行政院國家科學委員會專題研究計畫 成果報告

慢性化精神疾病的因應策略
研究成果報告(精簡版)

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Coping with Chronic Mental Illness

Introduction

People with chronic mental illness represent assaults on multiple areas of

functions. They have to face separation of family, friends, and other sources of

gratification; loss of key roles; assault on self-imagines and self-esteem; less personal

control over their life circumstances; weaker network of potential support; disruption

of plans for the futures; uncertain and unpredictable futures; and distressing emotions

such as anxiety, resentment, and helplessness; as well as illness-related factors as

permanent changes in mental or body functioning (Turk, 1980; Link & Cullen, 1990).

Reported from the Research, Department and Evaluation Commission, Executive

Yuan (1995), there were 27% hospitalized patients should be discharged from the

hospital but they were not being to do so. The reasons were (1)the unstable metal

illness symptom; (2)poor medication compliance on the mentally ill patients;

(3)resistance from the families for the care burden; (4)better medical and

rehabilitation services received; and (5)less family financial expenses by

hospitalization. These factors lead persons with chronic mental illness long-term

hospitalization and exclude them from the society. This is against the welfare policy

to encourage this vulnerable population back to the community.

Helping people with chronic mental illness with capacity to live in the

community and maintain a fulfillment life, practitioners need identify those psychosocial and behavioral contributors to and consequences of chronic mental illness in terms of enabling them to live with the illness. The study, therefore, explores how this vulnerable population coping with chronic mental illness after a long-term hospitalization.

Conceptualization of Chronic Mental Illness

This study started with the conceptualization of chronic mental illness as noted by Goldman, Gattozzi and Taube (as cited in Milazzo-Sayre et al. 1997). These scholars distinguished chronic mental illness in stages based on diagnosis, disability, and duration. They start with the individual's mental or emotional disorder (e.g., schizophrenia, recurrent depressive and manic-depressive disorders that may become chronic). In 1993, the Substance Abuse and Mental Health Services administration (as cited in Milazzo-Sayre et al. 1997) emphasized a broader definition for chronic mental illness as follows: "adults with a severe mental illness… 〔are〕 persons age 18 or over, who currently or at any time during the past year, have had a diagnosable mental, behavior, or emotional disorder of sufficient duration resulting in functional impairment which substantially interferes with or limits one or more major life activities" (as cited in Milazzo-Sayre et al. 1997, p.14). The definition of chronic mental illness employed in this study combines the above two definitions as follows:

"adults with a chronic mental illness being age of 18-65 years old, who currently or at

any time during the past years, have had a diagnosable mental illness, or emotional

disorder of sufficient duration resulting in functional impairment." Chronic mental

illness causes psycho-social functional impairment which would lead an inconvenient

and unsatisfactory life for people suffering this illness.

Suffering Chronic Mental Illness

Milazzo-Sayre, Henderson and Manderscheid (1997) found chronic mental

illness can erode or prevent the development if an individual's functional capacities in

relation to three or more fundamental aspects of daily life (e.g., self-care,

self-direction, interpersonal relationship, social transactions, learning, and recreation).

Such functional erosion may deter the development of their economic self-sufficiency,

an outgrowth of their social- and work-related capacity. Link & Cullen (1990) pointed

mentally ill patients suffer numerous psychological and social deficits.

For the psychological deficits, Torrey (1988) mentioned the "inner world of

madness" as a fearful state involving alteration of the senses; inability to synthesize,

sort, or integrate stimuli; feelings of unreality; and an altered sense of self, including

feelings of unreality; and an altered sense of self, including detachment of one's body.

For the social deficits, individuals with chronic mental illness who reported avoiding

social interaction to avoid exposure to rejection because of their illness indicated to

prefer turning to members of their own family rather than to persons outside the

family for emotional and practice support (Perlick, Rosenheck, et. al. 2001). This is

being discriminated by the society.

From above, people with chronic mental illness struggle more with life stressors

than do mentally health individuals and are often stigmatized against by their

community and society. They experience difficulties from the illness itself (i.e. denial

and uncertainty), the self (i.e. identity) and the society (i.e. stigmatizing, labeling and

exclusion)

Denial

Once people were diagnosed as having chronic illness or confronted their life

stressor, their spontaneous reactions are usually resistant and denying. They are afraid

their unknown illness and generate the uncertainty about their lives in the future. They

can't believe when they have this kind of misfortune and why this life stressor could

happen on them. As participants in the focus group said:

> "Why me?" "I was enforced to come here for my drinking" "I do not have mental illness.
> My parents misunderstand me." (Mr. Shun)
> "I was out of control for being cursed. I do not need to be hospitalized. Why my families
> do not take me home and keep me hospitalization." (Miss Wu)
> "I have no idea about mental disorders. I am not mental retardation why I was diagnosed as
> having psychiatric disorders."(Mr. Fang)

From the statement, persons with chronic mental illness denied and refused to

accept their illness. Most of them tried to find more information to verify unknown

events about their illness. This is their defensive mechanism to cope with this life stressor.

Uncertainty

People with chronic mental illness may perceive a feeling of insecure and vagueness in the present and in the future. Their lives become unpredictable, uncontrollable and unsafe because they sense "something unusual is going on"with their body or perception of feelings. From a study participant, Ms. Zhan, diagnosed having bipolar disorder, felt disturbed by the uncertainty of the illness trajectory. The period of exacerbation and remission of illness intrudes into her daily life tasks (e.g. domestic affairs, work, marital and family relationship). Her life becomes more difficulty to plan and her daily life activities must be revised frequently. It is unbearable for her to live in the remission with the potential return of depressive symptoms.

> For instance, "How will my life never be the same? This question that really bothers me is, when the hell is "someday? "

The situation of living with the trajectory of mental illness is an unpleasant but "normal features" experience for people with chronic mental illness. They had hard time in controlling their illness and felt difficult in managing a daily basis changes like "on/off syndrome" of their mental disorders. Though they tried to avoid the negative thoughts about the disturbance of their illness and attempted to reduce their

personal uncertainty by "passing" or "covering up", however, they still failed in

predicting and managing the uncertainty of illness. Mishel (1988) said uncertainty is a

kind of cognitive process of illness-stimuli and constructs meaning in life events.

Uncertainty can be viewed as a danger or an opportunity. For people with chronic

mental illness, uncertainty was a kind of fear and threat to their life because they were

unable to foretell their lives no matter in the present or in the future.

> "I don't know what this time holds for me. Part of me wants to set up a schedule,
> draw up an agenda of things to think about, decisions to make, work to do." "I
> have been ill for more than 10 years. I live day by day, no hope at all. After the
> illness, I always feel dizzy and have no fulfillment. I barely think I can pursue any
> plan in my future except regularly visiting the doctor, taking medication and
> accepting vocational rehabilitation on lime." (Mr. Chen, with schizophrenic
> disorder, said.)

Identity and Stigmatizing

Kelly (1992) defined self is an imaginative view of ego by ego; identity is a

self-linked to social context or social relationship which is a "social me". Tuner (1987)

stated one has identity when one is situated and cast as a social object and

acknowledged as a participant in social relations.

Chronic mental illness is usually viewed as a threat to self and identity, a loss of

body integrity and a disruption of personal life. When people have discredited

problem, they began to control information about these blemished aspect of self and

of "passing" and pretending to be "normal" (Goffman, 1963). They don't want to be

viewed as socially incompetent.

> Like a focus group member, Miss Wu, a schizophrenic patient, said, "When you have a mental disorder, everyone has an opinion about what you should do. People seem to think that not only are you mentally ill, you are also stupid."

They begin to reconstruct themselves for maintaining their self-integrity. When they reconstruct the meaning of their living experience, they might experience a transformation in their self-identity. The mentally ill individual shifts from a victim of circumstances to a creator of loss of normal self and struggle to be as normal as possible (Barroso, 1995). This is a cognitive response to the disintegration of self. Williams (1984) also stressed on the importance of reference between body, self, and society and reconstruction some sense of order from the fragmentation produced by chronic illness.

Stigma was viewed as a kind of discrimination for mentally ill persons. Goffman (1963) defined the stigma is an evidence of disgrace that is visible and takes the form of physical or psychological signs of disorder, weakness, immoral or pathology. He stated individuals might be deemed discredited because they lose boundary and specific of content and they are deviant from the normative order. Stigma brings the feelings of fear, guilt, and shame. Like discussion in the focus group:

> "Hallucination is such as cruel punishment. There are no fever, no blood tests to send people scarring in concern. Just the slow erosion of the self, as insidious as any cancer." (Mr. Zhou, a schizophrenic participant, said)
>
> "All my neighbors laugh at me as a nut for the times of hospitalization. I felt distressed and upset. I have been in the recovery process." "I am afraid the psychiatric diagnosis printed on my ID or being identified ever to be hospitalized after discharge." (Miss Gao, schizophrenic participant)

From above sentences, people with chronic mental illness expressed their despair,

helplessness, and powerlessness. Additionally, they may lost their self-confidence and

devalued themselves.

Labeling

Identity change concerns with potential labeling, stigma, and status passage and

of experience of power relations in social institutions (Kelly, 1992). Labeling has

pervasive negative consequences on psychological and social function (Link & Cullen,

1990). When people were labeled as mentally ill, they may lose their social identity

among the social situation. Definitely, the focus group participants reflected their

negative reactions from labeling. Ms Shu, said:

> "When did you start having symptom of ? "Now, I am labeled a hysterical woman. And the
> worst thing about it is that I feel humiliated than anger." "She tells me that I am 'quite
> depressed.' I cannot tolerate being labeled 'depressed'. 'Quite depressed' sounds more
> serious and feels 'quite' uncomfortable when applied to me. I tell her how humiliated I am
> that I cannot deal with it myself. I confess my hypocrisy, professing that I can help other
> people when I am such a mess self.

All above difficulties, such as denial, uncertainty, identity, stigmatizing,

labeling and exclusion formulate the massive stressors in the daily life for people

with the chronic mental illness.

Surviving Chronic Mental Illness: Stress, Coping and Adaptation

Stress has been conceptualized in a number of ways. Locke and Taylor (1990)

view stress as:

> First, the levels of stress that have deleterious health consequence can be reduced. Second,
> inputs that bolster health (or other outcomes that may be adversely affected by stress) can

be provided, and hence compensate for deleterious impacts of stresses. Third, the impact of stresses on health can be mitigated or buffered (House, 1981, p.5).

More broadly conceived, Lazarus and Folkman (1984) view stress as a stimulus, a response, and a transition. Stress is a stimulus because it includes many events that occur in a large environmental context to masses of people; stress is a response involving an individual-level reaction to environment events in life; stress is a transition that focuses on the relationship between the person and the environment. People with chronic mental illness already experience primary stress from the nature of their illness. Secondary stress may be generated by their interaction with family members, peers and others in society.

The secondary/social stress is associated with many of the social, physical, psychological, and behavioral factors noted in health and disease (e.g., life dissatisfaction, headaches, heavy perspiration, upset stomach, tachycardia, insomnia, etc.) (Dunseath, Beehr & King, 1995). Studies argue that social stress is central to the etiology of psychological disorder because the stress process many contribute to the development of a wide range mental disorder such as depression and infectious diseases (House, 1981; Pearlin, 1999). Pearlin (1989) described stress is the experience of the disruption of meanings, understanding and smooth function. Coping is what one does about that disruption. Aldwin (1994) found that a stress and coping approach to psychosocial adaptation acknowledges the contribution of both the person

and the environment, and seeks to understand the particular environmental context and personal skills and resources that provide for optimum adaptation. Hartfield (1987) noted that adaptation theory is based on evolutionary concepts, primarily on the notion that living organisms would do what is necessary to struggle to survive. In this struggle, certain behaviors develop that are defined as "coping mechanisms."

Coping mechanisms perform as deliberate, conscious efforts (cognitive, emotional, and behavioral) to control the stress response, and adapt to the stressful conditions. Coping is always bounded by the meanings and issues inherent in what counts as stressful with the goal of the restoration of meaning (Benner & Wrubel, 1989; Wiener & Dodd, 1993). By coping the things that people do to avoid being harmed by life strains (Pearlin & Schooler, 1978). There authors go on to say:

> The protective function of coping behavior can be exercised in three ways: by eliminating or modifying conditions that give rise to problems; by perceptually controlling the meaning of experience in a manner that neutralizes its problematic character; and by keeping the emotional consequences of problems within manageable bounds. (1987, p.2).

Within the above categories, responses that modify the situation are viewed as the most direct way of coping. However, where there is little possibility of changing or eliminating the problem, the stressful impact may be buffered by responses that function to control the meaning of the problem. Minuchin (1974) have argued that some individuals have learned maladaptive ways of coping with problematic situations that serve to maintain rather than eliminate problems, but

with appropriate intervention, new strategies can be learned. Greene and Lason (1991) also stated that coping skills, evoked naturally by the experience of stress, are behaviors carried out by an individual to regulate his or her feelings of emotional stress. To reduce, mitigate and/or buffer the stress process is important for people with chronic mental illness adapting into their illness and successfully surviving in the society.

Lazarus and Folkman (1984) have differentiated coping types as problem-focused coping and emotional-focused coping. The previous coping type is aimed at resolving the problem or taking action to eliminate or change the sources of stress; the latter is oriented toward managing the emotional distress evoked by stressful situation. Carver, Scheier and Weintraub (1989) further distinct problem-focus coping style (also referred as to task-based coping) as active coping/ direct action; planning; and seeking instrumental social support (e.g., advice, assistance, and information). Emotion-focused coping is discrete into seeking emotional social support (e.g., sympathy and understanding); positive reinterpretation (reappraising a distressful event as a learning or growth experience); acceptance of the reality of the situation; turning to religion; and "denial" or a reappraisal of the seriousness of the stressor, which is sometimes protective. Roger and Nash (1995) divide

coping styles into rational coping, emotional coping and avoidance-based

coping. Problem-focused coping is operative when people feel that it is

within their power to control or deal constructively with a stressor.

Emotion-focused coping tends to be the response when people feel that a

stressor is too difficult to mange, control, or overcome. From above studies,

coping strategies serve three functions: (1) changing the situation out of

which problematic experience arise, (2) controlling the meaning of the

problematic experience after it occurs but before the emergence of stress, or

(3) controlling the stress after it has emerged (Pearlin & Schooler, 1978).

People with chronic mental illness are able to well live with their illness by

ability to cope living stressors. The ability to cope requires both internal and external

resources. Internal resources refer to self-esteem and problem-solving skills; external

resources include family, social network, and organizational supports. Coping

resources refer, not only to what people do, but to what is available to them (Turk,

1980). Hence, the availability of coping strategies assists people with chronic mental

illness to better adjust their illness and living environments.

Methods

Integration of qualitative and quantitative methods

In this study, qualitative and quantitative methods were employed. Qualitative

and quantitative methods usually provide information on different levels of sociological description. Quantitative analyses show phenomena on an aggregate level and can thereby allow the description of macro-social structures; qualitative data may also relate to phenomena on macro-societal level (Kelle, 2001). Both their strength lie in their ability to lift the veil on social micro-processes and to make visible hither to unknown cultural phenomena (Kelle, 2001). To formulate adequate sociological explanations of certain social phenomena, it will often be necessary to combine both types of information, and thus use a 'trigonometrical' understanding of the triangulation metaphor.

Kelle (2001) continued to stress triangulation is a central concept for method integration. The model of triangulation: qualitative and quantitative findings are combined to give a fuller picture of the investigated phenomenon. The metaphor of triangulation is mutual validation, and the integration of different perspectives on the investigated phenomenon. It has original trigometrical meaning. The strength of triangulation is to reduce the risk of systemic distortions inherent in the use of only one method (Maxwell, 1988), and is less a strategy for validating results and procedures than an alternative to validation which increases scope, depth, and consistency in methodological proceedings (Flick, 1998).

The strength of triangulation is an important concept for this study and would

help to increase the validation of the study findings. In this study, we would identify

data triangulation, theory triangulation, and methodology triangulation that were

employed on this study. A rich variety of methodological combinations were used to

illuminate inquiry questions. Triangulations within a qualitative inquiry strategy can

be attained by combining both interviewing and observations, different mixing types

of purposeful samples, and taking into competing theoretical perspectives in analysis

(Patton, 2001).

Participants

The eligibility criteria for potential participants included: (1) between the ages of

18-65, (2) having been diagnosed with at least one chronic and persistent mental

illness (e.g., schizophrenia, major depression, bipolar) by licensed Taiwanese

psychiatrists using the criteria set forth in the DSM-IV, and (3) being able to report on

their illness history, the awareness of illness, the impact of illness, health locus of

control, self-esteem, self-identity and stigma, social support and coping strategies.

This stud was design to a sample of 180 participants. Patients had a diagnosis of

schizophrenia, major depression, and bipolar. In order to be eligible for this study,

participants had ever to be hospitalized for more than 1 year (Wiender & Dodd, 1993).

Resulting in an 86-item self-report questionnaire was administered to 140 individuals

with chronic mental illness with the assistance of the researcher. There were three

focus groups were organized and participants recruited from day hospital, male

chronic ward and female chronic ward. Each focus group contained 6-10 participants

to attended 6 sessions interview in each study site. A total of 73 respondents

participated attending in the experiment group and 67 respondents were control group.

All research participants, ranging between 18 and 65 years old, were referred directly

by senior mental health professionals from three hospitals in Taiwan (Jing-Ho Mental

Hospital, Yan Chau Branch, Kai-Suan Municipal Psychiatric Hospital and Tsyr-Hui

Mental Hospital). These three study sites agreed to collaborate with the researcher's

study provided that the study fulfilled the requirements of their institutional review

boards. The research protocol was also approved by the National Scientific Council,

07/2006 and informed consent was signed by all participants.

Measures

A multi-question, self-report survey was used to collect necessary data. The

questionnaires were divided into 5 sections, Socio-demographic, Awareness of Illness,

Illness Adaptation, Impact of Illness and Coping Strategy Scale in Schizophrenia,

which coincided with the research variables under study. These instruments were

designed for Taiwanese respondents based on Chinese culture.

A) Awareness of Illness

A revised version of Assessment of Insight in Psychosis scale (AIP) was used

(Su, 2002). This self-report questionnaire consists of 16 items covering 4 domains: the awareness of medication, insight, the awareness social impact, and awareness of illness barriers. Reliability analysis for the revised AIP scale yielded an internal consistency coefficient of .67 (n=106). The alphas for the subscales were internally consistent and reliable ranging from .54 to 92.

B) Illness Adaptation Scale

This self-report questionnaire consists of 41 items covering 4 domains: health locus of control belief (items 11-24), stigma (items 25-36), identity (items 37-41) and social support (items 1-10). Among 106 sample of psychotic patients, internal consistency of this scale ranged from .67 to .90 (Su, 2002).

C) Impact of Illness

The Impact of Illness Scale is a 13-item self-report measure designed to measure the degree to which situations in one's illness are appraised as stressful (Su, 2002). Impact of illness comprises 3 domains: adjustment difficulty, helplessness and positive management. The Reliability analysis for this scale yielded a high internal consistency coefficient of .91 (n=106). The alphas for the subscales were internally consistent and reliable ranging from .49 to 83.

D) Coping Strategy Scale

This study used Coping Strategy in Schizophrenia (CSS) scale (Xiao, 2001),

covering 35 items under six domains: positive emotion, avoidance/prolong, positive

cognition control, negative emotion, illness experience and bio-psycho dependence) to

evaluate the participant's coping with his or her mental illness. Among a Taiwanese

sample of 111 schizophrenic patients, internal consistency of this scale ranged

from .52 to .87 (Xiao, 2001). Reliability analysis for the overall CSS scale yielded a

high internal consistency coefficient of .88 (Xiao, 2001).

Data Collection

This study used a non-probability, purposive sampling technique to select a

convenience sample from this population of individuals diagnosed with severe mental

illness. Demographic information was collected during the interview and

double-checked by reviewing medical records. Interview was videotaped and

transcribed verbatim onto NVivo software. Among the tenets of the Grounded Theory

method is that data collection and analysis are interrelated process. Sampling proceeds

on theoretical grounds, in terms of concepts, their dimensions, and variations. The

coding paradigm of Grounded Theory proved to be adaptable to retrospective data and

led to the emergence of the core social/psychological process of coping with chronic

mental illness reported by respondents in this study. This method enhanced the

discovery of the dimensions of those coping processes people employ as they deal

with the disease and its consequences (Wiender & Dodd, 1993).

Results

Quantitative Findings

This study included 140 participants (78 men; 62 women). Most (41.8%) of the

participants were between 32 and 45 years old (mean age, 40), had never been

married (62.2%) and held senior high school diplomas (43.6%). The mean length of

chronic mental illness for all the study participants was 10.70 years (SD=7.98) and

54.5% of them had been hospitalized more than 3 times or less. 49.3% of the

participants feel their symptoms under stabilization condition. Over half of the study

participants believed in Eastern Religions.

Table 1 shows the means and standard deviation of the predictor for the

experiment group and control groups by illness awareness, illness adaptation and

coping strategies employed by persons with chronic mental illness. There were more

similarities than differences between the two groups on all these measure. It pointed

that all study participants were similar aware their illness and its impacts on

psychological and social aspects. The groups were only significantly different on the

avoidance-prolong coping strategy (t=-2.13, p$\leq$ .05). This findings indicates that the

participants in the group who felt tend to use less avoidance approach than did their

counterparts.

Table 1: Comparisons of Means on Illness Awareness and Illness Adaptation Scale between Focus Group and Non-Focus Group Participants (N=140)

	Experiment Group Mean (SD) N=73	Control Group Mean (SD) N=67	t-score (p-value)
Illness Awareness	4.03 (.85)	4.05 (.70)	-.35 (.72)
Illness Adaptation	4.06 (.58)	4.05 (.64)	-.09 (.93)
Social Support	4.62 (.87)	4.52 (1.11)	-.55 (.58)
Stigma	3.50 (1.05)	3.64 (1.13)	.75 (.46)
Health Control Belief	4.04 (.78)	4.09 (.78)	.34 (.73)
Identity	3.96 (.79)	3.92 (.74)	-.30 (.76)
The Self Impact of	3.76 (.75)	3.64 (.92)	-.89 (.38)
Illness			
Coping Strategies	2.17 (.85)	2.03 (.88)	-.97 (.33)
Negative Emotion	3.04 (.89)	3.06 (.85)	-.11 (.91)
Positive Cognition	2.17 (.91)	2.51 (.98)	-2.13 (.04)
Avoidance*	1.78 (.86)	1.74 (.77)	-.30 (.76)
Dependency	3.08 (.92)	3.05 (.85)	-.23 (.82)
Positive Emotion	2.37 (.90)	2.28 (.79)	-.67 (.51)
Illness Experience			

Note: All scales were scored so that higher score indicate more favorable ratings.
****$\leq$.0001, ***$\leq$.001, **$\leq$.01, *$\leq$.05

Table 2 shows the correlation results for the entire participants. The range of these correlations was from .19 to .77, 6 domains of coping scale were most frequently correlated with the difficulties generating from the illness. Of interesting, all participants tend to employ illness experience to cope with their chronic mental illness.

Table 2：Statistically Significant Correlation Associations between the Independent and the Dependent Measures for All Study Participants (N=140)

	1	2	3	4	5	6	7	8	9	10	11	12	13
1.Illness Awareness	1	.31**	.33**	.29**	.45**	.25**	.20*	.24**	.23**		.30**	.19*	.42**
2.Social Support		1		.23**	.46**			.36**			.42**	.21*	.62**
3.Dignity			1	.46**	.35**	.52**	.27**	.30**	.31**	.29**	.34**	.39**	.58**
4.Stigma				1	.41**	.45**	.45**	.22**	.42**	.29**	.31**	.39**	.75**
5.Health Control Belief					1	.36**	.31**	.26**	.30**	.27**	.27**	.34**	.72**
6.The Self Impact of Illness						1	.35**		.36**	.28**		.30**	.51**
7.Negative Emotion							1	.22**	.72**	.57**	.26**	.59**	.41**
8.Positive Cognition								1	.30**		.77**	.44**	.38**
9.Avoidance									1	.45**	.30**	.54**	.39**
10.Bio-Psycho Dependency										1	.26**	.51**	.35**
11.Positive Emotion											1	.52**	.46**
12.Illness Experience												1	.49**
13.Adaptation													1

Note: Correlation is significant at the .05 level (2-tailed). * = p≤ .05; ** = p≤ .01. Multicolinarity not reported.

Table 3 contains the results of modeling mental illness difficulties on coping domains, only overall illness adaptation significantly effect on negative emotion coping strategy (b= .66, β=.46, SE=.33, P≤.05) and illness experience (b= .75, β=.54, SE=.32, P≤.05). Social support (b= .22, β=.25, SE=.11, P≤.05) and dignity (b= .25, β=.22, SE=.13, P≤.05) were significantly in predicting employing positive cognition coping. Positive emotion coping employed was predicted by Social support (b= .22, β=.25, SE=.11, P≤.05).

Table 3: Multiple Regression Modeling Predictors on the Employed Coping for All Respondents with Chronic Mental Illness (N=140)

Predictors	Coping Domains			
Regression Models	Negative Emotion	Positive Cognition	Positive Emotion	Illness Experience
Regression Coefficients	b(SE) Beta	b(SE) Beta	b(SE) Beta	b(SE) Beta
Intercept	.98	.41	.95	.30
Illness Awareness				
Social Support		.22*(.11) .25	.22*(.11) .25	
Dignity		.25*(.13) .22		
Stigma				
Health Control Belief				
The Self Impact of Illness				
Illness Adaptation	.66*(.33) .46			.75*(.32) .54
R^2	.28	.20	.29	.27
Adjust R^2	.24	.16	.25	.23
F-value	7.25****	4.71****	7.73****	6.89****
Total df	139	139	139	139

Note:*$\leq$ .05; **$\leq$ .01; ***$\leq$ .001; ****$\leq$ .0001. Only Significant b and Beta coefficients are reported

Qualitative Findings

These are five interrelated themes emerged from the interview with group participants: (a) conceptions of the self, (b) avoidance-prolong, (c) active coping/cognition control, (d) emotional-oriented and (e)social support. The examples of each theme that follow are primarily extracts from interviews.

Conceptions of the Self: Normalization and Re-conceptualization

As illuminated by the Corbin and Strauss research, when a chronic mental illness intrudes, it sharply separates the person of the present from the person of the past and affects or even shatters any images of the self for the future.

"Who I was in the past and hoped to be in the future are rendered discontinuous with which

I am of the present. New conceptions of who and what I am-past, present, and future-must arise out of what remains" (Corbin & Strauss, 1988, p.10 as cited in Wiender & Dodd, 1993).

For persons with chronic mental illness, controlling symptoms, regaining a positive conception of self, dealing with stigma and discrimination, and trying to lead a satisfying life is increasing referred to as the ongoing process of recovery (Markowitz, 2001). Corrigan and Penn (1999) suggest that people with chronic mental illness can use a number of strategies to cope with stress and hardship in their daily life. From the qualitative analysis in this study, normalization and re-conceptualization were found to cope with the illness and reduce its impact for participants in reconstructing themselves and regaining their self-identity.

Normalization

Lee was diagnosed having major depressive disorder for 7 years. In Ms. Lee's situation, she wished to be able to deal with daily life affairs and was treated as a normal person.

"I am necessary for the shopping, invitation, cooking, clearing, and decorating but the actual family doesn't need me anymore. I have become invisible"
"The rhythm of the waves is hypnotic and endlessly reassuring. Still the gentlest lullaby I know. "Please, I am thinking, please don't make me get specific."

However, Lee's family couldn't view the emotional lows as not expectable transition like 'up days' and 'down days' that was a normal part of the psychological course of the illness. If they could treat her illness reactions as normal, they might feel better emotionally and were less disturbed by the down days.

Miss. Chen has been hospitalized for more than three years, she feels

comfortable in hospitalization except expecting her parents to visit her frequently. She

says,

> "I am not insane. I simply feel my head was ill and needs take medication. Now, I feel as
> normal as a person. I do not understand why few of my neighbors laugh at me. I have
> recovered."

An interesting insight by Mechanic (1984) also suggests that a coping

mechanism that might otherwise be labeled as "denial" may be useful incoming to

terms with the unusual changes in the life of a person with a major mental disorder. In

some instances symptomatic behavior is "normalized and the person does not become

a patient". As both Ms. Huang and Ms. Xu describe:

> "I feel no difference between before my ill and after. My son keeps visiting me and taking
> me home for few days. When I stayed at home, I cook, do laundry, shooing and buy
> grocery as a normal housekeeper" "I act normal but need take little medication."

All we know, shame, sadness, despair, hopelessness, powerlessness, and helplessness

are easy to be reflected from the people with chronic mental illness. Normalization is

the most ideal and useful coping strategy to deal with the negative emotions.

Normalizing means adapting to the situation at hand, finding ways to minimize the

impact of illness, disability, and regimen on daily life. Normalizing reduces disruption

and softens the impact of frailty and disability. Davis (1961) said the ideal strategy to

cope with the chronic illness is normalization, in which the attribute loses its

stigmatizing properties and no longer threatens legitimacy. Through exposure and

negotiation, the identity of stigmatized is redefined, so that salience is diminished, relevance is reduced, and ways of circumventing the strategies effect are found. In this study, focus group participants recruiting from day care programs were mainly found to use normalization to cope with their illness.

Re-conceptualization

Conceptualization the self is an import impact factor for people coping with their illness. The re-conceptualization would be an essential process on the self-identity and self-recognition for people experiencing chronic mental illness. We can tell the importance of the re-conceptualization from Miss. Lin. She said:

> "I have the feelings 'Sadness carried identification". You know where it's been on and you know where it's headed. Depression carries no papers. It enters my life unannounced and uninvited. Its origins are unknown, but its destination always dead-ends in myself."

From Lin's statement, we understand the need of managing stigma that may decrease a person's vulnerability toward negative self-definitions and social identifications. Meanwhile, it would bring the personal identity, hope for the people with chronic illness. During the beginning of Lin's depressive journey, she was unable to manage her stigma and kept carried her role performance in the family.

Mr. Fu has been ill for 10 years. He felt despair, helplessness, and powerlessness in the beginning years of his illness. At this time, Mr. Fu lost his self-confidence and devalued himself.

He said "My illness becomes so uncontrollable and impact me. When I was misbehaving and fighting with others, I felt anxious and troubled about many things. After that, I thought my life was totally destroyed and become a useless man."

"Hallucination is such as cruel punishment. There are no fevers, no blood tests to send people scarring in concern. Just the slow erosion of the self, as insidious as any cancer".

Kurzhan (2001) stated re-conceptualization of stigma evolves from the devaluation of an individual identity to the processes by which individuals satisfy certain criteria coming to be excluded from various kinds of social interaction. Hence, the re-conceptualization of stigma would be an important strategy to manage the stigma. It can help the people with mental illness to negotiate their identities and roles carried out, variously referred to as role play (Contu, 1951) and role performance (Turner, 1956). As Mr. Fu continued to describe:

"After having been ill for several years, I sense the illness carries positive and negative experience. Positive effect is to let me learn the value of the life and should not abandon myself. I tried hard to fight with the illness-this devil. When I won, I gain myself back and even feel happy and better than others. "

Mr. Shi also said: "After discharge from the hospital. I become stabled and could carry my performance as a teacher, a Christian and a son. The illness wouldn't impact me at all. I feel confidence about myself to spend times with my students, families and friends."

People with chronic mental illness are suggested to manage the stigma and devalued self and social identity through cognitive coping strategies to improve their poor social interaction. Meanwhile, they need to learn how to select both interaction patterns and the types of interactions with the others to adapt into the living environment. When Mr. Shi interacted with his friends, he understood selectively to release his information to the friends, which was his coping strategy to interact with

the friends.

> As Mr. Shi interacted with his friend/church fellows: "Mr. Chen, please tell us some stories.
> We may be able to relief your pain." "I feel like the doctor who holds the shot behind my
> back, hoping to hell. I strike a deal with them to for my own good." "I slightly tell them
> part of my stories."" I do not share whole stories with my friends. I usually tell the priest."

Mr. Shi selected the interaction pattern to make he feel more comfortable. He

tends to disclosure himself to the God father whom he trusts and tries to console the

impact of the symptoms. For coping this kind of situation, people with chronic illness

usually have to rethink how they live and who they are becoming (Chamaz, 1995).

They need to rebuild their legitimacy in their family, friends and social groups for

reconstructing a valued self and legitimate social identity. Moreover, seeking available

social resources can help them to decrease their risks and increase their opportunity in

recovery.

Hilton (1988) suggested the similar strategies for coping with chronic illness

include (1) mobilizing resources (e.g. information, support, strength, and relief from

others), (2) focusing on the construction of positive meaning of life, (3) buffering the

situation, (4) modifying the situation (increases the chance to have no recurrence and

prevention, sense of situational control over their health and life), (4) change in

attitudes (more tolerant, understanding, and empathetic toward others), confidence (I

am more integrated and not fighting it anymore, not thrilled if they find something),

and relationship (with others grew closer), and (6) reappraisal and changes in beliefs,

values, and goals. Some group participants focused on constructing positive meaning

of life, buffering the situation and becoming more confidence to fight for their lives.

As Ms. Luo said:

> "Each time the darkness comes I try to remind myself that it will not last. It will hurt me,
> but won't kill me. We know why this is happening. I just have to wait it out until the
> stronger dose of medication kicks in."…"The things wouldn't go too bad. I have my family,
> friends, medical staff to help me. We need think positively."

Positive illusions also can be another good approach to cope with the mental

illness because the "power of positive thinking" can boost the patient immune system

response to the illness or at least prevent it from being compromised by negative

mental state (Siegel and Schrimshaw, 2000). To encourage the patient maintaining a

positive state of mind is an essential strategy to cope with the illness. In Mr. Weng's

story:

> "I am dealing with my life. With experiences that aren't additive. A bad thing happening
> does not reverse a good thing. My life is not just one big equation in which I add, subtract,
> and balance to figure out how happy I deserve to be. But that's exactly how I live. I accept
> this situation."

Meanwhile, mentally preparing for the emotional upset, believing in the

possibility of long-term survival, manipulating the significance of disease stage,

refining "doing well" and being "healthy" are also important factors influencing on

coping with the chronic illness. In Mr. Fu:

> "The bottom line, I say to myself, is that my life has already almost slipped away from me.
> I have two choices: I can end it or fight like hell to save it."
> "I will fight it for as long as I can and hopefully I'll know when to quit."

From her statement, we can sense his mentally well preparation and his assumptive

worlds – fight for it.

Avoidance-Prolong

Avoidance and prolong is to minimize new information in order to neutralize

threatening content (Hilton, 1986). Aldwin (1994) described, taking a "wait and see"

attitude until the results of the follow-up pap smear are in is much better than focusing

on and obsessing over the problem. Like Mr. Wang said,

> "I do not want to think too much because it seems no future for me. My wife sent me
> hospitalization for treating my illness for several years. The families visit me but couldn't
> tell me when to discharge. I talk to myself: wait and see, not think anymore. They will take
> me home sooner or later."
>
> "I came to the hospital for my mother's own good. She wants me to come to
> hospitalization and dislikes me to contact with my relatives and friends. After the illness,
> lots of things out of control and I cannot manage them. I turn to lose the motivation to
> contact with my friends and relatives for preventing troubles happened."(Miss Yang said).

Mullen and Sules (1982) found that avoidance strategies were more effective in

reducing emotional distress in the short term, however, mobilizing a great deal of

effort and support for relatively minor problems may end up resulting in greater stress

levels-making a mountain out of a molehill (Aldwin, 1994). As Mr. Lee said,

> "For the illness, I was enforced to give up my dream. …This is regret for me. In the hospitalization, I
> need behave and ignore troubles. I dislike this environment but couldn't strive for anything. If I
> misbehaved, I would be restrained. I try hard to manage my temper. I get used to use passive way to
> let the things passing. I tend to go back my room to pretend sleeping or stay away the peers."

Many problems are minor and self-limiting, and ignoring minor problems is often a

reasonable strategy (Aldwin, 1994) but cannot contribution a positive health. As

Faeley, et al. (2005) stated, avoidance coping has consistently been associated with poorer health. Like Mr. Lee's feelings, "Most of time, I feel depressed, helpless and being ignored by my families and the things never not cheer me up."

Active Coping/Cognition control

One facet of "coping" is facing the disruption of this innate temporal process. This is the message communicated by the most common plaint of respondents in this study: "I feel so out of control." "It interrupts the family's development cycle". Mr. Fu described:

"The illness ruins my life and make my 30s become colorless and miserable."

Although loss of this temporal predictable is the most recurrent theme in the interviews, other dimensions of uncertainty are related to biographical temporality: *duration* (How long will the illness last? How long will the side effects of treatment last? How will it be before I feel better?; *pace* (Will the treatment outpace the disease? How long do I have to live? How soon and at what pace will deterioration take place? How soon before a recurrence develops somewhere else in my body?; and, *frequency* (How often must I go for treatment? How frequently will discomfort like insomnia by present?) (Wiender & Dodd, 1993). There questions do bother people with chronic mental illness, however, some of them have learned how to reconstruct their cognition and positively re-interpreting their illness.

Those respondents either from day care program or from chronic ward have

learned positive strategies from illness experience to take active coping or cognition

control coping with their unpredictable illness. Like Miss Zhuang and Miss Wu said,

> "Coming to the hospital, I have learned more updated knowledge than before. I know why
> I need to take medication, which kind of pills would effect on me, what is the side-effect of
> the medication, how to take care of myself, how to prevent the illness relapse, what kind of
> job I can do." "Mental illness is not so scaring but lots of people do not understand. I have
> learned how to live with my hallucination and maintain my work."
>
> "In the day program, I help many peers and feel the self as a useful." I feel self-fulfillment
> and happy to do rehabilitation." (Ms. Huang said).
>
> Miss Yang said: "when I feel uncomfortable, I have learned to talk with my Dr. or nurse.
> Taking the medication is really important for me to help control the illness. I leaned to
> growth from my illness and even cherish what I have now."

Emotional-oriented

Dealing with negative emotions is essential factor influencing on the people

experiencing the painful journey of mental illness. Like Miss Chu, she felt ambivalent,

helpless, and hopeless living in the suffering.

> " I found myself preoccupied with thoughts of death ." " I don't want to die because I hate
> myself. I want to die because, on some level, I love myself enough to have compassion for
> this suffering and to want to see it."
>
> When I was in ECT, " I sink again, like a 'hopeless swimmer'…I can't believe that I could
> be helpful to anyone."(Mr. Shu said)

Managing negative emotions would lead to a long-term psychological mal-adaptation

for the people with chronic illness. From Miss. Wu self mirroring reflection, she said:

> "The mirror is real. My imagine startles me…I see the hollowness of my cheeks, my tired
> hair, and the lifelessness of the face."

For coping with illness-related and solving emotional problems, emotion-oriented

coping involves attempts to reduce or eliminate the emotional distress associated with,

or cued by the stressor (e.g., minimization, distancing and accepting responsibility)

(Lazarus & Folkman, 1984). Such as Mr. Shi said,

> "I shouldn't let my down mood impact me. I still go to day hospital as usual and attend the
> rehabilitation program. I expressed my uncomfortable to the nurse for help."
>
> Mr. Kang, Mr. Qiu, Mr. Cheng and Mr. Zhang hospitalized in the chronic ward for more
> than 3 years expressed: "when I feel pressure, depressed, in the low mood, or distressed, I
> listen to the music, watch TV, or take a shower….try ways to get off my negative feelings."

Social Support systems-Family, Friends and Religion

Nowadays, social networks and social supports have become the crucial

important factor influencing the adaptive capability. The supportive response from

family and friends enables the patients to know how much they are loved and

strengthen the patients' motivation to fight with the illness and maintain their

self-esteem in the adjective and rehabilitative process (Turk, 1980). In Taiwanese

collective culture, most people with chronic mental illness experience their illness

journal pervasively depending on their supportive systems: family, friends, and

religion.

Family

Conrad (1987) stated families are pivotal actors in the world of illness and are

important as interpreters, caretakers, support systems and buffers. In Miss Wang's life:

> "After my illness, my family even more concern about me. I let them help me, really take
> care of me. It is especially true with my family, in it bringing me closer to my parents, from
> whom I've become more assertive. They visit me regularly and bring needy groceries for
> me during hospitalization."

Marital relationship also plays a special position in supporting Ms. Huang facing

the illness. She asked the husband to help her as a normal person rather than a patient.

> "I am sick of his help, of continually feeling like a patient with my husband. I tell him, 'I
> don't want you to help me. I want you to be with me.' 'I don't need a
> therapist-in-residence,' I say. 'I need a husband."

Ms. Huang's husband kept her dream alive during the hardest of times, when she

was unable to sleep, let alone to dream. He did help Ms. Huang experiencing her

painful journey of illness.

> She said, "he always be the truest of loves, the most trusted of critics, and the funniest
> damn person I ever known."

Friendship

Peer group would be viewed as social support for chronic ill patient (Follick &

Turk, 1978).

> When I was hospitalized, "I was arranged to join 'supportive group' that has magically help
> me to have friends to disclosure my feelings and deal with my angry. When I feel distressed,
> anxious and miss my family, I have them to keep companion with me. When symptoms
> attacked me, I have them hold me." Miss Chu and Miss Ge said.

Mr. Chen said, I joined the planting group in rehabilitation program to learn

vocational skills and release my anxiety. He said:

> "This group encircles me with love and serves as a constant reminder of the wonder of the
> self. The planting group provided quiet havens in which I could escape the chaos of life
> events."

Ms. Xu described:

> "I knew some good friends from my hospitalization. They know me. We are always on the
> same boat and understand how I feel. When my son did not come to visit me, I become
> very angry, depressed and self-blamed. They empathy me and encourage me. Friendship is
> one of the important ingredients to help me moving on my life."

Religion

Placing trust in a higher force or power is an important factor to help to cope

with their illness and going through the painful experience (Siegel & Schrimshaw,

2002). Like Mr. Shi's belief, he believed the God give him the strength to meet the

demands and stresses of the illness. He thought he had established a personal

relationship with God allowed him to sense emotionally supported.

> "If I feel one-tenth of that attachment to God, I would probably be in much better shape
> than I am right now. In a lot of ways. I want to be a more pious fellow and closer to God."

Hence, religion provided an interpretive framework that enabled him to find positive

meaning in the illness. Though he ever struggled in trusting in God when the things

were deviant from Mr. Shi's arrangement, he continuous admitted to God's

arrangement and attended religious activities like prayer, or meditation.

> "I go to church every weekend. From where, I release my pain and feel peaceful. The
> church fellows all understand my illness and accept me. I feel belonging there."
> "I believe in Buddhism and study Buddhist scripture would sublime me to a peaceful
> mind.." "When I feel not quest well, the scripture smooth me." (Ms. Zhuang & Miss Huang
> said)

Discussion

The study indicated that coping strategies are related to the illness adaptation in

terms of better managing their illness experience. Mishel (1988) defined adaptation as

biopsychosocial behavior occurring within person's individually defined range of

usual behavior, which is essential, a neutral zone containing adequate but not extreme

activation and also allows goal-directed behavior to continue. Adaptation is a kind of

psychosocial adjustment, recovery, stress, life quality, or health. People with chronic

mental illness finally adapted their illness, which means they know how to adjust their

psychosocial condition, to cope with the stresses, to reconstruct their conception and to maintain their quality of life and health. In this study, some factors expediting the adaptive process that bring us attention are normalization, active coping, and support system.

Hatfield and Lefley (1993) found some coping styles that are less useful and that may be maladaptive as well as associated with poor health such as a focus on emotional issue and ventilation of affect, and behavioral or mental disengagement. These styles avoid acknowledging and dealing with the problems. They continuously studied that a major coping strategy of persons with long-term schizophrenia-particularly those who have history of hospitalization-has been emotion-focused ventilation. The stressor and the perceived threat from the long-term hospitalization has not been the illness itself, but rather the system that purportedly serves those with the illness. Hence, avoidant coping has been found to be consistently associated with poorer health. However, this study found emotion-oriented strategy was one of popular coping styles for long-term hospitalized respondents. They select ignore or avoid their problems from the residents, family relationship, and unpleasant symptom conditions. They tend to passively cope with life stressors (such as listening music, watching TV, playing chess..etc.). Practitioners need to assist people with chronic mental illness to modify their coping strategy for a

better adaptation in a long-run.

Researchers have found that active coping style and coping style emphasizing social supports have both been consistently associated with better health (Hatfield & Lefley, 1993). Positive reframing and acceptance and resignation have also been related to better health. These coping styles might not help psychiatric patients to cope well with their chronic mental illness. Especially for persons with schizophrenia, however, active planning and actions to deal with the multiple stressors of the disease and its squeal have been impeded by an indifferent world and even by overprotective services providers (Estroff, 1981). For instance, some of respondents in this study expressed that hospitalization would be better than live outside alone because they do not need to worry about facilities fee and food supply. The mental health staff takes care of the medication and symptoms. The mental health institutions have provided most essential living supply to the residents. This study supported the long-term hospitalized respondents under overprotection from the mental staff which may cause them dependency, no motivation to develop living capacity, and no responsible for themselves, including regularly taking medication,

In point of fact, for persons disabled by schizophrenic symptoms, active coping is still generally possible under certain conditions. For many, the family or service provider system offers the medium for planning and instrumental support. Patients'

willingness to avail themselves of that which is offered-rehabilitation, skills building,

re-socialization, and medication for symptom stabilization- may be considered under

the rubric of active coping (Hatfield & Lefley, 1993).

From the study findings, the mental health practitioners need develop the

effective coping strategies for people with chronic mental illness. The intervening

strategies developed need consider the following contexts: (1) The disease- and

treatment-related context: the chronic illness varies along numerous conceptual

dimensions, including controllability, predictability, and severity (e.g., lethality, life

disruption). For example, disease course (e.g., progressive or remitting), prognosis,

lifestyle change requires, side effect-related toxicity and life disruption, and degree of

associated pain and disability all vary in controllability, predictability, and severity

across different chronic diseases that would impact on the adaptive outcomes; (2) The

environmental and cultural context: the more stressful life events were associated with

higher anxiety shortly after diagnosis in severe mentally ill patients, but not with

distress a year later. Multiple environments (e.g., community, family, work)

contribute to adverse health outcomes. Turk (1980) described an unhealthy

environment is those that threaten safety, that undermine the creation of social ties,

and that are conflict, abusive, or violent. These attributes would provoke adjustment

difficulties in those already contending with chronic disease. The ethnic and cultural

factors influence illness vulnerability, attention to and interpretation of somatic and

emotional changes, as person's actions regarding symptoms, and subsequent

interpretations and adaptation. (3) The interpersonal context and social support

involve interpersonal transactions that offer emotional comfort, information, concrete

aid, or enhanced self-regard. Social support and psychological adjustment relate to the

positive adaptation to several chronic diseases. Usually, the higher preoperative social

support predicted more positive postoperative adjustment. Conceptualizations of

social support include the use as a coping strategy, as a coping resource in

environment, and as dependent on personality attributes and coping of the individual

(Schreurs & de Ridder, 1997). The higher helplessness appraisals were associated

with passive coping in patients, which in turn was related to lower perceived quality

of emotional support, and greater psychosocial impairment and declining self-reported

heath over time. Inadequate relationships with medical staff also can be detrimental to

health and well-being. In addition to considering the potentially positive and negative

aspects of social support, the match between what the individual needs over the illness

course and what is offered by the social milieu influencing adjustment are important.

(4) The personal context: numerous personality and other individual difference

characteristics have been tested for predictive utility in adjustment to chronic disease.

Personality (or other individual differences characteristics) and coping (or appraisal)

have independent, direct effects on adjustment. Select demographic and personality attributes could be examined as risk or protective factors in adjustment and associate with their adaptation to the illness.

Implication for Practices

Mental health related practitioners need to be trained to provide and coordinate the much needed coping strategies and social support for the growing number of people with mental illness. Based on the above contexts, the practitioners can prevent the consequences of negative life stress through screening potential stress risks, assisting them to develop appropriate coping skills and linking them to useful and available social resources, either formal or informal support system. To maximize the social functioning of persons with chronic mental illness, the strengths and limitation in their lives must be assessed. Strength must be built upon, social interactions improved, and limitations lessened by active coping/cognition re-interpretation skills developed. Mental health practitioners are in a pivotal position to intervene in these activities. Mental health practitioners can also persuade families and helpers to allow and encourage persons with severe mental illness to join in more social activities. This activity may help them boost self-perception and self-confidence for better coping with their illness.

Implications for Further Research

How to assist people with chronic mental illness to live with their illness and obtain a satisfactory life? What kind of stressful life events impact them and should be buffered? This study serves as a starting point in how the people cope with their life fir surviving in the community and society. Further study needs to emphasize how the effective coping strategies could be developed? If the types of diagnosis would relate to the coping strategies employed effectively? Additionally, how to de-stigmatized and normalized the mental illness among the society would be essential factors to predict a better coping with the illness.

Reference

Aldwin, C. M. (2000). Stress, coping, and development: An integrative perspective. NY: The Guilford Press

Barroso, J. (1995). Self-care activities of long-term survivors of acquired immunodeficiency syndromes. Holistic Nursing Practice, 10,44-53

Benner, P., & Wrubel, J. (1989). The primacy of ccaring: Stress and coping in health and illness. Menlo Park, CA: Addison-Wesley.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically-based approach. Journal of Personality and Social Psychology, 56, 267-283.

Charmaz, K. (1995). The body, identity, and self. Adapting to impairment. The Sociological Quarterly, 36:357-80.

Charmaz K. (2000). Experiencing chronic illness. In GL Albrecht, Fitzpatrick R, Schrimshaw SC (Eds.) Handbook of Social Studies in Health and Medicine. Sage Publication: Thousand Oaks CA.

Conrad P. (1987). The experience of illness: recent and new directions, Sociology of Health Care. JAI Press Inc.6: 4-31

Coutu, W. (1951). Role-Playing vs. role-taking: An appeal for clarification. American Sociological Review 16:180-187

Corbin, J. M. & Strauss, A. (1988). Unending work and care: Managing chronic illness at home. San Francisco, CA: Jossy-Bass.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on

discrediting psychiatric stigma. American Psychologist, 54, 765-776.

Davis, F. (1963). Passage through Crisis: Polio victims and their families. Indianapolis: Bobbs-Merrill.

Dunseath, J., Beehr, T. A., & King, D. (1995). Job stress-social support buffering effects across gender. education, and occupational groups in a municipal workplace, Review of Public Personnel Administration, 15 (1), 60-82.

Estroff, S. E. (1981). Making it crazy: An ethnography of psychiatric clients in an American community. Berkeley: University of California Press.

Hartfield, A. B. (1987a). Coping and adaptation: A conceptual framework for understanding families. In A. B. Hartfield & H. P. Lefley (Eds.), Families of the mentally ill: Coping and adaptation (pp.60-84). New York: Guilford Press.

Elliot, J. (1991). Action Research for Education Change. Milton Keynes & Philadelphia: Open University Press.

Elliot G, Ziegeler HL et al (1982), Understanding stigma: Dimensions of deviance and coping. Deviant Behavior: An Interdiplinary Journal, 3:275-300

Farley, T. Galves, A. Dickinson, M. L., & Diaz Perez, M. J. (2005). Stress, coping, and health: A comparison of Mexican immigrants, Mexican-Americans, and Non-Hispinanc Whites. Journal of Immigrant Health, Vol. 7(3):213-220.

Flick, U. (1998). An introduction to qualitative research. London:Sage.

Follick, M. J., & Turk, D. C. (1978). Problem specification by ostomy patients. Paper presented at the 12th Annual Covention of the Association for the Advancement of Behavior Therapy,Chicago.

Folkman, S. & Moskowitz, J. T. (2000). Positive affect and the other side of coping. American Psychologist, 55:647-654

Goffman E. (1963). Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall, Englewood Cliffs, N.J.,

Greene, A. L., & Larson, R. W. (1991). Variation in stress reactivity during adolescence. In E. M. Cummings, A. L. Greene, &K. H. Karraker (Eds) Life-span developmental psychology: Perspectives on stress and coping (pp.195-209). Hillsdale, NJ: Erlbaum.

Hatfield, A. B., & Lefley, H. P. (1993), Surviving Mental Illness: Stress, Coping, and Adaptation, The Guilford Press

Hilton B.A. (1998). The phenomenon of uncertainty in women with breast cancer. Issues in Mental Health Nursing. 9:217-238

Hilton B.A. (1986). Coping and the uncertainties of breast cancer: Appraisal and coping strategies. Unpublished doctoral dissertation. University of Texas at Austin.

House, J. S. (1981). Work stress and social support. Reading, MA: Addison-Wesley.

In Horwitz, A. V. & Scheid, T. L. (Eds.)(1999). A handbook for the study of mental health: Social contexts, theories, and systems. Cambridge, U. K.: Cambridge: Kluwer Academic.

Kelle, U. (2001). Sociological explanations between Micro and Macro and integration of qualitative and quantitative methods. Forum Qualitative Sozialforschung/ Forum: Qualitative Social Research [On-line Journal], 2(1).

Kelly M. (1992). Self, identity and radical surgery. Sociology of Health & Illness, 14:309-415.

Kurzban R and Leary MR (2001). Evolutionary Origins of Stigmatization: The Functions of Social Exclusion. Psychological Bulletin, 127:187-208

Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer Publishing Company.

Link, B. & Cullen, F. T. (1990). The Labelling theory of mental disorder: A review of the evidence. Research in Community and Mental health. 6:75-101.

Locke, E. A. & Taylor, M. S. (1990). Stress, Coping, and Meaning of Work. In A. Brief and W. Nord (Eds.). Meanings of Occupational Work. Lexington, MA: Lexington Books.

Markowitz, F. E. (2001). Modeling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. Journal of Health and Social Behavior, 42(1):64-79.

Maxwell, J. A. (1992). Understanding and validity in qualitative research. Harvard Educational Review, 62 (3), 279-300.

Mishler, M. H. (1988). Uncertainty in illness. Image: Journal of Nursing Scholarship, 20:225-232.

Milazzo-Sayre, L. J., Henderson, M. J., & Mandersheid, R. W. (1997), Serious and and Severe mental illness and work: What do we know? In Bonnie, R. J. & Monahan, J. (Eds). Mental disorder, work disability, and the law. Chicago. The University of Chicago Press.

Minuchin, S. (1974). Families and family therapy. Cambridge, M.A.: Harvard University Press.

Pearlin, L. I. (1999). Stress and mental health: A conceptual overview. In Horwitz, A.V. & Scheid, T.L. (Eds.) A handbook for the study of mental health: Social contexts, theories, and systems (pp.161-175). Cambridge, U.K.: Cambridge University Press.

Pearlin, L. I. (1989). The sociological study of stress. Journal of Health and Social Behavior, 30, 241-256.

Pearlin, L. I. & Schooler, C. (1978). The structure of coping. Journal of Health and Social Behavior, 19, 2-21.

Perlick DA, Rosenheck RA, Clarkin JF et al. (2001). Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. Psychiatric Services, 52:1927-1632

Schreurs, K. M. G., & de Ridder, D. T. D. (1997). Integration of coping and social support perspectives: Implications for the study of adaptation to chronic diseases. Clinical Psychology Review, 17, 89-112.

Siegel K and Schrimshaw E (in press) Coping with the negative emotions: The cognitive strategies of HIV infected gay/bisexual men. Journal of Health Psychology

Stanton A.L., Collins C..A & Sworowski L.A.(2001), Adjustment to Chronic Illness: Theory and Research, In A. Baum, T.A. Revensen, J. E. Singer (Eds). The Handbook of Health Psychology

Torrey, E. F. (1988). Surviving schizophrenia: A family manual (rev. ed.). New York: Harper & Row.

Turk, D. C. (1980). Factors influencing the adaptive process with chronic illness. In I. G. Sarason and C.D. Spielberg (Eds.) Stress and Anxiety (vol. 6), New York: Hemisphere Publishing Corp.

Turner, RH (1956), Role-taking, role standpoint, and reference-group behavior. American Journal of Sociology 61:316-328

Weiner, C. L. & Dodd, M. J. (1993). Coping and uncertainty: An illness trajectory perspective. Social Inquiry for Nursing Practice, 7:7-31.

Williams, G. (1984). The genesis of chronic illness: Narrative reconstruction. Sociology of Health and Illness. 6:175-200.

蘇逸人.（2002）. 疾病覺知、疾病控制信念與社會污名：精神分裂症患者疾病心理適應之心理社會因應模式. 台灣大學心理學研究所碩士論文

蕭淑真.（2001）. 精神分裂患者因應策略評估量表之發展. 台灣大學護理學研究所碩士論文.