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Relevancy and Challenges of Recovery Model: a Primer Review

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Abstract

The conventional notion of treat-and-recover medical model could not quite describe the recovery process of people with severe mental illness. Although full restoration of functions were rare, ample evidence showed that many people with schizophrenia do not necessarily deteriorate over time, but enter into episodes of symptomatic remission. New concepts and values of recovery emerged with emphasis on personal agency and empowerment, are accepted as the core value of the mental health policies in some developed countries at a phenomenal rate. This paper reviewed the general concept and components of recovery, and argued with illustrations in hope, self-agency, and stigma that in spite of different cultural interpretation on personhood and the illness, the recovery model put forth by SAMHSA statement contained valuable relevancy for psychiatric rehabilitation in Hong Kong and perhaps elsewhere in Asia.

Keywords: recovery, Chinese, mental illness

Introduction

Over the decade, modern psychiatry in developed countries has witnessed a gradual shift of focus from mere concern of elimination or control of symptoms and restoration of functions to the recovery concept which defines 'recovery' as the holistic processes of coping against challenges imposed by mental disorders (Johnson 2008). More recognized now than at any time in the past, that a mental disorder, apart from the illness itself, often evokes secondary consequences such as 'exclusion from meaningful social roles', 'alienation from friends and family', and 'stigmatization in various spheres of life' (Perlick et al. 2001; Bengtsson-Tops 2004; Kylma et al. 2006). Recovery, from the consumer's angle, thus implies an attempt to overcome such barriers, by claiming back a life which is meaningful to the individuals (Deegan 1988; Anthony 1993; Substance Abuse and Mental Health Services Administration 2006). As the number of studies on recovery grows, it has become clear that recovery depends on the individual's internal drives to accomplish purposeful goals, as well as supports and opportunities from their external environment.

Challenges

Recovery theories thus present a major challenge to the traditional psychiatric perspective which presumed a poor prognostic outlook for people with schizophrenia. Stated in the third edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders, "a complete return to premorbid level of functioning in individuals diagnosed with schizophrenia is so rare as to cast doubt upon the accuracy of the diagnosis" (American Psychiatric Association 1980, p.191). Likewise, the fourth edition of DSM also asserted a low chance of schizophrenia patients making full return to normal functioning (American Psychiatric Association. 1994). Nevertheless, mounting evidence from last few decades indicated that recovery is in fact prevailing, and frequently found, in large scale schizophrenia studies (Andresen et al. 2003; Calabrese and Corrigan 2005; Jobe and Harrow 2005; Bellack 2006).

Meta-analysis of 320 clinical trials in the last hundred years estimated that 40% of people with schizophrenia showed signs of improvement within a few years subsequent to treatment (Hegarty et al. 1994). More recent evidence from medical outcomes of global long-term longitudinal studies indicated that 36-77% of participants could be classified as "recovered" or "improved" at the final assessment (Calabrese and Corrigan 2005).

These evidence not only refuted the inevitable 'down-hill' prognosis predicted for schizophrenia, but also demonstrated that one-half to two-thirds of the patients could experience extended periods of recovery after treatment. For instance, in the latest review published in the Canadian Journal of Psychiatry, it was remarked that "a moderate-to-large subgroup of (schizophrenia) patients potentially experience periods of recovery (including both the absence of major symptoms and adequate psychosocial functioning) lasting several years or longer…Long-term outcome is influenced by current treatments, but the personal strengths, the developmental achievements, and the resiliency of individual patients are equally or more important influences" (Jobe and Harrow 2005, p.892). In essence, quantitative evidence rehearse the same message as those put forth by many qualitative studies – recovery is possible among patients of schizophrenia, given the right incentives and a fitting environment.

The concepts of recovery

Conventionally, recovery has been studied from the patient's point of view, based on their experiential knowledge. Personal narratives were used as the primary tools to explore and to generate hypothesis about patient's subjective experiences in coping with mental disorders. However, due to the heterogeneity of recovery trajectories and lack of coherence in what recovery constitutes, the term recovery is often defined in a "soft" and "non-specific" manner. For instance, among policy statements, it has been defined in the United States President's New Freedom Commission Report as "a process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, it implies the reduction or complete remission of symptoms" (President's New Free Commission on Mental Health 2003, p.5). In New Zealand's Blue Print for Mental Health Service, recovery is defined as "the ability to live well in the presence or absence of one's mental illness and the loses that can be associated with it" (Mental Health Commission 1998, p.113). In the psychiatric rehabilitation field, it has been informally defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness…. involves the development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness" (Anthony 1993,

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p.19), or formally as "the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination" (Andresen et al. 2003, p.588).

In the consumer advocacy movement, the concept has been described as "not being an end product or result. It does not mean that one is 'cured' or does it means that one is simply stabilized or maintained in the community. Recovery often involves a transformation of self wherein one, both accepts one's limitation and discovers a new world of possibility… Thus, recovery is a process…It is not a perfectly linear process" (Deegan 1996, p.13).

In the midst of these diverse definitions, four defining features unfolded. Firstly, recovery is not the same as curing the disease or eliminating symptoms, a person need not be in remission from symptoms in order to be in recovery. Secondly, recovery relies on the development of a new self identity and a valued social role, sometimes above and beyond employment. It implies holistic improvement beyond one-sided restoration of functioning. Thirdly, recovery is an individualized process, unique for people with different preferences, strength and personal history. Personal responsibility to manage and control the illness is, however, necessary. Finally, recovery is a complex and non-linear process - a process that encompasses improvement, setbacks, fine-tuning of directions, rethinking and even change in life goals (Tennessee State Forum Partnership 2003). Put simply, the term 'recovery' refers to the lifelong psychological process of social adaptation, facilitated by a healthy sense of self (Andresen et al. 2003, p.588). In one statement, the term recovery can be summarized as: "the culmination of empowerment in which both internal strength and external connections act to create responsiveness for what happens to oneself and others" despise the limitations caused by a mental disorder (Ralph 2000, p.12).

Based on the existing body of research, the operational definitions of recovery can be classified into three different types: (1) Recovery as a stepwise process experienced by patients, (2) Recovery as an outcome criterion and (3) Recovery as a process facilitated by multiple mediators (or building blocks of recovery).

Recovery as personal experiential process – stage-wise model of recovery

Early study by Strauss (Strauss et al. 1985) on subjective experiences of people with severe mental disorders disclosed recovery as the process in which people played an active role to regulate their life in response to adverse circumstances. Later, Davidson and Strauss's study on discharged psychiatric patients unfolded the recovery process as one in which people actively seeks to "rediscover and reconstruct their functional sense of self" (Davidson and Strauss 1992). Following this major premises, there were also other attempts to construct a recovery model as different psychological stages of change, characterized by positive transformation in the individual's self agency. The key themes of these models included rebuilding resilience and revitalizing peoples' sense of self. A typical example is Klein's empirical rational model of recovery among people with schizophrenia. In this model, recovery was operationally defined as a multi-stage process, characterized by adaptation in three areas, including (1) changing relationship with self and others, (2) understanding and coping with functional deficits and (3) alternating treatment and personal strategies against symptoms (Klein 2005).

These consumer models have offered valuable insight into the life experience of people undergoing mental health recovery, but this proposed "soft" definition of recovery is obviously inadequate as criteria for research or evaluation. They give limited clues as

Table 1

Summary of Long Term Follow-up Studies on Schizophrenia Outcomes

Name of Study	Country	Recovered or improved (%)	Average follow up (years)	Recovery / improvement criteria
Burgholzli study (Bleuler, 1974)	Switzerland	53	23	5-year end state determined through clinical interview by M. Bleuler
Iowa 500 study (Tsuang & Winokur, 1975)	USA	46	35	Marital, residential, occupational, and symptom status rated on three point scales and combined into global measure
Bonn Hospital (Huber, Gross, & Schuttler, 1975)	Germany	65	22	Symptoms and social functioning assessed by examination; social recovery was defined as full time employment
Lausanne study (Ciompi & Muller, 1976)	Switzerland	49	37	M. Bleuler's 5-year end state criteria
Chestnut Lodge (McGlashan, 1984a, 1984b)	USA	36	15	Personal interview in which examiner rated subject on hospitalization, employment, social activity, psychopathology, and a global functioning score that combined these
Gumma University Hospital study (Ogawa, et al., 1987)	Japan	77	21-27	Follow-up interview on psychopathology, social relationship and residential status
Vermont Study (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987)	USA	68	32	Interviews using structured instruments (Harding, et al., 1987) for the collection of data on social functioning, hospital records, various symptom-based measures summarized with Global Assessment Scale
Maine sample (DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995)	USA	49	36	Criteria replicated the Vermont Study; Global Assessment Scale provided a global measure of psychological and social status
Cologne study (Marneros, Deister, Rohde, Steinmeyer, & Junemann, 1989)	Germany	58	25	Interview using Global Assessment Scale, Disability Assessment Scale, Psychological Impairment Rating Schedule, and Bonn criteria for categorization of psychopathological outcome
WHO International Study of Schizophrenia (Harrison, et al., 2001)	14 countries	48-53	15 and 25	Bleuler global assessment based on all information on course, symptoms, and functioning

Adopted from "Beyond Dementia Praecox: Findings from Long-term follow up studies of Schizophrenia" by Calabrese, J. D., & Corrigan, P. W. (2005). *Recovery in mental illness : broadening our understanding of wellness* (1st ed., pp. 63-84)

regarding how services are to be planned or evaluated. Up to the present, attempts to develop such tools to discriminate patient from one stage to another are still in the infancy stage (Andresen et al. 2006).

Recovery as outcome - criterion model of recovery

In response to the "soft" definitions of recovery, some researchers have proposed criterion definitions of recovery to fill the gap caused by diverging perspectives of clinicians and consumers. These definitions are often composed of a set of outcome criteria indicating a level of progress that allows the patient to function socially and vocationally with little interference from psychiatric symptoms (Bellack 2006). Two classical examples are recovery criteria models from Liberman and Nasrallah. Under Liberman's definition, a patient is said to be recovered if four conditions have been sustained for a minimum of two years, there includes: (1) Absence of, or mild level of psychotic symptoms, (2) Independent living, including treatment adherence and successful management of one's finance and possessions in supervised setting, (3) Active participation in school or work, and (4) Frequent engagement in social or recreational activities under normative setting (Liberman and Kopelowicz 2005). Similarly, Nasrallah and colleagues have developed the criteria for evaluating recovery with regard to effective clinical treatment. According to Nasrallah's definition, Recovery (or effective clinical treatment) of patients with schizophrenia is characterized by "sustained adherence to prescribed treatment regime; long term reduction in symptoms of diseases, treatment burden (side effect), and impact of the disease on the patient and members of his or her social circle; a long term increase in healthy behaviors and restoration of wellness" (Nasrallah et al. 2005, p.274). However, these definitions were composed consensually, not empirically. Besides, some definitions implied the necessity of on-going pharmacological treatment, as oppose to the original values of the consumer recovery theory (Roe et al. 2007). Finally, some criteria were not equally appreciated across different patients groups. For instance, some female patients may see successful marriage and fulfilling their role of full-time housewife as primary personal goals, hence half-time job or study would be irrelevant to them. These definitions tended to overlook subjective appraisal of patients, especially the extent to which patients are satisfied with life. As noted, subjective evaluation of life is imperative, given the high incidence of suicide among people with schizophrenia. Omission of subjective criterion may result in misclassifying individuals who demonstrated satisfactory functioning but debilitated by deep seated stigma, as fully recovered.

Recovery as process facilitated by multiple mediators – model of care for recovery

Growing recognition of consumer recovery philosophies from government bodies has initiated many new definitions of recovery. In the United States, official adoption of the recovery paradigm in national mental health policies resulted in having recovery theory re-conceptualized as a theory of care. These models were purposed to help professionals to plan recovery-oriented services in a tangible manner. In general, these models are often composed of a number of elements, prescribing the generic mediators or intermediate outcomes of recovery. For instance, Kelly and Gamble have conceptualized a five-factor model of recovery, covering the following components: (i) hope, (ii) spirituality, (iii) growth in self discovery, (iv)respect for being an individual and (v)supportive mentorship (Kelly and Gamble 2005). Ralph (2000) has formulated a four-dimensional model encompassing (i) internal factors, such as: awareness of the illness, recognition of the need to change, insight to initiate change, and determination

Table 2

Overview of Recovery Stage Model in Six Major Studies

Studies	Davidson & Strauss (1992)	Baxter & Diehl (1998)	Young & Ensing (1999)	Spaniol et al. (2002)	Andresen et al. (2003)	Klein (2005)
Size	N=66	N=40	N=18	N=12	N=50+	N=12
Subject	S+SMI	SMI	SMI1	S[2]	S+SMI	S
Stage I		1. Crisis recuperation		1. Over-whelmed by the disability	1.Denial, confusion, hopelessness, identity confusion and self-protective withdrawal	1. Pre-recovery: Overwhelm by onset of illness
Stage II	1.Awareness of a more active self		1. Initiating recovery	2. Struggling with the disability	2. Realizing that all is not lost, a fulfilling life is possible	2.Early recovery: turning points
Stage III	2.Taking stock of self 3.Putting self into action	2. Decision to get on, rebuilding independence		3. Living with the disability	3. Taking stock of the intact self, and of one's values, strength and weakness. Begin to work on developing recovery skills	3.Middle recovery: re-entering the world And engage with others
Stage IV	4. Appealing to the self	3. Awakening to restructured personhood, building healthy interdependence	2. Regaining & moving forward	4. Living beyond the disability	4. Actively working for a positive self identity, setting meaningful goals and taking control of one's life	
Stage V			3. Improved quality of life		5. Living a full and meaningful life, able to self-manage the illness, developed resilience and a positive sense of self	4.Late recovery: transcending mental illness

Adopted from: Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. Australian and New Zealand Journal of Psychiatry, 37(5), 591 and Andresen, R., Caputi, P., & Oades, L. (2006). Stages of recovery instrument: development of a measure of recovery from serious mental illness. Australian and New Zealand Journal of Psychiatry, 40(11-12), 973.

Note: 1. SMI stands for patients with severe mental illness
2. S stands for patients with schizophrenia

to activate change; (ii) self managed care like active management on the illness and coping with illness-associated barriers; (iii) external factors which involve support from others and the presence of a significant other to believe for their success; and (iv) Empowerment synergy, fusion of internal strengths with external factors to create self-help, advocacy and a corporate climate of care among people with mental illness (Ralph et al. 2000). Jacobson and Greenley (2001) have proposed a recovery model which composed of internal conditions including hope, healing (development of a self concept dissociated from sick-roles), empowerment (including a reduced sense of mastery) and connection (healthy social relationships with others); and external conditions including human rights consideration (such as reducing stigma and discrimination), positive healing culture (service values that foster personal growth under the concept of equalitarian partnership) and recovery oriented service (availability of recovery-oriented services based on the above values). As the number of models grew, the need to bring consensus on the scope and definition of recovery also intensified.

2006 National Consensus Statement on Mental Health Recovery

In December 2005, the National Consensus Conference on Mental Health Recovery has called together over a hundred experts and consumers to derive a unified definition of recovery. Service providers, researchers, families, advocates and consumers were able to agree on the meaning and scope of recovery during this conference (Substance Abuse and Mental Health Services Administration 2006). The consensus statement proposed a standardized definition of mental health recovery as "a journey of healing and transformation to live a meaningful life in a community of one's choice while striving to achieve maximum human potential" (Substance Abuse and Mental Health Services Administration 2005, p.4). The stakeholders also managed to summarize the primary guiding principles of recovery under ten recovery components, outlined as follows:

1. "Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines one's own life goals and designs a unique path towards those goals.

2. Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences, and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

3. Empowerment: Individuals have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, individuals gain control of their own destiny and influence the organizational and societal structures in their life.

4. Holistic Wellbeing: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, spirituality, creativity, social networks, community participation, and

family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. Non-Linear: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. Strength-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

7. Peer Support: Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

8. Respect: Community, systems, and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

10. Hope: Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process." (Substance Abuse and Mental Health Services Administration 2006)

This joint declaration provided a summary of practical wisdoms and experiential knowledge from consumers and recovery experts. The ten components, which represented the putative facilitators of recovery, are potential building blocks for reconstructing the full recovery process. After the SAMHSA statement, there was continuous effort to elaborate the recovery model and to propose new components of recovery. Bonney & Stickley (2008) analysed 170 articles written by service users, healthcare providers and policy makers, and identified six major themes of recovery: Self-identity, Service Provision Agenda, The Pros and Cons of Risk Taking, Social Domain of Recovery, Power & Control, and Hope & Optimism. Obviously the risk taking was for the first time considered.

However, there were criticisms that many of these building blocks were vague and subjective (Bellack 2006), and these components have to be operationalized before they could be empirically tested. The authors of this paper were the first to put the SAMHSA recovery model into empirical tests. Satisfactory results, however, were reported on the canonical functions of the recovery and the health-related quality of life measures (Chiu et al. 2010) and good fit of structural equations

with regard to the recovery components (Ho et al. 2010), with data drawn from a community sample of people with schizophrenia in Hong Kong. While the research group has started to develop and validate a more handy empirical recovery scale, the underpinning of the components and value base needs to be discussed before the research journey is further embarked on, and the queries whether the same value base should be adopted in Asia be addressed

Universal or culturally specific values?

Hope & self-agency

Hope was regarded as the essential ingredient of recovery. However, there are many definition of Hope. Hope has been defined as a condition "characterized by an anticipation of continued good state or release from perceived entrapment in health related literature" (Miller and Powers 1988, p.8). Elsewhere, it has been defined as optimism in achieving goals (Snyder 1995). Others make the distinction between general hope – an expectation of positive future development, and motivational hope – an expectation that one will make efforts to accomplish valued goals (Lysaker et al. 2004; Kylma et al. 2006).

Hopelessness is not only a core symptom of schizophrenia, but also a "contributing factor to the chronicity in Schizophrenia" (Kylma et al. 2006). Hopelessness appears "when the patient perceived the disorder and its consequences to be beyond his control, feels helpless, and has given up expectation to influence its course positively, thereby abandoning responsibility and active coping strategies. Thus, once established, hopelessness may become a central limiting factor in the efficacy of treatment and rehabilitation" (Hoffmann et al. 2000, p.148). Besides, hopefulness is an important factor that contributes to life satisfaction and other favorable outcomes of recovery. Hope elevates one's motivation and expectation for better outcome, which contributes to treatment compliance in patients with schizophrenia (Dearing 2004). Simply put, hope fuels one's recovery by elevating one's motivation to take personal responsibility and to connect with others. Several factors are associated with instillation of hope in patients, these include: relationships with other people, experiencing success in daily life, taking control over the illness, finding meaning in one's life (e.g. through cultivating spirituality) and building up a positive future prospect.

Personal determination, or the will to recover, played a crucial role to recovery of mental disorders. Self-agency - the capacity to engage in deliberate action - was a key mediator between "will" or "hope" on one side, and realization of recovery on the other side. Numerous personal narratives have documented the feeling of intense hopelessness accompanied with the loss of control, right at the time when diagnosis was disclosed (Deegan 1986; Andresen et al. 2003; Onken et al. 2007). Poor clinical prognosis and the presumption that patients with schizophrenia lack intellectual faculty to make mature decisions on their own often cause them to assume a dependent role in life course. In so doing, people with schizophrenia may relinquish their right to exercise the individual's personal agency altogether.

Studies on locus of control among people with schizophrenia have revealed the role of hope in prevention of secondary negative symptoms (Hoffmann et al. 2000)). Likewise, a large number of evidence have pointed to the fact that hopelessness may contribute to poor self concept, passive coping and absence of volition towards assuming personal responsibility (Liberman 2002). By extension, elevation of hope may provoke individual's agency and volition to pursue valued goals. Based on such understanding, local initiatives has attempted to facilitate

patients' quest for purposeful goals by Goal Attainment Program (GAP) which elevates patients' expectancy for living a 'normal life' (Ng and Tsang 2000). The results of this GAP showed that the majority (72%) of inpatients with schizophrenia were willing to take up employment upon discharge after completion of the program. More importantly, installation of hope was highly valued by all participants as a pre-requisite for personal growth.

Stigma

Studies on people with schizophrenia often identified social stigma and systematic exclusion as the primary sources of power loss (Byrne 1999; Thesen 2001; Hall and Cheston 2002). Stigma hindered recovery by generating lasting impact on people's self-esteem and social networks, causing adverse consequences such as delayed treatment, treatment-refractory symptoms, prolonged course and hospitalization, unemployment, isolation and abandonment from immediate family. While stigma have both subjective and objective leverages on recovery, consumer theories of recovery tend to place great emphasis on the psychological harm of stigma. According to the theory of internal stigma, internalized stigma affects psychiatric symptoms and life satisfaction by mediating one's self concept (self identity and self esteem). In societies where stigmatizing attitudes are prevailing, people with schizophrenia may consciously or unconsciously acquire stereotypic ideas of mental disorder in their own identity. Negative self identity may trigger feelings of inferiority, shame, insecurity and withdrawal, contributing to impaired general psychopathology. Additionally, some individuals may be tempted to accept grandiose delusions as a means to defend against further devaluation in one's sense of self. Likewise, social withdrawal may also limit individuals' access to employment and opportunities for achieving meaningful life goals, thereby reducing one's life satisfaction (Vauth et al. 2007). In some empirical studies, we found internalized stigma significantly correlated with a lower level of self esteem, empowerment and recovery orientation (Ritsher et al. 2003). Local studies estimated that up to 55% of people with schizophrenia concealed their medical identity in order to save themselves from experiencing stigma (Lee et al. 2005) and even carers did not hold views vastly different from the general public towards people with severe mental illness (Chiu 2007).

Further discussion

So far we have drawn both evidence from both overseas and local studies to illustrate that perhaps the similarity is greater than the difference on the understanding of recovery components. Although personhood in the East is largely described as collective and familial (Lu, 1998), the core longing of what one could have become in the journey of recovery has never been submerged. The core tenet of recovery has its origin from the Western concept of "Personhood" (Anthony 2004; Anthony 2005) underpinned by the ego-centered humanistic values such as "right to life", "liberty", "pursuit of happiness" and "self realization" (del Vecchio and Fricks 2007). Some researchers have questioned the feasibility of using such recovery principles in Chinese societies (Yee 2003; Tse 2004). Although the way stigma was experienced would vary according to different socio-economic systems under which the health and social care play their role, the existence of stigma situation and its subjective and objective barriers to one's inclusion are still the common facts.

If we were anywhere near to the SAMHSA statement of recovery, we will need to review why such values and needs are not claimed explicitly by our clients and carers. What is lacking to stop people from falling into the discourse that recovery is only possible when there is no longer the need to take drug? What

sort of service delivery model is needed to reflect our genuine beliefs that mental illness is treatable and one could recover to live a normal life, and what obstacles were out there that such fine goals were frustrated in reality? It is neither scientific nor humane to stop testing empirically the recovery model while argument and debate may continue. However, we must honestly admit that up until now, many recovery concepts were based largely on stakeholders' therapeutic philosophies instead of scientific evidence. We are just beginning to have some local research evidence and surely more theoretical clarity and research findings are needed before the recovery paradigm is adopted in mainstream psychiatric systems.

There are still many questions to be answered. If a recovery oriented program is to be considered, should practitioners adapt ALL recovery principles in one program? Are some principles more important than others in bringing about change? How much stronger is the effect of one recovery principle over another in delivering benefit to patients? For "recovery" to move from being a promising concept to one that is truly practical, much work is needed to evaluate its effectiveness. Without active evaluation, practitioners would risk planning futile interventions.

摘要

『復元』模式的關聯與挑戰－初步文獻概覽

傳統『治療-復原』醫學模式的看法並不能準確地描繪出嚴重精神病患的康復過程。雖然只有少數人能百份百的復原其功能，但相多當的證據顯示許多的精神分裂症患者不一定隨時間變差，反而是斷斷續續的進入沒有病 的時期。在已發展國家的中，關於『復元』的新概念和價值正在崛起，強調個人自主(personal agency) 與充權 (empowerment)，迅速地廣爲精神健康政策所接受。本文評閱現有文獻中關於『復元』的概念及其組成部份，以希望(hope)、自主(self-agency)及污名(stigma)等基本範疇爲例，主張縱使不同文化對個體及精神病有不同的詮釋，美國藥物濫用及精神健康行政處所提出的『復元』模式，對香港、以至亞洲的精神復健仍然有相當寶貴的關聯及含意。

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Upcoming Themes

The Hong Kong Journal of Mental Health is the official publication of the Mental Health Association of Hong Kong and is published on a half-yearly basis. It is an interdisciplinary journal intended to serve as a focal point for the exchange of information to both enhance the definition and development of the field of mental health and facilitate the applications of facts, principles, and methods derived from psychology, psychiatry, medicine, sociology, epidemiology, anthropology, social work, nursing, education and other health-related disciplines.

The Editorial Board has suggested several upcoming themes including (but not limited to) the following:

- Healthy Ageing
- Mental Health in Chinese
- Positive Mental Health
- Promoting Mental Health
- Substance Abuse and Mental Health

Manuscript submission should be sent to
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