



## CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

### Recovery oriented conversations in a milieu therapeutic setting

Ellen Andvig\* and Stian Biong

\*Corresponding author: Buskerud and Vestfold University College, Drammen, Norway

Email: [ellen.andvig@hbv.no](mailto:ellen.andvig@hbv.no)

Submitted for publication: 13<sup>th</sup> January 2014

Accepted for publication: 3<sup>rd</sup> April 2014

#### Abstract

*Background:* Norwegian health authorities place emphasis on recovery oriented practices in mental health services. Recovery is described as an active process with a focus on personal resources and supportive contexts. In the recovery process, the relationship between the person and the carer is of great importance. Conversation is a meaningful approach for developing a trusting relationship. Conversation also has importance in itself, because it establishes the foundation for human contact and gives the client the opportunity to be acknowledged as a person.

*Aim:* The aim of the study was to describe and explore what health professionals focused on in recovery oriented conversations with patients in a Norwegian mental healthcare centre.

*Methods:* This study was part of an action research project and had a qualitative and explorative design. Data were collected in multistage focus groups and were analysed using qualitative content analysis.

*Findings:* The findings highlighted the prerequisites for conversation, the content of conversation and different views on the topics of conversation.

*Conclusions:* The findings contribute knowledge about what promotes or inhibits recovery oriented conversations. Such conversations focus on the patients' everyday life, appreciating them as actors in their own lives, and facilitate shared decision making processes and working with hope. The study demonstrates that individual, cultural and contextual aspects play an important part in recovery oriented conversations.

*Implications for practice:*

- Practice development involves acknowledging and re-evaluating the possibilities for using conversations with patients as an approach and as a tool in person-centred and recovery oriented practices
- Relational competence is an essential part of enhancing recovery oriented conversation, and needs to be attended to in skills training and competence building
- Awareness and critical analysis of the clinical context is important to promote an active and participative patient role. Authoritarian cultures with concern about what is permitted or not may well be a barrier to shared decision making

**Keywords:** Conversation, person-centredness, recovery, practice development, action research, content analysis

## **Introduction**

The present study was part of an action research project based on a collaboration between a community mental healthcare centre (hereafter called the centre), a municipality that provided mental healthcare services and a university college in Norway. The centre was part of the specialised healthcare system offering rehabilitation and support and collaborated with the municipal mental healthcare team on patients' living conditions and everyday life issues. The patients in the centre had serious mental health problems such as psychosis, depression and mood disorders, and some were also addicted to drugs. Several of the patients stayed for a few months and several returned to the centre repeatedly during the action research project period.

The World Health Organization (2013, p 38) defines mental health as:

*'A state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'*

Mental health is more than the absence of mental illness. Comprehensive research reveals that persons with mental health problems can recover (Slade and Priebe, 2006). The Norwegian national strategies promote a recovery oriented approach in mental healthcare (Norwegian Directorate of Health, 2012).

## **Recovery**

There are three definitions of recovery typically referred to in the research literature and in service development:

- A personal process
- A social process
- An outcome – clinical recovery (Slade et al., 2012)

Recovery as a personal process is concerned with what is involved in living with and overcoming mental health problems and/or addiction problems. This definition has led to a better understanding of the importance of everyday life for people with mental health problems, and the importance of developing strategies for coping with everyday psychological and social problems (Deegan, 1988; Davidson, 2003; Slade, 2009).

In understanding recovery as a personal process, it is not central for people with mental health problems to become symptom free or overcome all problems. The goal is to live a good life as a citizen, and not to be seen and treated as a psychiatric patient or a drug addict. Recovery research describes several characteristics of the recovery process (Davidson et al., 2009; Leamy et al., 2011; Slade et al., 2012). Leamy et al. (2011) have developed an empirically based conceptual framework comprising five interlinking recovery processes: connectedness, hope and optimism about the future, identity, meaning in life and empowerment (CHIME).

Although each person's journey to recovery is individual, connectedness, identity and empowerment are particularly social in their conception (Tew et al., 2012). Tew (2011) claims recovery as a personal process is dependent on the available social opportunities and social support. Recovery as a social process is thus embedded in a contextual perspective. In Nordic and UK studies, recovery as an everyday life practice is particularly well described, with the focus on social conditions, life situation and social processes. Home, work, activity, education, money, social arenas, friends and family all have great importance for the recovery process (Borg and Davidson 2008; Topor et al., 2011; Perkins and Slade, 2012).

Recovery as an outcome, or clinical recovery, has a result orientation and has developed within treatment and rehabilitation contexts. Recovery is a concept that has been used in medicine and other health sciences for a long time; it describes an end status, an absolute, a final position of being symptom free or illness free (Slade, 2009).

Although recovery is to a great extent understood as movement towards a complete and meaningful life in the community, many persons with mental illness continue to be readmitted to hospital during their recovery process. Thus, the inpatient setting may have important implications for a person's recovery (Chen et al., 2013). Recovery competences are the attitudes, knowledge, skills and behaviours of the health professionals that exemplify the delivery of recovery oriented services to persons with serious mental health problems (Chen et al., 2013). In a review of several recovery competency frameworks, Chen et al. (2013) found that person-centredness was a central domain. In this article, person-centred care is therefore understood as an important part of recovery. In line with Tew (2011), we acknowledge that recovery as a social process creates social conditions that support the person on his or her personal recovery journey. However, for analytical reasons, in this article, person-centred care is understood as an important part of recovery as a personal process.

### ***Person-centredness***

Person-centredness has been defined as an approach based on the development of 'therapeutic' relationships between 'care providers, patients/clients/families and others significant to them in their lives'. It is based on 'values of respect for persons, individual right to self-determination, mutual respect and understanding'. This approach is possible when there are 'cultures of empowerment that foster continuous approaches to practice development' (McCormack and McCance, 2010, p 31).

McCormack and McCance (2010) developed a Person-Centred Nursing Framework that has four constructs:

- Prerequisites that focus on the attributes of the nurse, including professional competence and interpersonal skills
- Focus on the context in which care is delivered in the care environment
- Work with persons' beliefs and values, engagement, sympathetic presence, shared decision making and holistic care
- Expected outcomes, which are the results of effective person-centred nursing and include satisfaction with care, involvement in care, feelings of wellbeing and creation of a therapeutic environment

We understand the underlying philosophical assumptions of person-centred nursing and healthcare as humanising the health and social care systems (McCormack and McCance, 2010). Morse et al. (1991, p 122) describe caring as 'a universal characteristic... that forms the foundation of human society' and that is 'necessary for human survival – an essential component of being human'. Recovery as a personal process can be understood as reclaiming one's personhood. Personhood is defined by Kitwood (1997, p 8) as 'a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust'. To us, the link between recovery as a personal process and the Person-Centred Nursing Framework is the notion of personhood.

Skatvedt (2009) claims that conversation may be a meaningful approach and tool for becoming acquainted and developing trust. A conversation is also said to have importance in itself, because it establishes a foundation for human contact and gives a person the opportunity to receive respect and recognition of himself or herself (Fredriksson, 1999; Skatvedt and Scheffels, 2012). Williams and Tufford (2012) point out that persons with mental health problems want more time to talk with caregivers in a way that allows them to be recognised as complete persons.

### ***The milieu therapeutic setting***

Milieu therapy is defined as a way of organising daily activities in a social milieu to gain therapeutic effects and positive patient outcomes (Gunderson, 1978). Today, the setting for milieu therapy is said to be more individualistic, as opposed to the original, democratic, collectively anchored milieu therapy known as the therapeutic community (Oeye et al., 2009). The emphasis has shifted to more

individualised planning in inpatient settings (Whitely, 2004). The guidelines for the community mental healthcare centres (Norwegian Directorate for Health and Social Affairs, 2006) describe the need to create a therapeutic environment and point out that approaches and interventions to develop a therapeutic environment should be incorporated into a person's care plan. This indicates that such interventions may support recovery as both a personal and a social process; in our experience they can also promote clinical recovery.

### **Aim**

The aim of this study was to describe and explore what health professionals focus on in recovery oriented conversations with patients in a Norwegian community mental healthcare centre. The following research question was asked:

*How do health professionals describe recovery oriented conversations with the patients in a milieu therapeutic setting?*

### **Method**

#### ***Design***

This study was part of an action research project (Reason, 1994). Action research has the potential to facilitate descriptions of practice and lead to changes in the practice field through a dialogue oriented, cooperative approach (Hummelvoll and Severinsson, 2005). Cooperative research can therefore play an important role in assisting healthcare personnel in the integration of theory and research in their work setting, as it includes not only practical aspects but also the development and integration of the knowledge or theory on which the actions are based (Reason, 1994; Hummelvoll and Severinsson, 2005). The actual study described in this article was conducted in 2010, and used a qualitative and explorative design to investigate the experiences of the participants.

#### ***Participants***

Participants were recruited by self-selection (Hellevik, 2002). All members of staff who worked with patients were asked to participate in the initial phase of the project, and those who wished also attended the follow-up multistage focus groups. A total of 15 of 29 milieu therapeutic members of staff participated. One of their tasks was to create a therapeutic environment within the centre. Continuity was secured by ensuring that half of the participants were present at all the interviews. The participants ranged in age from 30 to 65 and comprised six mental health nurses, three auxiliary nurses, three social educators, two occupational therapists and one social worker. They had worked in the centre for between one and 15 years. There were four men and eleven women; the proportion of women in the sample reflected the higher proportion of women working in the centre.

#### ***Dialogue based teaching***

In the action research project, dialogue based teaching formed the action intervention. Dialogue based teaching is characterised by an interchange of clinical experience and theoretical reflections. The focus is on developing knowledge for action (Reason, 1994; Hummelvoll and Severinsson, 2005). The dialogue based teaching in the project included all healthcare personnel in the centre. It was conducted from 2009 to 2011 and included seven sessions on the topic of recovery oriented conversation. The teaching was intended to facilitate the articulation of practical and tacit knowledge. The sessions were led by one of the health professionals and the researcher (the first author of this paper). The researcher helped the participants discuss the meaning of recovery and person-centred care, user participation in theory and practice and conversations with patients. The sessions were structured by facilitating in depth reflections, promoting and stimulating the expression of different experiences in the group (Hummelvoll and Severinsson, 2005). Between the sessions, the participants tried out new practices.

### ***Data collection***

Data were collected in four multistage focus group interviews, in which different aspects of recovery oriented conversations between patients and health personnel were addressed (Hummelvoll, 2008). Focus group research is a way of collecting qualitative data and involves engaging a small number of people in an informal group discussion, focused around a particular topic or set of issues (Wilkinson, 2004). Participants are encouraged to talk to one another, ask questions, exchange anecdotes and comment on one another's experiences and points of view.

Multistage focus groups imply that the knowledge shared in a particular group is enhanced over the course of several meetings, leading to a deeper understanding of the agreed area of focus (Hummelvoll, 2008). The interviews were all moderated by the first author, who led the discussions, and a co-moderator who took notes and summarised the discussions. All interviews were held at the centre and lasted for about 90 minutes. They were audiotaped and transcribed.

### ***Data analysis***

Qualitative content analysis was used to analyse the data (Graneheim and Lundman, 2004) in a stepwise manner. The transcribed text of the first focus group interview was condensed and an initial analysis performed by the first author with two of the focus group participants. The reason was to broaden the initial analysis. In the second interview, the initial analysis was presented to the group and this interview focused further on topics that had arisen in the first analysis. Finally, when all four interviews had been conducted, the two authors of this paper carried out a content analysis of the data. The meaning units, subcategories and categories generated from this analysis are summarised in Table 1. Statements from the interviews were systematised by grouping them under different codes. The content of the categories was clarified, checked against the transcribed interviews and validated by statements from the interview texts. The categories represented the manifest content, or content aspect (Graneheim and Lundman, 2004). Coherent majority and minority perceptions were searched for in addition to specific examples related to the themes.

### ***Ethical considerations***

Approval for the study was granted by the Regional Committee for Medical and Health Research Ethics, the Norwegian Social Science Data Services and the Ombudsman for Research. Approval was also granted by the staff managers of the centre. In addition, the principles of confidentiality, voluntary participation and informed consent were applied (World Medical Association, 2008). No information that could identify the participants was included in the final report.

### ***Findings***

Through the analysis, we developed three categories:

- Prerequisites for conversation
- The focus of the conversation
- Different views on topics of conversation

<b>Table 1: Overview of the categories, subcategories and meaning units</b>		
<b>Category</b>	<b>Subcategories</b>	<b>Meaning units</b>
<b>Prerequisites for conversation</b>	Developing trust	Having a conversation presupposes a trusting relationship – that the parties feel secure with one another
	Sensing the right moment for conversation	A conversation can arise when one grasps the right moment, for example during a 20 minute car drive; it's about being sensitive to where the other person is.
	Having competence	I lack the skills to talk with the patients about difficult topics in their life. If I'm going to do it, I'll need supervision
<b>The focus of conversation</b>	Identifying patients' strengths	It can happen that the patients discover their resources during the conversation
	Stimulating action orientated reflections	The conversations make it possible for the patients to think aloud about their everyday situations, and this contributes to raising awareness and finding out what to do
	Exploring the patients' own solutions	I place an emphasis on the possibility for the patient to arrive at solutions himself during the conversation
	Describing feelings	I can say to the patient, it seems as though you're upset, and ask if that's true. This is a way of reflecting the other and contributes to put words to feelings
	Creating hope	Hope is the most important thing for a patient's recovery. When he has lost it, we must carry it for him
	Talking about life in general	It's important for the patient to experience that he can open up and be given space for his religious and existential thoughts
<b>Different views on topics of conversation</b>	To go as deep as possible	I talk to the patient about anything he wants to talk about, including the deepest depths
	To protect the patient	We must be careful about what we talk with patients about, because they're vulnerable and weak and have to be treated with care

### ***Prerequisites for conversation***

This category encompasses the three subcategories:

- Developing trust
- Sensing the right moment for conversation
- Having competence

*Developing trust.* The participants placed great emphasis on the development of a trusting relationship as a prerequisite for a helpful conversation. One participant used the expression 'wishing him well' about the importance of building a trusting relationship with the patient. Developing a trusting and safe relationship could often take time when the patients were struggling with problems and less able to engage in conversation. It was therefore important to take the necessary time to become acquainted and to build up an alliance. One participant described it in this way:



*'Being able to converse is dependent on a great deal of trust from the patients; one has to have a relatively strong alliance in order for the patient not to feel invaded.'*

*Sensing the right moment for conversation.* The participants were concerned that conversation should take place when the patient was ready – when they sensed that the moment had arrived and when there was contact, for example, when they were in the car after a visit to the patient's apartment. They used words such as 'intuition' and 'tuning in'. Their experience of patient availability and desire for contact concerned timing. When they knew the patients well enough, it was easier to read their signals. One remarked that:

*'It's important to be sensitive to the patient's expression.'*

Another expanded:

*'We must be receptive and attentive and listen to what the patient actually says and not interpret too much.'*

They focused on being available when the patient had the need to talk, showing that they cared, and involving themselves with the patient. For example, one participant was open for having conversations at night when patients had difficulty in sleeping, even though this was against the rules.

*Having competence.* The participants were concerned about the need for professional competence in conversations with the patients. One described this in the following way:

*'You can create a positive or a negative experience for the patient, it demands awareness from us. It requires experience, and there's a lot of knowledge you need to have assimilated.'*

The participant pointed to the need for developing interpersonal skills in order to have conversations that go beyond the topics of everyday life, and to be sensitive to the person's needs. Inexperienced participants expressed uncertainty about what they could talk to patients about. They preferred to leave conversations that went beyond everyday issues to the psychologist or psychiatrist. They expressed the need for more supervision, and a clearer role and responsibility related to more advanced conversations.

### ***The focus of the conversations***

This category encompasses six subcategories:

- Identifying patients' strengths
- Stimulating action orientated reflections
- Exploring the patient's own solutions
- Describing feelings
- Creating hope
- Talking about life in general

*Identifying patients' strengths.* The participants felt it was important to focus the conversations in such a way that the patients could discover their strengths:

*'This is about giving confirmation and recognition of the patient as a person. It can mean emphasising their strengths. But it can also mean emphasising that symptoms can mean something positive, something they can value and see as part of themselves.'*

This was related to the fact that the patients had experienced many failures throughout their lives and had difficulty in identifying their resources. They often needed help to rediscover these resources.

Several participants were concerned with seeing the common human aspects of the patient's mental health problems instead of focusing on diagnoses:

*'We must be aware about not diagnosing human problems and turning them into symptoms and diagnostic criteria.'*

The participants were concerned not to 'medicalise' normal, everyday, common human problems.

*Stimulating action orientated reflections.* The participants stated that stimulating the patient to reflect over his or her life was important in conversations:

*'This involves helping the patient to think aloud about his everyday situation – what can he cope with? After a while, his own reflections come up about what he can do. Then he's involved in his own reflection process about his own life situation.'*

They also focused on talking with the patient about setting goals and making plans for the future. This could involve topics such as finding a place to live, taking a study course or returning to work. One participant put it this way:

*'It's important that he has the opportunity to see alternatives, put words to thoughts he has about what he can manage and how he can prioritise.'*

They described the importance of the patient's goals being realistic and achievable.

The participants were also interested in talking with patients about their life experiences so that patients could see these in new contexts. They talked to patients about how they could tackle concrete challenges in their own lives, how to gain a better overview of daily life and about what could contribute to stress reduction. They then moved to what had happened in particular situations, what had functioned well, what not so well, and what they could learn that could be used next time.

*Exploring the patient's own solutions.* The participants were concerned that the patients needed to be involved in making decisions and finding their own solutions for the challenges of everyday life:

*'Through the conversation he can find out himself what's best to do.'*

Conversations often revolved around collaboration with the patient to find practical solutions to satisfy basic needs such as nutrition, activity, rest and hygiene – needs that could become neglected during difficult phases. Participants also collaborated with patients on decisions connected to leave of absence, overnight stays at home, contact with friends and relatives or financial concerns. One participant summarised:

*'There's a lot we negotiate with patients about.'*

Managing their own economic situation was a problem for many, and it was important to negotiate solutions that the patient could live with.

*Describing feelings.* The participants emphasised talking with patients about feelings that arose in everyday situations. The reason was that situations of conflict and aggression often occurred in the centre. The participants described the roots of such behaviour as feelings of dissatisfaction, anger and frustration. One participant put it like this:

*'Aggressive behaviour is a way of expressing oneself that isn't very useful, but it can be very healthy to ventilate such feelings. It can contribute to change.'*



After an episode of such behaviour, it was important for all those involved to talk about what had happened and to put words to feelings. In terms of therapy, and in order to prevent aggressive behaviour, participants focused on conversations with patients about resolving conflicts. These could be individual conversations or group conversations with several patients, dependent on the situation. Participants also invited patients to describe their feelings connected to different themes of life.

*Creating hope.* The participants were concerned with communicating hope to the patient:

*'When the patient is overwhelmed by feelings of helplessness and powerlessness, it can mean a great deal that we contribute in creating hope.'*

They put emphasis on the need for hope for the recovery process, and used expressions such as 'carrying hope for the patient'. One participant reported that he was concerned about:

*'Acknowledging the small steps that show the way forward when the patient doesn't see them herself and doesn't believe in recovery.'*

*Talking about life in general.* Many conversations were about topics that were relevant to the patient's everyday life:

*'We talk a lot about present issues, things the patient is concerned about. It may be that these are matters of course, about the small, everyday things in his life. It's not always the big things that are the most important.'*

The most experienced mental health nurses among the participants spoke of their conversations with patients about different themes of life, including existential and spiritual questions. They saw this as a central task of care. Examples of life themes they discussed were relationships with relatives, having children and starting a family, loneliness – for example in connection with holidays – and experiences of failure or success in patients' own lives. During such conversations, participants often shared experiences from their own lives. A precondition for being able to share life experiences was that they had worked through their experiences emotionally. When participants spoke with patients about religious or political topics, they were concerned with being attentive and understanding, but seldom shared their own perspectives. The exception was when they knew the patient well, as one participant pointed out. She gave an example of having talked with a patient about his religious experiences and sharing her own experiences of faith because they had met one another previously in church.

### ***Different views on topics of conversation***

This category had two subcategories:

- To go as deep as possible
- To protect the patient

*To go as deep as possible.* Some participants felt it was important to be as available and attentive as possible when patients took up serious topics from their life history – what they called 'the deepest depths.' This could refer to traumas from childhood such as incest or neglect. These participants felt that when patients took up such topics, it was important to take time to explore them. Several participants had such conversations in secret, because 'therapeutic conversations' were supposed to be reserved for doctors and psychologists.

To go as deep as possible was also about different life topics, such as politics and religion, when the patient brought these up. One participant remarked:

*'If it's normalisation we're after, we can't shield them from the world, whether it's about religion,*

*politics, sex or how we live in the moment. I think we should be a little less scared to talk about these issues, actually.'*

These participants also thought it was important to explore the patients' experiences of their mental suffering, for example, to talk about psychosis. One pointed out that psychosis could be a real world for the patients, and that it was therefore important to discuss this with them, if the patients were open to doing so.

*To protect the patient.* Other participants, however, were concerned about protecting the patient against conversations that 'went in depth'. They therefore kept conversations light rather than tackling 'serious topics', especially if the patient was going through a difficult period. They avoided speaking about both mental health problems and existential questions. One put it like this:

*'Conversations about existential matters can make the patient worse. We have to be careful, because patients are vulnerable and weak and have to be treated with care.'*

One important reason these participants gave for not talking with patients about existential questions or about their mental illness was that they feared such conversations could harm patients.

### **Methodological discussion**

That each group met several times contributed to a productive group dynamic, which created a broad range of ideas and viewpoints, and expanded the data material (Hummelvoll, 2008). One strength was that participants felt able to express different opinions – often disagreement. They were not concerned with reaching consensus quickly. The use of group interaction as data might allow exploration of insights that would otherwise remain hidden. A methodological limitation is the small sample from one community mental healthcare centre, which makes comparison with other centres difficult; there are reasons to think that healthcare personnel from other centres might think and act differently. It is also a limitation that only half of the healthcare personnel participated as more participants might have contributed to more nuances in the data.

### **Discussion**

The aim of this study was to describe and explore what the health professionals focused on in recovery oriented conversations with patients in a Norwegian community mental healthcare centre. The main findings are the three categories: prerequisites for conversation, the focus of conversation and different views on topics of conversation, presented in Table 1, above.

We have organised the discussion into four themes inspired by the person-centred processes in the framework of McCormack and McCance (2010). The themes are:

- Patients' beliefs and values
- Shared decision making
- Engagement
- Sympathetic presence

#### ***Patients' beliefs and values***

Working with patients' beliefs and values involves getting to know the person and supporting the process of finding out what is important and valuable in his or her life. The findings reveal that conversations between patients and staff often focused on concrete everyday life issues. Conversations about such issues made it possible to establish a common ground as well as to develop personal and social contact through which patients could talk about more central issues of life, such as values and beliefs (Lorem, 2006). In addition, it was of great importance that professionals showed interest in how mental health problems affected patients' daily lives, valued what might be seen as trivialities and acknowledged the 'little things' that might be important. This is connected to the importance of professionals' appreciation of patients as an individual human beings (Borg, 2007).

Work with patients' beliefs and values could be interpreted as actions and attitudes that support the patient and create hope for the future, for instance, identifying strengths and determining goals. Recovery has to do with finding a new identity and redefining the self, according to Anthony (1993). To talk about life in general by focusing on the patient's life history and existential and religious sides of life, as some participants did, can help the person to rediscover meaning in life. Spirituality is seen as an important component of individual recovery (Leamy et al., 2011). Conversations that address feelings may contribute to the person's sense of self, which, according to Kitwood's (1997) definition of person-centredness, is linked to being recognised, respected and trusted.

### ***Shared decision making***

Shared decision making has to do with facilitating patient participation in decisions affecting them, and is closely linked to working with patients' beliefs and values (McCormack and McCance, 2010). This is because it involves a process of negotiation that takes account of individual values and preferences (McCormack and McCance, 2006). However, Drake et al. (2009) claim that, for various reasons, persons with mental health problems may lack the information, empowerment, motivation and self-efficacy needed to participate in shared decision making. The findings of this study reveal that participants were concerned with helping the patients to find their own solutions and stimulate their reflections about everyday life challenges. These approaches can be related to supporting patients to take back control and get on with their lives. Highlighting strengths, stimulating reflection and finding solutions can help patients to be viewed as actors in their own life and in the shared decision making process. Strengthening patients' self-efficacy seems to be of fundamental importance in person-centred care as well as in recovery (Davidson, 2003; Borg and Davidson, 2008).

In this study, participants described their role of facilitating negotiation with patients about everyday life challenges. This suggests that the professionals assessed patients' values as central in decision making processes. They took account of the patient to form a common basis for action. Negotiation stimulates partnership and mutuality, and is central to the process of shared decision making (McCormack and McCance, 2010). But although the participants placed emphasis on ensuring that patients had the space to make decisions concerning their daily lives, in our experience there may be tension between a hierarchical power structure in the hospital context, in which decision making tends to be top-down, and patients' opportunities to make their own decisions concerning their recovery process. This is also described by Chen et al. (2013).

### ***Engagement***

In the recovery literature, engagement involves developing a collaborative working relationship with patients and attending to their recovery needs (Chen et al., 2013). The participants in this study were concerned with developing trust because of its importance in developing a collaborative relationship (Laugharne et al., 2012). Friendly and positive health professionals can create a milieu that nurtures recovery processes (Glover, 2005).

McCormack and McCance (2010) point out that engagement also has to do with recognising what the health professionals bring to the relationship, as the participants in this study did when they shared personal matters with patients. Professionals who give something of themselves, disclose aspects of their own personal lives and even bend rules, can alter patients' expectations of staff (Topor et al., 2006; Laugharne et al., 2012). This can be experienced by patients as being chosen and given special treatment, and is important for the recovery process (Topor et al., 2006). When both parties share, they can develop a relationship based on a sense of equality and sameness, which challenges professional standards of not sharing and of therapeutic neutrality (Karlsson et al., 2013).

It has been demonstrated that creating hope is important in the recovery process, as highlighted by this study's participants (Deegan, 1988; Leamy et al., 2011). Loss of hope can lead to giving up or withdrawal and may inhibit inpatients' outlook regarding opportunities for the present and the future

(Chen et al., 2013). Herrestad et al. (2014, p 1) argue that 'hope is a concept that opens different rooms for action in different contexts and that, accordingly, all interventions to create hope are contextually sensitive'. We see the participants' skills in creating 'rooms' for actions related to the patient's hopes as an important part of their engagement.

### ***Sympathetic presence***

Sympathetic presence has to do with both 'being there' and 'being with' patients (McCormack and McCance, 2010, p 100). The findings of this study reveal that the professionals made themselves available for conversations about patients' everyday life situations. Borg and Davidson (2008) found that practitioners who were available, who recognised the person's need for assistance or support in all kinds of practical matters, and who did not give the impression of primarily being interested in symptoms and problems, were highly valued by people with mental illness.

The findings also reveal the value participants placed on sensing the right moment for conversation. According to McCormack and McCance (2010), being available has to do with being authentically present. Focusing on the patient's needs and being attentive and available in the moment are underlined as aspects of sympathetic presence. Ervik et al. (2012) found that such a sense of moment could be understood as part of a largely spontaneous and informal approach to collaborative work with the patient, based on here and now. They emphasise that a prerequisite of such an approach is that health professionals are able to identify opportunities for collaboration, that they acknowledge the uniqueness and value of the individual, and that they act in the situation using their own background knowledge, experience and abilities. This can also be linked to attributes of the health professionals, as described by McCormack and McCance (2010) – in particular knowing the other person and having interpersonal intelligence. A strong interpersonal skill base is needed to develop a person-centred way of working.

The findings further indicate participants' differing approaches to addressing the suffering of the patient and differing views on topics of conversation. Those who discussed 'everything as deeply as possible' seemed to feel that they possessed the personal skills, experience and competence to do so responsibly. Others held back and acknowledged their own vulnerability in facing such themes, emphasising the importance of having competence and the need for support mechanisms such as clinical supervision. Such differing approaches may be linked to different levels of practitioner competence, according to McCormack and McCance (2010).

The findings also show that the health professionals' comprehension of how deeply they should go in their conversations with patients was connected to their views on protecting the patient. It is important that health professionals recognise the patient's vulnerability; this can be linked to respect for the zone of vulnerability we all have (Løgstrup, 2008). However, another perspective on protection of the vulnerable patient is the influence of the biomedical paradigm, which in our experiences as nurses views the patient as helpless and in need of expert help. McCance et al. (2013) suggest that within the biomedical paradigm, it might be more challenging to work with clear principles that promote participation and collaboration with the patient.

### **Conclusion**

We identified characteristics within the context that gave opportunity for recovery oriented conversations with patients. By focusing on patients' everyday lives, appreciating them as actors in their own lives and in shared decision making processes, and working with hope, this study documents a practice that is both person-centred and recovery oriented. The findings reveal ways of collaborating with the patient. Recovery oriented conversations can be understood as conversations linked to connectedness, hope and optimism about the future, identity, meaning in life and empowerment. The study demonstrates that individual, cultural and contextual aspects play an important part in recovery oriented conversations.

The content of the conversations indicates that there was some tension in the centre about the professionals' understanding of what collaboration with patients was all about. There were also diverse opinions about whether professionals should engage in informal conversations with patients. Several members of the professional team found their own ways of practising person-centred and recovery oriented care; they were professionally independent and followed humanistic values in their practice. Others were unsure about their professional role, and described how nurses and other healthcare personnel could feel unempowered and so follow the directions of the medical professions.

The findings suggest that practice developed in the form of dialogue based teaching, in which attention was focused on the skills associated with conversations with patients, which can stimulate the health professionals to be more conscious of these conversations, and enhance person-centred care and recovery processes.

### Implications for practice

- Practice development involves acknowledging and re-evaluating the possibilities for using conversations with patients as an approach and as a tool in person-centred and recovery oriented practices
- Relational competence is an essential part of enhancing recovery oriented conversation and needs to be attended to in skills training and competence building
- Awareness and critical analysis of the clinical context is important to promote an active and participative patient role. Authoritarian cultures with concern about what is and is not permitted may well be a barrier to shared decision making
- Creating hope and acknowledging everyday life issues are important parts of collaborative practices in recovery and person-centredness, and need to be integrated in the knowledge base and practice development
- Personal sensitivity and reflexivity are valued professional skills in recovery orientation and person-centred practices. Training and development programmes need to attend to these skills

### References

- Anthony, W. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*. Vol. 16. No. 4. pp 11-23.
- Borg, M. (2007) *The Nature of Recovery as Lived in Everyday Life: Perspectives of Individuals Recovering from Severe Mental Health Problems*. Trondheim, Norway: Norwegian University of Science and Technology.
- Borg, M. and Davidson, L. (2008) The nature of recovery as lived in everyday experience. *Journal of Mental Health*. Vol. 17. No. 2. pp 129-140.
- Chen, S-P., Krupa, T., Lysaght, R., McCay, E. and Piat, M. (2013) The development of recovery competencies for inpatient mental health providers working with people with serious mental illness. *Administration and Policy in Mental Health*. Vol. 40. No. 2. pp 96-116.
- Davidson, L. (2003) *Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia*. New York: New York University Press.
- Davidson, L., Tondora, J., Lawless, M., O'Connell, M. and Rowe, M. (2009) *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care*. New York: Oxford University Press.
- Deegan, P. (1988) Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*. Vol. 11. No. 4. pp 11-19.
- Drake, R., Cimpean, D. and Torray, W. (2009) Shared decision making in mental health prospects for personalized medicine. *Dialogues in Clinical Neuroscience*. Vol. 11. No 4. pp 455-463.
- Ervik, R., Sælør, K. and Biong, S. (2012) Å gripe øyeblikket. Om hvordan miljøansatte ved et lavterskelhybelhus erfarer samarbeidet mellom seg og beboerne. (Grasping the moment. About how milieu professionals at a halfway house experience collaboration between themselves and residents). *Tidsskrift for Psykisk Helsearbeid*. Vol. 9. No. 4. pp 302-313.
- Fredriksson, L. (1999) Modes of relating in a caring conversation: a research synthesis on presence, touch and listening. *Journal of Advanced Nursing*. Vol. 30. No. 5. pp 1167-1176.



- Glover, H. (2005) Recovery based service delivery: are we ready to transform the words into a paradigm shift? *The Australian e-Journal for the Advancement of Mental Health*. Vol. 4. No. 3. pp 1-4.
- Graneheim, U. and Lundman, B. (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*. Vol. 24. No. 2. pp 105-112.
- Gunderson, J. (1978) Defining the therapeutic processes in psychiatric milieus. *Psychiatry*. Vol. 41. No. 4. pp 327-335.
- Hellevik, O. (2002) *Forskningsmetoder i Sosiologi og Statsvitenskap* (Research Methods in Sociology and Political Science). Oslo: Universitetsforlaget.
- Herrestad, H., Biong, S., Borg, M., Karlsson, B. and McCormack, B. (2014) A pragmatist approach to the hope discourse in healthcare research. *Nursing Philosophy*. DOI: 10.1111/nup.12053.
- Hummelvoll, J. and Severinsson, E. (2005) Researchers experience of co-operative inquiry in acute psychiatric care. *Journal of Advanced Nursing*. Vol. 52. No. 2. pp 180-188.
- Hummelvoll, J. (2008) The multistage focus group interview: a relevant and fruitful method in action research based on a co-operative inquiry perspective. *Norsk Tidsskrift for Sykepleieforskning*. Vol. 10. No. 1. pp 3-14.
- Karlsson, B., Borg, M., Revheim, T. and Jonassen, R. (2013) To see each other more like human beings... from both sides. Patients and therapists going to a study course together. *International Practice Development Journal*. Vol. 3. No. 1. pp 1-12.
- Kitwood, T. (1997) *Dementia Reconsidered: The Person Comes First*. Milton Keynes: Open University Press.
- Laugharne, R., Priebe, S., Cabe, R., Garland, N. and Clifford, D. (2012) Trust, choice and power in mental health care: experiences of patients with psychosis. *International Journal of Social Psychiatry*. Vol. 58. No. 5. pp 496-504.
- Leamy, M., Bird, V., LeBoutillier, C., Williams, J. and Slade, M. (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*. Vol. 199. No. 6. pp 445-452.
- Loem, G. (2006) *Withdrawal and Exclusion: A Study of the Spoken Words as Means of Understanding Schizophrenic Patients*. Doctoral thesis. Tromsø, Norway: Institute of Community Medicine and Institute of Philosophy, University of Tromsø.
- Løgstrup, K. (2008) *Den Etske Fordring* (The Ethical Claim) (3<sup>rd</sup> edition). Copenhagen: Gyldendal.
- McCance, T., Gribben, B., McCormack, B. and Laird, E. (2013) Promoting person-centred care within acute care: the impact of culture and context on a facilitated development programme. *International Practice Development Journal*. Vol. 3. No. 1. pp 1-17.
- McCormack, B. and McCance, T. (2006) Developing a conceptual framework for person-centred nursing. *Journal of Advanced Nursing*. Vol. 56. No. 5. pp 472-479.
- McCormack, B. and McCance, T. (2010) *Person-Centred Nursing. Theory and Practice*. Oxford: Wiley-Blackwell.
- Morse, J., Bottorff, J., Neander, W. and Solberg, S. (1991) Comparative analysis of conceptualizations and theories of caring. *Journal of Nursing Scholarship*. Vol. 23. No. 2. pp 119-126.
- Norwegian Directorate of Health and Social Affairs (2006) *Distriktspsykiatriske Sentre - med Blikket Vendt mot Kommunene og Spesialiserte Sykehusfunksjoner i Ryggen* (District Psychiatric Centres - With Eyes on Municipalities and Back up from Specialized Hospital Functions). Oslo: Norwegian Directorate of Health and Social Affairs.
- Norwegian Directorate of Health (2012) *Nasjonal Faglig Retningslinje for Utredning, Behandling og Oppfølging av Personer med Samtidige Lidelser*. (National Guidelines for Assessment, Treatment and Follow up of People with Both Mental Health Problems and Addiction Problems). Oslo: Norwegian Directorate of Health.
- Oeye, C., Bjelland, A., Skorpen, A. and Anderssen, N. (2009) User participation when using milieu therapy in a psychiatric hospital in Norway: a mission impossible? *Nursing Inquiry*. Vol. 16. No. 4. pp 287-296.
- Perkins, R. and Slade, M. (2012) Recovery in England: transforming statutory services? *International Review of Psychiatry*. Vol. 24. No. 1. pp 29-39.



- Reason, P. (1994) Three approaches to participative inquiry. Chp 20 in Denzin, N. and Lincoln, Y. (Eds.) (1994) *Handbook of Qualitative Research*. London: Sage. pp 324-339.
- Skatvedt, A. (2009) *Alminnelighetens Potensial. En Sosiologisk Studie av Følelser, Identitet og Terapeutisk Endring* (The Potential of the Commonplace. A Sociological Study of Emotions, Identity and Therapeutic Change). Oslo: University of Oslo.
- Skatvedt, A. and Scheffels, J. (2012) Virksom uvirksomhet? Pauser som arenaer for følelsesmessig berøring og biografisk bevegelse (Working inactivity? Pauses as arenas for emotional touching and biographical movement). *Sosiologi i Dag*. Vol. 42. No. 1. pp 37-56.
- Slade, M. and Priebe, S. (2006) *Choosing Methods in Mental Health Research. Mental Health Research from Theory to Practice*. London: Routledge.
- Slade, M. (2009) *Personal Recovery and Mental Illness. A Guide for Mental Health Professionals*. Cambridge: Cambridge University Press.
- Slade, M., Leamy, M., Bacon, F., Janosik, M., LeBoutillier, C., Williams, J. and Bird, V. (2012) International differences in understanding recovery: a systematic review. *Epidemiology and Psychiatric Sciences*. Vol. 21. No. 4. pp 353-364.
- Tew, J. (2011) *Social Approach to Mental Distress*. Basingstoke, UK: Palgrave Macmillan.
- Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J. and Boutillier, C. (2012) Social factors and recovery from mental health difficulties: a review of the evidence. *British Journal of Social Work*. Vol. 42. No. 3. pp 443-460.
- Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I. and Davidsson, L. (2006) Others: the role of family, friends and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation*. Vol. 9. No. 1. pp 17-37.
- Topor, A., Borg, M., DiGirolamo, S. and Davidson, L. (2011) Not just an individual journey: social aspects of recovery. *International Journal of Social Psychiatry*. Vol. 57. No. 1. pp 90-99.
- Whitely, S. (2004) The evolution of the therapeutic community. *Psychiatric Quarterly*. Vol. 75. No. 3. pp 233-248.
- Wilkinson, S. (2004) Focus group research. Chp 9 in Silverman, D. (Ed.) (2004) *Qualitative Research: Theory, Method and Practice*. Thousand Oaks, California: Sage. pp 177-199.
- Williams, C. and Tufford, L. (2012) Professional competencies for promoting recovery in mental illness. *Psychiatry, Interpersonal and Biological Processes*. Vol. 75. No. 2. pp 190-201.
- World Health Organization (2013) *Comprehensive Mental Health Action Plan, 2013- 2020*. Geneva: WHO.
- World Medical Association (2008) *Declaration of Helsinki. Ethical Principles for Medical Research Involving Human Subjects*. Geneva: WHO. Retrieved from: [www.wma.net/en/30publications/10policies/b3/](http://www.wma.net/en/30publications/10policies/b3/) (last accessed 4<sup>th</sup> April 2014).

### Acknowledgements

The authors would like to thank Professor Jan Kåre Hummelvoll, Hedmark University College, Norway, for support and supervision in planning and implementation of the project.

**Ellen Andvig** (RPN, CANSAN), Associate Professor at the Faculty of Health Sciences, Buskerud and Vestfold University College, Drammen, Norway.

**Stian Biøng** (DrPH, RN), Professor, Faculty of Health Sciences, Buskerud and Vestfold University College, Drammen, Norway.