Personal recovery after mental illness from a cultural perspective: a scoping review

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Abstract

Background: Although personal recovery has become a well-known concept in most Western countries, it remains under-recognised in non-Western countries. **Aims:** This scoping review aimed to investigate how culture impacts the conceptualisation of personal recovery by evaluating how well the personal recovery framework CHIME (Connectedness, Hope, Identity, Meaning and Empowerment) fits amongst individuals from non-Western ethnic origin. **Method***:* A scoping review with systematic searches was conducted. Studies were included in the scoping review if they examined personal recovery among individuals from non-Western cultures. Articles were excluded if the target population had no experience with mental illness or had an ethnic Western origin. The review used the CHIME framework in a "best-fit" framework synthesis, to understand how culture impacted the understanding and experience of recovery. A comprehensive search of five databases (PsycInfo, ProQuest, EMBASE, MEDLINE and CINAHL) resulted in the inclusion of 76 studies out of the 1,641 studies identified. The search was conducted in February 2023 and updated the same month in 2024. **Results***:* The 76 studies demonstrated that the CHIME framework is applicable in non-Western cultures, with few adjustments to the subcategories. Generally, there was a greater emphasis on connectedness with others across all categories of CHIME, and religion was more frequently used as source to achieve the components of CHIME more often in non-Western cultures. Socio-structural factors influenced how personal recovery can be experienced, and important factors such as welfare benefits impacts recovery. **Conclusion**: Special attention should be given to the importance of relationships, especially family, in achieving recovery and religion should be recognised as a crucial element to experiencing connectedness, hope, identity, meaning and empowerment. To enhance the CHIME framework, integrating the sub-components shared responsibility and shared control would be beneficial. Socio-structural factors should be considered when using the CHIME framework.

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Keywords: culture, personal recovery, CHIME, non-Western, mental illness, "best-fit" framework synthesis

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Introduction

Mental illness affects people worldwide, and increased openness has sparked discussions on recovery (Slade, 2009). Traditionally, the discussion focused on symptoms; however, the concept of personal recovery, which emphasizes aspects beyond symptoms, has gained importance in both research and practice (Slade, 2009; Sofouli, 2021; WHO, 2021).

One of the most cited definitions of personal recovery was offered by Anthony (1993, p. 17):

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

The shift towards personal recovery has led to new policies and services, especially in Western countries (Slade, 2009; WHO, 2022). Nations like New Zealand, Australia, the USA, the UK, Ireland, Denmark, Sweden, and Norway have incorporated the recovery framework (Bejerholm & Roe, 2018). This reflects a move-away from traditional psychiatry's focus on symptom management, towards well-being and personal recovery (Bejerholm & Roe, 2018). However, this shift is less evident in non-Western cultures. Few countries in Asia, Africa, South America, and the Middle East have adopted personal recovery in their policies (Sofouli, 2021) due to a lack of infrastructure and budget in many middle-/low-income countries (Slade et al., 2014). For instance, Cambodia, Laos, the Philippines, and Vietnam lack comprehensive mental health policies and allocate < 1% of their health budgets to this area (Murwasuminar et al., 2023). These studies highlight significant differences in the adoption of personal recovery between Western and non-Western cultures.

Culture and personal recovery

The recovery process is closely intertwined with culture, which shapes individuals' attitudes, behaviours and perceptions (Çam & Uğuryol, 2019; Nolen-Hoeksema, 2020). For instance, in some Southeast Asian cultures mental illness and recovery are understood through a religious lens rather than the medical understanding, common in Western cultures (Murwasuminar et al., 2023). These cultural differences complicate the application of

Tabel 7. Middle eastern studies definition of elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other

Western frameworks in non-Western contexts. This review examines personal recovery in non-Western cultures, encompassing all countries outside of Europe, Australia, New Zealand and North America as well as ethnic minorities in these regions. Even though categorizing culture as "Western" and "non-Western" is reductionist and may imply a negative connotation, we have not found a more inclusive term.

CHIME Framework: Cultural application beyond West

Research on personal recovery reveals diverse perspectives, underscoring its personal and complex nature (Jaiswal et al., 2020). Nonetheless, Leamy et al. (2011) developed one of the most comprehensive models for personal recovery, CHIME (Connectedness, Hope, Identity, Meaning, and Empowerment). While influential in Western countries, research from non-Western regions is lacking (van Weeghel et al., 2019). A review of 228 studies urges more exploration of non-Western contexts to avoid a monocultural perspective. The authors stress the need to adapt the CHIME framework to diverse populations, emphasizing the need to adapt the CHIME framework for diverse populations (van Weeghel et al., 2019).

This scoping review aimed to explore the impact of culture on personal recovery with the following research questions (RQs):

RQ1. What is the nature of the evidence base on the significance of non-Western cultures in personal recovery?

RQ2. How well does the CHIME framework fit individuals of non-Western ethnic origins?

RQ3. What cultural adaptations are needed to improve the CHIME framework for diverse populations?

Method

The scoping review aimed to identify articles on personal recovery in non-Western cultures. A systematic search was conducted using a basic search string (Table 1), modified for each database's MeSH terms. Searches used free-text and indexed terms with truncation (*) and proximity operators across PsycInfo, ProQuest, EMBASE, MEDLINE, and CINAHL. The initial search was on February 14, 2023, and updated on February 29, 2024. Additional backward citation-tracing was performed on included studies' references.

Table 1. Search terms used in PsycInfo.

(culture change OR Sociocultural factors OR Cultur* OR Culture sensitivity OR Culture anthropological OR Multiculturalism OR Cultural diversity OR Cross culture psychology OR Cultural identity OR Racial and ethnic groups OR Cross culture differences OR Ethnic diversity) AND (Person* adj3 recover* OR Personal recovery OR Recovery (disorders) OR CHIME)

Table 2. Inclusion and exclusion criteria

Inclusion	Exclusion
● Empirical research in peer-reviewed journals ● Danish, Norwegian, Swedish or English language ● Articles that aim to explore personal recovery ● Articles that aim to explore CHIME ● Articles which target population is individuals that has experienced or is currently experiencing psychopathology ● Client's experience of personal recovery ● Interaction between non-Western cultures and personal recovery ● Individuals in non-Western cultures ● Adult population	● Target population is from Western cultures ● Articles that examine clinical or functional recovery ● Target population which has not experienced mental illness (clinicians or family) ● Personal recovery after somatic illness ● Organisational implementation of the personal recovery framework ● Articles that only examines minor aspects of personal recovery or does not aim to explore the experience of personal recovery ● Articles that are not peer-reviewed (discussions, editorials, personal opinions or theory construction) ● Children or adolescence ● Personal recovery in a Western context

Eligibility

Before screening, inclusion and exclusion criteria were established (Table 2). Articles had to be empirical, peer-reviewed, and in Danish, Norwegian, Swedish, or English. Studies on personal recovery, CHIME, and non-Western cultures were included, provided they connected culture with personal recovery *experiences*. Excluded were studies from clinicians' perspectives, intervention studies, and those on recovery after somatic disorders.

Study selection

The search yielded 1,641 results. Two reviewers screened all studies using Covidence, resolving conflicts through discussion.

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Data extraction

Data extracted included author, year, country, participant details (age, gender, diagnosis), procedure, aim, study design, conclusion, and CHIME elements studied.

Analysis

The synthesis used a best-fit framework synthesis, coding new studies against CHIME themes (Carroll et al., 2013). Three codings were conducted:

1. Overarching CHIME categories, coding 76 studies line by line.
2. CHIME subcategories, such as social connectedness, according to Leamy et al. (2011) definitions (e.g., peer support, relationships, support from others, societal inclusion).
3. Themes not represented in CHIME, resulting in an extended model incorporating both CHIME categories and newly identified themes.

Reviewers discussed and identified categories throughout the process.

Lastly, CHIME elements were scored from zero to five based on the significance in each study, and were summed to calculate the total weight.

Results

Figure 1 shows the PRISMA flowchart detailing the selection process. Searches in the five databases generated 1,641 results. After removing 321 duplicates, 1,321 abstracts and titles were screened, of which, 1,176 studies were excluded. Full-text screening was conducted on 145 studies, with 100 exclusions. Citation searching added 31, resulting 76 included studies.

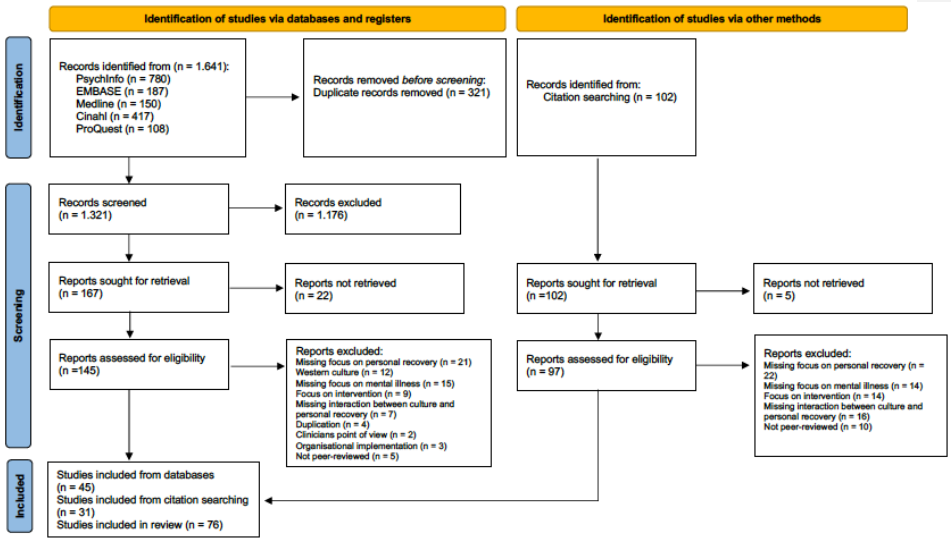


Figure 1. Flowchart of the systematic search

Evidence base

The 76 studies, published between 2006 and 2024, showed increasing interest in personal recovery in cultural contexts, with the most studies in 2023. Eight used quantitative approaches (Table 3b), seven used mixed-method (Table 3c), and 53 used qualitative approaches (32 interviews only; Table 3a). Nine studies replicated four datasets (Kuek et al., 2022, 2024; Pouille et al., 2021; Pouille et al., 2023; Tang, 2018, 2019a, 2019b; Tuffour, 2020; Tuffour et al., 2019).

Thirty-four studies were from Asian, primarily Taiwan and India. Nineteen focused on ethnic minorities in North America, while there were fewer studies from Africa (1), Middle East (3), and South America (3).

Diagnoses included schizophrenia (28 studies), depression (20), substance use disorder and bipolar disorder. Anxiety diagnoses were less represented, with few studies on PTSD (2) and OCD (2), and panic disorder and general anxiety (4). Eighteen did not specify diagnoses.

Data were organised into nine tables by design (Table 3 a-d), and content (Table 4 a-g).

Tabel 7. Middle eastern studies definition of elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other

Table 3a. Table of characteristics of qualitative studies. (-) indicates that information is missing. (+) denotes age and up. m: mean.

Author	Design	Gender	Age	Culture in target group	Mental illness
Agrest et al. (2018)	Semi-structured interview, focus group interview	11 men 13 women	19-60	Argentina	Mood disorder, personality disorder, schizophrenia, SUD
Amini et al. (2019)	Interview	7 men 13 women	23+	Iran	Depression
Antunes de Campos et al. (2023)	Semi-structured interview	13 women	31-77	Brazil	SUD
Armour et al. (2009)	Semi-structured interview	4 men 5 women	25-54	African minority in USA	Bipolar, depression, schizophrenia
Bingham and Kelley (2022)	Interview	6 participants	-	North American Native	SUD
Bone et al. (2011)	Visual art-based interview	1 man 1 woman	-	Indigenous	SUD
Brijnath (2015)	Interview	13 men 15 women	18+	Indian minority in Australia	Depression
Chen et al. (2006)	Interview	23 men 23 women	19-38	Taiwan	Depression
Chi et al. (2014)	Semi-structured interview	2 men 12 women	35-57	Taiwan	Depression
Clark et al. (2024)	Interview	15 participants	16+	Indigenous in Australia	Eating disorder
Doty-Sweetnam and Morrissette (2018)	Semi-structured interview	7 participants	32-68	Indigenous	SUD
Eltaiba and Harries (2015)	Interview	10 men 10 women	21-50	Jordan	Anxiety, depression, OCD, panic attack
Gandhi et al. (2020)	Interview	7 men 11 women	22-53	India	Schizophrenia

Table 3a (continued)

Author	Design	Gender	Age	Culture in target group	Mental illness
Gopal and Henderson (2015)	Interview	10 men 9 women	m: 37	India	Schizophrenia
He and Petrakis (2023)	Semi-structured interview	2 men 2 women	24-70	Chinese minority in Australia	Mental health challenges
Kanehara et al. (2022)	Semi-structured interview, focus group interview	16 men 14 women	16+	Japan	Mood disorder, schizophrenia
Kelner and Gavriel-Fried (2023)	Semi-structured interview	14 women	21-60	Israel	SUD
Kok and Lai (2017)	Interview	6 men 6 women	20-24	Malaysia	Depression
Kuek et al. (2022)	Online interview	4 men 17 women	21-51	Singapore	General mental illness
Kuek et al. (2024)	Online interview	4 men 17 women	21-51	Singapore	General mental illness
Kwok (2014)	Autobiographical case description	1 woman	-	Chinese minority in Canada	Bipolar
Lam et al. (2011)	Focus group interview	3 men 3 women	23-29	Hong Kong	Psychosis, schizophrenia
Lavallee and Poole (2010)	Focus group interview	-	-	North American Native in Canada	Depression, eating disorder, SUD
Lee et al. (2015)	Semi-structured interview	4 men 4 women	28-60	Asian minority in USA	Schizophrenia
Levy-Fenner et al. (2022)	Digital short film	9 people	-	Refugees in Australia	General mental illness
Lewis and Allen (2017)	Interview	9 men 1 woman	61-90	Alaska natives	SUD
Liu (2014)	Interview	4 men 4 women	27-52	Hong Kong	Bipolar, schizophrenia

Table 3a (continued)

Author	Design	Gender	Age	Culture in target group	Mental illness
Ma et al. (2023)	Semi-structured interview	5 men 6 women	22-55	China	Schizophrenia
Madill et al. (2023)	Photo-led interview	11 men 4 women	19-24	India	SUD
McCarron et al. (2018)	Interview	18 women	20-36	Alaska natives	SUD
Mizuno et al. (2015)	Semi-structured interview	11 men 5 women	m: 43	Japan	Schizophrenia
Ng et al. (2008)	Focus group interview	4 men 4 women	36-43	China	Schizophrenia
Nxumalo Ngubane et al. (2019)	Interview	15 women	21-70	Swaziland	Schizophrenia
Nygaard (2012)	Semi-structured interview	9 men 11 women	-	North American Native in Canada	SUD
Pouille et al. (2021)	Semi-structured interview	30 men 4 women	18-60	Immigrants in Belgium	SUD
Pouille et al. (2023)	Semi-structured interview	30 men 4 women	18-60	Immigrants in Belgium	SUD
Ricci et al. (2021)	Interview	4 men 6 women	33-71	Brazil	General mental illness
Saputra et al. (2022)	Focus group interview	11 participants	21-44	Indonesia	Schizophrenia
Saunders et al. (2023)	Photo-led interview	17 women	18-25	Latina in USA	Eating disorder
Song and Shih (2009)	Interview	12 men 7 women	22-46	Taiwan	General mental illness
Subandi (2015)	Interview and observation	7 participants	16-42	Indonesia	Psychosis
Subandi and Good (2018)	Interview and observation	6 patients and family	15-50	Indonesia	Psychosis

Table 3a (continued)

Author	Design	Participants	Age	Culture in target group	Mental illness
Tanaka (2018)	Interview and observation	5 men 7 women	62-82	Japan	Depression
Tang (2019a)	Interview	9 men 13 women	25-85	Chinese minority in England	General mental illness
Tang (2019b)	Interview	9 men 13 women	25-28	Chinese minority in England	General mental illness
Tang (2018)	Interview	9 men 13 women	25-28	Chinese minority in England	General mental illness
Tuffour (2020)	Interview	3 men 9 women	19-57	African minority in England	Depression, SUD, schizophrenia
Tuffour et al. (2019)	Interview	3 men 9 women	19-57	African minority in England	Depression, SUD, schizophrenia
Whitley (2016)	Interview	24 men 23 women	20-69	Caribbean minority in Canada	Bipolar, depression, schizophrenia
Whitley (2012)	Focus group and observation	40 men 10 women	-	African minority in USA	SUD, trauma
Yang et al. (2024)	Interview	12 women	20-65	Taiwan	SUD
Zaheer et al. (2019)	Semi-structured interview	10 women	19-51	Chinese minority in Canada	Bipolar, depression

Table 3b. Table of characteristics of quantitative studies. m: mean.

Author	Design	Participants	Age	Culture in target group	Mental illness
Fukui et al. (2012)	Questionnaire	121 men 91 women	m: 43	Japan	Bipolar, depression, schizophrenia
Gandotra et al. (2017)	Questionnaire	52 men 38 women	20-60	India	Bipolar, depression, delusional disorder, dysthymia, hypochondria, OCD, panic attack, schizophrenia
Lee et al. (2022)	Questionnaire	47 men 52 women	16-40	Singapore	Bipolar, depression, delusional disorder, schizophrenia, psychotic episodes
Moore et al. (2022)	Questionnaire	53 men 30 women	18-34	Ethnic minority in USA	Bipolar, depression, schizophrenia
Song (2017)	Questionnaire	297 men 290 women	m: 41	Taiwan	Affective disorder, schizophrenia
Tse et al. (2014)	Questionnaire	66 men 84 women	18-65	Hong Kong	Bipolar, schizophrenia
Wu et al. (2021)	Questionnaire	178 men 132 women	41-50	Taiwan	General mental illness
Young et al. (2020)	Questionnaire	100 men 166 women	m: 44	China	General mental illness

Table 3c. Table of characteristics of mixed method studies. (+) denotes age and up. m: mean.

Author	Design	Participants	Age	Culture in target group	Mental illness
Gopal et al. (2020)	Interview and questionnaire	55 men 45 women	m: 38	India	Schizophrenia
Ha (2016)	Interview and questionnaire	15 men 16 women	18+	South Korea	Schizophrenia
Kakuma et al. (2024)	Interview and questionnaire	5 men 4 women	18-75	Iran and Myanmar minorities in Australia	General mental illness, PTSD
Matsuoka (2015)	Interview, observation and questionnaire	2 men 6 women	64-89	Japanese minority in Canada	General mental illness
Pahwa et al. (2020)	Interview and questionnaire	46 men, 40 women	m: 41	India and USA	Bipolar, depression, schizophrenia
Siu et al. (2012)	Interview and questionnaire	72 men 65 women	m: 42	Hong Kong	Bipolar, depression, delusional disorder, dysthymia, hypochondria, OCD, panic attack, schizophrenia
Yu et al. (2021)	Interview and questionnaire	70 men 97 women	18+	China	Schizophrenia

Table 3d. Table of characteristics of articles using other methods. (-) indicates that information is missing

Author	Design	Included studies	Culture in target group	Mental illness
Hickey et al. (2017)	Discussion	-	International	General mental illness
Kuek, Raeburn and Wand (2023)	Scoping review	30	Asian perspectives	General mental illness
Leamy et al. (2011)	Systematic review	97	International (mostly Western)	General mental illness
Murwasuminar et al. (2023)	Systematic review	31	Southeast Asia	General mental illness
Pouille et al. (2022)	Systematic review of qualitative studies	15	International (minorities in USA)	SUD
Slade et al. (2012)	Systematic review	115	International (mostly Western)	General mental illness
Sofouli (2021)	Literature review	-	International	General mental illness
van Weeghel et al. (2019)	Scoping review	25	International (mostly Western)	General mental illness

Framework fit

This section addresses RQ2: how well the CHIME framework fits non-Western cultures.

Personal recovery

Multiple studies explored cultural variations in the definition of personal recovery, finding consistency across diverse cultures (Kuek et al., 2022; Murwasuminar et al., 2023; Slade et al., 2012), though the emphasis differed. Clinical recovery was often prioritized in Asian cultures (Kuek, Raeburn and Wand (2023), with an increased focus on functional recovery potentially linked to limited welfare support (Liu, 2014).

Understanding of personal recovery varied due to cultural perspectives on mental health (Antunes de Campos et al., 2023; Kakuma et al., 2024; Kuek et al., 2024; Kuek, Raeburn, & Wand, 2023; Nxumalo Ngubane et al., 2019) and linguistic differences (Kakuma et al., 2024)((Slade et al., 2012), highlighting challenges in translating terms like "personal recovery" in certain languages and regions.

The CHIME framework

Few studies directly evaluated CHIME's relevance in non-Western settings, yet those that did generally supported its applicability across diverse cultures. However, the diverse recovery narratives across non-Western contexts suggested that a single model may not capture the full spectrum of recovery experiences (Kuek, Raeburn, & Wand, 2023), with some studies preferring a classification into facilitators and inhibitors of personal recovery (Bone et al., 2011; Chen et al., 2006; Gandhi et al., 2020) (Table 4a-g).

Table 4a. Middle Eastern studies result on the elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Amini et al. (2018)	Support from family and staff. Communication with other patients.	Positive thinking. Seeking help increased hope.	Regain positive self-esteem. Support was important to do so.	God gives meaning to illness.	Responsibility for recovery. Feeling control by reading the Quran	Medicine was important.
Eltaiba & Harries (2015)	Being a part of the community. Family and others with mental illness were important.	Having a plan for the future. God gave hope.	New identity. Deeper and more reflective thoughts. High Stigma.	Meaning through religion. Illness was Allah's will.	Feel in control. Responsibility for recovery. Seeking information.	
Kakuma et al. (2024)	Social belonging was complex because of migration. Family reputation was important.		Gain a better understanding of yourself.	Religion and spirituality gave meaning. Lack of comprehension of the category.	Taking charge in life.	
Kelner & Gavriel-Fried (2023)	Peer relationships and friendships. Connection and relationships were necessary.		Labels as "normative" or "not normative"			
Levy-Fenner et al. (2022)	Family was primary support. Living in a new country was a barrier for support. Support from the state.	Having hope that you can rebuild life.	Experiencing war was a challenge for rebuilding a positive identity. Having a dual identity.	Meaning through religion. Generativity gave meaning in life.	Helping others with their mental illness. Control over the illness.	Creativity as a way to understand symptoms.
Pouille et al. (2021)	Relationship with God. Family, partners, friends and peers. Practical and emotional support. Religious centres. Cultural communities were helpful.	Financial resources and God as motivator. Intrinsic motivation grew. Social support increased hope.	Cope with stigma. Cultural identity as a resource. Various social identities.	Religion increased meaning. Forgiveness from God.	Limitations of neoliberal notions of individual autonomy which overlook societal responsibility	
Pouille et al. (2023)	Supportive social networks. Humanizing interactions. Holistic perception from others of the mental illness.		Intersection stigma on race and illness. Cultural identity. Internalised stigma was present.	Acceptance of mental illness.		

Note: Findings from the 76 studies regarding CHIME categories, along with an "other" category for findings outside the CHIME framework, categorized by geographic locations (Table 4a-g).

Table 4b. North American Native populations in Western countries results on elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Bingham & Kelley (2022)	Mentors in program were important, by increasing peer support.	Maintain positivity for family. Peers enhanced hope. Have goals for the future.	Personal growth after mental illness.	Being a giving person. Purpose in sharing testimonies. Reconnect with spirituality.		
Bone et al. (2011)	Connection to land and community. Romantic connection. Support from relations. Elders as supportive		Connection with cultural heritage. Challenge of dual identity.	Participating in traditional ceremonies. Teaching tradition. Giving back		
Clark et al. (2024)	A strong support system was important.	Connection with others was a motivator.	Awakening from mental illness	Be a good role model	Desire to take ownership	
Doty-Sweetnam & Morrissette (2018)	Supportive relationships. Guidance from Elders. Challenges with professional help. Support from family.	Positive attitude and belief in recovery. Valuing accomplishment.	Rebuilding cultural identity.	Role as knowledge keepers. Being able to extend support and hope to others. Spiritual meaning with illness.	Reclaiming power. Take agency.	Facing underlying issues. Colonialism.
Lavallee & Poole (2010)			Self-discovery and connection to ethnic identity. Internalised oppression.	Spiritual connection and healing increased meaning		
Lewis & Allen (2017)	Family members' support. Role models in treatment.		Cultural activities were important for identity	Role as respected Elders. Pass on traditional knowledge. Generative acts. Spirituality.		
McCarron et al. (2018)	Family support. Other support system. Emotional support, practical support, financial assistance. Community integration.	Family as motivation for recovery.	Gaining self-awareness. Increased independence	Religion increased meaning. Focusing on traditional AI values		

Table 4b. (continued).

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Nygaard (2012)	Supportive environment		Positive cultural identity. Positive self-identity	Engagement in cultural activities. Passing traditional knowledge on to children		Poverty as a challenge

Table 4c. South American studies results on the elements of recovery.

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Agrest et al. (2018)	Relationships in group therapy. Ability to see yourself in others. Clinicians made participants feel important.	Seeing others improve gave hope to.	Accept yourself and see yourself in a new perspective.		Responsibility to participate in treatment. Believe in your own abilities.	Physical surroundings in hospitals were important.
Antunes de Campos et al. (2023)	Peer group was important. Mutual support. Problems with mixed groups		Understanding themselves in light of illness. Overcome prejudices.	Role as mothers. Understanding disease. Role as women	Control over disorder. Reclaim responsibility. Confidence in skills.	Patriarchal culture in AA. Freedom in women's meetings. Gender roles.
Ricci et al. (2021)	Family, professionals, friends and peer-relationships had an impact on recovery. Information about mental illness increased support.	Hope returned with recovery	Changing the way of thinking and acting.	Acceptance of the illness gave meaning and increased hope. It was important to give a meaning to the illness.	Important to believe in oneself.	
Saunders et al. (2023)	Familial support. Role of familism.	Recovery for family.	Invisibility of mental illness. Shift in perspective			

Table 4d. African studies results on the elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Armour et al. (2009)	Being a productive part of society. Family and clinicians were important.	Having hope for the future. Dreams about better relationships. Belief in possible recovery.	Don't feel sorry for yourself. Appear normal	Meaning through God and church.	Focus on your own strength. Family increased responsibility. Belief in authorities.	Race discrimination. Economy related to work and transport.
Nxumalo Ngubane et al. (2019)	Family and support from professionals were important. Participants felt excluded by family and society.		Feeling better about yourself	Found meaning in religion and being involved in local society.	Participants knew best when they recovered	Hard to understand mental illness. Used witches and black magic as explanation. Work was important.
Moore et al. (2022)	Positive relationship between recovery and belonging to your own ethnic group. Social support was important.		Ethnic identity mediates your ability to focus on important aspects of life.			Structural racism as a barrier. Economic equality was important.
Tuffour (2019)	Family and relationships made recovery possible. Participating in social arrangement was important. Integration in society.	Medicine inspires optimism. Treatment gives understanding about mental illness.	Participants increased proud ethnic identity. This supported recovery.	Important to have a meaningful role. Religion played a big part.	Believing in your own strength.	Medicine and work were important.
Tuffour (2020)	Feeling connected to God and the church.	God gave hope for recovery, and belief for a better future.	Participants protested negative stereotypes	Seeking answers and meaning with God. Satan was a metaphor for mental illness.	Participants found control in praying.	
Whitley (2012)	Personal relationship with God. Fellowship in church.	Hopeful relationships. Faith in God and Gods ability to provide recovery		God as primary agent of change. Gratitude for the lessons learned and the ability to cope with hardships.	God is ultimately in control for their life. God is guiding decisions and actions.	Finding peace

Table 4e. Asian studies result on elements of recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Brijnath (2015)	Relationships are important. More stigmatisation from family in Indian populations. Being a burden to the family.	Belief in recovery. No hopeful relationships.	Finding a new identity. Medicine had an impact on identity.	Meaning through religion in the Indian group.	Important to feel in control and feel responsible for recovery. Barrier: dependence on society.	
Chen et al. (2006)	Family as support. Lack of support from husbands. Conflicts with in-laws	Optimistic attitude. Hope for recovery	Integrate themselves in new roles. Meeting societal expectations	Predetermined fate. Acceptance of mental illness.	Having internal encouraging conversation	
Chi et al. (2014)	Connections with professionals. Community support. Family members, friends, religion as support.	Belief in process of recovery.	Accept and embrace self. Shift in values	Meaningful activities. Befriending depression.	Responsibility for their lives. Impact on children. Avoiding harm to others	Recognise emotions and past coping mechanisms
Fukui et al. (2012)	Cultural differences in reliance on others. Reciprocal support.	Emphasis on hope. Hope as self-cultivation	Focus on humility			
Gandhi et al. (2020)	Family support. Peer support. Negative family climate. Dependency on family	Positive attitude and optimism	Participants reported no stigma in study	Peace of mind and meaningful role. Religious practices		Medication adherence. Fulfilment of basic needs
Gandotra et al. (2017)	Support from relationships. Emotional, informal and instrumental support	Hopeful relationships				Education levels and psychological recovery
Gopal & Henderson (2015)	Importance of social inclusion. Dependency on family		Discrimination was high. Self-esteem was only relevant in Australian sample		Role of family in empowerment. Independence. Giving doctors "Godly" status.	Being symptom free and regain social role functioning
Gopal et al. (2020)	Important to have relationships, getting married and have children.		Wanting to be normal			88 % of recovery was symptom remission.

Table 4e (*continued)*

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Ha (2016)	Peer support was crucial	Gained hope for the future and had dreams and goals	Self-awareness	Meaning in new role as peer supporter	Active rather than passive in treatment	
He & Petrakis (2023)	Connectedness through religious groups. Got economic, interpersonal and emotional support.	Having a positive attitude	The spiritual identity supported a positive self-image. Wishing to be a role model.	Spirituality increased meaning in life.		Religious conflicts in families were a barrier.
Ho et al. (2016)	Connection with God. Connection with spiritual community	Spirituality helped with short-term goals	Spirituality helped improve and change oneself	Spirituality were concrete goals		
Kanehara et al. (2022)	Compassion towards others played a big role.	Hope and optimism for the future.	Important to rebuild a positive self-image free of social stigma.	Participants sought meaning with mental illness.	Personal responsibility and control in life was important.	
Kok & Lai (2017)	Interaction with others was important. Family played a big role in recovery. Shame related to disappointing family.	Important to have dreams for the future.	Getting to understand yourself better.	Accepting both good and bad things in life. Meaning through religion.	Responsibility to live a meaningful life. Fulfil parents' expectations.	
Kuek et al. (2022)	Participants wanted to hide the symptoms and tried to appear normal. This decreased support.	Trying to be positive in current situation.	Participants identified with the illness. See themselves in a more positive light.	Hard to give meaning to mental illness.	Most experienced loss of control.	
Kuek et al. (2023)	Support from family and friends. Being part of a religious group. Professional support.	Maintaining a hopeful attitude	Grow and remerge as new people	Strong religious beliefs. Mental illness as a result of wrongdoings. Meaningful activities as work or hobbies.	Regaining control in life.	

Table 4e (*continued)*

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Kuek et al. (2024)	Desire for reintegration. Relief for supporters. Reciprocal support	Focusing on improvement. Sense of resignation regarding possibility of recovery	Live without the burden of stigma. Contribute to society and viewed as normal.	Fulfil role expectation	More autonomy over mental health. Greater sense of control	
Kwok (2014)	Support from family. Important to strengthen relationships. Trust in other people.	Follow your dreams and set up goals for recovery.	Break expectations about what it is to be a woman in Chinese culture. Overcome stigma.	Religion contributed to meaning.	Responsibility through reading books. Training skills in solving interpersonal conflicts.	
Lam et al. (2011)	Sense of normalcy in community. Connect with others through activities. Integration into the community	Better outcook on the future. Optimism and hope. Identifying positive changes	Concealing illness because of stigma. Positive change: clearer thinking, increased maturity, more considerate	Value of helping others. Normal social role	Illness as life-enhancing. Sense of control and developed strength	
Lee et al. (2015)	Instrumental support e.g., economic help. Being a burden for the family.				Authorities were important.	
Lee et al. (2022)				Less use of religion in recovery due to secularised nature of Singapore.		
Liu (2014)	Work professionals. Importance of friendships and peers. Communication with the Supreme Being	Think more positively.	Changes in the way of thinking. Changes in standards and lower expectations. Individuals through God's eyes. View themselves positively	Helping others. Accept themselves as persons with mental illness. Religious beliefs	Increase one's sense of usefulness and responsibility. Making decisions for oneself. Relinquishing control to a higher power	Work was important. Medication.

Table 4e (*continued)*

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Ma et al. (2023)	Easing burden on family. Developing trust in others. More social interaction	Family was motivation for recovery. Family goals increased pride	Relying on oneself. Self-support and taking action. Self-discovery. Taking good care of themselves to ease burden on family.	Religious beliefs. Meaning in life was for family.	Responsibility for family. Taking responsibility for one's life. Self-encouragement. Familism and responsibility to provide	
Madill et al. (2023)	Acceptance of support. Contact with recovery community.	Motivation to change		Meaning in supporting others		
Matsuoka (2015)	Peer support. Social workers.	Self-worth fostered hope. Shift towards positivity and optimism	Increased understanding and sense of self-worth. Cultural values as humility and modesty.	Accepting life. Not taking things for granted.	Acknowledge own worth. Control of life. Self-determination. Taking action	
Mizuno et al. (2015)	Interaction with healthy individuals. Importance of work as societal participation. Supportive friends. Integrate in society.	Clear intentions for future lives. Goals for the future. Positive outlook on life.	Complex interplay between self-identity and societal perceptions. Change in self-identity. Desire to "fit-in".	Sense of purpose. Contribute to others. Make a positive impact. Increasing knowledge of mental illness.	Responsibility to live properly. Striving for strength.	Medication.
Murwasuminar et al. (2021)	Integration in community. Support from family and friends. Connectedness through activities.	Hope. Hopeful relationships with professionals. Barrier in lack of knowledge	Stigma among traditional healers	Perception of the source of illness. Strengthen faith and reconnect with God.	Remain passive and avoid stressors. Family lead in seeking treatment.	
Ng et al. (2008)	Family and romantic relationships were important. Participants didn’t want to be a burden for the family.	Participants felt hopeless and doubted the possibility of recovery.	Wanted to be normal.	Hard to understand and give meaning to illness.	Using medication to feel control.	Economic independence. Medicine was important.

Table 4e (*continued)*

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Pahwa et al. (2020)	Social support from family and co-workers in India. Indian participants were afraid of being a burden for the family.		Indian participants experienced more stigma.			
Saptura et al. (2022)	Both friends and family improved recovery. Being a part of society was important. Felt a lot of stigmas, that made it hard.	Participants experienced hope	Gain insight into what started the problem. To know yourself.	Spirituality was important for recovery and meaning.	Self-control and mastery were mentioned.	Focus on being normal
Siu et al. (2012)	Low peer support. Connection was important. Respect.	Significance of hope.	Positive identity and overcoming stigma.	Finding meaning in life	Sense of control. Being active.	
Song (2017)	Family support was important					Resilience
Song & Shih (2009)	Feeling loved by parents was important. Clinicians, friends and society were a part of feeling connected.	Parents and professionals inspired hope.	Identifying as productive. Work was an important part of identity.	Meaning through religion.	Autonomy contributed to a feeling of normality. Important to be independent. Religion gave control.	Work and symptom remission was important.
Subandi (2015)	Being more open about the illness. Family played a big part in recovery. Important to be integrated in society.	Renewed sense of optimism. Motivation to reach recovery.	Change from being passive to being active. This change led to a more positive self-image and accept.	To understand the meaning of the illness.	Being active gave a feeling of control in life. Family helped control the illness. Religion impacted the feeling of control.	
Subandi & Good (2018)			Recovery was associated with reading the norms of society.			

Table 4e (continued)

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Tanaka (2018)	Emotional connection. Support from family, therapist and peers. Community support.	Hopeful relationships.	New perspectives. Maintaining independence. Positive self-identity. Re-discovering the self	Legacies would be passed down. Understanding illness and progress. Finding fulfilment. Spiritual satisfaction	Accomplishments and pride. Self-control.	
Tang (2018)	Professional support. Community meeting places. Information sharing.	Dreams of living a good life.	Racism. Employment as crucial to their self-worth	Helping others	Autonomy. Sense of control. Empowerment through knowledge. Role of others and community	Language barrier
Tang (2019a)	Connection in counselling. Enhancing social support.		Patienthood. Double stigmatisation.	Understanding mental illness. Embracing spirituality.	Family's role in decision-making. Self-care skills and taking control.	Medication.
Tang (2019b)	Connection in counselling. Enhancing social support.		Patienthood. Double stigmatisation.	Understanding mental illness. Embracing spirituality.	Family's role in decision-making. Self-care skills and taking control.	Medication.
Tse et al. (2014)			Chinese people are less likely to reveal mental illness			
Wu et al. (2021)	Trust in professionals increased quality of life.				Personal power was important. Important to believe in one's own abilities.	
Yang et al. (2024)	Integrate into community. Supportive networks. Family played a significant role. Professional workers.	Realistic view of recovery. Ongoing struggle. Completing task.	Believing in oneself. Overcoming fear of rejection. Changing for the better.	Participating in purposeful activities	Personal willpower. Mental control. Power of mindset. Sense of accomplishment. Autonomy.	

Table 4e (continued)

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Young et al. (2020)	Family provides emotional support, but could also be a barrier due to stress, stigma.		A positive self-image was important for recovery. It was important not to bring shame on the family.			Important to have a job.
Yu et al. (2021)	Family was important for recovery. Treatment was only effective if the participants received support from family.		Family affected how participants identified themselves.			
Zaheer et al. (2019)	Support from family and professionals was important for recovery.	Hope for the future increased with coping abilities.	New perspective. Others had a big impact on identity.	Finding meaning with the illness. Help from clinicians.	Responsibility for recovery. Focusing on own strengths.	Being normal. Medicine and work were important.

Table 4f. Elements of recovery in Caribbean studies

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Whitley (2016)	Recovery in being active in society. Family support was important.	Hope for the future was essential in recovery.		God and religion were important among Caribbean-Canadian		

Table 4g. Elements of recovery in international reviews

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other
Hickey et al. (2017)	Family was important for recovery in Taiwan. Important to include family in treatment in Taiwan.	Hope for the future and never give up in Taiwan.	Identity in Arab cultures is understood and defined by participating in a collective community.		Important to feel in control. The doctor has a strong authority in Arab cultures. Family gave autonomy in Arab cultures.	
Leamy et al. (2011)	Extra focus on community.		Collectivistic identity. Double stigma in ethnic minorities in Western cultures.	Faith community. Religion and God as a higher power.		
Pouille et al. (2022)	Love and support from family. Peer support. Community level recovery.	Harmful consequences of SUD as motivator. Spirituality motivated to stop misuse	Cultural identity. Positive self-view as traditional men. Minority-related experiences such as labelling.	Reconnecting with culture. Religion and spirituality. Meaningful relationships. Help others. Being role model for children.	Taking responsibility.	
Slade et al. (2012)			Spiritual identity. Cultural identity.			
Sofouli (2021)	Family plays a central role. Providing support	Estonian language lacks future tense and makes it hard to perceive and express hope		Spirituality was more present in non-Western cultures	Family member and professional make decisions	
van Weeghel et al. (2019)			Overcome double stigmatisation			

Social connectedness

The importance of social connectedness was universally acknowledged, though the nature of supportive relationships varied. Family and colleagues were primary sources of support in Asian cultures, while friends were more prominent in the USA (Pahwa et al., 2020). Cultural factors influenced these relationships, with concerns about burdening family members and upholding family honor being more pronounced in Asian and Middle Eastern contexts Kuek et al. (2022)(Brijnath, 2015; Chen et al., 2006; Kakuma et al., 2024; Lee et al., 2015; Ma et al., 2023; Pahwa et al., 2020).

Hope and optimism for the future

Hope and optimism were widely recognized as essential for recovery, albeit with cultural nuances. In Eastern cultures, hope was linked to self-cultivation and courage, whereas Western cultures emphasized mastery and control Fukui et al. (2012). Hope depended on perceived opportunities, with role models acting as both sources of inspiration and anxiety, illustrating a complex interplay between hope and insecurity Tang (2019).

Identity

Rebuilding identity was crucial across cultures, often involving self-acceptance and finding new purpose. Collective identity was particularly significant in indigenous communities, where connection to family, spirituality, and cultural heritage supported recovery (Bone et al., 2011; Doty-Sweetnam & Morrissette, 2018; Lavallee & Poole, 2010; Nygaard, 2012). Stigma, however, frequently complicated identity reconstruction (Amini et al., 2019; Armour et al., 2009; Brijnath, 2015; Eltaiba & Harries, 2015; Kanehara et al., 2022; Kuek et al., 2022; Kwok, 2014), especially among African Americans, where mental health stigma intersected with racial discrimination Armour et al. (2009).

Meaning

Finding meaning after mental illness was highlighted across studies, with cultural practices contributing to this sense of purpose (Bone et al., 2011; Chi et al., 2014; Pouille et al., 2022; Yang et al., 2024). Generativity—passing knowledge to younger generations—was valued in Asian and Native American communities (Doty-Sweetnam & Morrissette, 2018; Lewis & Allen, 2017; Tanaka, 2018).

Religion and spirituality played significant roles in recovery. Religion and spirituality were major sources of meaning, more so in non-Western than Western cultures (Brijnath,

Tabel 7. Middle eastern studies definition of elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other

2015; Hickey et al., 2017; Leamy et al., 2011; Sofouli, 2021; van Weeghel et al., 2019; Whitley, 2012), with religious beliefs framing mental illness as a form of trial or karmic consequence (Kuek, Raeburn, & Wand, 2023; Murwasuminar et al., 2023).

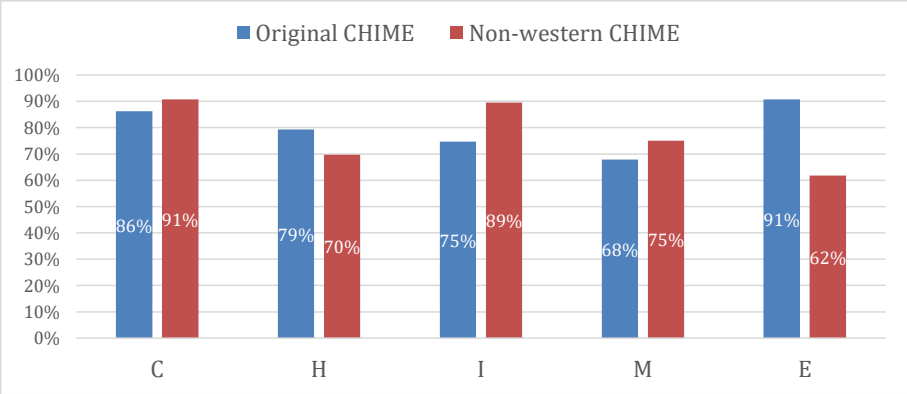
Empowerment

Empowerment involved personal responsibility and strength-based approaches. In Asian cultures, recovery often included a duty to uphold family reputation (Ma et al., 2023). However, family members sometimes shared responsibility for recovery (Gandotra et al., 2017), particularly when individuals lacked confidence (Wu et al., 2021). In some Middle Eastern cultures, doctors were seen as central to the recovery process, with individuals delegating responsibility to medical professionals (Gandotra et al., 2017; Hickey et al., 2017; Lee et al., 2015). Social and religious support also played significant roles in shaping empowerment (Antunes de Campos et al., 2023; Chen et al., 2006).

Weight of the CHIME elements

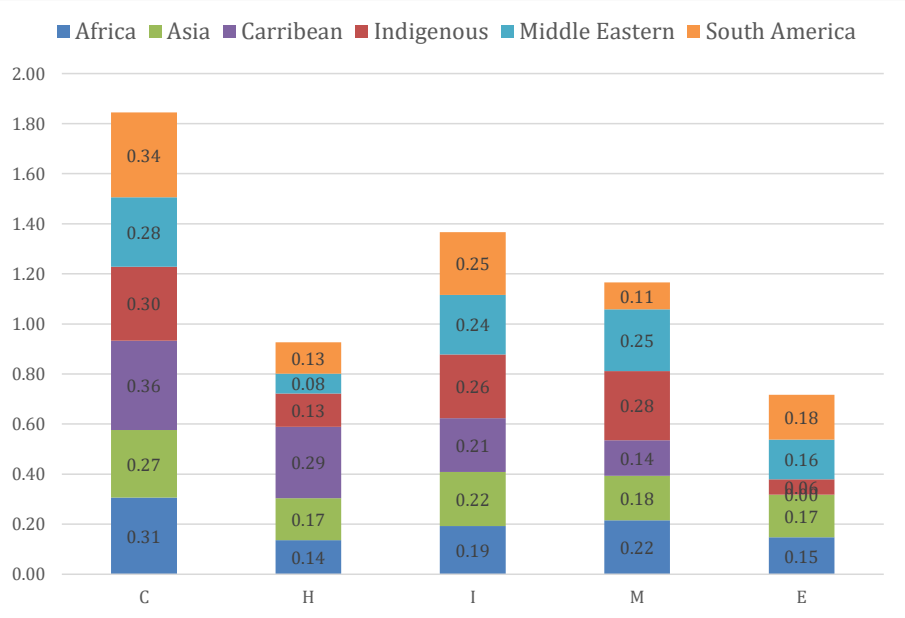
Connectedness was the most frequently mentioned element among the included studies (91%). Empowerment was mentioned the least (62%).

Figure 2. Percentage of studies examining CHIME-elements in Western and non-Western cultures.



When examining the weight of each element, Connectedness consistently received the highest score across all continents (Figure 3). Conversely, Empowerment received the least attention, followed by hope. Notably, in Asian, North American Native and Middle Eastern cultures, Meaning held great importance.

Figure 3. The summed weight of each element of CHIME divided by the total weight of all elements in each continent. Each element was rated on a scale from 0 to 5, 0: not mentioned at all; 5: frequently mentioned in the study.



Extended CHIME

Regarding RQ3, the analysis indicated that while the five CHIME categories were universally understood and applicable. Two subcategories need to be added to Empowerment: "shared responsibility" and "shared control" (Table 5).

Table 5. Summary of the synthesis of findings.

C	**Connectedness**	Peer support	Relationships	Support from others	Being a part of the community		
H	**Hope and optimism**	Belief in possibility of recovery	Motivation to change	Hope-inspiring relationships	Positive thinking and valuing success	Dreams and aspirations	
I	**Identity**	Dimensions of identity	Rebuilding positive sense of self	Overcoming stigma			
M	**Meaning**	Meaning of mental illness	Spirituality / Religion	Quality of life	Meaningful life and social goals	Meaningful life and social roles	Rebuilding of life

Tabel 7. Middle eastern studies definition of elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other

E	**Empowerment**	Personal responsibility	Control over life	Focusing on strengths	Shared responsibility	Shared control	

Note. Dark blue represents the main categories of the original CHIME model, light blue marks the original subcategories, and new subcategories identified in the analysis are suggested for greater inclusivity.

Discussion

This scoping review aimed to describe the nature of the evidence base of personal recovery in research with non-Western individuals, and to investigate how well the CHIME framework fits among them. The findings highlight how the CHIME framework aligns broadly with non-Western experiences of recovery, though adaptations may enhance cultural relevance across different global contexts. This finding expands upon a limited evidence base.

Nature of the evidence base

The number of studies investigating personal recovery and its interaction with culture has notably increased in the past five years. However, despite this growth, there remains a significant gap in the research, particularly from developing countries. Many of the studies included in the review focused on minorities in Western countries, indicating a need for research conducted in non-Western countries. While Asian cultures had the largest evidence base, it is important to note that these studies were predominantly from high-income Asian countries such as Taiwan, Hong Kong, Singapore and Japan. No research was conducted in Central America, Russia and the Pacific Islands and only one study was conducted in Africa.

Schizophrenia, depression, substance use disorder and bipolar were the diagnosis most frequently included in the studies. However, diagnosis such as anxiety disorders, eating disorder, and personality disorder were largely underrepresented, highlighting a significant evidence gap in this field. Further research should aim to include individuals with a more diverse range of diagnoses to provide a more comprehensive understanding of personal recovery across various mental health conditions.

Fitness of the CHIME framework

Across the 76 studies included, all five categories of the CHIME model proved relevant in the experience of personal recovery. However, it was observed that certain categories held greater significance than others in different cultures. For instance, meaning

seemed to hold greater significance among Asian, Native North American and Middle Eastern participants, compared to South American participants.

Religion and relationships in personal recovery

Religion plays a vital role in personal recovery, influencing all CHIME categories. Joshanloo (2014) highlights cultural differences, noting that Western cultures often view religion as a well-being tool, while in non-Western contexts, it is foundational to understanding life itself. Religion's importance in interdependent cultures exceeds the CHIME subcategory of "spirituality" within meaning. In terms of empowerment, religion shapes individuals' sense of responsibility rather than merely acting as a coping strategy, challenging psychology's tendency to separate religion from mental health (Reme, 2014). Relationships, especially family, are also central across CHIME categories, reflecting a stronger focus on connectedness in non-Western cultures. Markus and Kitayama (1991) note that while relationships in independent cultures often serve personal goals, in interdependent cultures, building relationships is the goal. Family bonds, emphasized more in non-Western recovery, are tied to the broader concept of familism, where family, including close-knit community members, takes precedence over individual needs (Tuffour et al., 2019) (Saunders et al., 2023).

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Empowerment

Empowerment is interpreted differently in independent versus interdependent cultures. The review shows empowerment mentioned less often than in Leamy et al.'s original CHIME study (2011), suggesting its higher relevance in Western contexts (Stuart et al., 2017). This may be due to researchers' priorities or its reduced importance in collectivist societies, where individuals often share responsibility for recovery decisions and place greater emphasis on relational aspects. Collectivist cultures prioritize group connection and interconnectedness, which contrasts with the Western focus on autonomy, personal control, and independence (Abdullah & Brown, 2011)(Heim et al., 2022) . Here, well-being is often linked to interpersonal harmony rather than individual mastery, with an external locus of control and belief in concepts like fate or divine plans (Kong et al., 2023; Stanhope, 2002). This cultural difference suggests that Western empowerment models may not fully apply to non-Western contexts, where humility and shared responsibility are emphasized, requiring a rethinking of patient involvement and empowerment approaches (Johnsen et al., 2017; Khanthavudh et al., 2023; Susanti et al., 2020).

Tabel 7. Middle eastern studies definition of elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other

Cultural differences in personal recovery

Culture can either facilitate or hinder the process of recovery, depending on specific cultural norms and how they shape individual needs (Çam & Uğuryol, 2019). Different cultures have distinct approaches to achieving recovery. For instance, some North American Native cultures believe healing occurs through harmony with nature, while certain Asian cultures emphasise conformity to norms and emotional self-control (Abdullah & Brown, 2011). While the CHIME framework appears applicable across different cultures, it is important to adapt each element to the specific context. For instance, directing treatment solely at the individual level may not yield productive results in societies that prioritise relationships and interdependence (Kuek, Raeburn, Liang, et al., 2023).

Limitations

A strength of the review is that it was guided by the PRISMA checklist (Tricco et al., 2018). Moreover, given the novelty of this field, a scoping review is particularly relevant, as it highlights existing evidence and identifies areas requiring further empirical support. Finally, reviewing 76 papers offers a comprehensive overview of the field.

However, several limitations are also present. Firstly, the differences in experiences of recovery found in this review can be the cause of factors other than culture. Amati et al. (2023) argue that before attributing differences in recovery to culture, one should consider how factors such as institutional racism and other socio-structural disadvantages affect different ethnicities. This suggest that to fully comprehend personal recovery, a political agenda on social justice and human rights needs to be included.

The inclusion criterion requiring studies to be written in English, Danish, or Norwegian may inadvertently exclude relevant non-Western research. Even though few non-English studies were identified during screening, that could be due to limitations in search terms. The inclusion criterion required the term "personal recovery" to be present in a paper, but many studies focused on related concepts like well-being, coping, resilience, post-traumatic growth, and quality of life. While these terms differ, they often overlap, and recovery concepts might be present even if not explicitly addressed (Lee et al., 2022; Young et al., 2016).

Future research

Considering the heterogeneity among non-Western cultures, further research on CHIME and personal recovery in various cultural contexts is essential. Future studies could explore how family and religion can be integrated into treatment within collectivist cultures and examine how different cultures prioritize elements of recovery, especially hope and empowerment. Research could also focus on culturally sensitive understandings of personal recovery.

The absence of linguistic representation of personal recovery may reflect a gap in expressing lived experiences calling for research on linguistic differences and metaphors across cultures offering insights into the boundaries and nuances of the recovery experience within each culture (Davies, 1990; Davies & Harré, 1990; Hacking, 2007).

Echoing Karadzhov (2023) arguing that future research should focus on understanding how oppressive social structures influence recovery and coping mechanisms among marginalized populations, especially ethnic minorities in Western countries, we advise future research to explore how socio-structural factors such as poverty and social marginalization impact recovery. Such insights can inform the development of anti-oppressive interventions to enhance recovery outcomes among marginalized individuals.

Conclusion

The CHIME framework shows universal applicability for describing recovery across cultures. However, adapting the "empowerment" category to include interdependent values would enhance its relevance to non-Western cultural contexts. In non-Western cultures, the importance of relationships and religion suggests that these elements should be incorporated more prominently within the CHIME model.

This review highlights a need for further research on underrepresented non-Western cultures. In particular, it is important to examine how social injustice and the absence of a national language dedicated to personal recovery can impact recovery. Additionally, focused studies on personal recovery in trauma and affective disorders are essential to filling current research gaps.

Tabel 7. Middle eastern studies definition of elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other

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Tabel 7. Middle eastern studies definition of elements in recovery

Author	Connectedness	Hope and optimism	Identity	Meaning	Empowerment	Other

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