

CHINESE CULTURAL VARIATION ON THE CLUBHOUSE MODEL IN TAIWAN*

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ABSTRACT

The clubhouse as a psycho-social model for community psychiatric rehabilitation has spread around the world. Yet, if the clubhouse model is to be meaningful and replicated in different cultures, a greater flexibility and/or reinterpretation of the “clubhouse” is needed. This article examines the practices of peer support in Taiwanese clubhouses within the context of a self-help movement for the family members of persons with mental illness. Two ways of understanding the clubhouse are identified: the clubhouse as a model and the clubhouse as a set of guiding principles. Historically, families have been the primary carers for the mentally ill in Taiwan and in the wave of democratization after 1987 family members became the driving force for collective action. The professional domination over family members’ associations divided the self-help movement into professionally led groups and anti-psychiatric groups; it also led to different interpretations of the clubhouse and of peer support. The professionally led group understands the clubhouse as a model and defines “peer” as a process of becoming through staff and members working together. The autonomous and psychiatrically skeptical groups understand the clubhouse as a set of guiding principles and define

*The research was supported by National Science Council, Taiwan (NSC99-2420-H-010-001-MY2).

“peers” as persons with shared experiences. In both cases, the clubhouse has served as an alternative to the domination of Western privilege and medical discourse. Adopting a Foucaultian approach, this article provides a historical account of how clubhouse ideas are understood in Taiwan today.

Key Words: mental health, community psychiatric rehabilitation, clubhouse, transnational diffusion of knowledge, Chinese culture

INTRODUCTION

The clubhouse movement is truly cross cultural. The ideas of the clubhouse thrive and are incorporated across the borders of nations, continents and cultures; the installations and modus operandi of the clubhouses, necessarily, have been modified according to context. The development of the clubhouse model around the world is not simply a direct translation of the Fountain House model, but rather a transnational social movement (Mandiberg, 2011), aimed at deconstructing and reconstructing the “spoiled” identity of mentally ill persons (Goffman, 1963). Yet, for the idea of the clubhouse to be meaningful and replicable in other cultures, a greater flexibility to interpret and reinterpret the methods of the clubhouse is needed. This study examines the practices of peer support in the clubhouses of Taiwan, where Chinese culture dominates and where greater flexibility is needed to obtain a merger between the global model and the local culture.

In this article, the clubhouse is studied as a discourse that is grounded in the everyday lives of specific historical moments (Foucault, 1965), rather than as a model with fixed ideas to be replicated everywhere. Therefore, the issue of fidelity (Lucca, 2000) is not a concern as variance from the clubhouse model is appreciated as a focal point to explore how the knowledge of clubhouse is situated and embedded in historical and social-political contexts (Haraway, 1988). This shift in conceptualizing the clubhouse as a discourse is meant to capture the variety of how the clubhouse is interpreted cross culturally, rather than to confirm the sameness of clubhouses around the world. Using Foucault’s (1977) idea of genealogy, the discursive practices of the clubhouse are traced and explored in the context of the self-help movement among family members of psychiatric patients in Taiwan. In Foucault’s conceptualization (1977), genealogy is a historical technique in which one questions the commonly understood emergence of various beliefs by attempting to account for the constitution of knowledge of objects within the time period in question. Therefore, the aim of this article is to provide a historical account of how the clubhouse has come to be understood in Taiwan and the conditions that make this understanding possible. As Foucault is concerned about the hidden history of the marginalized group, the family members’ self-help movement is chosen to be the basis of this project (Smith, 1990).

According to Chinese family ethics, families are expected to bear the burden of caring for psychiatric patients in the current mental health system—in policy and in practice (Hu, 1995; Wang, 1998; Wen, 1990).

The influence of clubhouse ideas in Taiwan is more than a program model; they have changed the patient/doctor discourse on mental illness, wherein a patient is given a new subjectivity as a member and treated as a collegial peer of workers and members. This transformation is articulated as a process “from patienthood to personhood” (Peckoff, 1992). The emancipating potential of the discourse within the clubhouse provides alternative language for those who seek to challenge and transform the medicalized mental health system. When the clubhouse was introduced into Taiwan in the early 1990s, political democracy was just developing. Exhausted family members became inspired by, and later, adopted the language of the clubhouse in their struggle against psychiatric domination of the mental health system.

A brief history of the mental health system in Taiwan will illustrate how family members of persons with mental illness carry most of the care burden and are given the least status within the system. Political democratization provided a chance for family members to mobilize for collective action. The article will then analyze the origin and development of the self-help movement of family members in Taiwan with a focus on their re-interpretation of the clubhouse in the context of their struggle with the state and the mental health profession. Two different ways of practicing the clubhouse programs will be presented to illustrate how social positioning of the family member groups shapes the interpretation of clubhouse. Implications for the conceptualization of peer support and the clubhouse will be presented as conclusions.

THE HISTORY OF THE MENTAL HEALTH SYSTEM IN TAIWAN

Familialization of Care for Mental Illness

Histories of mental health in Taiwan are mostly and unsurprisingly written from the perspective of modern Western psychiatry (Chen & Wang, 1987; Lin, 1994; Wang, 1993). All of them agree that the familialization of care for persons with mental illness, under a family ideology, is the outstanding characteristic of the Taiwanese mental health system. In contrast to the institutionalization history of mental health in the West, chronically ill psychiatric patients in Taiwan have always been cared for at home. The welfare state in Taiwan has been characterized as residual, developmentalist and influenced by the Confucianism of family ethics. In the 50 years of Japanese colonial rule (1895-1945), a mentally ill person was locked up in a small room next to the kitchen. During the Nationalist rule (1945-2000), state intervention was confined to the acute care of mental illness, thereby leaving most of the care burden to the family. Traditional Chinese

family ethics rendered the state invisible and care for the mentally ill was solely a private matter (Wang, 1998). Moreover, the Chinese belief in ancestor worship and the Buddhist idea of karma (the law of the causes and effects which may be spread over many lifetimes of oneself and other family members) further stigmatize mental illness since it is considered to be the result of misconduct by the individual's ancestors. Persons with a mental illness were and are seen as a disgrace and shame for the family. There is a long-standing and deeply ingrained tradition in Chinese culture (up to the present day) of hiding "insane" family members at home and resisting the intrusion of outsiders (Lin & Lin, 1978, 1981).

Thus, in the pre-democratic era, care for persons with mental illnesses was a family, and not a public, issue. One had to be low-income to qualify for public care. The only exception at that time were soldiers or veterans who left their hometowns, joined the nationalist army, retreated from mainland China to Taiwan with the government in 1949 and later developed mental illness (Huang, 1998; Skocpol, 1992).

The decision to seek mental health care, especially in cases of psychoses and major mental disorders, is usually made by the family rather than the individual (Lin & Lin, 1978). Treatments from various sectors of the health care system, including popular, folk, and professional (Western or traditional Chinese medicine), are often utilized in combination, simultaneously or consecutively (Kleinman & Lin, 1981; Wen, Chang, & Chen, 1985). Although modern psychiatry was introduced by the Japanese colonial government and, after 1945, supported by the nationalist government, multiple help-seeking behavior patterns for mental illness continue. Those families incapable of caring for their sick members tend to seek help from traditional Chinese medicine or traditional religions, such as Buddhism and Daoism.

Although the family cultural ethic had effectively kept the issue off the public agenda, physical and emotional fatigue sometimes left these families no choice but to send the patient away. By World War II, patients who were homeless or came from destitute families would be placed into one of the few almshouses, or just left wandering on the streets or in the countryside. To this day, worn-out family members of the mentally ill still talk about the knowledge of places—far away in the countryside—to "let the patient go." Other burned-out families have no choice but to leave the patient at charity asylums as the last resort.

Americanization of Mental Health System

The modern mental health system in Taiwan has been deeply influenced by the United States and was not fully developed until the mid-1980s. According to Wang (1993), there have been three waves of policy diffusion from American psychiatry since WWII. The first wave included the training of psychiatrists from major hospitals between 1951 and 1953. The second wave took place after 1967, following the new deinstitutionalization policy in the United States;

the Taiwan Ministry of Health began to establish community health centers with emphasis on prevention and follow-up of the discharged chronically mentally ill. The third wave involved the establishment of exchange activities with U.S. mental health institutions after 1971. The concept of community rehabilitation was introduced at that time and experimental projects, such as half-way houses and sheltered workshops, were implemented in major hospitals. Due to lack of stable financial support, programs of community rehabilitation failed to become a significant part of mental health policy and remained as marginal experiments in major hospitals.

Medicalization and Formalization of Mental Illness

Early anthropological studies of mental illness in Taiwan have documented the multiple forms of help-seeking behaviors (Kleinman & Lin, 1981; Wolf, 1972). Buddhist and Daoist temples became the major providers of substitute care for families. In the 1980s, a large charity asylum, Lung Hwa Tang (LHT), which in Chinese means the Hall of Dragon Metamorphoses, was called by clients “the last stop” on their long help-seeking journey of mental illness. LHT was administered by a Buddhist monk and sheltered more than 600 patients, providing life long care at a cost of around US \$10,000. LHT rejected medications from Western mental health and relied on traditional folk remedies. In 1989, four patients escaped from LHT, complaining of being treated inhumanely. This incident became the media headline to reveal the existence of undocumented institutional care for mentally ill persons and served as a catalyst for medicalizing the mental health system. The Mental Health Act in 1990 attempted to wipe out the charity asylums in the name of protecting the human rights of people with mental illness. However, with the intervention from the local health authority, LHT was later registered (2002) as half-way house with 200 beds. The popularity of LHT caused the Taiwan psychiatry profession great embarrassment because an unregulated asylum run by a monk was preferred over professional psychiatrists by families of psychiatric patients (Wen, 1990).

When family members were asked about their reasons for sending patients to LHT for life-long care, the response that “they could no longer bear the suffering and had no other choice” was nearly unanimous. Half of the patients had been wandering in the streets and a quarter of them had been arrested before they were sent to LHT (Wen, 1990). A diagnosis of mental illness was necessary for admission; thus, families of LHT had had prior experiences with Western psychiatric treatment. A new patient at LHT would be paired with a senior one in a chain (called “the chain of love”) to care for each other. Patients were under a strict daily work schedule raising chickens which generated revenue for LHT. Patients also were trained to play musical instruments and a band was organized which performed publicly.

The passage of the Mental Health Act in 1990 established the form of modern psychiatry in Taiwan. As the National Health Insurance in 1994 is the major financial source for the health care system, the NHI payment scheme determines the structure of the mental health service system. Most financial resources are devoted to Western medical care, including hospital, outpatient and institutional care, with very limited resources for community care. Day care and rehabilitation services are not fully covered or covered at payment levels that hospitals are unwilling to accept, leaving little room for the development of community rehabilitation.

A SELF-HELP MOVEMENT AMONG FAMILY MEMBERS

The Emergence of Grass-Roots Family Member Groups

Family members tended to be invisible in this process due to the stigma of mental illness. Family preferences for LHT over psychiatry were interpreted as ignorance. The family was typically seen by the health authority as uninformed, lacking in modern medical knowledge, easily fooled by unscientific religion, and in need of professional guidance. Under the Mental Health Act, a family member is the legal guardian for a person with mental illness and is required to ensure that person receives treatment, and is responsible for any damage caused. Although the demand on families was unreasonable and families are excluded from the policy making process, the Act passed without any challenge (Tang, 1997). Politically, the incidents at LHT provoked a power struggle between Western medicine and folk religion and the passage of the Mental Health Act in 1990 is seen as a triumph of the former over the latter (Tang, 1997; Wang, 1997). At the same time, the incidents, which symbolized the plights of families with psychiatric patients, provided a chance for family members to raise the issue of mental health care publicly.

Co-optation of Family Member Groups by the State

Pro-psychiatry groups for family members, called the Association for Psychiatric Rehabilitation (APR), were initiated in 1983 with support from the psychiatric hospitals. When the families of LHT residents gathered together to protest the government's intervention in 1990, the APR was mobilized to stand with the government. Thus, families did not organize themselves into a collective body to represent a "family voice" but were separated by the struggle between traditional approaches and Western psychiatry. With the

implementation of Mental Health Act, the health authority included the establishment of local chapters of APR on the agenda of the 3rd mental health network project (1996-1999). Family member groups were established island-wide, initiated by the psychiatric hospitals (Yu, 1998, 2000). The national APR, a coalition for APRs, was founded in 1997 as spokesperson for mentally ill persons and their families, symbolizing the successful implementation of state policy.

In contrast to the voluntary nature of self-help groups, the establishment of APRs as family member groups was state-led. This created a network for family groups where the subjective experience of family members had not been fully recognized and validated. Such a process, what Habermas (1987) called “colonizing the civil sphere,” jeopardizes the representation and autonomy of family members. Chen (1993) found that only 2 out of 21 groups were led by family members, most were led by medical professionals, primarily psychiatrists. The example of ARP tells a story of how NGOs can become a part of the state rather than part of the civil society. To differentiate between the two, Rigger (1996, p. 310) defines this type of NGO as “the state-led civil society” and excludes it from his definition of civil society.

The state-led family member groups in Taiwan have had a great impact on their development. Within the state-led family member groups, the mental health professionals determine whether family members can voice their needs within the group. While some groups can balance the potential conflict between family members and professionals, others have difficult struggles. Family members who fail in their conflict with the professionals tend to initiate new groups and develop anti-psychiatry attitudes; these groups have difficulty securing funding from the government.

Hsin-Ye was established in 1994; it the first self-help group of family members with a strong anti-psychiatry purpose. Their first collective action was in response to an NHI payment scheme to exclude meal costs from the long-term institutional care of psychiatric patients and asking families to pay. Before 1995, mental illness had been considered a type of illness and the responsibility of the Ministry of Health and was not included in the types of disability specified in the Disability Welfare Act. As a result, mentally ill persons could not benefit from programs supported by the Ministry of Social Welfare responsible for providing the funds for meals for the disabled. Hsin-Ye was able to organize nine family member groups together at a public hearing of the Congress to demand amendment of the Mental Health Act and the inclusion of mentally ill persons into the Disability Welfare Act in order to expand the sources of public funding. Their demonstration of kneeling down in front of legislators in a public hearing surprised and shocked the public and hit media headlines—which led to the inclusion of mentally ill persons into the Disability Welfare Act in 1995. Family members finally found a space in the public domain to voice their struggles in defining the needs and responses of the mental health system.

RESEARCH DESIGN

The research study is based upon the work of the first author as a cultural broker who has introduced and disseminated the clubhouse ideas from the United States to Taiwan for the past 20 years. The first author was an intern MSW student in Fountain House in New York City from 1989 to 1990 and began to introduce the concepts of the clubhouse model to Taiwanese practitioners of mental health after his return in 1990. His role as the key person in introducing the clubhouse to Taiwan provided the opportunity to observe the indigenization process of the clubhouse from ideas to actual everyday practices.

Rationale for Sampling

Clubhouse is not included in the service schemes of both mental health and disability welfare policy. Yet, the clubhouse model has been adopted by non-profit organizations for different reasons and received public funding under various categories as day care, social activity center, or sheltered workshop. There are four programs in Taiwan whose operations are claimed to be based on the clubhouse model (see Table 1). This article attempts to develop a historical account of clubhouse by contextualizing the different interpretations of clubhouse within the development of the self-help movement for family members. Hsin-Ye and Easy House were selected for comparison because they are family member groups and represent rather different stances toward clubhouse and psychiatry.

Table 1. Clubhouse Programs in Taiwan

Program	Hsin-Ye	Eden Fountain House	Easy House	My House
Date of set-up	1995	2003	2005	2007
Nature of Mother Organization	Hsin-Ye, anti-psychiatry, self-help group for family members	Eden Social Welfare Foundation, an NGO for persons with disabilities	APR Taipei, Pro-psychiatry, State-sponsored local association of mental health	National APR, Pro-psychiatry, State-sponsored national association for mental health
Current status	Operating with limited public funding	Following ICCD guidelines and is expected to be certified recently, receiving public funding as day care program	Certified clubhouse by ICCD in 2010, receiving public funding as social welfare center for the disabled	Operated as Social club. Lost public funding in 2009 and closed. Staff and members organize themselves to form a patient group to continue to operate without public funding

Eden Fountain House was not selected because the mother organization, Eden Foundation, a leading NGO on services for the physically disabled, is not engaged in the field of mental health. Eden Foundation sees the clubhouse as an innovative model for persons with mental illness and a good stepping stone to expand its service scope from that of physical disability to mental disability. Therefore, Eden Fountain House follows the International Center for Clubhouse Development (ICCD) standards in its operation to seek recognition from the public and the government, similar to Easy House.

The fourth program, My House, was established as a pilot project with public funding by the National APR. My House was first operated as a social club and lost its funding after two years. The National APR decided to close down My House, but the staff workers and members wanted to continue. With the support from staff workers, staff and members of My House formed a new group to continue and transform its model from social club to the clubhouse defined by ICCD standards. My House was not selected because it is struggling for its survival. It would be an interesting case to study in the future as a clubhouse run by a patient group.

Data Collection and Analysis

Empirical data on the two clubhouse programs are from two distinct research projects in which the first author was involved. The Hsin-Ye program data are from a one-year participatory action research project (Wan, Lin, Huang, Yang, & Wang, 2003). Because of its anti-professionalism and its distrust of experts, Hsin-Ye was suspicious about research. The 2002 research project was the first time that the experiences of Hsin-Ye were studied by outsiders. The research design adopted participatory action research to ensure participant involvement and control. The leader, key board members and workers of Hsin-Ye were invited to share their understanding and experiences of Hsin-Ye. The history and model of Hsin-Ye were described and stories of families were presented as illustration. Recognizing the unique culture of family member group, the report was presented in the language of Hsin-Ye. A research team of four experts, including a psychiatrist, a social worker and two academics (one is the first author) was formed. The experts did not interpret the text but provided reflexive feedback from their disciplines. The major limitation of this project was that it reflected the viewpoint of key persons and no members were interviewed. However, the first author has maintained a friendly relationship with Hsin-Ye and has had first-hand observation of the program on different occasions.

The Easy House program data are from a two-year research project (2008-2010) conducted by both authors. The first author, as the expert on the clubhouse, was invited to conduct a monthly forum which was open to both staff workers and members to discuss the gaps between the ideas and practices of clubhouse. Topics for the forum were decided collectively by participants. The second author

was co-leader of the forum and was responsible for taking notes and transcription afterward. The second author also conducted in-depth interviews with three out of 11 staff workers and five members from May 2008 to June 2009.

Comparison of Easy House and Hsin-Ye

Taipei APR and Hsin-Ye share the same history. Taipei APR was established in 1984 with assistance from hospital mental health professionals under state policy. Staff workers of Taipei APR tended to be retired mental health professionals from hospitals and the establishment of Taipei APR enabled mental health professionals to extend their influence beyond the walls of hospitals. Under the influence of American mental health thinking, de-institutionalization and community rehabilitation had been emphasized. In order to fulfill the definition of community, community rehabilitation programs, such as half-way houses, day care centers, and sheltered workshops, were operated outside the hospital but still run by mental health professionals. In this sense, Taipei APR served as a “white glove” through which mental health professionals from the hospital could receive government funding to operate community rehabilitation programs. Family members were excluded from decision-making processes and could only participate as volunteers. This exclusion led to confrontation between professionals and family members in 1992 when a group of family members tried to mobilize themselves to vote for family members in the election of the Taipei APR board. These family members failed and as a consequence established a new group for family members, Hsin-Ye.

Hsin-Ye heard about clubhouse through the first author’s lecture in 1994. Inspired by the clubhouse, Hsin-Ye used Fountain House to name its journal and circulated the documentary film “We Are Not Alone” by Mark Glickman, in its recruitment activities. However, Hsin-Ye did not adopt the clubhouse model in its practices and insisted on implementing its own rehabilitation model without public funding. On the other hand, Easy House was started by Taipei APR in 2005 when the Taipei County government decided to transform a sheltered workshop into a clubhouse and provided fiscal support (reflecting the state-led tendency of Taipei APR).

Both Easy House and Hsin-Ye have integrated ideas of the clubhouse into their practices. The key organizational difference between Easy House and Hsin-Ye is that the former tries to integrate professionals and family members into its operation while the latter is a pure peer group with a militant attitude against mental health professions. Easy House treats the clubhouse as a model, trying to fulfill the criteria of clubhouse standards set by ICCD. Hsin-Ye treats the clubhouse as a set of guiding principles which can be embodied in multiple forms and developed its own distinctive model of rehabilitation. Table 2 compares the different approaches to the clubhouse between the two programs.

Table 2. Comparison of Easy House and Hsin-Ye

Program	Easy House	Hsin-Ye
Organization	Taipei Association of Psychiatric Rehabilitation (Taipei APR)	Hsin-Ye
Attribute	Professionally-led; family members as volunteers and clients	Psychiatry-skeptical; family members as staff workers and board members
Board	Professionally controlled with limited involvement of family members	Family members only
Staff worker	Professional	Peer only
Stance toward clubhouse	Follow ICCD standards and were certified in 2010	Clubhouse as set of guiding principles which need to be changed according to local contexts.

DIFFERENT WAYS OF PRACTICING PEER SUPPORT THROUGH THE CLUBHOUSE

The story of Taipei APR and Hsin-Ye exemplifies the search for the autonomy of family members. Taipei APR is professionally led with strong support from the government, while Hsin-Ye is family member led and maintains a strong anti-psychiatry ideology with little support from the government. These differences shape how the clubhouse is interpreted differently.

Easy House: The Clubhouse as a Model and Peer Support as a Community-Building Process

Clients with similar experiences could comfort and support each other; staff workers did not have similar experiences of mental illness. However, the concept of “peer” in the clubhouse is not based upon experiences of the past but of the present and future. Member and staff worker can become peers because of experiences of working together, which is called partnership model (Staples & Stein, 2008, p. 178). Peer support in Easy House is interpreted as “we are a community” through the process of working together. Although staff workers and members do not share the same experience of being mentally ill, a sense of solidarity and therefore community can be built through working together. In clubhouse, the definition of “peers” moves beyond the fixed one of “being

the same” to a more fluent one of “becoming the same.” The client/doctor relationship in the medical model (Conrad, 2007) is redefined as member/staff partnership model in the clubhouse model. The empowerment paradigm in which the clubhouse model is grounded (Staples & Stein, 2008, p. 178) is subversive to the professionalism based on the medical model, which has become dominant paradigm since the passage of the 1990 Mental Health Act.

*From “You/I are Patient/Professional” to “We are a Community”:
Beyond the Boundaries of Professionalism*

In the clubhouse model, there are two roles: staff and member. These two roles are indispensable to each other in maintaining the operation of the clubhouse; staff workers and members are partners. With this new subjectivity for professionals in Easy House, there is no one who is in need of medical treatment. Most of all, staff workers do not make decisions for members, but support members’ decision-making. In this way, members are constantly encouraged to take their lives back into their own hands. The mechanisms of exclusion on which medical power depends are consciously removed. The professionals take a role of supporting friends rather than the role of all-knowing professionals. The model of the clubhouse exemplifies a new way of thinking. Many staff workers in Easy House, who were trained as social workers, consider the partnership with members in the clubhouse as “real” social work. Staff A had been trained as a psychiatric social worker for ten years and described her career as “a journey of searching for real social work.” In order to be with patients, she worked as a social worker in an acute care ward of a psychiatric hospital; yet, Staff A was not free to work with patients since the social worker can only take a case with referral from the nurse or doctor under their care plan. She described her experiences in the psychiatric hospital as “being closest to patients physically, but extremely distant from them emotionally.” After working in Easy House, she embraced the model completely:

I identify myself with the principle and value of the clubhouse. I think it is *real* social work. You can develop a new model. This social work is based on the belief that people, no matter how ill they are, have the potential to contribute to society. . . . (Staff A)

The staff worker no longer understands members through the categories of mental illness, but works with them and grows with them during the process. Relationships are established through accomplishing common goals by collaboration between staff and members. They are partners who work together and face life together, as “every member has the equal rights to participate in the affairs of clubhouse, regardless of his or her illness or ability” (Rule #4, ICCD, 2009).

To ensure the sense of community and to reject the stratifying effect of wages, work done in clubhouse is not paid. Instead of waged labor, work is re-defined

as activities that contribute to others' lives and thus is meaningful to members as well as others in the clubhouse. Work done in the clubhouse must reflect the needs of the community. The requirement of equal participation does not depend on the good will of staff but is ensured by the program design. The workload of each unit cannot be finished by staff workers alone; staff workers need the members' participation and assistance (Beard et al., 1982). In such arrangements, staff workers are constantly looking for members' strengths that will be of assistance and only staff workers who can work with members are able to stay. Although members do not have the authority to hire or fire staff workers, members can put considerable pressure on a staff worker if the staff worker cannot involve members to finish the workload. In this way, a strengths-based perspective is built into the clubhouse program rather than a model of professional practices not grounded in reality. Members' responses reflect a real need that makes real differences to others. It is an authentic relationship of reciprocity; members and staff establish trust and become a community.

In Easy House, the essence of community in the clubhouse model is learned by mistakes. In a society where a welfare state is less developed, persons with mental illness tend to count on family support rather than public benefits. Since financial pressure is a common issue in members' daily lives, staff workers and members in Easy House decided to take contract orders from a neighboring industrial area to increase income for members. Making a living by contract order was a popular form of work in Taiwan's early stage of economic development. In order to increase the level of participation, particularly women at home, the Taiwanese government promoted the policy of "Your home can be a small factory," encouraging all families to take contract orders from manufacturing companies to form a manufacturing chain. This was later called an "economic miracle" (Gold, 1986; Winckler & Greenhalgh, 1988). Awareness that the clubhouse standards prohibit paid work, staff workers and members in Easy House consulted with the first author and decided to give it a try. After the introduction of the contract order, members and staff workers began to be bombarded with difficult issues: how to distribute the income among members; how to calculate productivity. Members were split and the sense of solidarity turned sour in a short period of time. The project was called off after 3 months. Staff workers and members realized the importance of the voluntary nature of participation and its relevance to the community building in the clubhouse. This incidence also illustrates that the clubhouse model cannot be fully understood without practical experience. The clubhouse model needs to be learned in theory and in practice.

Working Together as Peers

By working together, the dichotomy of professional vs. client is transformed into a collective "we." The substitution of "we" with "you/I" is critical in reversing the unequal relationships in traditional programs of the medical model. The

hierarchical relationship between patient and the professional is substituted with a collegial relationship of solidarity. Involving members in every aspect of everyday lives in the clubhouse provides the base for staff workers to be peers of members as they accomplish tasks together. A member becomes someone who can be helpful and capable of contributing to others' lives, including those of the staff workers. Staff worker B, who had been working in Easy House for 2 years as her first social work job, notes:

One of the key features of clubhouse is to involve members in the decision making process, including its daily operation, interior design, so they have a sense of belonging. Why do you have to work with members? It is because you will see their strengths. You look for members' strengths that can be helpful to you. You are not there to manage them, but to depend on them to help you. I am not there to train them but to learn from each other. (Staff B)

By working together, staff and members are interconnected into a web of relationships of reciprocity and equality. The collegial nature of the relationship between staff and members is liberating to professional social workers. Compared with a traditional social work setting, staff workers felt that they were freed from the image of helping professional and could be a real person, expressing weaknesses and needs for help. Staff C, trained as a social worker, felt that she can be more like herself without the disguise of professional in the clubhouse:

I may encounter things that are beyond my ability. I never expect myself to be the one to solve all the problems. . . . I will share my problems with the group, so they can be understanding and be helpful. . . . I can relieve myself from being Mr. Know-all. (Staff C)

"We" as a Collective Unit Against the Hostile Outside World

The key features of clubhouse model, member participation and community building, do not fit comfortably with the managerial apparatus of government. Member participation tends to contradict an emphasis on professionalism; and the effectiveness of community building is difficult to demonstrate in a measurable way. The practices of the clubhouse tend to be questioned and thus excluded in the fiscal schema of governmental funding. The staff has to constantly learn to cope with the contradiction between government requirements and clubhouse principles. For example, Easy House has been contracted by the government to provide outreach services to mentally ill persons in the community. According to the contract, outreach service is performed solely by professional social workers but Easy House turned it into an activity in which staff workers and members conduct the outreach together. They developed a new term: peer-visiting. The peer-visiting program was proven to be beneficial to members who took part in it. One member had been a part of the outreach team and was given the assignment of training social work intern students. His new role as an

instructor to others and the trust he was given provided him a sense of competence. He said : “I am a member. I have to help others, like training those intern social work students. They gave me the task, and then I have a big harvest. It is great to be able to help others. I feel I am competent for these things” (Member 2). A staff worker also agreed with comments about the program: “People feel autonomous and confident by giving. For members, the outreach program provides opportunities for all to care for one another” (Staff D). However, these benefits such as raising self-confidence and building interviewing skills among members cannot be recounted in the final assessment of the outreach program because members are not supposed to participate.

The emphasis on community also challenges the tendency of emphasizing case work in the mental health system. However, dependency on public funding poses threats for Easy House as outside sources of authority may deny the joint efforts by staff and members. In the members’ perspective, staff workers and members become a community with a new identity opposite of the stigmatized “mentally ill.” This collective sense of community becomes a driving force for members to work hard in employment placements in order to keep the placements for the community. A member described his feeling about the placement as: “I do really care about the job, because I have been willing to help Easy House keep a good relationship with the employer. . . . If the relationship is stable, then the succeeding members will get the whole working procedure or the data to prepare themselves in advance. Then the problems will decrease. The employer will think good things about members of Easy House, and he would not worry so much” (Member 3). The member considered his role as “helping the clubhouse” instead of himself in maintaining a relationship with the employer. It was the sense of community that supported the member to hold on to the job, rather than individual account of personal interests, such as income or occupational achievement. However, the importance of community support and solidarity is not recognized and therefore devalued in government-funded programs.

Hsin-Ye: The Clubhouse as a Set of Guiding Principles and Peer Support as Family of Persons with Mental Illness

Splitting from Taipei APR, Hsin-Ye took a provocative position toward the medical profession. When the clubhouse idea was introduced to the family members of Hsin-Ye, they were thrilled and inspired. Mark Glickman’s autobiographic video “We are not alone” was replicated in the hundreds by Hsin-Ye as a vision for community rehabilitation. Hsin-Ye even named their magazine the *Journal of Fountain* after the first clubhouse, Fountain House. What they found in the clubhouse model was an alternate way of talking about mental illness and interacting with persons with mental illness which was totally different from the medical model. Thus, the clubhouse served as an alternate discourse and

provided a vision of how psychiatric patients could be treated differently; family members found a way of speaking about their needs through the clubhouse.

However, Hsin-Ye did not choose to replicate the clubhouse as an operational model but as guiding principles. Hsin-Ye was developed to provide a vision for family members rather than a model for psychiatric rehabilitation. There are several reasons for this choice. First, there was no role for family members in the clubhouse model that Hsin-Ye (as peer group of family members) could adopt. Second, Hsin-Ye insisted on maintaining itself as a pure peer support group without professionals; the mixture of staff with members in the clubhouse model threatened its anti-professional stand. Lastly, the design of transitional employment is not radical enough for Hsin-Ye as jobs are still controlled by employers. Adapting to the small-scale business and entrepreneur economy common in Taiwan, family members of Hsin-Ye decided to develop family member-owned businesses and thus become the boss themselves.

Clubhouse as an Alternate Way of Understanding Mental Illness

With the increasing medicalization of mental health, peer-based rehabilitation work in clubhouses is generally not well-received by mental health professionals; it is, however, welcomed by Hsin-Ye as an alternate way of understanding mental illness. Similar to the clubhouse's emphasis on peer support and member participation, Hsin-Ye emphasizes the importance of participation and mutual help among family members. The fundamental belief of Hsin-Ye is demonstrated in its slogan of "Help yourself first, so we can help each other. By helping each other, we deserve help from the society and government." In contrast to many community rehabilitation programs which provide limited or no involvement for families, participation of families is the core of the Hsin-Ye program.

Clubhouse inspires Hsin-Ye to reject the authority of psychiatry and to develop knowledge from their experiences. A successful businessman, Mr. S. C. Lin shares the belief of the clubhouse that work is the core of rehabilitation for persons with mental illness. However, in order to ensure the sustainability of job opportunities, he envisions small businesses owned by groups of the families and operated collectively by the patients and their family members; he calls these: "supported business."

The first stage is to form a core group of about thirty families which then develop a business plan. The headquarters office is composed of about four full-time workers, all family members, and serves as a platform to organize initiatives among family members. To start a Hsin-Ye program, a group of at least six families is required as the "seed group." The worker from the headquarters office will assist the seed group to connect with other families. When the group reaches 30 families, a Family Link is formally established which is the first stage of the Hsin-Ye program. The Family Link will meet regularly to develop a

business proposal with the assistance of a headquarters worker who is also a family member. Involving family members in the program-developing process is essential. Their involvement brings two major advantages: the family member knows the psychiatric patient the best; and involving family members in program development ensures the cooperation of family members in future program implementation. Through Family Link, Hsin-Ye reconstructs the social network for the involved families. There are more than 2,000 families registered with Hsin-Ye. Twenty Family Links have been established to date. These families visit each other and form strong social and emotional bonds. Similar to the life-long membership in the clubhouse, membership for the families in the Family Link is permanent regardless of the functioning level of the mentally ill patient. About one-third of the families (about 600) are engaged in discussion for their employment proposal.

Multiple-Community Building as Support in Rehabilitation Process

There is a five-stage process to achieve the goal of establishing a family member-owned supported business (see Table 3).

Once the Family Link is established, the second stage is focused on individual capacity building. Families encourage their ill family members to be active through a structured day program—a tennis team. The theory for tennis as a way to activate the patients came from Mr. Lin's experiences of searching for a cure for a hangover, which has been part of his work as a businessman. He found that speeding the circulation of energy through perspiration in exercise is effective. Believing that patients are poisoned by psychiatric medicine, which needs to be eliminated from the body, patients are required to join the tennis team in order to build up physical strength and regular daily routines. The tennis team

Table 3. Five-Stage Process of Hsin-Ye Model

Stage one	Organize 30 families as a mutual help group, called "Family Link"
Stage two	Basic individual capacity building of physical strength and social skill by tennis
Stage three	Visit 120 Friends of Hsin-Ye to build social network and self-esteem
Stage four	Develop partnership with business and modeling worksite according to future business model
Stage five	When the collective productivity of the worksite reaches certain level, the Family Link will establish its Supported business

helps to reconstruct the everyday living of the individual. Like the work-ordered day in clubhouse, the tennis team provides a chance for members to connect with other members and staff workers who are also family members paid by Hsin-Ye, as a community. Moreover, tennis clubs around Taipei city have organized themselves as a coalition with regular competition among the clubs. Taking advantage of the existing tennis clubs network, the Hsin-Ye tennis teams create opportunities for members to interact with tennis players from around the city.

The third stage is to strengthen the interpersonal relationship capacity of the member. Staff workers working in the headquarters are asked to introduce the ideas of Hsin-Ye to their own relatives and friends and invite at least 20 of them to join Hsin-Ye Friends, who are willing to be visited by members. This is a challenge to staff to demonstrate their ability to establish meaningful relationships with others and to convey Hsin-Ye's ideas. Until now, Hsin-Ye has recruited more than 120 Hsin-Ye Friends. With the staff companion, members have to learn to take public transportation to visit Hsin-Ye Friends in order to be ready for future home delivery tasks. Members have to successfully complete at least 120 customer visits in order to move on to the fourth stage.

The objective of Hsin-Ye Friends is to build a social network which is supportive to persons with mental illness and which later becomes a pool of potential consumers for the family-owned business. The visits by members are aimed at creating a meaningful interaction for both parties. At the beginning, both members and Hsin-Ye Friends will experience anxiety due to the effect of social stigma for mental illness. After the visits, members will have a chance to know each other as real persons rather than "mental patients." Through the collective effort of Hsin-Ye, a network of individuals who are supportive and friendly to persons with mental illness is established so that through successful person-to-person contact, the self-esteem of members can be elevated and the negative effect of social stigma can be diminished.

The fourth stage is to develop a collaborative relationship with the business the Family Link has chosen and to train the members to learn the skills necessary for that business. This stage is called "job plantation." The purpose is to introduce a work model from outside business into the workplace incrementally. The worksite starts as a sheltered factory, which is modeled according to the requirements of the collaborated business. Regular attendance and skill training are the major focus at this early stage. When members have identified with their work role and the team becomes stable, the worksite will be transformed and shifts its emphasis from training to productivity. If the productivity can reach the requirements of the collaborated business to prove its competitiveness in the market economy, the worksite will register as a for-profit enterprise with family members holding 60% of the stock to ensure their control as a family-run business. This is the fifth and last stage; members become employees without any change of worksite or colleagues.

“Job plantation” has proven to be a long struggle for Hsin-Ye. Hsin-Ye has tried at least three types of business models since they received government funding in 2002. Based upon Mr. Lin’s experience, Hsin-Ye identified the growing need for door-to-door delivery services as a potential business for psychiatric patients who are low-cost manpower and can take advantage of cheap public transportation. Hsin-Ye established a partnership with a mineral water company by providing home delivery for its products. Hsin-Ye is responsible for covering the salaries of members who provide door-to-door delivery and provide training for members. Because the number of beneficiaries was relatively lower than other sheltered employment programs, the government withdrew its funding after 2 years. Hsin-Ye later tried to develop door-to-door laundry delivery service and is now running a second-hand goods recycling shop with limited success. Without sufficient and consistent funding streams, Hsin-Ye can not maintain staff members for significant periods of time to establish the quality and depth of relationships that are foundational to members’ success. The fifth stage of supported business has not yet been reached due to the lack of financial support.

What makes Hsin-Ye unique is that the program will evolve as the collective functioning of the team members improve yet members remain the same which ensures continuity of social relationships. As family members serve as workers in the process, Hsin-Ye is designed to foster solidarity among members as well as their families. No one will be expelled from the program. Periodic breakdown is acceptable, and other members and family members will fill in until the ill person recovers. As the program evolves, some will upgrade their level of functioning while others remain at the entry level. However, the integrated multi-service model of Hsin-Ye also raises funders’ concern for low cost effectiveness; all the resources are limited to 30 members without possibility of turnover for other members.

As for the practices of self help, Hsin-Ye is a self help group for families as family members are stock-holder, staff worker and volunteers. The egalitarian relationship among members is not embodied in Hsin-Ye. The hierarchical relationship of parents and children in the family is replicated in the institutional structure of Hsin-Ye as staff workers and members. Although not documented, our observation shows that client participation is limited in the daily operation of Hsin-Ye.

In sum, clubhouse inspired Hsin-Ye to validate the experiential knowledge of families of persons with mental illness. Hsin-Ye is a clubhouse of guiding principles wherein psychiatric patients are provided with a community that belongs to them and a restorative environment within which members are able to lead meaningful and productive lives. However, unlike the clubhouse Easy House, Hsin-Ye altered the practices of the clubhouse operational principles according to local contexts. For instance, Hsin-Ye defines peers as those with similar experiences of caring for family members with mental illness. Staff workers are replaced by family members, so that family has a role to play. Hsin-Ye

understood clubhouse within their understanding of local context and made modifications where they thought necessary. In an economy wherein outsourcing parts of the production chain prevails, running a small business is a popular model of the entrepreneur. Hsin-Ye adopted the social enterprise approach (Shragge, 1997) rather than the typical feature of the clubhouse—the Transitional Employment program. Hsin-Ye takes advantage of the family members who are successful business people to establish their own businesses to ensure employment opportunities for members.

DISCUSSION

Despite a wide variance in meaning, mental illness is a category that disqualifies those designated individuals from participation in almost all decision-making aspects of their daily lives. In the light of classic works by Goffman (1961) and Foucault (1965), the transformation of madness is revealed: a set of knowledge and techniques regarding madness has gained scientific status and has become institutionalized as a regulatory apparatus, a process that we call “medicalization” (Conrad, 2007). The medicalization of mental illness in Taiwan came relatively late compared to Western countries. Medicalization was triggered by the incidents at LHT, initiated by the passage of the Mental Health Act in 1990 and reinforced by the introduction of funding through National Health Insurance in 1994. Yet, medicalization was met with constant resistance. The idea of the clubhouse was introduced at a time when family members were struggling for autonomy in the medicalized sphere of mental illness and represented a potential form of resistance to the medical discourse that had become dominant in the 1990s.

The discursive practices of the clubhouse in Taiwan are embedded in and shaped by two contexts. The first context is the democratization process which began with the lifting of Martial Law in 1987. This shift away from the authoritarian political control opened up new social fields of civil society to the public, including families of persons with mental illness (Gold, 1986; Hsiao, 1992). It is in the context of an emerging civil society that clubhouse was introduced and interpreted as an alternate response to the mounting demands for social provision of care for persons with mental illnesses.

The second contextual factor is the U.S. cultural hegemony in Taiwan since the Cold War. With the outbreak of the Korean War in 1951, the American government sought to bring Taiwan into the sphere of its Pacific strategy with a massive amount of military and economic aid. As a member of the Western anti-Communist camp, Taiwan is dependent on the United States for its military and economic security. Political and economic dependency bred a cultural dependency with the United States as the center, which Tomlinson (1991) referred to as “cultural imperialism.” Within such a structure, intellectuals in Taiwan tend to play the role of “cultural broker” and have been oriented in the footsteps of American academics (Chen, 1994; Chen & Chien, 2004). The clubhouse, although

marginalized in U.S. discussions about mental health, has a privileged status when introduced to Taiwan as an “advanced” model of community rehabilitation. As the cultural broker for clubhouse in Taiwan, the first author is acutely aware of the contradictions and dangers of talking about the clubhouse. I could speak of the clubhouse because of its origins in the United States; yet, my goal of talking about clubhouse has always been to support the suppressed voices under the professional domination over mental health. The danger is that when the audience listens, they might treat me as an expert and accept my interpretation as an authority; then, I would fail to open up new space of dialogue for grass-rooted voices and knowledge. In other words, clubhouse might become another expert voice on mental illness without empowering marginalized voices. This article is driven by the author’s anxiety of replicating existing power relations in his efforts of introducing the clubhouse concepts.

As an established Western model of community rehabilitation, the clubhouse was taken up by family groups differently but with the same goal, that is, to search for an alternative understanding of mental illness and different identity for mental patients. The practices of Easy House illustrate how the clubhouse is treated as a model to be embodied according the standards set by ICCD. This approach has enabled the professionally-led group to secure government support through cultural privilege as a U.S. model. On the other hand, the practices of Hsin-Ye follow the guiding principles of clubhouse but modify the specifics according to their local knowledge of the Taiwanese context. However, without credit as a clubhouse, Hsin-Ye cannot secure stable and sufficient funding. The founder of Hsin-Ye, Mr. Lin, complained that government officials constantly asked him to provide references of similar models in advanced countries to prove the model is workable. Mr. Lin replied, “why do we always have to speak through the U.S. experience? Why don’t our experiences count at all?” (interview on December 21, 2005).

The definitions of peer support in Hsin-Ye and Easy House are different. Easy House, following the clubhouse model, adopts an open definition of peers as partners, in which staff workers without a history of mental illness can be peers to members through working side by side. To the contrary, Hsin-Ye adopts a closed definition, in which peers are strictly limited to those with shared experiences of caring for family members with mental illness. The difference in defining peers based on past or present experiences illustrates the multiple ways of becoming peers that could expand our understanding, as well as practices, of self-help behaviors in the future. Both Easy House and Hsin-Ye are based on the democratization of services from the medical model with participation from members and families. Yet, both services offer limited egalitarianism: Easy House is limited by professionals; Hsin-Ye is limited by parents.

As both Hsin-Ye and Easy House recognize gainful employment as the goal of rehabilitation for their members, the different approaches to gainful employment raises the issue of ICCD standards and cultural diversity. Transitional

employment has been seen as a key feature of the clubhouse; 40% of active members are expected to be involved in transitional employment. However, implementation of transitional employment requires certain conditions which Taiwan does not have. Taiwan's economy has been developed based on the export-oriented industrialization since the 1970s. Hundreds of small businesses are set up and linked into different subcontracting networks as production systems to respond to various foreign purchases. This special form of economic organization is famous for its flexibility and is a phenomenon correctly called "boss island" (Shieh, 1992). The lack of large companies means there are few low-end and routine jobs available. Worst of all, the job opportunities are controlled by employers. Clubhouse takes the placement as an agency and demands the right of selecting members in exchange of guaranteed fill-in if members are unable to work. Families in Hsin-Ye decided to be the boss themselves. Therefore, the "supported business" model is based upon the specifics of Taiwan's economy. Although Hsin-Ye has not yet proven itself as a successful supported business, its approach is more radical and is echoed by the recent trends of social enterprise and consumer/survivor movement in North America (Church, 2006).

The practices of interpreting the clubhouse as a guiding principle in Hsin-Ye also reflect the different cultural understanding of family in the United States and Taiwan. The clubhouse model is aimed at supporting the member to regain a meaningful life within a community shared between staff workers and members; there is no role for family members in the clubhouse model. In Western culture, the autonomy of an individual is emphasized; perspectives and interests of family members and patients are different (Trainor, Pomeroy, & Pape, 1999). However, this is not the case in Taiwan. A person is not viewed as an adult until s/he gets married. It is common for mentally ill persons to live with their parents. The emphasis on family ethics in Taiwanese society means families take up most of the responsibility, and therefore family members have a stake and play a part in the process of changing the irresponsible mental health system. The fact that families have no role to play in the clubhouse pushed family members to develop the Hsin-Ye model. Ironically, although the Hsin-Ye model lives up to the inspirational goals of the clubhouse, it is not recognized by the international clubhouse community.

This leads to the issues of the limits of current ICCD practices and how the international clubhouse movement can move forward. The clubhouse movement continues to wrestle with problems presented by those entities that utilize the name "clubhouse" but do not live by the ICCD Standards. Therefore, it is considered by many in the movement to be necessary to stay true to clubhouse model via certification (Staples & Stein, 2008, p. 192). However, we need to recognize the danger of "staying true to clubhouse model" and its constraint on the formulation of international clubhouse community. Viewing clubhouse as a model means there is just one true way of "doing" clubhouse and this model is universally applicable to all cultural contexts. This positivist assumption of

single truth can pose serious threat to the capacity of dialogue between clubhouse and local cultures and hinder the possible enrichment on how clubhouse principles can be adapted. If we conceptualize the clubhouse as a transnational social movement against the “spoiled” identity of mentally ill persons, the clubhouse community should include those who recognize the clubhouse principles but are creative enough to modify the model according to local cultural contexts, such as Hsin-Ye. In other words, the certification approach has enabled ICCD to distinguish the “bad” clubhouse from the “good” clubhouse, but at the same time, it has also reduced the social vitality of clubhouse as a catalyst for the global social movement for alternative identities to “psychiatric patient” such as member, consumer, or survivor. The ICCD should move beyond the regulating body of clubhouse model and position itself as an engine for making the clubhouse a counter-discourse, available to those who seek alternative ways of interpreting and dealing with mental illness. The key lies in learning to appreciate those programs which deviate from the clubhouse model because these differences may bear new understanding of clubhouse, which may prove essential to the transnational circulation of clubhouse in the era of globalization.

ACKNOWLEDGMENTS

The authors wish to thank Thomasina Borkman, Magnus Karlsson, Thomas Powell, Ernie Lightman, Francesca Pernice-Duca, the anonymous reviewers, and the authors of this special issue for their helpful comments and feedback on earlier version of this article.

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