ESTUDOS DE PSICOLOGIA
Psychological Studies

RESEARCH REPORT

Clinical Psychology and Psychotherapies

Editor
Raquel Souza Lobo Guzzo

Conflict of interest
The authors declare that there are no conflict of interest.

Data availability
The research data are available from the corresponding author upon reasonable request.

Received
March 31, 2023

Final version
October 9, 2024

Approved
April 14, 2025

The practice of Recovery in Brazil based on the lived experience of health professionals: a phenomenological study

A prática de Recovery no Brasil a partir da experiência vivida de profissionais da saúde: um estudo fenomenológico

Daniela Dantas **Lima**[1], Vera Engler **Cury**[2]

[1] Autonomous Researcher. Fortaleza, CE, Brasil.
[2] Pontifícia Universidade Católica de Campinas (PUC-Campinas), Escola de Ciências da Vida, Programa de Pós-Graduação em Psicologia. Campinas, SP, Brasil. Correspondence to: V. E. CURY. E-mail: <vency2985@gmail.com>.

How to cite this article: Lima, D. D., & Cury, V. E. (2026). The practice of Recovery in Brazil based on the lived experience of health professionals: a phenomenological study. *Estudos de Psicologia* (Campinas), *43*, e230029. https://doi.org/10.1590/1982-0275202643e230029.

Abstract

The Recovery model, as a paradigm for mental health care, has been expanding internationally and is characterized by each person taking the lead in managing their own recovery journey. Its primary goal is not a cure or merely eliminating symptoms but rather the development of one's sense of self and citizenship. This study aims to phenomenologically describe and understand the lived experiences of providers in Brazil's Psychosocial Care Network in relation to this model. Grounded in Husserlian phenomenology, the research involved dialogical encounters with seven participants, after which comprehensive narratives were created. The following elements emerged: "the desire for change, but the experience of frustration"; "the desire to be heard but being a minority"; and "the desire to do more but feeling constrained". Results reveal that Brazil's Psychosocial Care has not yet incorporated the Recovery model. Swimming against the current, professionals feel a pushback and long for a distant, ideal place in which the trajectory of mental health services will have Recovery as their destination.

Keywords: Health personnel. Mental health; Psychiatric rehabilitation; Qualitative research.

Resumo

O modelo Recovery, enquanto paradigma de cuidado em saúde mental, tem se expandindo internacionalmente e caracteriza-se pelo protagonismo do indivíduo no maneho de seu próprio processo, visando ao desenvolvimento de si como pessoa e cidadão, e não a cura ou supressão de sintomas. Este estudo tem como objetivo descrever e compreender fenomenologicamente a experiência vivida de trabalhadores de serviços da Rede de Atenção Psicossocial em realação a esse modelo. O método desta pesquisa foi embasado na fenomenologia husserliana, tendo sido estabelecidos encontros dialógicos com sete participantes, a partir dos quais foram elaboradas narrativas compreensivas. Percebeu-se, assim, alguns elementos centrais: "o desejo por mudança, mas a vivência da frustração"; "o desejo de ser ouvido, mas ser minoria"; "o desejo de fazer mais, mas ter as mãos amarradas". Os resultados indicam que a Atenção Psicossocial no Brasil ainda

não incorporou o modelo de Recovery. Nadando contra a corrente, os profissionais sentem-se empurrados para trás e anseiam por um lugar distante e ideal, no qual o percurso dos serviços de saúde mental tenha o Recovery como seu destino.

***Palavras-chave**: Pessoal de saúde; Saúde mental; Reabilitação psiquiátrica; Pesquisa qualitativa.*

Najmanovich (2001) argues that contemporary sciences are in crisis, as the traditional epistemological paradigm has been surpassed. While this has long been a topic of debate in the human sciences, why does the biomedical paradigm still persist (Lima et al., 2014)? Health sciences have traditionally sought to understand the workings of the human body, yet this knowledge remains fragmented, focusing solely on biological processes and neglecting the central role of subjectivity in human experience. Medicine has been built and sustained on a perspective that overlooks what fundamentally distinguishes human beings from other living creatures – our subjective experience (Rocca & Anjum, 2020).

Psychiatry, despite being the medical specialty tasked with understanding and addressing what are termed mental, emotional, or subjective disorders, has similarly developed within a physiological framework. This approach tends to downplay the influence of sociocultural factors on what it labels as psychopathology. Furthermore, it often sustains the expectation of a cure and the belief that medication alone can miraculously relieve individuals of their suffering (Wade & Halligan, 2017). Within this paradigm, mental health challenges are located within the individual, and recovery is seen as their sole responsibility, believing that it is best measured through standardized assessments conducted by professionals.

With growing evidence that underscored the individual's subjectivity as not only part of the experience of suffering but also central to the process of healing, the biomedical model faced increasing criticism for its reductionism, having disregarded this reality for far too long (Lima et al., 2014; Rocca & Anjum, 2020). Even so, resistance to change remains strong (Wade & Halligan, 2017).

This wave of critique, emerging from a variety of perspectives, eventually reached psychiatry. In Brazil, this shift was propelled by the Sanitary Reform Movement, which led to the creation of the *Sistema Único de Saúde* (SUS, Unified Health System) and laid the foundation for the Psychiatric Reform Movement in the late 1970s (Fernandes et al., 2020).

The principles of Psychiatric Reform have been brought to life through deinstitutionalization and the establishment of a community-based network of care, emphasizing the freedom and citizenship of people with lived experiences of mental health suffering (Braga, 2020). Today, mental health services for these individuals are guided by a technical framework known as Psychosocial Rehabilitation. This approach is structured through decentralized, community-based mental health services that prioritize individuals' opportunities for social, cultural, political, and economic participation.

Psychosocial Rehabilitation strategies fundamentally focus on the process of rehabilitation, reclaiming one's full participation in society. Both mental health services and social movements recognize their importance in fostering opportunities for individuals with serious mental disorders, creating pathways for them to engage in their communities and pursue their aspirations (Nóbrega et al., 2018; Saraceno, 2011).

The Recovery Movement

In traditional biomedical models, the concept of recovery is typically understood as the remission of symptoms through treatment. When it comes to the so-called mental health disorders,

however, recovery has often been viewed as controversial or even impossible by conventional psychiatry, for certain diagnoses. The prospect of recovery was dismissed as unattainable by Emil Kraepelin, for instance, who concluded from his observations that people diagnosed with schizophrenia would inevitably experience a progressive decline, with no hope of recovery (Davidson, 2020; McCabe et al., 2018).

Yet, contrary to this belief, evidence now shows that clinical recovery is possible for up to two-thirds of individuals living outside of hospital settings. Perhaps more striking is the realization that, even when individuals deemed as "chronic cases" do not achieve the type of recovery defined by traditional medicine, they can still lead meaningful and autonomous lives when provided with adequate support and opportunities (Davidson, 2020). These facts have served as a powerful catalyst to sustain a paradigm shift in mental health care – one that reimagines the role of institutionalized care.

The Recovery model did not emerge from a theoretical framework but rather from the absence of effective biomedical interventions, and has since grown into an internationally recognized approach, characterized by each person taking the lead in managing their own recovery journey. At its core, Recovery is about the development of a sense of self and of citizenship in one's community, and not about a cure or the elimination of symptom (Egeland et al., 2021).

The concept of Recovery offers a phenomenological perspective on individuals and their experiences of becoming ill by seeing them beyond their mental health challenges. It seeks to explore who they are and to support their growth, so that, through their autonomy, they can continue to grow (Anthony, 1993; Davidson, 2020). Unlike the traditional understanding that recovery is the successful outcome of a treatment, the Recovery model views healing not as an endpoint result, but as an ongoing building process. This process involves developing self-awareness and learning from one's experiences of "illness" – a continuous journey of self-discovery and growth (Tondora et al., 2014). Recovery is ultimately a form of self-actualization, where individuals take the lead, and their development comes from engaging with their social environment (Davidson et al., 2021; Witkiewitz et al., 2020).

So, despite the wording, Recovery is not synonymous with being cured or eliminating symptoms. Rather, it centers on the individual's recognition of their own unique circumstances, including both limitations and strengths. Furthermore, Recovery entails reclaiming control over one's own life and defining a personal path forward. While this journey is deeply personal, the process of Recovery is also a shared responsibility with communities and consistent social policies (Anthony, 1993; McCabe et al., 2018).

In Brazil, the Recovery model has not been formally institutionalized as it has in some other countries, and practices directly based on this approach remain limited. Instead, mental health care within Brazil's public system is primarily guided by the principles of Psychosocial Rehabilitation. Aligning more closely with the Recovery model would mean further expanding this perspective – placing even greater emphasis on promoting autonomy and citizenship (Brandão et al., 2022; Silveira et al., 2017).

Some authors view Recovery and Psychosocial Rehabilitation as complementary approaches, suggesting that Recovery can enhance and advance mental health care in Brazil. They argue that it is both feasible and beneficial for services within the *Rede de Atenção Psicossocial* (RAPS, Psychosocial Care Network) to incorporate Recovery principles and reorganize their practices accordingly (Costa, 2017; Moreira & Onocko-Campos, 2017).

However, to treat Recovery merely as an extension of Psychosocial Rehabilitation would risk overlooking one of its most transformative elements – the shift from a traditional model of prescriptions and expert-driven directives to one of openness to a deeper understanding of each individual in order to find the best way of supporting them as they take charge of their own development.

A key distinction between the two perspectives lies in their focus. While Psychosocial Rehabilitation is primarily concerned with the implementation of services and interventions, Recovery is rooted in the individual's lived experience (Brandão et al., 2022). This model shifts responsibility from the professional expert to the individual, recognizing them as the primary agent in their own recovery. Contrary to traditional care in health, in Recovery, professionals are not responsible for guiding the individual toward a life of "normalcy", through their monitoring, care, evaluation and/or cure (Cidade et al., 2021).

Existing research suggests that many mental health professionals struggle to grasp the principles of the Recovery model. A recent literature review highlighted ongoing challenges in understanding Recovery, with some professionals continuing to interpret it as a clinical strategy focused on cure and have difficulty recognizing the inherently nonlinear nature of the recovery process (Gyamfi et al., 2020).

Given the relative novelty of the Recovery model in Brazil and its contrast with current practices, this study aims to phenomenologically describe and comprehend the lived experiences of providers from various services within the RAPS network in the interior region of São Paulo in relation to the Recovery model.

Method

This study follows a path grounded in the principles of the phenomenological method. Central to phenomenology is the belief that all knowledge arises from the unique interaction between an individual and the world. Its starting point is the lived experience itself, with a focus on reclaiming what defines the subject matter of this field – human subjectivity (Goto et al., 2018; Wertz, 2021).

Lived experience, or *lebenswelt*, refers to the pre-reflective experience of being in the world. It is the immediate, embodied contact individuals have with their surroundings before any separation between subject and object, from which consciousness arises. Therefore, getting to know an experience means understanding a person's way of being in the world from their own perspective. The way back to this experience – the phenomenological attitude – involves considering the experience itself as it is, prior to any theoretical understanding or preconceived judgement related to it (Amatuzzi, 2009).

In this context, direct access to another person's experience is not possible, and it cannot be described in an objective way. Another person's experience can only be approached through the researcher's own experience, and from their encounter emerges an intersubjective relationship, where it becomes possible to build knowledge. In this way, phenomenological research uses the researcher's own consciousness as the primary avenue through which understanding is uncovered (Brisola & Cury, 2016). According to Fadda and Cury (2021), this knowledge is revealed to the researcher's consciousness through the intersubjective terrain, emerging from the encounter with each participant, with each step guided by their own lived experience (Fadda & Cury, 2021).

Participants

In this study, one of the researchers was responsible for engaging with participants and conducted individual encounters with seven (7) mental health professionals working within Brazil's Psychosocial Care Network. These professionals – including physicians, occupational therapists, and psychologists – were identified through recommendations from a multidisciplinary residency program. The sole criterion for participation was the professional's willingness to engage in an encounter with the researcher and share their lived experiences in their respective work settings. Since participants were based in different cities, the encounters were conducted virtually via a video conferencing platform between July and September 2021. At the beginning of each encounter, the researcher invitated participants to express themselves and posed the following question: "Could you describe how your professional practice in mental health has been unfolding and whether you see any elements of the Recovery model in it?".

Instruments

After each encounter, drawing from the intersubjective experience shared with each participant, the researcher composed a comprehensive narrative. Through genuine interaction and adopting a pre-reflective attitude – one that was free from evaluative or intellectualized judgment (Amatuzzi, 2009) – the researcher immersed herself in the participants' expressed experiences. She reflected on the meanings and understandings that had emerged from the encounter, searching within herself for what had remained. These elements were then registered and formed the content of the individual narratives. This approach, using comprehensive narratives, was chosen for its excellence as a resource for phenomenological research analysis, providing a means of deepening the contact with the phenomenon being studied and allowing the researcher to describe and understand the subjective experiences conveyed in dialogical encounters (Brisola et al., 2017).

Procedures

Upon completing this stage, the researcher, using the same pre-reflective attitude, turned her attention to the expressions captured in the individual narratives, seeking to identify significant elements that bestowed meaning to the phenomenon being studied. These elements were then grouped, identified by themes, and used to create a synthesis narrative that incorporated aspects from all the individual narratives. In line with phenomenological analysis, the researcher described, understood, and interpreted the phenomenon of interest in this study – the experiences of mental health professionals in relation to promoting Recovery.

The phase of dialogical encounters was concluded when the researchers realized that the elements within the narratives formed a *corpus* that allowed for a deeper understanding of the experiences they sought to explore. In phenomenologically-oriented research, it is considered appropriate to end collection from additional sources upon reaching saturation, when the elements in the participants' accounts no longer provide new insights or descriptions of the phenomenon (Barreira & Ranieri, 2013).

This project complies with Resolution nº 196 of the National Health Council, established in 1996, regarding health research involving human subjects and was approved by the Research Ethics Committee of Pontitícia Universidade Católica de Campinas (PUC-Campinas), under CAAE nº 47846821.2.0000.5481.

Results

Through the participants' experiences, it became clear that the professionals had varying levels of knowledge about the Recovery model, with only a few identifying possibilities for integrating its principles into their practice. Recovery appeared to them as a distant, idealized place, and the trajectories of the mental health services to which they were connected did not seem aligned with that destination.

From the repeated readings of the synthesized narrative, several key elements emerged that reflect the experiences of these professionals. They will be discussed in the following section, namely: "The desire for change, but the experience of frustration"; "The desire to be heard, but remaining a minority"; and "The desire to do more, but feeling constrained".

The Desire for Change, but the Experience of Frustration

The psychosocial issues identified through the understanding of mental health as a subject of medical authority characterize Brazilian practices, as described by the study participants, as contradictory to the principles of Recovery.

One professional recalled that the identity of the *Centro de Atenção Psicossocial* (CAPS, Psychosocial Care Center) was linked to illness: individuals had to be unwell to enter and could only remain if their illness persisted. Despite this, they believed that the Caps environment was significantly better than any institutional asylum setting.

A participant related that she expected to encounter a different reality in her practice, describing her team as heavily doctor-centered, which she found very difficult. She observed practices reminiscent of psychiatric hospitals, from the time before the Recovery model. She said she worked in a team in which more than half were nurse technicians with no training in mental health care. Additionally, the management team was entirely composed of biomedical professionals, with no occupational therapists, psychologists, or social workers in leadership positions.

She lamented the lack of active listening in her workplace, where everything was reduced to prescriptions. She, as a psychologist, was only consulted when issues could not be objectively resolved. This led her to understand that she was part of a service focused on curing patients, often disregarding users' requests to not be medicated. In cases involving Psychoactive Substance (PAS) use, she noted a tendency for professionals to rely on the hope of a "miracle drug" that would ensure abstinence. She highlighted how medication always remained central to interventions.

Another professional described explicitly asylum-like practices in her service's approach to PAS users, including mandatory toxicology tests as a requirement for continued service access. Before she joined this institution, they had a pre-existing expectation of complete abstinence, which was viewed as an achievement. Despite operating in São Paulo's interior, a region known for its pioneering role in Brazil's Psychiatric Reform, she regretted that even psychosocial rehabilitation was not discussed in her city.

A different participant suggested that the biomedical model had a less anxiety-inducing nature, which might explain professionals' resistance to adopting a new perspective. She noted a lack of subjective engagement from her colleagues, observing how some accompanied what was happening without much critical reflection. She also perceived rigidity in professionals' posture, who often seemed to prioritize their professional identity over the needs of service users. In a similar vein, a psychiatrist participant commented that the RAPS needed a psychiatrist who was less of a doctor: "someone attentive to issue of the body, but who also allows space for other narratives to be built".

The Desire to be Heard, but Remaining a Minority

The professionals reported experiences within their teams where their colleagues did not share the same care paradigm that underpins the Recovery model, as was clear in the previous theme. Even though they recognized that the service practices contradicted not only the Recovery approach but also the practice of Psychosocial Rehabilitation and their own individual perspectives, they identified themselves as representing a form of "resistance" in the face of a harsh reality.

One professional lamented that their actions had become isolated, individual attempts, and were perceived by the rest of the team as simply giving users "a pat on the back". She stated that the pandemic had exacerbated the biomedical tendencies in practice, with service doors being closed and now monitored by security personnel from a private company – security guards who also monitored the doors of bars and businesses.

Another professional shared that the pandemic had worsened the already limited situation at the *CAPS Álcool e Drogas* (CAPS AD, Alcohol and Drug CAPS) where they worked, with even stricter control over the facility's entrance. She felt personally responsible for the service they were part of and said that they tried to implement more Recovery-oriented practices. However, she did not believe individual initiatives like theirs made sense. She believed these actions should be part of the service's core practices and, for this reason, felt constrained. During the pandemic, with the inability to hold group activities, she saw the service limiting its focus to bed-based care, with the primary goal being abstinence.

One professional expressed alignment with this perspective on a personal level but felt that their actual practice was inadequate, being that the service did not share the same affinity. They expressed discomfort with the fact that user participation often occured "by proxy," through the case manager, noting that individualized care plans (*Projetos Terapêuticos Singulares*) were not being created by the users themselves.

The Desire to Do More, but Feeling Constrained

The distance between the Recovery approach and the practices within the RAPS also seems to be contextualized in relation to Brazil's economic difficulties. The action based on the Anglo-Saxon model, as was evident in the encounters, is primarily hindered by the constant reminder that users always have basic needs that must be met before any other measures can be taken.

In the context of one professional's service (the Alcohol and Drugs CAPS), even bathing was restricted due to a lack of resources, with the specialist prescribing when users could bathe. Instead of engaging with users to discuss the resource limitations and collaborate on solutions, the service was chose to impose a decision. The same happened with meal distribution: there was not enough food for everyone, and decisions had to be made about who would and who would not receive a meal. "How can we address the subjectivity of a person who is hungry, who needs a bath?" she questioned thoughtfully. She also mentioned the dispute for beds, with users fighting over space in the AD unit, unlike other CAPS, where users would utilize the space solely to reflect on themselves, their projects, and seek care. That is why it was so important for them to have a place to stay, as she mentioned.

Another participant spoke about their service, saying the problem was the basic lack of human resources. Since the service's opening, they had never managed to have even the minimum team recommended: "How can we think about Recovery if we do not even have enough staff?".

They emphasized that with an average of 100 users per professional, it was impossible to create an individualized care plan.

Regarding the shortage of human resources and the resulting work overload, one participant explained that one of the reasons for not working with the Recovery model was the lack of time. She expressed her constant frustration at not being able to do what she believed should be done. She observed herself performing juggling acts, trying to keep users as stable as possible with very scarce resources.

Another worker shared that in their service, the difficulties had become overwhelming to the point where they had to change their approach. They used to think about how to improve the service and refine their actions, but now they could only focus on what was possible day-by-day. They connected these challenges to the setbacks in public policies that Brazil has been experiencing, stemming from the political moment, budget cuts, the scarcity of resources, low salaries, the poverty users were facing, and children who had not attended school for almost two years due to the pandemic. They also recalled that people who were actively involved with users' needs and in the anti-asylum movement had been fired. They also mentioned that salaries were being cut, and new professionals were being hired at salaries R$1,000 lower than what their colleagues were receiving.

The disregard for health and education policies, coupled with the lack of commitment to basic human rights, highlighted an outdated management style still tainted by a sad historical legacy. This was evident in the lament of one participant, who realized that the actions of the service she worked at were routinely affected by politically-driven interventions that were deeply authoritarian in nature.

Discussion

The reflection on what was shared by the participants points to a historical analysis of the limited ways in which health and illness processes have been understood. There is a complex journey that begins with philosophy, moves through science, and reaches contemporary Western culture, which has solidified a dualistic understanding of human functioning, legitimizing the medical focus on the body as a machine (Lima et al., 2014; Rocca & Anjum, 2020).

This view of humanity, closely tied to positivist and Cartesian influences, gave rise to what is known as the biomedical model. This perspective traditionally underpins the health sciences and remains dominant today. According to this model, illness is largely understood through a common-sense lens and shapes our cultural understanding of human nature, explains all health problems as disruptions in physiological processes, without considering psychological and social contexts (Rocca & Anjum, 2020; Wade & Halligan, 2017).

It seems that what professionals say about medications being the key to healing, about actions being based solely on prescriptions, about psychologists only being consulted when objective approaches fail, and about a clear and hierarchical division between technical knowledge and the inability of teams to listen to those they serve – these all represent the maintenance of the dominant, positivist discourse and view, which supports moralistic, biomedical practices that simply reproduce common-sense beliefs. Additionally, these actions contextualize the corollary, reinforcing the ideas they shared that "the identity of the CAPS is tied to illness," and sometimes one might even witness "explicitly asylum-like practices".

There also appear to be lingering remnants of a prejudiced view of these individuals as being incapable. When a participant mentions that their team "works without much critique",

they may be referring to the difficulty of breaking through cultural barriers, where professionals are not open to seeing the bigger picture or recognizing what is different. Furthermore, technical and objective approaches are simpler ways of practicing, and the avoidance of more challenging, time-consuming work can even stem from emotional resistance, as one participant noted: "The previous (biomedical) model is much less distressing".

It is understandable that a professional trained in traditional health systems may struggle to adopt a care perspective that is not a set of techniques or administrative innovations that can be applied independently of the context and culture that mold both professionals and service users (Desai et al., 2023; Rodrigues et al., 2022). Recovery starts from a different understanding of what it means to be human, of people's capacities, and, consequently, of what mental health is. This view is contrary to the biomedical model paradigm, which is why it may not be easily embraced by the average healthcare professional.

The recommendation of an individual therapeutic plan is presented as one of the major innovations proposed through Psychosocial Rehabilitation – creating specific plans that are tailored to the unique needs of each individual (Ferreira et al., 2022). Yes, it is a significant improvement over standardized treatments, but it still falls short when viewed through the lens of personal development, since the plan is not theirs; it is for them. It is created based on their needs, but not developed with their participation, let alone by them.

It is understood that, in their journey toward Recovery, mental health services in Brazil should work to change the healthcare model, shifting away from a professional-centered approach and instead fostering the autonomy and leadership of service users. Protagonism is, in a sense, so highly valued that the inclusion of long-term service users as hired members is one of the model's core principles (Brandão et al., 2022; Slade et al., 2024).

If the team insists on maintaining an approach rooted in the biomedical tradition, it is to be expected that service users will also remain unaware of the possibility of paradigm shifts. Regarding users' perceptions of their individual Recovery processes, McGabe et al. (2018) found in their study that their understanding was strongly influenced by the team's perspective – one that attributed their future well-being to medication –, credited their progress more to professionals than to themselves, and saw psychiatrists as a conductor of services. They understood their journey through the traditional view that they would never be cured and would need medication for the rest of their lives. Moreover, their relationships were centered on professionals rather than fellow users (McGabe et al., 2018).

Adversities seem to undermine any possibility of action in line with the values cherished by participants, such as the stagnation of their teams in relation to the potential for progress in the social care approach, economic difficulties, and setbacks in public policies. Even so, it was evident in the professionals' actions that there were consistent attempts to work outside this context. They seemed to be committed to staying true to their principles, daily facing the harsh realities of life and resisting as a way of fighting.

Regarding the lack of conditions for change, Brazil's historical and political context recently faced a setback due to certain positions that sought to dismantle some public policies in the field of mental health. At the time of this study, the SUS and Psychosocial Rehabilitation were under threat due to the fragmentation of certain mental health achievements in Brazil (Bandeira & Onocko-Campos, 2021; Brandão et al., 2022). According to Brandão et al. (2022), Brazil was facing "a political context of dismantling public policies, cuts in public health investments, precarious work relations, and the

emptying of formal spaces for social control"[3] (Brandão et al., 2022, p. 3, our translation), which made this context unfavorable for any discussions regarding Recovery. In a sense, this was clearly expressed as lament and frustration in the participants' expressions.

Vasconcelos (2017) states that Brazil's historical context distances it in several ways from the Recovery model, citing the "heavy historical burden of colonialism, imperialism, and dependence, now further burdened by neoliberal adjustment policies, with a strong fiscal crisis, the impoverishment of the working population, and the deterioration of social policies"[4] (Vasconcelos, 2017, p. 44, our translation). He argues that the current situation is likely to worsen, which is even more discouraging because, to implement Recovery policies, the country would still need to achieve far earlier milestones in terms of citizenship. Brazil has one of the worst profiles of social inequality, high rates of functional illiteracy and school dropout, and nearly half of the workforce is in engaged in informal labor.

Cruz et al. (2020), in line with what the interviewees reported, observe that the new actions in national mental health policy are an antithesis of what was envisioned by the psychiatric reform movement and being consolidated over the past 35 years. For them, the dismantling that the RAPS is undergoing is evident in practices such as "promoting psychiatric hospitalization and the funding of therapeutic communities, actions grounded in a prohibitionist approach to issues related to alcohol and other drug use"[5] (Cruz et al., 2020, p. 1, our translation).

Conclusion

The participants' expressions in this study revealed a clear alignment between their individual perspectives and the principles of Recovery, even though this was not explicitly stated. For these professionals, the importance of users' connections with their communities, the development of their sense of identity, the search for meaning in their lives, and control over their own path are seen as more relevant than the mere reduction of symptoms. Even facing undeniable adversity, the practices of these professionals showed consistency with their principles, reflecting (and being reflected by) actions that went against the harsh realities they were immersed in.

The most prominent characteristic of these encounters was the poor working conditions faced by the professionals, which stemmed from a complex combination of events. The encounters took place between July and September 2021, when the Brazilian population was still socially isolated due to the Coronavirus Disease 2019 (COVID-19) pandemic, suffering from a high daily death toll and a scarcity of vaccines. Furthermore, the change in government in 2018 went against the health management perspective of the SUS and led to limitations in public health investments, resulting in reduced human resources and salary cuts. Foundations started to take over the administration of health facilities, reducing public-sector hiring and allowing, with this shift, a reactionary mindset – contrary to the Collective Health approach – to take over management and dictate how health should be delivered in Brazil.

This had a tremendous impact on mental health, as professionals, influenced by the Psychiatric Reform Movement, had been developing a person-centered perspective focused on

[3] In the original text: "(...) um contexto político de desmonte de políticas públicas, cortes de investimento na saúde pública, precarização dos vínculos de trabalho e esvaziamento dos espaços formais de controle social".

[4] In the original text: "(...) pesado fardo histórico do colonialismo, imperialismo e dependência, agora acrescido de políticas de ajuste neoliberal, com forte crise fiscal, empobrecimento da população trabalhadora e deterioração das políticas sociais".

[5] In the original text: "(...) de incentivo à internação psiquiátrica e ao financiamento de comunidades terapêuticas, ações fundamentadas em uma abordagem proibicionista das questões relacionadas ao uso de álcool e outras drogas".

growth, in contrast to the biomedical approach that centers on illness and medication. Managed by private companies, mental health in Brazil reverted to being treated as a product, people with mental disorders were once again seen as sick patients, and RAPS professionals were forced to become mere reproducers of biomedical procedures and asylum-like logic.

How, then, could a cutting-edge model of care be imagined if services lacked human resources and service users did not even have basic needs like food? Without enough time or financial and human resources to promote autonomy and more socially focused actions, teaching people to take the bus or investing in collaborative economies are actions that seem far removed from the pressing daily urgencies. If some studies suggest that Recovery in Brazil would come as an advancement of the Psychosocial Rehabilitation model, how could this be possible in the face of such setbacks in public policies? This may seem like an obvious conclusion given the reality presented.

However, there seem to be two key takeaways from what was observed. Yes, socioeconomic difficulties appear to compel services to focus on urgent needs. But the ongoing, doctor-centered management also seems to be an obstacle that runs parallel to these difficulties. In other words, the biomedical culture appears to be a significant barrier to this potential transition. It is important to remember that Recovery initiatives were born, after all, out of the lack of resources to finance medical mental health care. With the deinstitutionalization of care in the United States, for example, users lost free access to mental health services, and their autonomous mobilization sparked a movement. The technology behind Recovery is simple and does not require costly investments like hospitals or specialized medical professionals usually do.

This raises the question of the strong influence of culture in maintaining an outdated, expensive, and ineffective model. A lack of knowledge, an unwillingness to engage in a more emotionally invested approach (such as being open to listening), the loss of power, hierarchical relationships, and control over knowledge by health professionals may be some of the factors hindering this transition to a Recovery model. Similarly, society may be struggling to recognize and accept its responsibility for those it prejudicially deems incapable. It is also likely that service users experience this difficulty and feel powerless, unable to imagine that they could care for themselves or change how care is provided, since their autonomy, sense of responsibility, and identity have historically been undermined.

References

Amatuzzi, M. M. (2009) Psicologia fenomenológica: uma aproximação teórica humanista. *Estudos de Psicologia* (Campinas), *26*(1), 93-100. https://doi.org/10.1590/S0103-166X2009000100010

Anthony, W. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23. https://doi.org/10.1037/h0095655

Bandeira, N., & Onocko-Campos, R. (2021). Itinerários terapêuticos de usuários que abandonaram o cuidado em Centros de Atenção Psicossocial (Caps-III). *Saúde em Debate, 45*(128), 91-104. https://doi.org/10.1590/0103-1104202112807

Barreira, C. R. A., & Ranieri, L. P. (2013). Aplicação de contribuições de Edith Stein à sistematização de pesquisa fenomenológica em psicologia: a entrevista como fonte de acesso às vivências. In M. Massimi & M. Mahfoud (Eds.), *Edith Stein e a Psicologia*: *teoria e pesquisa*. Ed. Artesã.

Braga, C. (2020). Argumentos para utopias da realidade e a experiência da reforma psiquiátrica brasileira. *Saúde e Sociedade, 29*(3), e190054. https://doi.org/10.1590/S0104-12902020190054

Brandão, A. D. L., Figueiredo, A. P., & Delgado, P. G. G. (2022). Incorporações e usos do conceito de Recovery no contexto da Reforma Psiquiátrica Brasileira: uma revisão da literatura. *Trabalho, Educação e Saúde, 20*, e00189174. https://doi.org/10.1590/1981-7746-ojs00189

Brisola, E. B. V., & Cury, V. E. (2016). Researcher experience as an instrument of investigation of a phenomenon: An example of heuristic research. *Estudos de Psicologia* (Campinas), *33*(1), 95-105. https://doi.org/10.1590/1982-027520160001000010

Brisola, E. B. V., Cury, V. E., & Davidson, L. (2017). Building comprehensive narratives from dialogical encounters: a path in search of meanings. *Estudos de Psicologia* (Campinas), *34*(04), 467-475. https://doi.org/10.1590/1982-02752017000400003

Cidade, A. L., Aquino, P. R. P., Bessa, S. L., & Oliveira, W. F. (2021). O papel do profissional de SM no processo de Recovery: uma revisão integrativa. *Cadernos Brasileiros de SM, 13*(35), 108–131. https://periodicos.ufsc.br/index.php/cbsm/article/view/76866

Costa, M. N. (2017). Recovery as a Strategy to Advance the Psychiatric Reform in Brazil. *Brazilian Journal of Mental Health, 9*(21), 1-16. https://doi.org/10.5007/cbsm.v9i21.69532

Cruz, N. F. O., Gonçalves, R. W., & Delgado, P. G. G. (2020). Retrocesso da Reforma Psiquiátrica: o desmonte da política nacional de saúde mental brasileira de 2016 a 2019. *Trabalho, Educação e Saúde, 18*(3). https://doi.org/10.1590/1981-7746-sol00285

Davidson, L. (2020). Recovering a sense of self in schizophrenia. *Journal of Personality, 88*(1), 122-132. First published 23 February 2019. https://doi.org/10.1111/jopy.12471

Davidson, L., Rowe, M., DiLeo, P., Bellamy, C., & Delphin-Rittmon, M. (2021). Recovery-oriented systems of care: a perspective on the past, present, and future. *Alcohol Research, 41*(1), 9. https://doi.org/10.35946/arcr.v41.1.09

Desai, M. U., Paranamana, N., Dovidio, J. F., Davidson, L., & Stanhope, V. (2023). System-Centered Care: How Bureaucracy and Racialization Decenter Attempts at Person-Centered Mental Health Care. *Clinical Psychological Science, 11*(3), 476–489. https://doi.org/10.1177/21677026221133053

Egeland, K. M., Benth, J. S., & Heiervang, K. S. (2021). Recovery-oriented care: mental health workers' attitudes towards Recovery from mental illness. *Scandinavian Journal of Caring Sciences, 35*, 998–1005. https://doi.org/10.1111/scs.12958

Fadda, G. M., & Cury, V. E. (2021). O Fenômeno da Intersubjetividade na Relação Psicoterapêutica. *Revista Subjetividades, 21*(Esp1), e9445. https://doi.org/10.5020/23590777.rs.v21iEsp1.e9445

Fernandes, C. J., Lima, A. F., Oliveira, P. R. S., & Santos, W. S. (2020). Índice de Cobertura Assistencial da Rede de Atenção Psicossocial (iRAPS) como ferramenta de análise crítica da reforma psiquiátrica brasileira. *Cadernos de Saúde Pública, 36*(4). https://doi.org/10.1590/0102-311x00049519

Ferreira, M. G., Ferreira, K. H. G., Souza, C. R. P., Ortiz, P. C. A., Almeida, R. G. S., & Silva, A. D. M. (2022). Singular Therapeutic Project in the management of complex cases: experience report in PEW-Health Interprofessionality. *Revista Brasileira De Educação Médica, 46*(1), e026. https://doi.org/10.1590/1981-5271v46.1-20210260.ING

Goto, T. A., Holanda, A. F., & Costa, I. I. (2018). Fenomenologia transcendental e a psicologia fenomenológica de Edmund Husserl. *Revista do NUFEN, 10*, 38-54. https://doi.org/10.26823/RevistadoNUFEN.vol10.n03artigo35

Gyamfi, N., Bhullar, N., Islam, M. S., & Usher, K. (2020). Knowledge and attitudes of mental health professionals and students regarding Recovery: A systematic review. *International Journal of Mental Health Nursing, 29*(3), 322-347. https://doi.org/10.1111/inm.12712

Lima, D. D., Alves, V. L., & Turato, E. R. (2014). The phenomenological-existential comprehension of chronic pain: going beyond the standing healthcare models. *Philosophy, Ethics and Humanities in Medicine, 9*, 2. https://doi.org/10.1186/1747-5341-9-2

McCabe, R., Whittington, R., Cramond, L., & Perkins, E. (2018). Contested understandings of Recovery in mental health. *Journal of Mental Health, 27*(5), 475-481. http://dx.doi.org/10.1080/09638237.2018.1466037

Moreira, M. I. B., & Onocko-Campos, R. (2017) Teresa. Ações de SM na rede de atenção psicossocial pela perspectiva dos usuários. *Saúde e Sociedade, 26*(2), 462-474. https://doi.org/10.1590/S0104-12902017171154

Najmanovich, D. (2001). *O sujeito encarnado: questões para pesquisa no/do cotidiano*. DP & A.

Nóbrega, M. P. S. S., Silva, G. B. F., & Sena, A. C. R. (2018). A reabilitação psicossocial na rede oeste do município de São Paulo: potencialidades e desafios. *Revista Gaúcha de Enfermagem, 39*, e2017-0231. https://doi.org/10.1590/1983-1447.2018.2017-0231

Rocca, E., & Anjum, R. L. (2020). Complexity, Reductionism and the Biomedical Model. In R. L. Anjum, S. Copeland & E. Rocca. Rethinking causality, complexity and evidence for the unique patient a causehealth resource for healthcare professionals and the clinical encounter. Springer. (eBook). https://doi.org/10.1007/978-3-030-41239-5

Rodrigues, E. T., Oliveira-Viana, M. M., Campos-Rizzi, F. N., & Campos, G. W. S. (2022). O desafio da formação interdisciplinar de graduandos de medicina: contribuições dos grupos Balint-Paideia. *Saúde em Debate, 46*(spe6), 41–54. https://doi.org/10.1590/0103-11042022E605

Saraceno, B. (2011). A cidadania como forma de tolerância. *Revista de Terapia Ocupacional da Universidade de São Paulo, 22*(2), 93-101. https://doi.org/10.11606/issn.2238-6149.v22i2p93-101

Silveira, A. R., Almeida, A. P. S., Souza, C. L., Prates, T. E. C., Rabelo, M. O., Sampaio, C. A., & Silveira, J. A. (2017). Recovery and the Brazilian experience in psychosocial care: dialogues and approaches. *Brazilian Journal of Mental Health, 9*(21), 13, 17-30. https://doi.org/10.5007/cbsm.v9i21

Slade, M., Rennick-Egglestone, S., Elliott, R. A., Newby, C., Robinson, C., Gavan, S. P., Paterson, L., Ali, Y., Yeo, C., Glover, T., Pollock, K., Callard, F., Priebe, S., Thornicroft, G., Repper, J., Keppens, J., Smuk, M., Franklin, D., Walcott, R., ... NEON Study Group. (2024). Effectiveness and cost-effectiveness of online recorded recovery narratives in improving quality of life for people with non-psychotic mental health problems: a pragmatic randomized controlled trial. *World Psychiatry, 23*(1), 101–112. https://doi.org/10.1002/wps.21176

Tondora, J., Miller, R., Slade, M., & Davidson, L. (2014). *Partnering for Recovery in Mental Health: Practical Guide to Person-Centered Planning*. Wiley Blackwel.

Vasconcelos, M. (2017) As abordagens anglo-saxônicas de empoderamento e Recovery (recuperação, restabelecimento) em SM II: uma avaliação crítica para uma apropriação criteriosa no cenário brasileiro. *Cadernos Brasileiros de Saúde Mental, 9*(21), 48-65. https://periodicos.ufsc.br/index.php/cbsm/article/view/69535

Wade, D. T., & Halligan, P. W. (2017). The biopsychosocial model of illness: a model whose time has come. *Clinical Rehabilitation, 31*(8), 995–1004. https://doi.org/10.1177/0269215517709890

Wertz, F. J. (2021). Objectivity and eidetic generality in psychology: the value of explicating fundamental methods. *Qualitative Psychology, 8*(1), 125–140. https://doi.org/10.1037/qup0000190

Witkiewitz, K., Montes, K. S., Schwebel, F. J. & Tucker, J. T. (2020). What is Recovery? *Alcohol Research, 40*(3), 1. https://doi.org/10.35946/arcr.v40.3.01

Contributors

Conceptualization, Methodology, Writing – original draft and Writing – review and editing: D. D. LIMA and V. E. CURY.