

## **Four Questions: One Answer**

**Robert Brooks, Ph.D.**

How would you answer the following questions?

What action on the part of physicians led to greater patient happiness and, very importantly, to better medical outcomes?

What changes in nursing home practices contributed to both residents and staff becoming more satisfied, resulting in a decreased use of medications for residents and less turnover of staff?

What is the dominant attitude possessed by adults with learning disabilities/differences (LD) and Attention Deficit Hyperactivity Disorders (ADHD) who display success and resilience compared with those who lack this attitude and are less successful?

What factors lessen ambivalence about entering psychotherapy or the likelihood of dropping out prematurely?

### **Different Environments and Populations but a Similar Answer**

These questions involve different environments and populations, but interestingly the answers to all four are rooted in a remarkably similar theme, one that is pertinent not only for how effectively each of us copes with life's challenges but also the ways in which we can help others to do the same. The theme may be subsumed under the description of "personal control," a concept about which I have written and lectured extensively and is highlighted in the book I co-authored with my friend and colleague Dr. Sam Goldstein, *The Power of Resilience: Achieving Balance, Confidence, and Personal Strength in Your Life*.

In our book Sam and I note that one of the main characteristics of resilient individuals is that they focus their time and energy on those situations over which they can have some impact, rather than on events that are beyond their sphere of influence. They take responsibility and ownership for their actions and recognize what I have frequently emphasized in my clinical practice and workshops, namely, "We are the authors of our own lives." Resilient people do not pursue happiness by asking or waiting

for someone else to change first but rather are guided by the question, “What is it that I can do differently to change the situation?”

The belief about authorship of our own lives is inextricably interwoven with another issue I have addressed in my work, that of intrinsic motivation. Experts in the field of motivation, such as psychologists Edward Deci and Richard Ryan at the University of Rochester, have emphasized that people are more motivated to engage in those activities in which they feel their opinion or voice is being heard and in which they are provided with genuine opportunity to make choices and decisions. In previous website articles I have detailed the motivation framework proposed by Deci and Ryan known as self-determination theory or SDT (please see my April, 2006 article).

If individuals subscribe to the importance of personal control and the tenets of SDT, they are more likely to assess to what extent they are afforded this kind of control in different settings, and to what extent they help to create what I call “motivating environments” in which cooperation, respect, and responsibility are the dominant behaviors. All individuals thrive in such environments.

Let’s return to examine the answers to the four questions I posed at the beginning of this article, all of which involve the presence of personal control, choice, and motivating environments.

### **The Action of Physicians**

In a *U.S. News & World Report* on-line article titled “OpenNotes Helps Keep Patients Informed and Engaged,” writer Neil Versel observes that in past years physicians and hospitals preferred that clinical notes written by a physician not be made available to a patient. However, Versel states that this practice is changing and that “some well-known institutions are demonstrating that patients are happier and have better medical outcomes when they are able to see everything in their own medical records.”

These institutions, which include Beth Israel Deaconess Medical Center in Boston, Geisinger Health System based in Danville, PA, and Harborview Medical Center in the inner-city of Seattle, have provided patients online access to their entire ambulatory health records, including the notes of clinicians. “The results of this initiative, labeled OpenNotes, have been resoundingly positive. In a yearlong study of the three organizations, 99 percent of participating patients said they wanted to continue seeing

their full charts, and 85 percent said that records access would be a factor in selecting future care providers. About two-thirds were more likely to take medications as prescribed after a year of OpenNotes.”

Versel writes that some physicians were initially concerned that open records would prompt patients to become more frightened and contribute to a deluge of calls and e-mails. However, this did not happen. In reality, patients became increasingly engaged in their own treatment and there was improved communication between doctor and patient. Records that are open to patients require physicians to convey medical facts more clearly and to use less jargon in their notes. This practice also encourages physicians to perceive their patients not just as recipients of medical care but as partners in the process. It reinforces a sense of personal control that enhances rather than hinders this process of care.

### **Nursing Home Environments**

The Taos Institute *Positive Aging* newsletter cited an article by Stacey Burling that highlights the positive impact that occurs when residents feel that their voice is being heard. The article details the ways in which nursing homes are changing from “being medically-oriented facilities . . . to resident-oriented dwellings, designed to make the people feel at home. . . . The new approach stresses giving choices to residents in terms of how they live, how they decorate their living spaces, when and what they eat, how long they sleep, and how they spend their time.”

Similar to the findings reported above about patients becoming more involved in their own treatment plans, inviting nursing home residents to make decisions about the environments in which they live proved very beneficial. “People who live in nursing homes are expressing their opinions about their facilities, and they are feeling much more satisfied than those who live in traditional facilities. The staff is happier as well, and there is less turnover. Because the residents are happier, they require fewer medications and restraints. They are also more likely to remain fitter, stronger, and more energetic.”

Peggy Sinnott, a director of health services for the Kendal organization, offers an interesting observation. “I can tell as soon as I walk into a nursing home what kind it is. If there are visiting hours, it’s not culture change. If you can’t have a birthday party for your mother, there’s no change.”

Permitting nursing home residents to make decisions about their living situation reinforces feelings of ownership and dignity that enrich and provide meaning to the lives of these residents.

### **Adults with LD and/or ADHD**

As many of my readers are aware, I have held a long-time interest in working with children and adults with learning and attention problems, especially in terms of their sense of hope and their ability to lead more successful, accomplished lives. Psychologist Paul Gerber has studied the characteristics of adults with LD and/or ADHD who are successful in their personal and professional lives compared with those who are not. He found that a basic attribute for success falls under the rubric of “control.” Gerber expresses the belief in an article published in the *ADHD Report*, “The more a person with LD and/or ADHD is able to take control of his or her life, the more likely the achievement of success. Control means making conscious and well-grounded decisions to take charge of one’s life. Moreover, it means adapting and shaping one’s thoughts, actions, and behavior to move ahead.”

It is not unusual for children or adults with LD or ADHD to wonder why they are the ones beset with these problems. A boy with ADHD once asked me, “Why did God choose me to be the one with ADHD?” Consistent with Gerber’s studies, I have found that a major task in therapy is to help individuals move beyond these questions and instead adopt the belief, “I’m not certain why I have LD or ADHD, but now that I know that I do, I must figure out with the appropriate assistance of others how to be successful even with these problems.”

Guided by the concept of “control,” it is imperative that clinicians engage patients as active participants in the therapeutic process. They must help patients not only to identify those choices and decisions that are within their power to make but also to encourage their patients to take actions to realize their goals. Therapists can facilitate a shift in their patients from a victim’s mentality to one of empowerment and ownership. They can guide patients away from obsessing about what in reality is an unanswerable question, “Why me?” to assuming a proactive problem-solving position that offers opportunities for change and realistic hope.

### **Lessening Ambivalence about Entering and Continuing Psychotherapy**

The importance of personal control was highlighted in research conducted by psychologists Oliver Schauman at the Institute of Psychiatry, King's College London and Warren Mansell, at the School of Psychological Sciences, University of Manchester. They reported their work in an article "Processes Underlying Ambivalence in Help-Seeking: The Loss of Valued Control Model" published in the journal *Clinical Psychology: Science and Practice* in June, 2012.

Schauman and Mansell observe that "a substantial proportion of people who are referred to therapy either do not attend their initial appointments or drop out early on." They offer several possible reasons for this ambivalence to seek or continue in therapy, identifying as a salient variable the extent to which clients feel they have some control "from the very beginning of the process of seeking help for mental health problems."

It is beyond the scope of this article to review the "loss of valued control model" or the perceptual control theory (PCT) that these researchers describe both to explain and overcome the barriers to entering therapy. Without wishing to oversimplify the theories advanced by Schauman and Mansell, the theme of patient control is prominent in their work. "What is of crucial importance here is the assumption that having reduced control over aspects of one's life is incongruent with how people want to live their lives."

We can readily see the way in which this last statement parallels the basic assumptions advanced by Deci and Ryan in their theory of self-determination and intrinsic motivation.

The question may be raised, "What are the most effective strategies to lessen a patient's perception that 'valued control' (similar to my description of 'personal control') is being compromised in therapy?" Schauman and Mansell contend that while patients represent a heterogeneous group, there are general principles applicable to all patients that can guide the interventions of clinicians to bolster a sense of control. They review research findings that demonstrated "a dramatic increase in initial therapy appointment attendance when clients 'opted in' to an appointment, rather than were given an appointment." What this involved were clients handling the appointment bookings themselves, which reduced waiting lists and increased attendance. The process of

“opting in” placed ownership in the hands of patients and helped them maintain a feeling of control.

As another illustration of increasing scheduled therapy appointment attendance, Schauman and Mansell recommend eliciting from patients what issues are most important to them to address in therapy. “A way of doing this would be that the professional making the referral (e.g., general practitioner) would have a brief discussion with the prospective client about what would be important to him or her to have control over and how the psychological services can best approach helping him or her. This information can then be passed on to the service provider, who can accommodate the referral process as much as possible through providing the client with choice over those aspects that are important to him or her.”

As I read this advice, I thought of an 11-year-old boy I saw in therapy early in my career prior to my appreciation of concepts such as valued or personal control. Similar to many young adolescents he did not want to be in therapy, feeling he was forced to do so. The way he typically handled his reluctance about therapy was to run out of my office at the hospital at which I worked, often at least 30 minutes prior to the scheduled end of the session. My insecurities as a young psychologist were heightened as I ran after him in the hallway and he loudly announced for all of my colleagues to hear (or so I thought they could hear), “You are a terrible therapist.”

Without my realizing it at the time, the seeds of my interest in the concept of personal control were being sown in the strategy I intuitively introduced. With the permission of this boy’s parents, I said to him, “I think that kids should have a choice if they want to leave a session with me early. I spoke with your parents and we agreed that you should have a choice of leaving 5 or 10 minutes before the session is scheduled to end. Just let me know in advance what you decide.”

He looked stunned by my statement and asked, “My parents really said that?”

“Yes. You can check with them.”

“Wow,” he replied, “But I would like to leave at least 15 minutes early.”

I was prepared for this response and countered, “I can’t do that. Look, I was glad I could get the okay for 5 or 10 minutes.”

Without further argument, he said, “I want to leave 10 minutes early today,” which he did. This was actually an achievement since he had been running out of my office at least 30 minutes prior to the session ending.

For the next four or five sessions he opted for the 10-minute “early release” (an interesting term he used) and then it went down to 5 minutes for several more weeks. Sooner than I expected the “early release” became a non-issue since he didn’t request it. However, what did occur was a productive involvement in our therapy meetings.

I know this technique will not be effective with every patient, but the success is certainly rooted in the ideas expressed by Schauman and Mansell about the importance of a patient feeling in control over particular variables in treatment.

### **A Basic Need**

As we have seen in the answers to the questions posed at the beginning of this article, those environments that are committed to providing opportunities for people to have personal control are more likely to nurture physical and emotional well-being, intrinsic motivation, and resilience. In many previous articles I have registered this belief in relation to school and work environments. As examples, please go to my December, 2003, September, 2004, December, 2009, and February, 2011 columns.

I believe that those in leadership positions in any organization should constantly ask the question, “Do I insure that the climate and practices of this organization invite and respect the input of all members of the community?” And even if we are not in leadership positions, we must at an early age be encouraged to assume responsibility for our own behaviors and address those negative conditions that are within our power to change.

Environments that are democratically based, that welcome openness and honor different perspectives, are those in which cooperation and respect rather than mistrust and disillusionment will flourish. These are the environments that produce satisfaction, accomplishment, intrinsic motivation, and ongoing personal growth—all significant components for success in our lives.

**<http://www.drrobertbrooks.com>**