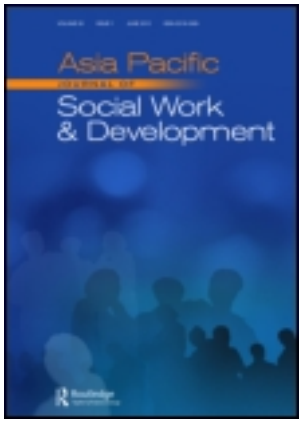

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Implementing a strengths-based model in facilitating the recovery of people with psychiatric disability

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There has long been a lack of recovery-oriented programs in Taiwan. The investigators launched the first program of this kind and applied the strengths perspective as the intervention model to facilitate the recovery of people with persistent psychiatric disability for two years. This study aimed to explore the attitudes towards and enactment of case managers on the application of the model. To fully understand the case managers' experiences, a qualitative approach with an in-depth interview was adopted. The interview was conducted twice with 10 case managers. The first time was three months after the program began and the second was one year after. The questions included their prior practice model, their thoughts about the strengths model, the changes in attitudes, their enactment of the principles of the model, the specific skills utilised, the impacts of the model on themselves and their organisation, the difficulties encountered and their coping methods. The transformation of practice modality took place incrementally, from pathology to a strengths and recovery-oriented mindset, from alienation to trusting and partnership, from directive to client self-determination, from being anxious to being flexible and patient, and from a single approach to a plural one. The investigators classified the case managers into four categories based on four aspects, i.e. belief, knowledge, enactment of the principles, and skills. The findings reveal that the belief system that case managers hold is critical. When they can fully embrace and internalise the perspective, they will practice efficiently. However, sometimes the belief and enactment are challenged and affected by external constraints. Therefore, the application appeared to be a bittersweet process for them and was filled with both successful stories and difficulties. The transformation of modality from pathology to strengths oriented is possible. Both system change and persistent application of this model are necessary for its future growth and development.

Keywords: recovery; strengths perspective; psychiatric disability; attitudes; enactment

Introduction

The field of psychiatric rehabilitation has entered into an era of recovery since 1990. In the west, recovery has been widely accepted as a service and treatment orientation. Recovery-orientated rehabilitation involves shifting the focus from illness and symptom control to a holistic view of the person and wellness, from pathology and deficit to strengths and potentiality (Amering, 2012; Anthony, Cohen, Farkas, & Gagne, 2002). In accord with this orientation, the components of service include self-direction, individualised and person-centred, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility and hope (Substance Abuse and Mental Health Services Administration [SAMHSA], 2005).

According to Probst (2009), these values and guiding principles share many themes with the strengths perspective, such as (a) building a healthy identity – not allowing

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problems to take on 'master status' but instead viewing strengths and positive aspects (e.g. talents, competencies, hopes, interests, etc.) as equally fundamental to the entity of self; (b) emphasising a natural support system and resources in the community; and (c) fostering connectedness, membership and participation. Additionally, the alignment between recovery and the strengths perspective is also on stressing empowerment, self-determination and partnership. Thus, the strengths perspective can be built into the case management model and can serve as the strategy to facilitate recovery.

Strengths-based case management (hereafter called the strengths model) has been utilised in psychiatric rehabilitation for about 30 years (Rapp, 1998; Saleebey, 2009). Marty, Rapp, and Carlson (2001) reviewed eight evaluation studies of the strengths model and found that this model could result in positive outcomes in decreasing hospitalisation, enhancing quality of life or social functioning, and increasing social support. Given its effectiveness, however, this model has not been systematically utilised in rehabilitation for consumers in Taiwan. The deficit model and problem solving were the predominant approaches held by the professionals. Thus, the investigators have conducted a study to evaluate how the strengths model could facilitate recovery for two years. It was an endeavor to promote both the recovery-oriented services and the strengths model.

Within this study, the investigators also explored how the professionals reacted to the strengths model, since both recovery orientation and the strengths perspective require mental health professionals to make substantial changes in attitudes and knowledge in services, such as being less formal in their professional roles and being able to manage their own anxiety when consumers take risks, and to respect their wants and decisions (Cleary & Dowling, 2009; Schrank & Slade, 2007). As Sowers (2005, p. 770) has argued, the professional role 'will become facilitative rather than directive in nature, hope inspiring rather than pessimistic, and autonomy enhancing rather than paternalistic'. Thus, the focus of this paper is to depict the case managers' attitudes towards this model and the extent of enactment on the principles through analysing the narratives of the professionals who participated in the study.

Professionals' attitudes towards consumers and recovery

The field of recovery-oriented rehabilitation is about interactions between people. Based on the consumers' point of view, the most critical facilitator or barrier to their recovery is how people interact with them (Farkas, Gagne, Anthony, & Chamberlin, 2005). Mental health professionals serve as role models and opinion providers with respect to their clients' symptoms management and daily life issues. They are also the ones whom consumers will encounter at their most vulnerable points and on whom they will rely for instrumental and expressive support (Wahl & Aroesty-Cohen, 2010). However, professionals' attitudes toward consumers are not all positive. Both the review by Schulze (2007) and the one by Wahl and Aroesty-Cohen (2010) revealed a mixture of positive and negative views. Many professionals held the view that mental health service consumers are dangerous, which is same as the public's belief. In addition, many doubted the possibility of recovery (Wahl & Aroesty-Cohen, 2010). The results warrant the need to pay attention to professionals' attitudes and behaviors with respect to the people they serve, especially when a recovery-oriented program is provided.

The strengths model

The strengths model views recovery as the ultimate goal for the rehabilitation service, and the journey of recovery is not a linear but a spiral uplifting process (Deegan, 1988). The

Table 1. The six principles of the strengths model.

Principles	Statement
1	People have the potential to learn, grow and change.
2	The focus is on individual strengths rather than deficits.
3	The client is the director of the helping process.
4	The case manager–client relationship is primary and essential.
5	The primary setting for our work is in the community.
6	The community is viewed as an oasis of resources.

strengths within people are used as the strategy to facilitate recovery. There are six working principles in this model (Rapp & Goscha, 2006; Saleebey, 2009; see Table 1). The first two are based on the ontological assumptions about people. First, change is a normal state of living and every individual has the potential to learn, grow and change. However, the goal must come from the wants, aspirations and desires of the individual. Second, it emphasises that people who face adversity or have a disability still have their own inner strengths and external resources that could be utilised for their own recovery. Thus, strengths should be assessed holistically and can be used as a strategy to enhance self-esteem and confidence, instill hope, and facilitate motivation for change.

In terms of methodology, this model posits that individuals' own knowledge of themselves and their ways of coping are valuable; thus, they are the experts of their life situation. Professionals are indeed experts; however, we need to explore, respect, value and use consumers' expertise. Thus, the model emphasises clients' self-determination (principle #3). The strengths model emphasises partnership between professionals and consumers through collaboration and dialogue, as well as using the informal and reciprocal relationship to foster consumers' participation and self-determination (principle #4). The contacts with consumers should be in the living environment of consumers where they feel most comfortable and are most familiar. This way is conducive to establishing a rapport and a genuine relationship as well as valuable for observing the environmental resources and strengths of the consumer (principle #5). It is also helpful for normalization and to help consumers rebuild their natural social support network. Therefore, consumers could establish their enabling niche and rebuild a satisfactory life in the community (principle #6).

Method

Research design

The investigators aimed to understand how case managers viewed this perspective and operated the six principles within the model. To capture the profound and multidimensional contents and changes in attitudes and enactment, a qualitative approach with an in-depth interview was adopted. The interview was conducted twice with 10 case managers. The first time was 6 months after the program began and the second was 15 months after it commenced.

Settings and participants

The experiment was conducted in two settings in southern Taiwan. Setting A is a day hospital within a major teaching hospital, with 80 consumers participating in the daily activities. The usual treatment included individual sessions and group activities. The

former included symptom assessment, discussion of medication, disease control-based case management, and vocational rehabilitation. The latter covered self-care, social skill training, vocational training, recreational activities and art or music therapy. There were eight case managers (subjects A–H) working in this setting, including a head nurse. Setting B is a small community rehabilitation center with around 20 consumers participating daily. They provided rehabilitations in self-care, vocational skill training and community participation. Four case managers (subjects I–L) were working in setting B. Among them, subjects K and L had left the agency for personal reasons in the middle of the project and were interviewed only once; thus they were not included in the analysis.

The directors in both settings agreed with recovery orientation and thus they were willing to join this initiative. All the staff members were expected to participate in the implementation of the strengths model so team spirit could be built and the members could support each other. Over the 2-year period, the case managers utilised the strengths model on 55 consumers. The predominant diagnosis was schizophrenia (81.8%), followed by affective disorder (9.1%). To have the model applied to relatively homogenous subjects, this study excluded consumers with intelligent disability, dual diagnosis and dementia.

All the case managers were female, with ages ranging from 23 to 43 (see Table 2). Their work experience in psychiatric disability varied a lot, from 1 to 18 years. Those in setting A were more experienced – all of them had been working in this field for more than five years – whereas those who worked in setting B had tenure between one and three years. Among them, eight were from a nursing background and the other two had education in sociology and occupational therapy respectively.

Training and supervision

Prior to the experiment, most case managers had very little training and experience in implementing recovery-oriented practice. To equip the case managers with knowledge of the strengths perspective, the investigators provided a two-day basic training at the beginning. Regular external supervision was conducted by the investigators to help case managers transform the principles of the strengths perspective into daily practice. For the first three months, the external supervision was held twice a month; after this it was held once a month. Related issues that emerged were also discussed in the regular internal meeting at each agency. Advanced training sections were provided in accordance with the needs of case managers for facilitating their operation on the strengths model.

Interview guide and procedure

An interview guide was prepared and provided to case managers before the interview took place. The topics included their prior practice model, their thoughts about the strengths model, whether there were any changes in attitudes, their attitudes and enactment of the principles and methods of the model, the specific skills utilised in facilitating changes in consumers, the impacts of the model on themselves and organisation, and the difficulties encountered and their coping methods.

The interviews were conducted in the case managers' workplace. The length ranged from 45 to 90 minutes. The case managers signed the consent form and were assured anonymity and that the information would only be used for the study. The narrative was tape-recorded for convenience of analysis. Each participant was given a gift of a $NTD500 or $USD18 voucher for a convenience store.

Table 2. Background information of the case managers.

Subject	Age	Position	Work tenure[a] (years)	Work experience	Education
Setting A					
A	29	Nurse	5	Acute ward, pressure relief ward, day hospital	Nursing
B	43	Nurse	18	Acute ward, pressure relief ward, home care, outpatient, day hospital	Nursing
C	38	Nurse	15	Acute ward, pressure relief ward, home care, outpatient, day hospital	Nursing
D	33	Nurse	10	Acute ward, day hospital	Nursing
E	35	Nurse	14	Acute ward, long-term care, day hospital	Nursing
F	36	Nurse	11	Acute ward, long-term care, day hospital, outpatient	Nursing
G	37	Nurse	16	Acute ward, pressure relief ward, long-term care, day hospital	Nursing
H	30	Nurse	7	Acute ward, pressure relief ward, day hospital	Nursing
Setting B					
I	43	Case manager	2	Intelligent disability, employment service	Sociology
J	29	Occupational therapist	3	Acute ward, rehabilitation ward, day hospital	Occupational therapy
K	42	Case manager	2	Community rehabilitation centre	High school information process
L	23	Nurse	1	Community rehabilitation center	Nursing

[a] Included only the years of work in the field of psychiatric disability

Data analysis

The script of each interview was transcribed into a dialogic text. The procedure of data analysis began with open coding and conceptual labeling (Strauss & Corbin, 1990). The initial open coding was conducted by research assistants and then further revised by the first author to ensure the inter-rater reliability. The open coding was then confirmed by each case manager. The coding was compared across subjects for extracting similar and different properties and themes. The narratives and coding were further compared between two interviews with each participant and across participants. The themes and pattern-related changes in attitudes and enactment of principles and methods were extracted.

Results

Attitudes toward the strengths model

For most case managers the two-day basic training was the first exposure of the strengths model; some had heard about the model through contacts with the investigators and others. The majority of the case managers held a problem-solving approach with a disease perspective prior to the experiment. Based on their narratives, the changes in attitudes towards and enactment of the strengths model from the first impression to the first interview and then to the second interview can be categorised into four types. The differentiation among the types lies in the initial impression towards the model as well as their attitudes and the level of enactment at the second interview. Below we describe, for each type, their first impression of the model, their reactions afterwards and their changes in attitudes.

Type 1: from feeling puzzled and experiencing difficulty to acceptance and application

First impression of the strengths model: puzzling and difficult

Five case managers (subjects A, C, D, F and H) were categorised into this type. They felt that emphasising strengths and utilising them as the strategy to facilitate changes in consumers seemed difficult. They wondered about whether they would be able to ignore the problems that consumers had (subject C), about the fact that most people focused on problem solving (subject A). They also wondered about how to lessen the problems if strengths were the focus (subject D), and they also felt a lack of clarity of how to implement the strengths perspective (subjects F and H).

> When I first heard that we need to see consumers' strengths, I thought that their drawbacks were so obvious, could the strengths override the drawbacks? I did not think so. (D-1-2)

> Initially I felt puzzled because there was so much material to digest. For me it was the first exposure to the model, I had the general idea of what it is about but I felt a bit fearful in terms of enacting it … On the other hand, it seems to be a nice model. (F-1-2)

With regard to the feeling of being puzzled, subject D mentioned that 'actually I could also see the ability of consumers and what their family could offer them before. Thus, I had already utilised their strengths, but not as structured' (D-1-1).

Reactions afterwards: trying to adapt and transform perspective and methods

The five case managers all tried to adapt to the new model via different ways; they started to change their tactics and skills while working with consumers. Subject A tried to change the daily languages and mentality, and focused more on strengths. She said that 'our use of

words was more sophisticated and tactful ... We emphasised more on strengths and less on drawbacks' (A-1-3). Subject C tried to change her perspective and tactics by first applying the model to the consumers of whom she did not have a negative stereotype yet. Subject D also tried to emphasize the strengths of and respect for consumers; however, she also thought it was necessary to set up regulations for proper behaviours (D-1-4). Subject F provided support and options for consumers to choose and encouraged them to try. Subject H tried to reduce feeling frustrated by the slow progress of consumers and increase empathy and acceptance, as well as to improve her relationship with consumers. She realised that sometimes consumers' problem behaviors were caused by their disease and that they also didn't like what happened. She said: 'I should offer him hope, let him have good feelings [about himself]' (H-1-3).

Changes in attitudes: more accepting, positive, client-centred, flexible, and belief in their potential for change among consumers

These five case managers gradually became more accepting of the model, which was reflected by their perception of consumers and the tactics used to facilitate changes. Subject C mentioned that emphasising their strengths made case managers become more accepting of consumers whom they disliked, and she learned to be relaxed when consumers presented problems, as she understands that the recovery process is back and forth. Also, she said, 'Once you establish a good relationship with the consumer, the potential for changes increases' (C-2-11).

Three case managers (A, D and H) became less directive, more patient and more respectful of the consumers' own pace. Previously, they would be eager to see the changes they expected and felt frustrated easily when the consumers could not meet their expectations. Subject A said: 'In the beginning I was hastened [i.e. I hurried them] , later I modified myself and learned to wait and give them some time to figure out what they want' (A-2-1). Subject F discussed options more with consumers and became more flexible and open. Before, she was strict with rules; now she would let the consumers understand her position and help them view it from a different angle.

The factors that facilitated attitudinal changes among these case managers included witnessing positive changes, help from group supervision, and peer support. Subjects A, C, F and H mentioned that the positive changes in consumers made them have stronger beliefs about the strengths model. When the model was applied to the consumer that case managers disliked, they saw huge differences afterwards. Subject C remarked: 'By focusing on his goodness, he became more willing to express himself. When you express [ed] your expectation about him, his bothersome behavior decreased' (C-1-5). Case managers also used the model on themselves and their family members, which brought positive changes to the relationship and made the case managers become more optimistic and flexible in facing difficulties. Group supervision was helpful in clarifying their doubt and questions as well as providing options and suggestions when the case managers were experiencing difficulty. As subject D said: 'I learned about how to implement the model; and yet when I tried to enact it I faced problems. There is a discrepancy between theory and practice. I mainly relied on supervision to clarify my questions' (D-1-4). Subject A mentioned that supervision provided her with support and options for tactics and skills. Once the entire team had utilised the strengths model, the case managers became more positive toward each other and provided support and suggestions when other team members encountered difficulties or frustrations. Subject A said: 'We mentioned "strengths" a lot in our team. We have internalised it' (A-2-13).

Type 2: from acceptance and application to committed with reservation

First impression of the strengths model: confirmation of own practice, positive and eager to utilise

Three case managers felt very positive when they first received the basic training for the strengths model. Subject G felt that her own practice was confirmed by the model. She used it to treat consumers as equal partners. The model made her feel more confident and powerful. She said: 'I don't need to explain the reason why I do it this way [e.g. cooperation with consumers] anymore' (G-1-3). Subject B was the head nurse of setting A. She had utilised the strengths model under the instruction of her director before the training. She recognised that the concepts of strengths, recovery and empowerment are important for rehabilitation. She commented that 'we are familiar with these words, and yet as you go deeper, you are not that clear [about the meaning]' (B-1-5). She thought that the strengths model provided a clear direction for reifying these concepts. Also, she received positive results from her trial case; thus she was in full support of this experiment. Subject E also felt very positive about the model and was eager to apply it. However, she commented on the difficulty of enacting the sixth principle, that 'community is an oasis of resources', since their role was primarily within the hospital, which was a big constraint.

Reactions afterwards: actively enacting the model

Ontologically, they placed more emphasis on the person, on his or her strengths and his or her positive side. As subject G commented: 'By using this model to cooperate with them, I think that we noticed the other parts of them, not just the patient part. The model changed our perspective of them' (G-2-1). Subject E mentioned that previously, when she interviewed consumers, she used to ask: 'Have you had any hallucinations or delusions lately?' Now she would ask about consumers' daily life, their recreational activities and what brought them nice feelings. Subject B thought that 'the biggest shock to me … maybe I should say "breakthrough" … is to respect them [the consumer] as a person, and [understand that] they are not equal to the disease; it is the disease that caused the problem' (B-1-8).

Methodologically, the case managers started to place emphasis on re-establishing partnership with consumers, and on their coping skills; to utilize more empowerment skills to facilitate changes; and to expand the scope of their work into the community. For example, subject E used to handle consumers' problems herself; now she would establish a good relationship with them first and facilitate them to think about alternatives. Subject B would tell her consumers not to focus on the symptom but to be aware of it and develop ways to cope with it. In order to facilitate changes, the three case managers all diligently contemplated different tactics to empower consumers, such as role-play, using role models, lots of discussion and encouragement, positive exception and focusing on past positive experiences. The model expanded their scope of work, as subject G explained: 'patients usually came to us whenever they had needs …. But, gradually I think that we need to guide them to grasp other things, not just us … So, we should emphasize more on outreach … and encourage them to do things with family' (G-1-21).

Changes in attitudes: committed, but with some reservations

The two major reservations that case managers had about the model were: (1) pathology cannot be dismissed totally; and (2) it would take a long time to make any progress if consumers were allowed to be the sole director of the helping process. Their experiences

revealed that the consumers' disease (psychiatric symptoms) still mattered and sometimes could be the roadblock to their goals. Subjects B and G still got upset when consumers returned to their old pattern of problem behaviours. However, the strengths model would remind them to adjust their perspective. Subject E mentioned that some consumers were so affected by their symptoms that they could easily encounter setbacks. She said: 'When this happened I would use the principle, "the client is the director of the helping process", to make myself feel better' (E-1-10). She also said: 'The premise of using the model is when consumers are in the state of symptom remission. It is no use to talk about strengths when a consumer is unstable' (E-2-5).

Subject G felt ambivalent about the principle that 'the client is the director of the helping process'. Sometimes it takes a long time for consumers to figure out what they want and the route to reach their goal. The case manager usually felt compelled to make decisions for them: 'It takes a lot of patience to wait for them, and the waiting is much longer than I thought' (G-2-7). Given the interior struggles that subject G experienced, subject G was quite clear that 'being dominant in the helping process could damage the relationship and push consumers away; expressing continuous concern is more important' (G-2-4). Subject E also found difficulty in implementing this principle when consumers were feeling comfortable with their status quo. 'If we follow their footsteps, sometimes we won't be able to have any breakthrough. They had maintained a relatively balanced life' (E-2-5). Despite these reservations, these three case managers continually tried hard to facilitate consumers' hopes and actions.

Type 3: from acceptance and application to fully committed

First impression of the strengths model: a good and applicable model

Subject J was an occupational therapist in a major hospital. She did not agree with the pathology and problem-oriented model in the hospital, so she left the hospital and joined setting B to increase her experience in working with consumers in the community. She felt that the strengths model offered her an opportunity for learning and was a good working tool. She tried to let go of her own existing framework and accept this new model. She grasped that the essence of the model was creating a partnership with the consumer. She said: 'In the hospital there is a hierarchy between professionals and patients. But, the interaction in the strengths model is different; it is partnership and companionship' (J-1-3).

Reactions afterwards: fully committed to enacting the model

Subject J constantly reminded herself not to focus on pathology. Methodologically, through supervision she realised that 'wants are real only when they come from consumers themselves; instead of the problems we put down and the plan we set up' (J-1-3 & 4). She became more flexible and open to any possibility. She mentioned that 'in the community or using the strengths model, you could not set any limits; in the community there are so many possibilities that you cannot ignore' (J-1-5). She used more outreach and community resources to help consumers mingle with the community. Gradually she formed a core and firm belief that was recovery and strengths oriented. She also benefitted from the application; she became more flexible and confident about herself.

Changes in attitudes: it is an empowering and useful model

At the second interview, subject J commented that the model is an effective model; she witnessed many positive changes in consumers. Her own thinking process became more

flexible; she could see consumers' behavioral patterns as a way of living and that there is no best way; any way is okay, there is no absolute good or bad. She tried to utilize any possible tactic to facilitate changes toward consumers' wants. When a consumer was in conflict with staff in setting B, she would think of how to use this as an opportunity for the consumer to grow. She internalised the strengths model very well.

Type 4: from pseudo-believing to feeling difficulty in enacting the model

First impression of the strengths model: believe the model on the surface

Subject I had received a short course on the strengths model prior to the two-day basic training. She had learned about and could speak about the language of the model. She also tried hard to enact it in her practice.

Reactions afterwards: felt difficulty in enacting the model

Subject I said, however, that she is 'a relatively unstable person internally' (I-1-1). She would get emotionally stirred by the unpleasant behaviors of consumers, such as compulsive behaviors or bad hygiene, etc. At the first interview she was candid about her doubt on how to enact the principle that 'the focus is on strengths instead of pathology'. She said: 'After all, they [the consumers] are sick and our primary task is to control their symptoms … Of course we could focus on their strengths, but in practice you would see their sickness first because they are sick' (I-1-7). In addition, she mentioned that she only partially implemented the third principle. She said: 'I tried many tactics to remind him. When I wanted him to speed up, I would give him the answer …. However, most of the time he would make his own decision' (I-1-7).

Changes in attitudes: feeling uncertain about her own ability in enacting the model

Subject I had been candid about her trouble in enacting the model, although sometimes she expressed positive experiences when she was in a good frame of mind. Despite many discussions during the group or individual supervision, subject I remained doubtful about whether she or others could truly view the consumers positively. She became even more judgmental toward consumers. She commented: 'I think we need to clarify what is "respect"…. When a person respects and loves himself/herself, her behaviors would let you respect him/her …. And naturally you would see his/her strengths' (I-2-1). Concerning the third principle, she said: 'We thought that they are the director, then I realised that they do not know that, which creates trouble in the work …. And I found that they would choose the easy way, staying in the comfort zone' (I-2-1). Her mind was often occupied by the deficits of the consumers and she could not truly enact the essential principles of the strengths model: the focus on strengths and self-determination.

The enactment of the six principles

The six principles represent the essence of the strengths model. The enactment of these principles could be reflected if case managers truly accepted the model. Based on their narratives, case managers revealed various levels of utilisation of each principle. Case managers could accept and believe in *the first principle: people have the potential to learn, grow and change* and found it easy to enact it. They instilled this perspective in consumers, contemplated various strategies to induce change, started to explore the ability of

consumers and gave consumers feedback on their changes. As subject F said: 'The first principle brought me bigger impact. Later I thought they had the ability to learn, but might use [it] the wrong way … or they might not be in that stage yet …. Now I would wait [for them] or tried to use other ways' (F-2-04).

Most of the case managers could utilize *the second principle: the focus is on individual strengths rather than deficits*. They started to find consumers' strengths in their daily practice by using the Strengths Assessment, to help consumers to see their own strengths, and to include their strengths in the individual plan of consumers. Through focusing on strengths they found that they could increase consumers' self- confidence and facilitate change. 'I found that he is good at counting money … Since we have a mobile store in our hospital, I encouraged him to work there as a volunteer', subject D said (D-2-03). However, most of the consumers still had some remaining symptoms and functional impairment, which could not be remedied by medication. Working with consumers daily, case managers sometimes got emotionally upset by consumers' problem behaviours, such as fixation, poor hygiene or lack of motivation, etc. They expressed the need to find a balance between strengths and pathology.

Concerning *the third principle: the client is the director of the helping process*, most of the case managers learned to respect consumers' wants and pace and their decision power and they tried to be relaxed and wait for them. This could reduce tension between case managers and consumers and was conducive to a professional relationship. Nevertheless, challenges occurred when consumers lacked motivation for change or were slow in actions for their goal.

The case managers could accept and enact *the fourth principle: the case manager–client relationship is primary and essential*. Once implementing the model, case managers experienced quick changes in the relationship in terms of rapport, level of disclosure, trust and closeness. Again, it could reduce the tension between consumers and professionals and facilitate the treatment. As subject C said: 'As the relationship gets better he would disclose his internal thoughts …. He would be willing to communicate his thinking' (C-2-09).

The case managers could accept *the fifth principle: the primary setting for our work is in the community*; however, they revealed different levels of enactment. For those in setting B, the nature of their work includes contacting clients and their family in the community. This model reminded them to do more of this. Subject J especially felt the importance of this principle. She remarked: 'It is important to cooperate with consumers' families, which is part of outreach. I felt that such cooperation could push consumers to change' (J-2-01). Nevertheless, the case managers in setting A found it hard to implement because their role is mainly in the hospital. To outreach, they need to get permission from their superior administrator, which is usually hard. However, despite the constraints, they still tried to enact it as much as they could.

Most of the case managers valued the sixth principle: *the community is viewed as an oasis of resources*. In setting B, they brought in volunteers to provide services in the agency, held community activities every Saturday to help consumers be aware of and utilize community resources, and established relationships and worked with consumers' family members. In setting A, case managers mainly utilised the resources in the hospital, such as the aforementioned post for being a volunteer, and worked with family members. And yet this was the least enacted among the six principles. The reasons included that case managers lacked knowledge of resources and did not know how to utilize them, and consumers lacked initiative, lacked help from family members in using the resources and lacked support from the hospital. Subject B said: 'we need to submit an application [to our superior administrator] if we want to go out. It is not that it is not possible, but other cases

had more urgent needs, for example those who live alone. They would put other cases in higher priority' (B-2-06).

Changes in methods, skills and self

The implementation of the strengths model resulted in changes to case managers' methods and skills when working with consumers, and changes within themselves. As for the *interaction with consumers:* first, case managers experienced changes in the nature of their relationship with consumers towards partnership and it became more empathetic, respectful and genuine. As subject I put it: '[I] accompany them with clear boundaries' and 'we were sort of like friends .... We did not just handle their problems, but also cared about them ... the things outside the range of our service goals' (I-1-4). Second, once the relationship had been enhanced, some consumers might view their case manager as a significant other and establish an attachment to their case manager. At first, subject C felt a bit worried about this phenomenon. In the second interview, she realised that the dependency was only part of the recovery process.

Case managers expanded the *scope of treatment* to family members. First they helped consumers to change and then brought about changes within the family, which is the so-called ripple effect. By working with family members, case managers helped them to understand more about the condition of the consumers and their positive changes to enhance their support for the consumers.

Case managers also revealed changes in *treatment skills*, such as: (1) working with consumers in a more natural and comfortable situation (e.g. walking and exercise) to enhance their relationship with the consumer; (2) utilising dialogue and cooperation more and being more flexible. As subject F said: 'I used to be more dominant ... I would say: "No, no. You should do such and such ...". Now I discussed their options with them more' (F-2-8); and (3) use of themselves as a role model. As case managers established a trusting and safe relationship with consumers, they used themselves as a role model for consumers. For example, subject E demonstrated a non-judgemental attitude toward consumers and thus he learned not to be overly critical toward others.

Case managers also benefited from implementing the model. First, they learned to see their own strengths and became more optimistic and self-confident as well as more courageous in facing difficulties. Subject J remarked: 'I can see more of my own strengths. I lacked confidence before and used to focus on problems and the negative side. While utilising this model, I tried to be more confident through the process' (J-1-18). Second, case managers positively reframed their personal and family situation. The model changed their perspective of viewing themselves and their family. For example, subject F could appreciate more of her family members' strengths. Subject J's view of her own lifestyle became more flexible. Subject I felt that she became more stable and mature within herself. Third, case managers utilised the strengths perspective with their family members, friends and colleagues, which was helpful in enhancing their relationships. For example, subject E felt it was good for her interaction with her children, and subject F helped her family members to see their own strengths while discussing some issues. In sum, case managers not only utilised the model with consumers but also for themselves, and experienced changes in both parties, which is called 'mutual recovery'.

Discussions and implications

To implement the strengths model, the case managers in this study had made a tremendous effort in adjusting their beliefs, attitudes and skills in working with consumers. And yet the

transformation process was not all smooth for everyone. Our findings revealed four types of participants regarding their attitudes and the level of enactment on the principles. The belief about consumers was the critical divider among the four types. Once case managers can fully embrace and internalise the first three principles (growth potential, focusing on strengths, and self-determination) of the strengths model, they will remain hopeful and be patient when consumers are not motivated, and will find tactics and skills to instill hope and facilitate changes. Subject J in Type 3 is a good example.

Overall, some case managers faced two challenges and two constraints in this study. The former involved doubt about the second and third principles of the model. The latter had to do with organisational regulations, which deterred the use of the fifth and sixth principles. The extent of the challenges and feelings of doubt among case managers is greater when compared with those who work in other fields in social services, based on the observations of the investigators. This has to do with the social stigma and self-stigma experienced by consumers as well as damage, disability and disadvantage among consumers. It may take longer to instill hope and empower them to take responsible actions. Therefore, case managers' patience and belief in consumers' ability to change are easily challenged.

Can we really ignore pathology?

The point was made quite clearly by Anthony et al. (2002, p. 100) that 'recovery can occur even though symptoms reoccur'. Weick and Chamberlain (1997) mentioned three strategies to put problems in their place in the strengths model: recognising problems only in their proper context, adopting simpler ways of talking about problems and paying less attention to the problem. Thus, the model does not ignore the real pain and suffering of people but emphasises figuring out constructive ways to meet, use or transcend the problem. On the other hand, professionals need to deliberately pay attention to consumers' aspirations and strengths at the time of trouble to shift the focus and to create a benign cycle. Haidt (2006) maintained that 'the human mind reacts to bad things more quickly, strongly, and persistently than to equivalent good things' (p. 29). It is a design of the survival mechanism that human beings need. Nevertheless, we also have the potential for growth and development. To bring about a change of direction, professionals need to reflect on their own values and their belief in consumers, and to remind their team members to keep returning to the strengths perspective.

The dilemma of self-determination

Self-determination is a critical strategy for empowerment. However, based on the case managers in this study, challenges occurred when consumers lacked motivation for change or were inactive about achieving their goals despite encouragement from case managers. Thus, the case managers became frustrated and wondered if it would be faster to use their authority to force consumers to act. Meehan, King, Beavis, and Robinson (2008) also raised the possible consequence of a rupture between patient choices and clinician-recommended treatment. They worried the consumers' needs might be neglected under a banner of recovery. In the investigators' opinion, there is no definite line for the two sides. Self-determination certainly cannot override professional ethics, such as putting consumers in a dangerous situation. In addition, this principle needs to go with genuine partnership. Through collaboration and dialogue, the professionals could exert influences and facilitate consumers to take responsible action. This is especially useful for Chinese

culture since Chinese people are relationship-oriented (Yang & Hwang, 1991). As a last resort, the only thing professionals can do is wait, be patient, express continuous concern and use the power of belief on the growth and change potential.

On the other hand, a few case managers found that they lost patience and felt tension under the demands of daily routines, high caseload or the pressure to fulfill the objectives set by the contractor or organisation. However, those objectives usually have to do with service outputs rather than recovery outcomes. Forcing consumers to be submissive might temporarily fulfill the required tasks; nevertheless, it will not be conducive to recovery in the long run. Based on our observations, the strengths model might take more time initially; however, it will lead to regaining autonomy and better management of disability, which will contribute to eventual recovery. When a heavy case load becomes a constraint, case managers could implement the full strengths model first on the consumers who are at the stage of contemplating change. This way usually leads to positive experiences for both consumers and case managers.

Organisational constraints

Setting A is operated within a hospital, which focuses on disease and deficit. The case managers are nurses whose roles are confined within the hospital, which deters outreach work with consumers and their natural support system. Setting B is in the community; the constraints come from the turnover of personnel, which prevents them from spending more time in the community. In addition, the case managers in the study were not well informed about the social welfare system and linking both the formal and informal system, despite suggestions made by investigators during supervision. Farkas et al. (2005) suggested that to facilitate recovery, organisational changes based on the key recovery values are necessary. However, such changes take a long time to happen and need staff members to continuously advocate for them. Possible strategies will be to empower the staff member to fight for change and to further demonstrate the effectiveness of the strengths model so that the policymaker could be convinced to adopt this model.

Nevertheless, this issue implies that when the strengths model is applied in a hospital setting, the fifth and sixth principles might be only partially implemented. Such a compromise needs to be accepted for the model to be utilised more in the medical setting or by professionals other than social workers, as their training does not focus on the linkage of social resources. Despite this fact, case managers should be encouraged to enact these two principles as much as possible. As a matter of fact, the case managers in this study were all in agreement with the essential role of family support in consumers' life, which is part of Chinese culture. Chinese culture emphasises mutual support among family members, especially the care of parents for their children. It would be conducive to consumers' recovery if the quality of relationships and interactions between family members and the consumers could be enhanced.

Contributions and limitations

This is the first study that specifically focused on professionals' attitudes towards and enactment of the strengths model. The positive attitudes that emerged among the case managers, as well as the issues raised in this study, could encourage further diffusion and provide a direction for future adaptation of the model. However, the training background of subjects was mainly in nursing and a few other areas. Future studies could continue to address this topic with subjects with different training backgrounds, such as social workers

and psychologists. Given this limitation, the study showed that the transformation of modality from a pathology-oriented system to a strengths-oriented system is possible. Both system change and persistent application of this model are necessary for its future growth and development.

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