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# Finding the will to recover: philosophical perspectives on agency and the sick role

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## ABSTRACT

Recovery from a range of common medical conditions requires patients to have the will to change their behaviour. The authors argue that the proper recognition of the role of willpower in recovery is necessary for effective treatment.

## INTRODUCTION

Patients with obesity, depression, addiction and personality disorders are among the hardest to help in both primary care and specialist settings. Their numbers are also high. The lifetime prevalence of major depressive disorder in the USA is 9.5%<sup>1</sup>; alcohol dependence is 3.8%.<sup>2</sup> Patients with personality disorder book 24% of all general practitioner consultations<sup>3</sup> and constitute 4.4% of the population in the UK.<sup>4</sup> The prevalence of obesity is increasing: in 2003–2004, 32.2% of the US population was obese.<sup>5</sup>

It is now common for patient organisations to demand more power in medical consultations. Moreover, there is evidence that clinical approaches that involve patients in their own treatment produce better outcomes.<sup>6</sup> This general trend towards patient empowerment and involvement is especially relevant to treatment of these conditions. For the core symptoms or maintaining factors of these conditions include actions and omissions: voluntary behaviours over which the patient has some degree of control. Recovery from these conditions thus requires the patient to have the motivation and will to change their behaviour: the patient must make choices to promote recovery, as opposed to delay or prevent it. In this paper, we explore how some of the assumptions underlying more traditional medical approaches to these conditions are detrimental to recovery. Patients should not be treated as passive victims of disease, but rather as responsible agents. We thus propose that the place of agency in medical care needs to be reconceived. We draw on contemporary empirical research on willpower to suggest an alternative approach.

## THE SICK ROLE

Imagine the following: your partner, normally energetic and cheerful, starts to change. They sleep late, and find it increasingly hard to get washed, dressed and go to work. They cancel plans and social engagements. At first, this change makes you angry. You feel they are being self-indulgent and irresponsible. But then your partner goes to their doctor. They are diagnosed with depression, and are put on medication. At this point, it is natural for your attitude to change. How? On the one hand, you now take the problem seriously: their struggle

is real.<sup>7</sup> On the other, you stop holding them responsible. They are suffering from an illness and so cannot help behaving like this: they need medical treatment, not moral judgement.

The point of this story is that it shows how we typically treat illness: namely, as turning a person whom we would otherwise take to be a responsible agent into a passive victim of disease. That shift is what changes your attitude to your partner. Their actions and omissions become symptoms: effects of the depression, a condition that has befallen them, as opposed to expressions of their own choices and will.

This idea of illness is famously codified in Talcott Parsons' analysis of the 'sick role'.<sup>8</sup> Parsons begins with the thought that illness is a biological condition that causes incapacity. That is why patients cannot recover simply by 'pulling themselves together'. Recovery requires a change in condition as opposed to attitude. Patients need medical treatment. For this reason, they are rightly exempted from a range of normal expectations and responsibilities. Patients may be excused, for instance, from work, chores or basic personal care, depending on the nature of the incapacity. Expectations and responsibilities are instead tailored to the sick condition: patients are expected only to want to get well, and to seek and comply with medical treatment—to do what the doctor orders.

## THE PLACE OF AGENCY IN ILLNESS

The 'sick role' obscures the fact that recovery can fundamentally depend on the patient's own active effort and will. There is a range of medical conditions where the core symptoms or maintaining factors include actions and omissions: voluntary behaviours over which the patient has some degree of control. These conditions include addictions and personality disorders, where taking drugs, self-harming behaviour, and angry outbursts are examples of core symptoms, as well as obesity and depression, where overeating and lack of exercise<sup>9</sup> are maintaining factors. As the case of depression shows, once a disorder has been diagnosed, we are often inclined to view this sort of behaviour as wholly compulsive. We may think of it as stemming from a force in the patient so strong as to leave them no choice, no alternative possibility of action. But that is a mistake. The behaviour may be very difficult to control, but it is not impossible: people change their habits, and recovery is possible. For instance, obese people do lose weight, addicts can quit, and patients who self-harm can stop and learn to cope with negative emotions in healthier ways. It is evidently possible for people suffering from these conditions to come to behave other than they typically do.

Indeed, that is why we think of this behaviour as involving actions and omissions that stem from the person's will, and not simply consisting in automatic, physical behaviour, like reflexes and involuntary movements. Patients have the power, however difficult it is to exercise, to do otherwise. For this reason, the core symptoms and maintaining factors express choice and agency, at least to a degree. Note that the notion of degree is important. Differences in the nature and phase of the condition in question, together with differences in individual patients, can affect the extent to which control is impaired or difficult to achieve. We need to acknowledge that, for many patients, changing their behavioural patterns is far from straightforward. However, recovery from these conditions requires a change in the core or maintaining behaviours. Given that these behaviours are actions and omissions, patients must decide to behave differently, and have the will to do it.

For this reason, patients must be active if they are to recover. They must be motivated to change the behaviour associated with the condition, and, given the difficulty of doing so, they may need great perseverance and will. With effort, patients can learn to resist the pull towards the problematic behaviour; with time, the effort required may lessen as new habits and skills for living develop and new possibilities open up. There is movement along a continuum: behaviour that starts out extremely difficult to resist, slowly becomes easier to control.<sup>10</sup> Perhaps eventually patients 'kick the habit', as we colloquially say. New habits become second nature.<sup>11</sup>

Of course, many medical treatments are unpleasant to undergo, such as a course of injections or chemotherapy. Compliance with these treatments may also require motivation, perseverance and will. But the exercise of will required to recover from this range of conditions is quite different from compliance with a treatment regimen for diabetes or cancer. In changing behaviour that is symptomatic or maintaining of a medical condition, a patient directly affects the condition. In complying with a treatment regimen, a patient acts so that the treatment can affect the condition. Symptoms are effects of a disease, while actions and omissions are things we do or fail to do. What is needed for recovery from these conditions is thus a change in role from the passive to the active: recognition that, despite their condition, the patient is an agent—a person who is capable of taking responsibility for their behaviour—and not merely a passive victim of disease.

Hence alongside conventional treatment, the clinical aim, with such patients, should be to offer help, support, and guidance through this difficult process of change: to enable a patient's agency to develop and improve their capacity for control, and help them to take responsibility for their well-being.

### MEDICAL ATTITUDES THAT DISCOURAGE AGENCY

Treating the patient as if they were a passive victim of the disease, and treating recovery as a question of medical interventions separate from the patient's own willpower, can disable efforts to help people recover, not facilitate them. Clinicians tend to assume that patients are responsible for their actions only up to a certain point, and then no longer. For instance, we assume a young man who routinely drinks to excess is responsible for his predicament and capable of abstaining. However, once 'harmful use' becomes 'alcohol dependence syndrome', he is treated differently. He is no longer seen as a responsible agent: someone who is free to make choices and act on them.

Certain conventional treatments, such as some kinds of medication and psychotherapeutic interventions, may bolster

resolve and willpower. Medication such as methadone and buprenorphine, for instance, can reduce the euphoric effects of opiates such as heroin, as well as mitigating unpleasant withdrawal symptoms, thus reducing positive reinforcement of drug taking behaviour together with some of the punishing effects of cessation. This may make it easier for addicts to maintain their resolve to quit by lessening the demands recovery places on their willpower. Appetite suppressants may work comparably in obesity. Similarly, motivational interviewing<sup>12</sup> attempts to resolve ambivalence and increase motivation to change, while some cognitive behavioural therapy-based interventions aim to increase energy and activity levels. For example, behavioural activation treatment for depression<sup>13</sup> is based on the premise that encouraging a depressed patient to gradually increase their level of activity from easy tasks (such as getting a drink of water) to more difficult tasks (such as preparing a meal) will lead via positive reinforcement to an improvement in symptoms and ultimately to recovery. Positive outcomes from these treatments provide evidence that agency and will are implicated in these conditions, for they make it easier for what agency and will the patient already possesses to become more effective, less damaging. However, neither in principle nor in clinical practice do they explicitly challenge the assumption that the patient is a passive victim of disease, as opposed to a responsible agent. Indeed, motivational interviewing, for instance, is specifically designed to sidestep this challenge.<sup>12</sup>

This can lead to policies such as harm minimisation, where heroin addicts are placed on methadone (itself an addictive opioid) for the long term rather than efforts being made to support abstinence. Some services designed to address self-harm also use this approach: rather than help the patient stop self-harming and improve their sense of self-worth or esteem, the aim is to help them to self-harm more safely.

The pessimism inherent in these policies may appear warranted. We know, for instance, that rates of recovery from heroin addiction are low.<sup>14</sup> But low rates of recovery cannot justify policies that fail to aim for recovery at all. We do not help patients by thinking that, at a certain point, they are in a sense beyond help. If we do not explicitly treat them as responsible agents, capable of choosing to make changes for the better in their lives, then it is less likely that they will find a way to treat themselves as such. And, if patients do not believe that it is in their power to change, then they cannot rationally decide or resolve to do so, let alone find the will to see it through. Hence, insofar as recovery depends on decision, resolve and willpower, it is imperative that patients see themselves as responsible agents, with a degree of control over their behaviour.

Medical interventions to help the patient gain better control can then take a variety of forms. We can help patients to make different choices: to want to change, and to feel motivated to change. We can help them decide to do so and to maintain their resolve as they struggle to change, both through pharmacological interventions and psychological support. We can help them cement changes so as to reduce the risk of reverting to old patterns: to develop new habits and skills for living that, over time, may become second nature. But the change is in the end up to them. They must learn to behave differently, and, to do so, they must want to behave differently and believe it is in their power to do so. None of these interventions can be adequately described if we adhere to a traditional disease model and 'sick role'. For symptoms, understood as causal effects of an underlying disease, do not lie under one's control as an agent. Only actions and omissions are directly subject to choice and will.

## OBJECTIONS AND CONCERNS

Recognising the role of willpower in recovery may cause concern. A first objection is that it may seem unscientific: we might fear that it takes the condition and its treatment out of the realm of scientific scrutiny and controlled trials. But this is a mistake. Willpower can be empirically studied. Self-control is a limited resource that can be depleted; previous demands on self-control lead to poorer performance on subsequent self-control tasks.<sup>15</sup> Conversely, practising self-control leads to greater self-control in the medium or longer term. Repeatedly engaging in a practice that requires the exercise of willpower leads to greater stamina in later self-control exercises.<sup>10</sup> This might broadly be called the ‘muscle model’ of the will: self-control gets stronger with exercise, but suffers fatigue in the short term in the same way that a muscle group does. Thus addicts are likely to find it harder to give up the longer they have neglected to exercise self-control. Similarly, this research suggests that we might help addicts to quit by slowly building their willpower across a range of domains.

A second objection is that recognising the role of willpower in recovery might seem to invite stigma and fail to promote appropriate empathy and compassion. Problematic attitudes among staff undoubtedly exist: the UK National Institute for Clinical Excellence guidelines on the management of self-harm, for instance, note that: ‘The experience of care for people who self-harm is often unacceptable’.<sup>16</sup> This is because staff perceive self-harm as voluntary in contrast with other injuries and illnesses they tend. As a result, they may treat the injury as the patient’s fault and the patient as unworthy of care. More generally, acknowledging that the defining symptoms of the illness are voluntary actions and omissions, subject to a person’s will, can make it seem as if the person simply needs to ‘pull themselves together’—a judgemental and no doubt unhelpful attitude.

But again, this concern is a mistake. Problematic attitudes can be corrected. Self-harm is indeed voluntary, although, once again, it is important to recognise that control comes in degrees. Pretending otherwise is not a viable solution to combating stigma. But staff can learn not to blame patients, and to treat them with care and respect. We can do this by promoting better understanding of the developmental aetiology of these conditions, together with a recognition of the genuine difficulty in changing these voluntary patterns of behaviour, and the importance of appropriate clinical treatment in making change possible. In essence, this is to emphasise some of the reasons why control is reduced or difficult to achieve, which helps to quell the instinct to find fault and to blame. Hence, although it may be difficult to achieve in practice, there is in principle no inherent bar to empathy and compassion. The correct solution to the problem of sustaining appropriate clinical attitudes cannot be denial of the fact that agency plays a role in the nature of and recovery from such conditions.

## AGENCY AND EMPOWERMENT

Recognising the role of willpower in recovery should not only inform our approach to clinical care. It should also lead to the re-empowering of the patient in the interaction. No longer does the patient have a disorder that the staff can understand and treat better than they can. Rather, they are the only one who can have any great effect on their problems: without the exertion of their own will, there can be no change. In a sense, recovery is much more straightforward, even if it is not easy: it depends in the end on the choices and actions of the sufferer, which can be

aided by medical technology and expertise, rather than being dependent on it. Research indicates that encouraging patient participation in treatment can lead to improved outcomes even in diseases such as diabetes.<sup>17</sup>

As problems such as obesity and alcoholism increasingly come to be seen as disorders,<sup>18</sup> people increasingly see themselves as less responsible for the problem, and less able to address it. This need not be the case. The fact that medical intervention can help does not entail that the patient is not an agent. Clinicians and patients alike can choose to treat patients thus. As we increasingly recognise the role of agency in these conditions, the nature of the ‘sick role’ will also change.

A final but essential caveat: acknowledging the role of the patient’s agency in a range of medical conditions must not affect the quality of care. As clinicians, it is our responsibility to treat all patients equally, to the best of our ability and without prejudice. That point must stand. But we do not do this by failing to treat patients as agents, as incapable of controlling their behaviour, when they are. The best treatment may involve emphasising the role of agency in order to aid recovery. An accurate understanding of the role of the will in illness and treatment is a prerequisite for effective clinical care.

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