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Recovery processes reported by people with severe mental illness in Brazil: systematic review and thematic synthesis

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DECLARATION OF CONFLICTING INTERESTS

The other authors declare that they have no conflict of interest.

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ETHICS

This study was approved by the Research Ethics Committee of UNIFESP, in accordance with Resolution CNS 466/2012, and registered at Plataforma Brasil, CAAE N. 2,394,928.

CONTRIBUTORS

JAO designed, conducted the study and collaborated with data analysis and manuscript preparation. FAPM collaborated with the selection of the studies and with the data interpretation. PRPA collaborated thematic synthesis analysis and codification of the descriptive and analytical themes. MCRA and WFO collaborated with the analysis, data interpretation and preparation of the whole manuscript. MS collaborated with the review, interpretation and supervision of the whole article. AG collaborated on the study design, data analysis and supervised the manuscript preparation.

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BACKGROUND

The Recovery movement originated in the United States, driven by the fight for human and civil rights that had spread across the nation. In the 1970s and 1980s, there were movements of mental health users who sought empowerment and advocacy. These movements were supported by civil rights struggles from the previous decades and first-person narratives (Davidson et al., 2016; Deegan et al., 1988). According to Anthony (1993), “recovery is a unique and deeply personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and useful life, even within the limits caused by the illness.” According to this classical definition, this process implies the “development of new meanings and goals in a person’s life as they overcome the catastrophic effects of mental illness”.

Personal recovery has been promoted and included as a paradigm of public mental health policies, especially in Anglo-Saxon countries (Slade, Amering & Oades, 2008; Slade et al., 2012). The World Health Organization (WHO) has also advocated for the incorporation of recovery as a principle in the mental health policies and routine practice of all countries (World Health Organization, 2021a; 2021b).

Different studies have identified measurable dimensions of recovery (Dell, Long & Mancini, 2021; Gyamfi et al, 2022). One such model is the CHIME framework proposed by Leamy et al. (2011), which is one of the most widely cited and used recovery framework worldwide. CHIME stands for Connection with others (Connection), Hope and optimism (Hope), Identity, Meaning and purpose (Meaning), and Empowerment. This model has been replicated, expanded, and supported by several studies (Weeghel et al., 2020).

However, despite the progressive expansion of the recovery paradigm, especially in English-speaking countries, the conceptualization and incorporation of this concept by Latin American countries, such as Brazil, is still incipient (Becker et al., 2023; Gamieldien et al., 2020; Lyons et al., 2022; Priebe et al., 2019; Vera San Juan, Mena & Andrade, 2021). We are still facing a period of consolidation in the mental health care community, even considering the existence of innovative practices

oriented towards recovery (Cubillos et al., 2020; Onocko Campos et al., 2017; Vera San Juan, Mena, Andrade, 2021).

There is an increasing consensus in Brazil that incorporating the concept of recovery may contribute to mental health care policies, expanding what has already been implemented from the perspective of psychosocial rehabilitation (Costa, 2017; Onocko Campos et al., 2017). In addition to cross-cultural validations of recovery measures (Silva et al., 2017; Ricci et al., 2020), most of the published studies only present subjective perceptions about this concept and the processes of lived experiences and dimensions among people with severe mental illnesses (Agrest et al., 2021; Vera San Juan, Mena, Andrade, 2021). There are also essays and theoretical papers analyzing, in a critical way, the insertion of the concept and perspectives of personal recovery, and its relationship with psychosocial rehabilitation practices already implemented in Brazil (Costa, 2017; Oliveira, 2017; Onocko Campos et al., 2017). Most of these works agree that a practice explicitly oriented to recovery would be a next step to advance mental health assistance in the country.

However, no papers have summarized the main themes emerging from primary qualitative studies in Brazil, which could provide a first empirically based recovery model emerged from a thematic synthesis to guide future research in the country. The present study aimed to synthesize qualitative studies that investigated the recovery process in the Brazil among people with severe mental illness. This was done in terms of the definition of each theme and the identification of its facilitators and barriers.

METHODS

This systematic review and thematic synthesis followed the Enhancing Transparency in Reporting the Synthesis of Qualitative Research – ENTREQ (Tong et al., 2012), which is the most internationally adopted checklist to guide reviews reporting and synthesizing qualitative studies.

Stage 1: Identification of the research question

The review question was:

“Which are the recovery processes, their characteristics, facilitators and barriers, from the perspective of people with severe mental illness in Brazil?”

Stage 2: Study search and selection strategy

Through a pre-planned search, the following Latin American and Brazilian databases were adopted for our search: BVS, LILACS and SciELO. The CAPES theses and dissertations database was also included to search for possible works that were not yet published through scientific articles. Additionally, the Pubmed/Medline database was used to search for potential Brazilian studies published only in international journals in English.

To build the search strategy, the PICO approach (acronym for the words Patient, Intervention, Comparison and Outcome) was adopted in its adaptation for qualitative studies. This adapted version is called PICo (Lockwood et al., 2017), and corresponds to the words: Population, Phenomenon of Interest, and Context. In this study, the population, as in most applications of this approach, is presented in terms of the pathology or clinical condition investigated, which, in this case, corresponds to mental illness. The phenomenon of interest was the recovery process in the Brazilian context. In addition, given this review was based exclusively on qualitative studies, focused on the narratives and experiences of people with mental illness, these terms were added in the search, as previously performed in a similar international review in the field of recovery (San Juan et al.,2021)

Based on this approach, a search strategy was built using Boolean operators and adopting the main keywords in the area in Brazilian Portuguese and English, such as: “knowledge,” “experience,” “narratives,” “mental health,” “recovery,” and “Brazil.” The term recovery was used both in its English original format, which is the most frequently adopted, in addition to it translation into Portuguese, present in the national academic literature, namely “reestablishment” and “overcoming.” The search strategy was implemented in October 2022. In addition, hand search was carried out in journals that are known to have published articles that report Brazilian research on the theme of recovery, specifically Cadernos Brasileiros de Saúde Mental (CBSM), Ciência e Saúde Coletiva, and Revista Iberoamericana de Psicologia. Hand searching was also conducted with dissertations or thesis and articles through

queries to peer researchers who have recently published studies in the field. Full texts were obtained for articles considered relevant for inclusion, being selected according to the eligibility criteria of the full review.

To establish consistency in the selection of studies, the retention of titles, abstracts and full texts, as well as the extraction and selection of articles, were carried out by two independent researchers. A third independent reviewer resolved discrepancies.

Stage 3: Study eligibility criteria

The studies included in this review followed the following criteria:

1. Focus on the recovery process in people with severe mental illness (including diagnoses of psychosis, such as schizophrenia, and severe depression) in Brazil, attending or not mental health services;

2. How this process was understood by the person;

3. Involved methodologies where participants' perspectives were explored openly; therefore, studies with fixed survey responses were excluded;

4. Studies published from the year 2000 onwards, considering that prior to that period there were no publications on the topic of recovery in Brazil. This was also done in a previous review about the use of the recovery concept in Brazil (Brandão et al., 2022);

5. Published in Brazilian Portuguese or English.

Articles were excluded under the following conditions:

1. If mental health problems were not the primary condition;

2. If the focus of the study was limited to a specific aspect of the recovery process (such as empowerment, for example), without mentioning the broader recovery process;

3. Studies in which the primary condition was substance misuse or exposure to traumatic events, as these fields have their own scope of literature describing specific and distinct aspects of the recovery process;

4. Studies that do not provide a definition or perspective of the recovery process and/or its characteristics, based on the narratives or reports of research participants, focused on: strategies to obtain a better level of the recovery process, factors that mediate or moderate recovery, quality of care and assessment of recovery due to an intervention;

5. Editorials / discussion / theoretical articles;

6. Duplicate studies.

Stage 4: Data extraction and article quality

References were exported to Rayyan Reference Manager to assist in the initial screening of titles, abstracts and full texts. For each study whose full text was retained for the thematic synthesis, the following data were extracted and tabulated: type of article, methodological approach, participant information, inclusion criteria, study location and summary of the study's main findings. Recovery themes reported in the studies in the results/discussion section were also tabulated. Results were categorized when themes were not explicitly presented. Emphasis was placed on recovery themes described as a result, not those that were presented as factors that helped or hindered the recovery process.

Quality of the studies was assessed using the RATS checklist (acronym for the terms in English: relevance, appropriateness, transparency, and soundness), a checklist specifically developed for the evaluation of qualitative studies (Clark, 2003) and comprising twenty-five questions about the relevance of the study question, adequacy of the qualitative method, transparency of procedures and solidity of the interpretative approach. To assess the quality of the retained articles, as performed by Leamy et al. (2011), RATS checklist response options were dichotomized into yes (1 point) or no (0 point), offering a scale ranging from 0 (low quality) to 25 (high quality). This evaluation was carried out by the same two independent evaluators who retained the articles.

Stage 5: Qualitative thematic synthesis

The qualitative studies synthesis was carried out according to the Thematic Synthesis model, proposed by Thomas and Harden (2008). According to this model, the synthesis is performed following the following steps: (1) line-by-line coding of the text of the primary studies; (2) organization of codes into descriptive themes (methodological analysis - meta-method); (3) interpretative construction of analytical themes (theoretical analysis - meta-theory). As a result, analytical themes offer a new interpretation that goes beyond primary studies.

An initial coding framework was developed and used to thematically analyze the studies using qualitative analysis in the MAXQDA Analytics Pro software for Windows. In this way, the main overarching themes and related subthemes occurring in the tabulated data were identified using inductive and open coding techniques, as proposed by Thomas and Harden (2008). Additional codes were created where necessary, and these new codes were regularly merged with the MAXQDA primary copy, all of which were applied across articles.

Once descriptive themes were created, the frequency with which these ones appeared in the included articles was identified. The count for each theme comprised the number of articles that mentioned the theme itself or in a subordinate one. At the conclusion of the conceptual framework thematic analysis design, descriptive themes were discussed and refined by all members of the research team and were merged into analytical themes.

RESULTS

Insert Figure 1 here

According to Figure 1, initial search identified a total of 1224 hits – with 155 duplicate papers, removed by the electronic reference management software Rayyan. Review of title, population and country location allowed for exclusion of a further 972 papers, and more 39 excluded papers based on hand-searching. Full-text

versions of 57 papers were retrieved, with the exclusion of 47 papers based on abstract. For the 11 remaining retrieved studies, application of the full inclusion and exclusion criteria led to exclusion of a further four papers, being three papers due to describe recovery as an outcome and one paper not from Brazil. Finally, only seven studies were retrieved for review and thematic synthesis, which comprised six papers and one dissertation (Agrest et al., 2021; de Miranda et al., 2014; Lopes et al., 2012; Marques et al., 2022; Orsi et al., 2021; Ricci et al. 2021; Vera San Juan, 2020).

Quality assessment and data extraction

Table 1 shows quality assessment using RATS scores by two independent evaluators. RATS scores ranged from 0 to 25 and the following classification was used for the convenience of this study: (1) scores below 15 were considered unacceptable; (2) scores from 15 to 25 were considered acceptable, being from 15 to 20 good and above 20 very good. All studies had at least acceptable quality, with scores ranging from 16 to 24. Only two studies had scores between 15 and 20 given by at least one of the two evaluators: de Miranda et al. (2014) and Lopes et al. (2012). All the other studies had quality assessment rated as very good. Regarding concordance between evaluators, a final rate of 91.4% of agreement was achieved, ranging from 76% to 100%.

Table 1 also offers a summary of all the seven studies information and characteristics. Studies were published between 2014 and 2022. A total of 83 participants were included, with reported age ranging from 21 to 71 years old, including 25 females and 43 males, not including the 15 participants from the study of Vera San Juan (2020), which did not report information about gender. Regarding data collection, three studies were based on focus groups (de Miranda et al., 2014; Lopes et al., 2012; Orsi et al., 2021), two used structured interviews (Agrest et al., 2021; Ricci et al., 2021), one adopted open narrative interview (Marques et al., 2022), and one was a semi-structured in-depth interview (Vera San Juan, 2020). For data analysis, Agrest et al. (2021) adopted the deductive thematic analysis, using Whitley and Drake (2010) recovery model. De Miranda et al. (2014) and Orsi et al. (2021) adopted Content analysis. Lopes et al. (2012) and Ricci et al. (2021) adopted Interpretive phenomenological analysis. Finally, Marques et al. (2022) adopted discourse analysis and Vera San Juan (2020) adopted the framework analysis.

Insert Table 1 here

Thematic Synthesis

Thematic synthesis was conducted by one of the reviewers from the previous steps and by a new one. First, narratives and reports were extracted from each study and composed the basis for the analysis. The synthesis was divided into three stages: (1) a free line-by-line coding of the primary studies' findings; (2) development of descriptive and (3) analytical themes. At the end of each stage, two other independent reviewers with expertise in research into recovery were invited to confirm the proposed results. The generated codes were organized into related areas, through an inductive methodology, to construct descriptive themes, which further assembled and composed analytical themes. Similarities and differences between descriptive themes were searched to create analytical themes. A total of 13 descriptive and four analytical themes emerged from thematic synthesis. Thematic analysis was adopted to all studies, focusing on the narratives of the perception of recovery of people with severe mental illness in Brazil. Table 2 shows all the descriptive and analytical themes, with the number of citations and which studies contributed for each of them.

Insert Table 2 here

Each analytical theme is presented as follows, with its respective descriptive themes, in terms of their definitions and their facilitators and barriers. Table 3 summarizes the main facilitators and barriers reported for each descriptive theme.

1. **Awareness:**

Awareness was composed by five descriptive themes, including the presence of Insight and Acceptance and even the lack of them, comprised by Psychotic Episode, Stigma and Pathologization. Then, Awareness can be defined as a

continuum process of dealing with and facing subjectively the scenario of having a mental illness and of becoming a person characterized beyond this condition. It also includes trying to achieve stigma reduction, by decreasing pessimistic thoughts and listening to others. Dealing with the delusional experience, as the manifestation of mental problems, lead to a behavior to face experiences of the symptomatology.

1.1 Insight

Participants reported the need for support from peers to better understand the illness, by self-knowledge. These lived experiences enriched and provided learning, with greater control of the illness, reduction of stigma, and overcoming difficulties. These decreased pessimistic thoughts, in finding and managing a better evolution for the illness, also changing the angle of vision, looking outside of oneself and identifying oneself as in a mirror. Empathy and self-reflection were considered fundamental to develop insight (de Miranda et al., 2014).

Lack of insight also appeared, in terms of statements that showed the desire for suicide appeared, being worked out through an approach of occupational therapy and physical activities. Feeling in a comfort zone, achieving improvement and perspective to overcome difficulties, going slower and feeling the limits were also considered. One person must always be confident in overcoming difficulties by lived experience and with the support of peers and friends. Memories and experiences for learning, overcoming insecurities and labels and stigma were also mentioned as an important factor for insight (Ricci et al. 2021)

Even in moments of delusion and depression, this factor could be managed with proper medication and correct diagnosis. Being aware of this process, reducing anxiety, was also an important factor, with the support of mental health professionals. Even if full recovery were not possible, people could be supported by improving every day and going back to do certain activities, such as acquiring manual skills (Orsi et al., 2021). Being calmer, working on the emotional aspect as a journey of overcoming, increasing the dignity of each one, empathy with others and collaboration and support between peers were mentioned (Marques et al., 2022). This was a road to be followed, even when needing medication and often wishing for retirement. (Agrest et al., 2021). Schizophrenia was also considered as a problem that came from family.

Violent episodes such as threatening were mentioned, which caused cognitive problems. The importance of the use of medication was mentioned. There was a feeling of being oneself authentic, as a way of achieving a labor activity, and the importance of reading to express oneself to have a good relationship with people (Vera San Juan, 2020).

1.2 Acceptance

Issues such as the comparison of mental illness with other diseases, such as diabetes, and how to control and manage this were addressed. Attending mutual support groups, sharing lived experiences and relearning aspects of everyday life was also mentioned (de Miranda et al., 2014). Being in a place of speech and listening were considered fundamental. The desire to kill oneself was often present, helped by the acceptance of the treatment, adopting the use of medication, and trusting the professionals, by participating and interacting with them (Ricci et al. 2021).

Talking and interacting with the right people, having a routine and hygiene habits also could help. Each one's path of overcoming obstacles was unique, and one should always think about changing for the better: what was and what might become, looking for opportunities and repositioning in society (Agrest et al., 2021; Marques et al., 2022). The feeling of rejection was also mentioned, and aggressive behavior of instructors at school. The importance of family support and use of medication, accepting the diagnosis and its respective treatment (Vera San Juan, 2020).

1.3 Psychotic Episode

In these reports, a desire to commit suicide and the phenomenon of hearing voices were reported, within a delusional process and outbreak. Narratives related to the desire not to live anymore, with a lot of anguish, sadness and despair also appeared. The aggressiveness of the voices and the need to seek external professional help were evidenced in these psychotic episodes (Ricci et al. 2021). Even with the use of psychiatric medication, the voices were still present (Lopes et al., 2012). Being afraid, being worried, not leaving home or having panic attacks were common mental health complaints (Vera San Juan, 2020). A great feeling of sadness, feeling like a burden on the family, having difficulty to get out of bed, made recovery process very difficult to happen (Agrest et al., 2021).

1.4 Stigma

The stigma associated with the illness arising from professionals, especially psychiatrists, was reported (Lopes et al., 2012). The coldness and pragmatism of these professionals were reflected in the attitude of placing themselves above the patients, in a vertical relationship. Another problem related to stigma was the use of prejudiced terms by relatives to describe their family member's condition (Orsi et al., 2021). The need of treatment and side effects from medication use also impacts the person's social and professional life, generating many lost years due to the illness. Being labeled as someone who attends community mental health services to solve their problems was also reported as stigmatized (Marques et al., 2022; Orsi et al., 2021). Problems at school, such as racism, were mentioned. The rejection of accepting the diagnosis of schizophrenia was also cited, especially due to its stigma in the society. Interpersonal communication was compromised, given the concern of other people when interacting with someone with mental illness. The fear of facing the job market, facing stress, and how to handle, without harming oneself even more were also mentioned (Vera San Juan, 2020).

1.5 Pathologization

The desire for suicide was reported in some narratives, with doctors pointing this out due to the mental problem. The diagnosis and use of medication are often a result of this, generating a sentence and negative prognosis that will be reinforced for the rest of the person's life. Pathologization also referred to the process of treating a behavior, experience, or feeling as defined by a symptom of an illness. In the context of mental health, it meant to reduce an individual's complex life experiences and emotions to a diagnosis or label, often resulting in stigmatization and negative self-image.

As for the studies that contributed to this descriptive theme, participants reported feeling pathologized by doctors, who often attributed their desire for suicide solely to their mental illness, without considering other factors such as life circumstances or social issues (Lopes et al., 2012; Ricci et al. 2021). Pathologization leaded to a negative prognosis and could make individuals feel trapped in their diagnosis, preventing them from seeing themselves beyond their mental health

condition (Lopes et al., 2012). It was expressed the desire to retire due to the difficult to work because of medication side-effects. This caused sleepiness although there was the feeling of not being sick. It was reported the wish of not taking medicine, but the fear of this causing psychotic crisis was also recognized. The feeling of being ill and the anxiety associated with this leaded to stopping important activities such as studying (Vera San Juan, 2020).

2. Protagonism

Protagonism was composed by three descriptive themes: Autonomy, Overcoming, and Empowerment. Protagonism can be defined as a sense of achieving agency, acceptance, self-confidence and self-esteem. It is also related to resilience, persistence, motivation and insights, providing willpower and quality of life. The narratives that comprised this analytical theme demonstrated the flexibility of participants in acting as the main stakeholder of their own journey, with a partnership posture and a sense of belonging related to self-realization and achievement of goals.

2.1 Autonomy

Aspects related to autonomy and acceptance were addressed and cited as important elements for the development of skills, based on self-confidence and self-esteem (de Miranda et al., 2014). Despite this, there was a questioning in the discovery process with a certain insecurity and difficulty in assuming a self-ruling posture in relation to individual and independent activities. The sense of protagonism was also achieved by a “trial and error” method and in tackling problems based on own perceptions and insights (Marques et al., 2022).

This theme emerged as a fundamental and essential aspect in the perception of recovery. In general, the speeches had an optimistic tone, with people acquiring more independence in facing adversity (Orsi et al., 2021). Aspects such as housing and work were also addressed, in addition to psychiatric follow-up to assume a process of acceptance in the use of medication and in the management of the mental illness (Agrest et al., 2021; Orsi et al., 2021). Art activities were mentioned as a way of use leisure time, as well taking care of other family members (Vera San Juan, 2020).

2.2 Overcoming

The narratives showed a certain fear in facing the disorder in aspects related to the outbreak, in which living with family members, professionals, and peers is something necessary. Fantasies generated by delusions brought anguish and depression, but there was a posture of overcoming limits, seeking help, supported by resilience and persistence (de Miranda et al., 2014). Motivation and the establishment of a routine were perceived even in the adoption of medications, with people working in a network and trying to improve, even if in different ways. The development of skills was also pointed out as an important factor, generating learning and self-realization and improving quality of life (Ricci et al. 2021).

In general, there was an optimistic perspective, despite the fear of recurrence of psychotic episodes, based on an attitude of facing adverse situations, even with restrictions and difficulties (Lopes et al., 2012). The recognition that delusions and hallucinations could be somehow controlled by medication pointed to a better way of facing the outbreak and the disorder, in the sense that it was necessary to have external help to face the problems (Lopes et al., 2012; Orsi et al., 2021). The search for new paths and perspectives, within a larger strategy to face difficulties and insights, also appeared in the narratives. Despite the optimistic tone, there was a recognition of the inherent limitations of oneself, with a realistic view of the problems and difficulties. Overcoming reality with learning and lessons from mistakes was also highlighted (Marques et al., 2022). Feeling accomplished and satisfied with oneself and one's achievements was also mentioned, centered on the potential of each one (Agrest et al., 2021) Stressful events related do sexual violence were reported, causing depression, but also resilience in overcoming these episodes (Vera San Juan, 2020).

2.3 Empowerment

The narratives pointed to the importance of achieving quality of life and living better as an aim. Involvement in activities with self-help and from others was important for empowerment. Willpower and resilience in overcoming adverse situations were also mentioned (de Miranda et al., 2014). Partnerships and self-realization were listed as important elements for the recovery journey and as a

progressive process in the experience of facing problems and feeling empowered (Ricci et al. 2021). As in the previous theme, fear of the outbreak, mental illness, delusions, and hallucinations also appeared, but there was an initiative-taking and confrontational posture, which characterized a sense of empowerment. The narratives were quite forceful in affirming the importance of having self-awareness and clarification to face difficulties (Lopes et al., 2012).

The importance of being part of groups appeared with a haughty and independent posture. The sense of struggle and determination of never giving up, also appeared, with a questioning of the medication, as this is pointed out as a factor that hinders labor and professional insertion (de Miranda et al., 2014). Recognition of the positive support from community mental health services was seen as fundamental to the empowerment process. Leisure and sports activities were mentioned, as well as specific factors related to the individuality of each one (Ricci et al. 2021). The non-acceptance of stigmatizing labels and framing was identified as important for empowerment. Then, empowerment was also identified in terms of ignoring prejudice and stigma (Lopes et al., 2012; Orsi et al., 2021).

Finally, getting empowered was characterized by the sense of being fulfilled with small things in life, valuing small routines in life and each one's way of being, learning through lived experience (Marques et al., 2022). Music was appointed has an important way to relax, and taking care of siblings, with the development of some home tasks. There was the desire of returning to the academic life, as a way of improving quality of life, supported by therapists and the community, although the respective is stress this event can cause (Vera San Juan, 2020).

3. Bond

Bond was composed by four descriptive themes: Peer Support, Belonging, Connection with Others and Welcoming. Bond can be defined as a sense of having common experiences, counting on the help of others, acceptance, self-confidence and self-identification. In addition, it is also related to group interaction, support network and feeling welcomed. The narratives that comprised this analytical theme cited the centered and right-based approaches, by sharing common experiences to

overcome anxiety, with a sense of acceptance to overcome difficulties. Willpower, sense of empathy and mutual collaboration were also mentioned.

3.1 Peer Support

Despite peer support was reported as one of the main facilitators of other descriptive themes, it was also categorized as a theme itself, for the following reasons. The participants' reports highlighted the importance of sharing common experiences, overcoming anxiety together, counting on the help of other people with the same diagnosis, collaborating by participating in groups, promoting acceptance and increasing quality of life. The pleasure of participating of a group and overcoming difficulties with the help of others was mentioned. Facing the illness and differentiating reality from what is a dream or fantasy, reducing anxiety and looking for solutions together, enabled finding oneself in the group, with peers, with a proposal for partnership and mutual help. The support network provided the opportunity to participate in various activities and workshops, combined with sharing lived experiences, through mutual contact with other peers (Agrest et al., 2021; Marques et al., 2022; Orsi et al., 2021; Ricci et al. 2021).

3.2 Belonging

The importance of listening to other users in their speeches was reported, acquiring self-identification through experiences lived in common. This provided a rescue of the social and emotional side through conversation and group interaction, with more respect and self-confidence. The speeches demonstrated that the participants felt themselves special when participating in activities with other people with the same diagnosis, increasing group attendance, in a more initiative-taking way, dealing better with the illness (de Miranda et al., 2014; Ricci et al. 2021). Solutions were found for certain problems, through attitudes based on willpower, providing greater emotional and psychological control.

The practice of physical activities in groups was identified as an important factor, providing and generating inclusion and a support network to face problems. Networking and volunteering were also pointed out as alternatives to paid work that promoted the sense of belonging through occupational activities (Agrest et al., 2021; Orsi et al., 2021). It was stated the difficult to have a job and the importance of taking

care of other family members. Leisure time and relaxing activities were mentioned to achieve happiness, such as drinking, smoking, watching some movie and walking around. It was also mentioned the importance of having friends and other relatives celebrating life. Going to church was reported to support life rebuilding, and as an important factor to a community respect (Vera San Juan, 2020).

3.3 Connection with others

Participants reported and pointed out the importance of acting within society to have greater pleasure and quality of life (Miranda et al., 2014). Group activities, with mental health professionals as partners on the journey, also contributed to creating connections. Difficulties were pointed out to obtain open spaces for personal realization and activities. Interpersonal networks with peers and friends were pointed out as fundamental to tread the journey of overcoming and managing psychological treatment. The evolution in the treatment, with the creation of connections, greater empathy and mutual collaboration, without putting one in the place of the other, were also elements addressed. The importance of the family was placed as an important factor, with the creation of bonds characterized by trust and mutual recognition, based on the support of the network, generating new experiences in social insertion (Agrest et al., 2021; Lopes et al., 2012; Marques et al., 2022; Orsi et al., 2021; Ricci et al. 2021). Therapist talks and having friendship were mentioned as important to return to academic life (Vera San Juan, 2020).

3.4 Welcoming

Feeling welcomed was pointed out as an important element to face discouragement and anguish, through the help of those who overcame their difficulties to those who were experiencing difficult times. The group was seen as a support “engine” and the network was considered as an important factor to overcome moments of crisis and outbreak (de Miranda et al., 2014; Orsi et al., 2021). It was mentioned the attempt to go back to school, and the search for people who can help me get back (Vera San Juan, 2020).

4. Hope

This analytical theme was composed by only a descriptive one: “Hope” itself in a continuum, including from a presence to a lack of it. Hope was reported in the studies as the perception of improvement of the quality of life, by overcoming loneliness and getting a feeling of accomplishment by daily activities and support of others.

At first, positive statements about hope were analyzed, pointing to mutual support groups attendance as an important tool to generate optimistic attitudes and behaviors. Having similar problems addressed and the perception of improvement in the peers' quality of life were pointed as important to strengthen a sense of realistic hope in these groups. Overcoming loneliness, making life more interesting, having the support of others were pointed out as elements of hope. The feeling of accomplishment and happiness, with less pessimistic thoughts, having life alternatives and possibilities to solve problems, lead to the improvement of oneself life (de Miranda et al., 2014).

Getting better, not getting discouraged, thinking that nothing is the “end of the world” and living in a group were elements of encouragement cited by people in mental suffering (Ricci et al. 2021). Being supported by lived experiences, even considering that “remembering is suffering” was mentioned. “Seeing life as a rainbow,” having “shining eyes,” going to church, winning battles and overcoming the difficulties that life imposes were also reported as elements of hope. Getting a job and continuing life, with plans related to studying, getting married, having children and starting a family were considered very important (Marques et al., 2022). Continued treatment, even being in a housing service, leading to the above-mentioned outcomes also revealed hope in many narratives (Agrest et al., 2021). There was a hope of, through therapy, having a professional activity, finishing College and developing romantic relationships, to have a house, a family and children, despite mental illness (Vera San Juan, 2020).

At the same time, there were pessimistic reports of hopelessness, associated with aspects of symptomatology that paralyze life and thinking that things will only tend to get worse. The need to use constant medication, feeling incapable, without a job, with fear and insecurity and feelings of dread and mental confusion that might paralyze life were mentioned (Lopes et al., 2012; Ricci et al. 2021). A fatalistic view of the illness as having no cure, with the responsibility of those feeling the loss, such as

mourning, abandonment, heartbreak, all resulting from the outbreak was reported (Lopes et al., 2012; Marques et al., 2022). Family traumas were often recurrent in the speeches, such as sexual abuse, rape, bullying and various humiliations, drug use, living with crime and violence in general. Living in poverty, being homeless, in situations of loneliness and abandonment dramatized were also mentioned as elements of hopelessness (Marques et al., 2022).

Insert Table 3 here

DISCUSSION

This study aimed to provide, using analytical and descriptive approaches, a first-in-field characterization of the main recovery processes identified by people with severe mental illness in Brazil. This was done through a systematic review and thematic synthesis. Six papers were identified and included to assemble our model. Our analysis identified thirteen descriptive themes related to recovery processes, and their respective facilitators and barriers. These descriptive themes were synthesized into four analytical themes: Protagonism, Bond, Awareness and Hope.

The participants from the studies also reported facilitators and barriers to the recovery process. The main facilitators were related to subjective aspects and personal growth, including motivation, development of skills, recognition of one's own limitations, and the cultivation of self-esteem and self-identity. Occupational factors, such as engaging in leisure and sports activities and establishing daily routines, were also identified as facilitators. Relational and interpersonal factors played a crucial role, including establishing common connections with society and, notably, engaging in peer-supported activities. Mental health services and adherence to treatment were recognized as supportive elements for recovery.

On the other hand, several barriers were also identified. Firstly, subjective factors such as insecurity, suicidal ideation, distress and depression were reinforced. The behavior of professionals, characterized by a lack of empathy and cold, as well as family traumas, were mentioned as additional obstacles. Other reported barriers

included housing and employment difficulties, the long-term use of medication and the label of being chronically ill, which contributed to stigmatization.

Most of the recovery processes, as well as their facilitators and barriers identified in this study, converged with those from international literature. Although this thematic synthesis was first drafted through an inductive approach, our findings have several components like those from the international literature on recovery. This is the case especially for the CHIME framework (Connectedness, Hope, Identity, Meaning and Empowerment) (Leamy et al., 2011). Despite the presence of Hope in both studies, the differences in the terminology, especially of Awareness, Protagonism and Bond, were in some sense equivalent to Identity, Empowerment and Connectedness, respectively. The main gap between of our findings and the CHIME framework was related to the term Meaning, which did not appear as an independent theme in our thematic synthesis. Nevertheless, specific descriptive (such as acceptance, belonging, insight, peer support and welcoming) and analytical themes such as Hope and Protagonism seemed to be a basis to have a meaningful life.

The processes identified in our model also converge with an overview that synthesized the international frameworks on recovery (Dell, Long, & Mancini, 2021). The study incorporated elements of psychological well-being based on findings from 25 studies. The primary theme in the synthesis was the definition of recovery as a transformation from a negative identity state to a positive state of psychological well-being, which is like the definition of our analytical theme Awareness. Four additional themes were identified in the review: social and environmental conditions, development of autonomy and responsibility, roles and relationships, and acceptance and insight, which also overlap with our themes Protagonism and Awareness.

Our findings also converged with the scoping review performed by Gyamfi et al. (2022), which synthesized 12 studies and proposed a framework called the Consolidated Framework for Recovery-oriented Services (CFRS). This framework comprised three domains: mechanisms and strategies, recovery as an internal process, and recovery as an external process. Mechanisms and strategies are related to approaches and interventions that may support the recovery process. Recovery as an internal process comprises attributes like the themes that emerged

from this review, specially, hope and empowerment. Finally, the external process of recovery describes attributes that could be attained through outcome measures, which are similar to the facilitators and barriers identified in this review. An emphasis was given to social inclusion and participation, relationship, quality of life, reduced psychological and social consequences of illness, which also appeared in our findings. (Gyamfi et al, 2022).

Despite the similarities with international literature, the model achieved in this synthesis also brings some unique characteristics. Firstly, some of the analytical themes were named with broader and broader terms, such as Protagonism and Bond. These two themes, specifically, were the most cited in the studies. The term Protagonism, despite not being so used in the English language, is frequently used in the Brazilian context. Perhaps this is related to the intrinsic characteristics of the process of deinstitutionalization and reorientation of mental health care in Brazil. The Italian model of Franco Basaglia influenced this process, with a focus on psychosocial rehabilitation and an emphasis on recovering the political and social role of people with severe mental illness as citizens (Onocko Campos et al., 2017). Consequently, such a history seems to justify the importance of protagonism in our model. Regarding Bold, the emphasis given to this theme in the studies also seems to be related to the characteristics of the Brazilian context regarding interpersonal relationships. This can be exemplified by the importance given to the sense of belonging and peer support as essential aspects of the recovery process.

LIMITATIONS AND STRENGTHS

This study has some limitations, such as the small number of studies included and analyzed, and the focus solely on recovery definitions rather than exploring the mechanisms and strategy which potentialize this process. However, this thematic synthesis provides an initial approach to the main recovery narratives of peers in Brazil. There is also a limitation in terms of geographical representation, given country's vast territorial extension and diversity and considering that the reviewed studies were conducted only in the Southern and Southeastern regions. Additionally, it should be emphasized that recovery is a concept that originated in English-speaking countries, which poses challenges when applying it in the Brazilian context. Finally, the review protocol was not pre-registered. Despite these limitations and differences

in terminology, most of our findings are aligned with the international literature, as showed above.

CONCLUSIONS

The findings of this study can be useful for future Brazilian studies focusing on the recovery process. Although the present study has some limitations, its results converge and agree with the international literature and point to possible aspects of the recovery process and journey related to the Brazilian context. Also, the outcomes of this thematic synthesis may support and guide the implementation of recovery strategies in our country.

The concept of recovery has its origins in the Anglo-Saxon context, and it is not yet being explicitly used in the Brazilian context. Although, based on national studies, the present review reinforces the idea that it is a universal process, which can also guide practices in mental health in Brazil. Perhaps a starting point is the dialogue with models that emphasize the promotion of citizenship as a way of promoting recovery, such as the five R's model proposed by Rowe (2015). Another possibility is the implementation of peer support interventions, which have grown in the country in recent years and are seen as one of the gateways to recovery-oriented practice in Brazil (Brisola et al., 2023). Finally, this framework may be adopted as one of the guidelines of a service of this type, considering that the Recovery College to be implemented in São Paulo will be the first initiative of this kind in Latin America.

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Figure 1: Flow chart of identified studies

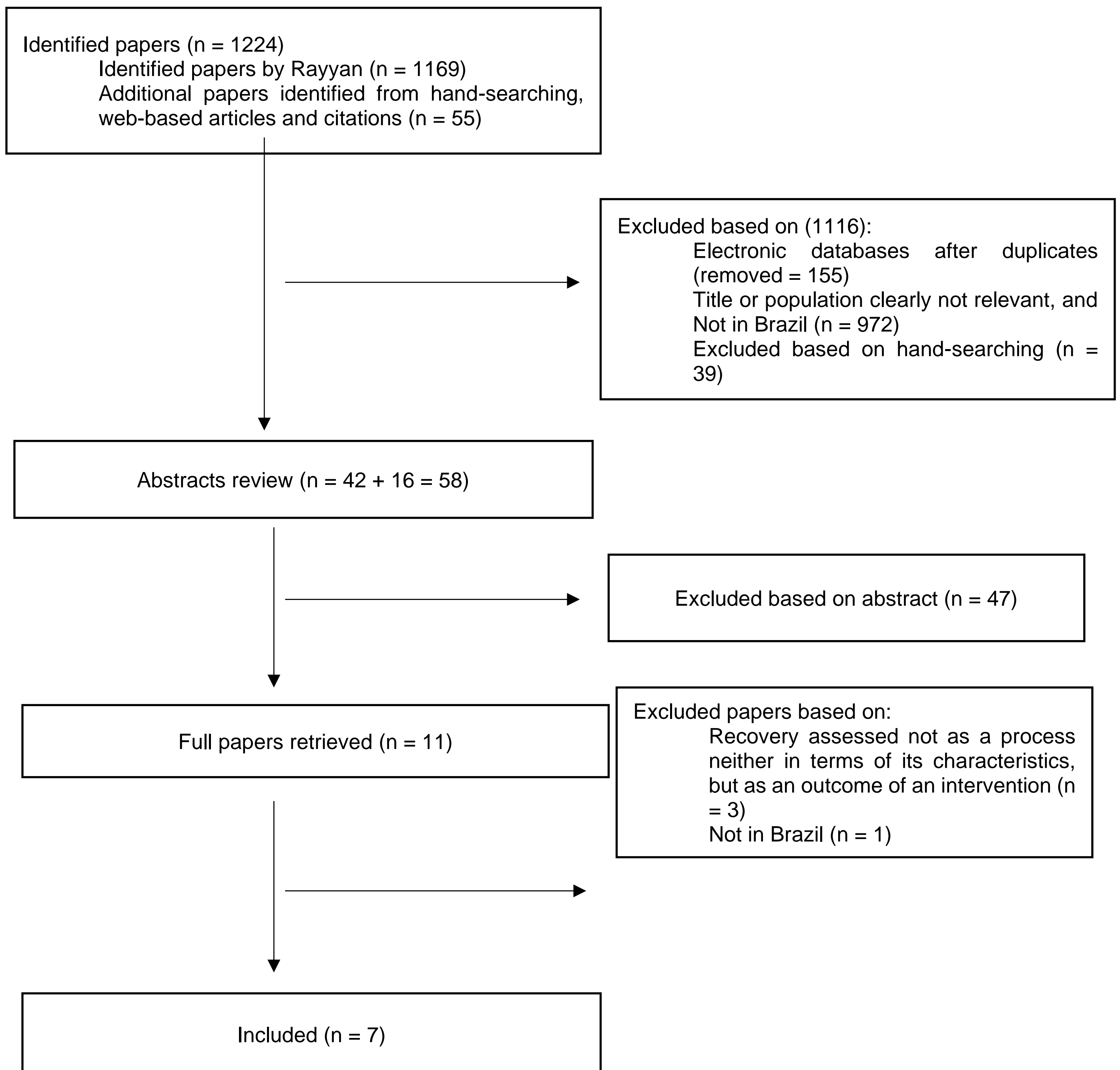

Table 1: Summary of studies information and characteristics

Study	Place (City)	Participants and diagnosis	Data collection	Data analysis	Final RATS rate (0 to 25)
Agrest et al., 2021	Rio de Janeiro	The study included users and professionals from Brazil and Chile. Only the quotes from Brazilian users' responses were extracted. These included 12 people with severe mental illness (9 users and 3 peers), with 4 as females and 8 males, and age ranging from 21 to 65 years old.	Structured interviews with open and closed questions.	Deductive thematic analysis using Whitley and Drake (2010) recovery model.	**24 (evaluator 1)** **21 (evaluator 2)** **87% (concordance)**
de Miranda et al., 2014	São Paulo	8 participants with schizophrenia, being 3 females and 5 males, with age range from 26 to 51 years old.	Focus group.	Content analysis.	**21 (evaluator 1)** **16 (evaluator 2)** **76% (concordance)**
Lopes et al., 2012	Campinas , Rio de Janeiro and Salvador	18 people with schizophrenia were selected, being 6 females and 12 males, with age range from 30 to 51 years old.	Participant observation techniques, semi-structured interviews and focus groups designed to take place in three stages over eight months.	Interpretive phenomenological analysis.	**19 (evaluator 1)** **19 (evaluator 2)** **100% (concordance)**
Marques et al., 2022	Montes Claros	12 participants with severe mental illness, 4 females and 8 males, with age range from 21 to 58 years old.	Narrative interview with the participants, who told their life stories with the experiences they deemed relevant.	Discourse analysis.	**22 (evaluator 1)** **21 (evaluator 2)** **95% (concordance)**

Orsi et al., 2021	São Paulo	8 people with schizophrenia over eighteen years old.	Focus group.	Content analysis.	**20 (evaluator 1)** **20 (evaluator 2)** **100% (concordance)**
Ricci et al., 2021	Campinas	10 people with severe mental illness, with 4 being females and 6 being males with age range from 33 to 71 years old.	Participant's life course interview using the McGill Illness Narrative Interview.	Interpretive phenomenological analysis.	**22 (evaluator 1)** **19 (evaluator 2)** **86% (concordance)**
Vera San Juan, 2019	São Paulo	The study included users and caregivers from Brazil and Chile, but descriptive data was not reported separately. Only the quotes from Brazilian users' responses were extracted, which included 15 people with schizophrenia spectrum disorders over eighteen years old.	Semi-structured, in-depth interviews.	Framework analysis.	**24 (evaluator 1)** **23 (evaluator 2)** **96% (concordance)**

Table 2: Analytical and descriptive themes derived from reviewed studies

Analytical themes	Descriptive themes	Agrest et al. (2021)	de Miranda et al. (2014)	Lopes et al. (2012)	Marques et al. (2022)	Orsi et al. (2021)	Ricci et al. (2021)	Vera San Juan (2019)
Awareness (103)	Insight (54)	X	X	X	X	X	X	X
	Acceptance (18)	X	X	X	X	--	X	X
	Psychotic episode (9)	X	--	X	--	--	X	X
	Stigma (12)	--	--	X	--	X	X	X
	Pathologization (10)	--	--	X	--	--	X	X
Protagonism (95)	Autonomy (39)	X	X	--	X	X	--	X
	Overcoming (27)	X	X	X	X	X	X	X
	Empowerment (29)	--	X	X	X	X	X	X
Bond (90)	Peer Support (30)	X	X	--	X	X	X	--
	Belonging (33)	X	X	--	--	X	X	X
	Connection with others (22)	X	X	--	X	X	X	X
	Welcoming (5)	--	X	--	--	X	--	X
Hope (46)	Hope itself (46)	X	X	X	X	--	X	X

Table 3: Facilitators and barriers for each analytical and descriptive theme

Analytical themes	Descriptive themes	Facilitators / Barriers	
Awareness	Insight	**Facilitators**	▪ Peer support groups attendance to better understand the illness ▪ Self-knowledge ▪ Change of perspective and decentering ▪ Use of proper medication and correct diagnosis ▪ Reduction of anxiety ▪ Development of certain activities, such as acquiring manual skills ▪ Increasing the sense of dignity ▪ Empathy, collaboration and peer support. ▪ Development of labor activities
		Barriers	▪ Suicide ideation ▪ Delusion and depression ▪ Wish for retirement ▪ Genetics ▪ Cognitive problems
	Acceptance	**Facilitators**	▪ Sharing lived experiences and attending mutual support groups ▪ Being in a place of speech and listening ▪ Attending treatment and trusting professionals ▪ Talking and interacting with the right people, ▪ Having a routine and hygiene habits ▪ Acceptance the diagnosis and its respective treatment
		Barriers	▪ Suicide ideation ▪ Feeling of rejection
	Psychotic episode	**Facilitators**	▪ Seek for external professional help
		Barriers	▪ Aggressiveness of voices ▪ Great feeling of sadness ▪ Feeling like a burden on the family ▪ Having difficulty to get out of bed ▪ Panic attacks
	Stigma	**Facilitators**	▪ Management of problems by the community mental health services
		Barriers	▪ Coldness of health professionals reflected in the attitude of placing themselves above the patients, in a vertical relationship ▪ Use of pejorative and derogatory terms by family members to describe mental illness ▪ Needing treatment and medication ▪ Lost years due to the illness in the person's social and professional life ▪ Racism ▪ Not acceptance of the diagnosis ▪ Feeling of rejection
	Pathologization	**Facilitators**	----
			▪ Suicide ideation ▪ Diagnosis and use of medication, generating a sentence and negative prognosis

		Barriers	▪ No consideration of other factors such as life circumstances or social issues ▪ Negative prognosis
Protagonism	**Autonomy**	**Facilitators**	▪ Development of skills in general ▪ Development of perceptions and insights ▪ Acceptance of the use of medication
		Barriers	▪ Insecurity and difficulty in individual activities ▪ Housing and work difficulties ▪ Depending on mental health services through life course
	Overcoming	**Facilitators**	▪ Motivation and the establishment of a routine ▪ Medication use ▪ People working in a network and trying to improve ▪ Development of skills ▪ Learning and self-realization ▪ Recognition of oneself limitations ▪ Realistic view of problems and difficulties ▪ Learning and lessons from mistakes ▪ New paths and perspectives
		Barriers	▪ Fear of facing the disorder ▪ Delusions ▪ Depression ▪ Bad effects using strong medication
	Empowerment	**Facilitators**	▪ Willpower and resilience in overcoming adverse situations ▪ Sharing lived experiences ▪ Initiative-taking and confrontational posture ▪ Self-awareness and clarification to face difficulties ▪ Importance of being part of group ▪ Sense of struggle and determination ▪ Attending mental health services ▪ Leisure and sports activities ▪ Non-acceptance of stigmatizing labels ▪ Learning from routines through lived experience
		Barriers	▪ Fear of the outbreak, delusions and hallucinations ▪ Stress
Bond	**Peer Support**	**Facilitators**	▪ Sharing common experiences ▪ Overcoming anxiety together ▪ Pleasure of participating of a group ▪ Increase of self-esteem ▪ Partnership and mutual help
		Barriers	▪ Mood oscillations
	Belonging	**Facilitators**	▪ Listening to peers ▪ Self-identification when sharing lived experiences. ▪ Focus on social and emotional aspects ▪ Group attendance in a more initiative-taking way ▪ Practice of physical activities in groups ▪ Inclusion and support from peers ▪ Networking and volunteering ▪ Sense of belonging through occupational activities ▪ Social network
		Barriers	----
	Connection with others	**Facilitators**	▪ Importance of acting within society ▪ Attending mutual support groups ▪ Creation of connections ▪ Empathy and mutual collaboration ▪ Family as basis for the creation of bonds ▪ Professional network
		Barriers	▪ Difficulties to obtain open spaces for personal realization and activities

	Welcoming	**Facilitators**	▪ Help from peers to overcame difficulties ▪ Support network from groups to overcome difficulties
		Barriers	▪ Discouragement and anguish ▪ Moments of crisis and outbreak
Hope	**Hope itself**	**Facilitators**	▪ Attending mutual support groups and living in a group ▪ Getting a job and maintaining life planning ▪ Desire to constitute a family
		Barriers	▪ Pessimism ▪ Need of long-term medication use, feeling incapable and lack of work ▪ Fear and insecurity ▪ Family tragedies and trauma recurrency, such as sexual abuse, rape, bullying and various humiliations, drugs, trafficking, living with crime and general violence ▪ Living in poverty, being homeless, in situations of loneliness

Figure 1: Flow chart of identified studies