Abstract

Introduction: Religion is an important impetus for recovery. However, there has been little work examining the role of religion in recovery for black African service users (BASUs) in England.

Aim: The aim of this study is to explore how religion influences recovery from mental illness for BASUs in England.

Method: 12 black African service users were purposively selected and interviewed using face-to-face semi-structured interviews. Data was analysed using interpretative phenomenological analysis (IPA).

Results: The study generates fascinating insights that BASUs views about mental illness and recovery are influenced by Pentecostalism and traditional African healing systems.

Discussion: The participants’ perceptions of their mental illness experiences and recovery which are characterised by the pragmatism of Pentecostalism and cultural beliefs are consistent with what is reported in the literature.

Implications for Practice: The findings of the study show that broad changes are needed to accommodate the religious coping of BASUs in their recovery journey.

Keywords: Religion, recovery, mental illness, black African, England.
Accessible Summary

Scientific rationale

Religion plays an important role in recovery. However, there has been little research examining its role in recovery for black African service users (BASUs) in England.

What is known on the subject?
  • Religion plays important role in recovery from mental illness.
  • Religion can have both positive and negative effects on recovery.

What the paper adds to existing knowledge?
  • It is conceivable for BASUs to engage with the mainstream mental health services at the onset of their symptoms.
  • BASUs see mental illness and recovery through the lens of religion. They mostly use Pentecostalism and traditional African healing systems to aid their recovery.
  • The mainstream mental health system and the traditional African healing system exist in harmony for BASUs who are open to simultaneously access both services.

What are the implications for practice?
  • There is a need to recognise that most black Africans have unique ways of practising their Christianity. Thus, broad changes are needed in the services to support religious coping tailored to the individual persons in their recovery journey.
  • There is a need for service providers and healthcare professionals to integrate Pentecostalism and traditional African healing systems into the recovery processes. It should equally be recognised that such changes could trigger confusion, dilemmas and paradoxes.
  • Service providers and healthcare professionals must build partnership and collaborative working with cultural practitioners and the clergy from the black African communities to facilitate recovery and address any misunderstandings.
Relevance statement

There is dearth of research into how religion influences recovery for BASUs in England. This perhaps reflects the lack of understanding about the significant roles Pentecostalism and traditional African healing systems play for BASUs recovery. Recognising that BASUs have unique ways of practicing their religion and integrating these into the service provision will go a long way to help the recovery journey of these service users.

Introduction

In recent years there has been an increasing interest from healthcare service providers in meeting the religious needs of all mental health service users in England. This practice has been driven by a host of policy documents (Department of Health, 1999; Department of Health 2011; Department of Health, 2005). Religion is particularly important for black people in general. Pritchard (2019) suggests that for most black people living in England, diasporic dislocations, structural inequalities, marginalization and constrained political influences have disenfranchised them and helped forge their interest in religion for two main reasons. First, to signify their senses of struggle and second, to gain inspiration from their compatriot clergies who occupy positions of power in churches. Religion undoubtedly, serves as a beacon of hope for most black people in England, yet there has been a dearth of explorations of how it contributes to Black African service users’ (BASUs) recovery from mental illness. The notion that the religious needs of most black Africans are not being met by the mental health services in England has been raised by Keynejad (2011), who argues that despite the fact that most black Africans may conceivably interpret psychotic symptoms in a religious context and seek help from religious leaders, their spiritual and religious needs are not adequately met by the services. It is astounding that there is lack of embedded understanding of religious coping of
BASUs in a multi-ethnic country like England. Thus, the aims of this research is to contribute to a deeper understanding of how religion contributes to BASUs recovery from mental illness, and to place such perspective at the centre of mental health nursing scholarship and practice.

**Religion and mental health**

Existing research recognises the critical role played by religion and better mental health outcomes (Koenig et al. 2012; Bonelli & Koenig, 2013; Koenig, 2009; Pargament et al., 2004). Yet, the relationship between religion and mental health has attracted ambivalence, scepticism and conflicting interpretations from many authors who argue that the existential experiences of religion are speculative and possible symptoms of mental illness (Koenig et al. 2012; Mohr et al., 2011; Mohr et al., 2006; Mohr, 2006; Wilding, Muir-Cochrane & May, 2006). Others argue that religious experience can have both positive and negative effects on mental illness (Pargament et al., 2004; Koslander & Arvidsson, 2005). Considering all this evidence, it seems that confusion around religion abounds, and it is difficult to understand the nuances of religion that are accountable to the seemingly important health benefits (Krause, 2015).

**Importance of religion to black Africans**

Religion is prominent in every sphere of life in many black African societies (Mbiti, 1990). In fact, many Africans experience and connect with a deity not only in churches or mosques, but in times of happiness and sadness, and in the fields as they cultivate their crops and look after their livestock (Juma, 2013). Africa is known for its polytheistic and multi-religious culture with most of their myths, symbols, and rituals tied to religion (Ezenweke, 2013; Mbiti, 1990, Turaki, 2006). Christianity, Islam and African Traditional Religions (ATR) broadly dominate religion in black Africa (Kpobi & Swartz, 2018). ATR is an umbrella term for traditional beliefs and practices that include belief in a Supreme Being, spirits, ancestors, mystical powers and traditional African medicine (Mbiti, 1990). However, limiting this discussion to Christianity,
evidence suggests that patterns of Christianity in the region mostly adhere to Pentecostalism (Biri, 2012; Ezenweke, 2013; Turaki, 2006) or Pentecostal-charismatic Christianity (Robbins, 2004) or “evangelical” or “Neo- Pentecostal” (Pritchard, 2019, p.2), a form of Christianity in which believers place emphasis on the gifts of the Holy Spirit, charismatic and ecstatic experiences of speaking in tongues, healing, and prophesying (Asamoah, 2013; Robbins, 2004).

**Pentecostalism in Africa**

Discussion of Pentecostalism in African context is by no means exhaustive for the purposes of this article. To begin with, Pentecostalism is inspired by various complex paradoxical dogmas, ranging from eschewing worldly affairs, embracing sober and simple lifestyles to accumulation of significant wealth (Pritchard, 2019). Baptism of the Holy Spirit, purification, endowment of the supernatural powers, and the gift to speak in tongues have been found to be important to Pentecostals across the world (Asamoah, 2013). Furthermore, Pentecostalism often employs fasting, deliverance, exorcism, vociferous prayer, anointing and anointing oils, holy water and incense in their rituals (Kpobi & Swartz, 2018; Omenyo & Arthur, 2013). Moreover, Pentecostalism assigns special importance to success and prosperity therefore, illnesses and misfortunes are commonly attributed to the destructive hands of evil spirits (Omenyo, 2011). Thus, it devotes its healing system in finding the equilibrium between the soul and body (Osafo et al, 2015).

Pentecostalism in the African context is conceptualised as a continuum of extremities manifested by fear and opportunity to free one from suppression, horror, demons, ill health and misfortune (Asamoah, 2013; Ezenweke, 2013; Turaki, 2006). Pentecostalism particularly appeals to many black African Christians because of its emphasis on healing from powers of darkness, spiritual protection and prosperity (Biri, 2012; Onyinah, 2006; Osafo et al., 2015;
Moreover, Pentecostalism is perceived by many Africans as an alternative healing system along with the orthodox health systems (Kpobi & Swartz, 2018), it is therefore utilised to heal a wide range of conditions including mental illness (James et al., 2014). In fact, many authors have suggested that because good health is of such importance in African societies, Pentecostal churches have seized on this as their modus operandi, and have overtly and covertly adapted, hybridized and re-interpreted traditional African religions as conduit to the performance of miracles or the mystery healing powers (Biri, 2012; Eagle, 2005). Such performances usually involve integration of physical, mental and spiritual rituals to help gain access to the Supreme Being or ancestors (Hammond-Tooke, 1974). Yet, in spite of the deliberate integration of the African traditional system into Pentecostalism, it seems paradoxical that some Pentecostal movements in the sub-region have taken seditious stance against the use of traditional African practices (Biri, 2012; Eagle, 2005). What remains unclear is how BASUs in England utilise Pentecostalism in their recovery. Before proceeding to examine the research methods, it is important to advice that the discussion above must be interpreted with caution because substantial heterogeneity exists in Africa, and it should not be presumed that there is a universal Pentecostal belief system across the continent, though it is almost certain that basic themes of Pentecostalism are universal in the sub-region (Buhrmann, 1984).

**Methods**

The aim of this study is to explore how religion influences recovery from mental illness for BASUs in England. This study, which seeks to understand how BASUs use religion to cope with recovery is exploratory in nature. Therefore, the most appropriate research approach for analysing the participants’ experiences is interpretative phenomenological analysis (IPA) because it is concerned with how people make sense of their lived experiences. Besides, it is
interpretative which allows researchers to capture and interpret the complexity and sense-making of the participants’ experiences whilst remaining close to their narratives. IPA is also fundamentally idiographic as it is committed to unravel the specificity and uniqueness of each individual case as well as the shared and esoteric experiences across cases (Eatough & Smith, 2017; Smith et al., 2009). Ethical approval was obtained from the City, University of London Research Senate Committee and an NHS Local Research Ethics Committee (approval reference number: 10/H050/46). All participants in the research gave informed consent.

**Research setting and participants**

The data reported in this paper are part of a larger study conducted by the researcher (Tuffour, 2017). Results from the main study revealed that BASUs conceptualised recovery as a pragmatic and subjective concept distributed across a continuum of clinical, functional and spiritual dimensions, resilience, identity and their social and cultural backgrounds (Tuffour, et al. 2019). The idiographic nature of IPA analysis requires a small sample size (Eatough & Smith, 2017). Thus, semi-structured interviews were used to collect data from 12 purposively selected participants who were first- or second-generation black Africans and self-identified as belonging to the geographical region of sub-Saharan Africa. The following three processes were used to recruit the participants: First, the research recruitment pack containing the participation information sheet and response slip were circulated at the research site inviting eligible participants to the study. Second, informal meetings and emails were sent to clinical staff informing them about the project and requesting them to support the recruitment process by signposting eligible service users to the researcher. Finally, the researcher arranged face to face meetings with eligible participants on the wards and community clinics telling them about the research and seeking their consent to participate.
The participants comprised of three men and nine women who were between 19-57-years old. Five of the participants were born in Sierra Leone, four born in Zimbabwe, one born in Zambia, one born in Ghana, one born in England with Ghanaian parents, and referred to his cultural heritage as Ghanaian. They were all receiving care from the mainstream mental health services. Six had diagnoses of schizophrenia, four paranoid schizophrenia, one organic delusional (schizophrenia-like) disorder, and one had severe depressive episodes. Contact with the services ranged from two to 18 years. All three men had struggled with illicit drug and/or alcohol dependency in addition to their primary diagnosis. All the participants identified themselves as religious and Christians. Though two of the participants went further to openly declare their denominations. One stated that she is a Jehovah’s Witness whilst the other declared herself as belonging to both SDA and Catholic churches. However, what stood out for all the participants is their embrace of Pentecostalism.

**Data collection**

Data was solely collected by the researcher via semi-structured interviews with the participants. To ensure rigour, interview schedule was developed from a pilot interview to serve as a guide for the interviews. The interview schedule was flexibly used to enable emergent interesting ideas to be followed up. Open-ended questions such as: Can you tell me how you first encountered the mental health services in England? and follow-up questions such as: What happened after you became unwell? were asked to elicit detailed accounts of the participants’ experiences. The duration of the interviews was between 35 and 60 minutes. This was largely dependent on the lucidity of the participants (Tuffour, et al. 2019).

**Researcher reflexivity**
It is important for IPA researchers to demonstrate reflexivity by honestly declaring how their values influenced the research process (Smith et al., 2008). Despite being a black African like the participants, the researcher adopted an etic perspective whilst using curiosity, open-mindedness, empathy and flexibility to understand how the participants’ experiences were shaped by their social, cultural and historical worlds (Finlay, 2011). Yet, he could not avoid unexpected issues and entanglements due to the participants’ perception that he was an insider (Tuffour, 2017, 2018). For example, one participant’s query to the researcher ‘are you a Christian?’ when narrating her experiences of prayers and divine intervention required some self-disclosure. In such an unexpected encounter, a reflexive journal kept during data collection and analysis enhanced open, honest and emotional attachment with the participants and the data. Feelings provoked at these stages were acknowledged and reflected on to enable analysis to remain close to the participant’s experiences (Dempsey, 2019; Eatough & Smith, 2017).

**Data analysis**

The interviews were transcribed verbatim and analysed manually in accordance with IPA principles. Three column tables were created for each of the interviews, and each individual interview manuscript pasted in the middle column (Smith et al., 2009). To look for shared and unique idiosyncratic themes across the transcripts, the following iterative steps were followed: reading and re-reading the individual interview transcripts several times for full immersion in the data and making initial notes, converting the initial notes into exploratory themes, returning to the transcript with a fresh perspective and clustering and mapping themes into emergent themes summarized with relevant extracts, and integrating them into inclusive table of superordinate and subordinate themes (Smith et al., 2009; Willig, 2008).
A narrative account (see findings) of convergence and divergence across all the transcripts was subsequently developed incorporating detailed analytic interpretation supported with verbatim excerpts from the participants’ accounts. Several steps were taken to ensure quality and rigour of the data analysis. For example, as stated above, the reflexive journal used to record initial thoughts, comments, and observation of the participants was helpful in contextualisation and development of the data analysis. Moreover, the immersive and meticulous attention to the participants’ experiences demonstrate sensitivity to their voices whilst simultaneously allowing the reader to check their interpretations (Smith et al., 2009). Regular supervisions were utilized with project supervisors for reflexive moments and to gain conceptual understandings about the emerging codes and subsequent themes. To ensure rigour, the research supervisors also acted as independent auditors by thoroughly reviewing a selection of interview transcripts, themes and patterns of code for coherency of arguments (Tuffour, 2017).

**Findings**

The following sections describe and interpret the participants’ accounts of how their religion and spirituality impacted on their mental illness and recovery. It is important to bear in mind that different interpretations of the data are possible as meaning making is at the helm of qualitative analysis, so it is plural, dynamic and multidimensional (Dempsey et al., 2019). A common thread highlighted throughout the analysis is the participants’ annotations of the significance of their religion in their mental illness and recovery journeys. At the onset of their mental illness, some of the participants felt that they were receiving messages from God or from spiritual beings. For example, whilst reflecting on the build-up of her mental illness, one participant portrayed a seemingly contented life after arriving in England as an asylum seeker.
She was living independently and had a part-time job as a cleaner. However, the critical moment for her was when she suddenly started hearing voices telling her to throw away all her belongings. When asked who could be telling her to throw away all her belongings, she replied that it was ‘perhaps God’.

Different interpretations can be inferred from this statement. First, it is plausible that this participant is deeply religious and is expressing that her experience is a spiritual conversation with God or supernatural beings. An alternative interpretation, to be suggested, albeit cautiously, is that she is expressing a belief that mental illness is something that could be inflicted by God or supernatural beings. If either of the above interpretations is true, then it could be suggested that the participant retained a significant interconnection between her spiritual and/or cultural beliefs and mental illness. However, it could be argued from a mental health nursing professional perspective that the participant was probably experiencing delusions and lacked the insight to understand her experiences.

Without any prompting, religion and spirituality were acknowledged by almost all the participants as very important in their recovery. Nearly all the participants seemed to overtly profess their deep faith in the Christian philosophy and Pentecostalism (Tuffour et al., 2019). For instance, two participants stated the following:

Church... It is a big part of my life...That’s where I show God that I trust him...He can hear me. He hears me when I pray.

I attend church for healing.

What is being alluded in the above statements are the participants’ beliefs in spirituality, church, particularly Pentecostalism to aid their recovery from mental illness.

Another participant was expressive of the importance of church, especially inter-denominational churches to her and her family:
When I was diagnosed she (her mother) would be confined to the Catholic church but now she’s open to any churches like the Pentecostal churches though she doesn’t like the SDA church, so she would go to the Pentecostal churches and also go to the Catholic church, though she prefers the Pentecostal churches because she said that there is more anointing there though I don’t think that’s the case. There’s anointing everywhere but she prays more, and I’ve learned to pray more as well and have faith in God that He’s going to be with me no matter the case that I’m in. And I also changed my denomination to being SDA, I think that’s more appropriate for me…I think it’s helping me because I’m able to rely on God. I’m able to rely on someone who can take care of me and make sure I don’t get sick again, guiding me to the right path and being SDA helped me…other denominations as well.

Though, spirituality and Pentecostalism appealed to all the participants in their recovery, but this individual’s pursuance of inter-denominational spiritual deliverance stands out from the rest of the participants. She also presented as being torn between two denominations, but she eventually succumbs to the allures of Pentecostalism.

Many affirmed that God provided hope for their recovery and comfort. For example, one person spoke about how she sought answers and assurances from God when she was diagnosed with mental illness:

I am a human being, if anything happens, I will ask God. I rely on Him and He is the one who looks after me…in Him we should trust…So I believe in God that with Him nothing would happen to me.

This participant is persuasive in her narrative that becoming closely connected to God is providing her with a deep sense of peace and comfort, and possibly a source of treatment. This was also echoed by another participant when she also spoke about her mental illness and hopes for recovery:

I know there is God who created me, who created the heaven and the earth, why should I worry; He is the only one who can help me, why should I worry. My worry will not solve the problem; it’s only when the time comes that God will solve the problem.

Her narrative declares that spiritual deliverance is her first line of treatment and it is only God who can offer her the prospect of recovery, rather than the mainstream mental health
services. Arguably, her relative passivity towards the mainstream mental health services is due to her staunch faith in spiritual deliverance. This was evidenced when she said:

I just pray to God that He will give me good health and to go forward and live on my own, yeah... I believe He will help me to become well, start to go to work and pay my bills and my rent.

This narrative evokes the participant’s reliance on the divine kindness of God for her resourcefulness and self-sufficiency. Similarly, another participant reported that she benefited from God and prayers she received from her family and church members:

God played a major role in my health...I received a lot of support from others...The church people came to pray for me...They visited me to pray for me that God should be loving... They came to visit me because they heard that I was not well, and they prayed for me... Prayer is a healer...there is healing in prayers.

Here, the participant’s declaration that ‘there is healing in prayers’ is a clarion call that prayers can reassure and help her in times of troubles and help her to recover from mental illness. For her, prayer acts as a conduit of sanctuary. Her narrative also shows a sense of belongingness that religion and spirituality can provide in one’s recovery.

Another participant also commented that her religion, membership of the church, and faith are helping her to cope with her symptoms:

I think it’s helping me because I’m able to rely on God. I’m able to rely on someone who can take care of me and make sure I don’t get sick again, guiding me to the right path... being a member of the [church] helped me ...it helped me to get closer to God and learn the truth.

For this participant, nothing is more reassuring than her faith and being able to rely on God to gain insight about her mental illness. She further reported that her faith in Pentecostalism was a crucial factor in her recovery:

There is anointing everywhere...I’ve learned to pray more as well and have faith in God that He’s going to be with me no matter the case...I think it’s helping me... I’m able to
rely on someone who can take care of me and make sure I don’t get sick again, guiding me to the right path.

Another participant also reported that his religious belief helped in his recovery journey.

Before I went into hospital, I was extremely religious, that kind of helped. Like hoping that I would be better sometime in the future...and it did kind of get better.

In the extract above, the participant appeared to cite his religious belief as a hope-inspiring factor. However, for some participants, religion appeared to have detrimental effect on their mental health. For example, one person openly spoke about her experiences of auditory hallucinations in the context of communication with God:

When it comes to religion, I’m still a Christian, though it comes more important to me when I become more confused because I feel as if I’m communicating more with God and other people but more with God because it feels like He’s talking directly to me, that’s not supposed to be the case.

The narrative above is a little incongruous for a person who professes to be a firm Christian. She seems to be wrestling with her faith, and there is an indication of resignation and pragmatism in her comment. She is perhaps suggesting that her religious beliefs could trigger or exacerbate her symptoms, yet there is a portrayal of warmth, hope and optimism of recovery in her narrative.

One person spoke about the negative association of religion and his mental illness when he recounted how his family ostracised and barred him from the family home because they are religious, and he is not:

I guess it’s just the way I was brought up because I was brought up in a family of Christian background and stuff like that. They believe everything can be prayed for and cured...That’s one of the issues I have with my parents as well because they are staunch Christians and I am not and that causes a huge problem.

For this participant, the strict Christian home environment set him in a collision with his family. In many black African cultures and other cultures around the world, religious views
are imposed on a person at birth. This participant was born into a Christian family and was
naturally expected to adhere to Christian values. He poignantly narrated how he was expelled
from the family home by his parents for ‘not following rules’. His experience is one of rejection
triggered by religion. Another participant spoke about her frustration with prayers:

    When I go there (Sierra-Leone) I try prayers...but it doesn’t work.

She was visibly sad and disappointed when she said that she is still experiencing auditory
hallucinations even after travelling several times to a prayer camp in her native country. Her
lived experience is one of disappointment and lack of confidence in prayers.

Some others spoke about how they find solace and hope in prayers and God when faced with
negative stereotypes because of their mental illness. This was evident when one person
stated:

    Well, I don’t have to think about these people because this not something I bought in
the shop, this is a sickness, no one want to be sick...I don’t care what people say. What
I will do is to pray to God to help me, if anyone say anything let them say anything,
because I don’t care about what they say. I know I didn’t go to shop and bought this for
myself, it has happened and it’s Satan who cause all these problems for us...This is life,
life is full of risk, life full of trouble, especially sickness, this is our enemy, our greatest
enemy is sickness, death. These two things are our enemies...well, thanks to God I
manage to live.

Here, the participant uses metaphor and pragmatism to convey causes, protest negative
stereotypes and coping mechanisms of her mental illness. The use of the metaphor ‘not
something I bought in the shop’ captures the tensions of a range negative emotions she
harbours for her mental illness. It evokes a sense that it is not her own choice or fault that she
has mental illness, and she shifts the causal factor to ‘Satan’. Satan is a metaphorical figure in
the bible associated with all things that are negative and hopeless. It seems that by evoking
that ‘Satan’ is the cause of her mental illness, the participant is rejecting any personal
responsibilities and placing the meaning of her mental illness with biblical interpretation. The
practice of placing ill health and misfortune in dialogue with biblical narration is commonplace for Africans (Turaki, 2006). Her narrative suggests a complex emotional and cultural association between evil spirits, fatalism, spirituality, Pentecostalism in mental illness and recovery. Perhaps the most striking overall feature of her account is that it captures what emerges throughout in the narratives of almost all the participants that they see mental illness and recovery through the lens of religion.

**Discussion**

The purpose of this study was to explore how religion influences recovery for BASUs in England. This exploratory study adds to the body of literature about recovery. In this section, the findings are situated to the existing literature, as well as a brief consideration of how the study contributes to mental health nursing practice.

Some participants felt that the onset of mental illness was a divine manifestation. This is consistent with many studies that have reported that many black Africans are likely to cite spiritual intercession as the cause of mental illness (Abbo et al., 2008; Ezenweke, 2013; Muga & Jenkins, 2008; Mzimkulu & Simbayi, 2006; Olugbile et al., 2009; Ventevogel et al., 2013). Reinforcing the above is the fundamental belief in the traditional African worldview that the world is filled with malicious and unpredictable supernatural powers, that people are at the mercy of these benevolent or malevolent impersonal powers, and that staying on good terms with these forces is a prerequisite for a happy and successful life (Ezenweke, 2013, Turaki, 2006 Mbiti, 1990).

The participants’ profound belief in Pentecostalism helped to mediate close personal connection with God and to release the perceived demons causing their mental illnesses. This is consistent with many studies that have suggested that most black Africans proclaim a
pragmatic gospel that seeks divine intervention to address practical needs and resolve all conceivable human problems (Asamoah, 2013; Ezenweke, 2013; Kyei et al., 2014; Osafo et al., 2015). The fundamental precept of Pentecostalism is to offer connectedness, self-esteem, optimism and hope when one is overwhelmed by alienation and disillusionment (Asamoah, 2013). This is parallel to the African worldview and spirituality (Onyinah, 2006), because it addresses the needs and aspirations of the ordinary and pragmatic African person trapped in a material world (Akrong, 2000; Asamoah, 2013; Mbiti, 1990; Turaki, 2006).

One participant’s disappointment in the impotent prayers she sought in her native country and the deliverance many sought from the Pentecostal-charismatic churches resonates with the suggestion of existence of quack prophets offering false prophecies and directions to vulnerable people (Asamoah, 2013). Moreover, it has been suggested that many of these organisations that claim to specialise in mental illness often stigmatise, dehumanize, abuse, and subject service users to inhumane treatment with the pretense of setting them free from bondages (Asamoah, 2013; Atindanbila & Thompson 2011; Ezenweke, 2013). Emerging evidence suggests that maleficent practices exist in the sprawling African Pentecostal-charismatic churches (BBC, 2016), though these are not well documented. Whatever the situation, this study advocates for a mental health care service provided within a spiritual or religious context consistent with human rights and the rule of law. Any inhumane, unsatisfactory or arbitrary service must be addressed by the fundamental principles of English law. Yet, looking at this from a different perspective, it appears that at the height of their mental illness symptoms, some BASUs abandoned and substituted Christianity that puts emphasis on faith, hope, and patience with the pragmatic ATR, that promises quick answers through a set of beliefs and ritual practices (Lado 2006; Hammond-Tooke 1974).
Consistent with the literature (Dein & Cook, 2015; Koenig et al. 2012; Mohr et al., 2011; Mohr et al., 2006; Mohr, 2006; Wilding et al., 2006), the findings revealed that religion had adverse effects on recovery for some of the participants. However, this study also helps to provide clarity that there is a contextualisation of Christianity within cultural practices that informs the BASUs religious heritage (Mokhoathi, 2017). In summary, the results of the present study capture the important roles religion plays for BASUs recovery from mental illness. Also, the common thread highlighted throughout the participants’ narratives is that their recovery is strongly influenced by the African traditional worldviews and Pentecostalism which are pragmatic in their orientation (Eagle, 2005).

**What the study adds to the existing evidence**

This study has offered an insight into a novel and innovative approach to understanding recovery and helps to bridge the gap between mental health research and service users from Sub-Saharan Africa. Interrogation of the data has provided an empirical, theoretical and conceptual understanding of religious coping of BASUs in England and drawn attention to a neglected but important area of knowledge. The study has provided insight to latent meanings that lie in the nuanced accounts of the participants revealing that BASUs in England use Pentecostalism and African cosmology for protective charms, exorcism, emotional well-being, hope and optimism, self-efficacy, autonomy and empowerment (Eagle, 2005; Turaki, 2006; Ross, 2010).

Furthermore, this study discredits the notion that BASUs mostly rely on spiritual intervention to manage mental illness (Ae-Ngibise et al., 2010; Rathod et al., 2017). What is known about the participants on commencing the research is that they were engaging with the mainstream mental health services at the onset of their symptoms. This helps to provide awareness that
the Western mainstream care system and the traditional African healing system can co-exist side by side (Airhihenbuwa, 1995; Eagle, 2005; Van Dyk, 2001) for many BASUs in England.

**Implications for clinical practice**

The evidence presented thus far in this IPA research demands broad changes in the services that provide religious needs tailored to the individual person. This means that the prevailing religious universalism in clinical areas (Pargament, 2002) should be considered as ethnocentric and outdated. Religious beliefs are privilege and joy, and should not be forced on people (Packer & Nystrom, 2006). The fact that the participants overwhelmingly professed that their recovery is influenced by Pentecostalism and their cultural worldviews suggest, albeit caution that it should be part of mainstream care for BASUs. There is a need for service providers to support interactivity between the available services and BASUs religious coping. Different ways of integrating Pentecostalism typified by energetic clapping, dancing, singing, praying, speaking in tongues must be explored by clinicians and service providers. A sympathetic approach would involve adapting the existing religious facilities in the clinical areas for such purposes. This could mean providing dedicated areas for BASUs to practice their religion vociferously and freely without any stigmatisation. Nonetheless, it should equally be recognised that spiritual reality comes with ambiguities. For example, the moral and spiritual dogmas of Pentecostalism that associates prayer for healing, repentance, sanctification and justification could be confusing and present dilemmas and paradoxes for clinicians (Asamoah, 2013). On the other hand, Eagle (2005) helpfully argues that alternative worldviews can exist in harmony even if occasional differences arise. An innovative way to overcome such complex dilemmas and paradoxes is for clinicians and service providers to explore the Pentecostal practices of BASUs and to support involvement of cultural practitioners and the clergy from the black African communities to do this.
However, several bottlenecks could affect such collaborative work. For instance, the clergy’s subjective beliefs, reliance on divine intervention and inconsistency in practices could pose serious conflicts with clinicians and service providers. Some of these difficulties could be easily resolved if their roles are carefully negotiated in advance (Kpobi & Swartz, 2018).

Maleficent practices of the clergy enlisted to support BASUs in their religious expression could be addressed by adhering to the local and government safeguarding policies which sets out a range of legal frameworks, responsibilities and best practices to protect individuals at risk of abuse or neglect (Office of the Public Guardian, 2019), as well as adopting policy commitments along that of Church of England (2017) that puts emphasis on vigilance, training, transparency and accountability.

**Conclusion**

The aim of this study was to promote awareness of black African perspective on how religion could promote their recovery from mental illness. The most obvious finding to emerge from this study is that BASUs see mental illness and recovery through the lens of religion. They also utilise both Pentecostalism and African traditional worldviews as stimulants for recovery. Although not surprising, considerable insight has been gained about the relationships between religion and recovery from the perspectives of BASUs. There is a need for service providers to develop strategies that embeds BASUs religious coping in service provision. A limitation of this study is that it explored the experiences of a small number of BASUs in England. What is now needed is a cross-national study examining the relationships between BASUs in England and other African countries if these findings are to be generalised.

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