Person-centred mental health care: myth or reality?

While the concept of a mental health service based on users’ needs is widely understood, it rarely exists in practice. Fred Ruddick describes how it can become a reality.

**Summary**

Person-centred mental health services are supposed to already exist in the UK but providing such services is a challenge for staff. This article examines the concept of person-centredness and suggests that services will only conform to its principles if staff are given adequate time and support to undertake appropriate continuing professional development.

**Keywords**

Person-centred care, continuous professional development

THE TERM ‘person-centred’ is commonly used by mental health service providers and is found in many team philosophies, the stated aims of services and in client-orientated information.

Care plans and working practices are said to be person-centred and the recovery model will require a person-centred approach so that clients can explore their thoughts and feelings, re-author their lives and discover a more accepting sense of self.

However, it is challenging to prove that services are truly person-centred. The rhetoric and documentation may tick all the boxes, but how person-centred is the day-to-day care offered by mental health nurses and received by clients?

In his pioneering work, counselling guru Carl Rogers (Rogers 1994, 1995, Thorne 2003) realised that for humans to flourish, conditions that encourage personal growth are required. He came to believe that personal growth could be cultivated through the power of relationships and that positive change was dependent on the qualities of the people involved. Effective therapeutic relationships were reliant on the presence of what Rogers called the core conditions, namely acceptance, genuineness and empathic understanding (Box 1). Such qualities, by their very nature, are hard to measure in a scientific manner, but their importance in the therapeutic alliance is recognised by many who have studied the therapeutic process (Wampold 2001, Roth and Fonagy 2006).

Service users agree with the importance Rogers placed on the relationship (Faulkner and Layzell 2000). When clients are dissatisfied with their experiences of mental health services, lack of respect from mental health professionals and lack of access to therapeutic time are common complaints.

**Close relationship**

In the quest to make meaning out of the psychological chaos associated with many mental health problems, time to explore thoughts and feelings is important. Personal growth is more likely in the presence of a person who values the client and is truly non-judgemental, open and honest, and makes the effort to understand the client’s world (Mearns and Thorne 1999).

Person-centred care has little to do with the often glib use of the term by mental health lecturers, nurses and service providers, but it is a vital aspect of a service often constricted by task-oriented systems and pressured work. Frequently, more importance is placed on targets and number crunching than on the quality of nurse-client interactions.

For many service users, the relationships they form with others, including mental health professionals, constitute ‘the most important factor in helping them cope with mental distress in their lives’ (Faulkner and Layzell 2000). In such relationships, an accepting and non-judgemental...
attitude communicated by the mental health professional can be a significant stimulus in developing a greater sense of self-acceptance in the service user. A supportive relationship, according to Faulkner and Layzell (2000), ‘enables people to feel heard, respected, valued and of equal worth’, all characteristics of a person-centred approach.

The importance of the relationship is reinforced in the chief nursing officer’s review of mental health nursing where she states: ‘Developing and sustaining positive therapeutic relationships with service users, their families and/or carers should form the basis of all care’ (Department of Health 2006).

**Spiritual dimension**

Spirituality has a symbiotic relationship with person-centred care but historically it has been overlooked as a source of healing for people in mental distress. Cornah (2006) reports that ‘clinicians either ignore an individual’s spiritual life completely or treat their experiences as nothing more than manifestations of psychopathology’.

For some clients, to talk of spirituality risks them being labelled as delusional and retreating from reality. However, the qualities that Rogers’ (1994, 1995) suggests are as important have a spiritual dimension – his core conditions of acceptance, genuineness and empathy are common core values to be found in a range of religious and spiritual teachings.

Mental health nursing students and qualified nurses, when asked, often claim attitudes of acceptance, genuineness and empathic understanding, but for many clients these qualities are lacking in the care environment. Johnston and Mayers (2005) consider an aspect of spirituality to be the search for meaning and purpose, which may or may not be related to a belief in a god.

Person-centred values agree with this perception to the extent that it is clients’ views of themselves,
their problems and the world that form the starting point in the search for meaning; clients’ views are non-judgementally valued and accepted as a foundation for making sense of their thoughts, feelings and purpose in life.

When helping another person explore their inner world – to turn fragmentation into wholeness, despair into hope and conflict into harmony – the journey is by association a spiritual one and the mental health nurse needs to be a confident companion.

The literature offers a general optimism that spirituality has a positive role to play in promoting and maintaining good mental health (Cornah 2006) although there is little research to show how this works. There may be some support for this view from the person-centred/humanistic school of thought, which is also concerned with how people make sense of their place in the world so that they can deal with their existential angst.

When service users are consulted about what matters to them in the care offered by mental health practitioners, they often refer to the therapeutic relationship as the ‘cornerstone’ of care (Forchuk and Reynolds 2001). Mental health nurses therefore require essential qualities, time and reflective space, to understand the client’s frame of reference (Ackerman and Hilsenroth 2003).

Some authors are sceptical that the accepted ideals occur consistently in practice. Moyle (2003) challenged the assumption that mental health nurses readily engage in therapeutic relationships with clients. In a study of people with depression in hospital, she reported that attention to clients’ emotional needs often dissipated soon after admission and that, after some time, distancing in the nurse-client relationship was observed. This is the opposite of what clients want; Shattel et al (2007) concluded that clients want nurses to take the time to know them as a whole person, rather than as a service user.

Time is often in short supply in mental health care systems so spending time ‘being with’ a client reinforces the fact that they are being valued, irrespective of any therapeutic strategies that might follow. Time is significant in the development of therapeutic rapport and an empathic understanding of others. Time offers a reflective space for both nurse and client, where meaning can be explored.

People with challenging psychological experiences commonly need time to make sense out of chaos, but in their moment of greatest need they may feel marginalised or dismissed by professionals.

Experience of the scarceness of time appears amplified to clients in hospital (Sainsbury Centre for Mental Health 1998) and it has been recommended that ‘inpatient care should be improved through measures that include increasing the time mental health nurses spend in direct clinical contact’ (Department of Health 2006).

Client need

Service providers claim that client need is what drives mental health services, but is this really the case? Some services apply arbitrary limits to how often a client can be seen, implying that things should be sorted out in a set period. Alternatively, when the allotted time is up, the client may be shuffled to some other part of the service to start the process of telling their story and building trusting relationships over again. This seems more like service-centred care.

A survey by the Royal College of Nursing (2007) reported that 74 per cent of those working in older persons’ mental health services considered the nursing establishment insufficient to meet clients’ needs. About one third of their time was spent on administration and clerical work (RCN 2007).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The Johari window</th>
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<td><strong>Known to self</strong></td>
<td><strong>Not known to self</strong></td>
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<tr>
<td><strong>Known to others</strong></td>
<td>Open self – information about yourself that you and others know</td>
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<tr>
<td><strong>Not known to others</strong></td>
<td>Hidden self – information about yourself that you know but others do not know</td>
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(Luft and Ingham 1955)
Mental health workers are required constantly to feed the bureaucratic system with paperwork, risk assessments and statistics, with consequently less time for client contact. Pressure to manage waiting lists in primary mental health care can result in a perceived need to ‘get them in and ship them out’. Success, it might be asserted, is in the statistics.

Barriers
For those who prize humanistic values, there seem, in practice, to be intrinsic barriers to person-centred mental health care, as defined by Rogers (1994, 1995). Acceptance of another person involves a non-judgemental attitude and unconditional positive regard. This creates a safe environment in which clients can explore their most sensitive thoughts and feelings. However, the enduring tendency in mental health services is to apply medical labels that mark a person as different (judgement) and can be the primary determinant of future treatment. Diagnosis may deflect nurses from working with the client’s subjective understanding of their problems, a central principle in a person-centred system. Some labels, such as schizophrenia or personality disorder, may cause further damage by attracting more negative attributes and more discrimination than other diagnostic categories.

Being genuine with clients is also difficult. Genuineness relies on transparency and honest communication which, for mental health nurses, may be tempered with caution as they balance the demands of the client’s family, the opinions of fellow professionals and ethical codes of practice.

Empathy is often considered the most important quality; without it we cannot gain a sense of other people’s feelings, and this can make us immune to their pain and suffering. When mental health nurses work under pressure in non-supportive environments, they may, in self-preservation, become self-centred rather than person-centred, which prevents them from empathising with the other person’s predicament.

Personal growth
It is in the therapeutic relationship that a person-centred mentality shows itself; true person-centred care is a product of genuine engagement with the person whose fears and aspirations are being disclosed. Unlike knowledge and skills, the therapeutic qualities of person-centred care require cultivation and experience. It is through exposure that individuals grasp the potency of a relationship in which you are accepted for who you are and not what you have done: a relationship where genuine non-defensive engagement is possible and in which there is a sense of being in tune at an emotional level (empathy).

Developing self-awareness is pivotal in the process of becoming person-centred and requires an ability to reflect on our own beliefs and the values that guide our words and behaviour.

Being person-centred is not like a light switch that can be turned on and off. The values of acceptance, genuineness and empathy become central to who we are and how we relate to others. American psychologists Joseph Luft and Harry Ingham created a simple tool to help people understand the development of their self-conception and ways of developing greater self-awareness. It is known as the Johari – a blend of their first names – window (Table 1).

The model suggests we can become more self-aware through introspection, self-disclosure and feedback. The danger here may be that those who commission and manage mental health services see their staff’s personal growth and the road to greater self-awareness as too imprecise and outside their organisation’s remit. Mearns and Thorne (1999) agree and caution us that, in professional circles, ‘the person-centred approach can sometimes be dismissed as facile or superficial, or even castigated as naive or misguided optimistically’.

Change in direction
If the vision of future mental health care is one where the individual takes centre stage, a greater emphasis on nurses’ values and attitudes is essential. The recovery approach, which is now a guiding philosophy and model of service user empowerment that has been adopted by the majority of all mental health services, demands that mental health nurses will be instrumental in helping their clients find value and meaning in their lives.

This is, however, dependent on nurses perceiving the importance of their own continuing self-development. In a survey conducted by the RCN (Jones 2003), mental health nurses were asked about the type of future education they wanted, suggesting that the following areas were important:

- Risk assessment.
- Managing violence and aggression.
- Psychosocial interventions.
- Working with people with a dual diagnosis.

True person-centred care is a product of genuine engagement with the person whose fears and aspirations are being disclosed.
Working with people with personality disorders.
Information technology and computer skills.
Leadership skills.

The importance of deepening self-awareness and of more person-centred relationships did not show up as significant areas for development. Despite clients wanting ‘the interpersonal’ to be central to the care they receive, there seems to be a leaning towards specific concrete skills, rather than the personal growth and development necessary for more real and respectful nurse-client relationships.

Concrete skills in themselves have more value to service users when they are embedded within a therapeutic relationship that acknowledges the whole person. In themselves they do not engage the service user in the therapeutic alliance so vital in promoting adherence with their treatment plan (Chaplin 2007). Jones (2003) goes on to say that ‘it has become widely accepted that the current structure of pre-registration programmes is failing to facilitate the development of adequate practice knowledge and skills’.

This challenges the argument that knowledge and skills, rather than attitudes, should be the focus of professional development.

Conclusion
To change direction from task-orientated, statistically-driven mental health services, we must invest in the personal development of the people who deliver care on the front line. This is vital if the needs of service users are to be valued in a truly person-centred culture, and requires greater attention to self-development with good clinical supervision and attention to the values, beliefs and attitudes of the practitioner.

Rogers’ teachings (1994, 1995), which consider the qualities necessary in the helper, need to be embraced, not just adopted, by mental health professionals, so that they are not simply rhetoric.

Service users continue to observe the lack of congruence between the written word about mental health care and their actual experience of it. Those who plan services must consider the basics of providing time for person-centred relationships to develop, because this is what clients need. Real person-centred care can help to meet a person’s spiritual needs but this depends on the person who provides it, not the paperwork.

We should ensure that, in ten years’ time, person-centred care is no longer an illusion and that this is confirmed by those who depend on our services.

Implications for practice

Greater emphasis on emotional intelligence (Goleman 2006) and the development of person-centred nurse client relationships based on Rogers’s core conditions should lie at the heart of all mental health education and training.

Clinical supervision should mirror the person-centred ethos with a focus on self-awareness, personal development, and the therapeutic alliance as primary factors in improving adherence to service user treatment.

Time with service users must be seen as a significant priority for mental health practitioners.

Services users need person-centred relationships based on acceptance, genuineness and empathic understanding to make sense of their psychological challenges during their recovery.

References


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