Research Article

Conceptualization of Personal Recovery among Community-Dwelling People with Schizophrenia: Theory Derivation Approach

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Abstract

Personal recovery is increasingly recognized as a vital outcome for community-dwelling individuals with schizophrenia. However, it lacks a well-defined conceptual framework in nursing research. This study aims to derive and present a nursing-specific conceptual model of personal recovery among people living on their own with schizophrenia, based on the Unity Model of Recovery (UMR). Using a theory-derivation approach, the author reviewed post-2011 literature in PsycINFO, CINAHL, and Google Scholar using terms such as “recovery”, “personal recovery”, “schizophrenia”, and “theory”, and examined analogous ideas from adjacent disciplines, selected the Unity Model as the parent theory, identified transferable content, and adapted/refined concepts for psychiatric nursing practice.

The resulting model integrates four attributes under three cornerstones—insight, hospitalization since onset, resilience, and family support, along with three environmental supports—social support, therapeutic alliance, and recovery-oriented nursing services. These components were labeled as fundamental for promoting personal recovery in individuals with schizophrenia living in the community. This research adds a novel theoretical framework that integrates clinical and personal recovery aspects, providing a comprehensive approach to nursing practice. The model focuses on improving the quality of life and well-being of individuals with schizophrenia by emphasizing strengths-based recovery, not only symptom control.

Keywords: *Personal Recovery, Schizophrenia, Theory Derivation, Model*

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Introduction

Schizophrenia is a progressive and chronic disorder. Approximately 21 million people or 1 in 300 people (0.30 % to 0.70%) of the world's population are directly affected by it (Global Burden of Disease Collaborative Network, 2024). Most of them might have to deal with residual psychotic symptoms for the remainder of their lives in the community, which can seriously affect their quality of life and functional recovery, whether they are young or elderly (Hofer et al., 2023). Health professionals, particularly psychiatric mental health nurses, who from a large group of community service health providers, must manage and assist with a steady stream of patients suffering from schizophrenia (Imkome, 2022). One of the problems of transitioning patients from the hospital to community care is ensuring continuity of treatment. Consequently, nursing care for individuals with schizophrenia is complex and faces numerous challenges, as the treatment approach requires long-term goals.

The objective of care for patients diagnosed with schizophrenia is to facilitate their recovery (Slade, 2009a; Sato, Watanabe, Maruo, Moriyama, & Furukawa, 2022). The former model used the bio-medical model, which is basic in mental health rehabilitation service models, because it focuses on clinical recovery outcomes, refers to overall symptoms' stability and remission, and social/vocational functioning attainment (Andreasen et al., 2005). Nevertheless, relapse and rehospitalization remain common, prompting a shift toward empowerment models, which recognizes personal recovery along with clinical recovery that does not focus only on psychotic symptoms, but supports the pursuit of individual goals, participates in valued social roles, and attaches to a community of their choice (Slade, 2009b, 2010; Braslow, 2013).

Personal recovery focuses on developing the potential strengths of people with schizophrenia instead of focusing on their weaknesses or focusing on living with the illness as well as beyond it. This supports the idea that personal recovery is a journey and not one with a fixed outcome. Therefore, personal recovery aligns with mental health outcomes defined by the World Health Organization (WHO) as mental health outcomes related to a state of well-being in which an individual realizes their abilities, can cope with the everyday stresses of life, can work productively, and can make a contribution to their community. In addition, mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living, and enjoy life (World Health Organization, 2022). In other words, personal recovery is an appropriate mental health

outcome for the care of individuals with schizophrenia. Thus, mental health professionals globally could use it to guide mental health policy and services. As a result, psychiatric mental health nurses (PMHNs) are one of the mental health professional teams that must comprehend the personal recovery phenomenon among people with schizophrenia in the community to design and develop nursing interventions toward personal recovery.

Although the mental health system recognizes personal recovery as an optimal goal (Slade, 2009b). The concept remains imprecise in mental health nursing. This ambiguity has kept practicing anchored in traditional biomedical interventions. Historically, mental health nursing developed alongside psychiatry in hospital settings, which embedded the biomedical model in nursing practice.

Accordingly, there is no clear consensus on how nursing should conceptualize personal recovery, and related studies are limited. As a result, nurses may—often out of protective concern—prioritize treatment and risk management over autonomy, choice, and person-defined goals. Clarifying personal recovery within nursing principles is therefore essential to guide services that promote recovery and improve the quality of life of people with schizophrenia.

To demonstrate the phenomenon of personal recovery in patients with schizophrenia living in the community from a nursing perspective, this study follows Walker and Avant's theory derivation guidelines (Walker & Avant, 2019). It is useful to have a better knowledge of personal recovery, which leads to the advancement of nursing science, to develop nursing interventions that enhance the outcomes of patients with schizophrenia.

Despite policy support for recovery-oriented care, the operational definition of personal recovery within nursing remains ambiguous. This ambiguity hampers care planning, patient engagement, and intervention design in community settings; therefore, a nursing-specific conceptualization is needed. Community care is characterized by episodic contact, self-management, and reliance on informal supports, which makes clear guidance for nurses especially important. For these reasons, this study used Walker and Avant’s theory-derivation approach to translate the Unity Model of Recovery (UMR) into a nursing-specific framework. Clarifying the concept at the theoretical level can guide nursing theory, inform nurse-led interventions, and support recovery-oriented policy and service development.

Objective

To derive and present a nursing-specific conceptual model of personal recovery among community-dwelling people with schizophrenia by translating and adapting constructs from the UMR using Walker and Avant's theory-derivation approach.

Literature Review

This review focuses on identifying the conceptual materials that inform the subsequent theory derivation, rather than aggregating empirical effects.

Personal Recovery

Personal recovery in mental health represents a paradigm shift from traditional symptom-focused treatment models to a holistic, individual-centered approach that emphasizes well-being and quality of life. Anthony (1993) defines personal recovery as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness, which often requires the adaptation of existing theoretical frameworks to capture the full spectrum of recovery experiences. One of the most influential frameworks in personal recovery is the CHIME framework, which identifies Connectedness, Hope, Identity, Meaning, and Empowerment as critical dimensions of recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

The personal recovery model is rooted in the understanding that recovery from mental illness involves more than the absence of symptoms; it encompasses the individual's journey toward a meaningful, satisfying, and autonomous life (Slade, 2009a). This model prioritizes the person's own goals and aspirations, recognizing recovery as a deeply personal and non-linear process. The recovery model has significantly influenced mental health services, promoting a shift towards recovery-oriented care. This approach supports the individual's recovery process by focusing on strengths and resilience, fostering a collaborative therapeutic relationship, and emphasizing the co-production of care plans (Le Boutillier et al., 2015). To link this literature to the present study's aim, this study uses these strands (e.g., CHIME; recovery-oriented practice) as the conceptual inputs that will be translated during theory derivation.

Theory Derivation

Theory derivation is a pivotal method in nursing research that contributes to the evolution and refinement of theoretical frameworks. Rather than relying on "analogy" in a loose sense, theory derivation selects a parent theory in a related field and translates, restates, and refines its concepts to fit a new disciplinary context. Walker and Avant (2019) describe theory derivation as a process that extends beyond the mere application of existing theories to the creation of new frameworks that can articulate and address emerging healthcare challenges. Theory derivation may expand upon the existing frameworks by incorporating new variables, refining the relationships among elements, or extending the theory to new populations or fields of practice.

There are five steps consisting of the following: (1) become thoroughly familiar with the literature on the topic of interest; (2) examine adjacent fields for transferable ideas; (3) select a parent theory to move and restate for a derivation; (4) identifying the content and/ or structure from the parent theory is to be used; and (5) adapt and refine these to produce a coherent framework that addresses the phenomenon of interest (Walker & Avant, 2019). This method has been instrumental in several areas of nursing research. For instance, McEwan and Wills (2021) discuss how theory derivation has led to the development of specialized theories in areas like pain management, patient education, and chronic disease management. In this study, the UMR serves as the parent theory guiding the derivation of a nursing-specific conceptual model for community-dwelling people with schizophrenia.

On this basis, the next section (Conceptual Framework) names the parent theory (UMR) and outlines the five derivation steps, ensuring an explicit bridge between the literature reviewed here and the study's conceptual objective.

Conceptual Framework

This study develops a comprehensive nursing-specific conceptual framework to enhance understanding and support of personal recovery among community-dwelling people with schizophrenia. The conceptual framework was derived using Walker and Avant's theory-derivation approach. It integrates key constructs from the parent theory—the UMR —adapted for psychiatric nursing. Here, parent theory means the primary theoretical framework selected from a related discipline and translated to a new context (Walker & Avant, 2019). Following Walker and Avant's theory-derivation approach, the author: (1) became thoroughly

familiar with scholarship on personal recovery and schizophrenia; (2) examined adjacent disciplines for analogous ideas; (3) selected the parent theory (UMR); (4) identified applicable content and structures from the UMR applicable to psychiatric nursing; and (5) adapted and refined for psychiatric nursing to produce a coherent model and discuss its implications. (Walker & Avant, 2019). Figure 1 summarizes Walker and Avant's theory-derivation approach steps. Guided by the UMR, this study applied Walker and Avant's theory-derivation steps to identify transferable concepts and adapt them for psychiatric nursing in community settings.

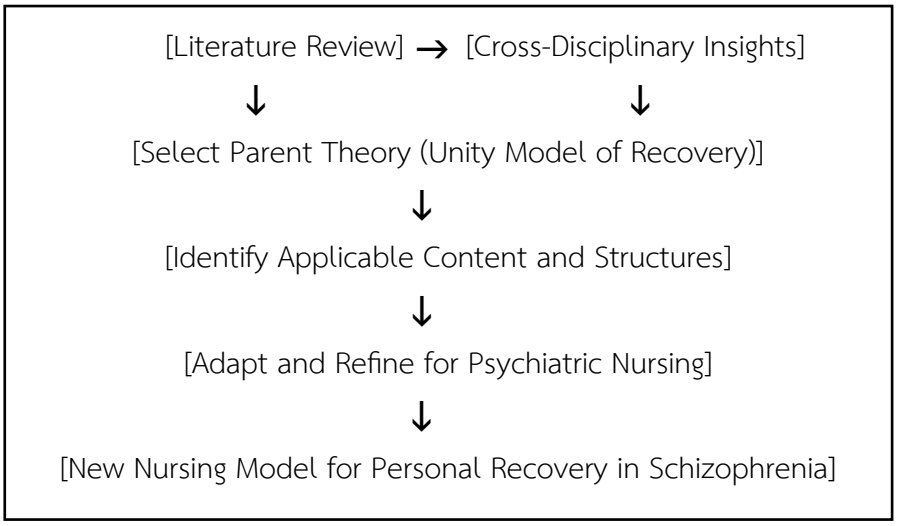

Figure 1 Theory-derivation steps used in this study

Source: Adapted from Walker and Avant (2019)

Methodology

This study employed a theory derivation approach, as outlined by Walker and Avant (2019), to develop a new model for understanding personal recovery among people with schizophrenia in community settings. This method involves translating and refining constructs from parent theory to fit nursing. The methodology was comprehensive, even though it did not adhere to PRISMA guidelines; the approach was structured by preplanning to ensure thoroughness in searching and involved a systematic literature review and adaptation of existing theoretical frameworks to form a new, derived conceptual model.

This conceptual study did not involve human participants. Instead, the data comprised scholarly sources (journal articles, book chapters, and theoretical papers) relevant to personal recovery in schizophrenia. Sources were identified in PsycINFO, CINAHL, PubMed, and Google Scholar using combinations of the terms "personal recovery", "recovery-

oriented", "schizophrenia", "theory", "model", and "framework". Given the conceptual purpose, PRISMA was not applicable because this was a theory-derivation study rather than a systematic review of empirical effects; PRISMA guidance did not apply (no PICO question, no risk-of-bias appraisal, and no quantitative synthesis). Instead, the author conducted a structured, purposive search to identify conceptually rich sources and followed Walker and Avant's five derivation steps to adapt and refine the model.

The selection criteria were as follows: (1) a wide range of peer-reviewed publications (articles or scholarly chapters); (2) articles or scholarly chapters written in English, (3) theoretical, conceptual, framework, or qualitative work addressing personal recovery and schizophrenia (within community or mental-health nursing context); (4) content that could inform, adapt, or refine concepts for a nursing model; and (5) published between 2011 and 2024 and full text available. Exclusions included duplicates, non-scholarly sources, purely biomedical symptom-remission measures without a personal-recovery focus, and studies unrelated to schizophrenia.

Data Analysis

Data analysis began with a thorough review of the literature on personal recovery from schizophrenia across multiple disciplines. The analyzing process involved synthesizing information from selected theoretical and empirical studies to inform the derivation of a new model. The theoretical derivation process involved five steps: (1) become thoroughly familiar with the literature on the topic of interest; (2) read widely in other fields for ideas to discover potential analogies; (3) select a parent theory to move and restate for a derivation; (4) identifying the content and/or structure from the parent theory is to be used; and (5) developing and/or modifying content or structure of the parent theory and restating in concerning term the phenomenon of interest, which in this case is personal recovery in schizophrenia.

Each phase was guided by the structured approach of theory derivation, with an emphasis on the transposition and modification of theoretical constructs to fit the nursing discipline's needs with regard to the treatment of schizophrenia in community settings.

Results

The analysis concluded with the inclusion of twelve articles (Leamy et al., 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012; Torgalsbøen,

2012; Nowak, Waszkiewicz, S'witaj, Sokół-Szawłowska, & Anczewska, 2017; Song, 2017; Chan & Lam, 2018; van Eck, Burger, Vellinga, Schirmbeck, & de Haan, 2018; Ballesteros-Urpi, Slade, Manley, & Pardo-Hernandez, 2019; van Weeghel, van Zelst, Boertien, & Hasson-Ohayon, 2019; Jagfeld, Lobban, Marshall, & Jones, 2021; Sari et al., 2021; Gyamfi, Bhullar, Islam, & Usher, 2022). Accordingly, the UMR from social work (Song & Shih, 2009; Song, 2017) was selected as the parent theory and served as the primary theoretical framework for this study. The derived nursing model refines selected factors from the UMR with support from the existing literature. The results of the five-step theory derivation were as follows:

Step 1: Targeting a Phenomenon of Interest

According to nursing theory growth in the domain of personal recovery is restricted; it was recognized that more conceptual knowledge was required to enable scientific study in this critical area. The phenomenon of interest was personal recovery.

Step 2: Review of Literature From Other Fields

It seemed appropriate to review the existing literature regarding a closely related phenomenon, personal recovery among people with schizophrenia emerged the concept from patients' and caregivers' perspectives about crucial personal growth beyond the illness from mental health issues. Thus, PMHNs needed to explain the phenomenon of personal recovery, understand the correlation between personal recovery and other variables, and identify gaps in knowledge.

There are gaps in the literature due to the absence of widely accepted conceptual frameworks to characterize the phenomenon of personal recovery and emphasize research on schizophrenia patients. Literature demonstrated that found (a) the SAMHSA, Department of Health and Human Services presented the SAMSHA Recovery framework were utilized 17 components were identified and four dimensions (SAMHSA, 2006, 2012) and (b) a framework for personal recovery by Leamy et al. (2011) were five factors (connected, hope, identity, meaning of life, empowerment: CHIME). Both existed beneficial for describing factors associated with supporting or obstacles to personal recovery through the agreement of multidisciplinary mental health experts. However, there is a limitation that those factors were not explicitly determined to be used only in the nursing field and do not operate from patients' perspectives. Factors of both frameworks could not explain personal recovery in line with the causal relationship pattern because there was no explanation of the direction. No study reported evaluating a set of factors associated with personal recovery simultaneously.

Step 3: Selecting a Parent Theory to Use for the Derivation

The parent field selected is a social worker. The parent theory is The UMR by Song (2017) provided in Figure 2, because using patients' perspectives is a good and insightful way to explain factors predicting personal recovery among people with schizophrenia in the community. Song and Shih (2009) developed this model by using a qualitative approach to reveal detailed successful psychiatric disability experiences of people in the community and capture the common nature and meanings of personal recovery processes and outcomes of them. The UMR has three key constructs including the following: (1) Three cornerstones were bio-psycho-social factors, including symptom remission & other illness variables, mental strength (resilience), and family support; (2) Environmental factors: formal support (welfare subsidy, help from medical professionals, treatment model and medical professionals, job opportunity and work cognition, and support in workplace) and informal support (intimate relationship, reciprocal friendship, supportive neighborhood, religious fraternity); and (3) personal recovery.

Three cornerstones and environmental factors were two sets of predictors correlated with personal recovery. The three cornerstones that attributed self-discovery in the restorative process to personal recovery result design. A sense of self-reconstruction helps patients cope with mental disease symptoms (e.g., relapses or co-morbidity) and improves internal psychology (resilience). Mutual benefit exchange between informal and formal networks in the whole ecological system is a significant source of support for a never-ending recovery process. The personal recovery effect helps those patients. Their social surroundings (e.g., family, friends, and colleges) can help them reduce stress and live a more fulfilling life with well-being.

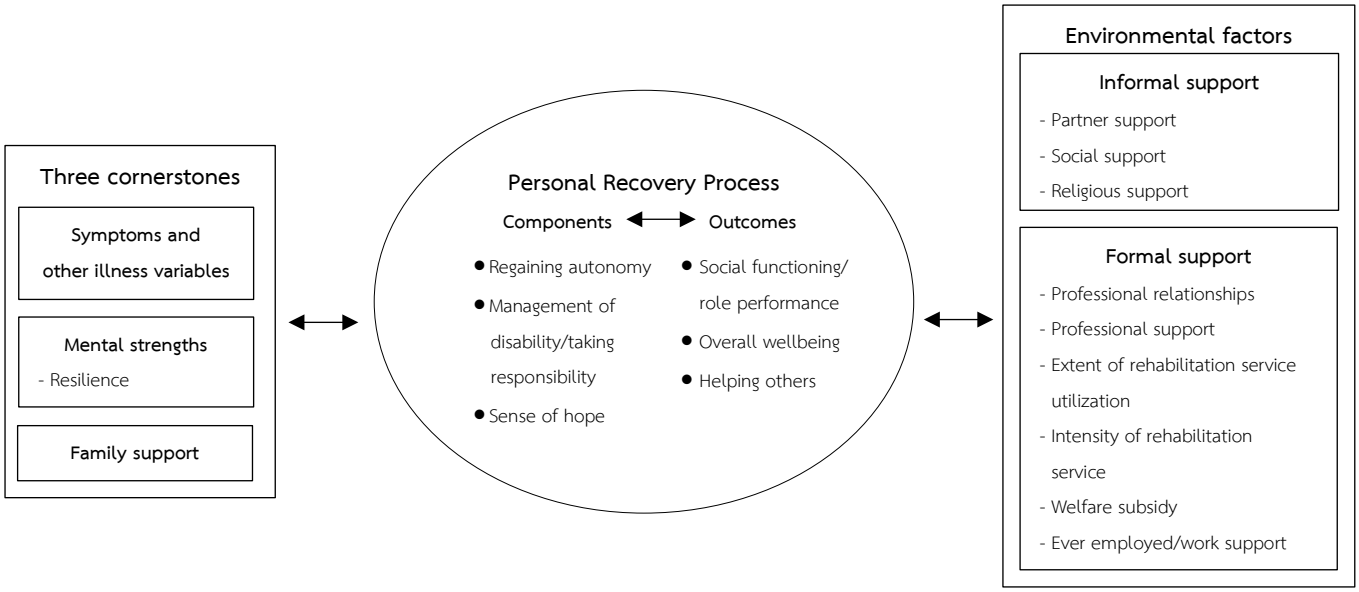

Figure 2 Adapted UMR for Psychiatric-Mental-Health Nursing in Community Care

Source: Author creation, adapted from The Unity Model of Recovery (Song & Shih, 2009; Song, 2017)

Step 4 and 5: Identification and Modification of Analogous Content or Concepts/Structure of the Parent Theory to Use in the Derived Model

The purpose of the derivation was to arrange the notions of the derived theory using the parent theory. The new field's content and concepts were used to generate a theory with a structure similar to the parent theory. The UMR was chosen as the basis for the derived model, which was then adjusted, redefined, and reorganized (see Figure 3). In order to develop theoretical statements for the derived theory of conceptual framework of personal recovery in people with schizophrenia, the following relational statements were generated from statements in the parent theory (the UMR). The major contribution to the derived model involves the examination of personal recovery as outcomes. This reconfiguration allows a better understanding of why two groups of predictive factors are associated with personal recovery in the nursing discipline. A table summarizing author derivations is provided (see Table 1).

The UMR has a distinctive structure that details relationships among the predictor variables, as well as their relations to personal recovery. Given the lack of theories to explain

personal recovery through patients' views, a decision was made to employ a simplified theory structure, which specified only the direct effects of the two group predictive factors on personal recovery. It was anticipated that once the key explanatory variables had been validated, attention could be directed in subsequent theory development and research toward specifying linkages. Although the structure of the parent theory was simplified for the present study, it seemed to represent an appropriate analog to be used for guiding future personal recovery research. Minor modifications made in the content of the parent theory to make it meaningful to the phenomenon of personal recovery among people with schizophrenia in the community are described below. They were based on empirical literature in the person recovery field that parallels the two group predictor factors contained in the parent theory. The new theory's structure and two main predictor groups were borrowed from the parent theory. New nursing concepts and content were defined to fit the borrowed structure and for use in formal statements from the parent theory.

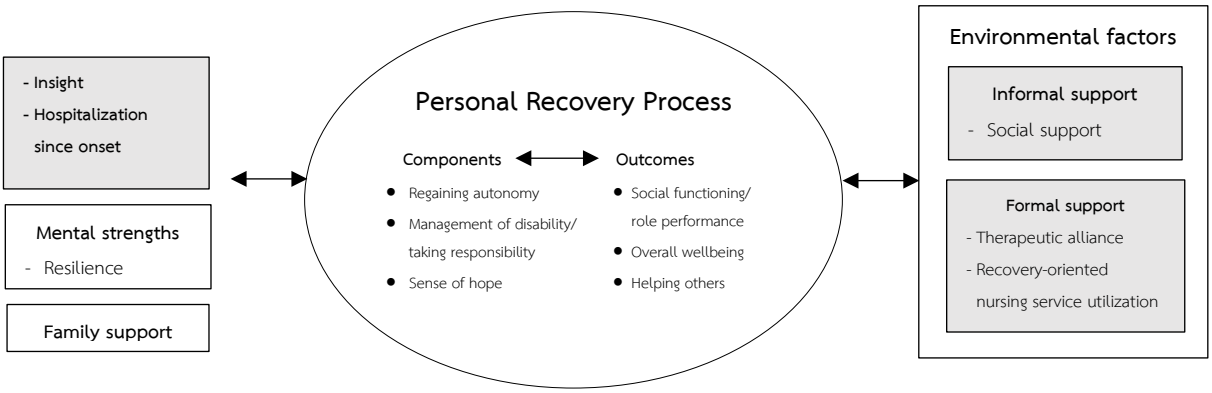

Figure 3 Derived Nursing-Specific Model of Personal Recovery (domains: clinical cornerstones; environmental supports)

Source: This model is derived from the Unity Model of Recovery (Song, 2017). Derived components from the UMR that are redefined or modified are shaded in grey.

To aid interpretation, Figure 2 summarizes the adapted UMR, and Figure 3 presents the derived nursing-specific model. The narrative proceeds in the following order: (1) elements added; (2) elements refined (moved/restated); and (3) elements not retained, with brief justification and citations where relevant. This study uses consistent terminology throughout—clinical cornerstones (insight, hospitalization since onset, resilience, family

support) and environmental support (social support, therapeutic alliance, recovery-oriented nursing service utilization). Table 1 provides a concise list of the added, refined, and not-retained elements referenced in the text.

Table 1 Parallel Definitions of the Parent Model (The UMR) and Derived Model

The UMR Concepts (Parent Model)	**Model Derivation** ***+Newly added, **Refined, ^Erased***
1. Three cornerstones	
1.1 Symptoms of remission and other illness variables are the necessary biological foundation for the recovery of psychiatric disability persons because they expressed that having insight into the disability and having symptoms of remission or developing good ways to deal with the negative effects of medications.	***+Insight*** Schizophrenia patients could describe and interpret psychotic symptoms and illness events rationally by accepting that they have a mental disease, including getting other people's views on their mental illness. cognitive insight was introduced in 2004 by Beck and colleagues (Beck, Baruch, Balter, Steer, & Warman, 2004), to describe the ability of patients with psychosis to distance themselves from their psychotic experiences, reflect on them, and respond to corrective feedback.
	+Hospitalization since onset The number of hospital admissions of schizophrenia patients due to elevated psychiatric symptoms, from the first episode until the recent admission (van Eck et al., 2018).
1.2 Mental strength **is resilience** which refers to the individual's ability to bounce back from negative emotional, difficult experiences and flexibly adapt to the changing demands of one’s life situation (Torgalsbøen, Fu, & Czajkowski, 2018).	

Table 1 (cont.)

The UMR Concepts (Parent Model)	Model Derivation *+Newly added, **Refined, ^Erased*
1.3 Family support refers to is instrumental, loving, and informative in assisting patients to repeatedly overcome symptoms, mental weakness, and social obstacles in the recovery process, and it instills unwavering faith and hope for a better life (Reupert, Maybery, Cox, & Stokes, 2015; Kusumawaty, Surahmat, Martini, & Muliyadi, 2021).	
2. Environmental factors	
2.1 Informal support	
2.1.1 Partner support able help to increase one's commitment to taking responsibility. They solve problems together	*****Partners support*** Partner support is subsumed within family support.
2.1.2 Social support refers to acceptance, good manners, and friendly support of neighbors, which could help people with schizophrenia to reintegrate into the community	
2.1.3 Religious support could aid in recovery in a number of ways: it could provide an unconditional channel to social activities and acceptance; it could help a person calm the mind, awaken the soul, and enrich the spirit; and the peace, strength, and a touch of humanity derived from hymns, worship, and meditation could empower individuals to face adversity courageously.	***^Religious support*** In the literature, religious support has no substantial evidence to support the association with personal recovery (Song, 2017; Yangarber-Hicks, 2004).
2.2 Formal support	
2.2.1 Professional relationships and Professional support refer to the type of help, including 1) Patience, care, encouragement, and emotional support. They treated them like family. 2) Empathy, trust, and respect when talking about problems, which increases	*****Therapeutic alliance*** The person's perception (with schizophrenia) of a collaborative, empathic bond with PMHNs. The three dimensions include positive collaboration, positive clinician input in, and non-supportive clinician input

Table 1 (cont.)

The UMR Concepts (Parent Model)	Model Derivation *+Newly added, **Refined, ^Erased*
the sense of self and internal control. 3) Adequate and effective advice and services, which made the patients stronger and better able to deal with life's stresses. 4) Instilling hope for recovery, which helped the patients find new ways to take control of their lives.	(Shattock, Berry, Degnan, & Edge, 2018; Thongsalab et al., 2024).
2.2.2 Extent & intensity of rehabilitation service utilization consists of the extent and intensity of psychiatric rehabilitation service utilization by clients. It summarizes the kind of services such as independent living and self-care training, physical activities, and symptom management training. Due to the different rehabilitation services in each country and literature, psychiatric rehabilitation service is synonymous with recovery-oriented service.	*****Recovery-oriented nursing service utilization*** refers to the degree or amount of perceived usage of services or care provided by the nursing team after the schizophrenic patient has been discharged from the hospital. These nursing care included activities performed by using direct care and care management during home visits and/or at outpatient follow-up visits, aiming to assist or help the schizophrenic patient to achieve personal recovery appropriate to his/her own capacities (Parker, Siskind, & Meurk, 2017; Davidson, Rowe, DiLeo, Bellamy, & Delphin-Rittmon, 2021).
2.2.3 Welfare subsidies could help people with subsidy problems and make it easier for them to get back into society and avoid relapses, which would help them get better.	***^Welfare subsidy*** While welfare support is often intended to alleviate financial stress and improve overall well-being, evidence suggests that it does not consistently correlate with personal recovery outcomes (Wickham et al., 2020). In literature has not shown a robust significant

Table 1 (cont.)

The UMR Concepts (Parent Model)	Model Derivation *+Newly added, **Refined, ^Erased*
	relationship between welfare subsidy with personal recovery (Song, 2017).
2.2.4 Ever employed/Work support refers to a job as a stage that shows the role of a good worker, a productive person, and a respectable citizen. The work role could improve both the person's sense of self and their ability to interact with others, which would help with their recovery.	***^Ever employed/Work support*** Evidence has reported a slightly significant relationship between ever employed and work support with personal recovery (Tse, Davidson, Chung, Ng, & Yu, 2014; Kukla et al., 2024).
3. Personal recovery process	
The personal recovery process illustrated both process components and outcomes. A sense of self, disability management, hope, willingness, and responsibility are crucial process components. outcomes consist of subjective self-efficacy, quality of life, and life satisfaction, as well as objective skill attainment, and role performance. Both are reciprocal connections that could not separate each other (Song & Shih, 2009; Leamy et al., 2011).	

Discussion

Using a theory-derivation process, this study reorganized the parent model into two predictor domains, that is, conceptual determinants of recovery rather than statistical predictors: (1) clinical cornerstones (insight, hospitalization since onset, resilience, family support) and (2) environmental supports (social support, therapeutic alliance, recovery-oriented nursing service utilization). This organization clarifies where nursing actions can directly influence personal recovery in community settings and provides a coherent structure for interpreting the model's refinements, as follows. Firstly, insight and hospitalization since onset were specified as clinical cornerstones (together with resilience and family support) that should be considered when assessing and measuring personal recovery in people with schizophrenia. Good cognitive insight in schizophrenia patients can be described as evaluating and correcting their distorted beliefs and misinterpretations which causes an interruption in the progress of personal recovery (Beck et al., 2004; Riggs, Grant, Perivoliotis, & Beck, 2012).

In addition, impaired cognitive insight may lead to poor treatment compliance and outcomes (Smith et al., 2004). People with schizophrenia who have severe psychotic symptoms and frequent hospitalization are less likely to enter remission. Thus, recovery may be limited (Ayano & Duko, 2017).

Secondly, the author retained family support as a protective factor and subsumed partner support under family support, because evidence indicates that partner support is typically treated as part of family/social support (Wyder & Bland, 2014). A key difference between partners and family members is that partners are in the relationship not by blood, but "by choice" (Perry & Pescosolido, 2015). Therefore, it is unnecessary to separate partner support from family support. Moreover, the author did not retain religious support as a stand-alone construct.

Thirdly, the study refined “the professional relationship” and “professional support” into a single construct: the therapeutic alliance, which derived from the formal support concept. Additionally, putting recovery-oriented nursing service utilization factor instead of the extent and intensity of rehabilitation service utilization factor. Two outstanding factors are the therapeutic alliance factor and recovery-oriented nursing service utilization factor representing clearly that the nursing approach impacts personal recovery among people with schizophrenia.

The therapeutic alliance between mental health and psychiatric nurse and people with schizophrenia has a vital impact on therapy outcomes, beyond therapeutic methods because is associated with more recovery orientation, less self-stigma, and more insight (Cavelti, Kvrgic, Beck, Kossowsky, & Vauth, 2012; Kvrgic, Cavelti, Beck, Rusch, & Vauth, 2013; Song, 2017). Additionally, in case the nurses provide adequate support and affinity and recognize the personhood of patients by utilizing recovery-promoting intervention then patients can perceive those supports and the collaboration and strengthen the affective bond between nurse and client. Accordingly, the bonding of the client and therapist (nurse) alliance is a trustworthy predictor of personal recovery, which is a positive outcome and independent of the variety of psychotherapy approaches and outcome measures (Ardito & Rabellino, 2011)

In literature, a recovery-oriented approach recognizes that each person is unique and should be respected for their decisions. Each person is the authority in their own life, and support should help them reach their goals. Different persons view recovery differently

(McKenna, Oakes, Fourniotis, Toomey, & Furness, 2016; Parker et al., 2017). Therefore, there is no doubt that recovery-oriented nursing services utilization are important for personal recovery of schizophrenia persons and will even be considered a primary influence for personal recovery. Many recovery-oriented services focus on the person and their symptoms, preventing relapse, and helping them understand that they have different dimensions that allow them to explore their path to recovery (McKenna et al., 2016; Parker et al., 2017; Davidson et al., 2021). In other words, the chance that a person with schizophrenia thought about the degree or amount of services or care provided by the psychiatric and mental health nursing team. They might figure out how to get on their own way to recovery.

However, erasing of religious support, welfare subsidy, and ever employed/work support variables because of slightly significant evidence to support the relationship between them with personal recovery included all these variables as unmodifiable in a direct nursing role. Thus, in the model derivation had not shown them as a key variable.

Anyway, rising, refining, and/or erasing those factors in order to make the parent model applicable to personal recovery among people with schizophrenia is the nursing phenomenon of interest in this study. Consequently, the proposed model contributes to conceptual understanding supporting the dynamic character of personal recovery among people with schizophrenia by carefully clarifying it through schizophrenia patients' views congruent with nursing paradigms. Thus, all five adapted factors are a broader knowledge of personal recovery and might provide a framework to depict factors that influence personal recovery, including providing the necessary factors for the nursing intervention design of community-dwelling mental health research toward the processes and outcomes of personal recovery among persons with schizophrenia.

Scholarly contribution. This work advances existing recovery frameworks in six respects. First, it translates the social-work UMR into a nursing-specific conceptual framework by making explicit the nurse-actionable pathways—the therapeutic alliance and recovery-oriented nursing service utilization—alongside four attributes under three cornerstones (insight, hospitalization since onset, resilience, family support). Second, it contextualizes recovery for community mental health nursing, where episodic contact and self-management are typical, clarifying when and how hospitalization since onset and insight constrain recovery. Third, it increases parsimony and clarity by subsuming partner support within family/social support and not retaining religious support, welfare subsidy, and work-support

as stand-alone constructs due to weak/indirect, non-nurse-actionable links. Fourth, it provides a coherent two-domain architecture (three cornerstones; environmental support) that aligns with nursing assessment and shared care planning. Fifth, it yields testable propositions for nurse-led intervention development and evaluation in community settings (e.g., stronger therapeutic alliance and greater recovery-oriented service utilization are associated with improvements in personal-recovery outcomes). Sixth, it specifies boundary conditions and local adaptation guidance (e.g., variation across welfare regimes and labor markets), enhancing external validity and implementation.

Recommendations

Recommendations for Applying the Results

1. Implementing the Nursing Paradigm

Adoption in clinical practice: Encourage psychiatric mental health nurses to integrate the comprehensive framework provided by this study into their daily practices. This model, which emphasizes cognitive insight, hospitalization history, therapeutic alliances, and recovery-oriented services, should guide interventions to ensure they are tailored to individual patient needs.

Training and developing: Develop training programs and continuing education courses that focus on the dynamic and individualized aspects of personal recovery. These programs should help nurses understand and apply the model effectively in community settings.

Integration into nursing curricula: Include the derived theories in nursing education curricula to help future nurses understand and apply complex models in their practice. This will prepare them to handle challenges uniquely presented in psychiatric mental health settings.

2. Holistic and Patient-Centered Care

Policy implementation: Advocate for healthcare policies that support holistic, patient-centered care approaches over traditional biological methods. This aligns with global mental health goals and supports the well-being and quality of life of schizophrenia patients.

Community awareness: Increase community awareness and education regarding the benefits of personal recovery models in mental health care. Highlight how these approaches contribute to better patient outcomes and overall quality of life.

3. Advancing Nursing Theory and Practice

Capability building: Convene workshops and symposia on applying the personal recovery nursing model (rather than generic paradigms), featuring live case demonstrations, co-design sessions with people with lived experience and carers, and communities of practice that review outcomes and refine local protocols.

Recommendations for Future Research

The findings of this study highlight the need for empirical testing of the proposed personal recovery nursing model in diverse community settings to establish its effectiveness. Future research should operationalize and validate the model's core elements—the clinical cornerstones (insight, hospitalization since onset, resilience, family support) and the environmental supports (social support, therapeutic alliance, recovery-oriented nursing services)—and examine nurse-led strategies that strengthen these elements in routine care. Pragmatic pilots and longitudinal designs (e.g., cohort studies, stepped-wedge or cluster trials) may be used to evaluate effects on personal-recovery outcomes (person-defined goal attainment, autonomy, self-stigma, quality of life) alongside clinical or service indicators (relapses, hospitalization days, engagement), with mixed-methods evaluation to capture implementation and context.

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