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ORIGINAL ARTICLE

Mental health recovery in a collectivist society: Saudi consumers, carers and nurses' shared perspectives

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Abstract

In 2019, the World Health Organization urged a global shift towards recovery-focused practices in mental health care. In Western nations, this transition often prioritised individualism over collectivism. In contrast, collectivist societies prioritise recovery through community and social support. This study explored mental health recovery from the perspectives of consumers, carers and registered nurses in a mainly collectivist society (Saudi Arabia) using a qualitative exploratory descriptive design. Sixteen consumers, ten carers and eight registered nurses participated in online semi-structured interviews. Inductive thematic analysis was employed to analyse English-translated versions of the 34 interviews. Consolidated criteria for reporting qualitative studies 32-item checklist were used. The study found that recovery was perceived as a process of transforming towards living a meaningful life of goals and values supported by trusted people who share moments of comfort and empowerment. A unique finding was the 'bond of recovery' a collectivist value that aid consumers' community integration in society. Saudi consumers' experiences of recovery were similar to consumers' movement narratives of recovery. Future research should establish a recovery-focused educational program that incorporates our findings into a recovery-oriented approach. This will facilitate providing a collaborative care between consumers, carers and nurses that centres around consumers' recovery goals and values.

KEYWORDS

carers, consumers, culture, interviews, mental health, nurses, qualitative, recovery, Saudi Arabia, thematic analysis

INTRODUCTION

In 2019, the World Health Organisation emphasised a global shift towards consumer-driven recovery in mental health services. Consumers describe recovery as a transformative process of changing attitudes, values, and goals to live a hopeful, meaningful life in the community despite mental health challenges (Andresen et al., 2003; Anthony, 1993; Deegan, 1988). The 1980s marked the rise of the consumer/survivor movement, which challenged the traditional biomedical model of mental illness. This movement, advocating a recovery-oriented approach, emphasised social context, humanity, spirituality, and collectivism in enhancing community integration and quality of life (Anthony, 1993; Frese & Davis, 1997; Pinches, 2004). This approach values social support and community contribution (Tse & Ng, 2014).

Western mental healthcare services are increasingly adopting recovery-oriented approaches Bird, Leamy, et al., 2014; Department of Health, 2011; Hawsawi et al., 2021; The Irish Mental Health & Recovery Education Consortium, 2020). However, challenges remain, including increasing rates of mental

health conditions and questions about the effectiveness of these services (GBD 2019 Mental Disorders Collaborators, 2022; Lally et al., 2017). Services often struggle to fully embrace recovery-oriented approaches due to organisational pressures (Edwards et al., 2019; Woods et al., 2019; Yeo et al., 2022).

Non-Western collectivist societies value that cultural factors like spirituality, language, and social belonging as crucial in recovery. Spiritual beliefs and practices across various religions provide hope and comfort (Ibrahim et al., 2022; Suryani et al., 2022; Tuffour, 2020). Language barriers impact recovery, as seen in Chinese consumers in the United Kingdom (Tang, 2019a). Social belonging is vital, but stigmatising attitudes within communities can be detrimental (Saavedra et al., 2022; Tuffour et al., 2019).

Research on carers' perspectives is scarce, but suggests that they view recovery in terms of social improvement and independence (Yuen et al., 2019). Healthcare professionals often focus on clinical improvement (Alhamidi & Alyousef, 2020; Ibrahim et al., 2021; Kuek, Raeburn, Chow, & Wand, 2023). This study aims to explore the perspectives of mental health recovery among consumers, carers, and nurses in Saudi Arabia, a collectivist culture, to improve collaborative care and inform recovery approaches worldwide.

BACKGROUND

The Kingdom of Saudi Arabia (KSA) which is part of the Gulf Cooperation Council, includes six Arab countries: Qatar, Bahrain, Kuwait, Oman, and the United Arab Emirates. As collectivist societies, these countries share the Islamic religion, Arabic language, and cultural values, beliefs, and traditions following the Islamic law in every aspect of functional and social life of their communities (Dardas & Simmons, 2015; Hickey et al., 2017).

In KSA, the community's beliefs, values, and opinions about mental health conditions and recovery are heavily influenced by culture. Many believe that prayer and reading the Holy Qur'an are crucial for maintaining good mental health and treating mental health conditions (Koenig et al., 2014). However, some cultural traditions, norms and views can hinder recovery, such as stigmatising mental health conditions as a spiritual possession, evil eye or lack of faith (Alattar et al., 2021). Despite the efforts of the Saudi media to increase awareness about mental health conditions and recovery, mental health conditions are still perceived as spiritual possession by some parts of the community (McCrae et al., 2019). This concept is contrary to Islamic teachings, which do not attribute mental health conditions to evil spirits, as noted by Koenig et al. (2014).

In studies on Saudis' public opinion, Aljedaani (2019) and Alosaimi et al. (2019) found that most participants had positive attitudes towards individuals with mental health conditions. However, many viewed mental health issues as biological conditions that required a cure, and some were unwilling to accept individuals with mental health conditions as friends or partners.

Medicalised views of mental health can lead to stigma, burdening individuals with labels like "crazy" and pressuring them to use religious and medical cures (Noorwali et al., 2022; Sharif et al., 2020). There is evidence that even health care professionals exhibit stigmatising attitudes towards consumers (Alyousef, 2017). Stigma discourages consumers from seeking help, placing added emotional responsibility on carers (Noorwali et al., 2022; Sharif et al., 2020). To reduce stigma and improve recovery, a shift from medicalised views towards supporting consumers' recovery must occur (Chester et al., 2016). This shift involves understanding and exploring recovery perspectives within Saudi Arabia's collectivist culture, which remains unexamined.

Research aim

To explore mental health recovery from Saudi consumers, carers and nurses' perspectives in KSA.

METHODS

Methodology

This study used an exploratory descriptive qualitative design using semi-structured interviews for data collection followed by inductive thematic analysis to describe the lived experiences of participants (Hunter et al., 2019; Polit & Beck, 2021). The research was underpinned by a social constructivism theoretical framework (Creswell & Clark, 2017). The consolidated criteria for reporting qualitative studies' 32-item checklist guided the reporting of this study (Tong et al., 2007).

Reflexivity

The main researcher (Author 1) identified her personal attitudes, values and beliefs before commencing data collection and data analysis. Personal assumptions may prevent the researcher from seeing and probing familiar meanings and producing a pure description of participants' views rather than the researcher's biases (Berger, 2013; Giorgi, 1997). Regular meetings with the research team, pre and post interview reflections and reflective journals were used to acknowledge and bracket researcher assumptions.

Participants

Purposive and snowball samplings were used to recruit consumers, carers and registered nurses who met the inclusion criteria (see Table 1). Two trained researchers (Authors 3 and 4) recruited participants from waiting rooms in two public hospital outpatient clinics for mental health conditions and substance use. Potential participants were provided with hard copies of the study information sheet and informed consent. Interested participants completed informed consent prior and a date was arranged for the interview.

To recruit people with mental health conditions living in the community, potential participants were recruited from a university in the same region as the two public hospitals. An invitation was sent to faculty members and students through the university email system. Potential participants who contacted the researcher via university email were given an electronic version of the study information sheet. Potential participants contacted (Author 1) to arrange a time for the interview. Participants were asked to referred others via social media channels to participate in the study. The snowballing method of recruitment where participants invite others, increased the number of potential participants who may normally have been reticent to share their experiences with a stranger (Graor & Knapik, 2013).

Data collection

Data were collected through semi-structured interviews using open questions adapted from Bird, Le Boutillier, et al. (2014) (see Table 2). This method facilitated an in-depth and rich description of participants' lived experiences with less guidance and more probing and investigating by the researcher (Author 1; Galletta, 2013). Interviews were conducted by Author 1 online using Zoom between August 2021 and February 2022 (Zoom Video Communications, 2023). Interviews lasted between 30 and 90 min. Participants said the online interviews made them feel comfortable and safe talking about sensitive and difficult experiences in their homes, often with a supportive person nearby, without feeling judged or watched by an interviewer. This has been noted in previous research (Hämäläinen & Rautio, 2013; Mealer & Jones Rn, 2014).

At the beginning of each interview, (Author 1) explained the need to audio-record the conversation, read the study informed consent and asked participants if they had any questions regarding the study information sheet. Participants who agreed to proceed gave their verbal consent, which was recorded as part of the interview. Participants who were recruited via the hospitals' outpatient clinics signed hard copies of the informed consent forms. During the interview, (Author 1) established rapport, showing empathy and guiding the participants through discussion using the interview questions as prompts (DiCicco-Bloom & Crabtree, 2006; Galletta, 2013). Recruitment was terminated at data saturation point, which was defined as when no additional codes could be identified during preliminary data analysis (Braun & Clarke, 2021).

Ethical considerations

Ethical approvals were obtained from both hospitals and the university's ethics committee boards. Participants' privacy and confidentiality were maintained by deidentifying personal or potentially identifying information and ensuring anonymity in interviews' transcriptions and translated texts. Research-related documents and collected data were coded and stored according to the University's Research Data Management Policy. After each interview, participants were debriefed for any emotional distress.

Data analysis

Inductive thematic analysis was chosen for data analysis due to its alignment with the exploratory descriptive qualitative design (Hunter et al., 2019; Vaismoradi et al., 2013). The analysis was performed

TABLE 1 Inclusion and exclusion criteria.

Participants	Inclusion criteria	Exclusion criteria
Consumers Number = 16	Adults 18 years of age and older Saudi citizens Diagnosed with mental illness or identified as a consumer of the Saudi mental health care system	Children under the age of 18 years old Non-Saudi People with cognitive impairment illnesses, disruptive behaviour, or intellectual disabilities
Carers Number = 10	Adults 18 years of age and older Cares for an adult with mental illness who uses the Saudi mental health care system or has lived in Saudi Arabia for more than 5 years	Does not identify as the carer of an adult with mental illness Non-Saudi
Nurses Number = 8	Registered nurses Adults 18 years of age and older. Saudi citizen Providing care for adults with mental illness and working in the Saudi mental health care system	Non-Saudi registered nurses Nursing students Nursing academics Have never provided care to adults with mental illness

TABLE 2 Interviews guide questions.

Participants	Consumers	Carers	Nurses
Interview questions	What does recovery mean to you? What supports recovery?	What does the recovery of your loved ones mean to you? What support their recovery?	What does consumer recovery mean to you? What support their recovery?

on English-translated transcripts of interviews, with the translations from Arabic to English and back performed by Author 1 and a bilingual translator. Braun and Clarke's (2012) six-stage thematic analysis, which includes data familiarisation, code generation, searching for themes and subthemes, themes' review, themes' naming and identification, and report, was performed using NVIVO-12 (Braun & Clarke, 2012).

In the first phase, (Author 1) familiarised herself with the data through close reading and rereading during the process of transcription, translation, and back translation. This allowed for the identification of potential patterns, ideas, and meanings. Next, (Author 1) generated initial descriptive and interpretive codes that were validated by (Author 6) and (Author 5) during regular data discussion meetings. Constant comparison of codes ensured precision in allocating textual data to the code that best represented their meaning.

In identifying themes, charts and diagrams were used to capture relationships of similarities and differences between codes. The grouping and regrouping of these codes generated themes and subthemes that described patterns of meanings in the data. The allocated themes and subthemes were reviewed, validated, and named by (Author 1), (Author 2), (Author 5) and (Author 6). Final themes and subthemes across consumers, carers, and nurses' findings were compared and contrasted to produce the final findings report. All authors participated in producing the final findings report, describing stories and narratives of recovery.

Rigour of findings

In this study, the methodological rigour of trustworthiness was achieved by carefully considering criteria such as credibility, transferability, dependability, and objectivity in the research process (Thomas & Magilvy, 2011). To attain data credibility, data were triangulated from three different participant groups, and the authors engaged in peer review and debriefing. The transferability of findings was established through the use of a modified version of Bird, Leamy, et al. (2014) that investigated personal recovery and achieved data saturation. This maximised the potential for research findings to be relevant in other contexts (Saunders et al., 2018). The authors' collaboration, transparency, and accuracy in reporting the research process ensured dependability, allowing for study replication and evaluation by other researchers (Morse, 2015). Objectivity was maintained through the researchers' continuous self-reflection, which involved recording personal values, beliefs, and reactions to minimise potential bias in their interpretations of the data (Berger, 2013).

Findings

Participants' demographics

Thirty-four participants were included in this study: 16 consumers, 10 carers and eight nurses. All participants met the inclusion criteria (Table 3). All participants were Saudi citizens living in KSA except for one carer who had moved from another Arabic country 5 years previously. All participants identified Islam as their religion. Most consumers were female employees, married with children, and diagnosed with bipolar disorder. Their average age was 32 years. Carers were mostly female full-time employees and cared for one consumer with an average experience of 8 years of caring. This group's average age was 41 years old. Nurses were mainly female, with an average age of 33 years. All were registered nurses, most with a bachelor's degree in nursing and an average of 8 years working in mental health care.

Findings of thematic analysis

Four major themes emerged: What is recovery?, bond of recovery, constructing a meaningful life and recovery values as caring goals. The final themes contained seven subthemes which are described below (see Table 4).

Theme 1: What is recovery?

This theme describes consumers, carers and nurses' shared perspectives about mental health recovery. It encompasses the following subthemes: Process of transforming towards living well and recovery properties.

Subtheme 1: Process of transforming towards living well. Consumers described their subjective lived experience of recovery as a process of transforming: Changing, adopting, coping and coexisting in order to continue to live well within the community. Carers and nurses did not define recovery like consumers. Carers observed consumers' positive transforming and adapting behaviours that enabled them to live well within the community while nurses only observed outcomes of symptoms improvement during hospitalisation.

TABLE 3 Participants demographics.

Participants groups	Consumers	Carers	Nurses
Total number	16	10	8
Female	13	8	3
Male	3	2	5
Average age	32 years old	41 years old	33 years old
Student	5	1	0
Employee (full-time)	6	4	All
Employee and studying	2	0	0
Not employee or student	3	5	N/A
Highest qualification			
Diploma	N/A	N/A	3
Bachelor	N/A	N/A	5
Master	N/A	N/A	0
Average years of caring as a carer	N/A	7 years and 7 months	N/A
Years of nursing experience in mental health	N/A	N/A	8 years

Abbreviation: N/A, not applicable.

TABLE 4 Findings themes and subthemes.

Themes	Description	Subthemes	Descriptions
What is recovery	This theme described recovery as a process of transformation of certain properties	Process of transforming towards living well	Recovery was described as a process of transformation that was experienced by consumers and observed by carers and nurses
		Recovery properties	Recovery properties are time, critical points, engagement and progress
Bond of recovery	It is a subjective lived experience of being bonded to, or with, a person through the recovery process	N/A	N/A
Constructing a meaningful life	This theme described goals and values for embracing a meaningful life	Recovery goals	Meaningful goals of recovery were experienced subjectively by consumers as a state of mind
		Recovery values	Consumers and nurses described meaningful recovery values
Recovery values as caring goals	All participants groups shared the values of comfort and empowerment. Consumers valued self-care before resorting to others	Shared moments of comfort	Times where consumers connected to carers and nurses to receive comfort and being empowered
		Shared moments of empowerment	
		Consumers' active role in their recovery	Consumers used and adopted a variety of self-care practices

Abbreviation: N/A: not available.

Consumers defined recovery as a process of forward, non-linear changing and transitioning between health: "a normal life (…) living my days like humans means my day (…) [is]ordinary" (Consumer 1) and illness: "I was inside a bubble that had a sound" (Consumer 4) where this transforming occurred through experiencing multiple moments of realisation over time. While consumers expressed this subjective experience by saying: "I have transformed. I became another person" (Consumer 2). Carers described what they noticed, observed and validated as a process of transforming, adapting and coping in living a normal life over time as a carer said: "I started noticing that the boy (consumer) changed" (Carer 8). Another carer said: "[she has changed] she returned to live her life normally." (Carer 10). Nurse observed the improvement in symptoms: "the changes that took place" (Nurse 3).

Subtheme 2: Recovery properties. From consumers' experiences in each transformation process, there were four essential recovery properties: time, moments of realisation, engagement and progress. Recovery came "with time" (Consumer 7) and it was necessary to go through a "turning point" (Consumer 9) of awareness and realisation regarding the current situation. These moments led to being engaged in a process of finding "…a

solution for this issue" (Consumer 15) and evaluating self-capacity: "I feel that I can tolerate what I am in now" (Consumer 4) and the possibility of asking for support: "I made a decision that I wanted to see someone (who can) help me with this." (Consumer 14). Finally, recovery progress was rated numerically by consumers as one said: "I feel there is an improvement but not in a high percentage. We might say 2 out of 10." (Consumer 12).

Carers denoted recovery as improvements in consumers' behaviours, values and attributes while living in the community. These improvements were indicators to carers and evidence of progress in the recovery process. They saw consumers building academic abilities, self-acceptance, compassion, independence, religious practice, sense of achievement and mental stability. For example, discipline in praying the five-time prayer was an indicator of progress: "It is impossible for my son to leave the obligatory prayer. It is impossible, even if he is asleep, he wakes up from his sleep, he gets up and prays, he prays the Duha prayer and he prays at the end of the night." (Carer 3). Another recovery cue was being able to perform daily tasks independently: "…She takes care of her home, takes care of her son, and raises her son. It means living a normal life." (Carer 2).

Nurses identified only time as a recovery property and described it as the period that consumers spent receiving and adhering to treatment in order to improve clinical symptoms at hospital environment: "Recovery (is) that one is affected with something and enters a period of treatment and comes out of this thing that he feels: His condition is better than it was when he first got into this problem." (Nurse 1).

Theme 2: Bond of recovery

The bond of recovery is a subjective lived experience of being bonded to, or with, a person through the recovery process. The bond of recovery was experienced between carers and consumers. It was manifested in carers' description of going through a process of multiple transitions between health and illness. These transitions matched their loved one's process of multiple transitions between health and illness in each process of transformation: "(If) a mental patient recovered, the whole house recovered. If he did not recover, God forbid, the whole house becomes a bit of a tick and becomes a mental patient" (Carer 9). This bond was described as strong, unbreakable and elastic, so it stretched to its limit during difficult caring times. A carer described a stretched bond when her son attempted to die by suicide, saying: "He said, no, I die". I said "ok you and me together. Let us die. What do you think?" (Carer 3).

Consumers recognised, felt and sought the bond of recovery through their empathy towards their carers: "Sometimes, it hurts my heart or my mind that they are getting tired, worrying about me. Or they get worried about me when I relapse. Not because they are bad, but because I do not like that someone becomes very worried about me. At the same time, they had never made me feel that no, you made us tired" (Consumer 7). Nurses described this bond of recovery in their depictions of the importance of family support to the consumer: "Family support is necessary for the patient to recover. The patient needs someone who helps him to restore his self-confidence and has hope and optimism; someone who enhances his self-confidence, not (weakens it); someone to tell him that he's going to be alright" (Nurse 8).

Theme 3: Constructing a meaningful life

This theme was highlighted when consumers described their efforts to rebuild a life with significance, purpose, fulfilment and achievements. They achieve this by setting recovery goals and practising specific recovery values. These values were also discussed by nurses. This theme has two subthemes: Recovery goals and recovery values.

Subtheme1: Recovery goals. Consumers expressed that living well, for them, could be defined by meaningful recovery goals that describe how they wanted to live their lives. These goals were freedom from restrictions imposed by mental health conditions: "Recovery, I can do the things I want from the day I wake up until I fall asleep" (Consumer 5), happiness: "…I became happy that I knew my illness and knew that I could deal with it and take my medications, and that is it" (Consumer 8) and healing: "…that healing from any negative feelings one feels" (Consumer 14).

Other consumers' goals were to achieve mental stability: "…a sense of balance. This is recovery. Feeling balanced. Internal comfort" (Consumer 9), mental strength: "I am strong and I see myself as strong because I originally did all these things, all by myself" (Consumer 3) and peace: "I am in peace with myself" (Consumer 4). Many consumers aimed to improve their self-confidence: "I am now shining" (Consumer 15), self-love: "This is for me in the end, for me to love myself" (Consumer 4), sense of accomplishment: "I have reached this stage. I am now thinking of completing my studies" (Consumer 11) and sense of control: "I really feel like I am. Well, I can control myself." (Consumer 3).

Subtheme 2: Recovery values. Consumers described achieving meaningful recovery goals of living well in their own terms by embracing values they learned during their recovery process. Consumers described values of gratitude: "I feel my illness or bipolar was an advantage for me. I mean, it is possible that without it, I have not become me at this time, or I did not know my path." (Consumer 9), humility: "I go to the person who I cursed if I knew him, I say to him sorry forgive me" (Consumer 15), integrity: "…integrity in my dealings with people." (Consumer 13), and coexistence: "…began to know how to coexist with it" (Consumer 3).

Hope was a common theme among consumers who expressed it as being positive and optimistic about the future: "I am certain that I will reach the end of the curve." (Consumer 3). The value of authenticity helped consumers to be true to themselves and what they felt: "One is true to himself. The most important thing is honesty with oneself." (Consumer 11). They also reported practising awareness of others to try to understand others' perspectives of them: "I mean, people around me here in the house might be, I do not know why I am defending them, but it might be that from their perspectives, they feel that the person (herself) is already cured so, they deal with her as a normal person" (Consumer 2). Others mentioned being independent and taking responsibility: "I started with myself, and I changed myself by myself. This is the magical word and the key: Self-responsibility." (Consumer 5).

Both nurses and consumers talked about recovery essential values as intrinsic to moving towards living well. The first value was self-awareness which a consumer described as: "the first thing is I helped myself that I would not deny what was inside me. I will not allow anyone to be between me and myself. I was very insightful" (Consumer 11) and a nurse said about consumers that they should "… observe a change in my (their) behaviour" (Nurse 8). The second value was self-acceptance, as a consumer said: "For me, recovery is to accept the illness." (Consumer 8) and a nurse elaborated that "…this is you. You must accept yourself." (Nurse 1). Determination was also essential for consumers: "I mean my will in the first place. I mean, the first thing I had was a will, and I had it." (Consumer 14) and nurses: "The patient who does not have the determination that he can be treated will neither be treated nor recovered; this is first" (Nurse 5). Finally, internal and external motivations were commonly described values among consumers and nurses. A consumer reported: "There was a feeling like this that told me no, you are strong" (Consumer 14) and a nurse said: "I have noticed that when the patients have things they like in their life, they will have a greater motivation to be treated?" (Nurse 6).

Theme 4: Recovery values as caring goals

Consumers, carers and nurses shared perspectives on the value of comforting and empowering consumers in living, trying, coping and adapting meaningfully. Consumers highlighted the importance of these moments, describing carers and nurses who supported them as "the circle of trust" (Consumer 15). In this theme, consumers also described the value of self-care through adopting and practising self-coping and self-management strategies.

Subtheme 1: Shared moments of comfort. This subtheme reported common perspectives of consumers, carers and nurses about the value of comforting consumers through empathy, compassion, listening and reassurance.

Carers and nurses provided empathy by understanding consumers' feelings and recognising their lived experiences of mental health conditions, which consumers both accepted and demanded: "There was someone who understood me" (Consumer 7). Carers showed empathy as a carer said: "I felt him, the mother is the one who truly feels her children" (Carer 3) and nurses who showed empathy of understanding consumers' experiences as one said: "We ourselves [become patients who] go to (…) hospitals to be treated". (Nurse 2).

Consumers' experiences of receiving compassionate care from the circle of trust were described as: "(…) my dears were very supportive to the extent [that they said to me] you do whatever you want, do whatever you want, but you be better. Are you ok? I mean, mama [her mother]. Until now anything might make me sad, mama will never tell me about" (Consumer 2). This compassion was the result of carers' emotional containment to their loved one's negative feelings: "I felt that he was missing the people around him. I tried to contain him" (Carer 6). Nurses also showed compassion, as one said: "You are dealing with people who have psychological disorders, so you always have to support, help and soothe them" (Nurse 8).

Consumers needed others to comfort them through listening: "It was associated with listening [and] understanding what the person is trying to communicate to you" (Consumer 9). In response to this need, carers showed acceptance of anything that their loved ones might say or do: "I accepted him, I helped him because I accepted him" (Carer 3) while encouraging consumers to talk: "I am the one trying to get out what is inside him" (Carer 6). Nurses also listened to consumers: "I [the nurse] will listen to her [the consumer] first then give her the appropriate advice, I mean, I will listen to what she says, I mean, her level of thinking" (Nurse 5). They also encouraged consumers to talk about their experiences: "I find it really useful to sit with patients and let each of them talk about his social experience and the things that he encountered." (Nurse 7).

Consumers wanted to feel reassured that the challenges they were experiencing were normal obstacles in the recovery process: "…reassuring (…) [the consumer] that what he is in is ordinary" (Consumer 16). Therefore, carers provided hope: "The road is difficult, but I had hope. Even if he relapsed, I have hope. An insistent, insistent, and insistent. Like that" (Carer 6). Nurses reassured consumers by comparing mental health conditions to experiencing chronic medical diseases, as some said: "…not to let him feel that he is a psychiatric patient. He is a normal person with normal disease. (…) it is a normal disease, the same as diabetes or pressure [hypertension]." (Nurse 3).

Subtheme 2: Shared moments of empowerment. Consumers, carers and nurses described the value of empowering consumers by supporting consumers'

rights and encouraging their autonomy, social inclusion, and validation. Consumers valued those who supported their rights to have a job or study as one said: "Patient's (…) situation must be accepted and try to accommodate him (…) without him losing his job" (Consumer 8). Carers supported consumers' rights: "(…) The appropriate parties (…) can find a suitable job for him [her son]" (Carer 4); they also encouraged the right to academic achievements: "I support her (…) admission to the university, and she is currently studying." (Carer 1). Nurses also supported consumers' rights: "You can live a normal and happy life, you want to work, and you can get a certificate" (Nurse 6). Nurse 2 suggested "It is supposed that we provide elective admission, assumed that the patient has no family, for the homeless".

Consumers described the circle of trust encouragement towards independency: "My father seeded independence in us." (Consumer 8) in which, carers showed respect of consumers' autonomy: "Do not restrict him. The mentally ill person does not like to be oppressed." (Carer 3) and encouraged a sense of responsibility and self-confidence: "Assigned them some leadership duties. Oh, gave them confidence" (Carer 1). Nurses also fostered a sense of responsibility: "He [consumer] helps himself and let people around help him" (Nurse 5).

Consumers felt that having someone close to them, being approachable and sharing daily activities was empowering: "My friend registered with me in the same gym. And she told me I will be with you in the first period until you commit" (Consumer 5). Therefore, carers tried to always be present with their loved ones as: "The person with him [consumer] will become his father, mother, brother, society and everything" (Carer 6). Nurses also exhibited attending behaviours by being present and approachable: "…taking care of him [consumer] and asking about him" (Nurse 4). Carers and nurses also wanted consumers to socialise within the community as a carer said: "(…) the acceptance of him by his family and then by his community." (Carer 3) and a nurse said: "to improve in dealing with people, (…) and communication with society is improved." (Nurse 7).

Consumers felt empowered when others observed the positive changes in their behaviour and told them about it. A consumer described how his daughter and wife observed and validated the positive changes in his behaviour, saying: "They have seen that this person was like this and changed, becoming this and continued every day and continue to take care of them and they support me." (Consumer 15). Carers validated consumers' positive behaviours through reward and convention: "As a supplication [reward] for her [consumer] and to buy her something to eat, or he would buy her and her friends so that she would be social." (Carer 5).

Subtheme 3: Consumers' active role in their recovery. Consumers developed self-care practices, coping strategies and self-management skills to support themselves and fulfil their needs before asking others for support. Consumers practised self-coping strategies of healthy eating: "I was eating healthy food" (Consumer 5), physical activities: "The thing that helped me the most is that I started playing martial arts" (Consumer 9), relaxation techniques: meditation, breathing, reading and listening: "I wanted this week as a recovery trip. So, that I meditate and things like this." (Consumer 7), religious practices such as reading the Holy Quran and praying: "I have certain religious things that I must do. This is one of the things I have learned and that I must never let go." (Consumer 10), sharing: "When I want to talk and ventilate, ventilating is so much comfortable" (Consumer 5) and writing: "When I write, I am at ease. When I describe myself, I relax a little, so this helps me recover." (Consumer 11).

They also used self-management skills such as caring for others: "Pets were giving me a feeling that I was doing something, giving something to someone. It relieved me very much, especially during depression episodes" (Consumer 9), time-management: "I was always busy myself as much as I could, and my day was following a routine" (Consumer 6), self-reflection: "If I get a certain idea, the first thing I ask myself is: Ok, so what does it mean?" (Consumer 10), self-reward: "…I compensate myself" (Consumer 15). A consumer described how she used her Islamic faith as guidance to overcome feelings of oppression, saying, "When I was praying and supplicating to my Lord, I supplicate and pray to him. It was as if he was sitting next to me, and I was talking to him like I talk to the doctor" (Consumer 14).

DISCUSSION

This study described consumers' lived experiences of recovery and carers' and nurses' perspectives of consumers' recovery. Last century, research focused on consumers' personal accounts of recovery (Anonymous, 1989; Anthony, 1993; Deegan, 1996). Recent literature shows a shift towards understanding consumers' recovery in different contexts, such as specific cultural backgrounds, daily living, and factors involved in this experience (Anderson Clarke & Warner, 2016; Nxumalo Ngubane et al., 2019; Tuffour, 2020; Tuffour et al., 2019). Few studies have explored the concept of recovery from the perspective of consumers, carers and nurses (Jacob et al., 2015, 2017; Noiseux et al., 2010; van Dijk et al., 2021). To our knowledge, this is the first study that conceptualised shared recovery experience among these three groups who were non-Western, non-English speaking individuals from a collectivist society.

Saudi consumers' experiences of recovery as a process of transforming to live well within the community were similar to earlier consumers' personal

accounts of recovery (Anonymous, 1989; Anthony, 1993; Deegan, 1996). Similarly, Asian and Greek consumers identified the recovery journey as a process of transformation that involves moments of realisation, engagement in finding solutions and progress towards recovery goals over time (Kaite et al., 2016; Kuek et al., 2022; Kuek, Raeburn, & Wand, 2023). These similarities suggest that the concept of recovery is a universal and humanistic phenomenon of living with a mental health condition and its limitations (Pinches, 2004).

This research uncovered a novel finding we have called the "bond of recovery" which describes how, when consumers were unwell, their carers were also impacted, and as the consumers' wellbeing improved, the carers recovered too. A similar concept to the bond of recovery was found in a study conducted in Israel by Galimidi and Shamai (2022). Their research explored carer-consumer interactions during the recovery process and found that when a consumer received family support and felt better, other family members also felt better. In the United Kingdom, Day and Petalas (2020) found a similar bond between consumers with mental health conditions and their siblings. This strong connection is a feature of collectivist values described in both the original vision of the recovery-oriented approach in the 1980s, and by current consumers' advocating for community integration through strong family bonding and support (Anthony, 1993; Davis et al., 2012; Edwards et al., 2019; Frese & Davis, 1997).

In this study, nurses only observed clinical improvements within the hospital-limited stay where they perceived time spent on treatment as a feature of the recovery transformation process, a common perception among nurses from collectivist societies who work in mental healthcare systems influenced by the biomedical model. Similarly, Thai and Indonesian nurses described the treatment period as an essential part of the recovery journey (Kaewprom et al., 2011; Tasijawa et al., 2021). In KSA, Singapore and Egypt, other healthcare professionals have described recovery as a transformation and improvement process in different aspects of the consumer's life (Alhamidi & Alyousef, 2020; Ibrahim et al., 2021; Kuek, Raeburn, Liang, & Wand, 2023).

Consumers described constructing a meaningful life by engaging in recovery goals and adopting values. In our study, recovery values identified by consumers, such as hope, self-acceptance, self-awareness and determination, were found in other studies from collectivist societies (Ibrahim et al., 2022; Saavedra et al., 2022; Suryani et al., 2022; Tang, 2019b; Tuffour et al., 2019). Both consumers and nurses felt that values of self-acceptance, motivation, self-awareness and determination should be adopted in order for consumers to achieve their recovery goals. Many consumers from Western cultures reported that experiencing these values has helped them achieve their recovery goals (Fulford et al., 2020; Jacob et al., 2015; Piltch, 2016). Other values of gratitude, hope and coexistence that Saudi consumers described have been reported in Western literature as facilitators for building resilience, improving functioning and maintaining meaningful interpersonal relationships (Chen, 2017; Emmons & Stern, 2013; Jacob et al., 2015).

This is the first study to find shared caring moments of comfort and empowerment between caregivers (carers or nurses) and consumers that can occur regardless of the environment and circumstances. Carers provide caring moments of comfort and empowerment in the community, aligning with the caring roles of carers of all cultural backgrounds (Waller et al., 2019; Yuen et al., 2019). Yuen et al. (2019) found that Chinese carers empowered consumers by encouraging them to find employment and reintegrate into society as active community members. Waller et al. (2019) found that Canadian consumers felt empowered when their families supported their recovery goals and enabled them to live meaningfully.

Nurses provide comfort and empowerment through communicating and connecting with consumers during caring moments. These interactions often involve talk therapy and communication skills within a hospital or mental healthcare unit (Browne & Hurley, 2018; Horgan et al., 2021; Hurley et al., 2022). Browne and Hurley (2018) found that mental health nurses used talk therapy as an effective approach to empower and comfort consumers while performing daily practices. Consumers valued mental health nurses providing hope, empathy, compassion, and empowerment through communication and connection (Horgan et al., 2021; Hurley et al., 2022).

Saudi consumers were actively helping and supporting themselves even when they resorted to their circle of trust support. This independency arises from a spiritual belief that consumers must rely on God's will, seeking solace through prayer and reading the Quran to cope with mental illness. Hamdy (2009) stated that accepting God's will and recognising that suffering is a part of life positively influenced consumers' sense of self-responsibility and independence in taking control of their lives despite their suffering. In addition, Hodge et al. (2015) noted that Muslim participants who engaged in daily prayer were less likely to report elevated levels of depressive symptoms. Spirituality was associated with high levels of resilience among consumers with mental health conditions of all cultural backgrounds (Schwalm et al., 2022). It was also regarded as an important aspect of providing a recovery-oriented approach for consumers of all cultural backgrounds (Pinches, 2004).

Limitations

The study has several limitations pertaining to sample size, geographical location, and the process of constructing meaning during translation. Our sample was relatively smaller in comparison to other studies on recovery within a collectivist cultural context (Aswini & Deb, 2021;

Durgu & Dulgerler, 2021; Kaewprom et al., 2011; Yuen et al., 2019). Also, the study sampled only one healthcare professional group, nursing. Future research could benefit from different healthcare professionals' perspectives. The data collection phase was confined to a specific geographical region in KSA, unlike other studies encompassing participants from various regions, each with distinct cultural values concerning mental health (Al Mousa et al., 2021). While significant efforts were made to ensure the validity of translated terms and meanings through rigorous translation methods, we acknowledge that certain cultural nuances were challenging to translate directly. This difficulty could potentially hinder comprehension for those from dissimilar cultural backgrounds (Kuzenko, 2017).

CONCLUSION

This study describes the experiences of recovery among consumers, carers, and nurses in a collectivist society. The findings show that participants commonly perceived recovery as a transformative process. The bond of recovery was identified as a novel finding specific to Saudi carers, consumers, and nurses' experiences. Defining recovery as a process of transforming and constructing a meaningful life was similar to previous studies conducted in both Western and non-Western cultures. However, this study suggests some fundamental differences in how recovery was experienced between individualist and collectivist societies. Future research should consider reimplementing the original vision of recovery-oriented approach when planning recovery-oriented care services for consumers from all cultural backgrounds (Anthony, 1993; Piat et al., 2021; World Health Organisation, 2019).

Relevance for the clinical practice

Our findings identify many possible ways to support clinical practice in planning for recovery-oriented care for consumers with mental health conditions to live well regardless of their cultural backgrounds. Policymakers should consider consumers' lived experience of recovery and consumers, carers and nurses shared caring moments as gateways for collaborative care centred around consumers' needs and oriented to their recovery goals. The bond of recovery can be considered as a novel method for the meaningful inclusion of carers in recovery care planning and supported decision-making (Beckett et al., 2013; Davidson et al., 2015). Understanding shared perspectives about recovery can contribute to improving nurse-carer collaborative caring efforts to support the recovery of consumers (Horwitz et al., 1998; Thota et al., 2012).

Nurses should consider the recovery properties of time, critical points, engagement and progress that lead to recovery transformation when caring for these consumers. This might augment and enhance their perception of recovery as clinical improvement, which is a limited view that might negatively impact consumers' recovery outcomes (Byrne et al., 2015). Recovery-focused educational sessions including these findings supported by the original recovery-oriented approach might improve nurses' knowledge and attitude and change their behaviour towards supporting recovery (Anthony, 1993; Hawsawi et al., 2021).

Nurses should maintain therapeutic relationships through connecting with consumers in caring moments (Zugai et al., 2015). Although they have limited time due to nursing shortages and high workloads, they can employ emotional intelligence and active listening while performing daily tasks (Browne & Hurley, 2018; Harris & Panozzo, 2019; Horgan et al., 2021; Ishii & Horikawa, 2019). This connection can reduce feelings of power imbalance between nurses and consumers especially in challenging situations such as de-escalation and restrictive practices (Browne & Hurley, 2018; Hawsawi et al., 2020; Hurley et al., 2022).

AUTHOR CONTRIBUTIONS

TH, JA, AW and PS contributed to the conceptualisation, design, analysis, editing and interpretation of the manuscript. RA and AR contributed to the data collection, method section writing and overall editing and reviewing of the manuscript. TH and RA contributed as researchers with lived experiences of mental health conditions.

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CONFLICT OF INTEREST STATEMENT

There are no conflicts of interest.

DATA AVAILABILITY STATEMENT

All data used in this review was collected based on ethical approvals from all study sites.

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