

Experiences of living with severe mental disorder: narratives about the personal recovery process

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Abstract *The article approaches the subject of recovery, a sociopolitical movement, field of studies and practices that aims, from the experience of people living with mental disorders, to promote a more optimistic outlook of the prognosis. Aiming to understand the recovery process of people who experience severe mental disorders, qualitative research was developed, based on Gadamerian hermeneutics. We conducted in-depth interviews, in the form of life narratives, with five people who recognize themselves in the process of recovery, and are part of a mental health patient group. Based on narrative analysis, three axes were organized: recovery process facilitators and coping strategies; barriers of recovery process; and relationship with diagnosis. The discussion is based on Canguilhem's theory; in the logic of psychosocial care, and in theories about the notion of recovery. We identified important intersubjective and sociocultural resources for recovery, however, we concluded that these same elements may constitute barriers to a creative existence, as the social norm remains crossed by the stigma that accompanies mental disorders, and by hierarchical power relations.*

Key words *Patients, Personal narrative, Mental health*

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Introduction

Recovery is defined as a field of study and, at the same time, of political and social activism of users and former mental health patients¹. In the academic field, it questions the deterministic and negative tendency of the prognosis of mental health problems, showing that the course of serious disorders, such as schizophrenia, can be as varied as unique life experiences^{1,2}. At the level of social movements, there is the struggle of users for a “collective resignification” of mental illness^{1,3}. Among these movements, the *Mental Health Consumer/Survivor Movement*³, founded in the USA in the 1970s by users who called themselves “survivors of the traditional psychiatric model”, intended to propose a more optimistic model of personal and political *empowerment* that they called “recovery”^{3,4}. The term, purposefully in quotation marks, signified that the recovery to which they referred was not synonymous with absolute remission of the disease and the recovery of a lost state upon onset³.

The motto *Nothing about us without us*, incorporated by this movement, refers to the struggles against *apartheid* in South Africa, when countless people engaged in resistance fronts suffered violence that caused physical disabilities. Around 1986, the organization of People with Disabilities of South Africa emerged, responsible for disseminating the slogan that gained wide social visibility⁵.

In the national literature, *recovery* has been translated as restoration, recovery and overcoming⁵. In this article, we adopted the term “personal recovery”, identified in the Portuguese version of the document “*Personal recovery and mental illness: A guide for mental health professionals*”⁶, because it is a broad term, as proposed by mental health users and defended by Anthony⁷, the seminal author of this discussion:

*Personal recovery involves much more than recovery from the disease itself. People with mental disorders may have to recover from the stigma they have incorporated into themselves, the iatrogenic effects of treatment environments, the lack of opportunities for self-determination, and the negative side effects of unemployment. Personal recovery is usually a complex and time-consuming process*⁷ (p. 527, our translation).

The World Health Organization (WHO) included personal recovery among the objectives of the Mental Health Action Plan 2013-2020⁸, approaching it as a state of health to be promoted by services and as a dimension aligned with the

personal and political strengthening of mental health among the population with mental health problems and psychosocial disabilities. Health systems and their services are called upon to incorporate this concept into their care practices.

In Brazil, since the 1970s, the Brazilian Psychiatric Reform Movement (BPR) has promoted the appreciation of the (inter)subjective experience in mental health care. The proposal to reinvent the clinic and politics has its most consistent elaboration in *Psychosocial Care*⁹, advocating care in a network composed of a set of devices that must respond to the complexity of the conditions attended. Such devices go beyond the field of mental health, including health actions and services in general and public policies for social protection, art and culture¹⁰.

It is a movement that is not without contradictions and setbacks, especially in recent years¹¹. In a scenario of political and epistemological disputes, Leal *et al.*¹² argue that descriptive psychopathology still has a strong influence on the way services understand illness and provide care. Used uncritically, this tool has produced harmful effects for the clinic, such as the lack of thematization about the relationship between the subject and his or her symptoms; the neglect of suffering that is not manifested through positive symptoms; and the elaboration of normalizing treatment proposals that do not require user participation.

In an attempt not to back down from the challenge of offering users a leading role in clinical practice, we link the theorization of physicians and philosopher Georges Canguilhem on the concept of health and studies on personal recovery. Canguilhem¹³ takes subjective experience as a basis to formulate the concept of health, noting that it should be thought of as an “organic state of which an individual considers himself the judge”¹³ (p. 57). In addition, health is related to the concept of vital normativity, considering healthy individuals capable of establishing and creating norms, new standards of functioning and ways of living¹⁴. Health lies in the potentiality of this capacity and pathology in its restriction.

According to Canguilhem¹⁴, health concerns an individual’s margin of tolerance in relation to “infidelities in the environment”¹⁴ (p. 64), so that a funneling in this margin would produce a “direct and concrete feeling of suffering and powerlessness, a feeling of a frustrated life”¹⁴ (p. 44). Health supports disease and is not related to a state of equilibrium but to the dynamics that allow creating norms and responding to different

situations. What characterizes a state as pathological is the conservative aspect given to the disease, the eminence of a conservative norm of life, which does not admit changes and imbalances. Illness is still a norm of life but an inferior norm because it does not tolerate deviations in its own condition.

Supported by this theoretical framework, we aimed to understand the process of personal recovery of people who have experiences related to severe mental disorders. Such studies face the challenge of valuing mental health users as citizens with rights and active participants in the processes of knowledge construction¹⁰.

Method

Through a qualitative method, i.e., life narratives¹⁵, in-depth interviews were conducted with people who have experiences of personal recovery¹⁶. The interviews were guided by a script composed of twenty-four open questions, arranged in 3 thematic blocks: (1) initial phase of illness and diagnosis; (2) cultural and socioeconomic factors that facilitate and hinder the recovery experience (social network, territorial resources, working life, education, family size, religiosity/spirituality, and self-recognition in terms of gender and race/color); and (3) public services, the role of health professionals and the state.

We interviewed five members of a collective of mental health users in a Brazilian metropolis. The choice of this group was intentional. This group consisted of people diagnosed with severe mental illness, all linked to a public institution that develops teaching, research and multidisciplinary and multiprofessional mental health care activities. The access route to these users was the collective itself – self-organized – and not the institution in which they are treated. The inclusion criteria for the study were being of legal age and being in a continuous process of psychosocial treatment. Psychosocial crisis at the time of the interview and the existence of legal protection were the exclusion criteria.

To access the participants of the collective, we contacted its coordinator via e-mail and, through her, scheduled a meeting with the group to present the study and reiterate the invitation to participate. After this meeting, which was attended by four members of the collective, the coordinator put us in contact with two more members. In the end, all interested people participated, totaling five.

The interest in an in-depth understanding of the subjective experience of each participant allowed us to design a study with a small number of subjects¹⁷. Without the pretension of generalization, we believe that the results constitute an interesting source of dialog and clinical substrate for reflection on the diversity and scope of factors that involve experiences of personal recovery.

We conducted five in-depth interviews, two in person and three via a virtual platform, according to the preference of the interviewees. With an average duration of seventy minutes, the interviews were audio-recorded, and from them, life narratives were constructed. We understand narratives as the fruit of a dialog permeated by the questions we ask the interviewees and the way we listen to what they have to say, based on our listening and our presence. After this dialog, we wrote a text summarizing and organizing what was said in the interviews, and in a second meeting, we presented the summary to each interviewee.

Four of the five interviewees were interested in this second meeting, in which the intention was not only to validate the expressed content but also to create a new opportunity for the production of interventions, as Onocko-Campos suggests¹⁸. Each of these four interviewees was attentive to the content that we read together, despite the long length of some life narratives (they were, on average, ten pages), producing interventions, suppressing content and/or grafting elements that they considered fundamental and that did not come to their mind at the time of the interview. Such interventions exceeded the changes in the text and produced effects on us. At one point while reading Pilar's narrative, for example, one of the authors became emotional and was able to tell her that her story was a source of encouragement and optimism for the reader to deal with their own personal suffering. Listening to her, Pilar was also moved. Regarding the interviewee who was not interested in listening to the constructed narrative, we understand that he trusted our ability to listen to him, and we sought to honor his trust.

The analysis of the interviews was based on the hermeneutic approach¹⁹, a framework that considers the effects of the (inter)subjective encounter between the interviewee and the interviewer, seeking to understand the meanings that the subjects attribute to their own experience in a process of negotiation between interlocutors²⁰. Thus, the established consensus considers and clarifies not only what the interviewee said

but also the social, epistemological and affective place from which we heard the interviewee. This approach consists of the recognition of interconnected meanings, dependent on the context and traditions with which we work: the Canguilhemian theory of the health-disease process; the logic of psychosocial care; and theories about the notion of personal recovery.

Through the interaction between the scientific literature, the research objectives and the analysis of the narratives, we composed thematic cores organized into three axes: (1) facilitators of the personal recovery process and coping strategies for living it; (2) barriers to the personal recovery process; and (3) relationship with diagnosis.

This study was approved by the Research Ethics Committee of the institution to which the study is linked (opinion 5,381,051), and all subjects signed an informed consent form, in accordance with Resolution no. 466/12 of the National Health Council.

Results and discussion

Research subjects

Four interviewees identified themselves as men, two as white and two as mixed race. The participant who identified herself as black was the only woman to participate in the study. Regarding age, the youngest was a 45-year-old man, and the oldest was a 67-year-old man. Regarding education level, three participants had completed high school, and two had completed higher education.

All interviewees are called by fictitious names. Any data that could identify them were removed from the narratives. In the case of Tony, we did not omit the references to the names that refer to his artistic work, as this was his request, aligned with the desire to publicize his work.

Facilitators of the personal recovery process and coping strategies for living it

The experience with religion/spirituality proved to be important in the narratives. Filipe valued faith as a helping factor in the recovery process, and he was able to recognize that a religious leader helped him seek mental health treatment, pointing out that the issue he raised was not related to religion but to health. The narratives of Pilar and Humberto highlight the impor-

tance of the church as a *space of social belonging, of spiritual comfort to be in communion with their brothers and sisters, as a Christian social group, and as a space to see people, worship God and chat.*

In our view, the narratives of Pilar and Humberto evoke the concept of *social support*, studied by Valla, Guimarães and Lacerda²¹, which values mutual help between people as a source of positive emotional and/or behavioral effects. Faced with contexts of deprivation and isolation in accessing services, the population has indicated therapeutic ways of dealing with their suffering, no longer restricted to the medical-therapeutic model but inserted in the category of social support, in which religious groups are included²¹. These groups can even collaborate in the care of people who need health services, as was the case with Filipe.

Continuing our research on the resources that facilitate personal recovery, we witness the importance of creative expression, as the following narrative shows us:

Tony relates the absence of seizures to the practice of some activity that is personal, remembering the time when he drank and was very afraid. At that time, he wrote two books on a typewriter, "Homem sem Cara" and "Symptoms", and after a while, the crisis passed; so, he believes that having an activity is very important to maintain balance. He has worked as a waiter and on TV Pinel [...] He says he loves art and considers that the study also helped in his recovery process, mentioning the poetry "Roldana" he wrote for the mother of his daughter, based on the knowledge of natural sciences. He remembers that he incorporated everything he studied, including electrons, protons, neutrons and pulleys, and wrote poetry.

Tony's experience reminds us of the approximation that Freud²² outlines between play and poetic activity, stating that in adult life, playing is transposed to artistic creation and the use of humor. In Winnicottian work, the creative act has a broader meaning than does artistic creation and can be approximated to the sense of Canguilhemian normativity insofar as it is characterized as "a coloring of every attitude towards reality", an act of creation in relation to external reality²³ (p. 95). Playing with words, Tony seems to have managed to be normative, to facilitate health and thus avoid crises.

All respondents point out that an important resource for personal recovery is their good bond with the reference institution, which in their view, offers multiple opportunities for comprehensive care. Tony added the importance of

other spaces, such as the Center for Coexistence and Culture, which is in a fragile phase due to the lack of funding:

Tony says that recently he was participating in the Centro de Convivência [and Culture], but it is close to closing its doors because it has no funding. He says that while there, he was learning to play some guitar chords and wrote a song called “Insane Madness”, available on YouTube. He reaffirms that the community centers are very important, as are the CAPS, but he states that their treatment is in his referral service, which, according to him, should be “registered”.

We noticed that despite the institutional impasses, which will be mentioned below, the institution to which these subjects are linked remains a firm foundation and reference for care. The service functions as a concrete anchor, with strong subjective repercussions for the subjects, fulfilling what is expected of services that replace asylums, that is, care that can be offered intensively, with a multidisciplinary team with access to diversified clinical tools⁹. The institution is a reference and has been allowing these subjects to find in it the stability necessary to continue in their personal journeys, and in this sense, it contributes to reaffirming the responsibility of the state for promoting actions in the field of mental health that positively affect living conditions and health. However, referencing Dias²⁴, one must ask whether the centrality that a single institution can assume does not limit the construction of other bonds, restricting the possibilities of a more varied network of dependencies that are essential for health²⁵. The example of Pilar awakens us to this theme, as she tells us that she only sought a family clinic when she was prevented, due to the pandemic, from going to a reference service for mental health care. Faced with this impossibility, she found more treatment resources, this time closer to home.

Another important aspect of the personal recovery process is what, in the field of psychosocial rehabilitation, Tykanori²⁶ calls the increase in the user’s contractual power, that is, their ability to exchange material and immaterial goods with their social environment. Humberto’s experience embodies this theorization:

Humberto does volunteer work at the church and at the mental health service to which he is linked. His source of income is a benefit he receives because his mother was a public servant. He states that he feels protected in a world “full of unemployment and inequalities out there”. He takes advantage of the moment to name himself

“the king of volunteer work” and says that “he only does volunteer work”. [...] When asked if there is any impasse in receiving this benefit, he mentions that if he gets married, he loses the right to it. He is concerned about this fact and says that people associate marriage with the fact that a person is more “balanced” but that unemployment is cruel.

Humberto seems to work toward his psychosocial rehabilitation and the increase in his contractual power, predominantly through his work as a volunteer. This does not exempt him from worrying about his financial life, with the possibility of not receiving this benefit if he gets married, something he very much wants. In addition, he recognizes the probability of encountering difficulties if he needs to enter the formal job market.

Dilemmas and difficulties related to working life also appear in Daniel’s narrative, in addition to the “impasse” of receiving his father’s pension, which is his source of income:

Daniel commented that he worked at a fast food chain, as a snack bar attendant, and at the IBGE when he applied for a position to collect PNAD data. He took the exam, but he had a cousin who worked at the IBGE and, according to him, “pulled some strings” for him to pass. His source of income is the pension he receives from his father. He says this money helps but also hinders his recovery process. Regarding the latter statement, he says that he was raised in a family that always spoke a phrase that marked him: “you don’t have to work”. Daniel associates this maxim with the fact that in his own words, it is only at age 60 that he can understand that work is necessary for human beings. He says he has a “tendency to idleness”, “not wanting to take the initiative to look for a job” but knowing that people “need to have their economic and financial independence”, which, in his view, is possible through work. He says that everyone gets a job, wherever it is, but that he “has a tendency not to want to work”.

Safatle²⁷ discusses the view of the subject within neoliberal logic as an “objectified” view, with little attention to the recognition of singularities. This view recognizes the psychologization of life but suggests that it is purposely engendered to respond to the model of productivity, functionality and consumption²⁷. In Daniel’s narrative, we see a concern regarding responding to this productivist model. Daniel does not seem to recognize the challenges of a person dealing with intense mental suffering, reading everything he “failed to do” from the perspective of a “tendency to idleness” and the fact that he “does not want to take

the initiative to look for a job”; as he indicates, he is accustomed to the modes of neoliberal subjectivation discussed by Safatle²⁷.

Barriers to the personal recovery process

There were many reports of barriers created by professionals to the process of personal recovery. Tony expressed difficulty in negotiating adjustments to medication dose:

Tony complains that in the service he attends, it is common to “fill the patient with medication” and that this type of conduct scares the patient. He says that “one should start small” and reports that he himself has already decreased the dose of lithium he took because he considered it “too high”.

Tony’s narrative reminds us that despite the advances with the new model of mental health care, we face many challenges for an effective change in the practice of care because although the problematization of the primacy of pharmacological treatment has space in the mental health debate²⁸, approaches that reduce treatment to the administration of psychotropic drugs persist.

Onocko Campos *et al.*²⁹ show the problems in the relationship between prescribing physicians and users in a study conducted in three Brazilian capitals; the difficulty of users to talk to doctors about drug treatment and the tendency to see the prescriber in a place of inaccessible authority were evidenced.

These results are different from those found by Serpa Jr. *et al.*³⁰, whose study developed with patients diagnosed with schizophrenia showed that these patients do not always use drugs as prescribed by psychiatrists, managing the dosage in their own way until they find a dose that satisfies them. However, the interviewed psychiatrists recognize this practice and say they are available to negotiate and review prescriptions with users³⁰.

Humberto brings up the centrality of the doctor/health professional-patient relationship to the course of treatment:

Some professionals are not very prepared to “take care of people”. For him, these people “talk beautifully”; they talk about ICD-10, about Freud’s compendium, but about the people, “they don’t even want to know”.

Balint³¹ was a forerunner in the discussion about the importance of the affective dimension, of exchange and of the relationship between professional and patient by stating that the personality of the physician and his or her relationship with the one to whom he or she directs his or her

care have important effects on treatment – both positive and negative. For this author, sometimes the doctor is the medicine itself, and in regard to medicines, occasionally, the way it is offered is more important than what is offered³¹.

To investigate the importance of the affective dimension, Peixoto, Mourão and Serpa Jr.³² conducted focus groups with psychiatrists and people diagnosed with schizophrenia in two Brazilian cities and reported that for psychiatrists, bonding is an important ally for treatment; its absence implies difficulties in clinical interventions.

Barriers to personal recovery arising from injustices related to gender and race were also present in other narratives, such as that of Pilar, who simultaneously exposes the two intertwined elements:

For Pilar, the fact that she was a woman and that she was “alone” made a difference in her recovery process, as she realized in her life that women are more devalued than men, especially black women – which is how Pilar defines herself. They feel that this is a factor that hinders and does not help, a factor that instead of positively influencing the recovery process in our society, negatively influences it.

Pilar is correct; there is great gender inequality in Brazil. The Brazilian Institute of Statistical Geography³³ estimates that in 2022, women represented 44% of the workforce; however, 55% were unemployed. The unemployment rate was also higher for women (11%) than for men (6.9%). Regarding the average salary of each gender, men earn 22% more than women³³.

Regarding the racial dimension indicated by Pilar, we reference Silva and Garcia³⁴ and agree that “to be anti-asylum is to aim to break with all the paradigms present in a markedly asylum society but also racist and misogynist” (p. 51), which should induce the production of policies in which race, gender and mental health are articulated.

In the field of health policies, the formulation of the National Policy for the Comprehensive Health of the Black Population, published in 2010 and the creation of the Racism and Mental Health Working Group in 2014 stand out. This movement is based on the recognition that racism is one of the determinants of the integral health of the black population and the understanding that their living conditions result from unfair social, cultural and economic processes present in the history of Brazil³⁵. It is possible that the effects of these policies did not directly affect Pilar’s experience of personal recovery, but pub-

lic policies that consider social complexity and assume, in their formulation, intersectionality as a guideline may support groups and individuals experiencing similar situations.

The marks of social injustice, patriarchy and coloniality favor stigma and prejudice toward people facing mental health issues. However, Pilar invites us to think about the skills we develop to deal with difficult situations and about the importance of thinking about the way our patients will manage their lives in the world, outside the spaces of care:

Pilar also credits her improvement process to the fact that she was able to “exercise slightly more patience” – including with her neighbor, who sometimes exhibits hostile and prejudiced behavior toward her and her health status, despising her and calling her crazy. When she was in crisis, she had much difficulty in being accepted, and she vented that this was a reason for a lot of annoyance.

It is interesting that Pilar credits her recovery process to the possibility of better dealing with stigma and exercising patience. This is an aspect addressed by Davidson *et al.*³⁶, who include overcoming stigma among the elements that comprise personal recovery. Similarly, among the strategies proposed by the “Plan of Action in Mental Health 2013–2020” developed by the WHO is the fight against stigma and social discrimination aimed at mental health⁸.

Relationship with diagnosis

Diagnostic imprecision is noted in Tony’s narrative:

When talking about the imprecision in his diagnosis, Tony associates it with Van Gogh because according to his Google searches, it is not certain whether the painter had schizophrenia or bipolar disorder. He says that like the artist, he has already received these two diagnoses – in addition to paranoid personality disorder. When he asked the doctor about this diagnostic inaccuracy, he was told that “the disease progresses”. Tony says he does not know if this statement makes sense because according to him, even doctors are “not sure of things”.

The “lack of certainty” reported by Tony, often associated with diagnostic imprecision, does not necessarily result from medical incompetence or a lack of medical knowledge, as it involves a complexity of factors that we could group under the term intersubjectivity. This refers to the interdependence between each person and the sociocultural, political, ethical and material environment in which they live.

Although diagnostic manuals propose to objectify subjectivity, often the symptomatic manifestations do not fit the descriptions, and therefore, it is worth following the Canguilhemian recommendation for health professionals to behave more like exegetes than repairers³⁷, supporting patients in the construction of a narrative about their own experience and accompanying them on the journey of personal recovery. Therefore, we believe that clinical tools that are more sensitive to *pathos* are needed, as proposed by Serpa Jr.³⁸, who propose that the axis of psychopathology is subjectivity – always connected with the world – which he named first-person psychopathology³⁸.

Some subjects perceive their subjective experience as unrelated to a formal diagnosis. Humberto’s understanding of schizophrenia illustrates well what we mean, as he is able to grasp, from the words “schizophrenia” and “paranoid”, what he experiences:

Humberto claims to have been diagnosed with paranoid schizophrenia and that he understands “more or less its diagnosis”. He says that he knows that schizophrenia is related to “seeing things that do not seem real” and that paranoid is related to a “certain mania of persecution”. He concludes, then, that this is how he understands his diagnosis and leads his life, trying to accept his limitations. At the beginning of the interview, he said that he felt dissatisfied with the diagnosis: he did not truly understand the reason why it had happened to him. However, as his narrative encompasses the process in which he discovered himself potentially capable of doing volunteer work, comments about non-compliance give way to a description of the way Humberto learned to lead life. He says that little by little, he learned how to cope, live, survive and accept the diagnosis and treatment. He says that there are various types of diseases and that everyone has one, this one – paranoid schizophrenia – is his and it is up to him, to know how to live with what he calls “this psychopathology”.

When talking about his diagnosis, Humberto presents an account of personal recovery that incorporates both the feeling of indignation with the illness and the feeling of progressive acceptance, as he discovers himself potentially capable of doing things that give him pleasure and is able to live with what he calls “this psychopathology”.

Tony, on the other hand, at a certain point in the interview, says something that goes beyond the perception expressed in the comments he had made regarding his diagnosis or, rather, the absence of an accurate diagnosis, saying: “I do not

seek to know what I have but to understand how I am". His lack of interest in the nosological category in which he is being included gives way to the effort to understand who he is, thus expanding his possibilities of existence. "To understand how I am" is something broader that involves but exceeds illness, reminding us of Canguilhem, for whom life does not recognize the categories of health and illness in the realm of science but only in the "plan of experience, that is, first, probation in the affective sense of the term (...) in a way that science can classify the experience but will not cancel out the embodied experience and the personal attempt to understand it"¹³ (p. 65).

Tony also makes a very important statement that perhaps explains his lack of focus around the "name" that says what he has. It reminds us that the diagnosis often brings stigma and guilt, which can reinforce illness as a solipsistic experience, whose prevention and overcoming are the responsibility of the individual, the consumer of biomedical technologies²⁷.

Final remarks

We sought to assess the experience of subjects capable of elaborating unique ways of experiencing their recovery, revealing the importance of intersubjective resources such as creative outlets and the opportunity to work as formal

employees or volunteers. Other elements that were included in the personal recovery journeys were religious institutions, health services, professional practice and cultural spaces. However, these same elements can constitute barriers to a creative existence because social norms intersect the stigma that accompanies mental health and because of the power relations in the professional field. Therefore, it is necessary to strengthen public policies capable of confronting this stigmatization and centralization of biomedical power, continuously discussing the paths of care. Consistent with the precepts of the field of study of personal recovery, these policies cannot be established despite the voice, narrative, and embodied experiences of users.

The research process constituted a listening and speaking experience for the researchers and interviewees. We listened to users' elaborations about their personal recovery process. However, they also listened to the narratives that we constructed about their interviews, dialoguing with our way of organizing and understanding the discourse, in a process of joint and participatory construction. Finally, we seek to value the social foundations that need to be strengthened in mental health care processes that incorporate the experience of illness or impediments to enjoyment of life as characteristics of human living and open more diverse and powerful networks of exchange for care.

Collaborations

Y Furtado participated in the conception and design of the work; production of empirical data; discussion of results; manuscript writing; critical review of content; and approval of the final version of the manuscript. L Miranda and AF Fonseca participated in the conception and design of the work; discussion of results; manuscript writing; critical review of content; and approval of the final version of the manuscript.

Funding

Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – 001; Fundação Oswaldo Cruz – Auxílio de permanência ao estudante.

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Article submitted 17/07/2023

Approved 17/09/2023

Final version submitted 19/09/2023

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva