International Journal of
Men's Social and Community Health

Original Article

THE MEANINGS OF MENTAL HEALTH RECOVERY FOR AFRICAN AND CARIBBEAN MEN IN THE UK: AN INTERSECTIONALITIES APPROACH

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Submitted: 5 November, 2021; Accepted: 11 May 2021; Published: 21 July 2021.

ABSTRACT

Racial disparities for African and Caribbean men are nowhere as stark as in mental health services and outcomes. Men from these communities who have been in contact with mental health services seemed to be stuck in a stalled cycle of recovery. This paper reports the findings from a study that aimed to explore how African and Caribbean men and their supporters conceptualise mental health recovery at the intersections of masculinity, racialised identities and mental distress. It illuminates the perspectives of service users, family, carers and practitioners on recovery in relation to ethnicity and culture.

Owing to the exploratory nature of this study, a qualitative design using a phenomenological approach was adopted to capture the dynamics of recovery processes and outcomes for African and Caribbean men across two study sites. Interviews were conducted with African and Caribbean men, their supporters and service providers. Interpretive Phenomenology Analysis (IPA; Smith J, Flowers P, Larkin M. Interpretative phenomenological analysis: Theory method and research. London: SAGE; 2009) was used to offer insights into how recovery was understood and experienced by study participants.

Seven overarching themes emerged from the data in relation to the meanings of recovery: recovering from social suffering, leading a normal life, (re)gaining control and agency, a sense of hope, (re)gaining identity, reduced medical involvement, and recovery being a healing journey.

The paper concludes that recovery is an ongoing process, not merely a narrow outcome to be achieved for men. The paper advances previous understandings by conceptualising mental health recovery for African and Caribbean men as a journey towards addressing individual and collective "social suffering" that occurs at the intersections of masculinity, "race" and mental distress, and moving to a better social location.

Key words: African; Caribbean; intersectionality; men; mental distress; recovery; social suffering

INTRODUCTION

Racial disparities in mental health services are a longstanding and significant issue in the United Kingdom.[1,2] Despite the introduction of a range of initiatives designed to improve services, such as "Delivering Race Equality,"[3] mental healthcare and treatment for Black, Asian and minority ethnic (BAME) populations remains characterised by more oppressive treatment, higher rates of detention under the Mental Health Act, and limited access to interventions in the community.[4] Men of African and Caribbean heritage, in particular, are most significantly disadvantaged regarding mental

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.52
Int J Mens Com Soc Health Vol 4(1):e83–e95; July 7, 2021.

health[5] and are likely to find themselves in a cycle of stalled recovery because of a combination of stigma, reluctance to seek help, and a history of poor and coercive treatment.[6]

The aim of the paper is to consider how African and Caribbean men and their supporters in the United Kingdom conceptualise mental health recovery at the intersections of masculinity, racialised identities and mental distress. We draw on the concept of intersectionality, which says that all forms of social categorisation or identity (e.g. ethnicity, gender, class etc.) overlap to create interdependent systems and multiple layers of discrimination and disadvantage.[7] Intersectionality helps us to understand how different social contexts lead to disparities in the way African and Caribbean men experience health and mental health. Gilbert et al.[8] suggest that an intersectional lens can help us to gain a broader understanding of how social experiences and structures affect unequal outcomes in health for black men. The authors[8] further suggest that what it means to be a black man is influenced by historical, social, cultural and economic factors. McKeown et al. also argue that the "complex interplay of race and gender….creates particular concerns in relation to black men that have implications for mental well-being."[9] An intersectional perspective can help to capture these factors in the lives of black men. Thus, the premise of this paper is that when these social dimensions are combined, it presents a unique conceptualisation of "recovery" and a complex range of challenges. We report findings taken from a research project funded by the National Institute of Health Research to explore the extent to which socially orientated approaches to recovery could better support African and Caribbean men to break the "stalled cycle of recovery." The paper advances previous understandings by conceptualising mental health recovery for African and Caribbean men as a journey towards addressing individual and collective "social suffering."[10,11]

PREVIOUS AND CURRENT UNDERSTANDINGS OF RECOVERY

The term "recovery" was introduced to mental health discourse in the 1970s by "ex-patient" groups as a way for them to make sense of their own experiences and as a challenge to the bio-medical model.[12] On one hand, "recovery" can be seen simply as living a meaningful life with or without the limitations caused by distress and mental ill health.[13] Numerous other studies have identified apparently common features of what recovery means, including hope, connectedness, freedom and choice/autonomy.[14,15] However, on the other hand, recovery is complex as each of these features may vary in importance between individuals such that recovery can mean different things to different people.

Medical versus social

A divergence in understandings of recovery is between those with clinical or social perspectives. The clinical perspective generally focuses on the alleviation of symptoms and the return of physical and psychological functioning.[16] This understanding serves within a "medical model" of illness[17] in which mental health difficulties are seen to have a pathological basis. Symptoms are to be treated by clinical "experts" until they decrease and disappear, at which point the patient is thought of to have recovered.[18] Recovery is a binary between "recovered" and "not recovered." From this point of view, recovery may not be possible for some, and so the focus shifts to managing symptoms.[19] Slade et al.[20] is critical that mental health services rely on notions of clinical recovery at the expense of how recovery is defined through experience by service users, the fluctuating nature of mental distress, and the impact of a wider socioeconomic environment.

Alternative approaches to recovery have been developed which compare and contrast clinical and personal dimensions.[20] The social model of recovery posits recovery as deeply personal and defined by individuals living a life that is meaningful to them: "the deeply personal process of changing one's attitudes, feelings, perceptions, beliefs, roles, and goals in life."[13] There is emphasis on hope, self-identity, choice, meaning and personal responsibility, and the central importance of relationships within recovery, which involves both peer involvement in recovery services and mutuality in relationships with professionals.[20] There is some evidence that more socially orientated approaches to recovery potentially lead to better outcomes for individuals by increasing social

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Int J Mens Com Soc Health Vol 4(1):e83–e95; July 7, 2021.

capital, resources, empowerment and full citizenship in society.[19]

In practice, recovery is likely to reflect a mixture of medical and social perspectives. People with mental health experience interviewed by McCabe et al.,[18] for example, offered multidimensional definitions of recovery; recovery was not a single state but a complex mix of the past, present, and future experiences that will change over time in relation to the circumstances in which people find themselves. Participants' understandings of recovery were, however, heavily influenced by the views of National Health Service staff and included an acknowledgement of the importance of medication to their future wellbeing. Participants were keen to have accepted the medical model perspective in order to be perceived as recovering.[18]

Recovery and ethnicity

There is a growing body of evidence on mental health recovery, yet it seems that a limited literature has explored meanings of recovery for BAME populations. This is important, given potential difference in norms and values between different ethnic groups. Exploring the intersections between ethnicity and mental health are also important, given the myriad ways that social structures and social identities, such as ethnicity, class, gender and mental health discrimination, have been found to mutually shape one's social conditions.[21,22]

Despite the well-documented evidence of significant disparities for African and Caribbean men in mental health, there is sparse literature that focuses on how this group understands their recovery. Brown et al.[23] explored perspectives of recovery of African and African Caribbean male service users in Lambeth, London. Recovery was often viewed in terms of returning to normality and regaining past potential. Respondents commonly spoke of "being able to move forward" with a positive outlook and live independently. In addition, regaining functionality, *"*having a purpose," contributing to society as well as being treated equally were considered key elements of recovery. Many respondents wanted to return to employment or education, and this was seen as a way of achieving their goals of moving on, regaining purpose and giving back to society.

Another UK study[24] explored issues around mental health recovery with a sample comprising BAME males only. Twelve men who attended a mental health project in Edinburgh (Men in Mind) were engaged in a discussion about recovery and the services/activities available locally to support the recovery process. Recovery was broadly seen as being a process of adaption and returning to a state of "normality."

Abimola et al.[25] conducted six focus groups with 63 BAME adults in Liverpool to explore their perceptions and experiences of mental health recovery. The ethnicity of the participants reflected the BAME population of the city, but exact proportions of African and Caribbean individuals were not stated. This study differed from Brown et al.'s[23] study and "Outside the Box"[24] by including both males and females as participants. For participants in the study, recovery was conceptualised in terms of being "happy," "getting better" and "coping with everyday situations." In addition, there was a belief among some respondents that recovery had to include the *"*absence of challenging behaviour." One notable finding was that a small number of people objected to the term "recovery," which they viewed as being confusing and not capturing the complex and varied journeys that individuals living with a mental health difficulty experienced.

Qualitative data on the lived experiences of nine African-American individuals recovering from serious and persistent mental health conditions were analysed by Armour et al.[26] The sample comprised four males and five females. Striving for normalcy once again emerged as a key theme with participants seeking to move forward and be a productive member of society. Participants strived to prove their credibility, for example, by demonstrating that they could manage their own life. There was a desire to be accepted, included and treated as equals. Participants sought stability in life and expressed a sense of urgency to gain key essentials, such as permanent housing, adequate finance and job-related skills.

Finally, Myers and Ziv[27] conducted semi-structured interviews with 20 African-American male service users at a peer-run mental health rehabilitation centre in a high poverty area of northeast USA. The aim of the study was to explore the way in which participants tried to take charge of their lives and recover from a psychotic disorder. Results showed that participants

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Int J Mens Com Soc Health Vol 4(1):e83–e95; July 7, 2021.

had seldom been given the opportunity in the past to tell their "mental health" story in their own terms. In fact, participants described multiple ways in which interactions with mental health services had resulted in a major loss of autobiographical power, which seemed to impact negatively on men's ability to recover.

Overall, these papers suggest that for men of African and Caribbean heritage in the United Kingdom and the United States, recovery is a multi-faceted concept with both internal and external dimensions. The internal dimension related to a sense of identity, regaining past potential (returning to a "normal" past), empowerment, achieving personal goals, and living a satisfying and hopeful life. Externally, recovery included a sense of social citizenship, feeling valued as a member of society and making a contribution to social life, being socially connected (i.e. family, friends), and "political survival" (i.e. living and confronting racial discrimination, mental health stigma and oppression). Recovery was conceptualised as a highly personalised process,[23,25–27] influenced by personal, social, cultural and political contexts. Some people objected to the term "recovery" for not capturing the complex and varied journeys that individuals living with a mental health difficulty experienced.[26]

METHODOLOGY

The overall aim of the current study was to find out to what extent socially oriented approaches to recovery could support African and Caribbean men in the United Kingdom to break the "stalled cycle of recovery."[6] It sought to illuminate the perspectives of service users, family, carers and practitioners on recovery in relation to ethnicity and culture; to describe the characteristics of activities that promote wellbeing for African and Caribbean men; and to explore to what extent socially oriented approaches to recovery address the lived experience of these men. Owing to the exploratory nature of this study, a qualitative design using a phenomenological approach was adopted to capture the dynamics of recovery processes and outcomes for African and Caribbean men across two large cities (City 1 and City 2) in the United Kingdom.

The research was reviewed and approved by Beckett University's department of Research Ethics (City 1).

SEMI-STRUCTURED INTERVIEWS

Fifty-nine discrete in-depth interviews were carried out with African and Caribbean men ("men," $N = 30$), family members/friends/carers ("supporters," $N = 15$) and service providers (community-based organisations, $N = 12$, and statutory mental health services, $N = 2$). Interviews were planned to be grouped into men–supporter–service provider "triads" to more thoroughly explore the dynamic contexts in which mental health recovery takes place. However, this was not possible in most cases; men were generally reluctant to nominate a service provider whom they felt had helped their recovery, because, in their view, their recovery was personal to them and involved little or no support from mental health professionals.

SAMPLING AND RECRUITMENT

Two regional study sites with ethnically diverse populations were included in this study. By including two study sites, our sampling strategy took greater account of the type and length of established communities, and variation by ethnicity, age, and regional environment and community support services. The sampling split between the two sites was approximately 60:40.

A key community informant approach, using service user and carer networks, was used to identify participants. Voluntary and community mental health groups embedded in each community were asked to identify men who could talk about their perspectives and experiences of mental health recovery. Inclusion criteria were that men be of African and Caribbean heritage, define themselves as being in recovery and not currently in "crisis," be living in the community, and be aged more than 18 years. To achieve a more diverse sample, we aimed to recruit men who had experienced contact with a range of services, such as forensic services, in-patient care, crisis services and community services.

DATA COLLECTION

Three interview guides were devised for different participant categories—men, supporters and service providers. The questions encouraged participants to identify their perspectives on recovery and to explore related environmental and service factors, including

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discrimination and stigma. Interviews were conducted in community venues that were known to the participants and where they felt comfortable. Interviews lasted between 20 and 100 min. All but one of the interviews were audio-recorded.

Following completion of all the interviews, men from across the two research sites were invited to attend a co-creation stakeholder event in either City 1 or City 2. The purpose was to discuss and corroborate with men the emergent themes from interview data. Each session lasted for approximately 3 h and was held in a community venue known to participants. Emerging findings, themes and dilemmas from the interviews were developed into stimulus materials, including vignettes, and presented to participants who were invited to reflect or comment on best practice in relation to recovery, and assisted to initiate developing ideas and plans for how these insights could be used to improve services that could promote recovery. The discussion from the two co-creation events was recorded as written notes and used to inform the final analysis of the interview data.

DATA ANALYSIS

Interpretive Phenomenology Analysis (IPA)[28] was used to offer insights into how recovery was understood and experienced by the study participants. IPA is premised on the expectation that participants share something in common and gather insights into how people make sense of a phenomenon in a given context, including the impact of the environment (lived space) on the phenomenon. The process involved full transcription of all the interviews, systematic coding of the text, cataloguing of codes, and searching for emerging and recurring patterns which are then grouped into broader themes. The analysis looked for personal significance, important relationships and significant events, and how these contribute to, support or otherwise affect recovery and resilience. The software program, NVivo 12, was used to manage the process of data analysis. Data analysis was not linear but iterative; emergent themes were discussed within the research team and at both the co-creation events, which informed the final analysis.

FINDINGS

Recovery did not have a single defining feature but consisted of many interconnected and overlapping aspects that collectively represent and contribute to recovery. As one man in City 1 said:

> I think several areas of your life holistically need to be looked at in order for you to make a full recovery, still being supported by your community mental health team. (City 1, Triad 7, Male)

The combination of aspects was unique to individuals, and men, supporters and service providers all recognised the need to think holistically about recovery. There was some divergence in the relative importance of different aspects of recovery between participant groups, but this was not as pronounced as expected. Men typically adhered to a social model whereas service providers often drew on medical model perspectives to emphasise men achieving certain care thresholds before their support could end (i.e. symptom reduction, paid employment, independent living). The following six overarching themes emerged from the data.

A HEALING JOURNEY FROM SOCIAL SUFFERING

Men, supporters and service providers agreed that recovery involved a process of psychological and physical healing. One man said, *"*recovery means getting better" (City 2, Triad 8, Male).

Another suggested:

> Well, I'm hoping that I'm in very good place. I must admit I'm feeling good. I've got to get myself back in shape physically. I'm working on that, and the next thing to experiment with is the mental. (City 2, Triad 1, Male)

All participants rejected the notion that mental health recovery involved being "cured," and some men did not like the word "recovery" as they felt it was too definitive. One man said:

> I mean you recover from a car accident, you recover from a broken hand, you recover from a broken leg, I don't think when it comes to mental health that the word recovery should be thrown about…there's a word out there but not recovery. You know, maybe how's your progression been since then? (City 1, Triad 3, Male)

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Recovery was thought of as a journey and a process that men experience that contributes to, and is informed by, their unique life histories, which the participants in this study, particularly the men, spoke about at a great length. The men in this study experienced historical and ongoing pain, suffering and anguish as a result of their social situations. We heard narratives around family trauma (i.e. divorce, separation), of being victims of—or witnesses to—physical, emotional or sexual abuse. Two issues specific to the men in this study were overcoming traumatic experiences of migration (either themselves or relatives travelling to or from England) and past and present experiences of being the victims of racism:

> I was born in [Caribbean] and I lived with my grandparents up until the age of eight…My mum left me when I was about one and a half to move [to England] with my father. So when I came over here, they were both strangers to me. It was like being say, "here, these are your parents" and to accept it, which is a massive thing for an eight-year-old. (City 1, Triad 8, Male)

> We grew up in a predominantly White area, so I experience[d] a lot of racism from outside. A lot of name calling and constant bullying. Also, I felt that that kind of behaviour started me on a downward spiral become more withdrawn and feeling very isolated, keeping myself to myself. (City 2, Triad 1, Male)

Their mental health involvement was generally experienced as coercive, aggressive and disempowering. When they emerged from hospital (or other form of treatment), men felt stigmatised by the mental health label. The stigma of mental health they experienced was particularly heightened within their own African and Caribbean communities. They felt "disliked"—perhaps avoided; unwelcomed in social groups, struggling to form friendships or to find personal love and esteem. Hurt in this way produced more hurt: rejection and dismissal, more loss and more suffering. Intimate relations and broader social bonds can become hard to sustain, and the person caught up in this may become atomized, anomic and lonely:

> Life is a battle, life is hard, it's a battle. You have to struggle, you got to fight to get what you want to achieve in life, you know. And when you're ill, it's no different. When you are ill, life is harder, you got to fight. And I want to fight. (City 2, Triad 13, Male)

> Recovery to me is someone that has come to a self-realization of what their issue is and they basically begin the journey of somehow allowing the impact of it to affect them less and less. (City 2, Triad 2, Service provider)

While these narratives are already documented in existing literature, we suggest these experiences are intrinsically linked to recovery as a form of social suffering. The recovery journey is not just about recovering from mental illness *per se* but is the latest struggle in lives characterised by overcoming ongoing adversities related to being a Black man.

Leading a "normal" life and being socially included

Being able to live the so-called "normal" life like everybody else was seen as a marker of recovery by men, supporters and service providers alike:

> Doing what's so-called normal…possibly getting a job, part-time, full-time. Increasing your social circle. (City 1, Triad 7, Male)

> Have a life like everybody else. (City 2, Triad 3, Supporter)

> I just like to live in the community, have strong ties with my family, have a relationship with someone of my choosing, a lady that would complement me, have children, get married. (City 2, Triad 15, Male)

Some participants associated a "normal" life with paid employment or employment-related activities, such as volunteering or training. Such activities were thought to both support men's identities, enabling them to feel useful and productive, and allow them to develop new skills. However, men who attributed the cause of their mental illness to employment-related issues placed less value on work as a mark of their recovery and had less desire to return to work. Another aspect of having a "normal" life was men forming social, familial and romantic relationships, which contrasted with the isolated experience of mental illness for African and Caribbean men described by participants.

CONTROL AND AGENCY

Given the prominence of being controlled in African and Caribbean men's experience of mental health treatment, it is not surprising that recovery was associated with men (re)gaining a sense of control and agency. Participants described men regaining

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control at two levels—control over internal factors ("internal control") and control over external factors ("external control"). What we describe as "internal control" referred to men having mastery over the symptoms and behaviours associated with their mental illness. Service providers and supporters, in particular, focussed on men having insight into their mental health, accepting their diagnosis and identifying triggers—perspectives closely aligned with a clinical model of recovery. This is not to say that symptoms have to be completely absent for men to be recovering. Rather, being in recovery meant men being able to manage symptoms such that they will not have a negative impact on their ability to fulfil other functions, such as maintaining a healthy diet, sleeping or socialising. Men also recognised the importance of managing their symptoms:

> Controlling my behaviour. Controlling my temper, controlling any habit, I've got myself involved in. (City 2, Triad 2, Male)

> Recovery is to understand yourself, you understand your mental health. You have knowledge, what does it mean to be diagnosed with something, and to be capable of recognizing how you feel and when you're not feeling well. (City 2, Triad 11, Service provider)

The second form of control, what we refer to as "external control," referred to African and Caribbean men (re)gaining a sense of agency and greater involvement in decisions affecting their lives. Firstly, there was a perception that men in recovery need to be able to exert more control over the overall direction of their lives: "Live the life that I want to live" (City 2, Triad 1, Male). Secondly, they need to be making more prosaic, day-to-day decisions and be able to take increasing responsibility for their routine self-management. A particular skill that men had to (re)learn as part of their recovery was managing the competing priorities of personal and social life and prioritising those that are the most important and/or the least detrimental:

> Definitely, you have to be able to live like an ordinary citizen and make decisions about your life which are going to impact on the way your life turns out. You don't want someone interfering with your life. (City 2, Triad 1, Male)

> Being in control of your life, doing what you want to do when you want to do. Not being controlled by other people, telling you what to do. (City 2, Triad 5, Supporter)

Service providers generally wanted to see men in recovery being reflexive of their current context, including their social, personal, financial and psychological circumstances, in order to make informed decisions. Men themselves placed a greater emphasis on independent thinking and understanding their personal goals/aspirations in order to make purposeful choices towards these self-determined goals. An example of this distinction is when one service provider described a man whose recovery stalled because he was not able to find a balance between looking after himself (i.e. personal care, healthy eating) and spending time with his girlfriend.

Some service providers, perhaps reflecting on funding targets and organisational capacities, described African and Caribbean men no longer being reliant on support services as a mark of recovery. Men themselves desired to feel that they were being listened to about decisions affecting their lives, rather than having total control—at least in the first instance. Men (re)gaining agency as part of their recovery does not mean men being completely autonomous individuals. Rather it is about striking a balance so that men have an appropriate influence over decisions affecting their lives and know when to seek support and help whenever necessary. This balance should change over time as, for example, men (re)gain the skills to make more decisions:

> It's not about people doing things by themselves, it's about people learning to take more control of their lives and knowing what they want in their life and being able to assert themselves to be able to ask for those things and knowing themselves and knowing their needs. (City 2, Triad 9, Male)

HOPE AND ASPIRATIONS FOR THE FUTURE

Men developing positive aspirations for the future were identified as a mark of recovery. Firstly, men, supporters and service providers all suggested that recovery included having hope with regard to men's current, generally adverse, situations and looking forward to a more positive future. Men drew on a

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Int J Mens Com Soc Health Vol 4(1):e83–e95; July 7, 2021.

range of resources to give them hope, including the support of family and friends, religion, and having positive Black male role models:

> I'm still in the game, I'm still fighting, still making each day count…it's having a positive mental attitude in everything that you do, and having that winner's spirit…and not counting the days but making the days count. (City 1, Triad 6, Male)

Another feature of positive aspirations for the future was regaining trust. A lack of trust in both oneself and other people was a common feature of mental health experience of the men in this study, and so part of the recovery process was about regaining those feelings. Trust was perceived as an enabler, allowing men to open up and share their thoughts and feelings. As one service provider said:

> So, the trust aspect becomes apparent where they start to become more open, and then in doing so then they feel comfortable to talk about the issues that they're facing…And in talking about it, that's then the beginning of the healing process. (City 2, Triad 2, Service provider)

IDENTITY

Mental illness was generally a negative, stigmatising experience that men did not want to be defined by, and so developing a more positive social identity was seen as a symbol of recovering. For some, this meant regaining a previous identity that was lost through the mental health experience—"You know, just being me again" (City 1, Triad 9, Male). It also meant adapting a previous sense of self or establishing a new identity entirely:

> [Recovery is] about making people feel good about themselves…we always try to encourage them and to say "This doesn't define your existence." (City 2, Triad 2, Service provider)

Reconciling what it meant to be an African and Caribbean man in English society emerged as a key theme across interviews, particularly for men, carers and service providers who attributed men's mental ill health to normative behaviours they associated with being a "Black man" (i.e. emotionally reserved, physically strong, superficial, womanising, competitive):

> Men who've grown up here, they don't know any difference, but they've grown up, I suppose, in their families so they're getting both the British culture and the West Indian culture or African culture…the two of, two aspects, two cultural things coming together so sometimes can be a hindrance. (City 1, Triad 7, Service provider)

> Well, it's about a man dealing with his emotions. … Black men ain't supposed to deal, they're not supposed to be emotional. We're supposed to be hard, we're supposed to be men. So even when you're in relationships, you really can't be emotional or vulnerable or, because it's seen as a weakness…with my wife, for example, I think she would take that weakness and use it when it's appropriate. (City 1, Triad 2, Male)

Aspects that participants felt would contribute to a more positive identity were being more aware—and proud—of "Black history" and being seen as someone able to give back to their community rather than aspiring to superficial/material things:

> They've been able to create an environment around themself, be in their own life or their immediate social network that actually feeds into who they are as an individual person, as an African Caribbean male. (City 2, Triad 5, Service provider)

REDUCED MEDICAL INVOLVEMENT

Being less involved with medical and/or social care services was highlighted as a mark of recovery. For men, this was most commonly expressed through a reduction in medication or coming off medication entirely. Most of the men in this study felt passionate about this aspect of recovery, and it was also recognised by service providers and supporters. One man said:

> I would like to be known to have recovered completely that I don't have no social services or the healthcare team giving me or administrating me or telling me to take medications. (City 2, Triad 5, Male)

There was, however, an awareness amongst most participants that medication can play a beneficial role in the recovery process, particularly helping men to manage their symptoms and during points of "crisis." Reducing medical involvement may be a long-term aspiration:

> I think it means being well, and having that support system around you, taking medication if you need to, and just having a healthy lifestyle. (City 2, Triad 16, Supporter)

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.52
Int J Mens Com Soc Health Vol 4(1):e83–e95; July 7, 2021.

> Recovery is a long journey and still going on it and it is very complicated, need medicines to be in part, in one part. (City 2, Triad 11, Male)

DISCUSSION

The findings presented here have much in common with previous research exploring narratives of mental health recovery for African and Caribbean men in the United Kingdom[23–25] and the United States.[26,27] Recovery was multidimensional and highly personalised,[23,25–27] influenced by personal, social, cultural and political contexts. Recovery for African and Caribbean men predominantly adhere to a socially orientated rather than medical perspective. Recovery was as an ongoing personal journey of improvement, adaption and development, rather than a set of symptoms that decrease and disappear. Service providers commonly considered service utilisation/discharge to be a marker of recovery, and some men similarly prioritised reduced medical involvement as important in their recovery. While some men may have internalised a medical perspective, it is perhaps more the case that, echoing McCabe et al.,[18] men wanted to be free from medical care, and so felt that they had to be seen to have accepted the medical model perspective in order to be perceived as recovering. This is not to discount entirely the medical aspects of recovery. Rather, more clinically orientated measures need to be nested within a more holistic meaning of recovery based around what is important to the individual. We expected a greater divergence in perspective in this regard, particularly between men and service providers. This may be because the sample of service providers mostly comprised non-governmental organisation (NGO) staff working from a "social model," rather than more medically orientated clinicians. It may also be that men, carers and service providers do agree that recovery is the same thing (the focus of this paper), but have divergent views about how it should be enacted.

The findings also suggest that the meaning of mental health recovery for men of African and Caribbean heritage in England has much in common with the meaning of mental health recovery for other populations. A number of features of mental health recovery were identified that were also recognised in previous studies with BAME and non-BAME populations alike, including hope, connectedness, freedom, choice/autonomy and living a normal/meaningful life,[14,15,23,25–27] there may be some universality to these features across population groups.

A perspective of intersectionalities enables an understanding that individual or personal features of recovery (i.e. hope, self-management, identity, healing and reduced medical involvement) are universal, but the social context in which they are experienced is altered for different groups. That is to say, the meaning of recovery for African and Caribbean men is qualitatively different from other groups because of the unique way their multiple identities create layers of disadvantage and discrimination. Recovery for African and Caribbean men is about trying to overcome not only their mental health symptoms but also the social suffering they experience at the intersection of being a man (i.e. gender norms) of African and Caribbean heritage (i.e. racial discrimination), and of experiencing mental health difficulties in British society (i.e. stigma). This fits with ideas of embodied masculinity[29] that suggest that masculinity is defined through social practices and daily circumstances. It also speaks of the notions of manhood that posit that what it means to be a man in racialised contexts is shaped by ethnic, racial and cultural factors.[30]

Social suffering captures the painful part of the lived experience of social domination and exclusion and describes the subjective effects of various conflicts between dispositions (habitus) and social contexts.[10] The idea of mental health recovery as a recovery from social sufferings draws attention to more than just African and Caribbean men's symptoms of mental health or the social situation they now find themselves in. It highlights their lived experience of inhabiting social structures of oppression and pain that arises from this, including feelings of humiliation, anger, despair and resentment, which become individualised and internalised. Understanding this offers an alternative to African and Caribbean men's typically stigmatising experience of mental health services,[6] which, to paraphrase Taylor,[31] misrecognise African and Caribbean men, imprisoning them in a false sense of being.

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.52
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Orientating our view of African and Caribbean men's recovery towards more social aspects plays into recent transformations in the mental health system to put users' perspectives at the centre of their care. This understanding, compared to the dominant clinical perspective, has implications for treatment and care. Firstly, in order for patients to progress, a shared understanding of recovery must be developed between service users and mental health professionals.[18] Eliciting the views of African and Caribbean men (alongside those of carers and service providers) starts to fill in the dearth of voices from BAME communities in mental health services, meaning that a professional perspective of recovery need not be projected onto service users.[18] This approach may help the development of responsive approaches that seek to redress power imbalances and identify socially and culturally appropriate care. The findings are timely and respond to growing international recognition that areas of professional practice should be opened up to greater public scrutiny, particularly in relation to the distribution of power between "service providers" and "service recipients". For example, men should also be given space to engage in self-determined activities informed by their unique life histories as part of their recovery. Secondly, appreciating not only where African and Caribbean want to get to in their recovery but also where they have come from through their life histories and mental health experiences—defined, in many cases, by ongoing trauma and violence—lead to a greater understanding of their current behaviour and hopefully a more sympathetic treatment response. While it may be difficult to be compassionate with a man perceived as aggressive, resentful, suspicious or violent, we need to appreciate that this is symptomatic of their ongoing social suffering. To paraphrase Williams,[32] clinicians need a "felt thoughtfulness" to feel the pain of their patient, even if they are angry, violent or self-destructive, and to think critically about the injustices that produce it. This calls for policy responses not just about treating the mental health symptoms of African and Caribbean men but also about addressing the social situations in which they find themselves.

LIMITATIONS

In this study, African and Caribbean men are largely treated as a homogenous group. We have not considered how issues of, for example, class, religion, country of descendance, or migrant status intersect. For example, we can say that most of the men in the study were not first-generation migrants and so may have experienced a greater degree of cultural assimilation than their first-generation migrant peers, which may have affected their understanding of recovery. However, this was not a significant feature of our analysis, so we cannot say with any certainty. Differences in the meaning of recovery may emerge if this group—"African and Caribbean men"—was disaggregated. In line with Tang,[21] we would agree that dimensions of recovery have diverse meaning and value across cultures and social groups. As such, there is almost certainly a value in exploring additional layers of identity.

CONCLUSION

We explored the intersections between masculinity, ethnicity and mental distress and how this informed conceptualisations of recovery for African and Caribbean men. We conclude that recovery is both a process and a journey of improvement, adaption and development, and not merely a narrow outcome to be achieved with men. An important finding of this study was that recovery for these men means recovery from social suffering. That is, recovery from the cumulative suffering of everyday life, recovery from the pain caused by social forces, and acknowledging the contribution that society and institutions make to worsening of social and health problems. While the findings presented here can apply to other groups of service users, we suggest that these have to be understood at the intersections of masculinity, ethnicity and mental distress in racialised contexts. It is only then that we can address the painful parts of the lived experience of disadvantage and, in the context of this paper, the persistent racial disadvantage experienced by African and Caribbean men.

DOI: http://dx.doi.org/10.22374/ijmsch.v4i1.52
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FUNDING

The research was funded by the NIHR School for Social Care Research. The views expressed in this paper are those of the authors and not necessarily those of the NIHR SSCR, NHS, the National Institute for Health Research or the Department of Health.

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