Using Narrative to Reflect on Three Therapeutic Models in Taiwan : Lessons for Community Approaches to Child Mental Health

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Abstract

As the shortcomings of deinstitutionalization become evident, models of institution-based therapeutic communities are starting to appear as promising alternatives. While institution-based therapy models produce desirable outcomes for some categories of mental illness, these lessons have not been applied to exploring community approaches to child mental health. To this end, we use an identity narrative approach to explore the relation between mental illnesses and childhood or adolescent development in narratives of patients treated under different therapeutic models for three conditions: severe mental illness (SMI), substance abuse and ADHD. Only the ADHD patients were children; the SMI and substance abuse treatment models were designed for adult patients. But all patient narratives showed the illness had roots in childhood. This secondary analysis examines patient narratives collected from three independent projects between 2005 and 2013. The oral history study of the Yu Li therapeutic model for SMI was conducted from 2005 to 2006. The project documenting a therapeutic model for substance abusers in the Tsao Tun Psychiatric Center was carried out from 2009 to 2010. Lastly, we took oral histories from participants in an ADHD family support group between 2011 and 2013.

The development and nature of these models will be illustrated first, then contrasted, to identify the key elements of empowerment in each type of therapeutic community. We further apply the Jonsen's four-topic approach to clinical decision making to clarify the ethical dilemmas in assignment of tasks and to distinguish how each division of labor affects patient empowerment. While considering the nature of illness or recovery for different categories of patients, we find narrative understandings are crucial for ascertaining the residual functioning of each patient, and for striking a balance between individual existence and social being. We conclude narrative medicine constitutes a specialized approach for building recovery models and promoting mental health.

Keywords : Attention Deficit Hyperactivity Disorder (ADHD), Empowerment, Illness narrative, severe mental illness (SMI), community based treatment program

Introduction

As shortcomings of the global trend of deinstitutionalizing treatment for mental illness emerge, new models in particular, institution-based therapeutic communities—appear as promising alternatives (Perry et al., 2014). The concept of a

therapeutic community began with Thomas Main's 1946 idea of the "hospital as a therapeutic institution," where professional authoritarianism is replaced by a patient-led democratic environment, avoiding some of the more authoritarian aspects of institutional care. In the therapeutic community approach, psychiatric patients are encouraged to take active part in their own and each other's treatment and rehabilitation programs (Main, 1946; Manning, 1989; Wentworth, 2011). Ironically, this ideal is easily undermined or even contradicted by the management structure of hospitals, an institution that is authoritarian in nature (Fussinger, 2011; Spandler, 2009). For about 40 years, the term therapeutic community has been perceived as pe jorative in the United States, except in the fields of drug abuse and addiction. Drug-free residential settings are therapeutic communities based on "a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility (Hanson and Glen, 2002; Moskalewicz & Welbel 2013; Abdel-Salam, 2012)." The concept is therefore contaminated with the shadow of social control, according to Glen; "[p]eer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills (Hanson 2002; Moskalewicz J, Welbel 2013; Abdel-Salam2013)." Therapeutic community has thus been regarded as an instrument of the total institution, until the Yuli model of therapeutic communities for the severely mentally ill was documented in a 2006 Taipei workshop. In the Yuli model, the severely mentally ill can maximize their residual functioning with professional empowerment and peer support. Not only is the spirit of democracy present in the Yuli Model; this model offers a promising option for balancing the opposed binary extremes of institutionalization and deinstitutionalization. Institution-based therapeutic communities may be an important practice that Taiwan can share with developing countries of China and Southeast Asia.

Institution-based therapeutic models produce desirable outcomes for certain categories of mental illness, but these lessons have not been applied to designing a community approach to child mental health. Therapeutic communities (TC) have been widely employed in group psychotherapy to treat adolescents with personality disorders (Barr et al., 2010; Baber & Rainer 2011; Hodge et al., 2010). In our view, those efforts mainly rely on peer pressure arranged by institutional control over docile bodies, within which little self-direction is evident—similar to some TCs for alcoholism or substance abuse (Goldner-Vukov & Moore, 2010; Foster 2010; Harvey & Jason 2011).

The critique of TCs as a method of social control emerged from democratic social and political discourses that employ Piaget's cognitive-developmental theory as an approach to cultivating a fully responsible citizen to engage in the bourgeois public sphere (Piaget, 1960, 1970 ; Habermas, 1985, 1991; Barbara, Peterman , 1997). It follows from functionalist arguments, then that the mentally ill are unsound citizens not entitled to the privileges of democracy. Authoritarian contamination of the term therapeutic community not only deprives us of a practical approach to a more humanistic and democratic medicine and democracy, but also promotes a new variety of marginalization and stigma that threatens its development.

Objectives

To avoid the pitfalls of authoritarian manipulation of participants and to ensure effective treatment outcomes, we compare the therapeutic effects of different kinds of democratic TCs, and relate these effects to the etiology of mental disorders in the child development process. Doing so may also serve as a lens for examining assumptions about child development embedded in so-called liberal democratic theory. Comparing

outcomes may be important both for sustainable maintenance of therapeutic effects, but also for promoting mental health in childhood.

To this end, we explore narrative understandings of therapeutic mechanisms in three kinds of TCs in Taiwan.

Methods

This analysis examines patient narratives collected for three independent oral history projects that took place between 2002 and 2013. These projects recorded narratives of various stakeholders in three kinds of therapeutic community, specifically: one for the Severely Mentally Ill (SMI), one for substance abusers, and support groups for ADHD children (Adams, 2009).

First, from 2005 to 2006, our research team assisted the Yuli Veterans Hospital staff with the narrative identification method for understanding schizophrenic patients through their oral histories and personal life experiences. Yuli Veterans Hospital, established in 1958, is situated in the long, narrow rift valley that stretches 100 kilometers from Taitung to Hualien, and is thus fairly isolated from other towns. Due to this geography, the patients of the hospital have been an especially marginalized population. Most were institutionalized for years before arriving at Yuli, having spent an average of eight years at public and private hospitals around the island, most receiving only custodial care. Most had already lost close contact with their families, or their families were long since exhausted by the burden of care.

Yuli has been developing its therapeutic model for severe mental illness since 1990. The model involves three layers of therapeutic community, based on the residual functioning of the patients. The mental hospital itself is the first layer; there patients are not only aware of their medication status but also can support each other through appropriate arrangements. The second layer consists of support networks formed in neighborhoods in the area of the mental hospital. Patients' neighbors and even employers can be supportive if professionals and institutions help them recognize the level of functioning of each patient. Finally, in the third layer of therapeutic community, medical professionals play an empowering role. For this, we aspire to establish nationwide institution-based support networks for the mentally ill, so that even psychiatric patients at the Yuli Veterans Hospital can return to their own home communities. Since 2005, oral history has been used as an approach to therapeutic community, guiding patients, their families, community residents, and professionals in understanding each other and recognizing each other's abilities and resources. For this analysis, we selected narratives of five residents whose psychotic symptoms began in childhood or adolescence.

The second case considered here is an oral history project we carried out from 2011 to 2012 documenting a therapeutic model for treating substance abusers at the Tsao Tun Psychiatric Center. The Jia Lao Village Therapeutic Community was first established in 2007 with funding from the Ministry of Health and Social Welfare (Lin 2011). It is a drug-free residential setting with a hierarchical treatment model in which later stages of treatment involve increased levels of personal and social responsibility. A majority of the residents had their first experiences with illegal substances as young adults, but a significant number began using as adolescents. After they leave the therapeutic community, only 40-45% of the residents manage to maintain stable employment. The recidivism rate is mainly related to environmental factors, especially contact with their previous interpersonal networks (Tsai 2012). For this project, we selected narratives of three residents who were juvenile substance abusers along with their primary caregivers.

The third case is a hospital-based ADHD family support group initiated in 2008 as an extension of

treatment for ADHD at a major medical center in central Taiwan for the purpose of resolving distrust toward medical professionals among families of children with ADHD. Such distrust has been a major barrier to families of children with ADHD accessing care and maintaining treatment relationships with child psychiatrists (Lee et al., 2013; Chen & Tsai, 2013). We collected oral histories of participants in the ADHD family support group between 2011 and 2013. To represent this project, we selected narratives of four ADHD children and eight of their family members.

We will first describe the development and nature of these different models for building therapeutic communities, and then compare and contrast them to identify the key elements that foster empowerment in each model. Then we identify the narrative pattern of each mental illness. Oral history using an identity narrative approach opens up continuity and flow of life experience, and may be used to organize a a new context that enhances autonomy of the patient (Tsai, 2011; Chen & Tsai, 2013).

The identity narrative method assumes that behind each person's rationality there is an individual structure of feelings that constitutes his or her own special logic of life. Psychiatric patients are no exception; their behavior and thinking have logic within their own realm. The difference is that the self-understanding of psychotic patients is subject to intrusion of voices or sensations that are not real, which causes them to experience life as occurring outside of their own volition. The narrative method of life history, with close listening to patients, helps them to distinguish the real self from the false self, and this is the crux of whether or not they can reach a turning point. The oral history process brings the patient back to his or her experience of the onset of illness and memory of being unwillingly committed to the institution. We have discovered that how a patient perceived the external imposition of being committed to enter a

therapeutic program is linked to the person's own understanding of their condition, the suitability of the environment for their recovery plans, and whether or not they are capable of exercising self-discipline (Huang, 2008; Tsai, 2010).

Next we further identify the core mechanisms of different kinds of therapeutic communities, trying to connect them and considering what they suggest about health promotion strategies for even ordinary people. To this end, we apply Jonsen's four-topic approach to clinical decision-making to clarify the ethical dilemmas in assignment of tasks of caregiving and self-care, and to distinguish how each division of labor affects patients' empowerment in relation to medical professionals (Jonsen, Suegler & Winslade, 2010). This approach provides sequential decision making guidance, beginning with medical indications, followed by eliciting patient preferences, ensuring quality of life and, finally, understanding the patient's unique context. Moreover, the patient's context is embedded in the narratives they and others provide, and their residual functioning can be identified using narrative analysis. The understanding thus produced becomes the foundation for wisdom sharing among mental health professionals, support networks, and the mentally ill themselves. Combining Jonsen's approach with narrative analysis allows us to empower the patients by striking a balance between their medical indications and their personal preferences, in an attempt to guarantee quality of life according to their own understanding.

Results

Considering the nature of illness and recovery for different categories of patients, we find narrative understandings are essential for ascertaining the residual functions of each patient and for achieving a balance between individual existence and social being.

In the Yuli Therapeutic model (YUTC), residual functioning is related to the extent to

which patients can produce thick description in the oral history interviews, integrate experiences, relate how they feel, and what they explain at different stages in sharing their life stories. For patients with limited residual function who must be confined in strict institutional care, caregivers at Yuli are making an effort to improve or maintain quality of life. Such patients have to rely heavily on the interviewer's support in shaping their life history narratives:

I: So, you want to keep mentally clear.

A: I want (it) to be clear as (in) my normal life. When I need to, I have to take a rest.

I: You feel better after taking a rest?

A: Yes.

I: How often does the psychotic episode happen? Is it bothering you frequently?

A: Just need to take a rest. At present, I don't feel too bothered. It's fine for me during the time period of the episode.

I: How do you cope with it when your illness occurs?

A: When I'm ill, I have to keep clean and sleep. I eat my meal first, then take a bath, change clothes and finally go to sleep.

I: Do these activities help?

A: Take a bath, change clothes, eat a meal, take a bath…no, the order is to eat a meal, then to take a bath, and then to sleep. Eating and sleeping are important. I need both. Sometimes, I may chat and have a cigarette… (A1002)

This patient has a good sense of how, and to what extent, he is able to live with his mental illness. Probably just as when we conducted the oral history interview, during which he needed a lot of sequential guidance/support to articulate his experiences, he needs daily professional and environmental support to maintain good quality of life. However, integrating medical indications with his preferences has produced his unique competence for maintaining a self-awareness lifestyle. His endeavors and contributions are significant in shaping the Yu Li Therapeutic Community.

Similar contributions are made by patients with better residual function; their narratives are more comprehensive than the previous one:

I have many ideas and tend to think too much. I just like thinking. It is my nature to indulge in flights of fancy. I so like to let imagination run wild by habit, friendships…unrealistic utopian fantasies are my daily favorites. I cannot resist doing it. However, I realize that I have to find a balance between fantasy and reality to be happy. (A1001)

This patient, a five-year full-time worker in the Bakery Shop in the YUTC, has learned a way to live with his schizophrenic symptoms. His achievement illustrates a very important foundation of how the Yu Li Therapeutic Community works; for patients with SMIs, the development of personal care skills is essential. With capacity produced by narrative understandings, these patients are keenly aware that they have to seek a desirable life balance with the help of psychiatric medications. Medication is very important for this patient to develop self-control skills. As another successful s chizophrenia patient described,

It is important to learn how to release emotion when I get overexcited. I do this partially with medication and partially by myself. Before I came for professional help, such stimuli would lead me to fight with other people. With some experience at calming myself down, I think that there is no benefit in me fighting with other people. It's no good for other people either. So when the emotion comes, I should first think about calming down and then try to find a resilient way to resolve the issue. It is not necessary to rely upon violence to solve problems. (A1005)

Recognizing the importance of medication and self-discipline is key to freeing SMI patients from the suffering of their illness. In addition, patients' self-awareness will lead them to control their behaviors and thus contribute significantly

to lessening their dependency on medicine. One patient said, 'I do not need so much medication after I came here. My own control when on regular medication, as well as behavior changes, is the reason. (A1003)' Being willing to make a change is very important here. With support from the mental health staff, patients may make up their own mind to control their behaviors. These patients have also made efforts to learn about their illness and treatments on their own through general or professional sources of information. Some may use medical journals or textbooks. Patients' narratives provide proof of the approach to medical treatment they expect.

Here, the most important tasks are to empower myself, to stabilize my clinical condition, and then to work. The work helps me enhance my capacity to react. I will then be free from indulging in psychiatric symptoms. To work is part of my medical treatment, i.e. group therapy. It is a clinical therapeutic process and occupational rehabilitation process arranged by the medical team. This is a positive therapeutic method for psychiatric patients. (A1005)

This patient at YLTC fully appreciates the importance of integrating medical and behavioral therapies. For this target patient population, work is an important part of symptom control. With support from personnel in the Yuli Therapeutic Community, these patients take an active part in their own treatment plans. The narrative competence of psychiatric patients is also an important resources for shaping collective life, whether they are deteriorating or in recovery mode.

The organization of social life may have contributed to the development of a particular illness in their childhood. We see similarities in the narratives of patients with SMIs in the Yuli Therapeutic Community:

I: Do you know at the very beginning how your symptoms occurred?

A: ....I do not really know. One morning before I went to junior high, I experienced some abnormal behaviors.......

I: What are abnormal behaviors?

A: Taking a cup like this. Picking it up and putting it down repeatedly, similar to what is described in psychiatric textbooks...

I: When did this kind of behavior begin?

A: In the third year of junior high.

I: how do you become aware of these behaviors? Or did someone else find them?

A: I could not understand why I was doing these behaviors. But I was out of control. A ha..., my father noticed them.

I: How long after was it before your father called for medical help?

A: Not long...one or two days. He phoned a friend in mental health within one or two days. I was admitted into a psychiatric hospital the day I visited its outpatient department. (A1003)

This compulsive behavior of this patient later on turned out to trigger violent actions that became part of his life journey until he arrived at the YLTC. Compulsive behaviors and violent actions almost became a whole way of life for this patient. Other patients' psychotic episodes may result from significant outside stress.

I: You passed the Comprehensive Entrance Examination and were entitled to attend Jian-Kuo High School (the top ranked high school in Taipei)...

A: But I did not go to that high school.

I: You did not go?

A: No. I did not go. There was too much academic pressure at that time. I did not want to attend this very competitive high school. The pressure became overwhelming after I graduated from junior high. In fact, the pressure was already significant at the beginning of junior high. Then I tried to bear it until I graduated from high school... I was sent to a psychiatric hospital at that time.

I: Where do you think that pressure comes from?

A: It's academic pressure. ....

A: I do not understand the way my mom preached to me. I don't know why, from my childhood up till now. It's just the way she is. I did not understand it throughout my school years. I do not know what was her purpose why she teaches me like that. It's so difficult for me. Even now. (A1001)

The stress that apparently was the major trigger of his schizophrenia was his mother's expectations about his academic performance. In his narrative, his mom's expectations for him limited his life opportunities and then became the main reason for his mental illness. For these patients, learning the etiology of their own illnesses is crucial for their later rehabilitation process.

I: When did you feel that you were not able to control yourself?

A: At technical high school.

I: What kind of experience was that?

A: At that time, we did not take a nap at noon. Then I.....somehow become disoriented and did not know what I was saying. One classmate did go to sleep. I felt strange if I did not take a nap. Later I reflected on that kind of feeling and considered it to be a kind of paranoia. It's a kind of persecutory delusion. I did have bizarre thinking. I suspected that the person who took a nap was a special agent assigned by a political party. He might have come from the Central Intelligence Agency to watch me. I was very suspicious at that time.

I: When did you learn the term, paranoia? How did you learn it?

A: Paranoia, the term I learned...I think that I learned it from my discussions with similar patients. Also from doctors and nurses.

This paranoid schizophrenia patient, who first experienced hallucinations in the final year of elementary school, began to understand the etiology of his illness during the recovery process. Understanding the illness is important for patients to make an effort at controlling its symptoms and

signs. In the process, they also develop mutually supportive relationships with other patients, along with guidance and empowerment from mental health professionals.

Compared to residents of the YLTC, patients at the Jia Lao Village Therapeutic Community (the JLVTC) for substance abusers in the Tsao Tun Psychiatric Center demonstrated higher cognitive functioning and comprehensive and coherent narrative competence. Patients at Tsao Tun have diverse backgrounds. They can take the initiative in forming a peer support group. Their major tasks should be reestablishing self worth, proper guidance on interpersonal interactions or cooperation, and even enhancing their ability to take practical action to help others in need. It is important for patients of the JLVTC to build self-confidence and to learn skills for interpersonal relations.

Compared to being in jail, where I experienced poor quality of life and food, I enjoy freedom here. We can buy and eat whatever we want here. Senior residents here usually take care of those who are younger. As newcomers, we are frequently asked what we need. They kindly told me to ask them if there was anything I didn't know. Once I made a request, they were very supportive and found solutions for me. Their longer experience staying here helped me a lot. They know very well about the regulations of this institution. The regular activities, including courses, were also helpful. They won't bully newcomers or discriminate against people of any background. Here people treat each other equally. (B1001)

The narratives of residents at Tsao Tun are quite coherent and go in depth into various life experiences. This resident regards the JLVTC as a supportive environment to help substance abusers rebuild their social life with different skills training. This culture of mutual support is very important for substance abuse TCs.

I came here on Dec. 8, 2009. It was my

first time here. There were very few residents. I felt that the environment was similar to a jail. The comparison with jail culture is very important because people at that time held similar ideas and even operated accordingly. None of the residents were seriously thinking about ways to resolve their own problems. Staying here was just a break from being prosecuted. Many substance abusers have opportunities. So they felt this was just a time period for relieving tension. At that time, very few people like me were willing to come here. Only one or two. So at the very beginning I was thinking, "why did I decide to go to another jail?" The fewer people were here, the more problematic the choice was. (B1002)

Fewer people in the program resulted in lack of development of a culture of mutual support. This patient identified the problem at the very beginning of the JLVTC. However, as regular activities developed and more residents came, differences from jail culture began to manifest. Another resident describes the regular activities and team-work at the JVLTC.

At the beginning, I really could not get used to it. We need to get up at 6:30 and then do exercise. At 8:30, we have a formal meeting. The schedule is tight, filled with classes and other activities. We are divided into groups with five or six people. Each group has to take turn cooking meals. There are other scheduled group activities. It took me about two months to get used to these activities……As time went by, I feel we have developed a kind of collective spirit. (B1001)

Regular activities and team work help residents in the JLVTC develop a coherent group. They then support each other with the support and restrictions of institutional regulations. The formation of a group culture is important to help residents develop appropriate interpersonal communication skills. Group culture is very important for building relationships of trust among residents.

Usually people form different cliques while discussing someone. There are so many small groups in our daily lives. People tend to criticize others, to spread scandals, to discuss personalities and to spread rumors and malicious gossip. Once we hear such gossip, we feel the person doesn't belong here. We may line up against that person. Then someone I support may inform the so-called bad person about my attitude toward him or her, and I feel wronged and ask why it happened. When such things happen, I resist and feel sorry for the group of people. (B1002)

Training people to be mutually supportive, rather than spreading rumors and malicious gossip, becomes essential for forging an appropriate group culture for the therapeutic community, especially for residents with high cognitive functioning. This is the most valuable part of the JLVTC; there is no such malicious culture here. It's a tough task for healthcare providers, because substance abusers often tend to be troublemakers.

In the past people always told me what I should do, but they rarely let me know why I have to do it and what was the meaning behind it. That is what we experience outside (the JLVTC). I would feel, "why should I have to follow what you say?" That became a normal response. Here they will talk to you if there is any problem; they will not just give you an order. They will let you decide what you want to do or not do, and inform you of the potential consequences of your decisions. We have to think and decide for ourselves. Then we will take full responsibility for our decisions. I feel it's great. Gradually I came to feel that I developed a sense of responsibility. (B1003)

The healthcare providers at the JLVTC have helped residents progress by providing a supportive environment and using excellent communication skills. This supportive environment allows residents to make their own decisions and to take responsibility for themselves. This kind of self-discipline is very important for them to resist temptation from the outside environment.

Residents here begin to develop positive thinking.

We become more active and responsive. Before, I just cared about myself. I only responded reflexively to other people's requests. Now I try my best to be perfect and take the initiative to help others. I have become less selfish. Now I am happy to help when people have difficulties. We are all about the same age. We did not know each other before we came here. We have now become a mutual support group. We have long chats together and share our experiences. (B1001)

The supportive environment in the JLVTC helps residents nurture positive attitudes towards their own lives. They then begin to support each other and take active part in the recovery program. In addition, one of their activities involves serving the disabled elderly, a project jointly arranged by the JLVTC and a leading NGO.

In the village, we learn to understand ourselves. In serving the elderly, we learn to help ourselves. Sometimes there are conflicts in the village due to our preconceptions. Such conflict is really hard to take. It results in contradictory feelings and causes emotional turbulence. While taking part in the NGO activities, we understand that there are people in need and many individuals serving as volunteers there. In the very beginning, we wondered how those people had so much leisure time to waste on the disabled elderly. It is true that the smell can make people uncomfortable when you are taking care of someone in a persistent vegetative state. Gradually we came to feel that such work was actually helping ourselves..... I go there to learn to be less selfish and to help others. (B1002)

Serving the disabled elderly takes residents through a process of identity transformation in which self-centered people learn to be tolerant and supportive of others. The wisdom that helping others is in fact helping themselves is the most crucial lesson in the JLVTC recovery process. This new identity helps them to have greater self control and make an effort to establish higher goals in their lives.

Recognizing and reflecting on the way they became substance abusers is also important for facilitating new identity formation. Most of the patients began to use drugs at about junior high. They obtained drugs through peer networks, beginning with amphetamines, ketamine and then cocaine or other harder drugs. They initially tried it simply out of curiosity. Those first experiences of exposure in general are not very comfortable; however, they may want to do it again even without a sufficient rationale. Their mind gets very excited and at the same time they easily lose their temper. Adolescents who get involved with these drugs become emotionally fragile and are easily angered.

Residents had different background stories about how they became substance abusers. Case B1001 was surrounded by peer drug users. He was reluctant to try it at the very beginning. However, after quarreling with his mother over their different academic expectations he was in a bad mood and abandoned himself to despair. "Partially due to curiosity and partially due to desperation about family members, I didn't want to worry about it and began to try it." For Case B1002, there was too much academic pressure in junior high and many classmates were enjoying amphetamines. These classmates told him that "amphetamines will help you stay awake all night and you can use them to study or cram for examinations." He then began to try it, but "did not know why the more he used, the worse my academic performance was." He reflected,

At the very beginning, the drug did enhance my ability to concentrate. It was really good because I would try my hardest to achieve a perfect performance. However, such intensity for concentration can make you become irritable. You become restless and even bad-tempered in doing your work. Then you start to have difficulty

focusing, because you are preoccupied by the idea that you want more (drugs). The worse your ability to concentrate, the poorer your performance becomes. (B1002)

This resident describes the drug addiction process in his narratives. A vicious cycle was taking place in his life. Case B1003 experienced the drug right before he went to junior high. He got it from his neighbors. The neighbor took him home and let him have some, using a lighter and aluminum foil to burn it. It then became peer pressure, because all his neighborhood network of friends was using it. "It becomes very natural for you to use it, otherwise you will miss out on a sense of belonging." One consequence is that those kids become hot-tempered and dislike going to school. Their schoolteachers do not understand the drug and are perceptibly afraid of their students. Residents' narratives show those teachers tended to smooth things over and ignore the bad students, despite their aggressive behavior. Schools then become an institution that is positively reinforcing drug use among these kids. They reach a point of no return when they switch to heroin; its withdrawal symptoms are too overwhelming for kids to endure. Committing crimes, staying in jail, running away from police, being prosecuted and feeling inferior then become 'normal' life. Therefore it is important that JLVTC allows residents to take responsibility for themselves, then begin to support each other and take active part in the recovery program. The JLVTC recovery process helps them to shape new identities, developing greater self control, and willingness to establish higher goals in their lives.

The narrative competence of ADHD children in family support groups is somewhere in-between that of the high functioning residents at the JLVTC and the low functioning residents at the YLTC. Moreover, these children are adolescents and their narrative capacities are still developing. Hence, interviews for this oral history project were frequently done with their parents present, treating each family as an interview unit. We also include adult ADHD cases in this analysis for their insight into the mechanisms that make this support group work and the narrative etiology of ADHD. ADHD families go through a disease discovery process similar to the patients mentioned above.

I: From what you said, there were so many things happening during elementary school. Could you describe them in more detail?

A3: It was not indicated in the teacher-parent communication book. I really do not know what happened in his class....

A: It was really not a big deal. I was fine for the first two years in school. Beginning in the third year, I no longer liked going to school. I did not want to study... After a while, I began to chat with classmates nearby. The teacher told me not to talk. I might stop for a while, about five minutes... then I talked to my neighbors again. By fourth grade, I occasionally fell asleep in class. Probably twice a week—maybe more. I slept through all my classes in my fifth year of school. One teacher even instructed my classmates not to wake me up, otherwise I would keep talking with my classmates. The teacher thought it was better for me to stay asleep. I really did not like to go to school.

...

A: ... at that time, schoolmates often asked you which group you belonged to. If one was involved in conflict with another group, she would ask us "Are you on our side? Or are you going to join hers?' I felt that if there were conflicts among our friends, I did not want to take sides, because it would not be right no matter which side you join. I would rather stay neutral. So...if I saw her in class, I'd still greet her. However, it was really a hard choice, because people would think that you belonged to the other side. Once they think this way, they won't listen to your explanations. They resisted. Then I got angry. They would start to threaten me. I thought it was good timing for

my mom to back me up.

I: Why didn't you inform your mother at that time?

A: At that time, I felt that, once I told my mom, she would definitely come to the school. I thought that she was probably very busy at the factory. I did not want to bother her. Since it was not a big deal, it was better to smooth things over this way. These people did not want me to be their friends. I did not want to be theirs either. So from time to time I was looking around for friends. (C1003)

ADHD children in general need some guidance to articulate their inner experiences. However, they do not require as much support as the residents of YLTC. At the same time, the children's narrative competence is certainly not as good as that of the residents at the JLVTC. The children with ADHD may not know how to describe the incidents or accidents they get involved in very well. Even if they clearly describe their life experiences in general, they still fail to present experiences related to losing control over their tempers. To find out about such aspects of their life experience, we must listen to their parents or supervisors.

A: ...... The trigger itself could be trivial or vital; it is a matter of perception. If it is a juvenile crime, the police come. Both of us parents and our son had to go to the police station. There was nothing we could do about it. All we could do was just listen to what people there were saying. My son was so nervous. He was also afraid. The sight of him there chills my heart—it's heartbreaking. I really did not know what to do and how to express myself. The police told him, "You are in trouble. Do you understand why you did this?" But he really did not know. (C3001)

Accumulated accidents, usually involving loss of temper and violence toward other people, causes parents to seek help from medical professionals. At the same time, people at school label the ADHD kids as bad students and people don't want to bother with them. Collaboration and coordination among schoolteachers, physicians and parents is essential for the treatment process. It is important to follow the guidance from experienced child psychiatrists:

I: Why do you want to take part in the family support group?

A: I want to help others. This condition may occur at any stage of anyone's life journey. If there is a possibility of early intervention, there would be fewer troublemakers like me than before in society. They won't injure others, hurt people's feelings, or violate social norms and ethics. I feel that we have to be responsible for our disease by seeking medical treatment, rather than put up with it. .....I am happy to learn that it was not a habit, but rather, my disease. In the past, I always thought it was a bad habit. I even hated myself because I could not change this bad habit. Now I have an excuse, because it is a disease, and that allows me to forgive myself. This forgiveness is possible under the assumption that losing my temper is not what I want. If it is what I wanted, then I am wrong because I am just 'going deep into the mountains, knowing well that there are tigers there.' That would be my fault. Since I recognize it now as a disease, I am obligated to seek medical care. (C2002)

This active participant is an adult ADHD patient. By seeking care for his child, he finally realized he was himself a victim of the disease. He then began to take a very active role in forming a family support group for ADHD. The way he regarded illness—as patients' responsibility to seek medical care—became a social norm shaping a new identity, one in which he possessed civic virtue. This is a shared belief that facilitated the formation of this family support group.

As a junior high biology teacher, I was so impressed by Dr. Chen's lecture. I was so impressed and enlightened by his talk. I also reflected on

the fact that a teacher like me had nonetheless been mistreating my child for years. It's my social obligation to disseminate knowledge to the public. These children are suffering from their biological condition rather than bad character. Their nature is good, but they need medical and social support to help them manifest their talents....If people have knowledge and a support system, they will treat ADHD children differently. (C3004)

Integrating behavioral with medical support is essential for the ADHD child. The narrative approach revealed this family support group turned out to be a self-aware therapeutic community for ADHD, because all stakeholders related to the ADHD child were working with the child and supporting each other. The support group provides a very important foundation for maintaining doctor-patient relationship for the adult ADHD patient.

I: When you began to take medication, did you start feeling better? In what way has your life changed since then?

A: After taking medication, I was suddenly able to concentrate on reading books. My ability to read is the most significant change. In the past, I could not read novels. I would forget them soon after I read them. I could not even read articles I was motivated to read—I would forget them as soon as I finished them. I could not remember the content.

I: So it's the way you read....

A: I could not learn.

I: What did you think about that situation?

A: It was really annoying that it was so easy for me to forget things. Even when I was chatting with my wife, she felt that I was not responding to what she was saying....medication improved me a lot....I became more affectionate and am able to chat with people normally. (C2002)

Medical treatment is crucial to help ADHD patients get free of their biological constraints. They then are able to enjoy reading and to communicate appropriately with other people. This was very true both for the ADHD children and their family members.

A3: Yes. He began to visit Dr. Chen's clinic in December 2012.

I: Now how do you feel? What do you think about your school activities or daily life?

A: I feel good, whether I am at school or at home...

I: As your mother said, you do not like to go to school, do you?

A: No, that's not true anymore. I now care very much about my academic progress....Now I really want to get the degree. I already told other people I study really hard before examinations. They asked me, 'Why do you need to study? You are not really reading textbooks.' 'No, I am reading,' I answer them. 'I want to succeed at school.' I am not really used to answering in that way...(smile) (C3003)

It is evident that medication did help this adolescent with ADHD change his attitude toward life; he came to care about his academic progress, which was not the case before. Also, his mother played an important role in facilitating her son's change. She spoke to her son as a friend, assuming a tone of equal status in conversations with him. These are important skills in behavior therapy; an authoritarian approach is not appropriate. ADHD children have to be motivated in their own ways; hence, supportive strategies are crucial for empowering them, along with help from medical professionals.

Interacting with ADHD children in an equal and supportive manner is very important. This is also related to the etiology of the children's behavior before they started receiving professional treatment. One leading figure in this family support group shared her experiences with ADHD children:

I think that no one really wants to behave with abandon. If someone behaves like this, what really matters is that they are emotionally

damaged on some deep level. Where there is hope, the ADHD child will soon find that they desire very much to be recognized and get approval from other people. However, this child may have faced only negative feedback for a long time, especially junior high students. They therefore have to behave like they don't care. (C3004)

It is important to realize that ADHD children are not competent to understand people's reactions. They live in their own world and unexpectedly trigger other's tempers. Then the kids are so ignorant as to make the situation even worse. It is a vicious cycle they experience frequently and even includes significant punishments. The problem is that they still do not understand at all, but their interpersonal relations become very harsh. This is the reason why ADHD children become troublemakers.

Discussion

The development and nature of these different models for therapeutic communities are clear, as are the key elements that foster empowerment in each model. For the SMI in the YLTC, the triggers of mental illness may have originated in their minds, for example, in paranoid thoughts (A1004), compulsive behaviors (A1003) and so on, or the illness may be a result of external forces (A1001). These triggers have become structural constraints for these patients and have limited their life opportunities since childhood. At the YLTC, patients' outside stressors are replaced with a support network through which they learn to open up to life opportunities, to the full extent permitted by their mental and medical constraints. Medical indications are the foundation, and may reshape their preferences accordingly, enriching their quality of life through the mutual support network extending from the mental hospital to the neighborhood environment surrounding the YLTC (Mortari & Pino 2013). It is important for SMI patients to recognize the necessity of medication and self-discipline for freeing themselves from the

suffering associated with their illness. Assessing narrative competence may reveal to what extent, and in what ways, these patients could be free from institutional support, or whether it might be possible to reduce the intensity of medical treatment.

As for the patients at the Jia Lao Village Therapeutic Community (the JLVTC), training substance abusers to be mutually supportive has become essential in forging an appropriate group culture. A supportive environment allows residents to make their own decisions and to take responsibility for themselves (Yardley et al., 2013). Self-discipline is paramount for them, as they must resist temptation from the outside environment (Abdel-Salam, 2013). They therefore begin to support each other and take active part in the recovery program. Finally, their work serving the disabled elderly draws residents into a process of identity transformation by which a self-centered person learns to be tolerant and supportive of others (Lima & da Mata, 2013). Analyzing the narratives of substance abusers using Jonsen's approach, it becomes clear that there are no strict medical constraints upon these patients. Medical indications are, in fact, by no means limited to pharmacological treatment, and more akin to behavior therapy for mental illness. Patients' preferences are shaped by contextual features rather than physical constraints, except within the very limited time period required to relieve withdrawal symptoms from heroin or other hard drugs. Whether the problem arose because they were surrounded by peer drug users (B1001), was a response to too much academic pressure (B1002), or they were seduced by the peer pressure from a neighborhood social network (B1003), their life opportunities are significantly restricted by both the effects of the drug and their life context. They are, in fact, victims of social illness, rather than mentally or physically disabled. Interpersonal relations are a key contributor to their behavior, and the realization that helping others is in fact helping themselves becomes

one of the most crucial lessons of the JLVTC recovery process (Tuchman & Sarasohn, 2011). The new context provided by the therapeutic community helps residents to form a new identity and develop greater self control, as well as to become willing to establish higher goals in their lives (Dermatis, James, Galanter & Bunt, 2010).

The adult ADHD patient's narrative (C2002) reveals that the family support group turned out to be a self-aware therapeutic community, because all stakeholders related to the ADHD child were working with the child and supporting each other. For this adult ADHD patient, the support group provided a foundation for maintaining the doctor-patient relationship. Appropriate medical indications are crucial for helping ADHD patients become free of their biological constraints and for helping children with ADHD change their attitude toward life. Since an authoritarian approach is not appropriate for this situation, we have to respect the preferences of ADHD children by providing supportive strategies that empower these kids, with help from medical professionals. Attention to context may lead us to realize that ADHD children are not competent to understand people's reactions. They live in their own world and unexpectedly trigger others' tempers. An accumulation of incidents, usually involving loss of temper or violence toward others, causes the parents to seek help from medical professionals. At the same time, the ADHD kids are labeled "bad students" and people don't want to bother with them. It is a vicious cycle they experience repeatedly, and they may even receive significant punishment. The child's context is therefore as important as medical indications for shaping patients' preferences. At the same time, social environment plays a very important part in their competence to pursue quality of life. The childhood etiology for children with ADHD in family support groups is somewhere in-between that of patients subjected to the contextual features of the JLVTC and the way

patients are limited by their physical/mental constraints in the YLTC.

One common feature of these different models of therapeutic community is that they cleverly liberate patients from their current physical, mental, or environmental constraints by finding potential life opportunities embedded in the narrative of each so-called mentally ill patient. These constraints allowed their illnesses to grow out of control by limiting life opportunities at a particular point of no return, in a manner that would be characterized by a vicious cycle in their life narratives.

In comparing and contrasting childhood or adolescent experiences related to the development of these illnesses, we realize experiences in youth not only offer important keys to the recovery process in each therapeutic model; they also indicate a common pathway for promoting mental health in children (Liehr et al., 2010). It is important to retain the full potential for social life in families with mental illness (Byrt 2013; Garland, Schwarz, Kelly, Whitt, & Howard, 2012) Moreover, competence in narrative understanding is essential for designing effective community-based treatment programs for children. A narrative approach will not only help construct a model of recovery, but also a model for promotion of mental health.

The findings of this research support the concept of a therapeutic community based on Thomas Main's 1946 idea of the "hospital as a therapeutic institution," where psychiatric patients are encouraged to take active part in their own and each other's treatment and rehabilitation programs (Main 1946; Manning 1989; Johnson et al., 2012). On the basis of Taiwanese experiences with therapeutic communities, we contest the discourse that regards TCs as a method of social control for the mentally ill or other kinds of deviant persons. We argue that democratic social and political discourses are flawed by employing Piaget's cognitive-developmental theory as an

approach to cultivating a fully responsible citizen who is prepared to engage in the bourgeois public sphere. These discourses regard efforts to develop therapeutic communities as authoritarian, but such claims are misleading and are contradicted by the therapeutic mechanisms described in this paper. Such criticisms are also clinically unjustifiable and unethical when examined through the lens of narrative understanding and Jonsen's method of ethical analysis. The assumptions about child development embedded in so-called liberal democratic theory are invalid, because the identity of each individual in this study is formed in the social fabric of interpersonal networks and cannot be understood as an atomized individual. Moreover, the support network for shaping individual identity in TCs could also be ideal for developing a sense of community as a foundation of democratic society (Perry et al., 2014; Yardley et al., 2013).

The teleological assumptions about child development embedded in modern authoritarian medicine should be challenged and replaced with a phenomenological one, in which narrative competence is the way people should learn from and support each other, shaping a sense of community and their own identity at the same time (Irene Wong & Stanhope, 2009) In this view, life is a journey that comes with various physical, mental and social constraints which everyone has to cope with. Children and the mentally ill in this sense are not too different from ordinary people.

However, in designing TCs that operate as a recovery program, participatory design is the way to ensure both effectiveness and the essence of what we value as democratic. It would be interesting to verify this hypothesis with a narrative approach to understanding ADHD children who did not receive support or intervention from their families. Our findings are in general consistent with the call for patient centered outcome research (PCOR), in which shared decision making becomes a must in clinical or policy settings (Selby, Beal, & Frank, 2012). This research also provides a model that complements PCOR with narrative methods, as a way of preventing its scientific paradigm from reproducing an authoritarian medical regime that makes the involvement of all stakeholders illusionary.

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