International Practice Development Journal

Online journal of FoNS in association with the IPDC (ISSN 2046-9292)

Recovery and person-centredness in mental health services: roots of the concepts and implications for practice

Jan Kåre Hummelvoll*, Bengt Karlsson and Marit Borg

*Corresponding author: Buskerud and Vestfold University College, Drammen, Norway
Email: jankhum@online.no

Abstract

Background: During the past three decades, the concepts of recovery and person-centredness have become familiar in mental health policy, practice and research, as well as in the voicing of service users' experiences of moving from mental distress and processes towards wellbeing and citizenship. Recovery, like person-centredness, is about a person retaining and keeping control over their life situation and being assisted in making informed decisions, and about supporting real partnerships between persons, families and services.

Aim: The aim of the article is to discuss the roots and developments of recovery and person-centredness, highlight some key strategies of these practice developments and show how the concepts and practices can nurture each other.

What this article adds to the topic: The roots of recovery are based in service user and activist organisations, and in disability movements, while the roots of person-centeredness can be traced back to Carl Rogers' work from the early 1940s, and also to humanistic-existentialist oriented models of care in the 1960 and 1970s. The two concepts are interdependent in that they presuppose each other. The key aspects of recovery can be summed up as:

- Recovery as a spontaneous, natural event
- Recovery as consequence of active treatment
- Recovery despite symptoms and functional impairments

Recovery is a personal, social and a spiritual process. Person-centredness is regarded as an essential component in good-quality care, and is understood as conveying a holistic approach characterised by respect for individuals and their unique experiences and needs.

Implications for practice: To make recovery and person-centredness influential in practice, four strategies are outlined:

- Realising the radical change involved in placing the person at the centre
- Acknowledging mental health problems as both personal and social
- Recognising and using knowledge embedded in the lived experience of service users, family members and practitioners
- Paying genuine attention to the spiritual process of recovery

Keywords: Recovery, person-centeredness, service user, practice development

Introduction
Systematic investigations of the subjective experiences of mental distress and of being a service user represent an important vehicle for drawing our collective attention to this knowledge base and encouraging us to listen carefully to the voices of individuals with mental health challenges. While the customary view of serious mental health problems within medical settings still may be that of a chronic debilitating disease resulting inevitably in a poor outcome, we now know that recovery is probable and possible, and that the realm of everyday life is the setting for recovery (Borg and Davidson, 2008; Davidson et al., 2012). It is in this context that people can figure out how to manage their problems by themselves or with the help of others. In this regard, qualitative studies of lived experiences have generated in-depth and concrete knowledge about the processes of recovery in the context of daily life, which may help steer practices towards becoming more person-centered. However, what is essential to understand about recovery is that a person's unique experience is the starting point for all actions. The collaborative process begins with trying to understand the person's experiences and life situation and how these affect day-to-day life from their point of view.

Greater emphasis on policies related to user involvement, human rights and the rights of persons with disabilities has contributed to the need for a wider knowledge base in mental health services. The concepts of recovery and person-centredness have contributed to this and have become familiar concepts in mental health practice developments and research. The concepts are prominent in official policy documents in various countries and also in the World Health Organization's *People-centred Health Care: A Policy Framework* (2007). This document identifies a number of gaps and weaknesses in current healthcare systems that need attention: they need to 'move beyond the traditional models of providing healthcare and of measuring health system performance', paying greater attention to 'system design, financing mechanisms and the focus and process of care' (p 6).

The aim of this article is to discuss the roots and developments of recovery and person-centredness, highlight some key strategies of these practice developments and show how the concepts and practices can nurture each other.

Recovery and person-centredness: rhetoric, ideals and reality
Community mental health care and outreach approaches have been established with the intention of drawing on the perspectives of person-centredness and recovery. However, such innovative services are often met by barriers rooted in the dominant psychiatric cultures and bureaucratic administrative procedures (Karlsson et al., 2008). Carl Rogers (1978) claims that person-centredness can be seen as radical for its attempts to give the person the central position and challenge bureaucracy and hierarchies in promoting the ideal of humans relating as equals. In many healthcare settings, such as traditional psychiatric hospitals, patients have been typically expected to be obedient and follow the professionals' programmes and orders. As we see it, the same challenges are present today, even though the recovery paradigm has been articulated and partly implemented in mental health services.

Recovery, like person-centredness, is about the person trying to find meaning and keep control over their life situation, with support for making informed decisions and for real partnerships with families and services. As researchers and clinicians working in mental health care settings, we have often found ourselves caught between competing realities. On the one hand, the vision statements of our workplaces inevitably sound humanistic and holistic, valuing the whole person and focusing on the person in context. On the other hand, there are health bureaucracies and procedures that by no means embody these values. First-person accounts tell us that the voices of service users are still not listened to, their knowledge is generally not recognised as valuable and what they say to practitioners may well be interpreted within a diagnostic framework rather than as a genuine exchange of crucial information (Kogstad et al., 2014). In this way, the person's story is translated into a third-person account through its rendition by different health or social care professionals; the first-person story becomes the professional's view of that story (Buchanan-Barker, 2009).

Recovery and person-centredness: roots and developments
Recovery

People have always found ways that lead to recovery and so been able to recover following illness experiences or functional problems. Some seek fellowship with friends and family; some look for good places to rest, meditate and be inspired. Others choose nature in order to experience tranquillity, a connection or nature's grandeur. Some choose culture, which can create recognition and stimulate meaning, while physical activity helps many to get a better grip on themselves. People recover in their own distinctive ways and it is precisely this realisation that lies behind the metaphor of recovery as a personal journey, and one on which a good travel companion may make the key difference. The route must be determined by the person based on their own values and preferences (Hummelvoll, 2012).

Recovery perspectives are often referred to as new. But the term 'recovery' has of course been in use for many years by service users as well as in healthcare.

Recovery, understood as an approach or philosophy, can be traced back to the moral treatment at the end of the 1700s, the therapeutic community after World War II and the antipsychiatric movement in the 1960s and 1970s. These all emphasise the importance of human treatment, self-help and peer support, and the significance of work and other structured activities. In antipsychiatry the overarching goal was to transform psychiatry from within by introducing an existentialist approach and valuing human experiences as opposed to diagnostic labels (Clarke, 1999).

The conceptual content of recovery for people with mental health problems is still relatively new. The civil rights movements from the 1960s onwards constituted the greatest driving force, based on ideas of self-help, empowerment and human rights. Recovery can thus also be seen as a political reaction against suppression, stigma and unsatisfactory services that focus on maintenance and compliance with treatment. In this respect it can be seen that recovery means professional power is challenged (Bonney and Stickley, 2008).

In the 2000s recovery-oriented mental health care practice has become an accepted term, being expressed in national standards and guidelines, although it reflects different contents and modes of practice. In other words, what was radical and challenging has gradually become a general ideology. The question is, how does this affect the authority of the concept? Maybe it leads to well-founded humanistic practices – or to the emergence of other concepts. An example of the latter is a concept that goes beyond recovery, namely 'reclamation'. The dictionary definition of reclaim is to seek the return of one's property; Buchanan-Barker (2009, p 686) says that in a psychiatric context it means regaining one's person status or value as a human being ('personhood') and life story. The Latin root of reclamation is *reclamare*, which means to 'cry out against'. This is precisely what individual patients and service users, as well as service user movements, have done for decades, leading to important improvements in the mental health care field. Taking back one's own life and life story is challenging because one has to go into a lengthy, laborious and challenging process of draining the effects of mental illness – transforming what once was perceived as meaningless and worthless into something that is valuable and worth pursuing.

Recovery is described as a process, an approach and a vision – or as a guiding principle (Hummelvoll, 2012). Roughly speaking, this can be divided into three main types:
- Recovery as a spontaneous and natural event. Even though the person has received a diagnosis, they can recover without treatment. Phenomena such as resilience and personal robustness may underlie this understanding of recovery
- Recovery as a consequence of active treatment interventions ('clinical recovery') implies that the person is free of symptoms and can manage the tasks of daily life
- Recovery as experienced even where the person still has symptoms and functional impairment, but carries the hope and ambition to live well and meaningfully in spite of circumstances

Prerequisites for recovery to happen – especially in the last of the three meanings above – are that opportunities in the community, nurturing environments and tailored help are available to help the person live a safe and dignified life (Borg and Davidson, 2008).

Recovery develops and occurs holistically in an interchange between the inner personal, the interpersonal, the social and the meaning-seeking journey.

The personal process is typically described in terms of regaining self-esteem and self-control, coping and moving beyond being a service user or patient. Here, redefining self is crucial, like renewing the understanding of mental health problems so that they become just one aspect of the person's identity. The personal process is also about reawakening hope for the future, developing a sense of meaning and purpose in life, and doing things you want to do.

The social process emphasises the dynamic relationship between the person and the environment. Living conditions, social welfare, feeling safe, work opportunities, community involvement, friends and family, helpful professionals and accessible services are essential for the recovery processes. Much of the recovery literature describes these life processes as dynamic and contextual, implying that regardless of the person's aetiological perspectives on the nature and causes of mental distress, it is in everyday life and the community that its consequences need to be addressed (Borg and Davidson, 2008). Recovery is not about cure, but about learning to live with and controlling what is distressing.

The spiritual process is related to the ideological world – that is, the world that creates perspective, height and depth of human life (Hummelvoll, 2012). Here the individual seeks meaning in life. Spirituality is not tied to any particular religion or tradition. Although culture and beliefs can have a central place, each person has their own unique experience of the spiritual, whether they have a religious faith or not. Spirituality is linked to the area where the personal meets the universal – the spiritual sphere of human experience (Culliford, 2005). It rests on three components: the need for meaning in life, the need for hope and will to live, and the need for trust and belief in oneself, others or God. Moreover, spirituality involves the experience of belonging, acceptance and feeling whole. Spiritual aspects of the recovery process are, for example:
- Working towards regaining hope and commitment in one's own life (Davidson et al., 2005)
- Participating in spiritual practices (Timms, 2010)
- Experiencing that one can mature through adversity (Culliford, 2005)
- Recovering in nature (Mayer et al., 2009)

As we see it, recovery processes encompass all the above three elements: the personal, the social and the spiritual, as well as the dynamic relation between them.

Person-centredness
Person-centred care is increasingly regarded as an essential component of quality care, and as a distinctive feature of a recovery-oriented system. Within mental health care, person-centeredness involves conveying a holistic approach and respect for the individual and their unique experiences and needs (Gask and Coventry, 2012; Morgan and Yoder, 2012). Thus, person-centred care is a collaborative process between the person seeking help and the practitioner in various contexts. Morgan and Yoder (2012, p 8) conducted a concept analysis of person-centred care, and found the defining attributes of person-centred care to be:
a. Holistic
b. Individualised
c. Respectful
d. Empowering

Further, within the healthcare environment, a person-centred climate includes:
  a. A vision and commitment
  b. Organisational attitudes and behaviours
  c. Shared governance

The result of such practices is expected to be improved quality of care, increased satisfaction with healthcare and improved health outcomes.

The concept of person-centredness has many-faceted roots, not at least from humanistic-existential-oriented models of care of the 1950–1970s – for example, Hildegard Peplau (1952) and Joyce Travelbee (1969). Person-centred approaches as professional practices and personal and political philosophy are often associated with Carl Roger's work from the early 1940s (Rogers, 1978). Involvement in world issues and social justice has long been a core element, together with relationship with the 'other' in a broad sense, belief in people's potential and critique of individualistic approaches. The ultimate goal for person-centred intervention is, to use Roger's term, 'becoming a person'. Paulo Freire is another whose work has contributed to the roots of person-centredness. Freire (1972) considers authenticity as an essential part of full humanness and envisages the goal of people becoming 'beings for themselves' – subjects of their own experiencing. He describes how human development and knowledge emerges through invention and reinvention, and the continuing, hopeful inquiry that human beings pursue in the world, with the world, and with each other. In seeing person-centredness as an agenda for social change, contextual and political issues need to be included in approaches and developments. Contextual factors are important because the 'whole truth' needs to be attended, including a person's nationality, class, gender, ideology and sexuality; an attempt to understand the person's place in the world. Political issues are important because working for person-centredness means a battle against the dominating ideologies of evidenced-based medicine originating in the medicalisation of mental distress (Proctor, 2006). Person-centredness has also become a central philosophy in the care of older people, those with dementia, those with learning disabilities, children, and to a lesser extent those with mental health conditions. In the latter, it is mainly in the Tidal model that person-centredness as a philosophy and concept is used (Barker, 2003; Lafferty and Davidson, 2006). The person-centred care processes can be described with three dimensions: being in relation, being in a social world and being with self (McCormack and McCance, 2006). In person-centred approaches, human relationships and caring are essential parts. The Norwegian philosopher Kari Martinsen (1989) describes how the term 'caring' consists of three different but equal elements: relational, practical and moral. The relational centres on a collective humanity on the basis that we depend on each other. Dependency in this context is not the opposite of independence; dependence of each other points to the universal moral principle that we can all at some time be in the position of needing help from others. This principle is therefore embedded in the other element of the term caring – praxis. It points to a situation where help is given unconditionally. Help and support is justified by the condition of the one in need, not by an expected result.

Conclusion and implications for practice

Although the roots and traditions seem to be different, recovery and person-centredness have common strands. People with mental health problems are primarily people. In order to understand what is going on in peoples' lives, as well as be a useful partner, we need to be interested in and curious about the person and collaborate as partners, where both parties have complementary and useful knowledge. This may sound obvious but, in spite of all policy statements and service transformations over the past 50 to 60 years, people with mental health problems are still seen as 'cases' and 'diagnoses'. If the perspectives and approaches of person-centredness and recovery are going to have a more real impact and contribute to real changes in peoples' lives, then at least four things need to happen:

First, we need to understand the radical change involved in placing the person at the centre. In current services, much of what is discussed, decided on and done is from the point of view of service systems

and professionals. Meeting the person as an autonomous individual in their social and cultural context involves developing collaborative partnerships. Harlene Anderson (2012) states that the essence of collaborative dialogue is the professional's stance: a way of being 'with' the other. This includes the notions of mutual inquiry, relational and social competence and privileging the wisdom and expertise of the person and their network. It also involves learning to live with uncertainty – that is, trying to avoid quick and premature decisions and not letting procedures stand in the way of the person's life.

Second, we need to acknowledge mental health problems as personal and social. The biomedical knowledge base is a barrier to understanding what is going on, as well as to meeting people as human beings in their local community with strengths and challenges in their lives. It is also a barrier to developing helpful care. The core problems identified may well be more related to the community than the person. WHO policies (2007) request commitment to this position, emphasising the transition from social marginalisation to full citizenship.

Third, life is not an outcome (Davidson et al., 2012). Mental health issues are about wellbeing and finding ways of getting on with life, and cannot easily be manualised or generalised. Recovery and person-centred approaches involve reawakening hope for the future, developing a sense of meaning and purpose in life and doing the things you want to do. They are about taking back control over your situation and nurturing and pursuing ambitions. Therefore, we need to expand the narrow evidence base where randomised controlled trials are seen as the gold standard. Practice-based evidence must be taken seriously in service transformation, where the lived experience of service users, family members and practitioners is recognised. We also need to explore local understandings of recovery and recovery-orientated services. Recovery is still a contested concept with a variety of definitions. In enacting recovery policy at a service delivery level, developing shared understandings of recovery in the local contexts is central. Furthermore, incorporation of the emerging knowledge from recovery and person-centred care into education and training for all mental health care professionals, service users and family members is essential.

Finally, in person-centred care we need to pay genuine attention to the spiritual process of recovery – the domain in a person's life where hope and meaning is sought. Spirituality has rightly been described as the forgotten dimension of mental health services. Spirituality has, among other things, to do with renewing hope and commitment in a person's life. This aspect of recovery contains hope and belief that it is possible to renew self-esteem and life goals – leading to the urge and motivation to change. Being hopeful can be spiritually grounded or be stimulated by others' faith in you (Davidson et al., 2005). Hope can be seen as an essential element in life because it sustains the passion for life – it may be a sense of general future opportunities or more specific, valued openings like getting a job or finding meaningful relationships (Repper and Perkins, 2003). Hope does not exist in a vacuum, but is embedded in interpersonal, reciprocal relationships.

These four aspects of mental health care may be guiding principles for professionals to take some steps forward and move beyond tokenism and rhetoric in order to support peoples' recovery processes by means of person-centred care.

References
Anderson, H. (2012) Collaborative relationships and dialogic conversations: ideas for a relationally responsive practice. *Family Process*. Vol. 51. No. 1. pp 8-24.
Barker, P. (2003) The tidal model: psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing*. Vol. 12. No. 2. pp 96-102.
Bonney, S. and Stickley, T. (2008) Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing*. Vol. 15. No. 2. pp 140-153.
Borg, M. and Davidson, L. (2008) Recovery as lived in everyday life experience. *Journal of Mental Health*. Vol. 17. No. 2. pp 129-141.
Buchanan-Barker, P. (2009) Reclamation: beyond recovery. Chp 77 *in* Barker, P. (Ed.) (2009) *Psychiatric and Mental Health Nursing. The Craft of Caring*. (2nd edition). London: Hodder Arnold. pp 681-691.

Clarke, L. (1999) Ten years on: the abiding presence of R.D. Laing. *Journal of Psychiatric and Mental Health Nursing*. Vol. 6. No. 4. pp 313-320.

Culliford, L. (2005) *Healing from Within: Spirituality and Mental Health*. London: Royal College of Psychiatrists, Spirituality and Psychiatry Special Interest Group.

Davidson, L., O'Connell, M., Tondora, J., Staeheli, M. and Evans, A. (2005) Recovery in serious mental illness: a new wine or just a new bottle? *Professional Psychology: Research and Practice*. Vol. 36. No. 5. pp 480-487.

Davidson, L., Tondora, J. and Ridgway, P. (2012) Life is not an 'outcome': reflections on recovery as an outcome and as a process. *Journal of Psychiatric Rehabilitation*. Vol. 13. No. 1. pp 1-8.

Freire, P. (1972) *Pedagogy of the Oppressed*. London: Penguin.

Gask, L. and Coventry, P. (2012) Person-centred mental health care: the challenge of implementation. *Epidemiology and Psychiatric Sciences*. Vol. 21. No. 2. pp 139-144.

Hummelvoll, J.K. (2012) *Helt – ikke Stykkevis og Delt. Psykiatrisk Sykepleie og Psykisk Helse*. Oslo: Gyldendal Akademisk.

Karlsson, B., Borg, M. and Kim, H. (2008) From good intentions to real life: introducing crisis resolution teams in Norway. *Nursing Inquiry*. Vol. 15. No. 3. pp 206-215.

Kogstad, R., Ekeland, T. and Hummelvoll, J.K. (2014) The knowledge concealed in users' narratives: valuing clients' experiences as coherent knowledge in their own right. *Advances in Psychiatry*. Vol. 2014. Article ID 786138.

Lafferty, S. and Davidson, R. (2006) *Person-centred Care in Practice: An Account of the Implementation of the Tidal Model in an Adult Acute Admission Ward in Glasgow*. Retrieved from: tinyurl.com/PCC-tidalmodel. (Last accessed 30th August 2015).

Martinsen, K. (1989) *Omsorg, Sykepleie og Medisin – Historisk-Filosofiske Essays*. Oslo: Universitetsforlaget.

McCormack, B. and McCance, T. (2006) Development of a framework for person-centred nursing. *Journal of Advanced Nursing*. Vol. 56. No. 5. pp 472-479.

Mayer, S., Bruehlman-Senecal, E. and Dolliver, K. (2009) Why is nature beneficial? The role of connectedness to nature. *Environment and Behavior*. Vol. 41. No. 5. pp 607-643.

Morgan, S. and Yoder, L. (2012) A concept analysis of person-centered care. *Journal of Holistic Nursing*. Vol. 30. No. 1. pp 6-15.

Peplau, H. (1952). *Interpersonal Relations in Nursing. New York: G.P. Putnam & Sons.*

Proctor, G. (2006) Therapy: opium for the masses or help for those who need it? *In* Proctor, G., Cooper, M., Sanders, P. and Malcolm, B. (Eds.) (2006) *Politicizing the Person-centred Approach – An Agenda for Social Change*. Ross-on Wye, UK: PCCS Books.

Repper, J. and Perkins, R. (2003) *Social Inclusion and Recovery: A Model for Mental Health Practice*. Edinburgh: Baillière Tindall.

Rogers, C. (1978) The foundations of the person-centered approach. *Education*. Vol. 100. No. 2. pp 98-107.

Timms, P. (2010) *Spirituality and Mental Health*. London: The Royal College of Psychiatrists Spirituality and Psychiatry Special Interest Group.

Travelbee, J. (1969). *Intervention in Psychiatric Nursing: Process in the One-to-One Relationship*. Philadelphia: F.A. Davis.

World Health Organization (2007) *People-centred Health Care – A Policy Framework*. Manila, Philippines: WHO.

Jan Kåre Hummelvoll (PhD, BA, RPN, RN), Professor of Mental Health Care, Buskerud and Vestfold University College, Drammen, Norway.

Bengt Karlsson (RN), Professor in Mental Health Care, Buskerud and Vestfold University College, Drammen, Norway.

Marit Borg (DipCOT), Professor in Mental Health Care, Buskerud and Vestfold University College, Drammen, Norway.