ID: 10.33881/2027-1786.RIP.14211

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Investigación | Research

Utility of a multidimensional recovery framework in understanding lived experiences of Chilean and Brazilian mental health service users

Utilidad de un marco de recuperación multidimensional para comprender las experiencias vividas de usuarios de servicios de salud mental chilenos y brasileños

Utilidade de uma modelo de recuperação multidimensional para compreender as experiências de usuários de serviços de saúde mental chilenos e brasileiros

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Rip 14²

Volumen 14 #2 may-ago
14 Años

2021

Revista Iberoamericana de
Psicología

ISSN-l: 2027-1786 | e-ISSN: 2500-6517
Publicación Cuatrimestral

Revista Iberoamericana de
Psicología
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Alt Title / Título alternativo / Título alternativo:

[en]: “Instead of workshop, I wanted to work”: Utility of a multidimensional recovery framework in understanding lived experiences of Chilean and Brazilian mental health service users

[es]: “En lugar de taller, quería trabajar”Utilidad de un marco de recuperación multidimensional para comprender las experiencias vividas de usuarios de servicios de salud mental chilenos y brasileños

[pt]: "Em vez de uma oficina, eu queria trabalhar": Utilidade de uma modelo de recuperação multidimensional para compreender as experiências de usuários de serviços de saúde mental chilenos e brasileiros

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Keywords / Palabras Clave / Palavras chave:

[en]: recovery, mental health, Latin America, user perspective, lived experiences

[es]: recuperación, salud mental, América Latina, perspectiva del usuario, experiencias vividas

[pt]: recuperação, saúde mental, América Latina, perspectiva do usuário, experiências vividas

Proyecto / Project / Projeto:

U.S. National Institute of Mental Health (T32MH103210); RedeAmericas, U.S. National Institute of Mental Health (U19MH095718); BeFITs, U.S. National Institute of Mental Health (R01MH122851).

Financiación / Funding / Financiamento:

U.S. National Institute of Mental Health (T32MH103210); RedeAmericas, U.S. National Institute of Mental Health (U19MH095718); BeFITs, U.S. National Institute of Mental

Submited: 2020-10-02

Acepted: 2021-02-10

Resumen

La comprensión y aplicación del concepto de recuperación, a pesar de sus posibles beneficios para los servicios de salud mental, aún se encuentra en incipiente desarrollo en América Latina. Si bien la reforma psiquiátrica en la región ha tenido algunos avances, el marco de la recuperación no ha sido suficientemente explorado. Whitley y Drake (2010) sugirieron un marco conceptual integral para la recuperación que incluye cinco dimensiones: clínica, existencial, funcional, física y social. El presente estudio tuvo como objetivo explorar las perspectivas de los usuarios chilenos y brasileños sobre la recuperación identificando su adscripción y aplicabilidad de estas cinco dimensiones. Se entrevistó a treinta participantes de la Intervención en Momento Crítico-Delegación de Funciones (CTI-TS) realizada en Santiago (Chile) y en Río de Janeiro (Brasil) sobre sus experiencias de recuperación. Se exploró la aplicabilidad del marco de Whitley y Drake al contexto de Chile y de Brasil. Los resultados mostraron que: 1. El marco era aplicable a esta población; 2. Las dimensiones presentaban un tipo particular de entrelazamiento y estaban influenciadas por una serie de procesos tales como la continuidad en el proceso de atención/cuidado/autocuidado, y sobresalía la funcionalidad y la esfera social; 3. Los valores culturales, el estigma y los determinantes sociales emergieron como factores cruciales que afectan el tratamiento y la recuperación. Se propuso una reinterpretación del esquema referencial. Los hallazgos representan un aporte a la literatura internacional sobre recuperación al aumentar la validez de este marco referencial multidimensional y su aplicabilidad a diversas poblaciones.

Abstract

The understanding and application of recovery, despite its potential benefits for mental health services, is still in its incipient development in Latin America. Psychiatric reform in the region has been broadly known and discussed; yet, the recovery framework requires further exploration. Whitley and Drake (2010) suggested a recovery framework including five dimensions: clinical, existential, functional, physical, and social, offering a comprehensive perspective of the recovery process. The present study aimed to explore Chilean and Brazilian users’ perspectives on recovery identifying their endorsement of these five dimensions. Twenty-four users and six peer support workers were interviewed on their experiences with the Critical Time Intervention-Task Shifting (CTI-TS) carried out in Santiago (Chile) and in Rio de Janeiro (Brazil). Using a framework analysis approach focused on the users’ recovery process, we examined the utility of Whitley & Drake’s recovery framework in Chile and Brazil. Results showed that: 1. The framework was applicable to this population; 2. For Chilean and Brazilian users, dimensions were intertwined and influenced by salient processes (i.e., continuum of care, centrality of functioning and social life); and 3. Cultural values, stigma, and social determinants (e.g., housing, welfare) were mentioned as crucial factors affecting treatment and recovery but had not been sufficiently accounted for in the framework. A reinterpretation of the framework was proposed based on Chilean and Brazilian users’ lived experiences. Findings add to the international literature on recovery by increasing the social validity of the multidimensional framework and expanding its utility to diverse populations.

Resumo

A compreensão e aplicação do conceito de recuperação, apesar de seus potenciais benefícios para os serviços de saúde mental, ainda são incipientes na América Latina. Embora a reforma psiquiátrica na região tenha feito algum progresso, a estrutura de recuperação não foi suficientemente explorada. Whitley e Drake (2010) sugeriram uma modelo conceitual abrangente para recuperação que inclui cinco dimensões: clínica, existencial, funcional, física e social. O presente estudo teve como objetivo explorar as perspectivas dos usuários chilenos e brasileiros sobre a recuperação, identificando sua atribuição e aplicabilidade dessas cinco dimensões. Trinta participantes do Momento Crítico Intervenção-Delegação de Funções (CTI-TS), realizado em Santiago (Chile) e Rio de Janeiro (Brasil), foram entrevistados sobre suas experiências de recuperação. A aplicabilidade da estrutura de Whitley e Drake aos contextos chileno e brasileiro foi explorada. Os resultados mostraram que: 1. O modelo foi aplicável a esta população; 2. As dimensões apresentaram um tipo particular de entrelaçamento e foram influenciadas por uma série de processos como a continuidade do processo de atenção / cuidado / autocuidado, destacando-se a funcionalidade e a esfera social; 3. Valores culturais, estigma e determinantes sociais emergiram como fatores cruciais que afetam o tratamento e a recuperação. Foi proposta uma reinterpretação do esquema referencial. Os resultados representam uma contribuição para a literatura internacional sobre recuperação, aumentando a validade desta estrutura multidimensional e sua aplicabilidade a diversas populações.

Citar como:

Agrest, M., Alves-Nishioka, S., D. Le, P. ., Dishy, G., Kankan, T., Dev, S., Mascayano, F., Dahl, C. M., Vera San Juan, N., Abadi, D., Whitley, R. , Tavares Cavalcanti, M., Valencia, E., Alvarado Muñoz, R., Yang, L. H. & Susser, E. (2021). Utility of a multidimensional recovery framework in understanding lived experiences of Chilean and Brazilian mental health service users. ***Revista Iberoamericana de Psicología*** , *14* (2), 117-132. https://reviberopsicologia.ibero.edu.co/article/view/1990

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Revista Iberoamericana de **Psicología**
ISSN-L: 2027-1786

Recovery in mental health is a powerful paradigm that emphasizes one's personal journey to live a meaningful and hopeful life, reintegrate into social life, rediscover purpose, and manage psychiatric symptoms **(Davidson, 2003).** Different from traditional psychiatric views, individuals with severe mental illnesses (e.g., schizophrenia) may fully participate in society, live independently, and engage in meaningful relationships **(Davidson et al., 2001).** Only a small proportion would require hospitalizations and may recover with intermittent, minimal-to-no additional support from specialized **centers (Alvarado et al., 2012; Davidson, Harding, & Spaniol, 2005).** Yet, the recovery approach has not been fully incorporated into the mental health field – -especially in non-English-speaking countries. In Latin America, mental health services and professionals tend to employ practices ranging from asylum methods, psychoanalytic approaches, and human-rights advocacy **(Caldas de Almeida, 2013).** However, recovery remains mostly unexplored.

In Latin America, there is often skepticism towards different approaches coming from English-speaking countries along with an argument advocating for greater visibility the developments the countries have made in international discussions **(Alarcón, Lolas, Mari, Lázaro, & Baca-Baldomero, 2020; Vera-San Juan et al., 2018)**. Recovery studies have mostly been conducted in English-speaking, high-income countries and results may not be directly translatable to other populations. There is a lack of research involving diverse populations, which may hinder the dissemination of the concept beyond developed countries.

In Latin America, the recovery approach has had limited impact on the general population and mental health professionals who may still endorse old tenets and stigmatizing misconceptions about people living with severe mental illness **(Mascayano & Montenegro, 2017).** In this context, the concept of recovery may offer a crucial shift on perceptions about mental health highlighting the lived experiences and celebrating resilience. The present study aimed to explore Chilean and Brazilian users' perspectives on recovery utilizing a multidimensional recovery framework.

Different Approaches to Recovery

Recovery has received several definitions. According to Anthony **(2005),** recovery is "the development of new meaning and purpose in life as a person grows beyond the effects of mental illness" (p. xvi). During the 1990s and 2000s, the concept blossomed in English-speaking countries, driven by the user-led social movements seeking to change the nihilistic and pessimistic approaches to severe mental illnesses prevalent in psychiatry. Understanding mental health recovery involves primarily understanding the lived experiences, hopes and preferences of those with psychosocial disabilities **(Crossley & Crossley, 2001; Deegan, 1988).**

The literature has distinguished two contrasting views on recovery, namely, to recover "from" and to recover "in" mental illness **(Davidson & Roe, 2007);** clinical recovery vs. social recovery **(Secker et al, 2002);** scientific model of recovery vs. consumer model or user-based recovery **(Bellack, 2006; Schrank & Slade, 2007);** recovery as a goal vs. recovery as a process **(Davidson & Roe, 2007).** On the one hand, one may recover from a mental illness to achieve an ultimate goal; on the other hand, one may experience a process of recovery in the midst of mental illness. The former is typically linked to professional-led research and services' goals, with mental health treatment being central to recovery and full or partial remission of symptoms as the priority. The other approach is aligned with user-led social movements that underscore the lived experiences and recovery process, which may or may not involve mental health treatment and the priority is to live well and with purpose **(Borg & Davidson, 2008).** The two views may seem as opposing each other but also as complementing one another **(Whitley & Drake, 2010).**

Several frameworks spanning the spectrum of these two views have paved the understanding of recovery. One of the most well-known and internationally cited frameworks is the CHIME framework **(Davidson, 2019; Slade et al., 2012; Vandewalle et al., 2017).** Developed from a systematic review, CHIME stands for Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment **(Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).** It highlights the characteristics, processes, and stages that people with mental illness may go through in their recovery journeys. Notably, only studies published in English were used in the framework development suggesting a lack of socially and culturally diverse experiences, particularly those from non-English-speaking countries.

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a study involving 100 users, mental health professionals, and researchers, and developed a model of recovery **(SAMHSA, 2010).** Mental health recovery is defined as a transformation journey towards a meaningful life in community, where individuals can strive for their full potential. Ten basic components would be essential to recovery: hope, person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility, and respect **(SAMHSA, 2010).** Despite being expansive, studies that utilize the SAMHSA model were mostly conducted in the U.S. and focused on the individual aspects of recovery such as empowerment and hope, while aspects such as peer support and culture were less frequently mentioned **(Ellison, Belanger, Niles, Evans, & Bauer, 2018).**

Aiming to capitalize on different perspectives on recovery and integrate mental health professionals' views with users' lived experience, Whitley and Drake **(2010)** developed a more comprehensive framework. It includes five dimensions: clinical, functional, physical, social and existential (see Table 1). The clinical dimension refers to symptom reduction and control, so they are not overwhelming and incapacitating to the person. The functional dimension involves being increasingly autonomous and successfully handling daily activities, participating in society, and being integrated in the community through giving and receiving from it. The physical dimension refers to improvement in physical health regarding self-care and receiving general care by professionals. The social dimension refers to the interpersonal and community aspects of recovery as people establish and maintain rewarding relationships with family, friends, peers, and significant others. The existential dimension highlights the experiences of hope, having a sense of responsibility and self-direction, and being empowered. Religion and spirituality are also integral to this dimension emphasizing the feelings of meaning and purpose **(Whitley & Drake, 2010).**

Table 1.
Whitley and Drake's framework. Dimensions of recovery in context

Dimension	Factors encompassed involved	Healers	Measurable
Clinical	Symptoms	Psychiatrists	Rehospitalization
	Medical care	General practitioners	Symptom severity
	Psychotropic medication	Community nurses	Adherence
	Talking and behavioral therapies	Case managers Assertive community treatment teams Clinical psychologists	

Dimension	Factors encompassed involved	Healers	Measurable
Functional	Employment	Supported employment specialist	Obtaining and maintaining employment
	Education	Vocational rehabilitation	Beginning and completing educational courses
	Housing	Housing specialists Case managers Social workers Teachers and educationalists	Obtaining and maintaining secure housing
Physical	Diet	Nutritionist	Caloric intake
	Exercise	Physical trainers	Level of exercise Weight, circumference
	Smoking	Addiction counselors	Substance abuse
	Substance abuse		
Social	Family	Family and friends	Social support
	Friends	Case managers	Social capital
	Peers	Social workers	Social activity
	Community	Community leaders	Community integration
	Social activity	Peers	Citizenship
		Religious leaders	Sense of belonging
Existential	Religion and spirituality	Religious leaders and congregations	Hope
	Agency and self-efficacy	A higher power (God)	Emotional well-being Spiritual well-being Sense of self-efficacy and autonomy
	Personal empowerment	Peers Family and friends Case managers Clinical psychologists	Sense of empowerment

Note. Taken with permission from Psychiatric Services, 61, December 2010 (p. 1249) and adapted for this manuscript.

Each dimension may overlap with others and have multiple connections. According to Whitley and Drake **(2010),** "clinical recovery can be heavily influenced by the other four dimensions" (p.1249). For instance, the physical dimension, encompassing factors such as diet, exercise, smoking cessation, and substance abuse, may not be clearly distinguished from medical care. The framework is useful to conceptualize important aspects of recovery because of its multidimensionality and emphasis on processes. When analyzing the unique trajectories of people with mental illnesses, it is important to attend to the interconnection between recovery dimensions such that improving one (e.g., functional dimension) may significantly improve another (e.g., existential dimension). Given the holistic perspective of Whitley and Drake's **(2010)** framework including different dimensions and their interconnections, the present study selected it to unveil the lived experiences of Chilean and Brazilian mental health users in recovery.

Latin American Heralds of Recovery

Chile and Brazil have a long tradition in community-based health and mental health services **(Alvarado et al, 2012; Amarante & Nunes, 2018).** The humanization of care (humanización or humanização) has been a characteristic of initiatives and policies implemented in the region **(Caldas de Almeida, 2013).** Yet, the notion of recovery has not been extensively assimilated into the local conceptualization of mental health. Beginning in the 1960s, Chile developed several strategies and programs that fit with what would be conceptualized in English-speaking countries as "recovery orientation of services" **(Marconi, 1971; Norambuena-Cardenas, 2016).** More recently, several studies

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ISSN-L: 2027-1786

have proposed influential community-based initiatives which could be articulated through recovery frameworks **(Alvarado, Schilling, & Jorquera, 2015; Minoletti, Sepúlveda, & Horvitz-Lennon, 2012; Sepúlveda et al., 2012).**

Since the mid-1980s, Brazil has developed a strong community-based mental health system rooted in the principles of psychosocial rehabilitation **(Leal & Delgado, 2007).** In the 2000s, the Centro de Atenção Psicossocial (CAPS; Psychosocial Care Center) expanded and is considered the most strategic resource to transform the mental health system **(Leal & Delgado, 2007).** The CAPS aim to promote mental health, develop an integrated clinical practice through multidisciplinary teams, and provide psychosocial reintegration for people with severe mental illness. Movements for user empowerment emerged in the centers, calling for more involvement and collaboration between mental health professionals and users **(Vasconcelos, 2013).** The CAPS has become a distinctive feature of Brazilian mental health care reform being well aligned with the recovery principles.

There is an increasing interest in the concept of recovery. In Brazil, for instance, a research group has conducted studies on recovery and user empowerment **(Baccari, Onocko-Campos, & Stefanello, 2015; Lopes et al., 2012; Vasconcelos, 2011)** culminating on the Interfaces Research group at University of Campinas and the Yale Program for Recovery and Community Health (PRCH), and the special issue about recovery in the Brazilian Mental Health Journal **(Onocko-Campos et al., 2017; Rowe & Reis, 2017).** However, the concept of recovery remains mostly unknown, having little influence on mental health research and services in the region. More research supporting and expanding the use of recovery frameworks are needed to disseminate the approach as it is useful and aligned with long-standing strategies.

Cultural Considerations in Recovery Frameworks

Latin American cultures have salient values such as solidarity and family support **(Sanabria, 2007),** which should be factored in when discussing recovery in the region. The importance of family, and more broadly the community, often overshadows individual goals and achievements. In the context of high inequalities and poverty, individual success may raise conflicting reactions of admiration or disapproval. Despite notable exceptions **(Price-Robertson, Obradovic & Morgan, 2017),** recovery frameworks have not extensively examined this collectivist perspective. Importantly, Catholicism, prevalent in Latin America, emphasizes a more collectivist perspective, while Protestantism tends towards a more individualistic one **(Cohen & Hill, 2007).** The disconnect between these cultural values (collectivistic vs. individualistic) may have affected a broader diffusion and buy-in of the concept in non-English-speaking countries **(Fukui, Shimizu, & Rapp, 2012; Zalazar et al, 2017).**

Chilean society has a strong emphasis on family bonds, cultivation of Catholicism, and distinct social classes **(Larraín, 2001).** Moreover, research observed that Chilean people often endorse gender roles (i.e., machismo), family support (i.e., familismo), work and financial stability, and social appearances and status **(Mascayano et al., 2015; Vera-San Juan, 2020).** As for Brazilian society, values such as cordiality, hospitality, aversion to formalities, cheerfulness, and creativity permeate interpersonal **relationships (Holanda, 1995; Lourenção, Montanari, Giraldi, & Costa, 2019).** At the same time, Brazilian culture also emphasizes patriarchy and authoritarianism, social and physical appearances linked to aesthetic beauty and being healthy **(Goldenberg, 2010; Vasconcelos, 2013).**

Considering these cultural idiosyncrasies, the concept of recovery should be contextualized to more adequately guide mental health services in the region. Latin American users' experiences of recovery may differ from those reported by individuals in English-speaking countries and be not fully captured in current frameworks. Although the concept of recovery is not new, it can be adapted and clarified to embrace other cultures and become more useful to professionals and users **(Adeponte, Whitley & Kirmayer, 2012).**

To address this, the present study aims to explore Chilean and Brazilian mental health service users' perspectives on recovery through identifying their endorsement of Whitley and Drake's **(2010)** recovery framework. Particularly, we examined the utility of this framework in understanding Santiago (Chile) and Rio de Janeiro (Brazil) users' interpretations of their mental health recovery.

Methods

Participants

Thirty interviews with Chilean ("C") and Brazilian ("B") participants of the community-based intervention, Critical Time Intervention-Task Shifting (CTI-TS), in Santiago, Chile, and Rio de Janeiro, Brazil **(Mascayano et al., 2019)** including 24 service users ("U") and six peer-support workers (PSWs; "P") were conducted. Users were all receiving ambulatory care and in different stages of their recovery process. Peers were community-mental health service users who had made significant progress in their recovery (e.g., full remission). Overall, 18 (60%) participants identified as male and 12 (40%) as female, and ages ranged between 21 to 65 years (see Table 2). Among users, 13 (54%) were diagnosed with non-affective psychosis and 11 (46%) with affective psychosis. Regarding education level, 33.6% of users reported grade level and 28.2% reported high school level. Similarly, 45.5% of users reported that their parents had a grade level education and 12.7% reported a high school level for their parents. PSWs were not asked to disclose their diagnosis and had similar backgrounds in terms of education level and parent education level.

Table 2.
Participants Demographics (N= 30)

Country	Participant		Gender	Age	Education Level
Chile	Users	C-U1	Female	50-65	Grade Level
		C-U2	Male	30-39	Grade Level
		C-U3	Male	21-29	High School Level
		C-U4	Female	40-49	High School Level
		C-U5	Male	50-65	Grade Level
		C-U6	Male	30-39	High School Level
		C-U7	Female	30-39	Grade Level
		C-U8	Male	30-39	Grade Level
		C-U9	Male	30-39	High School Level
		C-U10	Male	21-29	High School Level
		C-U11	Female	40-49	High School Level
		C-U12	Male	40-49	Grade Level
		C-U13	Male	30-39	High School Level
		C-U14	Male	40-49	Grade Level
	Peer support workers (PSW)	C-U15	Female	40-49	Grade Level
		C-P1	Female	40-49	Professional Studies
		C-P2	Male	40-49	High School
		C-P3	Male	40-49	Grade Level
Brazil	Users	B-U1	Male	30-39	Grade Level
		B-U2	Female	30-39	High School Level
		B-U3	Female	30-39	Grade Level
		B-U4	Female	50-65	High School Level
		B-U5	Male	21-29	High School Level
		B-U6	Male	40-49	High School Level
		B-U7	Female	30-39	High School Level
		B-U8	Female	21-29	High School Level
		B-U9	Male	21-29	High School Level
	Peer support workers (PSW)	B-P1	Female	30-39	Grade Level
		B-P2	Male	50-65	High School Level
		B-P3	Male	30-39	Grade Level

Procedures

Data were collected as part of a larger qualitative study implemented by 'RedeAmericas' (Regional Network for Mental Health Research in the Americas), one of the five collaborative hubs funded in the first cohort by the U.S. National Institute of Mental Health (U19 MH095718). RedeAmericas aimed primarily to evaluate the task-shifting of mental health services to address treatment gaps in middle-income countries and examine the barriers and facilitators for scaling up CTI-TS in the region. Local ethics committee of the Universidad de Chile (approved on 05/27/2011), the local Institutional Review Board (IRB) at the Universidade Federal do Rio de Janeiro (UFRJ; approved on 04/25/2011), the Brazilian National Ethical Committee (approved on 04/25/2011), and the IRB of Columbia University (approved on 04/21/2011) reviewed and approved the study protocol. All interviewees provided informed consent for their data to be used in the research. Additional details on study design and procedures are presented elsewhere **(Agrest et al., 2019; Mascayano et al., 2019).**

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Revista Iberoamericana de Psicología
ISSN-L: 2027-1786

The present study examined data from 24 out of 55 users across both sites and six out of all nine PSWs who were randomly selected to be interviewed providing an unbiased participant sample to share their experiences of the intervention. Open-ended questions allowed interviewees to also share about their broader experiences with mental health treatment and recovery process. Participants were interviewed in their native language (i.e., Spanish or Portuguese) in convenient locations (e.g., their home, CAPS). Interviews were audio-recorded, transcribed verbatim in Spanish or Portuguese by native speakers, and then translated to English by bilingual research assistants. Interviews lasted between 45 and 60 minutes.

Analysis

Analysis was embedded within the larger study in which the researchers developed an extensive coding framework for CTI-TS implementation, particularly specifying cultural and recovery aspects connected to the original research question **(Mascayano et al, 2019).** Data analysis within the larger study followed consecutive steps: (1) members individually coded the interviews and discussed the codes as group; (2) a thematic codebook was created identifying barriers and facilitators to implementation, cultural traits affecting treatment, and recovery; (3) disagreements on index codes were resolved through consensus; and (4) recovery themes from different participants were charted **(Srivastava & Thomson, 2009).** For the present study, we employed secondary data analysis and Whitley and Drake's **(2010)** framework was used to deductively analyze the recovery codes that spontaneously emerged from interviews. Recovery codes that were not fully captured in the framework were then aggregated yielding an enriched model. To increase validity of data interpretation, local implementation teams familiar with the local services and cultural nuances were involved in the analysis to comment and suggest modifications to the framework were consistent with field notes and observations during the intervention.

Results

Results are presented in two different sections: first, we present the recovery themes that fall under the five dimensions of Whitley and Drake's (2010) framework. Secondly, we present salient aspects of recovery specific to Chilean and Brazilian contexts that emerged from interviews and expanded the model. Figure 1 displays the relationships among dimensions and their factors as endorsed by participants. Findings combined Chilean and Brazilian responses and a further exploration of country-specific themes, although important and appropriate, would go beyond this study's scope.

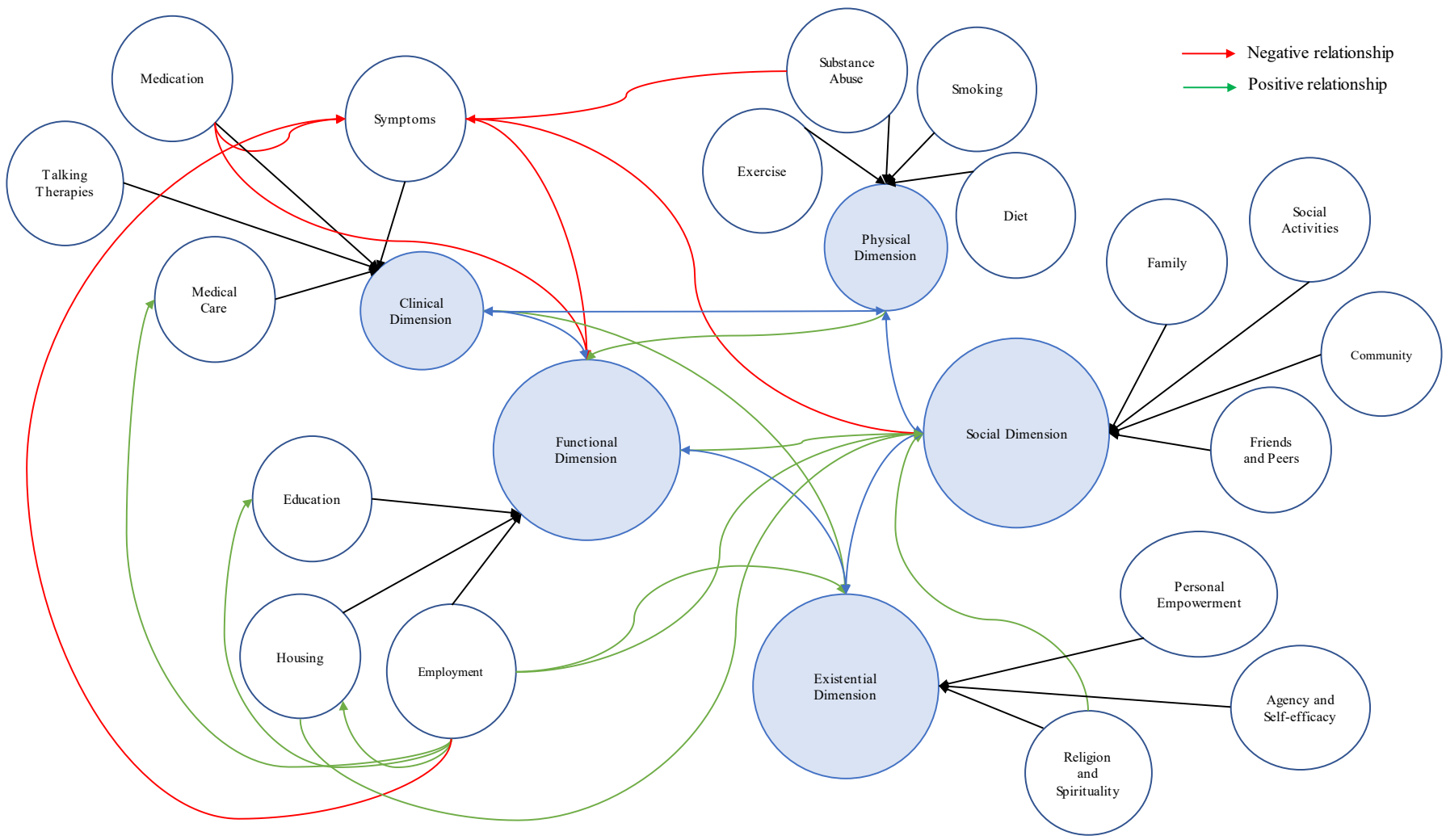

Figure 1. Recovery dimensions, factors and connections endorsed by participants

Emerging Themes Falling Under Whitley and Drake's Recovery Framework

Clinical Dimension: Symptoms, Medical Care, Medication, and Talking therapies

Participants frequently mentioned the clinical dimension as important to their recovery and described medication as helpful. A Chilean participant (C-P1) said: "when you have a good pharmacological treatment (...) then you are not limited" indicating the importance of controlling symptoms. A Brazilian participant (B-U3) also mentioned that not adhering to medication had detrimental effects for her:

> *"[I felt a] lot of sadness, a weight... is... pressure in the head... is... hearing voices ... seeing things... is... I did not want to talk to anyone, I did not want to see anybody (...) I stopped the medicines and had a bad relapse (...) I spent two years in bed to recover."*

In contrast, participants mentioned that medication side effects were significant challenges to daily life. A Brazilian participant (B-P1) described: "These medications I take at night make me so doped that I almost cannot go to the restroom to pee." She also reported stopping medications on her own to become pregnant and having to navigate turbulent moments to manage her mental illness along with fulfilling her family goals. This instance underscored the complex dilemmas individuals with mental illness experience to balance between treatment adherence and side effects and fulfilling other important personal and social roles pertaining to other recovery dimensions (e.g., social) such as starting a family.

Although medication was important, participants highlighted the need for comprehensive psychosocial interventions encompassing multiple factors such as social support and physical health. A Chilean participant (C-U11) argued that "[recovery is possible] with a good treatment, with family support and sport activities, workshops that are interesting to the patient." As such, the clinical dimension was contextualized according to functional and social dimensions.

Functional Dimension: Employment, Education and Housing

The functional dimension was salient for Chilean and Brazilian participants who emphasized that having a job, being increasingly autonomous and financially independent, and securing stable housing were essential in their recovery process. One Brazilian participant (B-U2) shared that caring for her mental health promoted her functioning and autonomy:

> *"You stay all day on the bed, you just get up to go to the bathroom or to take a shower or to brush your teeth. And, when you are under treatment you have breakfast ... for example, you took the medicine properly during the night (...) the morning you come here, you do things … you go home, you take a bath, you can even do some housework."*

Similarly, a Chilean participant (C-U5) said: "Now I am a little bit more independent, because previously they would have to give me even baths, but I have overcome these things because I try to make things for myself, because I want to get over this depression." Recovery for these participants included the ability to care for themselves and be active in their houses and communities.

A salient factor under the functional dimension was employment. Several participants directly or indirectly expressed that working was a hallmark of their recovery as it represented a means to be financially self-sufficient, provide for their family, and, ultimately, participate actively in society. A Chilean participant (C-U6) stated: "Instead of doing the workshop I wanted to work" identifying job opportunities as more helpful than workshops and coming to the community center for the recovery process. A Chilean participant (C-P2) reported that employment helped him to regain confidence to participate in social activities:

> *"[Before working] I would not visit the Mall. I would not go to a musical show. I would not go to a stadium to watch a soccer game. I was scared of people. And now, I can be in front of fifty people making a presentation and it doesn't bother me."*

According to participants, having a job implied many achievements and was extremely valued in Chilean and Brazilian cultures. Despite traditional gender roles salient in these countries (e.g., machismo), participants from both genders agreed that working positively affected their recovery. A Brazilian participant (B-P3) shared that he felt "free" and engaged in his community as he worked as a peer at CTI-TS helping other users. Working increased his engagement in the CAPS and interactions with others including his family:

> *"[My mom] said, "That is so good, my son! Are they going to hire you again [as a peer]?". I said, "No, mom, it's only a meeting". She said, "Ah, my son, if they offer you a job you have to take it. Working, yes, my son!"" (B-P3)*

Another Brazilian participant (B-P1) said:

> *"Wow, they [relatives] were so pleased! [They said] 'She got a job, she will earn her own money. She will work as a researcher. She will work with the patients, she as a patient will help other people who also have problems.' [My family was] very proud [of me]."*

Reintegration into social life seemed more effective than certain treatment activities since it allowed them to fulfill important roles.

At the same time, a Brazilian participant (B-U10) shared:

> *"[I do not] want to work full time (...) because the supermarket job is stressful, and I would end up stressed. Of course, I would make more money, but I would lose my pension. But I like to work two days so I'm not too stressed and receive less and not lose my pension. The job I have is good, the schedule I have is good because the pension I have isn't too much, so this is additional money."*

Working could also be a stressful experience and, particularly for individuals recovering from mental illnesses, it may hinder their recovery. Perhaps, due to fears of symptoms worsening, participants worried about losing a stable source of income (e.g., social welfare) or losing their job and being unable to find another. Interviews showed that employment is a complex status that, on one hand, promotes functioning and fulfillment of certain social roles, and, on the other hand, may generate anxiety and potentially hamper recovery.

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The complexity of recovery for individuals with mental illnesses was similarly expressed through the importance of housing. Different Brazilian participants presenting transient behaviors frequently stayed in shelters and shared that having a "permanent address" was crucial. For instance:

> *"I hoped [treatment] would ... get me out of ... the shelter, that's all. That's the only thing I wanted to get out of the shelter, that's what I asked for, to get me out of the shelter, that's all I wanted, for me to leave the shelter." (B-U6)*

Moreover, stable housing ("today I have a house, I have an address (...) I have my address here and everything… [even a] light bill") was possible when he moved in with a friend. Together, they were able to pay for their living expenses ("[we] gather our two incomes, our two benefits to be able to pay the rent, buy some food, so we can live together" B-U6). This example emphasizes that recovery is a multifaceted process: housing was possible through securing income (via social welfare) and adequate mutual support (a roommate).

Physical Dimension: Diet, Exercise, Smoking, and Substance Abuse

Both Chilean and Brazilian participants reported that caring for their physical health through adequate nutrition, avoiding smoking or using other drugs, and exercising enhanced their recovery and improved their quality of life. A Chilean participant (C-U11) said that having a good diet helped him to feel well and energized:

> *"Because it is a matter of energy. I'm good at eating bread, then all these fats make me tired, but when I feed myself in the morning with fruits or vegetables with cereals (...) I have plenty of energy for the whole day."*

A Brazilian participant (B-U6) explicitly mentioned quitting smoking as part of his recovery process. Another Chilean participant (C-U10) shared that using substances was detrimental for his mental health. Once he quit and engaged in physical activities, he made new friends, felt more active, and even pursued other interests:

> *"For me, it helped a lot when I started to participate in circus activities, juggling. So, I went from going to parks to use drugs to going to juggle, I started to change my circle [of acquaintances]. I stopped meeting the boys from the community because they only damaged me, and I started to do other things that motivated me a lot and this doesn't happen to others (...) I joined martial arts, I started to draw, to paint, I've joined a class about illustration."*

This instance suggested that caring for physical health involved other aspects of recovery such as increasing social support, engaging in meaningful activities, and finding satisfaction in one's life.

Social Dimension: Family, Friends, Peers, Community, and Social Activities

As expected, given Latin American cultures, family support was consistently mentioned by participants as central in recovery. A Brazilian participant (B-U12) stated that her family was at the same level as having faith in religion: "I find [strength] in God and in my family." Another participant (B-U2) reflected on the importance of her mother to her and to the whole family: "My mother is my supplier (...) [She] is the provider of the family." Two other Chilean participants also added that: "My mother always protects her son (...) But she also knows how important it is for me to do a job that works for me. She always gave me support, but she was also worried. Every family is like this, every mother is like this." (C-P2) and "[We] all turn to my mother [for solutions] (...) She is the pillar. This is what a matriarchy is about." (C-U9)

Participants indicated that reaching independence and not burdening family was a recovery goal. A Chilean participant (C-U8) mentioned that she quit using drugs "to stop disturbing my mom and to feel good about myself." Another Chilean participant (C-U12) said that she decided to engage in further treatment to feel better and "for my family, because they are also affected [if I'm not well]. If I get disorganized, my mom gets sick."

Also, another Chilean participant (C-U11) mentioned:

> *"I think that the love of the family has to do with it. Because I remember when I lived, worked and studied, I saw my mom and I kind of got happy again. (...) Every time my mom came, it gave me good vibes, of love, of being well, of feeling happy."*

Brazilian participants frequently mentioned friendships, stressing the value of having a social network that offers support and enjoyment. One Brazilian participant (B-U9) said: "As I told you, I have no friendships, I cannot have a life, right? I stay in the house inside my room." Another Brazilian participant (B-U7) reported that friends were those that would not go away when you tell them about having a diagnosis of schizophrenia highlighting the importance of sharing difficulties with peers. Notably, the same participant (B-U7) acknowledged that she would not disclose her diagnosis with others to avoid the label of "schizophrenic" and stigmatizing attitudes related to it.

On multiple occasions, Latin American participants mentioned that belonging to a religious community was extremely important for them. As proposed in the framework, religion promotes recovery in the existential and social dimensions being a source of hope and purpose as well as social support and community.

Existential Dimension: Religion and Spirituality, Agency and Self-efficacy, and Personal Empowerment

Overall, participants described their existential journey in recovery as linked to religiosity, social involvement, exercise, employment, and having family support and friends. In this sample, religiosity stood out as a frequently mentioned existential aspect of recovery. Many participants found comfort and hope in their faith. For instance, a Brazilian participant (B-U6) shared that "I trust that God is gonna help me." Another said that spirituality provided her strength: "I was even feeling more strength, right? I mean, in God, of course, I'm evangelical." (B-U12) For a Chilean participant (C-U11), religion also helped her to be more successful in her work:

> *"What makes me super good is the radio Maria, that is a Catholic radio (...) radio Maria teaches me to be tolerant, a good person, having values and all this has helped me a lot. And the success selling my products is due to radio Maria. (...) it helps me to relax, to placate my disease, to have more energy, to be more positive (...) God, religion, other*

people, accepting yourself and all these things that they teach us strengthen me as a person to have a healthier and beautiful life. To be happier with my environment."

Other existential elements of recovery endorsed were agency, self-efficacy, and empowerment. A Chilean participant (C-U3) said: "Because I was able to finish with... a period of my life that was like... a thorn in the flesh. [I wanted] to finish my studies, I feel more confident about myself, have more confidence. I'm also more responsible for myself." These instances highlighted that recovering from mental illness involved the individual's active engagement in treatment and other relevant activities (e.g., studying, working, house chores), which would lead to increased confidence, hope, and sense of purpose.

Interestingly, some Chilean participants described their recovery as achieving a goal (e.g., having a job). For instance, "I will continue attending treatment at the hospital until I have a job and then I will no longer go to the hospital." (C-U14) Meanwhile, other participants talked about recovery as a continuous process, highlighting the importance of meeting other people who were also recovering:

"There are illnesses that don't leave you. So...to know that this issue will stay, and you can have a relatively normal life whatsoever… This, I believe, is the important thing about knowing the trained peer [who was in advanced recovery]. To see a person who is...who is like you but can be normal." (C-U7)

Enriching Recovery Framework: Effects of Cultural Values, Stigma, and Social Determinants

Interviews highlighted that Chilean and Brazilian experiences with recovery were shaped by local values and characteristics. The ability to work or the importance of socializing with friends may go beyond functional and social dimensions, respectively, and reach the status of an existential aspect of recovery. The salience of employment and social network may be unique to more collective-oriented settings such as Latin America given its cultural value of contributing to and caring for family (e.g., breadwinner).

Facing stigma-related situations and coping with stigma were frequently mentioned. A Brazilian participant (B-U7) said: "I know there's really a society's prejudice when you say you're a schizophrenic, for sure. Even in the Psychology classes when you talk about schizophrenia, everyone already gets warned, you know?" Another participant talked about stigma within the religious community:

"I have the impression that they [in the religious community] consider them [people with mental illness] less (...) For example, this is very common... when there is news like "young person suicides due to depression", they say something like "ah poor guy" (...) I had some... shame. This is the word (...) I felt like I was in a position of weakness in front of them." (C-U3)

Stigmatizing attitudes were also common towards other users, including those in advanced recovery (e.g., PSWs). A Chilean participant (C-U8) expressed:

"I don't like to be with [mentally] sick people. I feel worse, like I feel sicker. I like to be with people who are fine (...) they [CTI workers] also were sick so they aren't kind of able to visit the patients... to help them with what a patient needs who is recently getting sick or who is chronic. Because they seem to be doped and all this."

A Chilean participant (C-U15) talked about the peer worker condescendingly: "[The PSW] ...was only a patient… [The community worker] was my monitor…and [the PSW] was her assistant." From the PSW's perspective, a Chilean participant (C-P2) shared that she had to navigate a variety of stigmatizing situations during her work such as when her psychiatrist apologized to her for being skeptical of her ability to work.

Another significant factor identified in the interviews was meeting basic needs. Participants discussed in different ways that their recovery was related to satisfying necessities such as having an income, securing housing, and transportation. A Chilean participant (C-U13) reported that he wanted to start his own business but was facing significant challenges to do so, particularly lack of support:

"I would be satisfied if they had just helped me with a place in a terrain. If they had said: 'Look, we are going to...we're working on providing you with...that you can have your own business in three months so you can work'."

Also, a Brazilian participant (B-U6) emphasized that securing stable housing and being able to leave shelter was extremely important in his recovery. His recovery included meeting basic needs such as housing so he could have a proof of address and access social benefits for instance. Receiving benefits (e.g., pensions, transportation) was described as a way to meet these needs and ensure access to treatment. A Brazilian participant (B-U3) said: "It was difficult to come to treat me here because I could not afford the bus...well...I did not know where to begin ... to get this bus card... Then there are a lot of little things that are important, and you are not able to do." These basic needs were prioritized or were pre-conditions to other therapeutic strategies suggesting that social determinants affected various dimensions of recovery.

Discussion

The Whitley and Drake (2010) is a comprehensive, multidimensional framework that emphasizes recovery as a process. Our findings suggest that the framework was applicable to Chilean and Brazilian participants' recovery experiences. Recovery dimensions were intertwined and carried multiple implications for their recovery indicating a complex and nuanced process. Additionally, cultural values, stigma, and social determinants (e.g., housing, welfare) emerged as essential factors for recovery.

Participants shared reflections and rich considerations about their clinical recovery indicating that they were aware of the benefits and limitations of clinical care. They emphasized the need for comprehensive treatments that include caring and promoting users' reintegration into society through improvement of daily functioning, active participation in family and community, employment, and housing. As proposed in the framework **(Whitley & Drake, 2010)**, the recovery dimensions are not separate but influence each other. The findings illustrated this multidimensionality and clarified the contextual factors that influence their interconnections.

Figure 2 shows a reinterpretation of the recovery framework based on the participants' lived experiences. The proposed framework

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may help expanding the concept of recovery in Latin America and other diverse settings, as it attempts to capture specific processes (i.e., continuum of care, centrality of functional and social dimensions) and contextual factors (i.e., cultural values, stigma, and social determinants) that were salient for participants.

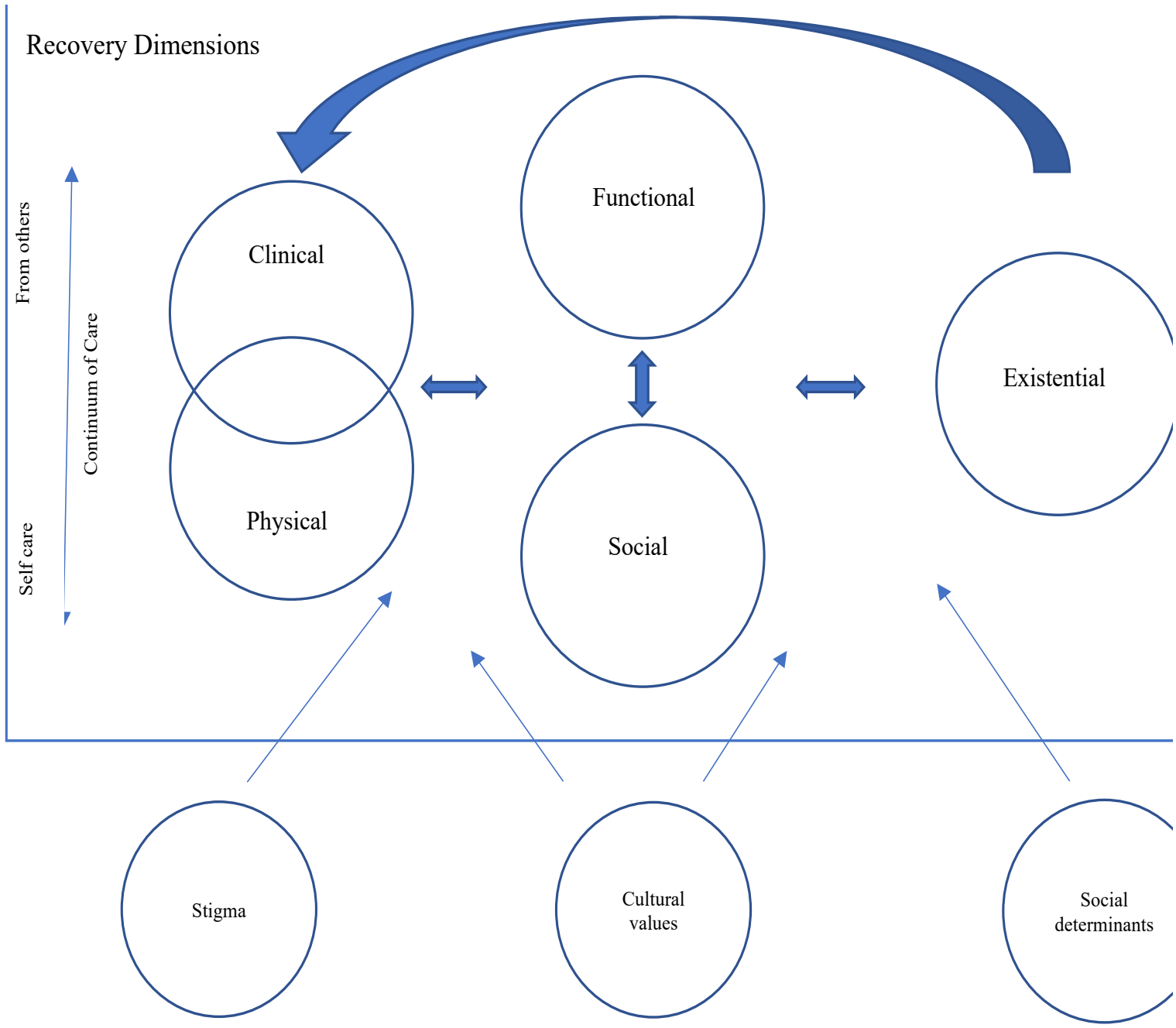

Figure 2 Reinterpretation of the Recovery Framework

Continuum of Care

An overarching theme observed across dimensions was the spectrum ranging from individual responsibility for one's recovery to the need for professional care and social support. Interviews highlighted the fine balance in the recovery process where users were empowered and took responsibility for their own care, while also being cared for by family members and mental health professionals. Well-being was described as a continuum between self-care and being cared for by others, which is only partially accounted for in the recovery framework.

According to participants, being actively engaged in treatment and taking ownership of it was indicative of recovery. The responsibility of caring for oneself influenced decisions such as participating in activities at the mental health center, adhering to medication, and choosing one's social network. At the same time, participants reported many instances when they heavily relied on family members, friends, and mental health professionals to cope with their mental illness. This continuum emerged as a relevant part of recovery permeating all dimensions. It is possible that the collective orientation within Latin American cultures **(Holanda, 1995; Sanabria, 2007)** shapes the concept of self-care emphasizing its deep connections with the interpersonal aspect of care.

Centrality of the Functional and Social Dimensions

Factors such as education, employment, and housing were highly prioritized as they enabled participants to have a sense of self-efficacy, purpose, and, ultimately, personhood. Research found that fulfilling certain social roles and expectations are crucial (i.e., matter the most) for individuals to be considered as members of society **(Mascayano et al., 2015; Yang et al., 2007; Yang et al., 2014).** Considering the community and family orientation prevalent in Chile and Brazil, participants who worked had a greater sense of belonging, which had been affected by mental illness. Endorsing the reflection that "for adults with mental illness, the single most important step to support a process of recovery is to work" (Thornicroft, 2006, p.233), Chilean and Brazilian participants shared many benefits of employment. Performing their social roles (e.g., working, studying) was both a promoter – -by increasing self-efficacy and confidence- – and an indicator of recovery.

Importantly, working seemed to be a "crossroad" for some participants. Holding a job and earning money could increase the risk of losing disability pensions or other benefits. The uncertainty of participants' symptoms may lead them to worry about their ability to maintain their

jobs while forgoing their benefits. Employment becomes almost a "risky" decision compared to the stability of – -even if reduced- – welfare assistance. Moreover, findings indicated that participants wished to receive more support from mental health services to find job opportunities and be reintegrated to the market. Thus, there are nuances and complexities in the recovery process that may be unique to certain societies such as Chile and Brazil where there may be a tension between the cultural value of contributing for society/family through employment, securing income, and access to welfare.

As expected, family and friends were relevant factors of the social dimension. Having social support was essential to participant's recovery pointing to the salience of family (familismo) and social bonds observed in Chile and Brazil **(Holanda, 1995; Larraín, 2001).** Notably, social support was intertwined with the functional dimension and both, in turn, would influence the existential dimension. For instance, working would not only provide for the family financially, but also promote the relationship quality as one participant described that her family was "proud" of her because of her job. Participants often mentioned that the support and encouragement from their family and friends enabled them to find satisfaction in life and well-being. Social support was also described as a motivator for recovery since they did not want to be a "burden," and instead wanted to care for their families.

Additionally, interviews showed significant links between the clinical, functional, and existential dimensions. Mental health treatment enabled participants to manage their symptoms and perform daily activities including socializing with friends and improving family relations. Improved function and social life would, in turn, enhance satisfaction and hope creating a positive cycle for participants. The functional and social dimensions were located almost as intermediaries between the clinical, physical and existential dimensions.

Conversely, concerns about housing and employment were underscored as detrimental to the recovery process. Participants struggling with meeting their basic needs (e.g., housing, stable income source) struggled with recovering from mental illness, as these stressors would significantly impact their mental health – -potentially worsening symptoms and leading to relapses. Given Chile's and Brazil's longstanding socioeconomic problems, many individuals with mental health disabilities face social vulnerability due to insecurity and restricted access to food, lack of stable income, and low education achievement **(Nepomuceno, 2013).** Meeting these basic and immediate needs becomes both challenging and requisites to users in their recovery journey.

Contextual Factors: Cultural Values, Stigma and Social Determinants

Influencing all recovery dimensions, contextual factors emerged as relevant for Chilean and Brazilian participants. Their recovery experiences underscored Latin American's specific social conditions and cultural values. Research has supported that culture is a significant factor affecting the experience of mental health users with their diagnosis, treatments, and recovery **(Myers, 2011).** Participants' accounts of their recovery journey highlighted the cultural values that they (and their communities) endorsed, such as familismo, emphasis on friendships, strong religiosity, and work. These values shaped how they perceived treatment (e.g., should be comprehensive going beyond medication/therapy), their needs (e.g., work, housing), and their recovery process (e.g., having friends and family). Participants who felt reintegrated into their families and communities and able to perform their social roles (e.g., do their chores, work) also reported increased sense of recovery.

Conversely, stigma was described as a barrier to recovery encountered within families, social networks, and mental health services. Stigma towards mental health has been extensively documented in English-speaking countries **(Parcesepe & Cabassa, 2013**) and Latin America **(Mascayano et al., 2016)** being associated with multiple negative consequences including rejection, social isolation, low self-esteem, and devaluation **(Mascayano et al., 2016).** Accordingly, participants shared various situations in which they were confronted with stigma and had to develop strategies to cope with it. Participants acknowledged the pervasiveness of stigma in Chilean and Brazilian society, mental health services, families, and within users and their direct effects on all dimensions of recovery.

Our findings highlighted that job opportunities had a salient function in participants' recovery process. Yet, it can be harmed by experiences with stigma. Some participants expressed stigmatizing attitudes towards peers (PSWs), assuming that individuals with mental illness were unable to support other users regardless of how advanced they were in their recovery. Indeed, research has found that impairments in functioning (including working) was significantly associated with perceived stigma suggesting that mental health users who are unable to work may face increased stigma **(Vázquez et al., 2011).**

Participants also reported negative attitudes towards other users on a social level. Some shared that they were uncomfortable socializing with other users preferring to be around people "who are fine." This perspective indicated that Latin American users held stigmatizing attitudes towards other individuals with mental illness, which potentially restricted their own recovery journey. Stigma directed towards one's identifying group, or internalized stigma, has been linked with negative outcomes including low self-esteem, low empowerment, and hope **(Livingston & Boyd, 2010).** To account for this influence, stigma was added to the recovery framework (Figure 2) as an external factor shaping individuals' recovery experiences.

Similarly, the role of social determinants (e.g., employment, housing) in the recovery process was emphasized as affecting all dimensions. Social determinants shape mental illness and, consequently, recovery by increasing vulnerability to poorer outcomes or enhancing protective factors **(Lund et al., 2018).** Participants described that when their basic needs were met, they were able to progress in their recovery and experience greater quality of life. Particularly, participants mentioned that they were able to function better in their daily lives (functional dimension) and have more positive experiences with others (social dimension). Including the influence of social determinants of mental health in the recovery framework would underscore that macro conditions (e.g., economy, politics) and policies (e.g., health system, welfare) impact recovery as much as community and family factors. Social determinants were even more salient to Chilean and Brazilian participants possibly because these countries face less favorable social and economic conditions compared to high-income, English-speaking countries, where most of the recovery framework has been developed.

Limitations

There are limitations that grant caution when interpreting and generalizing the results. The present study was a secondary data analysis of interviews conducted as part of a larger intervention study.

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As such, the interview guide was mainly focused on the intervention and did not explicitly include questions about recovery. However, participants naturally and repeatedly mentioned their experiences and process of recovery. Despite follow-up questions that were asked to clarify such experiences and provided more in-depth understanding, a second round of interviews or focus groups to confirm with participants themes and codes would have provided greater validity to the findings.

Interviews were the only source of information for the study. Employing methods of qualitative data collection and analysis such as triangulation of data using mixed methods and thematic saturation could bring more consistency of findings and qualitative validity to the study. Additionally, including individuals in recovery from mental illness in the analysis process and discussion would have provided unique insights to the study. Interviews were conducted within the intervention context which may have biased interviewers and participants to discuss, in greater length, recovery aspects pertaining to the clinical dimension over others (e.g., existential, functional). Thus, it is possible that rich details and experiences pertaining to other recovery dimensions were not fully discussed. Moreover, participants working as PSWs in the intervention study may have underscored employment due to their unique position within the project.

The study sample size is relatively small. Participants were recruited from two large urban cities of Chile and Brazil and are not representative of the diverse experiences with mental health recovery in these countries. Additionally, we aimed to discern, and present general patterns observed across the dataset, and a comparative analysis may reveal nuances of differences according to factors such as age, gender, ethnicity, and between the two countries. Despite these limitations, the cross-cultural qualitative nature of the study should be considered an asset for disseminating relevant information on recovery in Latin America.

Conclusions

Findings provide insight into the recovery process for mental health service users in Chile and Brazil and largely support Whitley and Drake's framework **(2010)** while enhancing the model. The recovery concept and framework were useful to conceptualize the lived experiences of Chilean and Brazilian users. Participants endorsed the five recovery dimensions while offering insights into the connection among dimensions and suggesting contextual factors not sufficiently accounted for in the framework.

The importance of comprehensive psychosocial interventions that integrate mental and physical care suggested a significant overlap between the clinical and physical dimensions. Aspects of functioning, such as employment and housing, were significant and more complex than described in the original framework. Family, religious community, and friendships were mentioned as having multiple implications in participants' recovery. The continuum of care was described as a delicate balance between being responsible for one's recovery and accepting help from others. Cultural values, stigma towards mental illness, and social determinants emerged as significant factors for Chilean and Brazilian users contextualizing the framework. Programs focused on recovery may have limited impact when social factors are not sufficiently addressed, which underscores the need for policies to include strategies to develop social determinants of mental health that ensure recovery conditions.

Latin American mental health services could benefit from the concept of recovery. The findings and reinterpretation of the framework are expected to promote its use in research and services in the region as it acknowledges relevant processes and factors. Moreover, Chilean and Brazilian users' experiences offer a deeper understanding into recovery that may be transferable to other populations including low/mid-income countries and diverse communities in high-income countries. The proposed framework emphasizes the interconnection among dimensions and the role of social determinants implicated in recovery that are also present in different countries, even high-income, English-speaking ones. The study adds to the international literature on recovery by increasing the social validity of the multidimensional framework and expanding its utility to diverse populations.

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