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Conceptions of Recovery and Relapse of Severe Mental Illness from the Perspective of Mental Health Personnel in Mexico City

THESIS

submitted in partial satisfaction of the requirements
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MASTER OF ARTS

in Social Ecology

by

Veronica Valencia Gonzalez

Thesis Committee:
Professor Susan Bibler Coutin, Chair
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DEDICATION

To my parents, siblings, and extended family members and friends for their continued support and encouragement.

Thank you:
Liduvina Valencia Gonzalez
Salvador Gonzalez Ruiz
Cristina Gonzalez
Santiago Gonzalez
Salvador Gonzalez, Jr
Silvia Valencia
Rafael Valencia Gonzalez

TABLE OF CONTENTS

LIST OF TABLES

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ABSTRACT OF THE THESIS

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by

Veronica Valencia Gonzalez

Master of Arts in Social Ecology

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Professor Susan Bibler Coutin, Chair

Objective: This study explores the concept of recovery from severe mental disorders from the perspective of mental health service personnel working in Mexico City.

Participants: For this study, 95 mental health personnel were recruited from mental health and addiction treatment facilities in Mexico City using convenience and snowball sampling techniques. Of those recruited to participate in the study, 64.2% were female. The average age of participants was 39.79 years, ranging from 24 to 68 years of age.

Method: The study used semi-structured interviews lasting an average of 90 minutes in length. Transcribed interviews were coded and analyzed for thematic content (Cohen & Struening, 1962) regarding the concept of recovery and relapse of mental illness.

Results: Of the respondents, 19% did not believe that recovery was possible for individuals with severe mental disorders; one-third of respondents believed that recovery was possible, and 46.6% thought recovery was sometimes possible. From the response analysis, eight categories were developed of factors affecting recovery of mental illness: treatment adherence, diagnosis type, family support, individual characteristics, social support, fatalism, treatment effectiveness, and

other. Meanwhile, 12 categories were determined for factors which facilitate relapses: treatment adherence failure, lack of family support, economic factors, lack of social support, lack of mental illness knowledge, individual characteristics, stress, ineffective treatment, environmental factors, type of diagnosis, part of recovery, and *other*.

INTRODUCTION

In 2017, approximately 13% of the global population, or 970 million people, had at least one mental or substance use disorder (Ritchie & Roser, 2019). Mental illness recovery has been a widely accepted pursuit worldwide (Mental Health Commission of Canada, 2009; New Freedom Commission on Mental Health, 2003). Unfortunately, a universal definition of recovery does not exist as it relates to mental disorders (Bonney & Stickley, 2008; Drake & Whitley, 2014; Pilgrim, 2008; Whitley & Drake, 2010), and these have changed over time.

The clinical or medical model focuses almost exclusively on the symptomatology of the patient. The goal is to ameliorate symptoms for the individual to lead a "normal" functioning (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Davidson & Roe, 2007; Pilgrim, 2008). This recovery perspective, which is heavily dependent on clinical outcomes and biomedical definitions, has been termed by some clinical recovery (Adeponle, Whitley, & Kirmayer, 2012; Pilgrim, 2008). The clinical recovery perspective stems from longitudinal studies of people who had been diagnosed with severe mental disorders, such as schizophrenia, which demonstrated partial to full recovery in 25-65% of subjects (Davidson et al., 2005; Davidson & Roe, 2007; Pilgrim, 2008). In this case, partial to full recovery is solely based on controlling patients' mental disorder symptoms. In this recovery model, people can be thought of being 'recovered from' mental disorder (Pilgrim, 2008). One benefit of this recovery perspective is that recovery is relatively easy to assess as recovery is measured by the reduction of symptoms (Adeponle et al., 2012). However, having the focus be exclusively on symptoms failed to recognize the patient as an individual, which led to pushback by these patients who advocated for themselves and their treatment, which lead to the recovery model.

The recovery model was inspired and advanced by individuals who have experienced

mental illness and mental health consumers (Adeponle et al., 2012; Davidson et al., 2005). In the recovery model, the goal is not to be 'recovered from' but instead to be 'in recovery.' The difference implied is that recovery is not an outcome. Instead, recovery is conceived as an ongoing process (Adeponle et al., 2012; Frese & Davis, 1997; Pilgrim, 2008). This recovery model has been termed personal recovery, aiming for the individual diagnosed with a mental disorder to live a safe, dignified, and personally meaningful life despite their psychiatric disorder (Adeponle et al., 2012; Davidson & Roe, 2007). Although personal recovery allows each individual to define recovery for themselves, some common concepts include hope, love, purpose, self-identity, connection, agency, empowerment, a sense of integrity, and overcoming stigma (Adeponle et al., 2012; Simpson & Penney, 2011). Other common themes in this recovery model include overcoming the effects of having a mental disorder, which may often include poverty, substandard housing, unemployment, loss of social roles, loss of purpose, and isolation (Davidson & Roe, 2007). However, one drawback of this definition is its broadness and vagueness, making this recovery model more difficult to measure and assess (Simpson & Penney, 2011). After all, how do you measure the dignity, a sense of purpose, or empowerment of an individual in any exact manner? It is less straightforward than measuring the number of hallucinations or catatonic episodes someone might have.

More recently, Whitley and Drake (2010) offered another perspective for recovery of mental illness, which brings together five superordinate dimensions of recovery: clinical, existential, functional, physical, and social. This perspective blends some of the components of the two previously mentioned models. This model's clinical component refers to reducing, improving, and controlling symptoms caused by the mental disorder (Adeponle et al., 2012; Whitley & Drake, 2010). The existential component includes hope, responsibility,

empowerment, agency, and spiritual well-being (Adeponle et al., 2012; Whitley & Drake, 2010). The functional dimension encompasses obtaining and maintaining valued social roles, including employment, education, and housing (Adeponle et al., 2012; Whitley & Drake, 2010). The physical dimension of the model involves improving physical health, well-being, and a healthy lifestyle. Finally, the social component refers to interpersonal relationships, such as improving and obtaining meaningful relationships with family, friends, and other community members (Adeponle et al., 2012; Whitley & Drake, 2010). This perspective was meant to broaden the components considered within the recovery framework while also recognizing that individual consumers will define recovery for themselves (Whitley & Drake, 2010). A benefit of this recovery perspective is that it incorporates components from both previously mentioned perspectives (clinical and personal).

ISSUES WITH PREVIOUS CONCEPTIONS OF MENTAL ILLNESS RECOVERY

The differing recovery definitions outlined above demonstrate the problem brought about the lack of an overarching universal definition of recovery as it refers to mental disorders. However, some researchers have pointed out another problem. These definitions have been dominated by European and American perspectives, which raises questions regarding their generalizability and applicability in other cultures (Adeponle et al., 2012). Some have pointed to the emphasis on individual processes and personal responsibility, concepts that might not be emphasized in other cultures, while also failing to consider those qualities that may be important for non-western cultures (Adeponle et al., 2012). Furthermore, even within profoundly individualistic societies, these models may not apply equally to all groups, noting that the emphasis on individuality and personal responsibility favor white European-American ideologies (Adeponle et al., 2012).

Given the dearth of mental disorder recovery research and theories among groups other than white Europeans and Americans, it is essential to explore this concept from different perspectives to see whether the theories and research are generalizable to other countries and cultures with different ethnicities. As globalization has allowed for more interconnectedness between nations and the people worldwide, changing the demographic makeup of many countries, it is crucial to consider the role of cultural perspectives. With the continual growth of the number of Latinos in the United States and other parts of the world, having a better understanding of recovery related to mental health among non-white populations becomes increasingly essential for non-Latin American countries. In 2015, there were 57 million Hispanics in the United States, and from 2000 to 2014, Latinos accounted for 54% of the total population growth in the U.S. (Korgstad, 2016). Furthermore, in 2015 24.2% of all practicing physicians in the U.S. were international graduates (Ganguli, Souza, McWilliams, & Mehrotra, 2017).

Little research has been conducted on how mental illness recovery is conceptualized in developing countries and non-western cultures. Furthermore, little research has explored how culture plays a role in defining recovery from mental illness. Early on, mental illness measurement instruments were translated verbatim without considering the content's pertinence to the population (Mora-Ríos, Bautista-Aguilar, Natera, & Pedersen, 2013). However, a 2016 study by Whitely found cultural differences that facilitated recovery in samples of Caribbean-Canadian and Euro-Canadian individuals with severe mental illness. Despite the recent interest in culturally competent approaches to various treatments, there is still a dearth of research and theories that address recovery from mental illness for non-western and non-white researchers or industrializing countries.

Furthermore, research from mental health service providers' perspective has been limited (Wahl & Aroesty-Cohen, 2010). Despite previous research demonstrating that a patient's outcome and treatment is impacted by a doctor or other healthcare provider bias (Thornicroft, Rose, Kassam, & Sartorius, 2007). Moreover, the limited research that has been conducted has mostly been conducted using students (Covarrubias & Han, 2011; Ng et al., 2011; Tsang, Tam, Chan, & Cheung, 2003) or nurses (Aydin, Yigit, Inandi, & Kirpinar, 2003; Bjorkman, Angelman, & Jonsson, 2008; Chambers et al., 2010) and has not generally included the vast array of personnel that interact with mental health service users. In the limited research that has been conducted in Mexico, for example, researchers have found that mental health service users consider mental health providers to be the second most significant source of stigmatization (Mora-Rios, Ortega-Ortega, & Natera, 2016). Findings such as those mentioned above suggest that it is imperative to understand how mental health service providers conceptualize and define recovery. It also demonstrates the need to explore the recovery concept from these distinct communities, groups, and ethnicities different perspectives to obtain a fuller, more nuanced picture of mental illness recovery.

Expected Contributions

Recovery is a crucial concept important in achieving adherence and in strengthening treatment and care of mental disorders. Hence, it is imperative to obtain comprehensive knowledge and understanding of the meanings, indicators, and other factors that facilitate people's emotional well-being from the healthcare teams' perspective that provides mental health services. The general objective of this article is to explore mental illness recovery from the perspective of mental health personnel in Mexico City. More specifically, this is an exploratory study investigates 1) mental health personnel's opinions about recovery for people diagnosed

with a mental disorder and 2) to analyze relapse attribution factors from the perspectives of mental health care personnel.

As an exploratory investigation, the study may offer future researchers guidance in the understudied area of recovery. The qualitative approach was used to explore and gain an understanding of recovery, which has been mostly unexplored and deals with the subjective experiences and situational meanings of recovery of the mental health professionals in Mexico City. According to Liamputtong (2010), qualitative research is essential when there is little knowledge of a research area dealing with 'the questions of subjective experience and situational meaning. In this study, recovery is being explored as understood by the mental health professionals in Mexico City, based on their experiences and interactions with the patients in mental health institutions.

METHODOLOGY

The data used for this study was originally part of a study designed to explore mental illness stigma and discrimination among various groups (including mental health professionals) in Mexico City. Although the study's main focus was mental illness stigma among mental health professionals, data that addressed recovery from mental illness were also collected from a subset of the original participants, mental health personnel. The mental health personnel were individuals working in mental health facilities and included psychologists, psychiatrists, nurses, social workers, and clerical staff. Approval was granted by the Ramon de La Fuente National Institute of Psychiatry ethics committee (EP09 4225.0).

Before recruitment, potential recruitment sites (mental health institutions) were briefed concerning the study objectives. Authorization to recruit at the site was obtained from all

participating institutions. Participating institutions made their facilities available to establish initial contact with potential participants. Additionally, each institution provided researchers with an area to conduct interviews. During initial contact with prospective participants, researchers briefed potential subjects about the interview, emphasizing that their participation was voluntary and that the project was independent of their employment institutions. On average, interviews lasted about 90 minutes. At the end of the interviews, participants were thanked for their time and allowed to ask questions.

Participants

Participant's Demographic Information			
		Number	**Percentage**
Sex	Male	34	35.8%
	Female	61	64.2%
Occupation	Psychiatrist	31	32.6%
	Psychologist	23	24.2%
	Social Worker	12	12.6%
	Nurse	20	21.1%
	Other	9	9.5%
Institution Type	Public	68	71.6%
	Public & Private	4	24.2%
	Private	23	4.2%
Age	Age Range	24 - 68	
	Mean Age	39.79	
Length of time working in mental health	Range in years	0 - 39	
	Mean in years	12.33	

Table 1: Participant Information

The participants' ages ranged from 24 to 68 years of age, with an average of 39.79 years. Of the 95 participants, 64.2% were female. The participants' job titles included: psychiatrist (32.6%), psychologist (24.2%), social worker (12.6%), nurse (21.1%), and *other* (9.5%), which included administrative personnel and pharmacy technicians. Participants reported working in the mental health field anywhere from less than a year to 39 years with an average time of 12.33 years. Most of the participants worked in public institutions (71.2%), while 24.2% reported working in both public and private institutes, and only 4.2% exclusively worked in private institutions. Only 57.9% of the participants had taken a mental illness/health-related continuing education course within the last five years. Finally, 60.6% reported that someone close to them had been diagnosed with a mental illness. See Table 1, for a table with participant information.

Research Team

The interview team consisted of a total of five people; two males and three females. Four of the interviewers had backgrounds in psychology, and one had a background in anthropology. All members of the research team were fluent in Spanish and had previous experience conducting research interviews. Moreover, all research team members had undergone training in the use of the instrument and interview script.

Interviews

The interviews included demographic questions (e.g., participant's sex, age, job title, years of employment in mental health care, marital status, place of work, and personal background history). Participants were also asked a series of open-ended questions regarding their professional experience, perception of occupational difficulties, opinion of the sectors most affected by mental disorders, experiences and attributions regarding mental illness stigma and

discrimination, suggestions to reduce mental illness stigma and discrimination, perceptions of mental illness recovery, and perceptions of the factors which favor relapses in people with mental disorders. The participants' entire interviews were used for the thematic analysis, and all instances which included references to recovery or relapse were coded and included in the analysis.

ANALYSIS

Thematic analysis (T.A.) (Braun & Clarke, 2006) allows the researcher to identify commonalities in the way participants speak about a topic, in this case, recovery from mental illness. T.A. was utilized because of its flexibility (allowing for both deductive and inductive coding) and accessibility. T.A. "allows [for] systematic identifying, organizing, and offering insight into patterns of meaning (themes) across a data set" (Clarke & Braun, 2017). Braun and Clarke's (2017) six phases of T.A. were utilized for the analysis. (1) The transcripts and interview notes were read in their entirety. (2) Systematic coding of the interviews and notes for identification, recognition, and labeling of relevant data. (3) Themes were developed from the meaningful, patterned clustering of codes. (4) Then the themes are reviewed using all the interviews in their entirety as an integrity check. (5) The themes are defined and labeled. (6) The information is disseminated. Recovery and relapse from mental illness from the perspective of mental health personnel in Mexico City were analyzed using these steps.

A person's interview transcript can include multiple codes or themes, including multiple codes within the same sentence. For an example see Appendix A which includes an illustration that shows the thematic coding of a participants' answer.

RESULTS

Is Recovery Possible?

Of the 95 participants, six were excluded because they did not have extended contact with the patients, although they worked in a psychiatric or addiction treatment center. That left 89 responses for analysis, of which 31.5% (28) answered that recovery was possible, while 18% (16) did not believe so, and 50.5% (45) stated that it depended on factors which they then named. It is important to note that the results come from one particular question: "Do you believe that recovery from mental illness is possible?" The participants were then able to define recovery and what it meant for themselves. With this in mind, it is essential to note that 18% of respondents who did not believe that recovery was possible tended to equate mental illness recovery with being cured.

Additionally, participants often noted the complexity and multiple factors involved in recovery. For example, Participant 85 (male psychiatrist aged 33 with seven years of experience) stated, "… well, it is important to note that a mind cannot be generalized. Generally, I do believe it [recovery is possible], but a person with a disorder with an appropriate treatment can reintegrate [into normal daily activities], but we cannot generalize."

Themes Associated with Recovery

Seven categories were developed from the themes derived from the thematic analysis of the interviews focusing on the responses, opinions, and thoughts surrounding recovery from mental disorders and the potential for those with mental disorders to reintegrate into their daily activities. Participants' answers could include more than one theme, and therefore, participants could be included in several categories based on their responses. The categories include

treatment adherence, individual characteristics/personality, type of diagnosis, family support, social support/network, treatment effectiveness, and *other*. See Appendix C for respondent quotes illustrating the themes.

Treatment adherence. Treatment adherence, which was referenced by 44.9% (40) of participants, refers to medication and psychological treatment adherence. It includes taking the medication as directed by the physician, attending appointments regularly, and actively participating in psychological sessions.

Diagnostic type. The type of diagnosis was mentioned by 37.1% (33) of respondents. It concerns the type of diagnosis a patient receives or the type of mental disorder a patient is diagnosed with. In the case of this theme, respondents tended to mention that recovery was more likely for certain types of conditions than others.

Family support. Family support was indicated as a factor by 27% (24) of the respondents; it encompasses any support (e.g., emotional encouragement, transportation, reminders to take medication, and such) given by immediate or extended family members and spouses.

Individual's personal characteristics. An individual's characteristics and personality were mentioned by 25.8% (23) of participants, and it refers to the individual's personality traits, characteristics, demeanor, and effort. As Participant 29, a 33-year-old female psychologist with seven years of experience put it, "The recovery, or control of the disease, would depend in the first instance on the acceptance of the condition by the patient, and afterward that they have a good adherence with the medication."

Support network. The support network was indicated by 25.8% (23) of the participants,

and it includes supportive individuals outside of the family unit, such as healthcare personnel, friends, coworkers, acquaintances, and the greater community as a whole.

Treatment effectiveness. The treatment's effectiveness was mentioned by 13.5% (12) of the respondents and referred to how well the patient responds to the treatment; usually, it was said concerning medication.

Other. Finally, 38.2% (34) of the respondents mentioned other factors, including structural factors, environmental factors, denial of illness by the patient, economic factors, social programs, stigma, mental health education (or its lack). For example, Participant 45, a 54-year-old male psychologist with 20 years' experience, notes, “A special emphasis needs to be placed on the importance of the local and larger government to establish governmental therapeutic centers and practices in communities.” While Participant 36, a 35-year-old male nurse states with ten years of experience, states, "Recovery depends on the constant assessment of the treatment, checking on its adequacy, and making sure lack of resources is not a cause for treatment cessation."

Factors Associated with Relapse

Here again, of the 95 participants interviewed, six were excluded because they did not have extended contact with patients. An additional 12 failed to discuss relapse in their interviews, leaving 77 respondents. Thematic analysis was conducted to analyze the answers from the 77 participants, 12 categories were established: treatment adherence failure, unsupportive family, lack of social support, economic factors, stress, individual characteristics/personality, lack of mental illness knowledge/education, type of diagnosis, ineffective treatment, environmental factors, relapse is part of recovery, and *other*. As with the

recovery themes, participant's responses could contain more than one theme and be in multiple categories. Participant quotes illustrating the relapse factor themes developed can be found in Appendix D.

Treatment adherence failure. That refers to both pharmacological and psychological therapy sessions and includes stopping a treatment or not doing so as directed. Treatment adherence failure was mentioned by 77.9% (60) of the respondents as a factor that contributes to relapses in people with severe mental disorders.

Unsupportive family. An unsupportive family was mentioned by 54.5% (42) of respondents and can include family members who do not believe the person has a mental disorder and/or encourages the person to cease participating in treatment.

Lack of economic resources. This was mentioned by 39% of participants, usually as a reason why the patient might have trouble adhering to treatment.

Lack of social support. Lack of social support was cited by 26% (30) of respondents and included all types of social support networks except for family members, for example, healthcare personnel, friends, coworkers, teachers, and community members.

Individual's personal characteristics. These included an individual's traits, character, motivation, and personality, referenced by 14.3% (11) of the participants.

Lack of mental health knowledge. The lack of mental healthcare knowledge and education were factors that were mentioned as contributing factors to relapse by 14.3% (11) of the participants.

Stress. Stress was suggested as a factor that may influence relapse by 11.7% (9) of

respondents.

Ineffective treatment. Was mentioned by 9.1% (7) of the respondents, with some respondents suggesting that some patients fail to respond to some or any medications.

Environmental factors. Environmental factors and surroundings were mentioned by 7.8% (6) of the respondents.

Mental disorder type. The type of mental disorder was cited by 5.2% (4) of respondents with specific mental disorders such as schizophrenia being named as disorders, which rarely show any improvement.

Part of illness. Meanwhile, 5.2% (4) of respondents believed that relapse is just part of the mental illness and is expected.

Other. Finally, 26% (20) of respondents cited other factors among them, biological factors, denial of the disease, treatment side effects, incorrect diagnosis, fears of becoming addicted to medication, and being tired of the treatment.

DISCUSSION

This study is a first step in conceptualizing recovery of severe mental illness from the perspective of mental health personnel in Mexico City. The study helps expand our understanding of recovery beyond high-income industrialized countries. Previously minimal research has been conducted regarding the concept of recovery in people with mental disorders in industrializing countries (Slade et al., 2012). Furthermore, most of the research involving mental health personnel has primarily consisted of nurses (Aydin et al., 2003; Bjorkman et al., 2008; Chambers et al., 2010) and has not included psychologists, doctors, and psychiatrists, who

are diagnosing and prescribing treatments to mental health service users (Wahl & Aroesty-Cohen, 2010). This study helped to elucidate factors that facilitate or impede recovery from mental illness according to mental health personnel who work in Mexico City. While previous studies have looked into factors associated with mental illness recovery from patients' perspective (Tew et al., 2012), it has been ignored when it comes to mental health providers.

The results demonstrated that most mental health personnel believe that mental illness recovery is possible, at least in some instances, and was dependent on how the respondent defined recovery. However, the study helped to highlight the complexity and multiple factors that the respondents believe are associated with recovery. It also provides insight into the impact that their personal experiences play in their beliefs about mental illness recovery, something previously found in a U.S. study by Osborn & Stein (2017). The results also illuminated the prevalence of the clinical orientation among mental health professionals in Mexico City. This should not be too surprising given that education on mental illness and treatment in Mexico primarily draws from the work being conducted in the United States. Therefore, it should be expected that the mental health professionals in Mexico would share orientations. However, this does pose the question of what framework might have been developed, were it not for the imposition of western conceptions of mental illness and mental illness recovery.

One of the most exciting discoveries of this study is what we did not find. Interestingly, most mental health personnel interviewed failed to mention their role in the patients' recovery process instead of focusing on social, environmental, and patient-centered factors. That, despite previous research showing the impact that doctors and their attitudes can play in patients' outcomes (Mondloch, Cole, & Frank, 2001) and stigmatization (Mora-Rios, Ortega-Ortega, & Natera, 2016).). Considering that mental health personnel are responsible for providing services

to these patients, one might ask what sort of expectations they have for the patients with mental disorders in their service and how it affects the care they provide? The study demonstrates the need for further training of mental health personnel in order to broaden the definition of recovery from one focusing on the traditional clinical concept to a more holistic approach.

Moreover, the study highlights the advantage that qualitative methods over quantitative methods when exploring a sensitive, complex, and nuanced issue, such as recovery from mental illness, which is evidenced by overwhelming qualitative studies in this area (Slade et al., 2012). Until more sensitive and culturally competent quantitative measures are developed, qualitative measures seem more adept at capturing respondents' nuanced beliefs.

Limitations

This study was an exploratory study to help to provide guidance and direction for further research in this area and, as such, has some limitations. First, the study's participants were all from Mexico City, and thus, they cannot be generalized to other locations. Secondly, the sample was not randomized, and participants self-selected into the study. Initially, the goal was to have personnel from various areas represented; however, some personnel occupation areas were not well represented. More research should be conducted in other locations in Mexico and using a random sample.

CONCLUSION

This exploratory study was incredibly insightful in that it is one of the first studies conducted in Mexico City that investigates the topic of mental illness recovery with a variety of mental health personnel. This study allowed the researchers to get a more nuanced picture of how mental health personnel in Mexico City perceive, think about, and conceptualize severe

mental illness recovery. This study found that mental health personnel view recovery in different ways. The ways that recovery is viewed are influenced by a variety of factors, as demonstrated by the themes developed in the analysis of the study. The same was true for the factors which were associated with relapse in mental illness. Factors included both external (e.g., finances and stress) and internal (personal characteristics) factors. Moreover, personnel were likely to name multiple factors influencing both recovery and relapse, demonstrating the complexity and multi-influenced nature of mental illness issues.

This study also demonstrated that mental health personnel in Mexico City tend to have a relatively grim view of particular mental disorders, like schizophrenia, compared to other mental illnesses. The finding is not surprising given that previous research around the world has found that schizophrenia is stigmatized and associated with pessimistic outlooks (Davidson, Schmutte, Dinzeo, & Andres-Hyman, 2008). Interestingly, Hugo (2001) found that mental health professionals based their pessimistic views were on their professional experience, much like the respondents in the current study. That is, respondents in Hugo's and the current study drew upon their personal experiences when making judgments about mental illness prognoses and recovery. Given the scarcity of resources for mental illness treatment in Mexico, maybe the mental health professionals' outlook and views expressed in the study could be considered realistic (given the current circumstances in Mexico City) rather than pessimistic. More research should be pursued in this area in order to continue expanding the understanding of recovery.

Moreover, it would be beneficial to also consider mental illness recovery from the patient's perspective, and their families to compare with those of the mental health personnel assisting them. Having perspectives from mental health personnel, mental health service users, and their families will help uncover any misalignment in treatment expectations and goals

between personnel and consumers. This study was a good start in learning about mental illness recovery in Mexico, but the work needs to continue.

REFERENCES

Adeponle, A., Whitley, R., & Kirmayer, L. (2012). Cultural contexts and constructions of recovery. In A. Rudnick (Ed.), *Recovery of People with Mental Illness: Philosophical and Related Perspectives* (pp. 109–132). Oxford, United Kingdom: Oxford University Press. http://doi.org/10.1093/med/9780199691319.003.0008

Aydin, N., Yigit, A., Inandi, T., & Kirpinar, I. (2003). Attitudes of hospital staff toward mentally ill patients in a teaching hospital, Turkey. *International Journal of Social Psychiatry, 49*(1), 17–26. https://doi.org/10.1177/0020764003049001544

Baccari, I. O. P., Campos, R. T. O., & Stefanello, S. (2015). Recovery: revisão sistemática de um conceito. *Ciência & Saúde Coletiva*, *20*, 125-136.

Bjorkman, T., Angelman, T., & Jonsson, M. (2008). Attitudes towards people with mental illness: A cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences, 22*, 170–177.

Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing, 15*(2), 140–153. http://doi.org/10.1111/j.1365-2850.2007.01185.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1017/CBO9781107415324.004

Chambers, M., Guise, V., Välimäki, M., Botelho, M. A. R., Scott, A., Staniulienė, V., & Zanotti, R. (2010). Nurses' attitudes to mental illness: A comparison of a sample of nurses from five European countries. *International Journal of Nursing Studies, 47*(3), 350–362.

https://doi.org/10.1016/j.ijnurstu.2009.08.008

Clarke, V., & Braun, V. (2017). Thematic Analysis. In *Journal of Positive Psychology* (Vol. 12, pp. 297–298). https://doi.org/10.1080/17439760.2016.1262613

Cohen, J., & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *The Journal of Abnormal and Social Psychology*, *64*(5), 349–360. http://doi.org/10.1037/h0045526

Covarrubias, I., & Han, M. (2011). Mental Health Stigma about Serious Mental Illness among MSW Students: Social Contact and Attitude. *Social Work*, *56*(4), 317–325.

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice*, *36*(5), 480–487. http://doi.org/10.1037/0735-7028.36.5.480

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, *16*(4), 459–470. http://doi.org/10.1080/09638230701482394

Davidson, L., Schmutte, T., Dinzeo, T., & Andres-Hyman, R. (2008). Remission and recovery in schizophrenia: Practitioner and patient perspectives. *Schizophrenia Bulletin*, *34*(1), 5–8. https://doi.org/10.1093/schbul/sbm122

Drake, R. E., & Whitley, R. (2014). Recovery and severe mental illness: Description and analysis. *The Canadian Journal of Psychiatry*, *59*(5), 236–242. http://doi.org/10.1177/070674371405900502

Frese, F. J., & Davis, W. W. (1997). The consumer-survivor movement, recovery, and consumer

professionals. *Professional Psychology: Research and Practice*, *28*(3), 243–245. http://doi.org/10.1037/0735-7028.28.3.243

Hugo, M. (2001). Mental health professionals' attitudes towards people who have experienced a mental health disorder. *Journal of Psychiatric and Mental Health Nursing*, *8*, 419–425.

Lauber, C., Nordt, C., Braunschweig, C., & Rössler, W. (2006). Do mental health professionals stigmatize their patients? *Acta Psychiatrica Scandinavica*, *113*(SUPPL. 429), 51–59. https://doi.org/10.1111/j.1600-0447.2005.00718.x

Liamputtong, P. (2010). *Performing qualitative cross-cultural research*. Cambridge University Press.

Mental Health Commission of Canada. (2009). Toward recovery and well-being: A framework for a mental health strategy for Canada (draft for public discussion). Retrieved from http://www.men- talhealthcommission.ca/ SiteCollectionDocuments/Key_Doc- uments/en/2009/Mental_Health_ENG.pdf

Mondloch, M. V., Cole, D. C., & Frank, J. W. (2001). Does how you do depend on how you think you'll do? A systematic between patients' recovery expectations and health outcomes. *Canadian Medical Association Journal*, *165*(2), 174–179. https://doi.org/10.1017/CBO9780511543579.020

Mora-Ríos, J., Bautista-Aguilar, N., Natera, G., & Pedersen, D. (2013). Adaptación cultural de instrumentos de medida sobre estigma y enfermedad mental en la Ciudad de México. *Salud Mental*, *36*(1), 9. https://doi.org/10.17711/sm.0185-3325.2013.002

Mora-Rios, J., Ortega-Ortega, M., & Natera, G. (2016). Subjective Experience and Resources for

Coping with Stigma in People with a Diagnosis of Schizophrenia: An Intersectional Approach. *Qualitative Health Research*, *26*(5), 697–711. https://doi.org/10.1177/1049732315570118

Mora-Rios, J., Ortega-Ortega, M., & Natera, G. (2016). Subjective Experience and Resources for Coping with Stigma in People with a Diagnosis of Schizophrenia: An Intersectional Approach. *Qualitative Health Research*, *26*(5), 697–711. https://doi.org/10.1177/1049732315570118

New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS pub no SMA-03–3832. Rockville Md, Department of Health and Human Services, 2003. Available at www.mentalhealthcommission.gov/reports/finalreport/fullreport-02.htm

Ng, R. M. K., Pearson, V., Lam, M., Law, C. W., Chiu, C. P. Y., & Chen, E. E. Y. (2011). What does recovery from schizophrenia mean? Perceptions of long-term patients. *International Journal of Social Psychiatry*, *54*(2), 118–130. https://doi.org/10.1177/0020764007084600

Noiseux, S., St-Cyr Tribble, D., Leclerc, C., Ricard, N., Corin, E., Morissette, R., & Lambert, R. (2009). Developing a model of recovery in mental health. *BMC Health Services Research*, *9*(1), 73. https://doi.org/10.1186/1472-6963-9-73

Penas, P., Iraurgi, I., Moreno, M. C., & Uriarte, J. J. (2019). ¿Cómo evaluar la recuperación en salud mental?: Una revisión sistemática. *Actas Esp. Psiquiatr*, *47*(1), 23–32. Retrieved from http://pesquisa.bvsalud.org/portal/resource/es/ibc-FGT-797

Pilgrim, D. (2008). `Recovery' and current mental health policy. *Chronic Illness*, *4*(4), 295–304. http://doi.org/10.1177/1742395308097863

Ritchie, H. & Roser, M. (2019) - "Mental Health". *Published online at OurWorldInData.org.* Retrieved from: 'https://ourworldindata.org/mental-health' [Online Resource]

Simpson, A. I. F., & Penney, S. R. (2011). The recovery paradigm in forensic mental health services. *Criminal Behaviour and Mental Health*, *21*, 299–306. http://doi.org/10.1002/cbm.823

Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: Ignorance, prejudice or discrimination? *British Journal of Psychiatry*, *190*, 192–193.

Tsang, H. W. H., Tam, P. K. C., Chan, F., & Cheung, W. M. (2003). Stigmatizing attitudes towards individuals with mental illness in Hong Kong: Implications for their recovery. *Journal of Community Psychology*, *31*(4), 383–396. https://doi.org/10.1002/jcop.10055

Wahl, O., & Aroesty-Cohen, E. (2010). Attitudes of Mental Health Professionals About Mental Illness: A Review of the Recent Literature. *Journal of Community Psychology*, *38*(1), 49–62. https://doi.org/10.1002/jcop

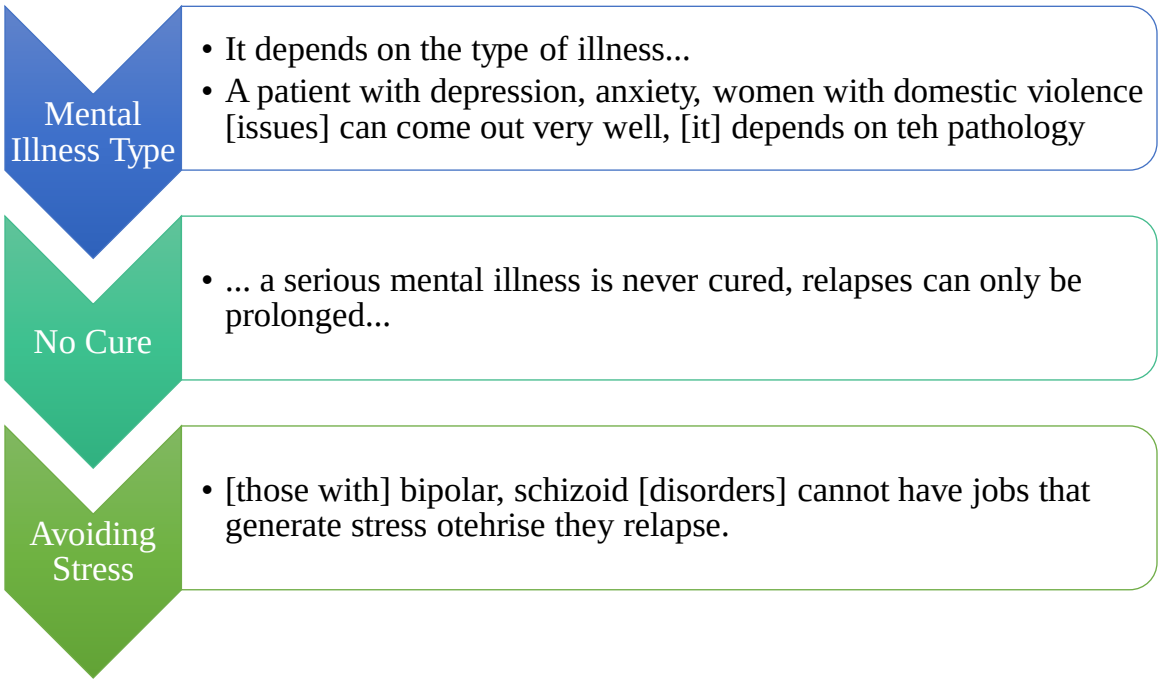
Whitley, R., & Drake, R. E. (2010). Recovery: A dimensional approach. *Psychiatric Services*, *61*(12), 1248–1250. http://doi.org/10.1176/appi.ps.61.12.1248

Whitley, R. (2016). Ethno-racial variation in recovery from severe mental illness: A qualitative comparison. *Canadian Journal of Psychiatry*, *61*(6), 340–347. https://doi.org/10.1177/0706743716643740

APPENDIX A

Coding Methodology

Response for participant 1, a 44-year-old female social worker answered, *Recovery depends on the type of illness, a serious mental illness is never cured, relapses can only be prolonged. [Those with] bipolar, schizoid [disorders] cannot have jobs that generate stress otherwise they relapse. A patient with depression, anxiety, women with domestic violence [issues] can come out very well, [it] depends on the pathology*.



APPENDIX B

Recovery Theme Response Examples

Treatment Adherence: 44.9% (40)

- ...the recovery of the psychiatric patient depends on the consistent with the treatment, especially the medication and the family support. (Patient 16, female age 38, nurse with 14 years of experience)
- They can be reintegrated into their daily activities if they continue their treatment this will depend on their mental structure. (Participant 90, female age 37, psychologist with 5 years of experience)

Diagnosis Type: 37.1% (33)

- Well yes, taking into account the prevalence of schizophrenia that is the least [likely], I mean, the one that cannot, it is the 1%, the majority of the rest can. (Participant 3, female age 31, psychiatrist with 5 yers of epxerience)
- Integration and recovery of people with severe mental disorder is possible for some conditions like in the case of depression. (Participant 84, female age 26, psychiatrist with 3 years of experience)

Family Support: 27.0% (24)

- With the help of the family people with mental disorders can recover and reintegrate to their normal activities. (Participant 38, female age 43, nurse with 18 years of experience)
- Well it depends a lot on the family environment and the seriousness of the illness, but even patients with serious illness, if they have good family support then it is easier. (Participant 12, female age 33, psychiatrist with 5 years of experience)

Individual's Characteristics & Personality: 25.8% (23)

- Yes, they can recover but this depends on the characteristics of the patient, however, each has a particular way of functioning in society. (Participant 51, female age 28, psychiatrist with 2 years of experience)

Social Support Network: 25.8% (23)

- A lot of it has to do with the genetics of each person and has a lot to do with family and institutional support. (Participant 87, female age 29, psychiatrist with 5 years of experience)
- In general, people recovering from a mental disorder depends on adherence to treatment, psychotherapy, and social support networks, particularly the family. (Participant 14, male age 28, psychiatrist with 3 years of epxerience)

Treatment Effectiveness: 13.5% (12)

- It is difficult to know, this will depend on the patient's response to the medication... some patients respond very well and have no symptoms but there are patients who are resistant to medications. (Participant 17, male age 58, psychologist)

Other: 38.2%

- If there is organic damage it is more difficult to reincorporate to daily life. (Participant 94, male age 52, psychologist with 26 years of experience)
- Recovery depends on the constant assessment of the treatment, checking if the medication is appropriate or can be replaced by a more economical one so that lack of financial resources is not the reason that treatment is discontinued. (Participant 36, male age 35, nurse with 10 years of experience)

APPENDIX C

Relapse Theme Response Examples

Treatment Adherence Failure: 77.9%

- Relapse are determined by following or abandonment of the treatment. (Participant 5, male aged 59, psychiatrist)

Lack of Family Support: 54.5%

- The support networks, and the family. Especially the family, of teh institution, and that they don't leave teh medications, too. (Participant 1, female aged 44, social worker)

Economic Factors: 39.0%

- Relapses are mainly due to the fact that patients or their family members cannot buy the medication due to their high cost. (Participant 61, female aged 43, nurse)

Lack of Social Support: 26.0%

- Maybe because there is no good support system, also economic factors... (Participant 66, female aged 38, social worker)

Stress: 11.7%

- Regarding the cause of relapses in psychiatric patients, they are mainly due to the abandonment of the pharmacological treatment by a supposed improvemnt and to stressful situations which they are exposed to in the family and work life. (Participant 26, female aged 32, psychologist)

Individual's Characteristics/Personality: 14.3%

- Relapses are due to 3 factors: 1) inadequate treatment; 2) economic factors, the patient and family do not ave money to buy the medicines; 3) the patient's own characteristics. Sometimes the treatment is adequate, there are resources to get the medication, but the patient does not want to improve, in these cases not much more can be done. (Participant 45, male aged 54, psychologist)

Lack of Mental Illness Knowledge: 14.3%

- Relapses have a lot to do with lack of information of how to handle the disease, with lack of resources of space for the people while the family is at work because we all have to work. (Participant 11, female aged 50, social worker)

Ineffective Treatment: 9.1%

- ... you would talk about non-adherence to treatment or having the wrong diagnosis or inadeequate treatment or economic factors. (Participant 27, male aged 31 psychiatrist)

Enviromental Factors: 7.8%

- Relpases are attibuted to the type of illness and aggravating factors in the environment that exacerbate the disease and lead to the abandoment of treatment. (Participant 6, male aged 59, other)

Type of Diagnosis: 5.2%

- Relapses can be attributed to the type of illness, agravating factors that can trigger the exacerbation of the disease and the abandonment of tratment. (Participant 6, male aged 59, Other)

Part of Recovery: 5.2%

- Relapses are a natural part of the disease... and recovery like relapses depend on biologic, psychologic, and social factors. (Participant 69, male aged 44, psychiatrist)

Other: 26.0%

- The main causes of patient relapse are lack of awareness of the disease, lack of support form the family coucpled with economic and cultual factors. (Participant 55, male aged 32, psychiatrist)