JACOBS PUBLISHERS

OPEN ACCESS

Jacobs Journal of Physical Rehabilitation Medicine

Short Communication

Suggesting a Synergy between Self-Determination Theory and Person-Centred Care

Karin Weman Josefsson*

Halmstad University/ University of Gothenburg, Sweden

**Corresponding author: Karin Weman Josefsson, Halmstad University/ University of Gothenburg, Sweden,*

Tel: 0046(0)704863559; Email: Karin.Weman@hh.se

Received: 01-29-2016

Accepted: 02-22-2016

Published: 03-14-2016

Copyright: © 2016 Weman Josefsson

Abstract

There seems to be interesting commonalities between self-determination theory (SDT) and person-centred care (PCC), especially when considering their respective value systems and foundations for practice. Both perspectives are based on the fundamental view of human beings as active and capable persons who will thrive if the social environment facilitates certain essential conditions. This short communication paper addresses potential synergy effects in combining these two perspectives in order to improve future applications and assessments of person-centred care. Opportunities for theoretical guidance, concept and measurement adoption along with practical implications are briefly discussed.

Keywords: Self-Determination Theory; Person-Centred Care; Autonomy; Health Care

Abbreviations

SDT: Self-Determination Theory;
PCC: Person-Centred Care;
HCCQ: Health Care Climate Questionnaire;
TSRQ: Treatment Self-Regulation Questionnaire

Introduction

Self-determination theory (SDT) [1,2] is a recognized theory of motivation with broad evidential support for its application in health care [3] and health behaviour interventions (e.g. [4,5]). The core of SDT is an organismic value system, considering people to have innate *motivational drives* towards growth, health and wellbeing. It is proposed that this natural tendency is fuelled by fundamental *psychological needs* to feel autonomous, (e.g. experience volition and choice of actions), competent (e.g. feeling capable to handle life demands) and related (feeling connected to and cared for by other people), and that satisfaction of these basic psychological needs could be either facilitated or thwarted by the social environment [2]. Main focus is put on the quality (not quantity) of motivation, that is, whether motivation is regulated by controlled (e.g. force, fear, guilt) or autonomous (e.g. enjoyment, curiosity, pleasure) forces. It is stipulated that if the basic psychological needs are satisfied (e.g. in a health care situation) using so called *autonomy support* [6], initially controlling regulations will become more autonomous through internalization, which in turn will lead to more sustainable behaviours and increased wellbeing [2,7].

Based on some interesting commonalities of the foundations of SDT and person-centred care (PCC); [8,9], this paper will address potential synergy effects from combining these two perspectives in health care. PCC is strongly advocated in international health care research and practice [10] and has growing empirical support (e.g. [11,12] also for recovery and rehabilitation [13]. PCC is founded in the hermeneutics of Paul Riceur, the psychology of personhood [14]

and the ethics of *personalism* [15]. The application of PCC is therefore centring on treating patients like persons and thus differs from patient-centred care because patients are persons and partners in care, hence not solely defined by their illness [16]. PCC should not be confused with personalized medicine (see Taegtmeyer, [17] for description), since the latter focus on genetic or phenotype distinctions [8] and pays little or no attention to philosophical matters and personal agency. The value system behind personalism can be associated to the organismic foundations of SDT as well as to the notions behind basic psychological needs. Both perspectives also focus on the person's subjective experience, which in PCC is defined as *person narrative* where personal resources and possibilities can be identified, founding a mutual action plan labelled the *working partnership*, which is central to PCC practice [8] and tap the needs for autonomy and relatedness. Both perspectives also view the person as an active, intellectual and capable resource, which in PCC is based on the philosophical viewpoint of *homo capax* [15], signifying the needs for competence and autonomy respectively. The organismic assumption in SDT proposing humans to have innate drives towards well-being [2,7] will shape the social climate and interaction between clients and counsellors in the same way as when patients are considered to be capable persons and partners in PCC [8] and this will facilitate all three psychological needs. Volition and personal agency constitute a powerful and vital human resource in both SDT and PCC, which according to SDT tenets could be expected to stimulate a positive emotional experience where people feel autonomous and efficient [2,7]. Essentially, this signify that both perspectives would consider a decision not to change (or not to comply) to be fully acceptable and altogether this represents an important step away from traditional top-down approaches using control, persuasion and even regular threats in patient/care-giver interactions. Moreover, this is also in line with the addition of *"Agree"* to the 5As model [18], and this inclusion of patient autonomy represents a new paradigm compared to the prevailing patriarchal value systems employed within health care. The theoretical understanding of autonomy, along with the practical implications of autonomy support provided by SDT could surely serve as a useful resource in the implementation of these guidelines and could also serve as an ethical-philosophical compass of human capacity in policy-making. The support of personal autonomy and control has been identified as imperative ingredients of PCC [19] and it should be noted that within SDT, autonomy cannot be equated with independence. On the contrary, autonomy is closely related to the conceptions of *volition* and *interest* discussed by Smith [15]. Furthermore, both perspectives emphasize the significance of the person and of social environmental relations. In SDT autonomy and well-being are thought to be facilitated through an autonomy supportive context [2,7] and the patient/care-giver relationship as well as the social setting is equally important in PCC [8] hence both have potential to satisfy the need for relatedness. To summarize, it is clear that both SDT and PCC inspired approaches - implicitly or explicitly - address satisfaction of the needs for autonomy, competence and relatedness respectively.

According to Price [20] person-centeredness might be understood as a counselling style or guiding philosophy/ethics. Within psychology, person-centeredness is typically based on the outlooks of existentialism and humanism and the work of Carl Rogers [21]. When aiming to promote a person's motivation and engagement towards healthy behaviours, personal involvement and empowerment are regarded as important keys to success [6]. In contrast to the traditional top-down approach where an expert deliver advice to a receiver; SDT [6] and PCC [8,22] share essential bottom-up philosophical foundations in their attitudinal values for applied work, where clients/patients instead are supposed to be highly involved in the processes and decisions of the counselling situation. Both perspectives encourage collaborative discussion, planning, problem-solving and decision-making, which in PCC constitute the *working partnership* [8] and in SDT a part of autonomy support.

Considering the abovementioned commonalities with PCC fundaments, SDT in itself might be regarded as person-centred, and this might in turn entail interesting implications for PCC assessment. Although several instruments have been developed, there is no consensus or gold-standard in PCC measures [23] and development of PCC assessment across services and contexts has been called for [24,25]. Within the field of SDT, several reliable and valid measures of psychological need satisfaction and motivational regulations have been developed over the years, for example health care climate questionnaire (HCCQ); [26] and treatment self-regulation questionnaire (TSRQ); [27] and conceivably such conceptualizations could be a complementary way to operationalize and measure PCC efficacy as an outcome.

Adding the concept of autonomy might transform the traditional (and highly controlling) term compliance, which is typically applied in health care (see [28] for concept description), also within PCC [9, 29], more in line with PCC values.

Furthermore, a recent study of patients' perceptions of PCC [30] concluded that some participants did not take active part in their own care according to PCC intentions and that a reason might be that care-givers lack adequate "pedagogic skills" to change traditional patriarchal (top-down) approaches to more empowering (bottom-up) strategies. Although the nature of the warranted pedagogic skills remains unclear, this is an important insight. There have been widespread calls in international research for basing interventions in adequate theory to increase the understanding of the mechanisms behind successful interventions and improving effective intervention tailoring [31-33]. The skills Alharbi and colleagues [30] call for are clearly tapping the basics of autonomy support, psychological need satisfaction and autonomous motivation in

accordance with SDT. Considering the commonalities between SDT and PCC value systems, the application of a psychological lens of understanding might indeed serve these purposes well. Accordingly, educating PCC practitioners in autonomy support might create added value and improved PCC efficacy, a suggestion preliminary supported by a pilot intervention by Weman-Josefsson and colleagues [34] in the field of exercise promotion. In line with recommendations for SDT practice [e.g., 4, 6, 35, 36], the intervention conveyed structure and involvement through autonomy support, also encompassing vital elements of the working partnership (e.g. through person narrative, documentation, goal setting and follow-up; see Ekman et al.[8]). In short, results showed that observed main effects in exercise level and intensity were mediated by motivation quality in accordance with SDT tenets. Such mechanisms might help explain intervention efficacy and active ingredients of intervention content, also in PCC contexts.

Conclusion

All in all, the commonalities of SDT and PCC in terms of value systems and practical implications might constitute, if not a happy marriage, at least a promising engagement. PCC would be likely to promote autonomy, and conversely autonomy support could be expected to promote person-centeredness. In the same way as Motivational Interviewing (MI) has been suggested to provide SDT with practical guidelines while SDT would provide MI with a theoretical framework [see 37-39], PCC could aid application of SDT in the specific contexts of health care while SDT contribute to PCC practice and evaluation with a firm theoretical foundation and valid measures.

Above all, SDT have potential to embody the spirit of PCC and contribute with explanations of the mechanisms responsible for observed effects in PCC research and practice.

References

1. Deci EL, Ryan RM. Intrinsic motivation and self-determination in human behavior. New York: Plenum Press. 1985.

2. Deci EL, Ryan RM. The “what” and “why” of goal pursuits: Human needs and the self-determination of behavior. Psychological Inquiry. 2000, 11(4): 227-268.

3. Ng J YY, Ntoumanis N, Thogersen-Ntoumani C, Deci EL, Ryan RM et al. Self-Determination Theory Applied to Health Contexts: A Meta-Analysis. Perspectives on Psychological Science. 2012, 7(4): 325-340.

4. Fortier MS, Duda JL, Guerin E, Teixeira PJ. Promoting physical activity: development and testing of self-determination theory-based interventions. Int J Behav Nutr Phys Act. 2012, 9: 20

5. Williams GC, McGregor HA, Sharp D, Levesque C, Kouides RW et al. Testing a self-determination theory intervention for motivating tobacco cessation: Supporting autonomy and competence in a clinical trial. Health Psychol. 2006, 25(1): 91-101.

6. Sheldon KM, Williams G, Joiner T. Self-Determination Theory in the Clinic : Motivating Physical and Mental Health. New Haven: Yale University Press. 2003.

7. Ryan RM, Deci EL. Overview of self-determination theory: An organismic dialectical perspective. Rochester: University of Rochester Press. 2002.

8. Ekman I, Swedberg K, Taft C, Lindseth A, Norberg A et al. Person-centered care - Ready for prime time. Eur J Cardiovasc Nurs. 2011, 10(4): 248-251.

9. Rasmussen E, Jörgensen K, Leyshon S. Person-Centred Care – co-creating a healthcare sector for the future. Oslo: Rosendahls, 2014.

10. Jordan JE, Pruitt S, Bengoa R, Wagner E. Improving the quality of health care for chronic conditions. Qual Saf Health Care. 2004, 13(4): 299-305.

11. Feldthusen C, Dean E, Forsblad-d’Elia H, Mannerkorpi K. Effects of Person-Centered Physical Therapy on Fatigue-Related Variables in Persons With Rheumatoid Arthritis: A Randomized Controlled Trial. Arch Phys Med Rehabil. 2016, 97(1): 26-36.

12. Larsson A, Palstam A, Lofgren M, Ernberg M, Bjersing J et al. Resistance exercise improves muscle strength, health status and pain intensity in fibromyalgia--a randomized controlled trial. Arthritis Res Ther. 2015, 17:161.

13. Fors A, Ekman I, Taft C, Björkelund C, Frid K et al. Person-centred care after acute coronary syndrome, from hospital to primary care – a randomised controlled trial. Int J Cardiol. 2015, 187: 693–699.

14. Harre R. The singular self. An introduction of the psychology of personhood. London: Sage. 1998.

15. Smith C. What is a person?: rethinking humanity, social life, and the moral good from the person up. Chicago Ill: University of Chicago Press. 2010.

16. Entwistle VA, Watt IS. Treating Patients as Persons: A Capabilities Approach to Support Delivery of Person-Centered Care. Am J Bioeth. 2013. 13(8): 29-39.

17. Taegtmeyer AB. Personalized Medicine. Mcgill J Med. 2007, 10(1): 51-52.

18. Whitlock EP, Orleans CT, Pender N, Allan J. Evaluating primary care behavioral counseling interventions(an evidence-based approach. Am J Prev Med. 2002, 22(4): 267-284.

19. Beadle-Brown J. Person-Centred Approaches and Quality of Life. Learning Disability Review, 2006, 11(3): 4-12.

20. Price B. Exploring person-centred care. Nurs Stand. 2006, 20(50): 49-56.

21. Casemore R. Person-Centred counselling in a nutshell (2 ed.). Warwick: Sage Publications Ltd. 2011.

22. Sandman L, Granger BB, Ekman I, Munthe C. Adherence, shared decision-making and patient autonomy. Med Health Care Philos. 2012, 15(2): 115-127.

23. Da Silva D. Helping measure person-centred care. London: Health Foundation. 2014.

24. Steenbergen EE, van der Steen RM, Smith S, Bright C, Kaaijk MM. Perspectives of person-centred care. Nurs Stand. 2013, 27(48): 35-41.

25. Nilsson A, Lindkvist M, Rasmussen BH, Edvardsson D. Measuring levels of person-centeredness in acute care of older people with cognitive impairment: evaluation of the POPAC scale. BMC Health Serv Res, 2013. 13: 327.

26. Williams GC, Grow VM, Freedman ZR, Ryan RM, Deci EL. Motivational predictors of weight loss and weight-loss maintenance. J Pers Soc Psychol. 1996, 70(1):115-126.

27. Levesque CS, Williams GC, Elliot D, Pickering MA, Bodenhamer B. Validating the theoretical structure of the treatment self-regulation questionnaire (TSRQ) across three different health behaviors. Health Educ Res. 2007, 22(5): 691-702.

28. Aronson JK. Compliance, concordance, adherence. Br J Clin Pharmacol. 2007, 63(4): 383-384.

29. Munthe C, Sandman L, Cutas D. Person Centred Care and Shared Decision Making: Implications for Ethics, Public Health and Research. Health Care Anal. 2012, 20(3): 231-249.

30. Alharbi TS, Carlström E, Ekman I, Jarneborn A, Olsson LE. Experiences of person-centred care - patients' perceptions: qualitative study. BMC Nurs. 2014, 13: 28.

31. Baranowski T, Anderson C, Carmack C. Mediating variable framework in physical activity interventions: How are we doing? How might we do better? Am J Prev Med. 1998, 15(4): 266-297.

32. Bauman AE, Sallis JF, Dzewaltowski DA, Owen N. Toward a better understanding of the influences on physical activity. Am J Prev Med. 2002, 23(2 Suppl): 5-14.

33. Noar SM, Zimmerman RS. Health Behavior Theory and cumulative knowledge regarding health behaviors: are we moving in the right direction? Health Educ Res. 2005, 20(3): 275-290.

34. Weman-Josefsson K, Fröberg K, Karlsson S, Lindwall M. Mechanisms in Self-Determined Exercise Motivation: Effects of a Theory Informed Pilot Intervention. Current Psychology. 2015, 1-11.

35. Fortier M S, Wiseman E, Sweet SN, O'Sullivan TL, Blanchard CM et al. A moderated mediation of motivation on physical activity in the context of the Physical Activity Counseling randomized control trial. Psychology of sport and exercise. 2011, 12(2): 71-78.

36. Su Y-L, Reeve J. A Meta-analysis of the Effectiveness of Intervention Programs Designed to Support Autonomy. Educational Psychology Review. 2010, 23(1): 159-188.

37. Deci EL, Ryan RM. Self-determination theory in health care and its relations to motivational interviewing: a few comments. The International Journal of Behavioral Nutrition and Physical Activity. 2012, 9: 24.

38. Miller WR, Rollnick S. Meeting in the middle: motivational interviewing and self-determination theory. The International Journal of Behavioral Nutrition and Physical Activity. 2012, 9: 25.

39. Vansteenkiste M, Sheldon KM. There's nothing more practical than a good theory: integrating motivational interviewing and self-determination theory. The British Journal of Clinical Psychology. 2006, 45(1): 63–82.