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ORIGINAL ARTICLE

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

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Abstract
This study explores recovery from severe mental disorders from the perspective of 89 mental health care professionals working in Mexico City, using a mixed method approach. The participants were recruited and interviewed from mental health and addiction treatment facilities in Mexico City using convenience sampling techniques. Transcribed interviews were coded and analyzed for thematic content regarding recovery and relapse of mental illness. On the quantitative level, we used a sample of 11 items from the Mexican adaptation of the Opinions about Mental Illness questionnaire to compare the attitudes of health personnel and consider differences by gender. Of the respondents, 18% did not believe that recovery was possible for individuals with severe mental disorders, but most believed in recovery in at least some cases. The results also indicated a strong orientation toward recovery in the clinical sense, focused on patients' symptomatology. There were significant differences in attitudes toward mental illness items by gender. Men showed more favorable attitudes than women ($F = 6.60$, $p = .05$). However, the small size of our sample limits the generalizability of the findings. Educational strategies based on social contact with persons with mental health problems could be useful in modifying negative attitudes toward mental illness.

Keywords Recovery and relapse meanings · Health personnel perceptions · México · Mixed methods · Mental health · Stigma

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Introduction

According to the World Health Organization's 2017 estimate of the global disease burden (IHME, 2018), approximately 10% of the global population, or 792 million people, had at least one mental health disorder (IHME, 2018). Recovery from mental illness has been a key concern around the world (Mental Health Commission of Canada, 2020). Unfortunately, there is no universal definition of recovery as it relates to mental disorders (Drake & Whitley, 2014; Pilgrim, 2008).

The definitions of recovery have changed over time. They began with the clinical model, which focused almost exclusively on the symptomatology of the patient and the amelioration of symptoms. The personal recovery model followed, whose aim was for the individual diagnosed with mental illness to live a safe, dignified, and personally meaningful life (Davidson & Roe, 2007; Adeponle et al., 2012). Next came the more holistic perspective of Whitley and Drake (2010), bringing together five superordinate dimensions of recovery: clinical, existential, functional, physical, and social. The definition of Noiseux et al. (2009), which describes recovery from mental illness as "a profoundly personal path that individuals may follow [that] entails work, particularly work on themselves, their feelings, desires, competencies, roles, and plans for the future," seems to be widely accepted, but a single and universally accepted definition for recovery from mental illness is still elusive (Penas et al., 2019).

Some critics have pointed out that these definitions are dominated by Western (European and American) perspectives, which raises questions regarding their applicability in other cultures (Adeponle et al., 2012). Little research has been conducted on the conceptualization of recovery from mental illness in developing countries and non-Western cultures, or on the role of culture in defining recovery. Early instruments for the evaluation of mental illness were translated verbatim, without consideration of cultural context (Mora-Rios et al., 2013). Research based on the mental illness recovery approach has been very limited in Latin America, although Brazil is one country where researchers have shown an interest in exploring it (Ferreira de Oliveira et al., 2021).

Research on the perspective of mental health service providers has also been limited (Wahl & Aroesty-Cohen, 2010), despite studies demonstrating that patients' treatment and outcome are affected by their bias (Thornicroft et al., 2007). This research has mostly been with students (Covarrubias & Han, 2011; Ng et al., 2008; Tsang et al., 2003) or nurses (Bjorkman et al., 2008; Chambers et al., 2010); it has not generally included the wide array of personnel that interact with users of mental health services.

The limited research that has been conducted in Mexico has found that mental health providers are the second most significant source of stigmatization, according to users of their services (Mora-Rios et al., 2016). Public stigma refers to the stereotypes, prejudices, and discrimination existing in society toward mental illness and those affected by it (Corrigan & Watson, 2007) and nowadays is recognized as one of the main barriers to deliver quality health care (Knaak, et al., 2017). Thus, it is imperative to understand how mental health service providers conceptualize and define recovery and to explore this concept from the differing perspectives of these distinct communities, groups, and ethnicities, to obtain a nuanced picture of the meaning of mental illness recovery.

Mexico is a country with deep inequalities: it is estimated that 17% of the population suffers from a mental disorder and only one in five of those receives care. Stigma and discrimination prevent people from seeking early treatment. In addition, economic and human resources are insufficient. Only 2% of the gross domestic product (GDP) goes to

mental health, equivalent to just over one US dollar per capita. The proportion of specialized personnel is only 3.7 psychiatrists and 2.2 psychiatric nurses per 100,000 population (Heinze et al., 2019). Like other Latin American countries, Mexico is moving toward a community-oriented care model aimed at improving quality of life and social inclusion (Secretaría de Salud, 2022). However, it is not clear whether mental health staff are prepared for these changes. The new model involves a paradigm shift from an emphasis on care to one that is more oriented toward recovery and resources for people affected by such conditions.

Recovery is a crucial concept in achieving adherence and strengthening treatment and care of mental disorders. It is thus important to have a fuller knowledge and understanding of the meanings, indicators, and other factors that facilitate people's emotional well-being from the perspective of the teams that provide mental health services. As an exploratory investigation, this study may offer guidance to researchers in the understudied area of recovery. A mixed method approach was used to expand our understanding of recovery, of the subjective experiences and situational meanings of recovery for mental health professionals in Mexico City, which have been mostly unexplored. The aim of this exploratory study was thus to examine mental illness recovery from the viewpoint of mental health personnel, specifically (1) the opinions of mental health personnel about recovery for people diagnosed with serious mental disorder, (2) the factors that mental health personnel associate with recovery from such disorders and the reasoning behind this association, and (3) responses to the Mexican adaptation of the Opinions about Mental Illness (OMI) questionnaire that are related to recovery, in order to make comparisons by gender.

Methodology

The data used for this study was originally part of a mixed methods study designed to explore mental illness stigma and discrimination among various groups (including mental health professionals) in Mexico City (Mora-Rios & Bautista, 2014). Although the study's original focus was stigma, data that addressed recovery were also collected from a subset of the original participants: mental health personnel. These participants were individuals working in mental health facilities and included psychologists, psychiatrists, nurses, social workers, and clerical staff. Data collection took place from January of 2009 through July of 2010. The details of the methodologies utilized for data collection have previously been published (Mora-Rios et al., 2013). Participants provided informed consent, and the research protocol was approved by the Ethics Committee of the Ramon de La Fuente National Institute of Psychiatry (Approval No. EP09 4225.0).

Participant Recruitment

Participants in this study were recruited from four mental health and addiction treatment centers in Mexico City, using convenience sampling techniques. The centers were chosen in accordance with two criteria: (1) that they specialized in mental health and (2) that they voluntarily agreed to collaborate on the study, after the aims were explained. Authorization to recruit at the site was obtained from all participating institutions, and they made their facilities available to establish initial contact with potential participants. Each institution

provided researchers with an area to conduct interviews. During initial contact with prospective participants, researchers briefed them about the interview, emphasizing that their participation would be voluntary and would in no way affect their employment. The interviews lasted an average of 90 min. At the end of the interview, participants were thanked for their time and allowed to ask questions. Pseudonyms were used to protect the confidentiality of the interviewees.

Participants

The inclusion criteria for participants were the following: be a health care worker in any discipline related to mental health and addictions in Mexico City, 18 years of age or older, of either sex, working in a specialized care center for 1 year prior to the interview, and agree to voluntary participation in the study.

Of the 95 participants, six were excluded because they did not have extended contact with patients, although they worked in a psychiatric or addiction treatment center. The participants were in the age range from 24 to 68 years, with an average of 39.79 years, and 64.2% were female. Their 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 for a period ranging from 1 to 39 years, with an average time of 12.33 years. Most worked in public institutions (71.2%), while 24.2% reported working in both public and private facilities, and only 4.2% worked exclusively in private ones. Only 57.9% of the participants had taken a mental illness/health-related continuing education course within the last 5 years. Sixty-six percent reported that someone close to them had been diagnosed with a mental

Table 1 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	

illness. Finally, 27% of respondents reported having been diagnosed with a mental disorder themselves and 20% had sought treatment (see Table 1).

Data Collection

Data for this study was collected in a semi-structured interview designed to explore the following topics: (a) sociodemographic data (e.g., sex, age, job title, years of employment in mental health care, marital status, place of work, and personal history); (b) professional experience, perception of occupational difficulties, basic knowledge about mental health, opinions about the aspects of life most affected in people with mental illness; and (c) experiences and beliefs regarding stigma and discrimination toward people with mental illness and suggestions to reduce it, perceptions of mental illness recovery, and perceptions of the factors which favor relapses in people with mental disorders.

The interviewing strategy was to ask open, exploratory questions to favor dialogue with respondents, for example, "What is your opinion about whether people with serious mental disorders can recover and return to their everyday activities?" and "What conditions favor relapses?" For purposes of this study, only the comments and responses relating to recovery were included. The participants' entire interviews were used for the thematic analysis; all instances which included references to recovery or relapse were coded and included.

Opinions About Mental Illness (OMI) Questionnaire

Items related to recovery were selected from the Opinions about Mental Illness (OMI) questionnaire developed by Cohen and Struening (1962), adapted for the Mexican population (Mora-Rios, et al., 2013; Altamirano, 2012), that consists of 59 items with a six-point Likert-type scale ranging from "completely disagree" to "completely agree." The two authors each reviewed the items separately and selected subsets of 11 items they believed should be included. They then met to agree upon a final list of recovery-related items. Participants' responses to these items were subsequently analyzed in relationship to their gender.

Research Team

The interview team consisted of two men and three women, four with backgrounds in psychology and one with a background in anthropology. All members of the research team had previous experience conducting research interviews, and all of them underwent training in the use of the instrument and interview script.

Data Analysis

Thematic analysis (TA) allows researchers to identify commonalities in the way participants speak about a topic, in this case, recovery from mental illness. It was utilized because of its flexibility (allowing for both deductive and inductive coding) and accessibility. TA also allows for systematic identification, organization, and insight of information from a dataset into patterns of meaning, or themes (Braun & Clarke, 2006). Clarke and Braun's (2017) six phases of TA were utilized for the analysis. Interview transcriptions were first reviewed for accuracy by three members of the team. Each of the interview transcripts

was then analyzed individually by members of the research team, who then met to discuss and make decisions about categories based on consensus. As the content of the interviews was clarified and new categories emerged, they were incorporated into a coding guide. The specialized software Atlas.ti (Ciscom Systems, 2011) was used to organize the categories of analyses. A single respondent's interview transcript could include multiple codes or themes, including multiple codes within the same sentence. For an example, see Fig. 1, which includes an illustration that shows the thematic coding of a participant's response.

On a quantitative level, the mean values for the items on the OMI were compared using Student's *t* test, with the 11 items as dependent variable and sex as the independent variable. The data were analyzed using IBM SPSS Statistics (Version 25) predictive analytics software.

Results

Is Recovery Possible?

About half of the respondents (45) said that recovery depended on a variety of factors; 28 believed that recovery was possible, while 16 did not. The participants were then asked to define recovery and what it meant to them. Among those who did not believe that recovery was possible, 16 equated mental illness recovery with being cured. One social worker, for example, said that "severe mental illness is never cured and the only thing that can be done is to prolong the time between relapses." A psychologist had a similar view: "Instead of talking about recovery they should focus on adapting patients to be independent."

Participants often noted the complexity and multiple factors involved in recovery. For example, a 33-year-old male psychiatrist with 7 years of experience said that "it is important to note that a mind cannot be generalized. I do believe [recovery is possible] … a person with a disorder with an appropriate treatment can reintegrate [into normal daily

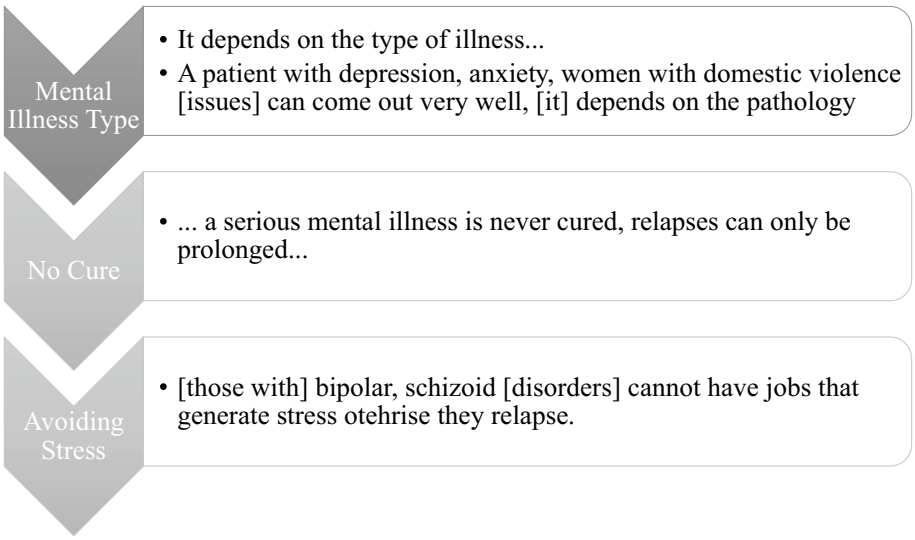

Fig. 1 Coding methodology

activities], but we cannot generalize." It was common for respondents to mention multiple contributing factors associated with recovery and to mention how these were interrelated. For example, a female psychiatrist noted that economic factors play a role in accessing medication, and that culture may influence a person's resistance to accepting a diagnosis. Lack of education and failure to educate a patient's family about the illness and treatment can all contribute to or hinder recovery. Even those respondents with a holistic view of recovery and relapse still demonstrated somewhat negative attitudes towards certain types of mental illness. Schizophrenia was often described by participants in grim terms. For example, according to a female psychologist, "schizophrenia is the bogeyman of psychiatric pathologies … because of how difficult it is for a patient to stick to a, to a treatment; on the other hand, when people abuse alcohol there is a better prognosis."

Definitions and Dimensions of Recovery

Seven categories were developed from the thematic analysis of the interviews focusing on participants' responses, opinions, and thoughts about 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, so individual participants could be included in more than one category based on their responses. The categories were treatment adherence, individual characteristics/personality, type of diagnosis, family support, social support/network, treatment effectiveness, and "other." See Table 2 for examples of responses illustrating the themes.

Lexicographic Analysis

A complementary lexicographic analysis was carried out of the most frequent words in the open responses related to recovery. The Wordcloud program (https://www.wordclouds.com/) was used to generate a diagram representing the words used, with the size of a word proportional to the frequency of its use. This visual resource complemented the previously described analysis by highlighting the key concepts in participants' responses. Prepositions were excluded. As can be seen in Fig. 2, the predominance of keywords is similar to that in the thematic analysis: support networks, family, adherence to treatment, type of disorder, and adequate pharmacological control were most common.

The most common theme was that of treatment adherence, which was mentioned by 40 of the 89 participants. Here, treatment adherence refers to compliance with medication and psychological treatment instructions, such as taking medication as prescribed, attending appointments regularly, and actively participating in psychological sessions. For example, a 38-year-old female nurse with 14 years of experience said that "the recovery of the psychiatric patient depends on consistency with the treatment, especially the medication." Diagnosis type was the second most frequently mentioned factor (33 respondents); it concerns the type of mental disorder a patient is diagnosed with. Respondents tended to believe that recovery was more likely for certain types of disorders than others. Family support was the third most mentioned theme (24 participants); it describes any support (e.g., emotional encouragement, transportation, reminders to take medication) given by immediate or extended family members, including spouses. Individual personal characteristics refers to an individual's personality traits, characteristics, demeanor, and effort. As a 33-year-old female psychologist with 7 years of experience put it, "The recovery, or control of the disease, would depend in the first place on the acceptance of the condition by the

Table 2 Themes related to recovery and examples

Theme	Illustrative quotations
Treatment adherence	• ...the recovery of the psychiatric patient depends on the consistent with the treatment, especially the medication and the family support. (Female nurse aged 38) • They can be reintegrated into their daily activities if they continue their treatment this will depend on their mental structure. (Female psychologist aged 37)
Diagnosis type	• 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. (Female psychiatrist aged 31) • Integration and recovery of people with severe mental disorder is possible for some conditions like in the case of depression. (Female psychiatrist aged 26)
Family support	• With the help of the family people with mental disorders can recover and reintegrate to their normal activities. (Female nurse aged 43) • 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. (Female psychiatrist aged 33)
Individual's characteristics or personality	• Yes, they can recover but this depends on the characteristics of the patient, however, each has a particular way of functioning in society. (Female psychiatrist aged 28)
Social support network	• A lot of it has to do with the genetics of each person and has a lot to do with family and institutional support. (Female psychiatrist aged 29) • In general, people recovering from a mental disorder depends on adherence to treatment, psychotherapy, and social support networks, particularly the family. (Male psychiatrist aged 28)
Treatment effectiveness	• 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. (Male psychologist aged 58)
Other	• If there is organic damage it is more difficult to reincorporate to daily life. (Male psychologist aged 52) • 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. (Male nurse aged 35)

Fig. 2 Word Cloud related to the recovery of people with serious mental illness

patient, and afterward that they have good adherence with the medication." The patients' support network was mentioned by 23 of the participants; it includes supportive individuals outside of the family unit, such as health care personnel, friends, coworkers, acquaintances, and the community as a whole. Treatment effectiveness was mentioned by 12 of the respondents; it describes how well the patient responds to treatment and usually referred to medication. Finally, 34 of the respondents mentioned other factors, including structural, economic, and environmental factors; the patient's denial of illness; social programs; stigma; and the availability or lack of mental health education. For example, a 54-year-old male psychologist with 20 years of experience noted: "A special emphasis needs to be placed on the importance of the local and broader government to establish government therapy centers and practices in communities." A 35-year-old male nurse with 10 years of experience said: "Recovery depends on the constant assessment of treatment, checking on its adequacy, and making sure lack of resources is not a reason to stop treatment."

Dimensions Explaining Relapses in People Diagnosed with Severe Mental Illness

Only 77 participants were considered for analysis of the relapse theme; 12 did not provide a response. Thematic analysis was carried out to analyze their answers, and 12 categories were established. Illustrative quotes can be found in Table 3. Many of the factors associated with relapse were also associated with recovery. As with recovery, participants' responses could contain more than one theme and be associated with multiple categories. It was common for participants to acknowledge the multicausal reasons for relapses, as, for example, in one response from a psychologist: "Well, it depends on a lot of factors because it is multicausal: sometimes a person's own personality or environment, or social networks, do not favor maintaining recovery, so people have relapses, they frequently relapse because of all these factors."

The most common factors that participants associated with relapse were treatment adherence failure, lack of family support, economic factors, and lack of social support: each of these were mentioned by at least a quarter of respondents. Treatment adherence failure was the most frequently mentioned, referring both to pharmacological and psychological therapy sessions, and included stopping a treatment or not doing so as directed. Lack of family support was the second most mentioned factor, and included family members who did not believe the person had a mental disorder or encouraged the person to stop participating in treatment. Lack of economic resources was next, and was often mentioned as the reason the patient might have trouble adhering to treatment. The testimony of one interviewee serves as an example; it reveals a certain disjuncture between the medical model of care and a self-care model related more to family cultural beliefs and methods of coping with illness:

It seems to me that the doctor invests little time in psychoeducation, I mean explaining the illness, in working a little more on acceptance of the illness, in managing support networks so they have good treatment adherence. I think that would help make the hospital less of a revolving door, if you ask the person how much they know about their illness and you explain to them what it is, that if you hear voices, if you take your medication, and you recommend to the family that they make sure the person takes their medication. But some families don't care if the person takes their medication or not, and they take them instead to a healer for herbs and special preparations, and if that's what happens, then I can't help you. (Psychiatrist, 49 years old, 21 years of experience)

Table 3 Factors related to relapse and example

Factor	Illustrative quotations
Treatment adherence failure	• Relapse are determined by following or abandonment of the treatment. (Male psychiatrist aged 59)
Lack of family support	• The support networks, and the family. Especially the family, of the institution, and that they don't leave the medic3ations, too. (Female social worker aged 44)
Economic factors	• Relapses are mainly due to the fact that patients or their family members cannot buy the medication due to their high cost. (Female nurse aged 43)
Lack of social support	• Maybe because there is no good support system, also economic factors... (Female social worker aged 38)
Stress	• Regarding the cause of relapses in psychiatric patients, they are mainly due to the abandonment of the pharmacological treatment by a supposed improvement and to stressful situations which they are exposed to in the family and work life. (Female psychologist aged 32)
Individual's characteristics or personality	• Relapses are due to 3 factors: 1) inadequate treatment; 2) economic factors, the patient and family do not have money to buy the medicines**; 3) the patient's own characteristics**. Sometimes the treatment is adequate, there are resources to get the medication, **but if the patient does not want to improve, in these cases not much more can be done**. (Male psychologist aged 54, psychologist)
Lack of mental illness knowledge	• 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. (Female social worker aged 50)
Ineffective treatment	• ... you would talk about non-adherence to treatment or having the wrong diagnosis or inadequate treatment or economic factors. (Male psychiatrist aged 31)
Environmental factors	• Relapses are attributed to the type of illness and aggravating factors in the environment that exacerbate the disease and lead to the abandonment of treatment. (Male aged 59)
Type of diagnosis	• Relapses can be attributed to the type of illness, aggravating factors that can trigger the exacerbation of the disease and the abandonment of treatment. (Male aged 59)
Part of recovery	• Relapses are a natural part of the disease... and recovery like relapses depend on biologic, psychologic, and social factors. (Male psychiatrist aged 44)
Other	• The main causes of patient relapse are lack of awareness of the disease, lack of support from the family coupled with economic and **cultural factors**. (Male psychiatrist aged 32)

Lack of social support was cited by 30 respondents and included all types of social support networks except for family members: for example, health care personnel, friends, coworkers, teachers, and community members. In addition, one interviewee believed that having direct experience with a psychiatric illness, either as a family member or personally, was related to a person's vision of recovery and how to respond to a relapse:

The fact that a person's recovery depends on their whole environment, not just on the person, but on everything around them, I think is a learning experience for them as well as

for those around them… . In my case, my mom had a psychotic break when I was about 10 years old. I remember that when my mom came home from the hospital, for me it was very strange to see her, and after having seen her at the height of her illness and then sick in bed. She had a difficult recovery, and the times were different then. Fortunately there are more things now. My dad didn't tell us anything then, but yes, a person can get their life back. I have heard co-workers say that there are hopeless cases. They think so because they often don't have previous experience, but in my case I have it. (Social worker, 45 years old, 10 years of experience)

Quantitative Analysis

Table 4 shows the findings from a comparative analysis by gender, using a Student *t* test. There were significant differences in five items. Women showed more negative attitudes toward people with mental health illness. They related more with the following statements: "Psychiatric patients who are discharged should not be allowed to marry" ($M = 2.78$, SD $= 2.30$) than men ($M = 1.5$, SD $= 2.14$), t (93) $= 2.53$, $p = .05$; "All mental health patients should be prevented from having children by a painless operation" ($M = 2.40$, SD $= 2.18$) than men ($M = 1.25$, SD $= 2.0$), $t(75.9) = 2.5$, $p = .05$; "Psychiatric hospitals should be located in areas as far away from the general public as possible" ($M = 2.13$, SD $= 2.4$) than men ($M = 1.0$, SD $= 1.99$), $t(83.2) = 2.26$, $p = .05$. "More tax money should be spent on the care and treatment of people with mental illness" ($M = 3.77$, SD $= .84$) than women ($M = 3.33$, SD $= 1.15$), $t(88) = -2.12$, $p = .05$. Although there were no significant differences in the remaining items, it is interesting that the highest scores in both groups were for items related to negative attitudes toward people with mental illness.

Discussion

This study is a first step in understanding the conceptualization of recovery from severe mental illness, from the perspective of mental health personnel in Mexico City. Few studies have been conducted regarding this concept in industrializing countries (Slade et al., 2012; Ferreira de Oliveira, et al., 2021), and this research helps to expand our understanding of this conceptualization to places beyond high-income industrialized countries. The results elucidate the views of mental health personnel in Mexico City about the factors that facilitate or impede recovery from mental illness. While previous studies have investigated factors associated with mental illness recovery from the perspective of patients (Tew et al., 2012), they have not looked at the perspective of mental health providers (Wahl, 2010).

Our results demonstrate that most mental health personnel believe that mental illness recovery is possible, at least in some instances. This is important, given that recovery-promoting competencies of mental health professionals have been demonstrated to be positively associated with recovery of patients (Jas & Wieling, 2018). Our interviews revealed that the belief of mental health personnel in the possibility of recovery was dependent on how they defined it. Those with more clinical definitions seemed to have more pessimistic views of recovery, likely because of the narrower definition tied to symptomatology and the amelioration of symptoms. Those with more holistic interpretations of recovery seemed to have more a positive outlook.

Our study also helps to highlight the complexity and multiple factors that the respondents believe are associated with recovery, factors they often described as being

Table 4 OMI recovery-related item responses by sex

Female			Male		
Items	Mean	SD	Mean	SD	*F*
1. Psychiatric patients who are discharged should not be allowed to marry (4)[1]	2.78	2.30	1.57	2.14	3.0*
2. People who were once institutionalized psychiatric patients are no more dangerous than the average citizen (8)	2.35	1.32	2.37	1.49	1.2
3. More tax should be spent in the care and treatment of people with serious mental illness (18)	3.33	1.15	3.77	.84	6.60*
4. People with mental illness should never be treated in the same hospital as people with physical illness (21)	2.72	2.24	2.08	2.14	.99
5. If our community health would services have enough doctor, nurses and aids, many of the mental patients would recover enough to live autonomously (23)	2.96	1.20	3.14	1.00	3.0
6. It would be madness for a person to marry someone who had been diagnosed with a severe mental illness, even if they appear to be fully recovered (24)	3.36	1.72	3.20	2.0	3.9
7. Becoming a hospitalized psychiatric patient means you have failed in life (32)	1.78	2.38	1,40	2.18	3.9
9. Although some patients with mental illnesses seem to be recovered, it is dangerous to forget, even for a moment, that they have a mental illness (45)	3.50	1.53	3.28	1.82	2.0
10. All patient in a mental health or in a psychiatric ward should be prevented for having children by a painless operation (51)	2.40	2.18	1.25	2.01	2.0*
11. Psychiatric hospitals should be located in areas as far away from the general public as possible (52)	2.13	2.45	1.08	1.99	21.9*

[1]Item number on the original questionnaire

*$p < .05$

interrelated. Our results provide insight into the effect of their personal experience on their beliefs about mental illness recovery, something previously found in a study in the USA by Osborn and Stein (2017). The interviews also revealed that greater contact with those affected by mental illness (and even personal experience with mental illness) was not enough to explain respondents' beliefs about recovery and relapse.

The results also show the predominance of a clinical orientation among mental health professionals in Mexico City. Mental health care in Mexico currently lacks other perspectives, perhaps leading to the exclusively clinical perspective on the part of the mental health personnel interviewed. This clinical orientation may present a challenge as Mexico seeks to reorient to a more holistic and community-oriented care model that seeks to improve the quality of life of those living with mental illnesses (Secretaría de Salud, 2022). The paradigm shift might be promoted by finding ways to involve more mental health advocates and people affected by mental illness in the education of mental health professionals. In fact, peer providers of mental health services have been found to help mental health service users by drawing on their own personal illness and recovery narratives (Mancini, 2019). The key findings from a 2020 study with 17 peer support workers showed that self-mastery was prevalent among all of the participants' recovery narratives, speaking to the importance of agency (Kerr et al., 2020); this study demonstrated what a powerful, and yet, underutilized tool peer providers are in mental health care.

One of the most interesting findings in our study is that most mental health personnel interviewed failed to mention their own role in the patients' recovery process, focusing instead on social, environmental, and patient-centered factors. Previous research, however, has demonstrated the impact of doctors and their attitudes both on patient outcomes (Mondloch et al., 2001) and on stigmatization (Mora-Rios et al., 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. Our findings demonstrate the need for further training of mental health personnel to broaden the definition of recovery from one focusing on the traditional clinical concept to a more holistic approach. As Halbreich (2022) notes, well-being is interdisciplinary, and it is important to incorporate this perspective into the educational curriculum of health care providers.

It is also important to carry out research on these issues in medium- and low-income countries in order to have a more comprehensive vision that includes the cultural differences in different regions. For example, the review of the approach to recovery of persons with severe mental illness (SMI), which included such countries, found that family networks and spirituality were more meaningful, whereas autonomy was more important in high-income countries (Gamieldien et al., 2021).

Regarding gender differences, our study found more favorable attitudes toward people with mental illness among men than among women. Similar findings were found in previous studies in western societies (Holtzinger, et al., 2012). Given the limitations of the sample, these findings must be taken with caution, but they clearly require further investigation.

The use of a mixed method strategy was highly useful in exploring the multiple dimensions of recovery, as well as the economic, personal, social, and cultural barriers that participants saw as interfering with the well-being of people with mental illness. Using methodological triangulation, it was possible to explore the factors they associated with recovery, as well as to identify some of the gender differences, which

could contribute to the development of measures to sensitize health care personnel and improve care for mental health.

Limitations

This was an exploratory study 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 cannot be generalized to other locations. Second, the sample was not randomized: participants self-selected into the study. Initially, the goal was to have personnel representing different areas, but it was not possible to recruit sufficient personnel from some areas. Further study should be carried out in other locations in Mexico and using a random sample.

Future Research

It would be worth promoting further research on skill-based training to improve the quality of interpersonal contact between mental health professionals and people with psychiatric diagnosis, to promote more positive attitudes on mental health. In Mexico, it continues to be a challenge to incorporate people with lived experience of mental health conditions (PWLE). However, doing so could be a catalyst for developing a more holistically oriented perspective on recovery. Although it is true that there have been small changes in the perceptions of people with mental health problems, the fatalist vision surrounding these representations is still present in society, and it is expressed in the health care personnel providing care. Stigma and discrimination are social and cultural phenomena that are changing slowly in Latin America. It is thus important to promote research on this issues and carry out follow-up studies to evaluate changes in the attitudes of health care personnel over time.

Conclusion

This exploratory study was one of the first studies conducted in Mexico City to investigate the topic of mental illness recovery from the perspective of a variety of mental health personnel. It provides a nuanced portrait of how mental health personnel in Mexico City perceive, think about, and conceptualize recovery from severe mental illness. The study found that mental health personnel view recovery in different ways, and that these views are influenced by a variety of factors, as demonstrated by the themes developed in the analysis. The same was true for the factors they associated with relapse in mental illness. Factors included both external factors, like personal finances and stress, and internal factors, such as personal characteristics. Participants were likely to name multiple factors influencing both recovery and relapse, demonstrating the complexity and manifold nature of mental illness issues.

This study also demonstrated that mental health personnel in Mexico City tend to have a relatively grim view of some mental disorders, like schizophrenia, compared to other mental illnesses. The finding is not surprising, given that previous studies around the world have found that schizophrenia is stigmatized and viewed with pessimism (Davidson et al., 2008). Interestingly, Hugo (2001) found that mental health professionals based their pessimistic

views on their professional experience, much like the respondents in the current study. That is, they 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, the outlook and views they expressed in our study might, given the current circumstances in Mexico City, be considered realistic rather than pessimistic. More research should be pursued in this area to continue expanding the understanding of recovery.

Participants' responses in our study reveal an inclination toward a clinical orientation concerning recovery, one that focuses heavily on symptomatology and less on the holistic well-being and integration of the patient. This clinical view of mental illness and recovery will need to change, as Mexico is seeking to shift to a more community-oriented approach to mental health care. One way to do so would be to find ways to incorporate more mental health advocates, as well as mental health professionals who have themselves dealt successfully with mental illness, in education and training. At the same time, resources must be increased to meet the demand for mental health professionals in Mexico.

Finally, it would be beneficial to also consider mental illness recovery from the perspective of patients and their families, to compare these with the perspectives of the mental health personnel assisting them. Such a comparison would help to rectify any misalignment in the treatment expectations and goals of personnel and patients. This study was a good start in learning about mental illness recovery in Mexico, but the work needs to continue.

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Declarations

Conflict of Interest The authors declare no competing interests.

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