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CULTURAL COMPETENCE COLUMN

Teaching Nursing Students the Value of Person-Centered, Recovery-Oriented Relationships

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Nursing school is one of the most difficult things I have done in my life. Almost halfway through the journey, I sometimes feel down . . . almost depressed and just scared. Sometimes I ask myself if these are all worth it and why am I doing all this for? The Prosumer group presentation moved me in such a way as if I heard what I have always been looking to hear during my low moments: inspiration. They are not victims; they are survivors. They opened their presentation with a quote that I will probably carry for the rest of my life: "Even when happy moments happen, I still ask myself if this is all worth it, and the answer was always no". It hit me like a truck because I was having those same thoughts and I got worried that I might end up in depression if nursing school does not finish soon! One can read the Mental Health textbook, study all the power points, and read all the articles about the topic of trauma, depression, etc. But nothing, NOTHING, is better than listening to people who have experienced all these disorders tell their story and although painful, share their experience and use it to motivate and inspire others. If all people who work in Mental Health had the same ideology, beliefs, and values as the Prosumer group, the world will be a better place not just for mental health clients, but for everyone."
Undergraduate nursing student

It is our contention that nursing students, as well as other health care professional students, best learn the principles and application of both Person-Centered Mental Health Care and of Recovery-Oriented Services from individuals and groups who

have had a lived experience with mental illness. Our belief in this way of learning is the consequence of the story of our partnership, as an outcome of which Janet Paleo and her colleagues have had a critical role for over ten years in educating thousands of undergraduate nursing students. In an article published earlier in *IMHN*, "Community & Scholars Unifying for Recovery," we described the convergence of events that led to this "remarkable partnership" (Jones, Gray, Paleo, Braden, & Lesser, 2008). We described the work of the Prosumer Group (the result of Janet's strength and resiliency in her struggle to recover from mental illness) and the profound impact that working on a partnership project with the Prosumer Group had on undergraduate nursing students. As written by a student, "Through this community partnership, I was introduced to a different way of learning in which the information that would normally be taught and read was, instead, heard and seen. It was reality; it brought everything into perspective for me" (Jones et al., 2008, p. 501).

While the events that led to our educational partnership and its outcomes seemed at the time to be driven mainly by intuitive and organic processes, upon reflection, we see the goodness of fit between the underlying principles of our partnership and both Person-Centered Mental Health Care and Recovery-Oriented Services frameworks described in the literature. The philosophical principles and practices, as well as the intended goals, are somewhat similar for Person-Centered Care and for Recovery-Oriented Services (Cook, 2005; Livingston, Nigdam-Jones, & Brink, 2012). Person-centered care, often called patient-centered care, is an approach to providing healthcare that emphasizes and respects the needs, values, and choices of people. Much of the research literature regarding patient-centered care and related constructs has been built on the foundation of shared decision-making between service providers and patients (Livingston et al., 2012). N. Mead and Bower (2000) identified five key dimensions in their conceptual framework of patient-centeredness: viewing health in a holistic manner, seeing the patient as a person with needs that extend

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beyond their illness, sharing power and responsibility with patients and helping them collaborate in their own care, building therapeutic alliances with patients and maximizing the therapeutic value of the patient-provider relationship, and understanding how the personal qualities of the provider influence quality of care. Recovery-oriented mental health services share many of these same features, though a major and significant difference is that recovery-oriented services are *always consumer driven*, never provider led.

To illustrate the congruence between our educational partnership and the essential elements described within the literature on Person-Centered Mental Health Care and Recovery-Oriented Services, we present the literature within the following categories; (a) research articles that include the voices of consumers and their supporters, (b) research review articles that contribute to the development of person-centered and recovery-oriented conceptual frameworks, and (c) clinical articles written by mental health care specialists, consumers of mental health services, and consumers who are also mental health care specialists.

RESEARCH ARTICLES: INCLUDING THE VOICES OF CONSUMERS

Brophy, Roper, Hamilton, Tellez, and McSherry (2016) report on the important contribution that the voice of consumers and their supporters can make to help improve mental health services. In their study, themes emerged from the analysis of data collected through a series of focus groups in Australia about the use of seclusion and restraint and its impact on the people involved. They identified major barriers to recovery involving human rights violations, trauma, control, isolation, dehumanization, and “othering” (when an individual or group becomes mentally classified in somebody else’s mind as “not one of us”). Examples of poor practice identified by the consumers and their supporters included the use of excessive force, lack of empathy along with paternalistic attitudes, and lack of communication and interaction (Brophy et al., 2016). Two other research studies, one conducted in Canada and one conducted in England, used patients’ and providers’ perceptions to better understand the strengths and gaps in services in patient-centered and recovery-oriented care within Forensic hospital settings (Livingston et al., 2012; McKeown et al., 2016). Of significance, the study by Livingston and colleagues found that patients and providers shared similar views of the therapeutic milieu and recovery orientation services.

RESEARCH REVIEW ARTICLES: CONTRIBUTING TO THE DEVELOPMENT OF PERSON-CENTERED AND RECOVERY ORIENTED CONCEPTUAL FRAMEWORKS

Peer support has been recognized as an essential element of Recovery (Davidson, Chinman, Sells, & Rowe, 2006). Miyamoto and Sono (2012), in conducting a review of the literature on peer support, revealed several unifying principles of peer support across this literature. Peer support is based on the

TABLE 1
Characteristics of the Recovery Journey

Recovery is an active process.
Recovery is an individual and unique non-linear process.
Recovery is a journey that has stages or phases.
Recovery is a struggle.
Recovery is a multidimensional process.
Recovery is a life-changing experienced.
Recovery is a process aided by a supportive and healing environment.
Recovery is a trial and error process.

idea that those who have experienced mental illness can offer help and support to others and on the assumption that people who share similar experiences can offer each other emotional, appraisal, and informational support and hope. The literature review determined that those with mental illnesses will benefit by coming together to provide aid for each other in the context of supportive social relationships. In addition, peers who understand what the experience of having a mental illness is like are providing services to their fellow consumers with mental illnesses. Peer staff are individuals who have chosen to publicly disclose their history of mental illness and subsequent recovery, with the intention of using these experiences in concert with their clinical talents and skills to assist clients who were currently dealing with active psychiatric problems. The peer support model is rooted in the belief that significant interpersonal relationships and a shared sense of community lay the foundation for the process of healing. Ultimately, however, Miyamoto and Sono conclude from their review of the literature that the true value of the peer support interaction is not the focus on a shared psychiatric history, but rather the focus on a *relationship between empathic human beings*.

The purpose of a review conducted by Leamy, Bird, Le Boutillier, Williams, and Slade (2011) was to synthesize published description and models of personal recovery into an empirically based conceptual framework. The emergent framework included the following two components: characteristics of the recovery journey (Table 1), and categories of recovery processes (Table 2). Of note, the recovery journey may occur *without professional intervention* (Leamy et al., 2011). Moreover, the identified categories of recovery processes are highly consistent with the principles underpinning what the Prosumer Group teaches our undergraduate nursing students.

CLINICAL ARTICLES WRITTEN BY MENTAL HEALTH CARE SPECIALISTS, CONSUMERS OF MENTAL HEALTH SERVICES, AND CONSUMERS WHO ARE ALSO MENTAL HEALTH CARE SPECIALISTS

In Carpenter’s (2002) and in Hensley’s (2012) articles, both authors successfully argue that the principles of person-centered, recovery-oriented care are deeply aligned with the

TABLE 2
Categories of Recovery Processes

Connectedness
Hope and optimism about the future
Rebuilding/redefining a positive sense of identity
Finding meaning in life
Empowerment

principles underpinning their discipline, Social Work. For example, Hensley describes how “patient-centered” care is a concept that gives primacy to the voice and the concerns of the person using the health care services and that this is logically congruent with her discipline’s goal to provide equitable and empowering services to clients living with a mental illness. Both authors challenge traditional psychiatric services for taking decision-making away from their clients and assuming that their clients cannot speak for themselves. Moreover, Carpenter reminds us how since at least the 1980s, consumer-survivors, many accomplished mental health professionals themselves, have given voice to the consumer-driven recovery vision through publications describing their own recovery journeys.

These personal stories are most powerful, and, to quote again our undergraduate nursing student, “NOTHING, is better than listening to people who have experienced all these disorders tell their story and although painful, share their experience and use it to motivate and inspire others.” S. Mead and Copeland (2000) both consumer leaders, use their own experiences to explain the meaning and significance of recovery. They emphasize the importance of hope, personal responsibility, education, advocacy, and peer support. They also address critical issues such as the nature of the therapeutic relationship, the place of medications in symptom control, and the need for attitudinal changes in mental health professionals. While they acknowledge that they have seen progress made in the integration of recovery-oriented care into some systems of mental health care, they urge for further progress in building person-centered recovery-oriented therapeutic relationships.

Health care professionals need to relate to us that they have their own struggles and own that change is hard for all. They need to look at our willingness to ‘recover’ and not perpetuate the myth that there is a big difference between themselves and people they work with. Support then becomes truly a mutual phenomenon where the relationship itself becomes a framework in which both people feel supported in challenging themselves. The desire to change is nurtured through the relationship, not dictated by one person’s plan for another. The outcome is that people don’t continue to feel separate, different, and alone. (S. Mead & Copeland, 2000, p. 321)

In describing her own recovery journey, Clayton (2013), a community psychiatry researcher, explains that:

Person-centered care is not a magic wand that makes all the pain of mental illness and trauma go away, but it is the foundation upon which a life of dignity can be built or restored. The person-centered

care that I received helped me find the sense of self that carries me through the difficult times I still experience (p. 626).

Janet Paleo teaches our students:

Person-Centered Care, as I define it, is about the person being the center of the treatment. As a patient, I know what I am willing to do and what I won’t do, no matter how good it is for me. When working with a professional in a relationship, we can have a dialogue about my treatment. If there is something I won’t do, then working together we find a solution to achieve the outcome I want to achieve. As in all relationships, there is give and take. Building the trust and the willingness for both sides to take risk is essential in a person-centered approach. Only when we create the partnership, open the dialogue and become a team, can a real good outcome be achieved. One of the things my last psychiatrist did, which I didn’t understand at the time, he told me that he knew he would be reading about me in his journals one day. He saw the potential in me, not the “illness.” He saw me greater than I could see myself, and today I can also see myself through his eyes.

In conclusion, most people, whether they have been involved with a mental health system or not, have difficulty identifying their goals and the component steps and needed actions to achieve them. It is hazardous to think that the achievement of recovery goals is a linear process, which is one of the expectations felt by many people receiving services in the traditional psychiatric system. Consumers of mental health care services feel they are expected to make progress in a linear fashion and if their “progress” takes a detour or does not look like what the treatment team thinks it should, it is considered a setback or relapse; terms that do not highlight strengths.

Existing person-centered and recovery-oriented services frameworks seen in the literature may differ somewhat in their worldview of what is person-centered care and what is recovery. Nevertheless, they are all attempting to challenge the traditional psychiatric system, where the goals are solely symptom reduction, where the focus is too narrow, and treatment is far too often only medication based. When the focus of care is truly person-centered and recovery-oriented, it is about individuals living the life they want. The focus may be on how to live with symptoms or how to manage symptoms, but always in order to achieve individual goals. The latter focus requires a willingness to accept risk on the part of the clinical team as well as on the part of the consumer; it takes time and it takes patience. It takes time to allow people to dare to dream again, and it takes patience to allow people to learn what works and what does not work. This requires a level of partnership and trust that is demanded in a fruitful person-centered, recovery-oriented relationship.

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