regardless of the 'real' reason underlying someone's mental illness, recovery oriented services should acknowledge and explore this traditional belief system and discuss experiences/preferences for non-medical treatment (Ae-Ngibise *et al.*, 2010).

Personal recovery in an Arabic context

Very little research has been conducted that could inform a model of personal recovery in an Arabic context, particularly in the Gulf region. Most recovery models in the West are underpinned by qualitative studies of service users' recovery experiences. The only comparable study from the Gulf region was conducted in Saudi Arabia with eight female service users with a diagnosis of obsessive compulsive disorder (Al-Solaim & Loewenthal, 2011). Participants in this study felt pride when they were able to be compliant with the teachings of Islam. The importance of religion is also suggested by other studies that demonstrate frequent use of traditional (religious) healers in the Gulf region (Al-Faraj & Al-Ansari, 2002; Al-Subaie, 1994; Salem *et al.*, 2009). One study in particular demonstrated that the people who access traditional healers may be receive spiritual, rather than clinical, benefits from these treatments (Al-Subaie, 1994).

Given the importance of religion and traditional healers, it stands to reason that a recovery-oriented mental health service in the Gulf region should consider non-medical understanding of mental illness and actively explore these beliefs with service users. We acknowledge that it may sometimes be difficult to reconcile medical and non-medical beliefs about mental illness; however, recovery for many in the Gulf region may rely on non-medical interpretations of their experience. Additionally, increased coordination between medical services and traditional healing may provide a more holistic approach to recovery in Arabic countries. This collaboration could simultaneously address clinical recovery and also offer service users the opportunity to (re)connect with, and draw

strength from, their faith. Admittedly, they are certain risks associated with traditional healing practices (World Health Organization, 2013). However, formal collaboration between traditional healers and mental health services would make it easier to regulate these practices and prevent potentially harmful outcomes.

In addition to the importance of faith in personal recovery, Al Solaim and Loewenthal (2011) also found that participants were able to cope more effectively with stressors when they had strong family and social networks. This finding mirrors all three non-Western recovery studies described above. However, there is little understanding of how mental health services in Arabic countries can support these networks.

If we look to the international literature on family and social connectedness, we find that this is primarily seen as an individual responsibility (Tew *et al.*, 2011). In this regard, services aim to support the service user to make positive connections. However, another approach, which moves away from individual responsibility, is for services to work with families and communities with the aim of fostering connections and mobilizing resources (White, 2009). It seems likely that both approaches (i.e., individual and social) are important in an Arabic context. Unfortunately, it is not clear how mental health workers should best engage in work with families and communities. Research in the area shows that educating families does not seem to be adequate; mental health workers also need to provide training on coping and stress management (Macleod *et al.*, 2011). In terms of social connectedness, working with communities seems to have received less attention than working with families. This may be because community engagement is

sometimes outside of the scope of practice for some health care professionals (Thornicroft *et al.*, 2010). However, one area that shows promise is facilitating the development of supportive communities where service users are experts by expertise. For example, mental health professionals have provided training for service users to act as peer support workers, service development consultants, and advisors on research projects (Simpson *et al.*, 2013; Tew *et al.*, 2011). This creates a role in healthcare and research communities for service users to make a valuable contribution.

In Arabic countries, it may be helpful to examine the scope of practice for mental health service providers and consider including working with families and communities as a part of these roles, if it is not already included. Importantly, staff members should be provided with training on how to teach coping and stress management to families. Community engagement initiatives that locate responsibility with the community and not the individual service user should be piloted and evaluated. Additionally, creating opportunities in certain community groups for service users to contribute as experts by expertise has promise. This work will be challenging due to stigma, lack of resources, and a myriad of other factors. However, increasing the capacity of families and communities to provide support for service users seems to fit well within the context of collectivist society. Additional qualitative studies in the region would help to clarify the main aspects of recovery in an Arabic context.

Summary

It is widely accepted that personal recovery is an individual process and that what works for one person may not work for someone else. Because of this, we caution that one size does not fit all. The fact that recovery-oriented services are being increasingly implemented worldwide does not necessarily mean that the practice is appropriate or effective. Personal recovery is an easy 'sell' because the concepts are straightforward, responsibility is partially shifted to the service user, and a focus on the positive can be reassuring. From the many service user narratives and descriptive research articles that have been published, we know that recovery undoubtedly *happens* for many people. However, there is very limited evidence to support the development of recovery oriented services in contexts where recovery has not been studied. Additionally, current conceptualizations of personal recovery may not even be transferrable to non-Western contexts. Perhaps more importantly, an uncritical incorporation of a Western-biased recovery model into non-Western mental health services may lead to the imposition of inappropriate values on people receiving treatment (Cross *et al.*, 2000). This means that recovery concepts need to be modified to incorporate the values, customs and beliefs of service users in non-Western contexts. These modifications then need to be carefully evaluated. Continued research into the strategies that people use to manage their illness, as well as what services can do to support this self-management, is needed in a range of sociocultural contexts. This will help to identify culturally appropriate ways to improve services and contribute to the global discussion on personal recovery in mental illness.

Competing Interests

The authors declare that they have no competing interests.

Authors' Contributions

All authors made substantial contributions to the conception and design of this article. XX was responsible for the literature review and manuscript preparation. XX and XX were responsible for critically review and revision of the manuscript. All authors read and reviewed the final manuscript.

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