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FACTORS, PROCESS AND OUTCOMES OF RECOVERY FROM PSYCHIATRIC DISABILITY: THE UNITY MODEL

LI-YU SONG & CHAIW-YI SHIH

ABSTRACT

Background: Despite the fruitful findings on related issues of recovery in the West, some researchers have called for more studies on the factors that facilitate recovery and international literature on recovery to be made available. Moreover, to date, a united model that integrates outcome, component process and contextual factors of recovery has not yet been developed. Thus, this study explored the recovery experiences of persons with psychiatric disabilities (hereinafter called consumers) in Taiwan and extracted the key facilitators for developing a preliminary unity theory of recovery.

Material: In-depth qualitative interviews of 15 consumers in recovery and their caregivers were held. Over a research period of two years, consumers were interviewed twice. The dialogue of each interview was transcribed into text and a narrative summary of the storyline for each participant was also prepared.

Discussion: For most consumers, the journey of recovery was an incremental process of progress, yet few of them mentioned a turning point and its significant change on their life. Regaining social roles seemed to be a necessary but not sufficient outcome indicator for recovery. While symptom remission, mental strength and parental support were the cornerstones for recovery, the treatment model and professionals got the credit for it too.

Conclusion: The recovery process occurs within a complex context of various stages and multi-facilitators. The forces of three cornerstones, essential components and contextual facilitators all influx into the river of recovery and emerge as one united mechanism that supports the consumer's spiral progress through the journey of striving for autonomy.

INTRODUCTION

During the last few decades, the perspective of recovery has been widely accepted as the major treatment orientation in the field of mental illness (Turner-Crowson & Wallcraft, 2002). Through the empowerment movement and the voices of those who had recovered from the results of longitudinal follow-up studies (e.g. Deegan, 1988; Leete, 1989; DeSisto *et al*., 1999), the consumers were perceived as having great potential to improve their function in daily living, overcome disabilities and live a fulfilling life with or without psychiatric symptoms. Liberman & Kopelowicz (2002) proclaimed that as we move into the 21st century, a 50% recovery rate for persons with schizophrenia

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should be within reach, if we know what the efficacious paths to recovery are and how they can be made available to the consumers.

Since the inception of the vision of recovery for mental health in the 1990s (Anthony *et al*., 2002), the definition and outcomes, the themes and components process, and the stages and mechanism of recovery have drawn a lot of attention in the West. The review by Andersen and colleagues (2003) also showed that significant progress had been made in many aspects of recovery. Yet, Ridgway (2001) and Carpenter (2002) still called for more and further research on the recovery process and the other influential factors that could promote recovery. Besides, it seems that until now no unity model could cover the entire structure and component process of recovery that has been developed. Therefore, the current authors tried to propose an integrated and comprehensive model of recovery that could serve as a theoretical framework for research and the development of intervention strategies.

Recovery is a complex process. As Jenkins and Carpenter-Song (2006) argued, since recovery had been occurring in such a context of interlocking personal, cultural, social and pharmacological causes and effects, the subtle and unique cultural influences should be particularly emphasized. Upon a cultural comparison on recovery, Stanhope (2002) attributed the better outcome of consumers in India than in the US to the traditional Indian cultural emphasis on interdependence, externalized locus of control (fate) and family involvement. Such a finding implies that the wisdoms emerging from recovery experiences of consumers in different countries need to be sincerely respected and documented, and it is hoped that a heuristic or meaningful vision and useful intervention strategies of recovery can be drawn or adopted from these experiences (Turner-Crowson & Wallcraft, 2002). Therefore, this study aimed to gather the text of personal narratives as well as interpret the nature and meanings of those who had been living through the process of recovery in Taiwan. To date there has been only one introductory article of recovery presented in a Taiwanese academic journal (Song, 2005); the present authors purported to promote a recovery paradigm by revealing the successful experiences of recovered consumers, and tried to develop an integrated model of recovery for future research and practice. Specifically, this study had three aims:

1. To explore important components and contextual factors and outcome indicators appearing in the recovery process of the consumers in Taiwan
2. To understand the nature and meanings of and relationships among the factors and indicators.
3. To construct a preliminary unity model (or theoretical framework) of recovery.

METHOD

A qualitative approach through in-depth interviews was adopted to capture the thorough experiences and the common nature of the recovery process and outcomes of the participants. Thereby the essences and the meanings of the holistic unity and complete structure, as well as the core mechanism, the stages and the contextual factors, of the complex phenomenon of recovery could be described, analyzed and interpreted (Moustakas, 1994; Wolcott, 1994; Coffey & Atkinson, 1996).

Participants

Purposive sampling (Lincoln & Guba, 1985) was adopted using four criteria for recruiting potential participants: (1) being hospitalized at least once; (2) currently taking actions toward a clear goal of

restoring their life again; (3) regular social participation; and (4) not being hospitalized during the past year. Potential participants who were regarded as 'being in recovery' were selected through the recommendation of professionals in mental health agencies around the country in Taiwan. By adopting the 'theoretical sampling' strategy (Strauss & Corbin, 1990), the size of the sample was dependent upon whether the data about the experience of recovery appeared to be saturated and comprehensive enough to construct the theoretical framework of a unity model. Caregivers of the participants were also interviewed to provide complementary information and to serve as a triangulation device for validating data credibility (Lincoln & Guba, 1985). To examine the stability of each participant's functional status and stage of recovery, a second interview was conducted one year later that also served as the 'prolonged engage' strategy (Lincoln & Guba, 1985) to increase data credibility. Thus, a total of 19 participants and 11 caregivers were interviewed the first time, and 15 participants completed the second interview. The sample profile of 15 participants is presented in Table 1.

Instruments and procedures

The empathetic and rapport relationship with the participants was established through initial contact to explain the purpose of this study and to reach a written agreement of their participation. The time and place of interviews were mainly based on each participant's own choice. The full content of the interviews was recorded. A semi-structured interview guideline was used and an extra copy was prepared for the participants. The second interviews took place one year later and

Table 1
Background information of consumers in this study

Label	Sex	Age	Education	Marital status	Age of onset	No. of hospitalizations	Caregiver interviewed
F1	M	24	High school	Single	22	1	Yes (T21)
F2	M	32	College	Single	19	1	Yes (C21)
F3	M	46	College	Married	21	1	Yes (C31)
F4	F	22	College	Single	16	1	Yes (C61)
S1	M	35	College	Single	28	1	Yes (T31)
S2	M	41	College	Married	14	28	Yes (T41)
S3	M	40	Master	Single	20	1	Rejected
S4	F	39	College	Single	32	1	Yes (H11)
S5	M	33	College	Single	24	7	Rejected
S6	M	25	High school	Single	18	1	Rejected
N1	M	32	High school	Single	18	0	Rejected
N2	F	25	High school	Single	16	2	Yes (T91)
N3	F	29	High school	Single	19	1	Rejected
N4	M	43	Junior high school	Single	18	7	Rejected
N5	F	21	Junior high school	Single	13	0	Yes (Y11)
T1	F	34	College	Married	21	10	Yes (T11)
T2	F	26	High school	Single	21	0	Rejected
T3	M	46	Elementary	Separated	41	1	Rejected
T4	M	25	High School	Single	17	–	Yes (C11)

F: Full recovery; S: semi-recovery; N: novitiate recovery; T: not interviewed the second time

were conducted by phone. The content of the interviews comprised three parts: outcomes of recovery (current functional status, coping strategies, attitudes and appraisals on life situation, as well as current symptoms and effects of medication); process components (essential constituents for changes between past and present, and turning point); and contextual factors (the various facilitators for change).

Data analysis

Each interview was transcribed into a dialogic text and a narrative summary of each participant's life story, in accord with the major themes of recovery, was formulated. The above two texts were sent to each participant for a personal check that confirmed both credibility and dependability of basic data description and analysis (Lincoln & Guba, 1985). The procedure of data analysis began with open coding and conceptual labelling. All the facilitating and contextual factors of the process and outcomes of recovery were identified and classified into various categories and dimensions. The basic concepts grounded from initial codes were completed by two research assistants and then further reviewed and revised by the authors for 'member checking' its dependability (Lincoln & Guba, 1985). Then the themes or patterns of different coping strategies and multi-functional status at various recovery stages were further compared and analyzed. Finally, a conceptual framework was constructed that integrated the stages and outcomes, cornerstones, components and the context of the phenomenon of recovery into a synthesis of various constituents as a whole (Miles & Huberman, 1994; Moustakas, 1994; Wolcott, 1994; Coffey & Atkinson, 1996).

RESULTS

Outcomes, stages and turning points of the recovery process

Based upon both the subjective, cognitive evaluation of the protagonists and the objective tasks of daily living they performed, the multiple functional status of the protagonists' recovered life had been generally explored, upon which outcome indicators were identified (Figure 1), including self-efficacy, support with intimate family relationships, etc. The core of the recovery process that emerged from the above indicators was *striving for autonomy of life domains in mental and social aspects*. The autonomy of life domains was further demonstrated by two basic life functions: i.e. independence and competence. *The concept of independence* indicates the extent to which the protagonists could have alternative choices and free decisions over the various life aspects, by which they could enjoy mastery and satisfaction in adjusting the role of self to the context of their life world. *The function of competence* refers to efficacy and achievement in performing the fundamental life tasks of self-care and care for others in the different parts of their personal social networks, upon which they could hope for a better life and a greater quality of life. The idea of functional status was extracted to capture the dual nature of outcome indicators, which represented the interaction of the subjective force of inner self to the objective tasks of the external environment of the protagonists.

Based on the different functional statuses of the 15 protagonists, three distinct functional stages were identified. Five protagonists (N1 to N5) who had been 'struggling with the disability' were classified into Group I and named as *novitiate recovery,* just like a crescent moon beginning to light up the sky, or a child who has begun to learn to take care of himself with the assistance of

others. Six protagonists (S1 to S6) who appeared to be 'living with the disability' were sorted as Group II, *semi-recovery*, like a half moon with its evident existence, or a youth who can enjoy the benefits of self-care. The Group III of four protagonists (F1 to F4) who were regarded as 'living beyond the disability' had entered the third stage of *full recovery,* like a full moon achieving a complete entity or an adult who can take care of both self and others. This sole finding of three recovery stages is mostly in accord with the results proposed by Davidson and Strauss (1992) and Spaniol *et al*. (2002).

Novitiate recovery – struggling with the disability (Group I)

The members of this group described the beginning experience of recovery as they 'once felt like a normal person', yet relapsed after the first interview because they stopped taking medications due to annoying side effects. Under family, social and professional support, they actively participated in job training or activities, and learning living skills and interests that were helpful for personal growth. They were anxious for an independent self and life. However, they seemed to have no significant competence or persistent control over either themselves or their life situations. They were more or less unsatisfied with their present life and felt hesitant and uncertain of pursuing their life goals.

> 'I did change jobs all the time. Now I am a saleswoman in a dress shop. But *I don't think I fit it well*. It seems that being in a rush has made me feel stressed, and *I couldn't make a sale [or a living] in the right way*.' (N2)

Semi-recovery – living with the disability (Group II)

Those who were living with the disability had already begun their new roles in many aspects. And yet, sometimes the negative social impacts of the disease still bothered them. They were happy and capable in most aspects of life but looked forward to a more stable, promising full-time job and a more understanding and rewarding interpersonal relationship with other people. In short, they were happy and satisfied with life, yet aware of not being in total control of all their life aspects; thus, they could not help but worry about the future.

> 'I can tell you that I am happy and yet feel really tired. Ever since the onset of the disease when I was 20 years old, *I have been fighting against it*. The most tiring fact is the continuity of the negative impacts of the disease. …. It seems to never end. I might not get a job, plus the social responsibilities, social expectations …; *I cannot let go of these thoughts (or worries)*.' (S3)

Full recovery – living beyond the disability (Group III)

Those who were able to live beyond the disability could enjoy a normal life and perform successful social roles and functions. Their symptoms of disease were well controlled. They had a high sense of self-efficacy and could pursue major life goals with full confidence, resolution and dedication. Moreover, some of them could even transcend themselves by being willing to help others with psychiatric disabilities or by actively participating in advocacy for the consumers. One thing worth noting is that most of them did perform a contributing role to their social networks and successfully maintained the mutually beneficial relationship with the other members of the networks.

> 'I would like to help other persons with psychiatric disabilities to recovery and live a better life. I hope that *I could help others solve their problems instead of being a troublemaker*.' (F3)

Turning point

Only four (N2, S2, S4 & S6) of the protagonists mentioned that there had been a turning point in their personal recovery experience. The turning point showed that the protagonists had a dramatic or fundamental change in their life attitude toward recovery. This significant change was also based on a strong sense of self-awareness, or as Davidson & Strauss (1992) termed it 'discovering a more active self', that brought the protagonists to face the very existence of their life. At this moment they suddenly became free men who could be masters of themselves and make choices in their lives. Then they decided to commit themselves to a life promise of both discovering their unlimited potential and taking responsibility for their existence. Upon such a life promise, they began to dedicate themselves to as many useful and meaningful life roles as possible for both themselves and for those people who loved them. The protagonists told their life stories about the turning points in recovery as follows.

- *Touched by parental love*. N2 and S4 were deeply touched by their parents' perseverance in caring for them, no matter how many times they were in and out of hospital. The unconditional love of their parents induced in them the desire to get better.
- *Inspired by religious influences.* For example, the warm atmosphere of religious gathering and humane care of church members made S4 feel as if they were genuinely concerned, which facilitated her continuing progress in the journey of recovery.
- *Responsibility related to marriage*. S2 admitted that after getting married and having an intimate relationship with his wife, for the first time in his life he was clearly aware of his sense of social responsibility.
- *Motivated by medical professionals.* S6 mentioned that his psychiatrist told him that his disease might be cured given the advancement of psychiatric medications in the near future. Such a hopeful vision from a professional infused zeal and courage into his life. Thus, he complied with his medication, which helped him smoothly accomplish progress in other life aspects.

Cornerstones and essential components of recovery

Three cornerstones

The recovered self, just like any other normal human life, had been built upon three basic cornerstones of biological, psychological and social systems. The three respective cornerstones that emerged from this study coexist like a triangle and its three angles – lose even one and the entity (recovery) no longer exists. Upon these cornerstones the protagonists can both construct a larger external structure and components of their recovered self, and elaborate the better internal furnishings and elements of informal and formal social networks in their life world.

Symptom remission or gaining control. Having insight into the disability as well as the side effects of the medication seemed to be the first step in the recovery process. Either symptoms of disease or side effects of medication would blur the protagonists' sense of self, which caused a deterrence in the progress of recovery. Thus, having symptoms of remission or developing effective coping strategies for side effects of medication appeared to be the necessary biological foundation for recovery. For the novices of N2 and N4, the unpleasant side effects of medication made them stop taking it from time to time, and soon after that they inevitably relapsed. For the protagonists of semi- or full recovery, not only was there no serious problem in compliance with taking medications but the medications had been working well for them. For example, S3's account showed the importance of symptom control.

> 'I knew that someday my disease would be cured, and I had the hope for a new life. I had been actively taking medications as if I were closer to the goal of becoming a normal person as each day passed by.' (S3)

Mental strengths: self-reliance, hardiness and resilience. Obviously, without these mental strengths the protagonists could not constantly ignite their willingness to recover, persistently take actions in achieving their goals, and continually strive for a better life for themselves and for other people. Almost all members of Groups II and III demonstrated such strengths in their recovery. Not surprisingly, mottos such as 'always having the courage to face challenges of life' and 'never giving up' showed their positive mentality or life attitude of hardiness, resilience and self-reliance. For example, S3 had also demonstrated his determination to recover by the following expression.

> 'I always give myself a chance even when facing the most helpless and hopeless situation. I always see hope in my life, the never-ending hope. That is why I can recover again and again. … Yeah, I would fight for it until the last breath.' (S3)

Family support. Almost every participant mentioned the importance of family support to recovery, especially the support of parents, and predominantly from the mother. They usually said: 'My mother (and/or father) never gave up on me'. Family support seemed to be instrumental, affectionate and informative in helping the protagonists repeatedly overcome the symptoms, mental weakness and social obstacles in the recovery process, and everlastingly induced faith and hope for them to pursue a better life. For example, F3 recalled how his mother supported him:

> 'My recovery mainly depends on my mother's perseverance in taking care of me. She never gave up on me. *Whenever I straggled or stumbled along the way of recovery, my mother would pull me up and encourage me to move on*. I was so lucky to have my mother accompany me. I would not know what to do without her.' (F3)

Essential components

The reconstruction of the protagonists' mental structure and social networks depends on three essential components. Like concrete is mixed with the three essential ingredients of stone, sand and cement, the recovery process could not exist without its three essential components. However, since awareness of the existence of self urging the transformation of oneself serves as the core of the circular recovery process, this insightful awareness also plays the role of *water* that can circulate and cement every life aspect of the protagonists into a solid and whole entity. Thus, the following three components appear to be the necessary ingredients for the reconstruction of a recovered self and its life world.

Sense of self and internal control. When the protagonists began to sense what they wanted and to realize that they could make choices for their life goals and try to take action, they regained the magic touch with their 'self', and vice versa. Surprisingly, to experience the sense of self is also to take control over oneself, by which the protagonists began to acquire internal control of life. Such personal experiences of autonomy made the protagonists believe that they were normal again. Based on the functional status of self proposed by Davidson & Strauss (1992), the novitiate or semi-recovered protagonists had reached the levels of 'taking stock of oneself' and 'putting the self into action', while only the fully recovered ones could reach the ultimate level of 'appealing

to self'. For example, F2 said: 'I know I am improving. I am capable of doing things, although not as good as what I used to be [before onset]. I can handle things without problems'. For recovered novices, they had been working very hard to improve themselves and their life situations. Yet part of their self was still shadowed by the disability; thus, their autonomy was restrained.

Management of the disability. Most protagonists said that they could accept the disability and had made tremendous efforts in coping with it. Multiple coping strategies had been adopted by different recovered group members. The fully recovered protagonists were able to detect the warning signs of their symptoms and return to professional help, and further to appeal to self potentials and strengths and engage mutual help with their personal social network. For example, F2 said: 'Since my brain is damaged, I have to work harder. If my classmates study one time, then I must study four or five times'. The various and multiple coping strategies adopted proved to be effective. However, the extent of the effectiveness in managing the disability seemed varied by the degree of sense of self, internal control and mental strengths of the protagonists, more than by the types of coping strategies adopted.

Hope, willingness and action. Deegan (1988) stressed the importance of hope, willingness and action for life goals on recovery. Once the protagonists were aware of self-existence, they began to accept themselves and other people, and to have hope for purpose and meaning in life. They would even learn to find and establish their own life goals, and most of them could work deliberately throughout their life for a greater self and a better world. The fully recovered protagonists had clear and promising goals for their lives. The semi-recovered might only set up a general goal for independence in their lives and further inclusion with the community. For example, S3 stated: 'I want to do my best to be normal, and go back to the mainstream of society'. The novices only looked forward to being treated better (N5), having an intimate relationship (N3 & N4), and improving self-image and social relations (N2).

Social network factors

Nine facilitators were extracted in the environment that helped to consolidate the three cornerstones and strengthen the essential components of recovered life. The facilitators from social networks are described briefly as below.

Facilitators from informal networks

Intimate relationships. Those protagonists (F1, F3 & S2) who had an intimate relationship admitted that it played an important role in the recovery process. S2's mother commented that marriage increased his commitment to taking responsibility. F1's mother said: 'I think that their relationship is good for them. When his girlfriend feels stressed, he encourages her and listens to her and they solve the problem together'.

Reciprocal friendships. Friendship means acceptance from others; this could boost a person's self-esteem and recreational activities that friends do together enrich people's lives. Moreover, friends could provide good advice for coping with the disability. As N2 said: 'I have a friend, a best friend. … She knew when I was going to relapse and sent me to the emergency room... She did not despise me a bit'.

Supportive neighborhood. Acceptance, kind manners and friendly support of neighbours could help the protagonists to reintegrate into the community. For example, S4 was warmly accepted by most neighbours who had true concern for her.

Religious fraternity. Religion could help the protagonists toward recovery in many ways. First, religious fraternity provided an unconditional channel to social activities and acceptance

(S4 & N4). Second, the religious teaching could help a person calm the mind, awaken the soul and enrich the spirit (F3, F4 & N1). Third, the hymns and worship could give a person peace, strength and a touch of human existence (S4). Fourth, prayers and meditation could help people empower them-selves to face adversity bravely.

Facilitators from formal networks

Support in the workplace. About half of the protagonists (F1, F3, S2, S6, N1, N4 & N5) said that the workmates who they had met in the shelter workhouse or at work helped them expand their life domains as well as increase life satisfaction. For example, F1 said: 'It [the shelter workhouse] is good because I can meet lots of friends. I am bored at home. I have been happier since I got here'.

Job opportunity and work recognition. By being given job opportunities, the protagonists had a stage on which to demonstrate the role of an able worker, a productive person and a respectable citizen. The work role could enhance both the sense of self and social participation of the protagonists. For example, almost every time F3 submitted a CV, he could get the job he wanted. He regarded himself as a person with productivity and a willingness to work hard; something that had won him the respect of his neighbours.

Help from medical professionals. Most protagonists were thankful for the medical professionals who gave help that they regarded as crucial in facilitating recovery. The types of help included: (1) *patience*, *caring, encouragement and emotional support* – they had taken care of them like a family member; (2) *empathy, trust and respect* in discussing issues, which enhanced the sense of self and internal control; (3) *adequate and effective advice and services*, which increased strength and competence in coping with life stress; and (4) *instilling hope for recovery*, which helped the participants explore new frontiers for life autonomy.

Treatment model. F2 had experienced two very different treatment models in two hospitals. The first one was traditional and had been too conservative and cautious to allow the participants to take any adventurous steps toward independence. He thought that such an orientation of treatment had delayed his progress in recovery. The second one made him feel better and get recovery finally. The staff at the second hospital valued human service and the core content of service or training was focused on basic abilities in performing the activities of daily living, including self-care and recreation. S3 advocated a complete recovery-orientated model for participants in the future:

> 'Strictly speaking, until now many medical professionals have not really emphasized recovery. I think that we should let them see the importance of this approach. Many professionals do not truly believe that there is always hope for us. …. Each individual of us has different needs, and giving more choices is good for us. … For us, the ultimate goal is to recover.' (S3)

Welfare subsidy. Welfare subsidy could ease the financial pressure of consumers and increase the possibility for them to re-enter the community. For example, S4's psychiatrist helped her apply for welfare subsidy so that she could get financial assistance in receiving psychiatric services.

Unity model of recovery: the core mechanism of autonomy that unites all

The *core of the recovery mechanism* found in this study was *striving for autonomy over life domains in mental and social aspects*. The autonomy over life domains was further demonstrated by two basic life functions of independence and competence. The unity model of recovery as the entire framework of the recovery process (Figure 1) is first represented by various types of the functional

status of autonomy in three stages, as well as the turning points for the journey of the spiral progress of recovery, which indicates the major milestones in the entire voyage of the discovery of self. Second, three cornerstones found in this study are holistic and integrate the biological, psychological and social systems of a recovered person. These cornerstones are the sea on which the vessel of self-discovery can sail on the voyage of recovery. Third, the component indicators, which include

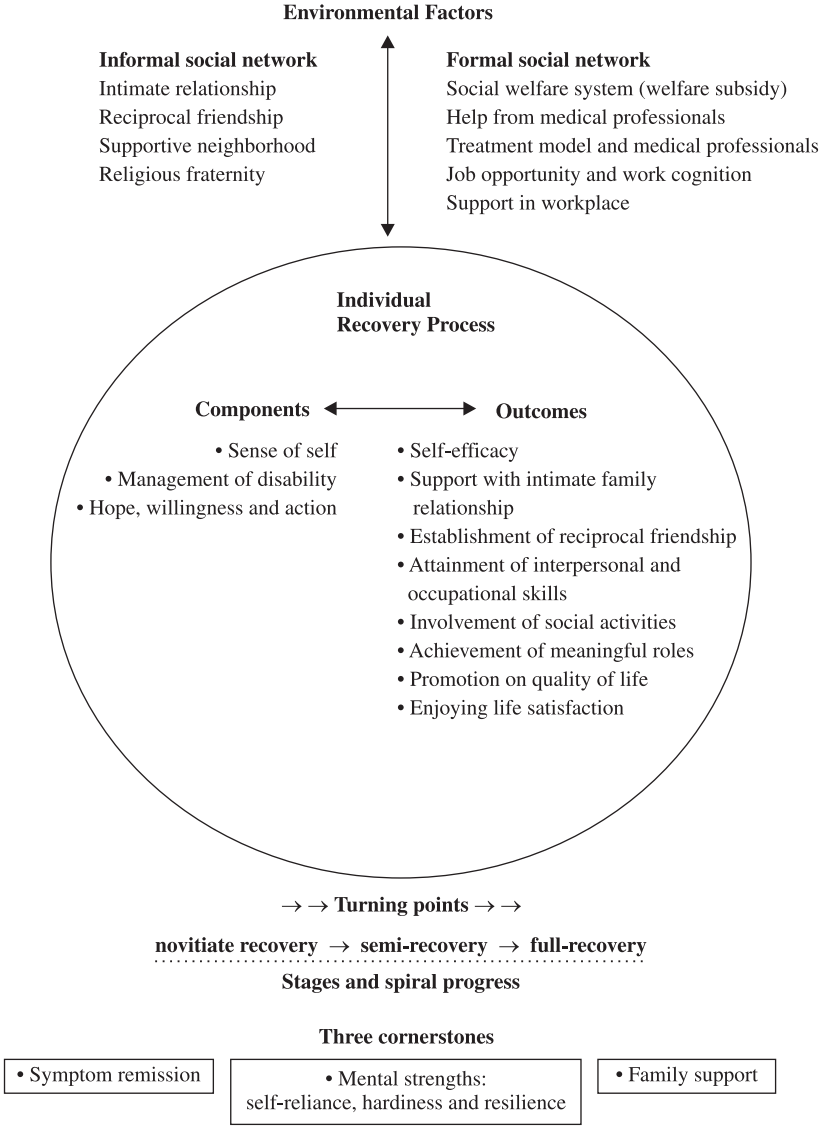

Figure 1. Unity Model of Recovery – striving for autonomy over life domain

awareness of self as well as the buffer effect on symptoms and the main effect on growth of self, are the skeleton of the vessel of recovered life; while the outcome indicators of self-realization and social achievement are the necessary fuel and stock to supply the vessel to continue the voyage of recovery. Fourth, the environmental factors are the supplies and surplus goods for a never-ending voyage of recovery by mutual beneficiary exchange with the informal and formal networks in the entire ecological system.

DISCUSSIONS AND IMPLICATIONS

The significance of social role in recovery

Andersen *et al*.'s review (2003) did not confine the definition of recovery as acquiring externally valued roles. Nevertheless, all of the protagonists in this study had strived very hard to re-enter into the community and, at last, to have a capable social role. Achieving better quality of life and greater life satisfaction seemed to be related to the awareness of their fitness with and vitality of the social role that the protagonists could play in their social networks, and the meaning and value endowed to the roles by their recovered self. Therefore, simply being able to acquire a social role was the necessary outcome criteria for the protagonists who were considered recovered, and the extent of how independent and competent a social role they could demonstrate was the significant outcome indicator.

The meaning of turning point for recovery

As suggested in the literature (Jenkins & Carpenter-Song, 2006), many protagonists in this study experienced recovery as an incremental process. Yet, four protagonists in this study mentioned that there had been a turning point for recovery that brought them a significant and fundamental change in their lives. At the moment when they had been deeply touched or genuinely moved by any force of parental love etc, a strong awareness of the existence of self and strength emerged from inside themselves. Thus, the force of care and love from the significant others in the protagonists' personal social network could bring hope, faith and a cause for them, which helped to reframe the life script of their destined role in the world.

The importance of three cornerstones of recovery

As Roe *et al*. (2007) mentioned that symptoms of the disease and its negative effects could not be carelessly neglected or intentionally avoided. Those who were semi- or fully recovered had developed effective coping strategies in managing symptoms, and utilized sufficient personal mental strength, social support and professional assistance in buffering the negative impact of symptoms; thus, they could enjoy a normal and better life.

Parents had practised an indispensable obligation in taking care of the protagonists in Taiwan. It is a Chinese cultural expectation for parents to always look after their offspring, even after their children have reached adulthood, and especially not to abandon any family suffering from a disability. This seems to be the common cultural strength among Asian countries as mentioned by Stanhope (2002). However, it does not imply that the future cohorts of the consumers' parents in Taiwan are willing to carry on such an obligation under the impact of the new modern ideology of individualism. Chinese society certainly should wisely cherish, utilize and cultivate such a particular strength of family support, and cautiously keep this family force from being overused or

risking burnout. Nevertheless, Jenkins & Carpenter-Song (2006) observed that since social support had been working as a reciprocal process, almost all of the protagonists in this study maintained good relationships with their parents. It was also rewarding for parents to witness the growth and progress of their children's recovery from disability.

As the mental strength of the protagonists also played an important mediator in the recovery process, professionals could take it into thoughtful assessment and utilization for preparing and carrying out a plan of recovery. In addition, the multiple supports of the protagonists' social networks could be carefully utilized to interact and thereby increase the force of their mental strength.

Credits of treatment model and professionals

There is a lack of research that has examined whether the various treatment models and professional roles have been the effective or influential facilitators for consumers' recovery. In this study, the consumers in Taiwan accredited both the treatment models and psychiatric professionals as important facilitators to their recovery. This finding supports the viewpoints of Coursey *et al*. (2000) and Russinova (1999) that professionals' attitudes have critical effects on recovery outcomes. The treatment model and services that Taiwanese consumers preferred were recovery-orientated. Therefore, the values and principles of psychiatric rehabilitation proposed by Anthony *et al*. (2002) and Cnaan *et al*. (1990) could be employed to guide the design of such treatment models. Professionals could deliberately infuse consumers with hope for life and faith in self during rehabilitation in order to help them find potential strength to enhance their multiple functional outcomes.

Strengths and limitations of the study

This study is the first report on the consumers' accounts of their recovery in Taiwan. The authors' understanding of and insight into the phenomenon of recovery were not only based on the protagonists' personal stories, but were inspired by field experience in community rehabilitation programmes with the consumers. Since the process and outcome of recovery had always been too complex and profound, the content of various multiple functional statuses at different stages might not be completely explored due to the unsaturated narratives of the protagonists or limited subjects. In addition, the findings could not differentiate the coping strategies used regularly or adopted particularly at various stages by the protagonists of the three recovery groups. These two limitations of this study need further exploration in a future study.

Through the construction of a unity model, the core mechanism of recovery has been theoretically explained and practically described. Hopefully, such a unity model could inspire more consumers and professionals to discover greater strength and support from oneself and one's environment in planning and fulfilling the mission of recovery.

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Li-Yu Song, PhD, Professor, Graduate Institute of Social Administration and Social Work, National Cheng Chi University, Taiwan, ROC.

Chaiw-Yi Shih, PhD, Associate Professor, Department of Social Policy and Social Work, National Chi Nan University, Taiwan, ROC.

Correspondence to: liyusong@ncnu.edu.tw