

*SPECIAL ISSUE*

***CLIENT-CENTRED PRACTICE: AN EXCHANGE OF  
VIEWS***

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# Ask, Listen and Learn: What Clients with a Mental Illness Can Teach You about Client-Centred Practice<sup>1</sup>



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## *Abstract*

**Context:** Professionals providing treatment and rehabilitation for people with severe and persistent mental illness need to re-focus on clients assets and lived experiences.

**Objective:** To provide an overview of the complementary philosophies of psychosocial rehabilitation, client-centred practice and qualitative inquiry.

**Method:** In this article we report findings from a number of qualitative studies that demonstrate what can be learned by asking, listening and learning from persons living with severe and persistent mental illness. Therapists are challenged to relinquish outdated assumptions and practices and are provided with a 'to do' list for implementing client-centred practice, that is grounded in a client's perspective and carried out in a client-friendly way.

**Conclusion:** There is a core set of ideological values that are integral to providing client-centred care. Adopting these values in everyday practice can enrich a professional's appreciation of a person's lived experience of mental illness and focus services toward meeting his or her needs.

**Key Words:** client-centred practice, psychosocial rehabilitation, qualitative research, mental illness

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## One Therapist's Experience of Listening to Clients and Changing Her Approach to Practice

When describing what she learned from a qualitative research study with clients with severe and persistent mental illness, Susan Nagle (1997) wrote:

*As an occupational therapist I prided myself on the fact that I stressed clients' strengths and did not focus on their illness. The findings of this study have made me step back and recognize that I should give a client's illness more thought. Though I always want to emphasize what clients can do I must remember that the illness experience is a devastating one that continues to impede occupational engagement. . . I did not appreciate how much work they undertook to manage and control illness' (p 219) . . . we must give credence to how they have made sense out of their lives. We need to trust in their choices. . . (p 220). . . People knew themselves really well and from knowing themselves very well, they were able to make informed choices. Choices of what to do, choices of where to do it and who to do it with. I think there's a myth that sometimes people say that people who have a mental illness are unmotivated. I didn't find anybody who was unmotivated. Some people were doing more than other people. It wasn't because they were unmotivated but because they had made active choices based on what they knew about themselves. Based on, if I do more, I'm not going to feel well. Another thing that really impressed me is how important social connections were. Some people said to me, 'I could do more, but then I wouldn't have time for the people that I care about'. They recognized that doing more meant giving up something else. . . They'd come up with that balance that made them more content and kept them healthy, and kept them happy (p 186)*

Nagle's reflections on what she learned from the participants in her study and how that knowledge challenged her previously held assumptions and altered the manner in which she practised occupational therapy illustrate the title and lesson of this chapter.

In this chapter we will explore the way in which client-centred practice in the field of mental health can be implemented successfully and with satisfaction for both the client and the therapist simply by asking, listening and learning from the expertise of those who live with the illness.

The proposition that we can learn by asking and listening is based upon two primary philosophies: the principles and practices of psychiatric rehabilitation (including the process of recovery) and qualitative research studies. Both of these philosophical approaches are compatible with the core values of occupational therapy and its advocacy of client-centred practice.

## Psychiatric Rehabilitation and Recovery: Principles and Practices

In their definitive text on psychiatric rehabilitation, Anthony et al (2002) provide concise summaries of the key values and basic principles of this approach to practice (Boxes1–2).

### Box 1 Basic principles of psychiatric rehabilitation

- ❑ A primary focus of psychiatric rehabilitation is on improving the capabilities and competencies of persons with psychiatric disabilities.
- ❑ The benefits of psychiatric rehabilitation for the clients are behavioural improvements in their environment of need.
- ❑ Supporting dependency can lead to an eventual increase in independent functioning
- ❑ The two fundamental interventions of psychiatric rehabilitation are the development of skills and the development of environmental supports.
- ❑ The focus of psychiatric rehabilitation is on improving residential, educational and vocational outcome for persons with psychiatric disabilities.
- ❑ Active participation and involvement of individuals in their rehabilitation process is the cornerstone of psychiatric rehabilitation
- ❑ Long-term drug treatment is an often necessary but rarely sufficient complement to a rehabilitation intervention.
- ❑ Psychiatric rehabilitation is eclectic in the use of a variety of techniques.
- ❑ Hope is an essential ingredient of the rehabilitation process.

Reproduced with permission from Anthony et al 2002

### Box 2 Key rehabilitation values

- ❑ Person orientation: A focus on the human being as a whole, rather than as diagnostic label or illness.
- ❑ Functioning: A focus on performance of everyday activities.
- ❑ Support: A focus on providing assistance for as long as it is needed and wanted.
- ❑ Environmental specificity: a focus on the specific context of where a person lives, learns, socializes, or works.
- ❑ Involvement: A focus on including individuals as full partners in all aspects of rehabilitation.
- ❑ Choice: A focus on the person's preferences throughout the process.
- ❑ Outcome orientation: A focus on evaluating rehabilitation in terms of impact on client outcomes.
- ❑ Growth potential: A focus on improvement in a person's success and personal satisfaction, regardless of the person's current difficulties.

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Consistent with the emphasis on growth potential and the principle of hope, the process of recovery from mental illness is receiving greater notice within the literature and programme models. Drake (2000) emphasises that individuals with severe and persistent mental illnesses still need to believe that life offers a better future, that they can manage their own illnesses with support from professionals, and that they can attain satisfaction in normal, personally meaningful adult roles. The mental health consumer (client) literature suggests that recovery is a very personal process that involves attention to attitudes, values, feelings, goals, skills and roles in life (Anthony 2000, Deegan 1993). A qualitative study that explored the concept of recovery from a

client perspective concluded that building an improved sense of self prevents the individual from being overwhelmed by the illness, and helps them move toward control over their illness (Davidson & Strauss 1992). Herman's (1992) work indicates that feelings of being helpless and a perception of social isolation are part of the experience of recovery from traumatic illness. Occupational therapists can apply this learning in a client-centred practice by facilitating client empowerment and reconnection with society as part of the individual's recovery plan.

The emphasis in psychiatric rehabilitation on the necessity for client participation and active involvement in choosing, getting and keeping satisfying occupational roles indicates that asking, listening to and learning from clients is crucial to successful outcomes.

### **The Values and Strategies of Qualitative Research**

Cook (2001) examined the way in which the values, beliefs and language of occupational therapy are consistent with those of qualitative research inquiries. She stated:

*'Qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them' (Denzin & Lincoln 1994), and 'Enabling occupation means collaborating with people to choose, organize and perform occupations which people find useful or meaningful in a given environment' (CAOT 1997). These two quotations reflect many of the values and beliefs that the profession of occupational therapy and the adherents of qualitative inquiries hold in common. Both hold a view of reality in which the person's perspective and meanings attached to actions are central to understanding human behaviour. Therefore, in order to make sense of others' behaviour, close, intimate interaction between the experiencer and the learner is essential. Both occupational therapists and qualitative researchers recognise that the individual has the knowledge and expertise of the phenomenon of study and that we are often the learners, not the experts (p 3–4)*

The principles and strategies of qualitative research are based on the beliefs that the qualitative researcher cannot have any preconceived hypotheses when entering a study, that the emic perspective (the perspective of the individual experiencing the phenomenon) is critical, and that the importance of subjective meaning is paramount to understanding the phenomenon under study. The strategies used for data collection such as in-depth interviews, participant observation in the natural setting, focus groups and participant action research (PAR) further emphasise the belief that the individual experiencing the phenomenon is the expert (Corring 2001a,b, Laliberte-Rudman & Moll 2001, Rebeiro 2001a). Respect for the participants' expertise regarding the phenomenon of interest is fundamental to ensuring evidence-based practice (Corring 2004a). Spradley (1979, p 34) expresses this value as follows:

*I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand?*

Occupational therapy's values and beliefs about occupation and occupational beings fit with the qualitative research paradigm. We can use qualitative strategies in everyday practice settings to begin to understand the world our clients live in as they learn to cope with mental illness. The questions we as occupational therapists ask when we conduct research as part of our everyday work with clients, are the kinds of questions that can only be answered with methods that are capable of capturing process and meaning, rather than linear causality and variable relationships of discrete parts of the occupational person (Cook 2001).

### **Implementing a Client-Centred Model: Relinquishing Outdated Assumptions and Practices**

Occupational therapists must challenge the perceptions/assumptions we have all learned that persons with mental illness are helpless, unable to make decisions for themselves and without hope for recovery. As Deegan (1992, p 12) states, the central attitudinal barrier to recovery is that:

*psychiatric disabilities cannot be self-determining because to be mentally ill means to have capacity for sound reasoning. It means one is irrational and crazy. Thus all of the thoughts, choices, expressions, etc. of persons who have been diagnosed with mental illness can be ignored.*

These outmoded ways of thinking about mental illness have influenced our services in a manner that perpetuates dependence and lack of choice and control for clients. Adopting the values and principles of rehabilitation, recovery and qualitative inquiry necessitate changes in our way of thinking and doing in our work with persons with mental illness

In the results of one of the first qualitative studies conducted to explore the definition of client-centred care from a client perspective (Corring & Cook 1999), clients talked of the negative attitudes they had experienced in their relationships with service providers. They provided examples of derogatory attitudes, sarcasm, indifference and stigma. This has led them to be cautious in their relationships with professionals, and in many cases to have settled for less than what might have been possible as they integrate the negative attitude toward mental illnesses found not only in society, but also in the places they seek help into their own self-concept. In a qualitative study looking at quality of life issues for individuals with severe and persistent mental illness, clients described the benefits of supportive relationships with professionals. Taking the time to listen, to be kind, to be understanding, to treat them like an adult and to not judge them were emphasised as critically important to the person receiving services (Corring 2004b).

The identity of therapist as ‘expert’ has to be put aside and replaced with a focus on understanding the client’s perspective of their illness and how to facilitate occupation in an environment of their choice. Occupational therapists have to give up practice elements that have their beginnings in the medical model. We have to give up our views on what everybody ‘should do’ and focus on what they ‘want to do’. Occupational therapists have to stop using the DSM-IV as a primary reference point and use instead the lived experience of the client as the primary reference point. Occupational therapists have to give up the notion that these clients ‘can’t do’ and focus on what they *can* do. Performing a functional assessment that looks at what a client can’t do, sends a message to your client that you are focusing on their deficits before getting to know them as an individual, and may result in them lowering their expectations about themselves and their abilities. Professionals who do not seek to understand the person behind the illness, who treat the individual as an illness rather than as a human being, and who fail to respect the individuality of the person’s needs, add to the burden of those living with the illness (Corring 2004b).

Professionals, including occupational therapists, must stop thinking about what is different about the world of the person with a severe and persistent mental illness and focus instead on understanding what things in their world mean to the individual. We need to stop the practice of asking retrospective questions to inform our treatment and rehabilitation plans, and replace them with our observations of the ‘ordinary round of everyday activities’ in their life (Angrosino 1998, p 268). Angrosino relates his work with a client named Vonnie Lee, a person labeled as mentally retarded. He talks of what he was able to learn and understand about Vonnie’s world once he allowed himself to think differently:

*My encounter with Vonnie Lee taught me that his worldview was not a failed approximation of how a ‘normal’ person would cope, nor was it, when taken on its own terms, intrinsically disordered. His fixation on the bus is only ‘disordered’ or an ‘attempt at adjustment’ if we assume the rest of us are not without our own fixed ideas regarding the world and our place in it. Were we to suffer the misfortune of being labeled ‘retarded’, would all of our ideas, attitudes, and practices stand up to scrutiny as being unimpeachably ‘normal’? Once we start looking for evidence of ‘disorder’, then ‘disorder’ is almost certainly what we find. If anything, Vonnie Lee’s logic is more clearly worked out and better integrated than that of more sophisticated people; his ‘retardation’ may, indeed, lie in the way he has purified his obsession down to its basics rather than veiling it in varieties of symbolic discourse like ‘normal’ people do. Interviewing him in a way that arose out of normal activity did not merely ‘contextualize’ his disorder; it removed the emphasis on disorder altogether (p 267).*

The importance of listening to the person’s story, exploring the subjective experience of the person experiencing the illness, and not making premature assumptions about their world should



be a part of our everyday work, says psychiatrist John Strauss (1994). Doing so will deepen our understanding of what it is like to live everyday with a mental illness, and perhaps shed new light regarding what is 'normal' or 'abnormal'. In a qualitative study exploring quality of life issues for persons living with severe and persistent mental illness, participants emphasised their wish to be seen as a 'normal' human being, and to be accepted as normal by the rest of society (Corring 2004b). Not being seen as 'normal' results in the continuing stigmatisation of the mentally ill, and thus decreases their opportunities for fulfilling their goals and dreams for the future. Many have settled for much less than they might have, given a different response from society. The paradox of disability, as Hasselkus (2002) points out, is that people with disabilities are caught between the need to recognise and accept their disabilities as part of themselves while desiring to see themselves as 'normal'. She challenges occupational therapists to moderate our tendency to divide the world into those who are able and those who are disabled. She encourages us to see the world as 'a many-peopled place, one full of all kinds of persons with great diversity in body and mind, all of which are "normal" in their own way relative to each other' (p 56).

Challenges to our outdated assumptions and practices can be found in studies of client perspectives on issues important to them.

### **Lessons Learned: Studies of the Client Perspective on Issues in Mental Health**

The following summaries of qualitative studies with persons with a mental illness illustrate how asking, listening carefully and learning from these experts can teach us a great deal about implementing client-centred practice. These studies provide descriptions of how clients perceive themselves, how they want to be perceived and treated, what they value, what they enjoy doing, what they want to do, and how much and in what circumstances they want to do it. By listening carefully to what they told the researchers, we can change and adapt our previously established routines of practice, and hopefully enable more satisfying and successful lives for our clients. These studies have implications for promoting health and management of illness based on the important lessons provided to us through client experiences of severe and persistent mental illness.

#### *Client perception of client-centred care*

Corring and Cook (1999) describe the elements of client-centredness from a client perspective. The results focus on two themes: the client in the client–service provider relationship and the client in the social and mental health service systems. Clients describe what's wrong, what's needed and how they have been affected. Clients defined client-centred care as requiring the service provider to adopt a caring, positive and welcoming attitude, to develop full relationships with their clients, to find common ground with their clients in order to build partnerships, to ensure that clients are involved in informed decision-making, to facilitate recovery, to not tolerate stereotyping and stigmatising behaviours, to ensure accountability and to advocate for laws that protect vulnerable individuals (Corring 1996, 2004a). Perhaps occupational therapists should



assess the client-centredness of their practice using these parameters.

### *Client satisfaction*

Client satisfaction with services has been emerging as an important outcome domain within the mental health field. The direct involvement of consumers of mental health programmes in the development of outcome measures is a recent phenomenon and coincides with the trend of consumerism. In a qualitative study that used in-depth interviews, service recipients of a Program of Assertive Community Treatment (PACT) team were asked what characteristics of the service they found satisfying. Findings were organized into two major themes: the direct services provided by the team that they found helpful, and the benefits of the helping relationship offered by the PACT clinicians (Raymond 1999). We can learn from this study that it is not so much what we do, but our manner of doing.

### *Occupational deprivation*

In a study that explored the experience of occupational deprivation, MacGregor (1995) was 'alarmed' that:

*informants reported that health professionals, rather than being empathetic and supportive, were perceived as patronising, controlling, focused on disability rather than ability, unwilling to listen to the issues in the informants' lives and generally unaware of the concerns of individuals with disabilities . . . One informant discussed how an occupational therapist saw her only as a patient in a psychiatric hospital. . . ignoring the fact that the individual had recently completed an honours bachelor's degree (p 75).*

The informant described her distress at being directed to hook an ice cream cone rug when a few weeks earlier she had been studying textbooks in preparation for exams. A professor of anthropology described the experience of making a door mat in occupational therapy with similar contempt (Murphy 1986).

These two studies exemplify the negative impact of ignoring the principles and values cited earlier in this paper in Boxes 1 and 2.

### *The client in the community*

Another qualitative study used a narrative approach to explore a client's life story of living with a severe and persistent mental illness. Three main themes were identified: the early years, being in hospital and being in the community. The first theme was organised into two categories that recounted experiences of early family life in a family living in poverty. The second theme revealed the client's experience with early symptoms of illness leading to hospitalisation, the experience of being in hospital and the learning that occurred in hospital. The final theme

described previous attempts at community living that were unsuccessful, the current successful experience of community living, the realisation that there was more to learn, and future hopes and dreams. Reading this client's story enables the reader to gain an understanding of the life experience of one client living with severe and persistent mental illness (Labbe & Corring 2003).

Over the last 30 years, people with severe and persistent mental illness have moved from traditional institutional settings into the community. Little attempt has been made, however, to understand the client's experience of living in community-based residential settings and their perceptions of what makes for a satisfactory quality of life. A qualitative single case study explored one client's life experiences within two community based settings. The overall theme that emerged was the importance of having a dream. Embedded in this theme was the importance of various environmental characteristics and their impact on the client's quality of life. Important environmental characteristics included personal freedom and choice, physical environment, social environment, opportunities to learn new skills, presence of structure without restriction and opportunities to live a 'normal life' (Mallon 1999). Studies by Rebeiro and Cook (1999) and Rebeiro (2001b) also describe the importance of social and cultural environmental factors in providing clients with satisfying experiences. Therapists can learn from these studies that the occupational contexts are every bit as important as the occupational doing and merit their attention.

### *Leisure*

Occupational therapy emphasises having a balance in one's occupations. However, leisure is often focused on less, due to the seemingly 'more important' areas of self-care and productivity. Various studies have identified leisure as an important factor in improving life satisfaction and overall well-being for individuals without mental illnesses. Studies of leisure involving individuals with mental illness living in the community are sparse.

- ❑ A qualitative study that examined the perspective of individuals with mental illness living in the community regarding how involvement in leisure impacts their life found two key themes (Casier & Corring 2003): the first theme identified the importance of a healthy balance of 'work' and leisure in one's life; the second theme identified barriers and enablers to leisure involvement. Findings emphasised the important role that leisure plays in the lives of individuals living in the community with a mental illness.
- ❑ A study of the enjoyment experiences of clients by Emerson et al (1998) also indicated the importance of leisure activity as a valued occupation. One of her surprising findings was how often her participants most enjoyed solitary leisure pursuits.
- ❑ In a study of the daily routines of persons with a mental illness, Cheema et al (2002) reported that many of their participants had no routines other than contact with a mental health professional, and that the primary leisure activities were drinking coffee and smoking.

These studies illustrate the need for occupational therapists to pay attention to issues of leisure and also to understand that, contrary to previous practice, these may not necessarily require clients to participate in social groups.

### *Work and productivity*

A study that examined the lived experience of work for individuals living with mental illnesses found that there were many challenges that work presents for them. Themes included the challenges in their pursuit of employment, the benefits they felt as part of a supported work programme and finally the importance of work in terms of self-esteem, self-confidence, adding structure to the day, overall life satisfaction, socialization and a feeling of contributing to society (Willis 2000). Corring (2004b) reports the importance of part-time employment in consumer-run alternative businesses to the individual's quality of life. Rebeiro and Allen (1998) also report the satisfaction and enhanced self-esteem experienced by a person working as a volunteer.

In a study exploring the role of work or/and its lack in the lives of persons with a mental illness, Nagle et al (2002) reported that although clients expressed the hope or desire to be employed, many are striving to maintain a balance between their social lives, what they do and their health; as the title of the article states, they are 'doing as much as I can'.

All of these articles suggest that our ways of thinking about work and productivity need to be re-conceptualised. While it is important for therapists to continue to understand the value of work in people's lives, we also need to understand the work involved in managing the day-to-day experience of a severe illness. This awareness should enable us to understand the seeming contradiction between a client's desire for paid work and their reluctance or inability to pursue it at any particular point in time. However, it should be emphasised that this does not mean lowering expectations or diminishing a vision of a future.

### *Self-care*

Another qualitative study (Rowan 1999) that asked individuals with mental illness how they would define self-care indicated that self-care involved several broad components, including health practices, coping mechanisms, responsibility and routines, enjoyment, pleasure and solitude. Factors that impacted a person's function in the area of self-care were the person's state of health and the person's subjective feeling about self. Interventions guided towards the individual's feeling about his/ herself may prove more effective at promoting self-care than interventions targeted directly at the individual's health and hygiene practices. In addition, increased interventions in the areas of coping mechanisms and symptom management may improve the individual's ability to function in all areas, including self-care.

### *Quality of life*

All of the individual lessons that can be derived from these studies are reiterated and comprehensively explored in two studies that examined quality of life issues for individuals living with severe and persistent mental illness (Corring 2002, 2004b). These studies reported that quality of life was dependent on achieving management of the illness, establishing supportive relationships, maintaining meaningful occupation and developing a positive sense of self. Occupational therapists who understand the importance of such experiences can do much to positively impact quality of life for these individuals in a client-centred way.

### **Implementing Client-Cared Practice in Mental Health: A 'To Do' List**

- ❑ Occupational therapists need to recognize that this approach to practice is time intensive, as you have to get to 'know' the client. An hour is not enough to develop goals and a rehabilitation plan. Anthony et al (2002) and Farkas et al (2000) explain in great detail the process of and skills needed for effective rehabilitation. The three phases of psychiatric rehabilitation involve multiple steps in diagnosing a person's readiness for rehabilitation and the required skills and the needs for resource acquisition or modification. The planning phase requires details of the who, what, when, where and for how long of intervening to provide services. The intervention phase puts into action those plans in terms of skill development and use, and resource development and use. An effective process of rehabilitation requires all three phases within an agency designed in terms of the psychiatric rehabilitation values which are consistent with the values of client-centred occupational therapy. In order to accomplish effective rehabilitation, both therapists and their employer must be committed to the time, patience and commitment required to meet the programme objectives.
- ❑ Thus, occupational therapists have to become the cultural leader/ change maker. Occupational therapists need to implement a culture of client-centred/client-directed practice/rehabilitation by living the principles and ensuring the use of appropriate language and practices that fit the culture. In a study of innovation and leadership in mental health, Cook (1995) describes the pivotal role played by an occupational therapist that used her professional values as a resource and mandate for action. By constantly, over a period of 3 years, maintaining a cultural vision and language of client-centred practice she accomplished her goal of instituting individual rehabilitation and support for persons with schizophrenia. The clinic she brought into being was the first of its kind in Canada. This therapist was not in an administrative position when she began her quest, but was able to persuade others to join it. No matter what our position in the agency, community or hospital, we can and must be cultural change agents.
- ❑ Since empowerment is a participatory, learning process that changes power relations, everyday practice is an important arena for producing change. Changes in daily routines, interactions and structures are practical ways of engaging in empowerment, even if these produce only localised shifts in power. For professions who claim to be client-centred, such as occupational therapy, the call is to actually be client-centred in the talk, actions and

structure of everyday practice – to demonstrate and facilitate participation, social change, collaboration, reflection, experience, risk taking and inclusiveness in the everyday arena (Townsend 1998).

- As occupational therapists we must teach, advocate and enable. Winner commented:

*I think it is important to ask yourself who are you working for; what do people say they need; what is the best thing you can do. Advocacy is a big issue – probably more so in mental health but perhaps it's the same in other areas. There are a lot of issues with long term progressive illnesses, from the quality of life that people enjoy, drugs that are covered, or not covered, programming for employment and things like that. You can't do just what your job description says, I think occupational therapists should advocate for social change and try to push that whole area. Sometimes we don't do it because we don't feel it's our role but if you are looking to improve quality of life then you have to look at all aspects of it (p 2).*

- Don't give up or give in. In a study that examined a client definition of client-centred care (Corring 1996), one client described the importance of a service provider who didn't give up:

*She came and she would spend hours with me and she stayed with me fifteen years, like I'm talking about whenever I needed her I would call her except at home. You know if somebody finds once in their history somebody who cares that could make all the difference. Cause what happened, when she started telling the staff that I was really sick they started believing me, then they found out about my thyroid and liver disease, they all started apologizing to me. Now for somebody to believe me after all those years, that's when I started getting well . . . (p 76).*

- We need to really listen, even when, and especially when, the client is in the midst of an illness exacerbation. As one client in Corring's (1996) study stated:

*When I'm less well I'm less capable of making rational choices, when I'm at my worst, in my very worst, in the psychosis, I still am capable of some rationalization and it's like [other client's name] said himself even in psychosis there's an element of reality there and you're still connected to other people when you're really ill. I'm still capable of having input, even when I'm really ill and I want that chance, it's my life, I don't want people running it for me. Give me the atmosphere where I can handle my own life and let me take off with that, give me my independence, my dignity, my pride cause I'll fight you for it if you don't give it to me, I'll damn well take it and I think if we have that pride and dignity we're running our own lives (p 75).*

- We have to recognise that time alone may be a good and valued thing (see Emerson et al 1998 cited above). Just as many of us enjoy solitude and time out, so do our clients. We have been taught that one of the 'problems' of persons with a mental illness is their lack of social skills and the experience of social isolation. We need to follow their lead of when and how much social life they want, need and can manage.

- ❑ Similarly, we have to recognise that the client has priorities, which may take precedence over what others think they should be doing. In order to do that, we have to give up the traditional control/authority of a professional. The achievement of a balance of authority is central to client-centred care but is difficult to accomplish (Mishler 1986).
- ❑ We need to look for creative ways for clients to tell us what they know and what they want. For example, one student, while collecting data for a qualitative study looking at the life story of a woman living with schizophrenia (Labbe & Corring 2003), found that the client was uncomfortable in discussing the signs and symptoms of her illness. Recognising the importance of a doll that the client cared for like a child, she asked the client to describe her illness to her doll. The client was then able to tell the story of her illness without experiencing the distress that she had felt previously. This not yet qualified, but extremely intuitive, occupational therapy student had creatively called upon her observations of the meaning of the relationship of the doll to the client to assist her in telling her story in a way that she found less stressful.
- ❑ We must use evidence from the literature, perhaps by following the five-step process recommended by Hammell (2001):
  1. Define a question arising from client-identified issues.
  2. Search the literature for relevant current research papers that are grounded in client perspectives.
  3. Critically evaluate the evidence for its relevance and usefulness.
  4. Integrate the best research evidence with clinical expertise and client choice.
  5. Evaluate the effectiveness of subsequent interventions in relation to the initial client-identified needs in cooperation with the client to ensure relevance and timeliness of evaluation.
- ❑ We need to develop an interpretive ear to evaluate our clients' expressions of wants and needs. For example, what does it mean when the client says 'not yet'? It probably does not mean 'never' and this feeling can be explored with the client. As Nagle et al (2002) reported: 'Informants wanted health professionals to gently encourage and instill hope but they also wanted them to listen and trust that they will do more when they are ready.'
- ❑ Do some research yourself – ensure that your practice is evidence based by grounding it in a client perspective. It is time for occupational therapists to exhibit congruence between theory and practice. We cannot say we are client-centred if we routinely leave the client's perspective out of inquiries into the effectiveness of our practice, and out of the inquiries that build or reaffirm the philosophical bases of our profession (Corring 2004a). Ask and answer the following who, what, when, where and why questions:
  1. What is the issue or clinical irritation you are interested in knowing more about?
  2. When, where and with whom can you best explore the issue?
  3. What might you find as a result of the exploration of the issue?

4. What difference will the results make to your practice and why is this important?

**Box 3 Resources for implementing client-centred care in your agency and practice**

International Association of Psychosocial Rehabilitation Services

It is suggested that you, as an individual, or your agency/programme join the International Association of Psychosocial Rehabilitation Services (IAPSRs). The Association's membership entitles you to a subscription to the Psychiatric Rehabilitation Journal, newsletters and discounts on texts, reprints and evaluation tools. Contact details are: International Association of Psychosocial Rehabilitation Services, 601 N Hammonds Ferry Road, Suite A, Linthicum, MD 21090-2412, USA; Phone # (410) 789-7054, Fax (410) 789-7675; E-mail: [membership@iaprs.org](mailto:membership@iaprs.org); website [www.iaprs.org](http://www.iaprs.org)

Highly recommended reading

- ❑ Psychiatric Rehabilitation Journal
- ❑ Psychiatric Services Journal
- ❑ Anthony W A, Cohen M, Farkas M, Gagne C 2002 Psychiatric Rehabilitation. Centre for Psychiatric Rehabilitation, Boston, MD
- ❑ Cook J V 2001 Qualitative research in occupational therapy. Delmar Thomson Learning, Albany , NY
- ❑ Farkas M, Soydan A. Gagne C 2000 Introduction to rehabilitation readiness. Center for Psychiatric Rehabilitation, Boston, MA

## Conclusion

There is a core set of ideological values in occupational therapy practice that we don't always use. We, as a profession, have often stayed with our old ways and been led by others' values (i.e. the medical model that focuses on the illness rather than on the person), but if we were to put into practice our own fundamental values, along with those of psychiatric rehabilitation and qualitative research strategies, we would go a long way to achieving an orientation to asking, listening and learning from clients about those things that are most important to them and then to use that knowledge as the basis for directing what we do. Suggested resources for implementing client-centred care in your agency and practice are outlined in Box 3.



## References

- Angrosino M V 1998 On the bus with Vonnie Lee: explorations in life history and metaphor. In: Creswell J W (ed) *Qualitative inquiry and research design: choosing among five traditions*. Sage, Thousand Oaks, CA, p 257–269
- Anthony W A 2000 A recovery-oriented service system: setting some system level standards. *Psychiatric Rehabilitation Journal* 24(2):159–168
- Anthony W A, Cohen M, Farkas M, Gagne C 2002 *Psychiatric rehabilitation*. Center for Psychiatric Rehabilitation, Boston, MD
- Canadian Association of Occupational Therapists 1997 *Enabling occupation*. CAOT Publications ACE, Ottawa
- Casier S, Corring D J 2003 Leisure from the client perspective: when do you have too much? *Research Insights of the Regional Mental Health Care London/St Thomas*, St Thomas 2(2):1–50
- Cheema P, Choi L, Epp S, Maranan J, Cook J 2002 A multi-site, exploratory, descriptive study of the daily activities of persons with a severe and persistent mental illness. The University of Western Ontario Occupational Therapy Conference on Evidence Based Practice. London, ON: University of Western Ontario
- Cook J V 1995 Innovation and leadership in a mental health facility. *American Journal of Occupational Therapy* 49(7):595–606
- Cook J V (ed) 2001 *Qualitative research in occupational therapy*. Delmar Thomson Learning, Albany, NY, p 3–9.
- Corring D J 1996 Client-centred care means I am a valued human being. University of Western Ontario, London, ON
- Corring D J 2001a Focus group research. In: Cook J V (ed) *Qualitative research in occupational therapy*. Delmar Thomson Learning, Albany, NY, p 75–87
- Corring D J 2001b Participant action research. In: Cook J V (ed) *Qualitative research in occupational therapy*. Delmar Thomson Learning, Albany, NY, p 13–23
- Corring D J 2002 Quality of life: perspectives of people with mental illness and family members. *Psychiatric Rehabilitation Journal* 25(4):350–358
- Corring D J 2004a Ensuring a client perspective in evidence-based rehabilitation. In: Hammell K, Carpenter C (eds) *Qualitative research in evidence-based rehabilitation* Churchill Livingstone, Edinburgh, p 65–76
- Corring D J 2004b 'Being normal': quality of life domains for persons with a mental illness. University of Western Ontario, London, ON
- Corring D J, Cook J 1999 Client-centred care means that I am a valued human being. *Canadian Journal of Occupational Therapy* 66:71–82
- Davidson L, Strauss J 1992 Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology* 65:131–145
- Deegan P E 1992 The cycle of disempowerment and despair. *Psychosocial Rehabilitation Journal* 15(3):3–19
- Deegan P E 1993 Recovering our sense of value after being labeled. *Psychosocial Rehabilitation Journal* 31(4):7–11
- Denzin N, Lincoln Y 1994 *Handbook of qualitative research*. Sage, Thousand Oaks, CA
- Drake R E 2000 Introduction to a special series on recovery. *Community Mental Health Journal* 36(2):207–208
- Duff S 2005 2004 CAOT innovative practice award winner. *Occupational Therapy Now* (March/April): 11–12
- Emerson H, Cook J, Polatajko H, Segal R 1998 Enjoyment experiences as described by persons with schizophrenia: a qualitative study. *Canadian Journal of Occupational Therapy* 65(4):183–192
- Farkas M, Soydan A, Gagne C 2000 *Introduction to rehabilitation readiness*. Center for Psychiatric Rehabilitation Boston, MA
- Hammell K W 2001 Using qualitative research to inform the client-centred evidence-based practice of occupational therapy. *British Journal of Occupational Therapy* 64(5):228–234
- Hasselkus B R 2002 *The meaning of everyday occupation*. Slack, Thorofare, NJ
- Herman J 1992 *Trauma and recovery*. Basic Books, New York
- Labbe J, Corring D 2003 I've come a long way, living with a severe and persistent mental illness: Sally's life story. University of Western Ontario, London, ON
- Lablerte-Rudman D, Moll S 2001 In-depth interviewing. In: Cook J V (ed) *Qualitative research in occupational therapy*. Delmar Thomson Learning, Albany, NY, p 24–57
- MacGregor L J 1995 An exploratory study of the personal experience of occupational deprivation. University of Western Ontario, London, ON
- Mallon C 1999 *Community housing for people living with chronic mental illness: a client's perspective*. University of Western Ontario, London, ON
- Mishler E G 1986 *Research interviewing: context and narrative*. Harvard University Press, Cambridge, MA
- Murphy R 1986 *The body silent*. Holt, New York

- Nagle S 1997 I'm doing as much as I can: pathways to occupational choice. University of Western Ontario, London, ON
- Nagle S, Cook J V, Polatajko H 2002 I'm doing as much as I can: occupational choices of persons with severe and persistent mental illness. *Journal of Occupational Science* 9:72–81
- Raymond M 1999 Assertive community treatment: program evaluation from a client's perspective University of Western Ontario, London, ON
- Rebeiro K L 2001a Participant observation as a research strategy. In: Cook J V (ed) *Qualitative research in occupational therapy*. Delmar Thomson Learning, Albany, NY, p 58–74
- Rebeiro K L 2001b The labyrinth of community mental health: in search of meaningful occupation. In: Cook J V (ed) *Qualitative research in occupational therapy*. Delmar Thomson Learning, Albany, NY, p 293–306
- Rebeiro K, Allen J 1998 Voluntarism as occupation. *Canadian Journal of Occupational Therapy* 65:279–285
- Rebeiro K L, Cook J V 1999 Opportunity, not prescription: an exploratory study of the experience of occupational engagement. *Canadian Journal of Occupational Therapy* 66(4):176–187
- Rowan R 1999 An examination of the self-care needs of individuals with schizophrenia. First Annual Conference Presenting Independent Studies in Evidence Based Practice. London, ON: University of Western Ontario
- Spradley J 1979 *The ethnographic interview*. Harcourt Brace Jovanovich, Fort Worth, TX
- Strauss J S 1994 The person with schizophrenia as a person II: approaches to the subjective and the complex. *British Journal of Psychiatry* 164(S23):103–107
- Townsend E 1998 *Good intentions overruled: a critique of empowerment in the routine organization of mental health services*. University of Toronto Press, Toronto
- Willis AL 2000 *The role of work for individuals with chronic mental illness*. University of Western Ontario, London, ON

## Rehabilitation in the 21<sup>st</sup> Century – Partnership not Prescription.



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#### **Abstract**

*Progressive general health care practices involve the patient and promote self determination. Psychiatric rehabilitation must also be based on choice, partnership and recovery. This commentary reviews Corring & Cook's article from this perspective and points out implications for occupational therapists in the 21<sup>st</sup> century.*

Corring and Cook's excellent article takes on one of the most important implications of current trends in mental health practice. The importance of listening to one's client in order to facilitate recovery from serious mental illnesses cannot be overstated. For many years, the conventional wisdom in the field of mental health has been that severe mental illnesses result in inevitable deterioration. Professional practice has therefore focused on managing psychopathology and its symptoms. A wider variety of outcomes have been identified over the past thirty years however, particularly for individuals with schizophrenia (Desisto et al., 1995; Harding et al., 1987a; b.; Sartorius et al., 1996). These outcomes included regaining functioning over the long term, developing friendships and living satisfying lives (Farkas et al., 2005; Harding & Strauss, 1984; Liberman et al., 2002; Ridgway, 2001).

### **Recovery Vision for Mental Health Services**

Thirty years of empirical evidence, as well as first person accounts (Deegan, 1996; Fisher and Ahern, 1999; Leete, 1989; Mead & Copeland, 2000) support the notion that recovery from serious mental illnesses is possible and is not a rare or unusual event. Recovery has been defined as the journey to "take back one's life" or to gain or regain a meaningful life (Farkas, 2007). "Meaning in life" cannot be regained without self determination and choice. These values are therefore fundamental for any service that intends to facilitate recovery ( Farkas et al., 2005).

Consistent with the emergence of a recovery vision for mental health services, and psychiatric rehabilitation's historical emphasis (Cnaan, Blankertz, Messinger & Gardner, 1988), consumers in general health care services as well as mental health services are increasingly recognized as key decision makers in conducting shared decision-making with their providers (Wills and Holmes-Rovner, 2006). In the U.S., the influential Institute of Medicine's *Crossing the Quality Chasm* calls for health care to be patient-centered. Specifically, care is to be respectful of and responsive to individual patient preferences, needs, and values. Patient values should guide all clinical decisions. *Crossing the Quality Chasm* also provides "Ten Rules to Guide the Redesign of Health Care" stating that the patient is to be the source of control (*Crossing the Quality Chasm*,

2001). The idea of client centered services is, therefore, a principle of increasing importance and relevance across all types of health related services.

In addition to these reports in general health care, recent documents from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) emphasize principles and characteristics of consumer- and family-driven care. Consumers have the primary decision-making role regarding the mental health and related care that is offered and the care received ([www.mentalhealth.samhsa.gov/cmhs/AdvisoryCouncil/consumerdirvedraft.asp](http://www.mentalhealth.samhsa.gov/cmhs/AdvisoryCouncil/consumerdirvedraft.asp)) and families have the primary decision-making role in the care of their own children ([www.tapartnership.org](http://www.tapartnership.org)). This recent emphasis on client driven care and shared decision making in general health care, and mental health care in particular, is a reflection of the psychiatric rehabilitation field's three decade long focus on the importance of choice and self determination.

As cited in Corring's article, the principles and values of psychiatric rehabilitation are based on the cornerstone of choice and self-determination, consistent with the psychiatric rehabilitation's fundamental belief that rehabilitation is done *with* people and not *to* people. In fields other than occupational therapy or rehabilitation per se, Adams and Drake (2006) note that in progressive care systems, "The practitioner becomes a consultant to the client, helping to provide information, to discuss options, to clarify values and preferences, and to support the client's autonomy." Such a collaborative process aims to decrease the informational and power imbalance between the practitioner and the client which is accomplished by increasing the client's information and autonomy or control over all aspects of the recovery process (Farkas et al., 2005).

### **Re-orienting Assessments Towards the Client's Vision**

Listening and learning from one's partner is the only method possible for true partnership or collaboration in an era of recovery. The emerging role of therapists or providers as facilitators and coaches who interact with consumers as individual people rather than cases or labels (Anthony et al., 2002; Farkas et al., 2005; Farkas, 2007) requires the shift that Corring so ably points out from "expert" to "understanding the client's perspective". In this framework, Corring discusses the current limitations of functional assessments. In addition to the problem she discusses of focusing on individual deficits before getting to know a client as an individual, functional assessments (as often practiced) prevent any true listening process—i.e. an exploration with the client about how the functions to be assessed relate to his or her vision of recovery and what a meaningful life might look like for him or her.

Functional assessments are often checklists of behaviors that are generically thought of as important to self care and daily living. These behaviors are assessed in standardized ways with little regard to their meaningfulness or relevance to the hopes and aspirations of the consumers involved. "Grooming behaviors" may be critically important to someone seeking a job as a bank teller and unimportant to someone whose goal is to work as a computer programmer from his or her home. The generic aspect of these checklists also reduces the relevance of the assessments to

any perspective or sense of meaningfulness to the consumer. “Conversation skills” of a certain type (e.g. “the ability to present synthesized information in a lively manner”) may be important to one’s hopes of becoming a professor and not at all important to one’s goal of becoming a homemaker. The intended role should provide the filter through which critical skills and supports are identified and assessed. The identification of skill strengths and skill deficits are only important to the recovery process insofar as they further the hopes and aspiration of an individual in a particular domain of life. Otherwise they contribute to the experience of the individual as a passive “object of evaluation”, overwhelmed by the deficits identified, deficits that have little discernable relevance to the recovery vision an individual has of his or her life. Psychiatric rehabilitation techniques have long been designed to help individuals move towards their own recovery vision. The systematic techniques developed facilitate individuals in choosing their definition of a meaningful life (i.e. setting an overall goal), assessing themselves in relation to this goal in terms of their current skills and supports and then designing interventions to help them achieve their goal by strengthening the skills and supports they need (i.e. Cohen et al., 1986; 1989; 1990; 2000; Farkas et al., 2000).

### **Focus on Healthy Functioning**

Later in the article Corring and Cook make an excellent point about the wrenching dichotomy consumers are often faced with by typical mental health services that apparently ask them to “accept” their disabilities and the natural desire to see oneself as “normal”. The World Health Organization’s latest framework on health, functioning and disability addresses this difficulty directly. The International Classification of Disability and Functioning (ICF) points out that shifting to a health paradigm puts the notions of ‘health’ and ‘disability’ in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity. The ICF thus ‘mainstreams’ the experience of disability and recognizes it as a universal human experience.”<sup>1</sup> Descriptions of functioning and environmental factors are categorized as related to “health”, “activity” or “participation” factors, rather than “impairment”, “disability” or “disadvantage”. The impact of this shift is to reduce the importance of “accepting one’s disability” and the resultant conflict between “disability” and “normalcy”. Asking the person to engage in a description of his or her health, activity or participation provides a life-affirming, recovery-oriented direction for an assessment process rather than asking an individual to surrender to a particular diagnosis or disability label as the presumed starting point for interventions.

Corring and Cook’s article points out the critical importance for the field of occupational therapy to abandon the medical model both as researchers and providers of services and move towards client directed, client centered practice and qualitative research tools. Certainly, given international trends occupational therapy must take up the serious challenge presented by Corring

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<sup>1</sup> <http://www.who.int/classifications/icf/en/index.html> Retrieved July 25 2008.

and Cook, if it is to facilitate recovery for individuals with serious mental illnesses and thus remain relevant to mental health practice in the 21<sup>st</sup> century.

## References

- Adams JR. & Drake RE. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal*, 42, 87-105.
- Cohen MR., Farkas MD., & Cohen B. (1986). *Functional Assessment: Psychiatric rehabilitation trainer technology*. Boston, MA: Center for Psychiatric Rehabilitation, Boston University.
- Cohen MR., Farkas MD., Cohen B., & Unger K. (1990). *Establishing an overall rehabilitation goal: Psychiatric rehabilitation trainer technology*. Boston, MA: Center for Psychiatric Rehabilitation.
- Cohen MR., Forbess R, & Farkas M. (2000). *Developing readiness for rehabilitation: Psychiatric rehabilitation trainer series*. Boston, MA: Center for Psychiatric Rehabilitation at Boston University.
- Cohen M, Nemec P, Farkas M, & Forbess R. (1989). *Case management: Psychiatric rehabilitation trainer technology*. Boston, MA: Center for Psychiatric Rehabilitation.
- Cnaan RA., Blankertz L, Messinger KW, & Gardner JR. (1988) Psychosocial Rehabilitation: Toward a definition. *Psychosocial Rehabilitation Journal*, 11(4), 61-77.
- Deegan P. Recovery as a journey of the heart. *Psychosocial Rehabil J.* (1996) 19(3): 91-7.
- DeSisto MJ, Harding CM, McCormick RV, Ashikaga T, Brooks GW (1995) The Maine and Vermont three-decade studies of serious mental illness. I: Matched comparison of cross-sectional outcome. *British Journal of Psychiatry*. 167: 331-8.
- Farkas M, Cohen MR., McNamara S, Nemec PB., & Cohen BF. (2000). *Assessing readiness for rehabilitation: Psychiatric rehabilitation trainer series*. Boston, MA: Center for Psychiatric Rehabilitation at Boston University.
- Farkas M, Gagne C, Anthony W, Chamberlin J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal.*; 41(2):145-53.
- Farkas M. (2007). The vision of recovery today: what it is and what it means for services. Special Article. *World Psychiatry*, 6:2, 1-7.
- Fisher D, Ahern L. (1999) People can recover from mental illness. Newsletter of the National Empowerment Center. Spring; 8-9.
- Harding CM, Brooks GW, Ashikaga T, Strauss JS, Breier A. (1987a) .The Vermont longitudinal study of persons with severe mental illness, I: Methodology, study sample, and overall status 32 years later. *American Journal of Psychiatry*; 144, 718-26.
- Harding CM, Brooks GW, Ashikaga T, Strauss JS, Breier A. (1987b). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcomes of subjects who retrospectively met DSM-III criteria for Schizophrenia. *American Journal of Psychiatry*; 144(6): 727-35.
- Harding CM, Strauss JS. (1984). How serious is schizophrenia? Comments on prognosis. *Biological Psychiatry.*; 19(12):1597-1600.
- Harding CM, Zahniser JH. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *ACTA Psychiatrica Scandinava*. 1994; 90 Supplement 384: 140-6.
- Institute of Medicine. (2001). *Crossing the Quality Chasm: Quality Health Care in America*. Washington, DC: National Academies Press.
- Leete E.(1989) How I perceive and manage my illness. *Schizophr Bull.* 1; 15(2): 197-200.
- Lieberman RP, Kopelowicz A, Ventura J, Gutkind D (200). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*. 14: 256-72.
- Mead S, Copeland ME. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*. 36(3): 315-28.
- Ridgway PA. Re-storying psychiatric disability: Learning from first person recovery narratives. (2001). *Psychiatric Rehabilitation Journal*. 24(4): 335-43.
- Sartorius N, Gulbinat W, Harrison G, Laska E, Siegel C. (1996). Long-term follow-up of schizophrenia in 16 countries: A description of the International Study of Schizophrenia conducted by the World Health Organization. *Social Psychiatry, Psychiatric Epidemiology*. 31: 249-58.
- Wills CE. & Holmes-Rovner M. (2006). Integrating decision-making and mental health interventions research: research directions. *Clinical Psychology: Science and Practice*, 13, 9-25.

## Are Asking, Listening, and Learning Really Enough?



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#### *Abstract*

*In this commentary the author explores the extent to which Corring and Cook's recommended approach to treating people with severe and persistent mental illness is novel, and the extent to which this approach is consistent with evidence-based practice. He argues that Corring and Cook are advocating some very old ideas and some very basic clinical skills. He concludes by suggesting that a client-centered approach and the astute use of qualitative observations are essential clinical skills, but that additional skills and more evidence-based approaches are necessary for optimal clinical care.*

Corring and Cook's reprinted article is a delightful and stimulating read for anyone in the health care field – particularly those of us who try to help individuals with severe and persistent mental illness. It is clearly written, and the reader cannot help but be impressed with the authors' sincerity and compassion. It is also written with partisan zeal: the authors have definite views on the value of client-centered practice and qualitative research, and they are not afraid to tell you what these views are. Nor are they afraid to tell you that these views are the “right” views.

Another endearing quality of the article is the way the authors' tone and spirit might evoke some memories of an almost-forgotten era of passion in the reader's youth, at least for those of us of a “certain age”. After reading the article several times, I felt compelled to locate and shovel the dust off some long-forgotten books written by people like R. D. Laing and Thomas Szasz (e.g., Laing, 1967, 1969; Szasz, 1974). Buried in the bliss of memories from my undergraduate days, I recalled that I once firmly believed that understanding and compassion were the *sufficient* ways to help people with severe mental illness, and that hospitals and medication were not the solution. Those were really the days, and I am grateful to Corring and Cook for reconnecting me to those fresh and bright times.

### **Carl Rogers, Pioneer of Client-centered Approaches**

The goal of a commentary, however, is to critically evaluate the ideas to stimulate thought and discussion. To begin, one might note the authors' challenge to therapists to “relinquish outdated assumptions and practices”, and implement a (presumably newer) client-centered approach that incorporates qualitative observations. It could be argued that they are proposing nothing new at all. Client-centered approaches have been around since Carl Rogers first began advocating them in the late 1940s and early 1950s (e.g., Rogers, 1951). This approach has been particularly prominent in the very field the authors are discussing - mental health - for well over 50 years. Qualitative approaches have been around for even longer (see Platt, 1985, for some interesting history). Moreover, examination of course descriptions in any current university calendar will



reveal that the development of effective communication skills (“asking” and “listening” in the authors’ terms) are core elements in the first-year curriculum of virtually all health-related professions, as are rapport-building and the development of astute observational skills. An initial criticism might therefore be that the authors are advocating some very old ideas and some very basic skills. This criticism could be countered, however, by asserting that it never hurts for us to be reminded that these things are important in clinical practice and for the optimum care of our clients/consumers (or “teachers”, as the authors might argue).

### **Fit With Evidence-based Practice**

A second issue might be the “fit” between Corring and Cook’s proposals and evidence-based practice. Evidence-based practice is something that is embraced by many health-care practitioners, and rejected by many others. Still others remain blithely unaware that there are “levels” or “degrees” of evidence, some weaker, some stronger, and that different types of evidence are not necessarily equal. For better or worse, however, and regardless of how people might feel about it or how well they understand it, evidence-based practice is unavoidable in this era of accountability – at least for those of us who wish to get paid for our services. Our colleagues in occupational therapy are doing some great work in this regard, by the way (see, for example, Holm, 2000; Law & MacDermid, 2008; von Zweck, 1999). Determining how Corring and Cook’s proposals blend with evidence-based practice might be a worthwhile exercise. Evidence-based practice is certainly mentioned several times. On the first occasion, the authors assert that “respect for the participants’ expertise regarding the phenomenon of interest is *fundamental to ensuring evidence-based practice*” (p. 5, emphasis added). On the second occasion, they recommend that “you *ensure your practice is evidence based by grounding it in a client perspective*” (p. 13, emphasis added). Elsewhere, however, they make it pretty clear that the “medical model” (p. 6) and use of *DSM-IV* as a “reference point” (p. 6) are among the “outdated” assumptions and practices that we should relinquish. By inference, I think we could include biological approaches in general and quantitative research in this list. They then suggest that the “identity of the therapist as ‘expert’ has to be put aside and replaced...” (p. 6). These are all very interesting ideas and they raise some particularly interesting philosophical issues. Whether or not these proposals will lead to optimum client care, and whether or not they are truly consistent with evidence-based practice, are questions open to some debate, however.

I think the main limitation of this article is the implication that client-centered practice and qualitative research are separate from (and better than) the “other” approach to client care (What to call it? Biological? Medical? Quantitative? Compassionately hard-nosed?). Many of us would argue that the two approaches are meant to be combined, and that they actually complement each other. A client-centered approach is a necessary basic clinical skill to build rapport with the client. It also helps the clinician understand the client, understand the client’s strengths, understand the client’s problems, and understand the client’s needs. It is not an effective intervention in its own right; it is the foundation upon which an effective intervention is added. (And one should really reclaim one’s identity as an “expert” to do this properly.) Qualitative

observations form an important part of a comprehensive assessment in any health-related discipline, and they are valuable when it comes to tailoring an intervention to the specific needs of a client or in understanding why an intervention is not working. On their own, however, they will not provide convincing evidence that your assessment is accurate or that your intervention is effective. Qualitative research more generally is a very useful tool and it is a valuable initial stage or complement to quantitative research. It can help you identify important variables in an area that is new or an area that is not well understood. It can guide your thinking when there is no existing theory to guide you. It can help you define variables or explicate constructs. It can help you understand *why* something works or does not work. It does not, however, have the power or strength of a randomized, placebo-controlled experiment. It cannot confirm or disconfirm precise, theory-driven hypotheses. It cannot identify causal relationships. It cannot provide classification rates for your assessment tools. It will never be able to determine the causes of severe and persistent mental illness, nor unlock the secrets of cure.

Corring and Cook have argued very eloquently and very convincingly that asking, listening, and learning are extremely important components of effective client care, and I agree completely. These three things are just the starting place of good care, however, and represent a strategy for imaginative sampling of phenomena, which happens to be a starting point for investigative research.

### References

- Holm M B. (2000). Our mandate for the new millennium: Evidence-based practice. *American Journal of Occupational Therapy*, 54, 575-585.
- Laing,R.D. (1960). *The divided self: An existential study in sanity and madness*. London: Tavistock Publications.
- Laing,R.D. (1967). *The politics of experience*. New York: Pantheon Books.
- Law M, & MacDermid J (Eds.). (2008). *Evidence-based rehabilitation: A guide to practice* (2<sup>nd</sup> ed.). Thorofare, NJ: SLACK Incorporated.
- Platt J. (1985). Weber's *verstehen* and the history of qualitative research: The missing link. *British Journal of Sociology*, 36, 448-466.
- Rogers CR. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.
- Szasz TS. (1974). *The myth of mental illness: Foundations of a theory of personal conduct* (Rev. ed.). New York: Harper & Row.
- von Zweck C. (1999). The promotion of evidence-based occupational therapy practice in Canada. *Canadian Journal of Occupation Therapy*, 66, 208-213.

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## Must We Live in Two Different Worlds?



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#### **Abstract**

*Corring and Cook offer a timely reminder of the potential benefits of understanding client perspectives in effectively delivering any interventions – “medical” or “psychosocial”. Rather than seeing the medical versus recovery (or client centered) approaches to intervention and qualitative versus quantitative approaches to research as competitors, we need to recognize the strengths and limitations of each and work towards their integration.*

I think it would be a very callous individual who could openly quarrel with most of the points being made by Drs. Corring and Cook. Their comments contain much wisdom not just for occupational therapists, but all clinicians. Unfortunately, one more endorsement of these positions by me or anyone else is unlikely to have the sort of impact that they are seeking – a change in the behaviour of clinicians so that they come to better understand the perspective, hope, priorities, values and decisions of clients and integrate these into clinical practice. This is just one manifestation of the following paradox. The importance of respecting and understanding the perspectives and strengths of clients seems to be recognized at an intellectual level by the vast majority of those who work in the mental health field. On the other hand, as the authors argue, we often pay little attention to it in working with clients. Why is this and what can be done about it?

### **A Matter of Ideology?**

Is it simply a matter of ideology? Corring and Cook sometimes use language that suggests that they see this issue in ideological terms. William James (1907, 1975) and subsequently Hans Eysenck (1954) and others distinguished between two basic temperaments. James considered the tough-minded to be those individuals who are empirically oriented, those who 'go by facts.' The tender-minded are rationalists who 'go by principles'. According to James, the history of philosophy is largely the story of the clash between these two temperaments. He was certainly not the last to note that the tough-minded often think of the tender-minded as sentimentalists and softheads; while the tender-minded feel the tough-minded to be unrefined, callous, or brutal. Are the recovery and client centered clinicians and qualitative researchers members of the tender-minded camp and the biologically or medically oriented clinicians and quantitative researchers members of the tough minded camp? Are their hardwired temperaments such that there will seldom be much productive exchange between them? In working in a variety of mental health setting from large psychiatric hospitals to small community mental health programs over many years, I have often encountered debates and disagreements between clinicians who sometimes

seem to be archetypes of these temperaments. Thankfully, however, such disagreements or differences in practice do not always seem to reflect basic personal characteristics.

### **“People More Often Need to be Reminded Than Informed”**

Is it simply a matter of declarative versus procedural knowledge? There are many things that we know on an intellectual level, but do not enact. We fully accept and can declare many principles concerning personal ethics, professional standards, effective parenting, and financial responsibility, which are not consistently reflected in our behaviour. Rather, our actions are often more reactions to pressures and demands, the need to simplify and set priorities, and our reliance on how others are doing things as a guide to our own behaviour. I suspect such factors make substantial contributions to the tendency to focus on disability rather than ability; failure to address the clients’ broader context in treatment planning and implementation; and not (hopefully in very few cases) behaving with courtesy and civility. Instead of the above paradox being a clash of temperaments, is it a failure on the part of most of us to consistently act on the basis of our principles? As Samuel Johnson is often quoted as saying “People more often need to be reminded than informed”. There is some evidence from social psychology that reminding people of values and principles can influence their behaviour. Perhaps by offering such reminders, the qualitative research and recovery and client centered writings reviewed by Corring and Cook could facilitate desirable changes in clinical practice.

### **Biological Mediators and the Sense of Self**

The strength of the medical approach to treatment is that for many (but by no means all) individuals with serious psychiatric illness, medical interventions can represent the most important single intervention for reducing the defining clinical symptoms of a disorder. The weakness is that because of the dramatic effects that such intervention can sometimes have on the most striking signs of illness, there is a tendency to overlook the importance of other interventions and the importance of understanding client perspectives in effectively delivering any interventions – “medical” or “psychosocial”. In the field of early intervention for psychotic disorders, for instance, one sometimes hears the proposition that all that matters is that clients take their medications. When this position is being argued, it is often from the perspective of reduction in florid, positive symptoms.

As Corring and Cook emphasize, the reduction of such symptoms is not the only outcome of importance, or even the most important from the client perspective. Furthermore, a focus on the biological mediators of such symptoms generally leads to some variation on a diathesis-stress model of illness. In turn, such models immediately implicate the importance of understanding a person’s strengths and goals, the narrative not just of their illness but of their life, their sense of self and then helping them to develop skills and modulate environmental circumstances. The latter are, as Corring and Cook indicate, a fundamental aspect of the recovery and client centered approaches. Even in the field of psychotic disorders there is evidence that interventions that

utilize such factors can be effective in reducing symptoms, improving functioning and increasing quality of life – even in some patients considered to have limited response to pharmacotherapy (Kingdon & Turkington, 2005; Sensky et al., 2000).

### **The Need to Address Subtleties in Qualitative and Quantitative Research**

There are strengths and weaknesses to both qualitative and quantitative approaches to research. Qualitative approaches are essential in helping us identify the subtleties of individuals' goals and perspectives. Narratives of people's experiences can be far more compelling than statistical tables. Such approaches are also more likely to help us understand the influence of transitional events, circumstances and an individual's thinking that evolve over time on the course of illness and the recovery process. In contrast, it seems to me that quantitative methodology using aggregated data can provide important demonstrations of the relative importance of variables across individuals. One of the problems with quantitative methods is that they often tend to focus exclusively on understanding individual differences in vulnerability at a single point in time rather than how individuals' changing circumstances, thinking, hope and sense of self have implications for recovery over time. We should be developing better quantitative measures of the latter factors based on insights from qualitative studies. What are the most important components of self-identity, social support, hope, and resilience that evolve over time? I am not denigrating the importance of qualitative research when I say that we need to develop good measures of such factors and integrate them into quantitative research. I agree with the authors that clients are the experts we need to draw on in better understanding and measuring these important aspects of recovery.

On the whole, however, this article reinforces my impression that rather than seeing the medical versus recovery or client centered approaches to intervention and qualitative versus quantitative approaches to research as competitors, we need to recognize the strengths and limitations of each and work towards their integration.

### **References**

- Eysenck HJ. (1954) *The Psychology of Politics* London: Routledge & Kegan
- James W. (1975) *Pragmatism* Cambridge, Mass: Harvard University Press (originally published in 1907)
- Kingdon DG., Turkington, D. (2005) *Cognitive Therapy of Schizophrenia* London: Guilford Press
- Sensky T, Turkington D, Kingdon D, Scott JL, Scott J, Siddle R, O'Carroll M, Barnes TR. (2000) A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication *Archives of General Psychiatry* 57; 165-172.