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Perceived autonomy support, psychological needs satisfaction, depressive symptoms and apathy in French hospitalized older people

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ABSTRACT

Based on the self-determination theory, the aim of the present study was (1) to provide a better understanding of older people's psychological needs satisfaction in geriatric care units, then to link this information with depressive symptoms and apathy; (2) to examine whether the perceived autonomy support from health care professionals differs between needs satisfaction profiles; and (3) to investigate for all participants how each need satisfaction was related to depressive symptoms and apathy. Participants ($N = 100$; $M_{age} = 83.33$ years, SD = 7.78, 61% female) completed the measures of psychological needs satisfaction, perceived autonomy support, geriatric depression and apathy. Sociodemographic data were also collected. Cluster analyses showed three distinct profiles: one profile with low-moderate need satisfaction, one profile with high-moderate need satisfaction and one profile with high need satisfaction. These profiles are distinct, and did not differ in terms of participants' characteristics, except gender. Multivariate analysis of covariance (MANCOVA) revealed that participants with low-moderate need satisfaction profile have significantly higher level of depressive symptoms and apathy, and lower levels of perceived autonomy support than participants of the two other profiles. Moreover, for all participants, regression analyses revealed that both competence and relatedness needs satisfaction significantly and negatively explained 28% of the variance in depressive symptoms score and 44% of the variance in apathy score. Our results highlight the interest to examine more thoroughly the variables fostering autonomy-supportive environment in geriatric care units, and to deepen the relationship between competence and relatedness needs satisfaction and depressive symptoms and apathy.

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1. Introduction

With advanced old age, the use of health care services including hospital by older people increase. In 2012, the population aged 65 years and over represented 17.1% of the French population, and more than 40% of older people were hospitalized (Anbar et al., 2012). Hospitalization presents specific stresses and research has shown that hospitalization could contribute to negative short and long term health outcomes such as a prolonged hospital stay, a more rapid admission to nursing home and an increased mortality (Andela, Dijkstra, Slaets, & Sanderman, 2010; Hartgerink, Cramm, Bakker, Mackenbach, & Nieboer, 2015). To fight against this in France, a geriatric care sector was created with the dual aim of ensuring the older people's access to appropriate care and optimizing management of hospital stays. This sector is defined as a device covering the integrality of possible paths for older people while taking into account the evolving nature of his or her needs (e.g. Lang et al., 2010). It includes various functional units and in particular rehabilitative or convalescent care units (SSR). In SSR units, older people are admitted after stroke, surgery or chronic condition, and 53% of their population are older people over 70 years. By offering functional rehabilitation or convalescence, the SSR units aim at fostering, where possible, a patient's return to his or her home (Coquelet & Valdelièvre, 2011). However, during their hospital stay, older people are exposed to a risk of functional physical or psychological degradation that can make "the bed of the loss of autonomy" (Tuetey, Karcher, Groc, Vogel, & Lang, 2015). Consequently, SSR units are organized to enable older people to put in place all the necessary elements for their return to autonomy, and satisfy their psychological needs.

One of the interests of the present study is the notion of perceived autonomy support and the extent to which health care professionals enable older people to experience their degree of

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autonomy. To our knowledge, few studies have investigated the relationships between perceived autonomy support by older people, satisfaction of psychological needs and psychogeriatric syndromes such as depressive symptoms and apathy. Several authors have shown a link between the loss of autonomy, deterioration of health, hospitalization and the onset of depressive and apathetic symptoms (e.g. Prina et al., 2015). Depressive symptoms and apathy are often considered as prevalent in aging in people with and without dementia, are important indicators of older people's poor mental health and are linked to an increased use of health services (e.g. Beekman, Deeg, Braam, Smit, & Van Tilburg, 1997). Stern and Bachman (1991) have shown that depressive symptoms and apathy could result from stroke and surgery, and in SSR units a low level of satisfaction of needs was identified as associated with these psychogeriatric syndromes (e.g. Ferrand, Martinent, & Charry, 2015). Other studies on older people have shown that low scores of depressive symptoms and apathy can be viewed as positive indicators of mental health and are associated with satisfaction of psychological needs, understood as motivational mechanisms that energize, direct, and sustain human behaviors and considered as necessary for improved mental health (e.g. Deci & Ryan, 2000). It seems, thus, necessary to better understand the link between perceived autonomy support, satisfaction of psychological needs and psychogeriatric syndromes in SSR units. Self-determination theory (SDT; Deci & Ryan, 1985, 2000) is the theoretical support for this study. It is a macro-theory of personality and human motivation that can be useful to explain these issues.

1.1. Autonomy support from health care professionals

The *Cognitive Evaluation Theory* (CET; Deci, 1975) is a mini theory, within SDT, which highlights the role of autonomy support. Autonomy support concerns an atmosphere where individuals are not pressured to behave in a specific way, and where they are endorsed to be themselves (Ryan & Deci, 2004; Ryan, Patrick, Deci, & Williams, 2008). In the health domain, promoting autonomy support among older people does not refer to merely leaving them alone to decide and act for themselves. Rather, it means encouraging them to make choices about how to behave, providing them the information they require for making the choices, and respecting the choices they make. For health care professionals, it also means helping them by translating information to facilitate more reflective lifestyle choices and commitments to health-related change, a process in which support for autonomy is involved. Some studies have shown that health care professionals can be taught to be supportive of psychological needs (e.g. Williams McGregor, King, Nelson, & Glasgow, 2005). Some positive key variables that define an autonomy support have been identified: a good coordination of the whole of the healthcare team, the transversal skills, the flexibility to customize the care of each patient, and the implementation of supportive communication behaviors. More specifically, a supportive communication behavior includes good patient listening, empathy towards the patients taking into account their views and difficulties, acknowledging patients' feelings, and the communication of information required for their rehabilitation or convalescence and the opportunity to make choices in different ways to manage their health (e.g. Williams, Freedman, & Deci, 1998). Some researchers indicated that it was important for health care professionals to give significance in all these variables in the decision making and problem solving and to develop a patient centered attitude facilitating satisfaction of basic psychological needs (e.g. Deci & Ryan, 2002). In contrast, health-care professionals' behaviors that aim to induce change in behavior, thought and feeling by applying external pressure or various contingencies are considered as controlling (e.g. pressure-inducing language; use of contingent rewards; excessive controlling behavior, Ryan & Deci, 2000). As proposed by Ryan and Deci (2008) autonomy-supportive environment includes attitudes and practices in a given context, and is related directly or indirectly to psychological needs satisfaction that fosters autonomously motivated behavior. In turn this behavior facilitates the individual's self-organization and self-regulation of actions and experiences, and leads to improve his or her mental health.

1.2. Basic psychological needs

The *Basic Psychological Needs Theory* (BPNT; Ryan & Deci, 2000) is another mini theory that states that mental health is a consequence of the satisfaction of the three basic psychological needs. These needs are innate, universal and essential for growth and personal and social development (Ryan & Deci, 2000). They are part of the psychological integral architecture of the human being applied to all, regardless of culture, gender and age (e.g. Deci & Ryan, 2000). The need for autonomy refers to the experience of will and psychological freedom. The need for competence implies that individuals want to interact effectively with their environment in order to feel competent to exercise their capacities and overcome challenges. The need for relatedness pertains the desire to feel connected with, and mutually supportive of, significant others. Vansteenkiste and Ryan (2013) have indicated that a low level of need satisfaction did not necessarily imply need frustration. Bartholomew, Ntoumanis, Ryan and Thøgersen-Ntoumani (2011) have suggested that these constructs (satisfaction vs frustration) were different and lead to different outcomes. Ferrand et al. (2015) have shown that in SSR units, depressive symptoms and apathy were present, and have demonstrated a negative association between competence need satisfaction and depressive symptoms and apathy. Rahman, Hudson, Thøgersen-Ntoumani and Doust (2015) have shown that competence need satisfaction predicted an increase in autonomous motivation, physical quality of life and habitual physical activity, as well as a decrease in depressive symptoms during a supervised cardiac rehabilitation exercise program. Baard, Deci and Ryan (2004) have shown that an autonomy-supportive environment allowed the development of competence and relatedness needs satisfaction. In sum, these two needs seem particularly interesting to study because they appear to be a source of behavioral change depending of their degree of satisfaction.

1.3. Apathy and depressive symptoms

Apathy is characterized by (1) a loss of initiative in usual activities, hobbies and pursuits; (2) a loss of interest in social engagement and interpersonal activities; and (3) an emotional blunting (loss of emotional responses to positive and negative events, the lack of excitement or intensity in emotions). Individuals would be diagnosed as «apathetic» where two or three of these dimensions were affected (e.g. Mulin et al., 2011). Apathetic patients are more likely to see their involvement in daily tasks deteriorate, and apathy is considered as a regression marker and a gateway for the dependence and dementia (e.g. Hazif-Thomas & Thomas, 2004). Depression is defined behaviorally by the American Psychiatric Association (2013) and highlights specific symptoms such as depressed mood, suicidal thoughts, feelings of guilt and powerlessness, lack of energy, insomnia and overeating or loss of appetite. Apathy and depression are considered as partially overlapping constructs. Indeed, they share symptoms such as loss of interest in activities, unwillingness to act or accomplish anything, poor energy, feeling of fatigue, psychomotor retardation and loss of hope. However some previous studies have

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