

# Treating learned helplessness in hospital: a reacquaintance with self-control

*The concept of learned helplessness has been applied successfully to psychological interventions for the elderly and outpatients with chronic illness. However, learned helplessness goes largely undetected in general hospital inpatients. This article addresses this and outlines simple techniques for treating learned helplessness on the ward.*

The concept of learned helplessness has long been a causal theory of depressive symptomatology (Seligman et al, 2001). It was first proposed on the basis of experimental evidence that animals, if exposed to an inescapable aversive stimulus, become profoundly passive. Such learned behaviour became so deeply engrained that it was extremely difficult to modify the behaviour in later situations where the aversive stimulus could now be avoided, e.g. by pressing a lever. This state of passive behaviour has been described as learned helplessness. Subsequent work has led to the proposal that learned helplessness in humans who have been in trapped situations results in cognitive, motivational and emotional deficits. New learning is difficult as there is a lack of motivation, and depressive symptoms are seen, such as a depressed affect, lack of motivation and anhedonia.

## Clinical application

It is also proposed that the learned helplessness theory can be applied to the behaviour of patients in a hospital environment. The very nature of a hospital admission, it is argued, imposes a forfeiture of a patient's sense of personal control over what happens to them in hospital (Goffman, 1961; Taylor, 1979; Raps et al, 1982). In many situations this is unavoidable since patients in hospital must be subjected to numerous medical and surgical procedures. These procedures, although hopefully in the patient's best interest, are not generally requested by the patient but by the clinician. The patient does not have any significant control over when they are to be carried out, short of outright refusal. Most doctors will have experience of patients' frustration when an operation must be cancelled or when a last minute slot for a computed tomography scan becomes available and the patient must be taken down immediately regardless of whether he/she currently has visitors or is about to eat lunch.

The patient has no more control over the mechanisms of his/her immediate recovery from illness, and it is the

clinician who informs the patient, objectively, of his/her current state of health, after first asking the patient how he/she is 'feeling' subjectively. The time until discharge is dictated by the clinician and can be subject to daily revision and prolongation. All these factors can lead to the patient feeling powerless. He/she can become low in mood and develop severe symptoms of depression, for which he/she may be referred to liaison psychiatry services.

The model of learned helplessness has been applied to elderly, institutionalized populations as a causal theory of elderly patients' behaviour and affective disturbances (Faulkner, 2001). Data by Goodman and Hess (1999) have also provided compelling evidence in support of the learned helplessness model in patients with implanted cardioverter defibrillators. Combined with the earliest studies by Raps et al (1980), data from older population studies have provided good evidence that empowering patients can serve to alleviate the cognitive, emotional and motivational deficits previously described. These ideas have been formulated into the theory of 'learned mastery', an equal and opposite reaction to learned helplessness (Volpicelli et al, 1983; Peterson et al, 1993).

## Attributional styles

Undoubtedly, certain patients are more at risk of developing depressive states as a result of learned helplessness. Seligman and colleagues proposed that those predisposed to learned helplessness have a certain 'attributional style' (Abramson et al, 1978). A negative attributional style in a person, which predisposes him/her to developing learned helplessness in stressful situations, is described as internal (problems located within the self), stable (the problem is unremitting) and global (it applies in all circumstances). An example might be a student who, upon failing an anatomy viva, tells his/her friends that he/she is no good at any aspect of medicine (internal, global) and never will be (stable). Alternatively he/she might blame the examiner for asking unreasonably difficult questions on the day, and feel confident that there are plenty of other areas of medicine to suit him/her after passing the viva next time.

Whatever the causal theories of learned helplessness, treatment of the condition should be the primary concern of clinicians. Many doctors believe that psychological well-being is positively correlated with increased recovery rates

from physical illness, and that depressive conditions can delay recovery considerably (Kiecolt-Glaser et al, 2002).

## Learned helplessness in liaison psychiatry

The authors believe that learned helplessness is a significant clinical entity in hospitals. Depressive disorders are twice as common in medical inpatients than the general population (Royal College of Physicians of London and Royal College of Psychiatrists, 2003). It is certainly the authors' experience that a significant proportion of the referrals received from general hospital wards with symptoms of depression are cases in which learned helplessness would appear to play a major role. There is a poverty of recent literature concerning learned helplessness in adult hospital inpatients, and thus there is an understandable lack of information on ways of treating this condition in the general ward setting. Concerns have been raised within the intensive treatment unit (ITU) setting specifically, that such patients are particularly vulnerable to learned helplessness. Jones and O'Donnell (1994) proposed that providing patients with information in the form of a booklet would be beneficial. Such information covered topics such as explaining the process of transfer from ITU to a general ward, advice on how to improve one's sleeping pattern, and also included advice on the use of positive thinking techniques in an attempt to improve patient morale.

Other self-help behaviours have been suggested to combat the 'learned response to chronic illness' (Braden, 1993). In Braden's study, psychoeducation was given in the form of weekly classes, each approximately 2 hours long and designed for use in an outpatient setting. Many of these techniques, aimed at increasing a patient's sense of self-mastery, require instilling in patients a degree of control that is often impractical on a general ward. Alternatively, attempts to raise patients' optimism may inspire scepticism if they are perceived to be unrealistic. In the authors' experience, patients with learned helplessness benefit from a more tempered and realistic approach to the reacquaintance with personal control. Such an approach uses simple cognitive exercises that can be taught to patients within any ward setting by any member of the clinical staff.

## Cognitive exercises for patients

The cognitive tasks are given to the patient on a twice-weekly basis throughout their hospital stay. The basic tasks in the first 3 weeks involve:

### Week 1

- Provide a written description of a situation each day in which you feel at your most helpless. In addition note down any ways in which you could feel more in control of this situation.
- Write just a few lines on what you consider to be the best thing about each day and the worst thing, and why (the patient cannot use the same topics on more than one day).

These tasks establish a pattern of helplessness that can then be addressed in specific ways.

### Week 2

- Do something totally new each day. This must be something you have never done before. You must think of what you will do on the day of doing it and not plan ahead. It can be a relatively simple task such as brushing your teeth with your non-dominant hand; write down your experience of doing this (it is important to emphasize that each task can only be done once, and should not be repeated on subsequent days).
- Explore a totally new aspect of your immediate environment each day. Suggestions might be a trip to the hospital shop or visiting a part of the hospital not previously explored; write down your experience of doing this.

These tasks test the patient's motivation and willpower to change his/her behaviour.

### Week 3

- Give yourself a 'treat' each day. Describe what this was and how this felt.
- On each day, describe one thing that you wish to achieve after leaving hospital. This should be different for each day.

These tasks encourage positive self-control and planning.

Further tasks in subsequent weeks, if required, would be further tailored to suit each patient's individual needs. If the locus of control remains external, some of these tasks may need to be repeated.

A common ground rule for these exercises is that once the day's exercise has been completed it can not be used again. Also the patient is encouraged to do the 'homework' in a written format so that it can be recalled efficiently at team reviews and serve as additional cognitive stimulation for the patient. Some of the initial tasks are designed to test a patient's motivation and willingness to change. It is very important that the team attend to homework and that the patient is encouraged and educated about learned helplessness wherever possible.

Usually patients find these exercises extremely rewarding and ward staff frequently comment on mental state improvements. Patients working on these tasks often take the opportunity of educating other patients about these exercises. This demonstrates a further effect of reacquainting patients with the notion that they can indeed exert a measure of self-control over their immediate situation. Once this sense has been instilled, patients can be seen to actively search to identify further opportunities to exert control, often by the sharing of experiences with others and helping them to come to terms with their own respective problems. This phenomenon has been noted by Spiegel et al (1989) in their work providing supportive-expressive group therapy for women with secondary breast cancer. In these groups, women developed a 'carer and caring' role for other

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women in the group, which became a closely-knit community. Spiegel and colleagues noted that in both conventional and complementary therapies, the role of 'carer' was often lost in these women as their disease progressed. There has been some evidence that women attending such a group have a better quality of life and may live longer than women who did not have the opportunity of attending such a group.

The authors understand that some cases of learned helplessness are more resistant to treatment than others. Such resistance may be related to the patient's attributional style as described earlier. Also, it is important to remember that unexpected setbacks in the patient's physical recovery may be associated with a re-emergence of helpless feelings and pessimism. In such cases it may indeed be necessary to commence a course of antidepressant treatment, with recovery from depression occurring for approximately one in every four patients treated this way (Gill and Hatcher, 2002). Selective serotonin-reuptake inhibitors are currently favoured as the first-line treatment of choice, and seem 'reasonably acceptable to patients' (Royal College of Physicians of London and Royal College of Psychiatrists, 2003).

## Conclusions

Learned helplessness is a distinct clinical entity that is often encountered on general medical and surgical wards and is more prevalent throughout the hospital environment than is generally acknowledged. The authors accept that their view may be biased by the likely increased prevalence of more complex clinical cases in the many tertiary referral units at University College London Hospital. However, they would postulate that similar cases might be at risk of going unnoticed in the general hospital environment until symptoms reach an intensity to prompt a referral to psychiatric services for 'depression'.

The authors believe that the symptoms of learned helplessness can be easily treated on the wards by any member of clinical staff, if one is vigilant to its early detection. The early treatment and hopeful reversal of

the cognitive, emotional and motivational symptoms of learned helplessness using some of the exercises described in this article may well save a patient from an inappropriate label of depression in the later stages of their hospital stay. Renewed research into the prevalence of learned helplessness throughout the hospital setting, may identify those at most risk and likely to benefit from early intervention. The Attributional Style Questionnaire, as developed by Seligman et al (Peterson et al, 1982) could be administered to those patients expecting a long hospital stay. Cohorts of those with and without a negative attributional style could then be followed throughout their admission, using referrals to liaison psychiatry for depression as an outcome measure. This could help to identify those potentially at risk of developing learned helplessness. Qualitative techniques such as content analysis of both individual patient interviews and focus group transcripts may give further insight into the role of learned helplessness in 'depressed' hospital inpatients.

The authors would also encourage staff to use simple exercises previously described with patients requiring moderate to long inpatient stays to bring about a prompt reacquaintance with their internal loci of control in an effort to speed physical and psychological recovery. **BJHM**

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## KEY POINTS

- Prolonged hospital inpatient stays can lead to a profound sense of losing personal control.
- Perceived loss of control often results in depressive symptoms and can prolong inpatient stay.
- Simple exercises to remind patients that they do still have control over their lives can have a positive effect on wellbeing and speed recovery.
- Any member of the medical or surgical team can administer simple cognitive exercises for learned helplessness.
- Further research is needed to identify those susceptible to learned helplessness when in hospital and to evaluate the extent of this phenomenon in general hospital inpatients. Qualitative research methods may be particularly useful in this situation.