Toward Holistic Recovery: Exploration of Multidisciplinary Orientations in Mental Health Care
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Toward Holistic Recovery: Exploration of Multidisciplinary Orientations in Mental Health Care

Ma. Cristina Santos, Francis Michael P. Yambao
Graduate School, Centro Escolar University
Manila, Philippines
santos2545251@mnl.ceu.edu.ph

Abstract

This study examines the lack of recovery by integrating the multidisciplinary functions of various professionals to develop a step-by-step protocol. A qualitative thematic analysis using the Braun and Clarke approach was conducted based on data collected from ten mental health professionals, including psychiatrists, psychologists, primary care doctors, guidance counselors, social workers, nurses, and behavioral therapists, ranging from beginning to experienced professionals. This research used Ludwig Von Bertalanffy's General Systems Theory and Bruce J. Biddle's Role Theory. Effectively implementing mental health interventions across modalities requires understanding multiple disciplines, the surrounding challenges, and the influence of culture. This paper explored mental health experts' views on holistic recovery, identified barriers and enablers to collaborative multidisciplinary teamwork, and examined different viewpoints on relapse, motivation, and compliance. Overall, the qualitative thematic analysis using the Braun and Clarke framework revealed nine themes. First, the predominant theory applied in this study combines cognitive-behavioral and ecological skills-building within a biopsychosocial framework. Success in behavior change does not involve reaching clinical excellence; rather, it is about functional recovery, self-efficacy, and consistent adherence. The major predictors of successful transformation and recovery milestones are the client's readiness, therapeutic alliance with warmth (pagkalinga), and small early wins such as improved sleep. The relationship between the biological and environmental factors was seen to be a 40/60 ratio, where socioeconomic factors (pamasahe, medicine shortages), family stigma (nag-iinarte), and disorganized environment are the barriers to recovery. Lastly, relapse should not be viewed from a punitive perspective but as a learning phase, following immediate medical treatment, followed by trigger identification and family-based routine co-regulation. Overall, five key routines have been established as follows: sleep, physical activities, meals, mindful check-ins, and balanced allocation of time.

Keywords: *Braun and Clarke, thematic analysis, biopsychosocial, pagkalinga, relapse prevention, multidisciplinary care, and mental health routines*

Academic Profile

Ma. Cristina Santos, MAEd, RGC,RPm is a licensed Guidance Counselor and a registered Psychometrician. She is a psychology practitioner and an educator with a passion for promoting mental health, personal growth, and holistic development. She is committed to guide, educate, and inspire others toward meaningful growth, and a healthier, more empowered life.

Dr. Francis Michael P. Yambao is an academic and industry leader. He holds a Bachelor of Arts degree in Communication, holds a double master's degree in Linguistics and Business Administration, and a double doctorate degree in Educational Management and in Business.

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Throughout his career, Dr. Yambao has demonstrated a commitment to education and leadership. He has served in various roles, including Program Chair, Dean, Principal and VP for Academics for various institutions. Currently, Dr. Yambao serves as the president and chairman of the Speech Communication Organization of the Philippines (SCOP) and P.R.O of the Philippine Association of Graduate Education (PAGE). He is also the Dean at the Graduate School of Centro Escolar University, where he continues to share his expertise and passion for education.

Introduction

The topography of mental health care in the Philippines is navigating a critical shift toward integrated, person-centered recovery. While individual disciplines such as medical practitioner (physician, nurse, and behavioral therapist) psychiatry, psychology, guidance and counseling, and social work have long established their roles. The modern Filipino context demands a more cohesive, multidisciplinary approach. Recovery is no longer viewed through a single lens but as a multifaceted process requiring the synchronized expertise of a diverse clinical and community team.

Currently, the challenge lies in the fragmentation of services. A patient may receive pharmacological intervention from a psychiatrist, cognitive support from a psychologist, and academic or career guidance from a guidance counselor, yet these efforts often remain uncoordinated. Alibudbud (2024) explicitly diagnoses the structural fragmentation within the Philippine mental health landscape. He notes that historical care paths isolate psychiatric and specialized clinical institutions from educational settings and primary care units. Furthermore, he argues that the absence of a unified multidisciplinary referral protocol leaves vulnerable patients navigating a disjointed system,

To achieve holistic recovery, it is essential to harmonize these various orientations, ensuring that the social worker's focus on environmental stressors, the psychiatric nurse's clinical management, and the behavioral therapist's skill-building is all aligned toward a single, unified goal. Perez (2025) provided important references for enhancing the role of general practitioners in community health work emphasizing the active participation of **community member.**

This synchronization requires a framework that respects the distinct clinical boundaries of each professional while fostering a "shared language" of care. In the Philippines, this integration must also account for local legal standards and the cultural nuances of "Bayanihan" (communal unity), where the recovery of the individual is inextricably linked to the support of the collective. Reyes (2024) emphasize that the law legally mandates health facilities to shift from a

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purely biomedical model to a comprehensive, multi-sectoral, and integrated psychosocial model. Meanwhile, Doctor (2025) explores how cultural misinterpretations of symptoms (such as viewing executive dysfunction as voluntary drama or nag-iinarte) create barriers to care.

This study addressed the gap by synthesizing the specialized functions of the multidisciplinary team. By evaluating how these different core roles can work in tandem, this study serves as the basis for the development of a Guidance Manual. This manual will provide a structured protocol for inter-professional collaboration, ensuring that every facet of a client's well-being is addressed with clinical precision and holistic compassion.

Theoretical Framework

This study adopts the General Systems Theory (GST) framework, a model established by Ludwig von Bertalanffy to analyze systems as holistic, interdependent units. This theory provides the logic for understanding how various clinical inputs and feedback loops allow a multidisciplinary team to function as an adaptive, evolving entity dedicated to client recovery. General Systems Theory (GST) posits that a system's properties cannot be reduced to its individual parts but emerge from the relationships between them. In view of holistic recovery, the multidisciplinary teams (MDTs) are viewed as a "system" where the counselor, medical practitioner, and social worker are interrelated subsystems.

In the context of a synchronized counseling model, this study also utilizes Role Theory. According to Biddle's (1986), individual conduct is a product of social positions and shared norms. This theory provides the basis for defining the 'shared expectations' of each core role, ensuring that every practitioner's behavior aligns with the holistic objectives outlined in the Guidance Manual.

Conceptual Framework

This study is anchored on Sunnybrook framework for interprofessional team collaboration which was intentionally created by Maclaney et.al (2022) as a set of collective team competencies. The framework was developed using a comprehensive literature search and consensus building by a multi-stakeholder working group and supported by a broad consultation process that included patient representation, organizational development and leadership, and human resources.

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Fig. 1 Sunnybrook Framework



Research Questions

1.How do the specific diagnostic criteria used by medical practitioners differ from the behavioral observations of humanistic practitioners when classifying client non-compliance as either a clinical symptom or a lack of motivation?
2.What specific familial, spiritual, or systemic triggers are found by Filipino clients as the primary catalysts that shift their mindset from resistance to active engagement in the recovery process?
3.To what extent does the perceived ratio of biological versus environmental influence vary among MDT members, and how do these varying feelings create "blind spots" in the formulation of holistic treatment plans?
4.What are the core components of a unified protocol that successfully redefines relapse from a "clinical failure" to a "learning stage" within a multidisciplinary framework?
5.Which collaborative intervention strategies are most effective in addressing the socioeconomic and policy-based barriers that consistently impede client progress after clinical stabilization?

Literature Review

Recent literature underscores that while multidisciplinary teams (MDTs) are the "gold standard" for complex care, their success is heavily dependent on structural clarity rather than just the presence of multiple experts. According to Maclaney et.al (2022) healthcare teams that practice collaboratively enhance the delivery of person-centred care and improve patient and systems outcomes. Also, as per Ingels et. Al (2022) each member of the team is critical to the overall understanding of interprofessional teamwork in healthcare and provide information to areas for future advancement that will help in healthcare practice. Meanwhile, Schie et. Al (2025) developed strategies to navigate emotional dynamics of teamwork, aligning with the concept of mentalising-self-reflection, empathy, and relational interpretation.

Across the duration of this research, one message comes through clearly: people do better when

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mental health care is integrated, team-based, and centered on their real-life goals. Integrated behavioral health in primary care and the Collaborative Care model consistently improve access, speed up treatment, and reduce symptoms of depression and anxiety, while proving cost-effective in the long run. (Reist et al., 2022; Reising et al., 2021) These approaches work because they bring together primary care providers, mental health specialists, nurses, social workers, and other professionals who share information, use common tools like routine screening and outcome tracking, and plan care around what matters to the person and their family. [Integrated Behavioral Health Care integrative review] Schweitzer et al., 2023 Studies also show this teamwork can be cost-effective and increase satisfaction for both patients and providers, especially when programs adapt to specific groups such as older adults, students, perinatal women, and people with substance use disorders. (Reist et al., 2022).

At the same time, the literature is honest about the hurdles: services often sit in silos, roles can be unclear, relationships between professionals may be strained, funding is complex, and many teams lack consistent training—especially for youth, people with intellectual and developmental disabilities, and those with co-occurring medical conditions. Integrated Behavioral Health Care integrative review from Giacomini & Rizzotto, (2022); Greenwald et al., (2024) Țenea-Cojan et al., (2025) Practical solutions recur across papers: define roles and shared workflows, hold regular case conferences, use measurement-based care, build sustainable payment models, and invest in cross-training so teams can adapt for special populations. As per Integrated Behavioral Health Care integrative review from Reising et al., (2021) Schweitzer et al., (2023) Lok et al., (2025).

Newer frameworks reflect this shift toward whole-person care. Adapting problem-oriented records to mental health, entering on problems, resources, and goals (PRoGO) helps teams align around a person's challenges, strengths, and aims, not just diagnoses. Leucht et al., (2025) Pediatric and youth-focused models underline the value of prevention, early identification, brief evidence-informed treatments, and tight links with schools and community services, showing meaningful drops in anxiety and depression when teams work in sync. As stated by Colizzi et al., (2020) Schweitzer et al., (2023) for complex comorbidity and eating disorders, evidence emphasizes coordinating medical and psychological care, clarifying roles and communication, and measuring outcomes beyond symptoms such as functioning, satisfaction, and continuity of care, though more rigorous evaluations are still needed as per the report of Țenea-Cojan et al., (2025) and Bray et al., (2024).

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Finally, strong systems make holistic recovery possible. Sustainable financing and supportive policies, team training and capacity-building, and EMR tools for screening, registries, and tracking all help teams deliver consistent, equitable care. Integrated Behavioral Health Care integrative review as cited by Heraclides et al., (2024); Ogundele & Morton, (2022) Račetović et al., (2023) Taken together, this body of work points to a simple, human truth: holistic recovery is more likely when multidisciplinary teams align around the person's life, share responsibility, and use clear data and steady collaboration to guide compassionate progress as reported by Giacomini & Rizzotto, (2022) Reist et al., (2022) and Schweitzer et al., (2023).

Method

Research Design

The study adopts a Qualitative Research Design with a particular focus on lived professional experience to identify, analyze and interpret patterned meanings (themes) that will extract the specialized functions and grey areas reported by practitioners, to bridge the gap between abstract theory and a functional manual.

Respondents

Respondent No.	PROFESSION	No. of Year in the Profession
1	Social Worker	4
2	Nurse	15
3	Guidance Counselor	13
4	Psychologist II	2
5	Primary Care Physician	5
6	Psychologist	1
7	Behavioral Therapist	7
8	Psychologist	6
9	Guidance Counselor	9
10	Psychiatrist	3

The participants were 10 mental health professionals, who were chosen for their different specializations and different experience levels, from early career to senior practitioners. Considering all the above, the cohort consisted of social science professionals such as psychologists and guidance counselors, and a medical team comprising psychiatrists, a behavioral

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therapist, a nurse and a general physician to provide a holistic multidisciplinary approach.

Data Gathering Procedure

The information collection was carried out in a particular order to facilitate an overall synthesis of professional roles. A researcher created instrument was designed and transformed into a Google Form to enable structured responses remotely. This tool is then handed out via electronic communication to the targeted multidisciplinary participants. Finally, the information gathered was manually tabulated and encoded, and used as raw material for the thematic analysis, which explores the synchronization of the different clinical and social orientations that is an essential element in the proposed protocol as a basis for the development of the Guidance Manual.

Research Instrument

No standardized instrument was employed. Data was gathered through researcher's survey questionnaire. Thematic coding is the main analytical tool used.

Statistical Treatment

No statistical treatment was applied in this study since this is a qualitative study. Data analysis was executed into clustered themes with codes and exemplar quotes.

Results and Discussion

THEMATIC CODING (Statement of the Problem)

1. How do the specific diagnostic criteria used by medical practitioners differ from the behavioral observations of humanistic practitioners when classifying client non-compliance as either a clinical symptom or a lack of motivation?

Table 1: Q1

THEME	DESCRIPTION	EXEMPLAR QUOTE

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Medical Practitioners (Clinical Symptom Focus)	Distinguishing Clinical Symptoms from Lack of Motivation	Psychiatrist(R10): Focuses on the syndrome aspect. States that anhedonia is "can't feel pleasure even when trying" and executive dysfunction is "impairment in starting and planning tasks despite intention, tasks are 'cognitively heavy'". Reduced goal-directed activity is reported as Avolition (in psychosis). Primary Care Physician (R5): States that anhedonia/executive dysfunction affects more than one domain and continues in spite of wanting to do so. But unmotivated is usually situationally and value oriented. Looks at consistency, Nurse (R2). Selective lack of motivation is motivational. If it is present in a lot of places and the person wants to change but is unable to do so, then it's probably a clinical symptom.
Humanistic/Cognitive-Behavioral Practitioners (Behavioral Observation Focus)		Guidance Counselor (R9) Recognised as more serious, and may exhibit a mental health disorder. Psychologist (R4): Identifies that "lack of motivation" may be due to option, habit formation, or feeling overwhelmed, and that this is remedyable with support or encouragement. When a person is motivated to engage, underlying mental health problems (anhedonia, executive dysfunction) are associated with clinical symptoms. Psychologist (R6): Anhedonia is episodic or situation-dependent, and may be ongoing and affect functioning. Psychologist (R8): "I don't distinguish - anhedonia is an extreme form of lack of motivation. This is a special view that implies that the distinction is not so sharp as it is often believed and that there is a continuum between types instead of only two categories.

Interpretation:

The analysis shows that there is a significant difference between the understanding of a clinical symptom and lack of motivation among medical practitioners (Physician, Psychiatrist, Nurse) and humanistic leaning practitioners (Guidance Counselor, Psychologist, Social Worker, Behavioral

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Therapist).

To sum up, medical practitioners are concerned with the pervasiveness, physiology and syndrome of symptoms, sometimes requiring medical evaluation. Humanistic practitioners interpret and evaluate motivation based on situational factors, goal-directed behaviors, and sensitivity to external cues/goals, and note when the symptoms signal a more serious clinical problem that warrants referral.

2. What specific familial, spiritual, or systemic triggers are found by Filipino clients as the primary catalysts that shift their mindset from resistance to active engagement in the recovery process?

Table 2: Q2

THEME	DESCRIPTION	EXEMPLAR QUOTE
Trusting Therapeutic Alliance / Pagkalinga	Catalysts for Active Engagement: Connection and Ownership	"Pagkalinga," the client would not open up if he/she did not feel that you care for him/her. (R3). Likewise, adherence (R10) is strongly and positively associated with a strong therapeutic alliance and one supportive family member
Ownership and Self-Reflection		Guidance Counselor(R3): "It's when the language changes from 'My parents make me so angry' to 'I know when I get angry I am in the 'blame game'; now it's time to see how I can change the way I react". Psychologist (R4): Describes the turning point as "a sense of insight or hope" and clients "begin to realize that things can change and that they can make a difference. This includes taking responsibility for own choices and practicing of new skills. Primary Care Physician (R5): "When patients realize their symptoms are controllable and not a personal problem, and when they feel supported rather than judged, then they're more willing to pursue a systematic approach.

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Small, Rapid Wins & Validation:		Psychiatrist (R10): Identifies the turning point when clients are gaining a "small, rapid win that they can connect to and attribute to their own effort" (e.g., improved sleep) and also when they are feeling "genuinely understood rather than judged. When a family member confirms their struggle ("naiintindihan ko, kasama mo kami") engagement is often unlocked. Psychologist (R8): Notes when clients start showing up for themselves and when they start having small wins and then they start believing them or even questioning them, or self-criticizing.

Interpretation:

The data from the ten (10) practitioners focuses on the following key catalysts: Connection and change within the individual. For the "Therapeutic Alliance" (The trust) is the most important. The family can also pose an external barrier when there is stigma, but, when supportive, the family's validation (naiintindihan ko, kasama mo kami) is a strong motivator for engagement.

3.To what extent does the perceived ratio of biological versus environmental influence vary among MDT members, and how do these varying feelings create "blind spots" in the formulation of holistic treatment plans?

Table 3: Q3

THEME	DESCRIPTION	EXEMPLAR QUOTE

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Environmental Emphasis (More than Biological)	Biological vs. Environmental Influence: A Spectrum of Emphasis	Social Worker (R1) "Based on handled clients, environmental factors weigh more and show stronger influence on the process". Guidance Counselor (R3) "While biology sets the 'floor,' the environment (family/systemic/social) usually builds the 'house.' In the Philippines, the extended family system and socioeconomic stress are massive. I'd say it's a 40/60 split" (biological/environmental). Psychologist (R4) "I tend to put slightly more emphasis on environmental and social influences, because a person's relationships, daily routines, and life circumstances often have a big impact on their recovery". Primary Care Physician (R5) "While biology may influence predisposition and symptom severity, environmental factors such as family dynamics, socioeconomic stressors, culture, and access to care, often determine whether recovery is sustained". Therapist (R7) "I am leaning more towards environmental factors as genetics is already fixed but environmental factors". Guidance Counselor (R9) Attributes 40% to genetics and 60% to environmental factors.

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More Balanced/Integrated View		Nurse (R2) "I believe both play important roles, but I personally see environmental factors as having a stronger day-to-day impact. Genetics and brain chemistry can create vulnerability, but support systems, environment, and life circumstances often decide whether recovery is sustained". Psychiatrist (R10) Attributes "40% biological vulnerability (genetics, neurochemistry, medical comorbid), 60% environmental/systemic factors (family dynamics, trauma, poverty, access to services, stigma). Biology sets the threshold; environment and opportunities often figure out trajectory and maintenance". Psychologist (R6) "They both affect the recovery process, that is why it is important that we see the biopsychosocial perspective".
Unique Perspective (Heavier Environmental)		Psychologist (R8) "Thirty percent genetics and epigenetics. Seventy percent upbringing, especially parental behavior. Plus, society they grew up in, including economic bracket".

Interpretation:

There is a shared understanding of the importance of both biological and environmental influences, but not the same shared understanding or weight, leaving gaps:

Potential Blind Spots:

The disproportionate use of One Domain:

Those who firmly believe that almost everything is environmental may fail to see the important biological pre-dispositions or medical co-morbidities that need particular treatment (e.g., medication). On the other hand, if there is too much focus on biology and the systemic psychosocial stressors (family, poverty) are not addressed, recovery is a steep mountain to climb, as stated by the R3: "You can have the right brain chemistry, but if you go back to the toxic or impoverished environment, the recovery won't happen".

Incomplete Treatment Planning:

A team member whose specialty is in his/her perceived strong area (e.g., social worker on environment, psychiatrist on biology) may not see the importance of incorporating factors outside this primary focus in the overall treatment plan for the client. Comprehensive and coordinated treatment which has a holistic approach to prevention, promotion, rehabilitation, care and support is critical to meeting the mental health needs through a multi-disciplinary, and user-centered, treatment and recovery plan.

Opportunities Unrealized:

Disagreements regarding beliefs may cause poor agreement on priorities for treatment. For example, a psychologist may focus on making changes in the person's environment, while a physician may focus on medication without fully understanding how the environment may impact medication adherence

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and/or general wellness. To avoid blind spots (R4), as the Biopsychosocial model proposes, such an approach must include these perspectives.

4.What are the core components of a unified protocol that successfully redefines relapses from a "clinical failure" to a "learning stage" within a multidisciplinary framework?

Table 4: Q4

THEME	DESCRIPTION	EXEMPLAR QUOTE
Normalization of Relapse	Relapses as a Learning Opportunity and Integrated Process	Most practitioners explicitly say that relapse is "a learning stage" (R1), "part of the recovery process" (R2), "a slip, not a fall" (R3), or "expected in chronic conditions" (R10).
Trigger Identification and Analysis		Relapse presents an "opportunity to analyze what triggers were missed" (R3). It signals the need to "review biological, psychological, and environmental factors" (R4) and "map triggers" (R10).
Adjustment of Strategies and Care Plans		Relapses is an "opportunity to adjust strategies, build resilience, and strengthen skills" (R4). This involves refining the "wellness/recovery plan," adjusting medication/skills, and reconsidering family roles (R10).
Strengthening Coping Mechanisms and Resilience		Relapse is used as an opportunity to "understand triggers, strengthen coping strategies" (R4) and make the client's "resilience even stronger" (R3).
Integrated Relapse Prevention Planning		While specific plans are not detailed, the concept of a "relapse prevention plan" is mentioned (R3).
Multidisciplinary Review and Psychoeducation		Relapses require a holistic review by the team, moving beyond just pharmacological interventions (R4). Psychoeducation frames relapse as "data for personalization, not failure" is vital (R10).

Interpretation:
A universal opinion is that relapse is considered a learning process and not a failure. A unified protocol would standardize these steps and help to ensure that they are communicated consistently throughout the MDT and with the client, from "What happened?" to "What can we learn, and how can we adapt moving forward?

5. Which collaborative intervention strategies are most effective in addressing the socioeconomic and policy-based barriers that consistently impede client progress after clinical stabilization?

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Table 5: Q5

THEME	DESCRIPTION	EXEMPLAR QUOTE
Early Referral and Coordination of Services	Collaborative Strategies for Socioeconomic and Policy Barriers	The Primary Care Physician (R5) highlights their role in "early identification, risk stratification, and coordination of referrals" Guidance Counselor (R3). Social workers, by their nature, "serve as the navigator for the client that will help them get to where he needs to be" within their environment (R1
Family Involvement and Support Systems		Family stigma or "nabaliw" is a significant barrier (R10). A "strong, trusting therapeutic alliance plus one supportive family member who is engaged in care" significantly improves adherence (R10)
Leveraging Community Resources and Policy Advocacy		Psychiatrist (R10): Mentions using "free meds when available, coordinate with barangay health workers," and coordinating "care across LGU services, PhilHealth benefits where applicable.
Psychoeducation (Culturally Attuned		Providing psychoeducation that links biology, behavior, and environment "in simple, culturally attuned terms" helps clients and families understand conditions and treatment of drivers (R10).

Interpretation:

The data indicated some collaborative approaches, and emphasized community engagement and systemic advocacy. Effective practices include a holistic and integrated, multi-disciplinary approach across the community level that includes existing policies (such as the Mental Health Act), focuses on social determinants of health, engages in stigma reduction and builds trust and rapport with clients and families.

Conclusions

1.This study shows evidence of a unified recovery perspective that focuses on a biopsychosocial approach with practical, CBT-informed skill building and a humanistic, culturally supportive approach.

2. Safety is the base of successful behavior change, owner of changes, self-efficacy and sustainable functional recovery and skill mastery are most important.

3.The multidisciplinary team (MDT) members show diverse weighting of the biological and environmental influences, but there is a consensus that positive changes are most likely to be seen when the client is ready, there is a strong therapeutic relationship (pagkalinga), and the family is involved.

4.Clients will move from resistance to recovery when they have some initial successes, begin to shift from blaming to self-reflection, and feel understood and safe.

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5. External barriers including socio-economic factors, family stigma and unsupportive families are identified as key barriers.
6. Avoiding moral judgment, the differentiation between "lack of motivation" and clinical symptoms is based on pattern, persistence, and syndromic indicators.
7. Safety will be first and relapse is seen as a learning opportunity, not a failure, for trigger mapping and plan refinement.

Recommendations

Based on the study's conclusion which sets up that long-term recovery relies heavily on a trusting alliance, family-supported lifestyle structures, and reducing socio-economic friction, the following are recommended subjects for modification based on the needs and situations:

1. **"Toward Holistic Recovery" (The Outcome):**

We have rolled out the core practical outcome of our "Toward Comprehensive Recovery" initiative, positing that full recovery cannot be achieved if patients are viewed merely as a collection of symptoms. This integrates three groups of professionals consisting of medical staff, mental health practitioners, and social workers to develop a unified lifestyle plan, shifting the definition of successful treatment from mere clinical perfection to functional recovery to help patients resume their social roles.

2. **Exploration of Multidisciplinary Orientations: (The Process):**

This study explored how diverse clinical lens's view recovery. This is the operationalization of those orientations. It celebrates the medical orientation somatic stabilization, the psychological/behavioral orientation, habit formation; the systemic/social orientation, family co-regulation, and access friction.

3. **Operationalizing Pagkalinga (The Cultural Core):**

This co-created pathway is a process that converts the cultural notion of pagkalinga (relational warmth and care) into a cross-disciplinary clinical process. It ensures that whenever a vulnerable patient steps through any door of the multidisciplinary team, they have a caring, continuous and welcoming pathway of care and do not encounter any systemic friction in the process; that they are safely passed down the pathway and taken to long-term recovery.

4. **Future Research: Unifying Care Across the Rhythms of Life**

This study shows that recovery is not a symptom fix but rather achieving full width of life. In this spirit, we propose that future research should explore which specific way of combining five pillars into one, simplified plan for each patient and at the end of the day discuss how all the good ideas said and different know-how can be translated into a clear system to achieve what was shared earlier as an aspiration to basically create a sustainable little rhythm of active recovery that brings patients back home.

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