Psychiatric nursing practice is rooted in the healing power of the interpersonal nurse-patient relationship, as described by Hildegard Peplau (1952/1991), an early leader in the development of modern psychiatric nursing. Nurses generally agree that nursing practice should be patient centered in the sense that effective working relationships are formed with patients to provide nursing care that incorporates an understanding of the patient’s perspective. Beyond patient-centeredness, psychiatric nurses view nursing care as helping patients work through mental health concerns that are marked by anxiety and non-adaptive coping behaviors, to achieve mental health recovery.

Recovery has been defined as a process of healing and transformation that results in the ability to achieve full potential in living a meaningful life (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). It includes healing processes such as self-direction, individualized and person-centered care, empowerment, holistic recovery, strengths-based care, mutuality, respect, and responsibility (SAMHSA, 2004). Person (patient)-centeredness is one of multiple processes that support recovery.

Peplau’s (1952/1991, 1954) theoretical model of the nurse-patient relationship emphasized mutuality as an essential process for an effective nurse-patient working relationship to foster growth in constructive coping responses toward the goal of recovery. Mutuality is characterized by both individuals sharing information and collaborating to make decisions in relation to jointly agreed-on goals. For example, a nurse and a patient may work together to identify healthy coping strategies for managing anxiety and to make decisions about which strategies to use.

More recently, the concept of mutuality has been reframed and extended in the concept of shared decision making (SDM). SDM is a process for achieving high-level mutuality in health care interactions that involve decision making about therapeutic options. It involves clinicians and patients working together as peer-level partners with mutual expertise (professional and experiential) to exchange information and clarify what is most important in deciding what to do. In reality, most interactions in health care, including psychiatric nursing care, are driven by a traditional model, in which clinicians take a highly directive role with patients in therapeutic interactions and decisions to be made about managing mental health issues. But for multiple reasons, the
traditional model of health care is beginning to shift to a more mutual partnership between clinicians and patients.

At a broader policy level, SDM represents a proposal for health care quality reform that envisions patients as consumers who take a more active role in their own care and carries an expectation that clinicians (as a standard of practice) will support interactions and decision making characterized by a high level of mutuality. There is a consensus that SDM in mental health care has potential to improve outcomes, including those consistent with meaningful mental health recovery (SAMHSA, 2004, 2008). In studies of people making health-related decisions in non-mental health situations, SDM has been shown to reduce decisional conflict and to improve patient involvement in decision making, communication with health care providers, knowledge, satisfaction, ability to make choices, and consistency of decisions based on matters most important to the patient (O’Connor et al., 2009). In recent studies of people experiencing schizophrenia or depression, SDM has been shown to be associated with improved satisfaction, involvement in care, and improved functional status (Simon, Wills, & Härter, 2009). Because of these favorable research findings, at least five U.S. states are considering evaluations of SDM as a means to improve quality of care, satisfaction, and cost effectiveness of care (Kuehn, 2009).

But SDM is not without controversy, especially in mental health care. Not all health care decision-making situations should necessarily rely on implementing all aspects of a fully shared decision-making process (i.e., patients may be incapable of full participation in decision making in extreme emergencies). People who experience serious mental health problems over a lengthy period of time may often need training in becoming more empowered participants in their own recovery. Although research has shown patient interest in SDM, clinicians have concerns about the capacity of some patients’ participation, especially those who are experiencing severe mental illnesses.

Here, a key question is, Which aspects of SDM are most appropriate for different circumstances? Even a severely ill patient may be interested in health information and in sharing information about personal preferences. Clinicians are often concerned about the time needed to engage in shared decision making with patients, although recent research shows that SDM does not necessarily take more time beyond usual approaches with patients (Loh et al., 2007). In addition, while nurses largely agree that being patient centered is appropriate, nurses and other health care providers often differ in their assumptions about what should be the optimal model of the therapeutic relationship for work with their particular patients and patient populations. For a given patient, should the approach be more traditional (directed more by the nurse), mutual (shared by the nurse and patient), or consumerist (directed more by the patient)? Although most clinicians make some attempt to be patient centered, shared decision making and recovery still remain ideals in health care.

What do you think about the concept of shared decision making in psychiatric nursing practice? To what extent are healing processes for recovery implemented in your facility? JPN would like to hear from you!

REFERENCES


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