The Concept of Patient Motivation
A Qualitative Analysis of Stroke Professionals’ Attitudes

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Background and Purpose—The purpose of this work was to investigate how stroke rehabilitation professionals understand the concept of motivation and the ways that they use this concept in their clinical practice.

Methods—This qualitative study used semistructured, in-depth interviews with the professionals working in the stroke unit of an inner-city teaching hospital in the UK.

Results—Motivation was a frequently used concept and was described as an important determinant of rehabilitation outcome. Motivation was attributed to patients on the basis of their demeanor (proactivity was equated with motivation, passivity with lack of motivation) and their compliance with rehabilitation (compliance was seen as indicative of motivation, noncompliance as a lack of motivation). These criteria were found to have blurred boundaries. The determinants of motivation were located partly in personality factors but also in social factors. Central among the social factors were aspects of the professionals’ own behavior taken to positively and negatively affect motivation. Some professionals reported treating unmotivated patients differently from motivated ones, especially if these unmotivated patients were elderly. Motivation was described as a potentially dangerous label.

Conclusions—Professionals are wary of the concept of motivation yet commonly use it in their clinical practice. The blurred boundaries of the criteria used to identify motivation mean that patients must strike a delicate balance between proactivity and compliance to avoid being categorized as unmotivated. The way the concept of motivation is used in clinical practice might have negative implications for patient care, eg, when reticent yet motivated patients are labeled unmotivated. (Stroke. 2002;33:444-448.)

Key Words: motivation ■ professional attitudes ■ rehabilitation ■ stroke

The literature on physical rehabilitation frequently refers to patient motivation in explaining differences in outcome among patient groups with similar pathologies.3 Indeed, several studies have lent empirical support to the hypothesis that patient motivation is a determinant of rehabilitation outcome.2–4

Although rehabilitation professionals commonly adhere to this hypothesis,5–7 only 1 study has set out to analyze the concept of motivation used by professionals in their clinical practice. King and Barrowclough8 found inconsistencies in what rehabilitation professionals identified as motivated and unmotivated behavior and concluded that this finding justified the removal of the term “motivation” from the lexicon of physical rehabilitation. However, that study focused on behaviors that professionals associate with motivation and did not examine their views on the nature of motivation itself. In addition, evidence that the concept of motivation is deeply ingrained into rehabilitation professionals’ thinking2–4 casts doubt on the conclusion of King and Barrowclough that the term could simply be forgotten. As such, how professionals understand the concept and use it in their clinical practice remains a relevant topic of study.

This relevance is augmented by studies suggesting that certain conceptualizations of motivation can have negative effects on patient care. Hoffman9 and Becker and Kaufman10 found that when motivation is regarded as a quality of the patient’s personality and when this interpretation is communicated to patients, feelings of self-blame can occur when recovery is incomplete.9 These feelings can negatively affect quality of life after discharge.10

Because motivation is so poorly understood and yet so widely perceived to affect outcome and because certain professional conceptualizations of motivation have been reported to affect outcome, this study analyzed the concepts of motivation used by a group of professionals working in stroke rehabilitation.

Methods

Study Design
Semistructured, in-depth interviews11 were conducted with professionals working on the stroke unit of an inner-city teaching hospital in the United Kingdom.

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Sample
We decided to interview all 32 professionals, hereafter referred to as the multidisciplinary team (MDT). We stressed that participation was voluntary and that all information would be treated in confidence.

Because there was a high turnover rate among the nursing staff, all nurses listed on the staff rota for \( \approx 3 \) months, including night staff, auxiliaries, and agency nurses, were approached for interview.

Only 1 interviewee, a member of the study team who did not communicate any information about the study to other interviewees, had knowledge of the study’s concern with the concept of patient motivation. The other interviewees were told only that the study was investigating factors affecting rehabilitation outcome after stroke.

Interviews
We thought that an interview format that gave respondents a high degree of control over the conversation would elicit unprompted responses. These responses were thought to be more valid representations of the professionals’ views on motivation than anything obtained with more structured approaches. Consequently, we used semistructured interviews. Although each interview covered the same broad topics (Table 1), new topics introduced by the interviewee were discussed as and when they arose.

The interviews were conducted in private by the same member of the study team (N.M.). A second team member read a random selection of interview transcripts to check that there were no differences in the way different professional groups were interviewed.

Analysis
Interviews were taped and transcribed, and their content was analyzed. Initially, this involved a close reading of interview transcripts for emergent themes, which were then coded. The codes in each interview were compared with those in the other interviews to find broader categories that meaningfully linked codes across interviews. We called these relational categories. The method used to derive such categories is known as constant comparison. Although we created the categories, we took care to ground them in the content of the interviewee’s responses. An example of this process is shown in the Figure. Divergent responses within a relational category were not necessarily taken to invalidate that category; they could signify interesting dissent among the interviewees. When such divergence existed, it was reported and examined.

Results

Sample
All 32 professionals in the stroke unit agreed to be interviewed. The characteristics of the sample are listed in Table 2.

Recognizing Motivation and Lack of Motivation
Although the interviewer never introduced the topic of motivation, all 32 professionals spontaneously mentioned motivation, usually when listing the determinants of rehabilitation outcome. Five professionals thought that predictions of outcome based on motivational assessment were to be avoided, and many stressed the difference between low motivation and depression. Descriptions of motivation centered around 2 patient qualities: the patient’s demeanor and compliance (or otherwise) with rehabilitation.

Motivation Is Indicated by Patient Demeanor
Almost three quarters of the MDT members (22 of 32) associated motivation with a bold and proactive demeanor, involving certain appropriate forms of behavior: asking relevant questions (eg, the reasons for performing a specific exercise) rather than focusing on trivial issues, asking for more rehabilitation, showing an understanding of rehabilitation, initiating therapeutic activities, and performing therapeutic exercises when alone. Descriptions of behaviors included the following: “...they [motivated patients] sort of take a more aggressive approach to their rehab...perhaps ask questions...just an interest in their situation and their progress and what they can do to help themselves” (interview 12; physiotherapist). Half of the professionals (16 of 32) described unmotivated patients as displaying a converse demeanor marked by passivity, pessimism, noninteraction with therapy staff, and little apparent interest in rehabilitation.

Motivation Is Indicated by Patterns of Compliance With Rehabilitation
Nearly half of the professionals (14 of 32) described motivated patients as compliant with rehabilitation: “...they’re...
just doing everything that you say for them to do” (interview 9; physiotherapist). Conversely, the rejection of rehabilitation was seen as indicative of low motivation.

Divergent Responses
One occupational therapist stated that compliance was not sufficient for a patient to be considered motivated. She differentiated between patients doing things just “to please you as a therapist” and those possessing a quality she called “intrinsic motivation.” These patients augmented their compliance with a desire to recover for themselves.

Some MDT members felt that motivation, patient demeanor, and patterns of compliance did not relate in straightforward ways. For example, some professionals (8 of 32) described how certain motivated patients failed to comply with treatment; they rejected standard procedures for performing rehabilitation exercises and took risks in therapy. Similarly, other professionals explained how some unmotivated patients actually possessed the sort of boldness and proactivity usually equated with motivation: “They don’t want to go to physiotherapy....why should they have to do it if they don’t want? Sometimes they just refuse blankly, ‘No, I’m not going!’” (interview 26; nurse).

Thus, for some professionals, the line between behaviors taken to be indicative of motivation and those thought to show lack of motivation was not a rigid one. Other professionals thought that there may be forms of motivation beyond those recognized by rehabilitation professionals. The possible implications of this idea for patient care are discussed below.

Causes of Motivation
Motivation Is Caused by Personality Factors
About half of the professionals (14 of 32) thought that motivation was determined partly by the individual patient’s personality: “I think personality has a lot to do with it...possibly whether you’ve got a tendency to be an optimist or a pessimist” (interview 3; physiotherapist). Five professionals described how this effectively placed rehabilitation outcome in the hands of the patient: “You have to say...if you make the effort it will come back...it’s all up to you” (interview 31; nurse). The framing of motivation in terms of individual personality seemed to be reflected in the language used by some professionals, who described motivational levels in terms normally used for judging character. Motivated patients were seen as “fantastic”; unmotivated ones, as “lazy.”

Motivation Is Affected by Clinical Factors
Almost all the interviewees felt that certain clinical factors (age, stroke severity, cognitive function, depression) could affect motivation. Age drew the most comments. Almost all professionals who considered age a factor believed that increasing age correlated with low motivation: “I think age has a lot to do with it. I think the younger a person is, the more desire there is for them to leave hospital and regain their independence and as normal a life as possible. But I think the elderly person will probably sit back” (interview 28; nurse).

Motivation Is Affected by Family Factors
Although familial encouragement was seen as positively affecting motivation, a nurse described how families could reduce motivation by pushing the patient too hard to make gains. Overprotection was also described as diminishing motivation.

Motivation Is Affected by Cultural Factors
Almost three quarters of the MDT members (22 of 32) described how the patient’s cultural norms could affect motivation. Foremost among these were norms legitimizing dependency during a period of disability, eg, fatalistic religious norms that present disability as a deserved state rather than something to be overcome.

Motivation Is Affected by the Rehabilitation Environment
A stimulating ward environment, involving things like communal meals and a well-maintained day room, and group treatment sessions in which patients can share beliefs about rehabilitation and observe each other’s progress were suggested by 11 professionals to be positive determinants of motivation. Significantly, all of these professionals also thought that their stroke unit fell well short of providing this sort of stimulation. Commonly, the environment was described as stultifying, with patients being given little encouragement to mingle with each other, and institutionalizing: “...some people get institutionalised as well, they don’t want to leave this sort of safe environment” (interview 8; physiotherapist).

The raw materials of therapy were felt to be “biased” against certain cultural groups in a way that could negatively affect motivation. One speech and language therapist described how her therapeutic tools were oriented toward patients from Western cultures: “The material we use is very white, English, American biased and might not be appropriate for people from other ethnic backgrounds...” (interview 24; speech and language therapist).

Motivation Is Affected by the Professionals’ Behavior
A quarter of the professionals (8 of 32) described how aspects of their own behavior, eg, labeling patients, could diminish patient motivation: “Labeling patients is something I have major concerns about...it’s not just labeling patients who are motivated or unmotivated, but labeling patients who are successful or unsuccessful or likely to get better or not get better. Whatever sort of labels you want to attach to people actually get in the way...because it then becomes a self-fulfilling prophecy” (interview 14; doctor).

Having low expectations of how patients will perform in rehabilitation was described by 2 professionals as having a negative effect on motivation. Three professionals reported feeling guilty about patients they could not motivate. One described how the sense of failure professionals feel about patients who do not make gains can be projected onto patients in a way that can reduce their motivation.

Three professionals mentioned sharpness with patients as reducing motivation, although a doctor reported that being prescriptive with patients to engage them in rehabilitation was necessary to maintain the morale of the MDT.

One professional mentioned how giving out “mixed messages” to patients about their role in rehabilitation could negatively affect motivation, eg, if physiotherapists encouraged independence and nurses encouraged dependency by doing too many things for the patient.
Changing Patients’ Motivation

In keeping with the belief that their behavior could affect motivation, almost all the professionals (27 of 32) thought they could increase patients’ motivation. The most commonly cited technique was to strike up a rapport with patients and to chat with them about their lives. Although this was reported as having a motivating effect in itself by three quarters of the professionals (24 of 32), such chats were described as facilitating 3 more specific ways of increasing motivation: setting rehabilitation goals that were perceived as relevant by the patient, providing information about rehabilitation, and accessing and using the patient’s cultural norms.

Setting Relevant Rehabilitation Goals

Chatting with patients to find out about their prestroke lives and interests was said to allow professionals to set rehabilitation goals that the patient perceived as relevant. More than half of the professionals (18 of 32) thought that setting relevant goals had a positive effect on motivation. Some professionals added that these goals ought to be small and achievable to demonstrate to patients that they were making progress: “...it’s a reasonable goal, it’s achievable, and you try to make it something that’s meaningful for the patient” (interview 21; nurse).

Providing Information About Rehabilitation

Creating a rapport with patients allows easy transmission of information about rehabilitation, a strategy reported by about half the MDT members (18 of 32) to have positive effects on motivation. This information concerned the nature of recovery (assuring patients that they were recovering and dissuading them from unfavorably comparing themselves with other patients), how patients could expect to fare at home if no rehabilitation gains were made, why certain exercises had to be performed, and why those exercises had to be performed in specific ways.

Information provision was not used just to increase motivation; 5 professionals reported that the “problematic” aspects of high motivation (eg, risk-taking behavior) could be offset by providing information about the negative consequences of such behavior.

Accessing and Using the Patient’s Cultural Norms

Easy communication is also described as facilitating access to the patient’s cultural norms. One professional reported that using these norms can increase patient motivation. She described how discovering that an unmotivated patient believed his disability was God’s will allowed her to present rehabilitation in an attractive way: “...saying to the gentleman that it’s the will of God that he survived it, and it’s the will of God that he found himself in the rehab unit. And that he needed to take the opportunity of the rehab unit that was provided for him and that it was all right to do that” (interview 11; occupational therapist).

Another professional reported using gender norms to motivate a female patient to “brighten herself up.” She felt such “feminine talk” could have positive effects on motivation.

Who Gets Encouraged?

Some professionals believed that all “unmotivated” patients were equally deserving of encouragement. However, some professionals (10 of 32) felt that older patients responded less well to encouragement. The most common reason given for this was that older patients “have less to live for”: “...at the end of the day if a 75 year old was to reject therapy I would be more willing not to push. I would fight harder to make a 50 year old because of what I know about life really, you’ve got a long time ahead if you’re 50. If you’re 75 you haven’t got that long and have a different outlook” (interview 16; speech and language therapist).

Nine professionals reported a preference for interacting with motivated patients, and 1 physiotherapist felt less inclined to interact with the very patients it was claimed could benefit from encouragement— unmotivated patients: “If you know you’ve also got to go and motivate them...it’s very hard. You tend to try and get it over with in the morning...you can almost do that for yourself as much as for the patient” (interview 6; physiotherapist).

Discussion

The value of qualitative methods in health-related research is well recognized. Using semistructured interviews is an efficient way to investigate an underresearched topic and to allow interviewees to accurately mediate their opinions in their own terms. Depth and richness of findings, rather than generalizability, are the touchstones of qualitative research. We recognize that our findings are drawn from a particular stroke unit in a particular country. The members of the unit will have particular cultural beliefs, including beliefs about the nature of health care and disability. Further research is useful in determining beyond doubt whether our findings can be generalized to other stroke units or to populations other than stroke patients.

However, the stroke unit we studied had a high rate of staff turnover, and many of our interviewees, especially the nurses, junior doctors, and junior physiotherapists, had been members of the stroke unit for only a short period of time before the interview. This makes it less likely that our findings are merely reporting the idiosyncratic entrenched understandings of one particular stroke unit. We do recognize, however, that this does not guarantee that the unit lacks an idiosyncratic ethos.

Clinical rehabilitation literature has tended to conceptualize motivation as an inherent personality trait. This model of motivation is embraced by some of the professionals in our sample, even though studies have described its negative effects on patient care. Many MDT members were also quite comfortable categorizing patients as motivated or unmotivated. Observational work conducted in the MDT team meetings as part of another study showed how these labels were readily used in clinical practice. Furthermore, the quality of being unmotivated was reported to be grounds for typifying patients as “lazy,” as viewing work with them as a chore, and especially in elderly patients, for not encouraging them. A recent study has suggested that a perceived lack of encouragement and support from professionals can itself serve to demotivate stroke patients for rehabilitation.

However, many professionals claim awareness of the negative effects of the labels “motivated” and “unmotivated.”
The fact that professionals simultaneously report that motivational labels have negative consequences and yet still use these labels in their clinical practices suggests that there might be a difference in the public narratives presented by professionals when being interviewed by a researcher and the private narratives they use in their clinical practice. Further observational research (perhaps ethnography) might illuminate such private narratives.

The criteria professionals use to recognize motivation have been shown to have blurred boundaries. “Motivated” patients are expected to be proactive, but this proactivity must never manifest itself in a strong-willed rejection of therapy. Similarly, motivated patients are expected to be compliant, but this compliance must never be the total compliance associated with a lack of “intrinsic” motivation. In effect, patients walk a fine line regarding how their behavior is viewed; a delicate balance has to be struck between compliance and proactivity if the patient is to avoid being seen as unmotivated and therefore receiving a potentially damaging label. A recent study has suggested that a lack of information about rehabilitation and the sending out of mixed messages regarding whether passivity or proactivity is the correct way to behave while being cared for in a stroke unit can demotivate stroke patients for rehabilitation.

Caregivers walk a similar tightrope; good social support is seen as essential to maintain patient motivation, but this support must not become overprotection. Studies have suggested that overprotection by caregivers or stroke professionals can serve to demotivate stroke patients for rehabilitation. Caregivers must also encourage the patient without pushing too hard.

It also seems possible that rigid adherence to the professionals’ criteria for identifying motivation could wrongly categorize certain patients. Quiet, passive, noninteractive patients could still be keen to participate in rehabilitation. The confidence (or perhaps the vocabulary) to express any understanding of the rehabilitation process might be tied to social class and educational factors. Some patients could be motivated for recovery but might not view physical rehabilitation as the most appropriate means.

In summary, although it might be unreasonable to expect clinicians to follow King and Barrowclough’s suggestion to stop using the concept of motivation altogether, greater sensitivity to patients’ beliefs and the context in which those beliefs are formed might prevent patients from being marginalized under an inaccurate and possibly damaging interpretation of the concept of motivation.

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References
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