Determinants of Personal Recovery in People with Schizophrenia in Asia: A Systematic Review and Meta-Analysis Report

*Patraporn Bhatarasakoon, Ratree Thongyu**

Abstract: Personal recovery in schizophrenia emphasizes hope, identity, meaning, and empowerment beyond symptom reduction. Although numerous predictors have been identified in Western contexts, Asian-specific evidence remains limited. This study aimed to evaluate factors associated with personal recovery in people with schizophrenia in Asian contexts, focusing on personal experience rather than clinical remission. The systematic review followed the JBI methodology for etiology and risk, and was registered with PROSPERO (CRD42020179623). Six databases and gray literature were searched for studies published between 1990 and 2021 examining factors related to personal recovery in people with schizophrenia across Asian countries. Only quantitative analytical observational studies were included. Two reviewers independently selected, appraised, and extracted data. Meta-analysis was conducted using MedCalc software.

Results from 2,343 records, 11 studies met the inclusion criteria (5 for meta-analysis, 6 for narrative synthesis). A meta-analysis showed a significant, moderate, and negative correlation between structural self-stigma and personal recovery (r = -0.409; 95% CI: -0.549 to -0.246; n = 681). Narrative synthesis revealed that clinical factors consistently impeded recovery. Psychological resources facilitated recovery, with hope showing the strongest protective effects (r = 0.641), followed by self-efficacy and self-esteem. Social support enhanced recovery, while loneliness created barriers. Male gender and later onset age were associated with poorer outcomes. In conclusion, personal recovery requires multi-domain interventions targeting hope cultivation, stigma reduction, social network strengthening, and symptom management. These findings provide evidence-based priorities for recovery-oriented practice in Asian contexts, though limitations include study heterogeneity and cross-sectional designs. Future research should explore culturally tailored longitudinal interventions.

Keywords: Asia, Determinants, Meta-analysis, Personal recovery, Schizophrenia, Systematic review

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Introduction

Schizophrenia is a persistent, severe psychiatric disorder that impacts millions of individuals globally. In Asia, its prevalence increased from 8.42 million in 1990 to 14.96 million in 2021, with a higher burden among males.[1] Recovery in schizophrenia encompasses three distinct but interconnected dimensions. Clinical recovery emphasizes the alleviation of symptoms and the restoration of cognitive functioning. Functional recovery focuses on restoring work capacity and social functioning. However, personal recovery—arguably the most meaningful to patients themselves—represents individuals' subjective sense of purpose, empowerment, and personal agency in rebuilding their lives.[2,3]

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The integrated components include spirituality, empowerment, quality of life, positive attitude to life, positive self-perception, and hope.[4]

While clinical and functional recovery have received extensive research attention and established evidence-based interventions, personal recovery remains critically understudied. The clinical and functional recovery has been studied and improved primarily through the treatment regimen, which includes both pharmacological and psychosocial interventions, in the hospital. The main outcome is the level of cognitive function and the remission of psychotic symptoms.[5] This gap is particularly concerning given that personal recovery often determines long-term sustainability and quality of life outcomes. Unlike objective clinical measures, personal recovery captures what patients themselves value most: regaining hope, meaning, and control over their lives.

Emerging evidence suggests that personal recovery is influenced by a complex interplay of psychological, social, and personal factors beyond traditional clinical parameters. Several studies have investigated factors associated with personal recovery. The selected factors included cognitive insight,[3,6] medication adherence, addiction, coping, social support,[3] loneliness and quality of life.[7] These various factors may serve as the mediator and the contributor to personal recovery in people with schizophrenia.

Recent studies have further advanced the understanding of personal recovery in schizophrenia. Thongsalab et al. clarified conceptual definitions of personal recovery among people with schizophrenia, emphasizing the multidimensional nature of recovery in Asian populations.[8] At the individual level, Concerto et al. highlighted the role of mentalization in facilitating recovery processes, suggesting that cognitive and social-cognitive mechanisms should be considered when designing recovery-oriented interventions.[9] Complementing these conceptual advances, Yu et al. showed that disability and quality of life mediated the relationship between clinical and personal recovery, underscoring the importance of functional outcomes in recovery trajectories.[10] A systematic review and meta-analysis demonstrated that self-stigma exerts a pervasive negative influence on functioning while strongly predicting depressive symptoms across cultures, reinforcing stigma as a critical barrier to recovery.[11]

In addition, cultural perspectives have enriched the current understanding of recovery, such as a mapping of Asian perspectives, showing that personal recovery is often interpreted as a return to pre-illness roles while being embedded in religious and social values.[12] This evidence has been extended, demonstrating through a scoping review that recovery is defined differently in non-Western contexts, where connectedness, family, and religion play more prominent roles compared with Western frameworks.[13] Together, these findings indicate that while core elements of recovery are universal, their enactment is strongly shaped by cultural values and social structures. This highlights the importance of culturally responsive approaches when applying recovery-oriented models in Asian populations.

Parallel developments have also highlighted the role of interventions and social mechanisms in promoting recovery. Evidence has been synthesized from group peer support interventions, concluding that such programs improved empowerment, hope, and social connectedness among people with mental health conditions.[14] Similarly, Demirli et al. examined future self-continuity and demonstrated its significant association with personal recovery in schizophrenia, pointing to psychological resources that strengthen recovery identity and resilience.[15] These findings collectively suggest a paradigm shift from symptom remission toward psychosocial empowerment, with growing attention to mechanisms that sustain recovery in daily life.

A comprehensive synthesis of existing evidence is urgently needed to guide evidence-based practice and transform recovery outcomes for this vulnerable population. From a literature search, we found two existing systematic reviews[16,17]; however, one focus on the clinical and personal recovery comparison,[16]

another one[17] examined factors associated with personal recovery among people with psychotic disorders, organizing findings according to the CHIME framework (Connectedness, Hope, Identity, Meaning, Empowerment) globally, these reviews did not focus specifically on people with schizophrenia in the Asian context, where cultural values, family dynamics, stigma patterns, and healthcare systems may fundamentally influence recovery pathways.

This gap is particularly critical given Asia's unique sociocultural landscape. Asian societies often emphasize collective identity, family honor, and social harmony—factors that can profoundly shape how individuals experience stigma, seek support, and define their recovery. Without region-specific evidence, clinicians across Asia lack culturally relevant guidance to support their patients' recovery processes.

Therefore, this review addresses a crucial knowledge gap by systematically evaluating factors associated with personal recovery, specifically among people with schizophrenia in Asia. By examining cognitive insight, coping strategies, social support, and personal factors within this cultural context, we aim to provide evidence-based foundations for developing culturally responsive interventions that honor both individual recovery goals and Asian cultural values, ultimately improving outcomes for the millions of people with schizophrenia across the region.

Review question

In this review, we explored: What factors determine personal recovery in people with schizophrenia?

The specific question was: What is the association among selected factors such as cognitive insight, coping, social support, quality of life, and demographic variables with the personal recovery of people with schizophrenia in Asia?

Inclusion Criteria

The review considered studies involving individuals aged 18 years or older who have been diagnosed with F20.0 schizophrenia or schizophrenia spectrum disorders by DSM-5 or ICD-10. We excluded studies that included people with schizophrenia who used substances.

Exposure of Interest

This review considers studies that examine cognitive insight, coping, social support, quality of life, hope, and personal factors associated with the personal recovery of people with schizophrenia.

Outcomes

This review considers studies that include the outcomes, including the level of personal recovery. These outcomes will be measured by tools such as the Recovery Process Inventory (RPI), the Questionnaire about the Process of Recovery (QPR), the Recovery Assessment Scale (RAS), the Recovery Assessment Scale-Revise (RAS-R), the Subjective Recovery Assessment Scale (SRAS), and the Stages of Recovery Instrument (STORI).

Context

As we mentioned in the background, cultural context may significantly influence the personal recovery of people with schizophrenia. All Asian countries were added as keywords for searching.

Types of Studies

This review included only quantitative analytical observational studies—namely, prospective and retrospective cohort studies, case-control studies, and analytical cross-sectional studies that report on the risk associated with personal recovery.

Methods

This systematic review followed the etiology and risk review methodology recommended by JBI, and the protocol was registered in PROSPERO (CRD42020179623). The report adhered to the PRISMA guidelines for systematic review reports, ensuring that all important elements were accurately reported. The literature search was conducted on September 27, 2021. The details of the method are as follows:

Search Strategy

A comprehensive, three-phase search strategy was implemented to identify both published and unpublished studies:

Phase 1: Initial scoping search – Limited searches in PubMed and CINAHL identified relevant articles to analyze text words in titles/abstracts and index terms for strategy development.

Phase 2: Comprehensive database search – The full search strategy was adapted and executed across six databases identified in the following information sources section.

Phase 3: Reference screening – The reference lists of all studies selected for critical appraisal were manually reviewed to identify additional relevant studies.

Keywords and index terms were customized for each database's specific requirements. Initial search terms are detailed in **Table 1**. The search results of all databases are detailed in **Appendix Table A1.**

Table 1. Initial keywords

Exposure/independent variables	Outcome/ dependent variables	populations	context
factors or determinant factors or factor influencing or factor association or factor correlation or correlated factor or associated factor or social support or resilience or psychiatric symptoms or internalized stigma or quality of life or cognitive insight or coping or hope or personal agency or self-esteem	personal recovery or subjective recovery or recovery	schizophrenia or schizophrenic patient or severe and persistent mental illness or SMI or psychosis or severe psychosis or psychiatric patient	"Asia" or "Cambodia" or "Qatar" or "South Korea" or "North Korea" or "Kazakhstan" or "Kyrgyzstan" or "Kuwait" or "Georgia" or "Jordan" or "China" or "Saudi Arabia" or "Syria" or "Cyprus" or "Japan" or "Timor-Leste" or "Turkey" or "Turkmenistan" or "Tajikistan" or "Thailand" or "Nepal" or "Brunei" or "Bangladesh" or "Bahrain" or "Pakistan" or "Palestine" or "Myanmar" or "Philippines" or "Bhutan" or "Mongolia" or "Maldives" or "Malaysia" or "Yemen" or "Laos" or "Lebanon" or "Vietnam" or "Sri Lanka" or "United Arab Emirates" or "Singapore" or "Afghanistan" or "Azerbaijan" or "Armenia" or "India" or "Indonesia" or "Iraq" or "Israel" or "Iran" or "Uzbekistan" or "Oman"

Information Sources

Studies published in the English language in PubMed, CINAHL, Web of Science, EMBASE, JBI database, and Cochrane Library from 1990 to 2021, when the first study on recovery was published. The gray literature, such as Google Scholar and Science Direct, was also included as a search resource.

Study Selection

The systematic literature search identified a total of 3,288 records across multiple databases. The search strategy encompassed nine major databases: PubMed (500 records), CINAHL (180 records), Web of Science (786 records), Embase (827 records), Cochrane (250 records), JBI (33 records), Google Scholar (162 records), Science Direct (73 records), and ProQuest (477 records).

Following duplicate removal, 2,343 unique records remained for screening. Two reviewers independently selected the potentially relevant studies against the inclusion criteria. During the initial screening phase, 2,285 records were excluded following the title

and abstract screening, leaving 58 reports deemed potentially relevant for full-text evaluation.

At the full-text screening stage, 42 reports could not be retrieved, reducing the pool to 16 reports for detailed eligibility assessment. Of these 16 reports, five were subsequently excluded: three due to different outcome frameworks and two due to various outcomes that did not align with the review objectives.

Ultimately, 11 studies satisfied the inclusion criteria and were incorporated into the final review. These include five studies that provided quantitative data suitable for meta-analysis, while six studies contributed to the narrative synthesis component of the review.

The search and selection process was documented using a PRISMA flow diagram **(Figure 1)**. No disagreements arose between the reviewers.

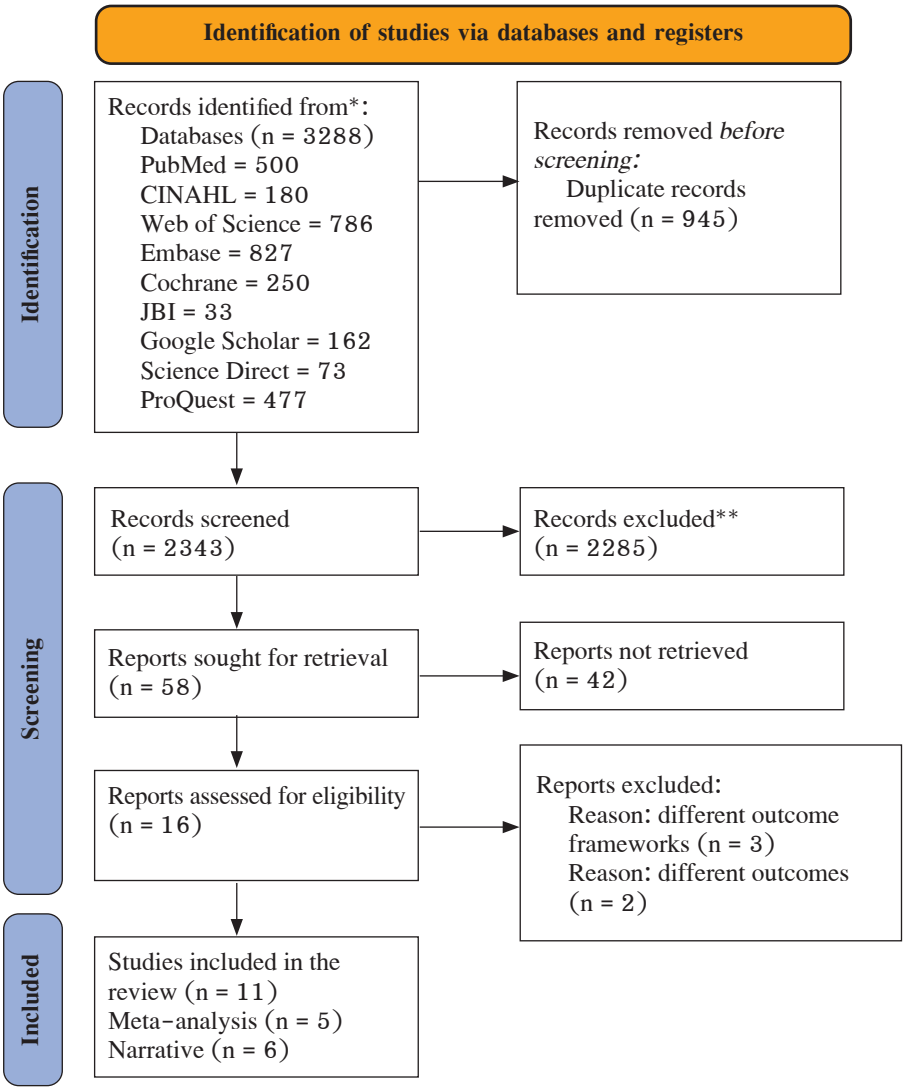


Figure 1. PRISMA Flow diagram
Source: Page MJ, et al. BMJ. 2021;372:n71. doi: 10.1136/bmj.n71.

Assessment of Methodological Quality

Critical Appraisal Results

Following the pilot test of using the checklist on one study to gain an understanding of every item between the reviewers, the critical appraisal was conducted independently for the remaining papers. The discrepancy among reviewers was rechecked, and a discussion was held to reach an agreement. Several methodological limitations were identified through a quality appraisal using JBI checklists for the 11 included cross-sectional and cohort studies. Among the ten cross-sectional studies, only 50% adequately identified confounding factors (item 5), and merely 10% implemented strategies to address confounding (item 6), potentially compromising the validity of associations. The only included cohort study failed to meet the criteria for confounding management (item 5), completing follow-up assessments (item 9), and strategies for addressing incomplete follow-up (item 10). These methodological deficiencies may limit the reliability of effect estimates and introduce bias in the pooled analyses. The details of the quality appraisal of each included study result are summarized in **Tables 2 and 3**. And the characteristics of the included studies are detailed in the **Appendix in Tables A2 and A3.**

Table 2. Critical appraisal of the included analytical cross-sectional study

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Hasson-Ohayon I M-EM.[23]	Y	Y	Y	Y	N/A	N	Y	Y
Lim M LZ.[27]	Y	Y	Y	Y	Y	Y	Y	Y
Mitsunaga-Ohmuro N ON.[29]	Y	Y	Y	Y	N/A	U	Y	Y
İpçi K YM.[30]	Y	Y	U	Y	Y	N	Y	Y
Roe D M-EM.[7]	Y	Y	Y	Y	Y	N	Y	Y
Sari SP AM.[28]	Y	Y	Y	Y	Y	U	Y	Y
Young D, Cheng D, Ng P.[24]	Y	Y	Y	Y	N	N	Y	Y
Mak W, Chan R, Wong S, Lau J, Tang W, Tang A.[26]	Y	Y	Y	Y	N	N	Y	Y
Singla N AA.[25]	Y	Y	Y	Y	N	N	Y	Y
Chan K, Lam C.[31]	Y	Y	Y	Y	N	N	Y	Y
%	100.0	100.0	90.0	100.0	50.0	10.0	100.0	100.0

Note: JBI checklist for analytical cross-sectional studies (8 items): Q1 = "inclusion criteria clearly defined" (p.269)[10]; Q2 = "study subjects and setting described in detail" (p.269)[10]; Q3 = "exposure measured validly and reliably" (p.269)[10]; Q4 = "objective, standard criteria used for measurement of the condition" (p.269)[10]; Q5 = "confounding factors identified" (p.269)[10]; Q6 = "strategies to deal with confounding factors stated" (p.269)[10]; Q7 = "outcomes measured validly and reliably" (p.269)[10]; Q8 = "appropriate statistical analysis used" (p.269)[10]; "Y" = Yes, "N" = No, "U" = Unclear, "N/A" = Not Applicable

Table 3. Critical appraisal of the included cohort study

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11
Kurt A, Ersan E, Savas I.[22]	Y	Y	Y	U	N	U	Y	Y	N	N	Y
%	100.0	100.0	100.0	100.00	0	100.0	100.0	100.0	0.0	0.0	100.0

Note: JBI checklist for cohort studies (11 items): Q1 = "two groups similar and recruited from the same population" (p.257)[10]; Q2 = "exposures measured similarly in both groups" (p.257)10; Q3 = "exposure measured validly and reliably" (p.257)[10]; Q4 = "confounding factors identified" (p.257)[10]; Q5 = "strategies to deal with confounding stated" (p.257)[10]; Q6 = "participants free of outcome at start of study" (p.257)[10]; Q7 = "outcomes measured validly and reliably" (p.257)[10]; Q8 = "follow-up time sufficient for outcomes to occur" (p.257)[10]; Q9 = "follow-up complete and reasons for loss described" (p.257)[10]; Q10 = "strategies to address incomplete follow-up utilized" (p.257)[10]; Q11 = "appropriate statistical analysis used" (p.257)[10]; "Y" = Yes, "N" = No, "U" = Unclear, "N/A" = Not Applicable

To assess publication bias, formal statistical tests were employed to detect small-study effects. The Egger's regression test yielded an intercept of -6.0210 (95% CI: -17.7290 to 5.6869, p = 0.2002), indicating no statistically significant skew in the funnel plot. Begg's rank correlation test yielded Kendall's Tau = 0.0000 (p = 1.0000), confirming the absence of a significant association between effect sizes and their precision. Both statistical tests provided consistent evidence against the presence of publication bias among the included studies. However, these tests have limited power to detect bias when fewer than ten studies are included, and the possibility of publication bias cannot be entirely excluded.

Data Extraction

Data extraction was executed independently by two reviewers in JBI SUMARI with standardized extraction tools.[18] The pilot test was conducted among the reviewers to ensure the same understanding of extracting each item before commencing the rest. Extracted data encompassed exposure variables of interest (including subcategories where applicable), study populations, methodological details, and outcome measures directly relevant to the review objectives.

All exposure and outcome variables were continuous, and their relationships were quantified using Pearson product-moment correlation coefficients. The extraction process achieved complete inter-reviewer agreement with no discrepancies requiring resolution.

Data Synthesis

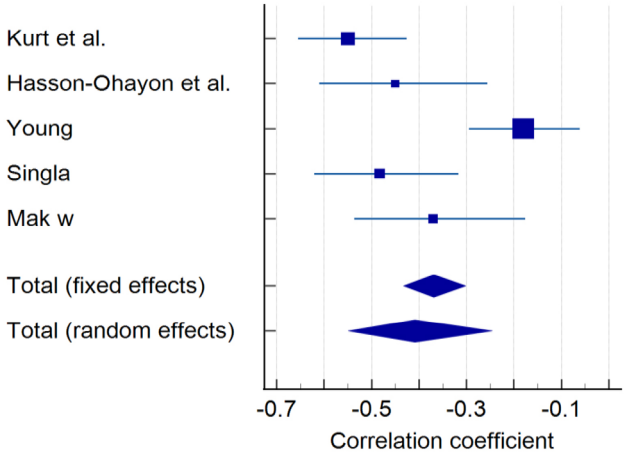
Statistical meta-analysis was conducted using MEDCALC software,[19] which employs the Hedges-Olkin[20] method to calculate weighted summary correlation coefficients. The analysis utilized Fisher's Z transformation of correlation coefficients under both fixed-effects and random-effects models, with 95% CI calculated for all analyses.

Heterogeneity was assessed using two complementary statistics. Cochran's Q test aims to evaluate the weighted sum of squared deviations from the pooled effect estimate, with p-values < 0.10 indicating significant heterogeneity. The I^2 statistic quantified the percentage of total variation attributable to true heterogeneity rather than chance, where 0% indicates no heterogeneity and higher values reflect increasing between-study variation.[21]

Results

The Association of Self-stigma and Personal Recovery

Five studies[22-26] were combined into the proportional meta-analysis. Due to the heterogeneity (Q = 21.29, p = 0.0003; I^2 :inconsistency = 81%), the random effects model was repeated and yielded similar statistical significance to the fixed effects model. The analysis demonstrated an inverse correlation between self-stigma and personal recovery, with a summary correlation coefficient of -0.409 (95% CI = -0.549, -0.246; n = 681). The details of the correlation are presented in **Appendix Table A4.** The forest plot is displayed in **Figure 2.**



Heterogeneity test: Q = 21.29, p = 0.0003; I^2 = 81%

Figure 2. Forest plot of the proportional meta-analysis

Despite significant heterogeneity, there is robust evidence for a moderate-to-strong negative association between self-stigma and personal recovery across diverse study populations and settings.

To enhance the interpretation of the synthesized evidence, the GRADE approach was employed to evaluate the certainty of the association between self-stigma and personal recovery. The overall certainty was rated as moderate, due to serious inconsistency (I^2 = 81%) and potential publication bias. Despite these limitations, the consistent direction and magnitude of the effect across studies suggest a meaningful, moderately negative association between self-stigma and recovery outcomes. A detailed summary of findings is presented in Appendix **Table A5.**

Narrative Result

The six studies revealed a complex web of factors influencing personal recovery, though their exposure diversity prevented statistical combination. Each study illuminated different pieces of the recovery puzzle, collectively painting a comprehensive picture of what drives—or hinders—the personal recovery journey.

Clinical symptoms emerged as significant barriers to recovery. Lim et al.[27] demonstrated that depression exerted a moderate negative influence on the personal recovery process (QPR-15), with correlation coefficients ranging from r = -0.529 to -0.544. Similarly, Roe et al.[7] found that mood symptoms, as measured by the BPRS (Brief Psychiatric Rating Scale), showed a smaller but statistically significant negative association with subjective personal recovery (RAS) (r = -0.17; p < 0.05).

Psychological resources proved to be powerful catalysts for personal recovery. Most remarkably, Sari et al.[28] identified hope as the strongest predictor, showing both a robust correlation with recovery (r = 0.641, p < 0.001) and exceptional predictive power (β = 0.672, p < 0.001). Self-efficacy also contributed positively, though more modestly, with Mitsunaga-Ohmuro and Ohmuro[29] finding a significant association between Self-Efficacy (GSES) and personal recovery process (QPR) (r = 0.49; p < 0.01). Additionally, İpçi et al.[30] demonstrated that self-esteem significantly predicted subjective recovery (B = 0.315; t = 3.241; p = 0.002), while hopelessness acted as a negative predictor (B = -0.232; t = -2.473; p = 0.015).

Social connections formed another critical dimension of personal recovery. Roe et al.[7] revealed that social support moderately enhanced recovery (r = 0.33; p < 0.001), while loneliness created

substantial barriers ($r = -0.32$; $p < 0.001$), highlighting the profound impact of interpersonal relationships on recovery trajectories.

Stigma and demographic factors also shaped recovery experiences. Chan and Lam[31] found that both self-stigma content ($B = -0.49$, $p < 0.001$) and self-stigma process ($B = -0.29$, $p < 0.001$) significantly hindered personal recovery. Furthermore, İpçi et al.[30] identified that being male, a diagnosis of schizophrenia, and older age of onset were all negatively associated with subjective recovery (SubRAS), suggesting that certain demographic characteristics may create additional recovery challenges.

Discussion

Principal Findings

This systematic review and meta-analysis highlight that personal recovery in schizophrenia is shaped by a multifaceted interplay of psychological, social, clinical, and demographic factors. A meta-analysis of five studies ($n = 681$) revealed a significant, moderate negative correlation between self-stigma and personal recovery ($r = -0.409$; 95% CI: -0.549, -0.246), confirming that internalized stigma represents a substantial barrier to recovery across diverse populations.[23] This finding aligns closely with recent cross-cultural meta-analytic evidence showing a moderate negative correlation between self-stigma and functioning ($r = -0.39$) and a strong positive correlation with depressive symptoms ($r = 0.49$) across 53 studies from 22 countries.[32]

However, the interpretation of these findings requires careful consideration, given the significant methodological limitations identified in the quality appraisal and the substantial statistical heterogeneity. Critical deficiencies were observed in the management of confounding factors, with only 10% of cross-sectional studies implementing appropriate control strategies, and inadequate follow-up assessments in cohort studies. These methodological weaknesses may introduce residual confounding and selection bias, thereby compromising the validity of the reported associations. Furthermore, although both fixed- and random-effects models were employed, high heterogeneity persisted ($I^2 = 81\%$); no formal sensitivity analysis was conducted. This omission may reduce confidence in interpreting the robustness of pooled results. Moreover, the observed heterogeneity suggests considerable variability in study populations, methodologies, or contextual factors that may limit the generalizability of pooled estimates. Consequently, while the meta-analysis provides a valuable quantitative synthesis, these methodological constraints necessitate a cautious interpretation of the strength and directionality of the associations.

The Centrality of Hope and Psychological Resources

Perhaps the most striking finding from the narrative synthesis was the exceptional influence of hope on personal recovery ($r = 0.641$, $\beta = 0.672$). Remarkably, our findings converge with and exceed the strength of associations reported in other meta-analytic evidence. Van Eck et al.'s comprehensive meta-analysis found only small to medium negative correlations between symptom severity and personal recovery ($r = -0.21$),[16] while our hope findings suggest positive psychological resources may be more powerful predictors than clinical factors are barriers. Similarly, Sari et al.'s Indonesian study reported an identical correlation between hope and recovery ($r = 0.641$),[28] suggesting this relationship transcends cultural boundaries. The constellation of psychological resources—including self-efficacy, self-esteem, and the absence of hopelessness—emerged as protective factors that collectively strengthen recovery resilience. These findings align with structural equation modelling research showing that resilience and self-esteem act as mediators between clinical symptoms and recovery outcomes.[33]

Clinical Symptoms and Social Connections

The consistent negative associations between clinical symptoms (depression, mood disturbances) and personal recovery underscore that symptom management, while not sufficient for recovery,

remains necessary. Van Eck et al.'s meta-analysis found that affective symptoms showed stronger negative correlations with personal recovery ($r = -0.34$) than positive ($r = -0.20$) or negative symptoms ($r = -0.24$),[16] consistent with our findings. However, the moderate rather than strong correlations suggest that symptom reduction alone cannot guarantee recovery progress.

The social dimension revealed both healing potential and capacity for harm. While social support demonstrated a moderate positive association with recovery ($r = 0.33$), loneliness showed an equivalent negative impact ($r = -0.32$), highlighting that the quality and meaningfulness of social connections appear crucial.

The Persistent Challenge of Self-Stigma

The challenge of self-stigma—internalized negative beliefs about one's own mental illness—represents perhaps the most insidious barrier to recovery because it operates from within. Unlike external stigma from others, self-stigma becomes part of one's self-concept, making it extraordinarily resistant to change. In Asian cultures, this challenge may be particularly pronounced due to collectivist values that emphasize family honor, social harmony, and conformity to group norms. The concept of "face" (*mianzi*) and concerns about bringing shame to the family can intensify self-stigmatization, as individuals may internalize not only personal inadequacy but also responsibility for family dishonor.[34,35] Traditional beliefs about mental illness as spiritual punishment or character weakness, combined with high expectations for academic and professional achievement prevalent in many Asian societies, may further compound self-stigma.[35] Our meta-analytic finding regarding self-stigma, combined with narrative evidence showing significant negative impacts of both stigma content and process, reveals stigma as a pervasive threat to recovery that requires culturally sensitive intervention approaches in Asian contexts.

Our correlation of $r = -0.409$ falls between moderate negative correlations reported for self-stigma's associations with functioning ($r = -0.39$) and its strong positive association with depressive symptoms ($r = 0.49$) in larger cross-cultural analyses.[23] The fact that internalized stigma showed such consistent negative associations across diverse studies suggests that anti-stigma interventions should be considered a core component of recovery-oriented care. Recent intervention research has demonstrated that therapeutic programs specifically targeting internalized stigma can achieve significant reductions with sustainable effects.[36,37]

Current Intervention Landscape and Gaps

A critical examination of existing intervention reviews reveals significant gaps between our evidence-based recovery factors and current treatment approaches. Morin and Franck's systematic review of rehabilitation interventions found that traditional approaches primarily focus on cognitive remediation, psychoeducation, social skills training, and cognitive behavioural therapy (CBT) for symptom management.[38] While these interventions demonstrate effectiveness for functional outcomes, they largely overlook the psychological factors our review identified as most powerful predictors of personal recovery, particularly hope, self-efficacy, and self-stigma reduction.

Recent systematic reviews of personal recovery facilitators found that interventions specifically targeting personal recovery remain limited, with most approaches still emphasizing symptom-focused rather than recovery-oriented outcomes.[39] Notably, peer support interventions showed significant but small effects on recovery ($SMD = 0.29$)[40] and empowerment ($SMD = 0.22$),[41] suggesting that interventions incorporating lived experience may be more aligned with personal recovery principles than traditional clinical approaches.

The evidence reveals a concerning disconnect: while hope emerged as the strongest predictor of personal recovery in our review, systematic searches revealed limited evidence of hope-specific interventions for schizophrenia, despite growing recognition of hope's central role in recovery processes.

In summary, although this review included studies conducted exclusively in Asian populations, the identified factors—such as hope, self-efficacy, stigma, and social

connection—reflect universal human experiences that are likely applicable across cultural contexts. Therefore, the findings may be cautiously generalized to non-Asian populations and diverse healthcare settings, especially where person-centred recovery is prioritized. Nonetheless, cultural adaptation and contextual validation should accompany implementation.

Clinical Implications and Future Intervention Development

Our evidence base, when compared with existing intervention literature, reveals critical opportunities for enhancing recovery-oriented care. Current rehabilitation interventions primarily target cognitive and functional domains but inadequately address the psychological and social factors most strongly associated with personal recovery. We recommend developing comprehensive interventions that systematically target:

1. Hope-building interventions as primary targets, given hope's exceptional predictive power ($r = 0.641$)[41]
2. Self-stigma reduction programs combining cognitive restructuring, narrative therapy, peer support, and psychoeducation
3. Self-efficacy and self-esteem enhancement through structured goal setting and achievement experiences
4. Social connection facilitation, addressing both loneliness reduction and meaningful relationship building

The central role of hope, which exceeded effect sizes found in most current intervention studies, suggests that narrative therapy, goal-setting interventions, and meaning-making activities may represent underutilized high-impact approaches compared to traditional symptom-focused treatments.

Limitations and Future Directions

Critical methodological limitations emerged from quality appraisal, with cross-sectional studies showing substantial weaknesses in addressing confounding factors (only 50% adequately identifying confounders, 10% outlining management strategies). The diversity of exposure variables severely limited the meta-analytic synthesis, with only five studies examining self-stigma that were suitable for statistical combination. Additionally, this review included studies published in English. However, the original studies were conducted in an Asian country where English is not the native language, which may have excluded relevant evidence reported in their local languages and potentially introduced language bias. Furthermore, the absence of sensitivity analyses, such as subgroup or leave-one-out analysis, limited our ability to explore the potential sources of heterogeneity in our combined result.

Future research should prioritize the development and evaluation of interventions that systematically target the recovery factors identified in this review. Specifically, researchers should: design hope-focused interventions incorporating goal setting, meaning-making, and future orientation; develop comprehensive anti-stigma programs targeting both stigma content and processes; create integrated interventions addressing multiple recovery domains simultaneously; and conduct adequately powered longitudinal studies establishing temporal relationships between interventions and personal recovery outcomes.

Conclusions

Personal recovery in schizophrenia is significantly influenced by identifiable psychological, social, and clinical factors. This systematic review and meta-analysis reveal a clear hierarchy of associations: hope demonstrates the strongest relationship with personal recovery ($r = 0.641$, $\beta = 0.672$), while self-stigma shows a robust negative association ($r = -0.409$), indicating that higher internalized stigma substantially impairs recovery outcomes.

The evidence establishes that psychological factors—particularly hope, self-efficacy, and self-esteem—demonstrate stronger associations with personal recovery than traditional clinical indicators. Social connections and meaning-making emerge as additional

significant determinants, while self-stigma appears to function as a barrier that may systematically undermine other recovery-promoting factors.

These findings emphasize the multifaceted nature of personal recovery, extending beyond symptom management to encompass psychological empowerment, social integration, and existential aspects. The strong associations identified provide an empirical foundation for understanding which factors are most critical to recovery processes. However, the predominantly cross-sectional evidence limits causal interpretation, and substantial heterogeneity suggests these associations may vary across populations and contexts.

Future research should prioritize longitudinal designs to establish temporal relationships between these factors and recovery outcomes, while also investigating the mechanisms through which hope, self-stigma, and social factors influence recovery trajectories in people with schizophrenia.

Author Contributions

Conceptualizing the protocol, Finalizing the protocol, Selecting and appraising eligible studies, extracting data, confirming data synthesis, and writing the manuscript: P.B.

Drafting the protocol, Selecting and appraising the eligible studies, Extracting and synthesizing data, and writing the manuscript: R.T.

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Declarations

The authors acknowledge the critical importance of promoting equity, diversity, and inclusion in mental health research. This systematic review on personal recovery in schizophrenia was conducted with particular attention to the Asian context, recognizing that recovery experiences may vary significantly across cultural and socioeconomic backgrounds.

The reviewers, as members of the nursing institute in Thailand, bring lived experience of the Asian healthcare context and cultural perspectives that inform understanding of stigma, family dynamics, and recovery processes in this region. This positioning offers valuable insights into how cultural values, such as collectivism, family honor, and social harmony, may uniquely influence personal recovery trajectories in Asian populations.

The research team is committed to promoting inclusive research practices that honor diverse perspectives on mental health and recovery. We recognize that personal recovery is deeply subjective and culturally informed, and our findings should be interpreted within the specific contexts of the populations studied. We encourage future research to include diverse voices, particularly those from underrepresented communities and individuals with lived experience of mental illness, to ensure that recovery-oriented interventions are culturally responsive and equitable.

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Appendix

Table A1. Search results

Using the keywords listed in **Table 1**, a search was conducted on September 27, 2021. The number of studies yielded by this search is as follows for each data set.

Databases	Study found	total	Duplicated remove	total	Final
PubMed	500	3,288	95	945	2,343
CINAHL	180		93		
Web of Science	786		240		
Embase	827		277		
Cochrane	250		99		
JBI	33		18		
GScholar	162		99		
ScienceDirect	73		24		
ProQuest	477		0		

The example below presents the complete search strategy for PubMed, including Boolean operators, MeSH terms, keywords, applied limits, and the number of records retrieved. This ensures transparency and reproducibility.

Database searched: PubMed (via NCBI)

Date of search: September 27, 2021

Language limit: English

Publication year limit: 1990–2021

Keywords PEO and Context	Result	Duplication	Final
((“factors”[Title/Abstract] OR “determinant factors”[Title/Abstract] OR “factor influencing”[Title/Abstract] OR “associated factor”[Title/Abstract] OR “correlated factor”[Title/Abstract] OR “social support”[MeSH Terms] OR “resilience”[MeSH Terms] OR “psychiatric symptoms”[Title/Abstract] OR “internalized stigma”[MeSH Terms] OR “quality of life”[MeSH Terms] OR “cognitive insight”[Title/Abstract] OR “coping”[MeSH Terms] OR “hope”[MeSH Terms] OR “personal agency”[Title/Abstract] OR “medication adherence”[MeSH Terms] OR “self-esteem”[MeSH Terms]) AND (“personal recovery”[Title/Abstract] OR “subjective recovery”[Title/Abstract] OR “recovery”[Title/Abstract]) AND (“schizophrenia”[MeSH Terms] OR “schizophrenic patient”[Title/Abstract] OR “psychosis”[MeSH Terms] OR “SMI”[Title/Abstract] OR “severe mental illness”[Title/Abstract]) AND (“Asia”[MeSH Terms] OR “Thailand”[Title/Abstract] OR “Cambodia”[Title/Abstract] OR “Qatar”[Title/Abstract] OR “South Korea”	500	95	405

Table A1. Search results (Cont.)

Keywords PEO and Context	Result	Duplication	Final
[Title/Abstract] OR "North Korea"[Title/Abstract] OR "Kazakhstan"[Title/Abstract] OR "Kyrgyzstan"[Title/Abstract] OR "Kuwait"[Title/Abstract] OR "Georgia"[Title/Abstract] OR "Jordan"[Title/Abstract] OR "China"[Title/Abstract] OR "Saudi Arabia"[Title/Abstract] OR "Syria"[Title/Abstract] OR "Cyprus"[Title/Abstract] OR "Japan"[Title/Abstract] OR "Timor-Leste"[Title/Abstract] OR "Turkey"[Title/Abstract] OR "Turkmenistan"[Title/Abstract] OR "Tajikistan"[Title/Abstract] OR "Nepal"[Title/Abstract] OR "Brunei"[Title/Abstract] OR "Bangladesh"[Title/Abstract] OR "Bahrain"[Title/Abstract] OR "Pakistan"[Title/Abstract] OR "Palestine"[Title/Abstract] OR "Myanmar"[Title/Abstract] OR "Philippines"[Title/Abstract] OR "Bhutan"[Title/Abstract] OR "Mongolia"[Title/Abstract] OR "Maldives"[Title/Abstract] OR "Malaysia"[Title/Abstract] OR "Yemen"[Title/Abstract] OR "Laos"[Title/Abstract] OR "Lebanon"[Title/Abstract] OR "Vietnam"[Title/Abstract] OR "Sri Lanka"[Title/Abstract] OR "United Arab Emirates"[Title/Abstract] OR "Singapore"[Title/Abstract] OR "Afghanistan"[Title/Abstract] OR "Azerbaijan"[Title/Abstract] OR "Armenia"[Title/Abstract] OR "India"[Title/Abstract] OR "Indonesia"[Title/Abstract] OR "Iraq"[Title/Abstract] OR "Israel"[Title/Abstract] OR "Iran"[Title/Abstract] OR "Uzbekistan"[Title/Abstract] OR "Oman"[Title/Abstract]))			

Table A2. Characteristics of included studies – Cohort Study Form

Study	Country	Setting/ context	Participant characteristics	Groups	Outcomes measured	Description of main results
1.Kurt A, Ersan E, Savas I.[22]	Turkey	Psychiatric outpatient clinics at Niğde Training and Research Hospital and its affiliated Community Mental Health Center (CMHC)	145 participants diagnosed with schizophrenia or schizoaffective disorder (DSM-5). Inclusion: at least 1 year CMHC services or regular outpatient follow-up without CMHC; no comorbid psychiatric/developmental disorders; no major physical conditions affecting function; at least 18 years; consent provided	Hospital group: 64 patients CMHC group: 81 patients	1. Self-Stigmatization Scale for Patients (SSI-P) 2. Subjective Recovery Assessment Scale (SRAS)	A statistically significant negative correlation between SSI-P and SRAS scores ($r = 0.550$; $p < 0.001$), with indicates greater self-stigma associated with lower recovery.

TableA3. Characteristics of included studies – Analytical Cross-Sectional Study Form

Study	Country	Setting/ context	Participant characteristics	Groups	Outcomes measured	Main description of results
2. Hasson-Ohayon I Mashiach-Eizenberg M.[23]	Israel	Psychiatrics rehabilitation services covering housing, employment and leisure activities	80 participants aged 22 – 66 years with schizophrenia or schizoaffective disorder	–	1. The Self-Concept Clarity Scale (SCC) 2. Internalized Stigma of Mental Illness Scale (ISMI) 3. Meaning in Life Questionnaire (LRI) 4. Recovery Assessment Scale (RAS)	Recovery was negative associated with self-stigma ($r = -.45$, $p < .001$) and positively with meaning in life ($r = .60$, $p < .001$); no significant association with self-concept clarity ($r = .11$, $p < .05$).
3. Lim M LZ.[27]	Singapore	Outpatients recruited from the Institute of Mental Health (IMH)	66 individuals diagnosed with schizophrenia or schizoaffective disorder, aged 21–65 years, fluent in English, and capable of providing informed consent. Exclusion criteria included current illicit substance use, neurological disorders, or intellectual disability.	–	1. The questionnaire about the Process of Recovery (QPR-15) 2. Positive and Negative Syndrome Scale (PANSS) 3. Calgary Depression Scale for Schizophrenia (CDSS) 4. Personal and Social Performance Scale (PSP) 5. Herth Hope Index (HHI)-abbreviated 6. Internalized Stigma of Mental Illness Scale (ISMI)-brief 7. Empowerment Scale 8. WHO Quality of Life Assessment-Brief Form (WHOQOL-BREF) 9. Ryff Scales of Well-Being	The QPR-15 showed moderate, statistically significant correlations with most psychological variables (Spearman's $rs = 0.521$–0.687), except for WHOQOL- BREF item 6 ($rs = 0.472$), which was low. Associations between the QPR-15 and clinical variables were generally significant but of low magnitude ($rs = 0.105$ to -0.544), with depressive symptoms (CDSS) being the only clinical factor demonstrating a moderate inverse correlation ($rs = -0.529$ to -0.544).
4. Mitsunaga-Ohmuro N ON.[29]	Japan	Acute care unit in three psychiatric hospitals located in Miyagi Prefecture	Thirty-four participants, of whom 33 (97%) had schizophrenia, and 1 (3%) had schizoaffective disorder	–	1. The Questionnaire about the Process of Recovery (QPR) 2. Japanese version of the Recovery Assessment Scale (RAS) 3. Self-Identified Stage of Recovery Part A (SISR-A) 4. Positive and Negative Syndrome Scale (PANSS) 5. General Self-Efficacy Scale (GSES) 6. Rosenberg Self-Esteem Scale (RSES)	Self-efficacy, as measured by the GSES, was positively correlated with QPR scores ($r = 0.49$; $p < 0.01$), indicating that higher perceived self- efficacy was associated with greater recovery process scores.

TableA3. Characteristics of included studies – Analytical Cross-Sectional Study Form (Cont.)

Study	Country	Setting/ context	Participant characteristics	Groups	Outcomes measured	Main description of results
5. İpçi K YM.[30]	Turkey	Psychiatry Outpatient Clinic of Kocaeli University Medical School	120 patients with aged ranging between 18 and 65 years of age who comprised graduates of at least primary school and comprised diagnosed with schizophrenia or schizoaffective disorder according to DSM-5 (APA 2013) and comprised in their maintenance therapy period.	–	1. Positive and Negative Syndrome Scale (PANSS) 2. Clinical Global Impression -Severity (CGI-S) 3. Global Assessment of Functioning (GAF) 4. Subjective Recovery Assessment Scale (SubRAS) 5. Internalized Stigma of Mental Illness (ISMI) Scale 6. Rosenberg Self-Esteem Scale (RSES) 7. Beck Hopelessness Scale (BHS) 8. Beck Depression Inventory (BDI) 9. Social Functioning Assessment Scale (SFAS)	Male gender associations (z=-2.697; p =.007), a schizophrenia diagnosis (z=-2.505; p= .012), and later age of onset associations (rs=-0.211; p= .021) were associated with lower subjective recovery. Hopelessness was negative predictor of recovery (B = -0.232; t = -2.473; p = 0.015), whereas self-esteem was a positive predictor (B = 0.315; t = 3.241; p = 0.002).
6. Roe D M-EM.[7]	Israel	Psychiatric rehabilitation residential centers across six large cities	159 adults (19-66 years) with schizophrenia or schizoaffective disorder	–	1. Recovery Assessment Scale (RAS) 2. Brief Psychiatric Rating Scale Expanded (Modified BPRS-E) 3. Multidimensional Scale of Perceived Social Support (MSPSS) 4. Social and Emotional Loneliness Scale—short version (S-SELAS) 5. Manchester Short Assessment of Quality Of Life (MANSA) 6. The Global Assessment Functioning Scale (GAF)	Mood symptoms showed a small negative association with recovery (RAS) (r = - 0.17; p < 0.05). Perceived social support correlated positively with recovery (r = 0.33; p < 0.001), whereas loneliness correlated negatively (r = - 0.32; p < 0.001).
7. Sari SP AM.[28]	Indonesia	psychiatric hospitals	115 adults with schizophrenia (18-60 years) who were clinically stable to complete questionnaires and able to provide informed consent; exclusions were intellectual disability/organic mental disorder and symptom exacerbation.	–	1. Calgary Depression Scale for Schizophrenia (CDSS) 2. Schizophrenia Hope Scale-9 (SHS-9) 3. Recovery Assessment Scale-revised (RAS-R)	Hope showed a strong positive association with recovery (r = 0.641, p < 0.001) and was a significant predictor (β = 0.672, p < 0.001).

TableA3. Characteristics of included studies – Analytical Cross-Sectional Study Form (Cont.)

Study	Country	Setting/ context	Participant characteristics	Groups	Outcomes measured	Main description of results
8. Young D, Cheng D, Ng P.[24]	Hong Kong, China	Four residential psychiatric halfway facilities, two sheltered workshops providing supported employment opportunities, and five community -based mental health centers	266 adults aged 18–60 years with a DSM-5 diagnosis from their medical officer and receiving services from participating NGOs	–	1. Recovery Assessment Scale (RAS) 2. Internalized Stigma of Mental Illness (ISMI) 3. Rosenberg Self-Esteem Scale (RSE)	Recovery (RAS) correlated positively with self-worth (RSE-SW) (r = 0.65, p < 0.01) and negatively with self-deprecation (RSE-SD) (r = – 0.28, p < 0.01). RAS was inversely associated with ISMI total (r=– 0.18, p < 0.01) and its subscales—shame (ISMI-Sh) (r = –0.20, p < 0.01), perceived discrimination (ISMI -Pd) (r =– 0.15, p < 0.05), and social withdrawal (ISMI-Sw) (r =– 0.18, p < 0.01).
9. Mak W, Chan R, Wong S, Lau J, Tang W, Tang A, et al.[26]	Hong Kong	Seven public specialty outpatient facilities and substance use assessment clinics located across multiple districts in Hong Kong	374 participants: mood disorders 43% (n=160), substance use disorders 33% (n=124), and psychotic disorders 24%, (n=90)	Psychotic disorders (n = 90); mood disorders (n = 160); substance use disorders (n = 124)	1. Perceived discrimination from the public 2. Perceived discrimination from health care professionals 3. Self-Stigma Scale 4. Mental health service engagement 5. Recovery Self-Assessment–Revised 6. Behavior and Symptom Identification Scale 7. Recovery Assessment Scale (RAS) 8. Recovery Markers Questionnaire (RMQ) 9. Test Life Satisfaction Scale (TLSS)	Within the psychotic – disorders subgroup (n = 90), self-stigma negatively predicted personal recovery (b = –0.37; p < 0.001), whereas service engagement (b = .32; p < 0.001) and recovery orientation of services (b = .23; p < 0.001) were positive predictors.
10.Singla N AA.[25]	India	Postgraduate Institute of Medical Education and Research, Chandigarh, (July 2014–June 2015)	100 outpatients with schizophrenia (18–65 years), illness duration ≥ 2 years, able to read Hindi/English; exclusions: organic brain syndrome and intellectual disability	–	1. Stages of Recovery Instrument (STORI) 2. Positive and Negative Syndrome Scale for Schizophrenia (PANSS) 3. Indian Disability Evaluation Assessment Scale (IDEAS) 4. Functional Social Support Questionnaire (FSSQ) 5. WHO Quality of Life-BREF	Better self-care (r = 0.35, p < 0.001) and physical health (r = 0.43, p < 0.001), and higher overall WHOQOL-BREF score (r = 0.32, p = 0.001) were associated with more advanced recovery stages (STORI). Greater internalized stigma (ISMIS total, 5 components: r = –0.48,

TableA3. Characteristics of included studies – Analytical Cross-Sectional Study Form (Cont.)

Study	Country	Setting/ context	Participant characteristics	Groups	Outcomes measured	Main description of results
					6. Ways of Coping Checklist (WCC) 7. Internalized Stigma of Mental Illness Scale 8. Scale to Assess Unawareness of Mental Disorder (SUMD) 9. Knowledge of mental illness	$p < 0.001$); excluding stigma resistance: $r = -0.48$, $p < 0.001$) and higher current unawareness of illness (SUMD total: $r = -0.28$, $p = 0.005$) were associated with lower recovery stages.
11. Chan K, Lam C.[31]	Hong Kong, China	Community -based mental health service centers managed by four nongovern-mental organizations in Hong Kong	The majority of participants (94.2%) were prescribed psychiatric medication. The primary diagnoses included psychotic disorders (46.6%), depressive disorders (41.2%), bipolar disorder (5.8%), anxiety disorders (4.5%), and other disorders (1.9%).	-	1. Level of Expressed Emotion (LEE) Sscale 2. Internalized Stigma of Mental Illness (ISMI) Scale 3. Self-Stigmatizing Thinking's Automaticity and Repetition Scale (STARS) 4. Modified Colorado Symptom Index (MCSI) 5. Specific Level of Functioning (SLOF) Scale 6. Recovery Assessment Scale (RAS) 7. Satisfaction With Life Scale (SWLS)	Both self-stigma content ($B = -0.49$; $p < 0.001$) and self-stigma process ($B = -0.29$; $p < 0.001$) were significant negative predictors of personal recovery.

Table A4. Meta-analysis: correlation

Variable for studies	studies
Variable for number of cases	Sample size
	Sample size
Variable for correlation coefficients	correlation coefficient
	correlation coefficient

Determinant factors of personal recovery SR

Study	Sample size	Correlation coefficient	95% CI	z	P	Weight (%)	
						Fixed	Random
Kurt et al.[22]	145	-0.550	-0.654 to -0.425			21.32	20.87
Hasson-Ohayon et al.[23]	80	-0.450	-0.609 to -0.256			11.56	18.27
Young D, Cheng D, Ng P.[24]	266	-0.180	-0.294 to -0.0610			39.49	22.63
Singla N AA.[25]	100	-0.483	-0.621 to -0.317			14.56	19.36
Mak W, et al.[26]	90	-0.370	-0.536 to -0.176			13.06	18.86
Total (fixed effects)	681	-0.369	-0.433 to -0.302	-9.993	< 0.001	100.00	100.00
Total (random effects)	681	-0.409	-0.549 to -0.246	-4.648	< 0.001	100.00	100.00

Test for heterogeneity

Q	21.2901
DF	4
Significance level	P = 0.0003
I^2 (inconsistency)	81.21%
95% CI for I^2	56.28 to 91.93

Publication bias

Egger's test	
Intercept	-6.0210
95% CI	-17.7290 to 5.6869
Significance level	P = 0.2002
Begg's test	
Kendall's Tau	0.0000
Significance level	P = 1.0000

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Table A5. GRADE summary of finding table

Outcome	No. of studies	Effect Size (r)	Certainty of the evidence (GRADE)	Reasons for downgrading
Association between self-stigma and personal recovery	5	-0.52 (95% CI: -0.68 to -0.35)	Moderate ●●○○	High heterogeneity (I^2 = 81%), possible publication bias

GRADE Legend: ●●●● = High; ●●●○ = Moderate; ●●○○ = Low; ●○○○ = Very Low

ปัจจัยกำหนดที่มีอิทธิพลต่อการคืนสู่สุขภาวะส่วนบุคคลของผู้ป่วยโรคจิตเภทในทวีปเอเชีย : รายงานการทบทวนอย่างเป็นระบบและการวิเคราะห์อภิมาน

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บทคัดย่อ : การคืนสู่สุขภาวะส่วนบุคคลในผู้ที่เป็นโรคจิตเภทเน้นองค์ประกอบด้านความหวัง อัตลักษณ์ ความหมายของชีวิต และการเสริมพลัง นอกเหนือจากการลดอาการทางคลินิก แม้ว่าจะมีการระบุปัจจัยทำนายหลายประการในบริบทของประเทศตะวันตก แต่หลักฐานเฉพาะในบริบทของเอเชียยังคงมีอยู่อย่างจำกัด วัตถุประสงค์: เพื่อประเมินปัจจัยที่สัมพันธ์กับการคืนสู่สุขภาวะส่วนบุคคล (personal recovery) ของผู้ที่เป็นโรคจิตเภทในบริบทของเอเชีย โดยให้ความสำคัญกับประสบการณ์ที่มีชีวิตอยู่จริงมากกว่าการหายจากอาการทางคลินิก (clinical remission) การทบทวนอย่างเป็นระบบนี้ดำเนินการตามระเบียบวิธีการทบทวนอย่างเป็นระบบของสถาบัน JBI สำหรับการทบทวนปัจจัยสาเหตุและปัจจัยเสี่ยง และโครงร่างได้ลงทะเบียนไว้ในฐานข้อมูล PROSPERO (รหัส CRD42020179623) ดำเนินการสืบค้นข้อมูลจากฐานข้อมูล 6 แหล่ง รวมถึงวรรณกรรมอื่นๆ โดยครอบคลุมงานวิจัยที่ตีพิมพ์ระหว่างปี พ.ศ. 2533–2564 ที่ศึกษาปัจจัยที่สัมพันธ์กับการคืนสู่สุขภาวะส่วนบุคคลในผู้ที่เป็นโรคจิตเภท ผู้ประเมิน 2 คน ดำเนินการคัดเลือก ประเมินคุณภาพ และรวบรวมข้อมูลอย่างเป็นอิสระ การวิเคราะห์อภิมาน (meta-analysis) ดำเนินการโดยใช้โปรแกรม MedCalc Statistical Software

ผลการศึกษาพบว่า จากบทความทั้งหมด 2,285 เรื่อง มีงานวิจัยคุณภาพสูงจำนวน 11 เรื่องที่เข้าเกณฑ์ (5 เรื่องใช้ในการวิเคราะห์อภิมาน และ 6 เรื่องใช้ในการสังเคราะห์เชิงพรรณนา) การวิเคราะห์อภิมานพบความสัมพันธ์เชิงลบระดับปานกลางอย่างมีนัยสำคัญระหว่างการตีตราตนเองกับการคืนสู่สุขภาวะส่วนบุคคล (ค่าสหสัมพันธ์รวม = -0.409; 95% CI = -0.549 ถึง -0.246; n = 681) การสังเคราะห์เชิงพรรณนาพบปัจจัยทางคลินิกเป็นอุปสรรคต่อการคืนสู่สุขภาวะส่วนบุคคล ขณะที่ปัจจัยทางจิตวิทยามีบทบาทในการส่งเสริมการคืนสู่สุขภาวะส่วนบุคคล โดย “ความหวัง” แสดงอิทธิพลเชิงปกป้องสูงสุด (r = 0.641) รองลงมาคือความเชื่อมั่นในตนเอง และการเห็นคุณค่าในตนเอง การสนับสนุนทางสังคมช่วยส่งเสริมการคืนสู่สุขภาวะส่วนบุคคล ขณะที่ความรู้สึกโดดเดี่ยวเป็นอุปสรรคสำคัญในการคืนสู่สุขภาวะส่วนบุคคล ด้านคุณลักษณะประชากรที่สัมพันธ์กับผลลัพธ์ที่แย่ลง ได้แก่ เพศชาย และอายุเริ่มป่วยที่มากกว่า โดยสรุป การส่งเสริมการคืนสู่สุขภาวะส่วนบุคคลในผู้ที่เป็นโรคจิตเภทจำเป็นต้องใช้กลยุทธ์แบบบูรณาการในหลายมิติ โดยเน้นการปลูกความหวัง การลดการตีตรา การสร้างเครือข่ายสังคม และการจัดการอาการทางคลินิก ผลการศึกษานี้เสนอประเด็นสำคัญตามหลักฐานเชิงประจักษ์สำหรับการพัฒนาการดูแลในรูปแบบที่เน้นการคืนสู่สุขภาวะส่วนบุคคลในบริบทของเอเชีย อย่างไรก็ตาม ยังมีข้อจำกัดด้านความหลากหลายของงานวิจัยที่คัดเข้า และการดำเนินงานวิจัยแบบภาคตัดขวาง การวิจัยในอนาคตควรพัฒนาและประเมินผลการให้การช่วยเหลือที่สอดคล้องกับบริบททางวัฒนธรรม และการดำเนินวิจัยแบบติดตามระยะยาวเพื่อชี้ให้เห็นความเป็นเหตุและผลของปัจจัยได้ชัดเจนยิ่งขึ้น

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