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**To cite this article:** Christina Papadimitriou, Nick Caddick & David A. Stone (2021) Re-thinking patient motivation in clinical rehabilitation encounters: insights from different theoretical perspectives, *Qualitative Research in Psychology*, 18:1, 23-49, DOI: [10.1080/14780887.2018.1464090](https://doi.org/10.1080/14780887.2018.1464090)

**To link to this article:** <https://doi.org/10.1080/14780887.2018.1464090>



Published online: 08 May 2018.



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## Re-thinking patient motivation in clinical rehabilitation encounters: insights from different theoretical perspectives

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### ABSTRACT

We use analytic pluralism to discuss and analyze a data excerpt from the medical rehabilitation of an inpatient with spinal cord injury and his physical therapist to examine how the concept of motivation is used in clinical practice. We employ three theoretical perspectives in order to explore ways of understanding this concept: Social Determination Theory, Phenomenology, and Narrative Inquiry. We present and argue for multiple ontologies as a new way forward to understanding complex human phenomena such as motivation.

### KEYWORDS

Analytic pluralism; medical rehabilitation; motivation; qualitative methods; spinal cord injury

The current health care climate increasingly values person-centered care<sup>1</sup> as the appropriate way to motivate and care for patients (Institute of Medicine 2001). In medical rehabilitation, person-centered care is predicated on the person's autonomy and choice (the person's self-determined motivation) in setting his or her own goals, breaking down status hierarchies between persons served and providers, and optimizing their partnership (Law 2002; Sumsion & Law 2006). This approach to care argues that the person served (patient, family, *and* caregivers) ought to be at the center of service provision, which should involve advocacy, empowerment, and respect for the person's autonomy, voice, self-determination, and participation in decision making (<http://rnao.ca/bpg/guidelines/person-and-family-centred-care>). In arguing for all this, the motivation of the person to engage and act becomes significant to this model of care.

Though person-centered care is currently culturally preferred and valued by many health care and professional organizations, it has been difficult to implement in practice (Gzil et al. 2007; Mead & Bower 2000; Armstrong 2008). Within medical rehabilitation, some of the challenges include insufficient or unclear relevant evidence and limited critical reasoning to appraise the evidence, limited time with patients, and a lack of administrative support (Pellat 2004; Lewin et al. 2001). Several scholars (e.g. Gibson et al. 2009; Gibson, McPherson et al 2015; Carnevale & King 2012; Hammell 2006, 2013) argue that person-centeredness

requires a shift or rethinking of the ways health care organizations are organized and how providers interact with persons served. Additionally, implementing person-centered care may rely on the ways in which providers and researchers understand, appreciate, and act on what they understand to be the person's motivation. Inspired by critical disability studies (Gibson 2016), in this article we use methodological pluralism (Clarke et al. 2015; Clarke, Caddick & Frost 2016) to critically examine the topic of motivation in inpatient spinal cord injury (SCI) rehabilitation from multiple perspectives. Our aim is to reveal new ways of understanding, appreciating, and acting on patient motivation in the context of person-centered rehabilitation.

Methodological pluralism brings together “multiple methods, data collections, theories, analyses, or disciplines within the same research project” (Clarke et al. 2015, p. 368) to develop more complex, dynamic, and nuanced understandings of the phenomena under study. Pluralism can be used to develop multiple interpretations of a single data set within qualitative research, recognizing that “a data set can tell us about a number of different things, depending on the questions we ask of it” (Willig 2013, p. 19). In this article, we specifically make use of the concept of *analytical* pluralism, that is, the application of multiple theoretical lenses to analyze the same data extract. A pluralist approach to studying patient motivation acknowledges there is no one “best” or superior theory that can settle the “problem” of motivating persons served to reach clinical goals. Likewise, pluralism maintains there can be no theory-free knowledge and all understanding is tied to our theoretical perspectives. Our choice to use analytical pluralism does not imply a kind of “anything goes” relativism, where all perspectives are considered equal and an endless array of potential interpretations are espoused. Rather, we use this approach to discover what happens when we change or combine our theoretical lenses, and we seek to highlight both the values and limitations of different theoretical understandings.

Importantly, pluralism can also help to *diversify* understandings of patient motivation beyond the dominant theoretical approaches. While the clinical literature on motivation is large and diverse, dominant understandings rest on taken-for-granted assumptions about autonomy and choice (Smith 2013). To both explicate these taken-for-granted assumptions and to diversify—and potentially deepen—our understandings, we first present a data extract from a clinical exchange between a physical therapist (PT, pseudonym Jean) and a newly spinal cord injured adult (pseudonym Terence) as part of their routine interactions in a free-standing rehabilitation hospital in the midwestern United States, and a debriefing interview between the PT and the first author. Next, three different theoretical analyses are applied to the data extract to reveal how each analysis shapes different possibilities for understanding. The first perspective is self-determination theory (SDT), chosen because it is commonly taught to students in the allied health sciences and appears to

appeal to health care providers in general (e.g., Rahman et al. 2015). We then offer a second, phenomenologically informed approach to reveal how motivation is understood in the context of embodied temporal disruption, acutely experienced by Terence within the health care setting. Third, we employ a narrative approach to illustrate the *drama* of the rehabilitation setting and how getting *caught up* in different stories is central to the unfolding action between the person-served and PT (Frank 2013).

We reveal through this tripartite analysis how clinicians use the concept of motivation in practice, what clinicians mean by it, and how the concept may be impoverished. It is important to study this phenomenon *in situ* because it elucidates taken-for-granted assumptions about the so-called hard-to-motivate patient and “doing” care. These assumptions, if unexamined, may hinder a person-centered approach to care (McPherson 2007; Cott, 2004a, 2004b; Sacristan 2013). More importantly, they may hinder quality of care and outcomes for the person served. The value of appreciating a multiplicity of interpretations in understanding human behavior in a health care setting is useful for researchers, scholars, and professionals because it allows us to re-think our assumptions, address our disciplinary blinders, and appreciate new ways of approaching our work. The article then takes up a number of practical and theoretical implications for providers and scholars.

Finally, in the discussion section, we explore the possibility of going beyond pluralism at the methodological level and consider the value for practitioners of taking a pluralist ontological position in the following sense. Disciplinary paradigms create regional ontologies within which the objects of their understanding are made meaningful and subject to formal description, testing, and experimentation (Stone 2013, 2014). As Kuhn demonstrated, disciplines do this by a combination of a) formal methods, rules, procedures, and approaches that can be rationally reconstructed, communicated, and followed by others, and b) informal methods, rules, and ways of doing and understanding things that are implicit, tacit, and extra-rational (Kuhn 2012; Stone 2013). These latter elements, however, cannot be rationally reconstructed and shared across disciplines; one can only be socialized into them. The result, as Kuhn saw it, was that scientists from different disciplines are not simply trying to communicate across methodologies but also across worlds (Kuhn 2012; Pickering 2017).

As is now well understood, this situation often makes efforts to work across disciplines, and even subdisciplines where regional ontologies do not well align, incapable of producing “coherent theoretical understandings and explanations of phenomena” (Clarke et al. 2015, p. 183). But for clinicians and practitioners, whose attention is less focused on understandings and explanations than the persons they are working with, it may be easier to operate in a world that admits to multiple ontologies (Mol 2002; Pickering 2017; Graham & Herndl 2013).

Following Mol, we explore the possibility that practitioners can readily engage in *negotiating* the meaning of motivation across ontologies (in the words of our title, coordinating “insights from *different* theoretical perspectives”) to meet the needs of their practice while eschewing the epistemological baggage that often (but need not necessarily) plagues researchers.

### **Data excerpt: “patient is difficult to motivate”**

The data excerpt comes from the first author’s research in one inpatient SCI unit in a large independent rehabilitation teaching hospital in the United States. The SCI unit has approximately 100 beds, sees both new and chronic SCI patients, and employs about 12–15 full and part time PTs and occupational therapists (OTs) and speech language pathologists. It has dedicated rehabilitation nursing staff and a medical director who is research active. One major goal of the original research was to study allied health providers’ understandings and practices of person-centeredness in inpatient rehabilitation for adults with SCI. The research methodology used was ethnographic, that is, observing and being part of activities in the unit, audio-recording clinical encounters among consented therapists and patients, and interviewing providers and patients about their experiences with their care. (Please see Papadimitriou 2012 for further methodological details.) The research was reviewed by institutional review boards at both university and hospital sites.

The data describe an audio-recorded clinical exchange between a physical therapist, Jean, and a paraplegic adult patient, Terence, who had experienced a complete traumatic SCI (Papadimitriou 2012). Terence was a 19-year-old African-American who had experienced a gun-shot wound (it was unclear if the shot was intended for him or whether he was in the wrong place at the wrong time) and who lived with his mom. Terence was not verbally or emotionally expressive during his stay. He allowed the first author to observe his inpatient PT, OT, and group therapy activities. He was more verbally expressive and smiled, even laughed, when he was able to use the Wii games during OT sessions and when he talked to another inpatient in the unit that he befriended during their stay. Jean is white, 32 years old, talkative and attentive, thought of as seasoned, and had been working with persons with SCI for approximately six to seven years. The data also describe an impromptu interaction between Jean and the first author a few minutes after Jean and Terence’s clinical session. Jean expressed many of her emotions regarding her encounter with Terence. The data for this encounter were not audio-recorded due to the impromptu nature of the exchange and are derived from the author’s field notes.

### ***Clinical encounter***

During this PT session, which occurred in the patient's room, Terence (T) thought he had a bowel accident.

PT: ok, let's check on that. Where is your mirror?

T: I don't know.

PT: ok well if you were home and you couldn't find your mirror, what would you do to check? T does not answer.

PT: Well, you would put on gloves and check if you had a bowel accident. T doesn't respond. PT looks at me with exacerbation.

PT: well, we can't do our session until we figure this out, so let's see. She proceeds to find gloves.

I excuse myself and leave the room because allied health providers on the floor had specifically asked me to not be present or collect data during bowel and bladder trainings due to their sensitive nature for patients with SCI.

### ***Impromptu encounter between PT and researcher***

Jean came out of Terence's room, and bumped into me and said:

Wanna talk about a patient that is hard to motivate and work with? T will be going home in one week and I'm frustrated because he doesn't take any of my suggestions toward exercising or pain management. I try to educate him, explain his pain to him, and how his particular pain works for him... You know he is always in pain, and he scratches his elbow, he scratches it with his belly binder, the hard surface, and then makes it bleed and that is not good. So I explained it to him, don't know how many times, that his elbow pain is residual pain and it comes from his neck. So we work on the neck. We do stretches and different exercises, and then it [pain] feels better. So I say to him, "See T, when we work on the neck it means less pain on the arm, right?" so let's do them. He says, "I don't know if they are working." So I'm frustrated. Like when we do the exercises his pain goes down to zero or one, how can he say he doesn't know if it's working? It IS working.

She takes a breath and looks at me. I nod to express that I follow what she is saying and smile in an effort to encourage her to continue talking. She returns to the clinical session I observed in Terence's room, saying:

I mean, I don't know what else to tell him, you check, that's what you want to do. Figure it out. But you know, he is not problem solving with me, he is like, "I don't want to do that," and I'm like, "well, I would not want to do that either, but if you don't have your mirror, I don't know what else to tell you."

I nod. She continues:

"I had all the ideas, he had nothing to offer."

Jean is animated as she explains this. She says, “I am frustrated because I like him, I see his potential. I don’t want him going home and sitting on his butt and getting a huge sore the size of..., [pauses] he already has a sore.”

She says that during his whole stay she has not heard him verbalize one goal on his own. She emphatically says “not one goal.”

I am in disbelief because I have seen T enjoying playing the Wii with the OT, so I say, “well, except for playing the Wii,” and Jean says, “well yes, except for that.” She takes a breath. “I keep asking myself; what am I doing wrong?”

“Do you think it’s something you are doing wrong?”

“I don’t know, some patients just don’t click with some people, you know; it’s chemistry. [pause] He needs to go home and figure it out himself.”

I nod. “How come T was still in bed at 11am?”

“He said he had no clean clothes to wear and was waiting on his laundry. So I asked him, “So you didn’t do laundry? And he said, “My laundry was not done.”

With animation Jean says to me, “I mean how he expects to be independent if HE doesn’t DO his laundry?! Right? And he tells me that “at home someone does my laundry.” So, you know, I tell him, “Do you ever want to live on your own? Don’t you want to be independent?”

Then says to me, “I tell him he’ll do nothing if he doesn’t learn to be independent.” She pauses. “I don’t know if he doesn’t get it, like abstractly, like it doesn’t compute to him, if he doesn’t want to get it, or if he is incapable of putting it together”

## Methodological note

Our methodological pluralism derives from our collective theoretical, disciplinary trainings and our expertise in qualitative methodologies. It also encompasses narrative inquiry (Frank 2010, 2012), discursive psychology (Potter & Wetherell 1987), ethnography and auto-ethnography, phenomenologically informed sociology (Stone & Papadimitriou 2010; Papadimitriou & Stone 2011) and critical rehabilitation research (Gibson 2016). The following questions were chosen to achieve our goal of illustrating the multiplicity of possible interpretations regarding the topic of motivation within this data excerpt:

- (1) Using phenomenologically informed sociology, we can ask, what is Jean’s (the PT) web of significances (Heidegger, 1962; Weber 1949; Geertz 1973), such that Terence appears to be unmotivated and disinterested in his own care program? A web of significances is a concept that captures those aspects of Jean’s experiences (including being a PT but also a person in the world) that may not be visible to



- her (she may not be able to recognize them, let alone articulate them) and are relevant in this instance because they inform the ways she interprets Terence's behaviors (Stone & Papadimitriou 2015).
- (2) Using self-determination theory, we ask how Terence's core motivational processes are being influenced by his interactions with Jean and with the rehabilitation environment in which he finds himself immersed.
  - (3) Using phenomenology and narrative approaches, we ask, how is culture influencing the way the PT understands or interprets Terence's behavior? By culture we mean the rehabilitation organization with its policies, norms, and assumptions about the delivery of care, the provider, the person served the responsibilities, expectations regarding patient compliance, the provider competencies and performance, trends such as the medicalization of rehabilitation treatment, and wider cultural narratives which shape how persons served experience illness and disability.
  - (4) Using all approaches, what does the PT need to help Terence? Does she need signs that point to Terence being interested in all this? Does she need Terence to be problem solving without her?
  - (5) Using all approaches, we ask, what is Terence saying with his actions in this moment?

These questions stem from current evidence that indeed organizational culture influences the ways that providers and persons served interact in health care settings and that understanding the details of these influences is important if we want to achieve person-centered care (Opie 1997, 1998; Papadimitriou & Cott 2015).

In what follows, we consider these questions by applying our chosen three interpretive frameworks to the data extract. We begin with what might be considered a more "traditional" theoretical approach to motivation in the form of self-determination theory. We then proceed to offer additional interpretations through phenomenology and narrative, before concluding with a discussion of what we might learn by considering our data from these different perspectives.

The multiple analyses were applied as follows. First, three analytical perspectives were selected based on a mixture of theoretical and practical concerns (Clarke et al. 2015). Theoretically, SDT was selected because, as indicated above, this perspective has an intuitive appeal and understanding within the health care professions. Practically, we as researchers selected sociologically informed phenomenology and narrative inquiry based on our theoretical proclivities and what we thought we might bring to the data by applying our different conceptual and theoretical imaginaries. We acknowledge that the analytical process was at least partly researcher-driven in that



certain understandings became privileged by virtue of the researchers' background and training. As Honan et al. (2000, p. 9) suggest, however, this demonstrates the "constitutive force of theory" in *all* forms of qualitative analysis and how different people are differently prepared to view the same situation, much the same as a piece of music or artwork might "speak" to people differently depending upon their culture and background.

Second, each analysis was then carried out independently, with two analyses carried out by one researcher and the third carried out by another. In each case, the theoretical concepts peculiar to each perspective were applied *after* the data were collected to make sense of what was happening in the interaction between Terence and his PT. For the researcher conducting two analyses, the SDT analysis was carried out initially and then, with a practice akin to Gubrium and Holstein's (2009) "analytical bracketing," set this aside to work on the narrative analysis. Third, draft forms of each analysis were compared and contrasted with the other two in order to consider the similarities and differences which emerged from seeing the data through the different theoretical lenses. Accordingly, each analysis was carried out separately, and we make no claims that we are integrating the findings from each perspective. Rather, we consider what each perspective can tell us about the situation in an additive fashion, without claiming superiority for one perspective over another. We ask the reader and the clinician to consider how *all* of the perspectives we present may be "true" in ways that honor the vivid complexity of human life and interaction.

## Motivational theories

One theory of motivation that could be applied to interpret and understand the data extract is SDT (Ryan & Deci 2000). SDT is a popular and much-researched theoretical framework used by psychologists interested in explaining why and how people can be engaged and proactive in pursuing daily tasks and life goals or, alternatively, how they can be passive, alienated, and unmotivated. Proponents of SDT also use it to explore the social conditions that facilitate the engaged and proactive state and those which undermine or thwart it.

Two of the key postulates of SDT are as follows. First, people are assumed to possess a natural and innate tendency toward psychological growth and integration, social development, and personal wellbeing. In the context of the extract above, we might say that Terence would naturally be endowed with an innate drive to maximize his independence and personal autonomy as a key goal of his stay in rehab. The innate human tendency toward growth, learning, and creativity is what is referred to in SDT as "intrinsic motivation" (IM). IM is a state in which someone is actively engaged in a particular activity for the simple reason that they both value and enjoy that activity and want to keep on doing it. SDT also postulates a number of other forms of

motivation such as external regulation and a-motivation, which explain why people participate in activities not purely for the sake of them. One goal of SDT is to explain how IM can be facilitated and sustained as opposed to these other, more controlled forms of motivation, which are less conducive to psychological wellbeing. SDT thus describes a range of different types of motivation that exist along a scale or continuum from a-motivation and external regulation at the one end, describing the most alienated reasons for taking part in activities, and intrinsic motivation at the other end, describing the most integrated and self-determined reasons for participation.

Second, SDT assumes there are three innate psychological needs—for competence, autonomy, and relatedness—that everyone naturally possesses and that, when satisfied, lead to psychological health, optimal functioning, and wellbeing. Autonomy refers to individuals' belief that they are the originator or author of their own choices and behavior, that their actions are self-determined. Competence refers to the perception an individual has that they are good at what they do, and relatedness denotes the fundamental need that people have to be connected to others as part of satisfying personal relationships. These three needs are, moreover, integral for understanding motivational processes because satisfaction of them is assumed to promote positive engagement and IM while failure to satisfy these needs (or when they are thwarted during interactions with others or by situational factors) undermines engagement and leads to alienation. In the context of the extract, we might suggest that Terence's psychological needs are being undermined in some way by his interactions with the PT and that as a result he is alienated from the rehabilitation context and disengaged from working collaboratively to achieve the goal of independence set for him by the PT.

With these basic postulates briefly sketched out,<sup>2</sup> let us now consider the extract in greater depth through the theoretical lens of SDT. From the outset of the extract, we can see there is trouble both for Terence and for the PT in the way in which "motivation" is reportedly absent from Terence's actions in the rehabilitation context. For instance, on line 6 we learn that the PT is frustrated because Terence "doesn't take any of her suggestions" (line 17) and that her attempts to educate him are met with a failure to get through to Terence. We might infer from the language used to describe these interactions that the PT's instructions to Terence exhibit a "controlling" form of interaction. That is, the way in which she makes her suggestions (*demands?*) fails to support Terence's basic need for autonomy. In the language of SDT, Terence's behavior is "externally regulated," coordinated by the PT's own agenda rather than through any internal volition of his own. Similarly, the fact Terence is "being educated" (line 18) by the PT suggest that Terence's role in the process is relatively passive—he is an idle recipient of the PT's knowledge and instructions. The PT's frustration with Terence's resistance

toward complying with her wishes can be read as further evidence that it is *her* goals, rather than Terence's, which form the focus of their interactions.

There is a clear discordance, evident from the start of the clinical encounter, between the PT's efforts to get Terence to problem solve with her and Terence's apparent lack of willingness to cooperate in this process. Again, we may infer from Terence's responses (or lack of responses) that he does not value the behaviors suggested by his PT as central to his self-care regime (e.g., ways of checking for a bowel accident). He is yet to "internalize" these behaviors as valuable or worthwhile; to integrate them, that is, into his core sense of self. Therefore, his interest in carrying out these behaviors of his own volition is low. There is also evidence in this part of the interaction that the PT's frustration derives in part from Terence's failure to live up to her expectations. When PT says, "I had all the ideas, he had nothing to offer" (lines 34–37), she indicates her expectation that Terence should be actively involved in his rehabilitation in order to achieve the aim she desires for him (i.e., his ability to live independently and care for himself).

To achieve the aim of independence desired for him by his PT, Terence is further expected to set goals for himself (lines 38–39). Following the postulates of SDT, if Terence were to set his own goals and work toward achieving them, his behavior would, by definition, be more self-determined. He would therefore be more likely to work harder at them. That Terence is unable to overcome his motivational inertia and begin setting goals for himself is again a source of frustration for the PT as she laments that he has set "not one goal" on his own during his rehabilitation. As suggested above, interactions between Terence and the PT are structured around the activities that the PT deems important for Terence's rehabilitation. Activities that Terence himself might consider valuable or engaging seem not to have been considered and are not on the agenda. Even activities that Terence has shown some interest in (i.e., playing the Wii) are seemingly dismissed by the PT as unimportant or irrelevant to achieving the goals she has set for him.

According to SDT, the PT has been unable to find ways of relating successfully to Terence. Terence's fundamental and basic need for relatedness is not supported by these interactions. We may suggest that if the PT was able to cultivate a more warm and trusting relationship with Terence, he may be more upbeat and engaged during his interactions with her and more willing to begin "internalising" the self-care behaviors she wishes to impute to him. Rather than being externally driven, Terence would thus begin to integrate these behaviors into his core sense of sense. He would come to value such behaviors and perform them on his own because he believes in the benefits they will confer upon his rehabilitation. We are told that Terence seemed to lighten up and engage more when talking with one of his peers whom he befriended at the hospital. Terence's need for relatedness thus appears to be satisfied by other interactions within the rehabilitation setting,

but not with his PT. Based on this interpretation, one potential avenue to explore for getting Terence to engage more in his rehabilitation could be to find ways of involving his new friend in goal setting and working together toward achieving certain outcomes.

We can also interpret the PT's own frustration through the lens of SDT. Throughout the extract, we are given numerous indications of the PT's frustration regarding *her inability* to connect with Terence and to engage him in rehabilitation. This is made more explicit on line 42 when she states, "I keep asking myself; What am I doing wrong?" The interaction with Terence is possibly undermining the PT's sense of her own competence because she feels she is failing to get through to him. Terence, in turn, is not living up to her expectations of him as a patient, and she does not understand why this is happening. The result is that the PT's fundamental need for competence is undermined by her involvement with Terence and thus her frustration with Terence grows deeper, possibly serving only to alienate him further from the process of rehabilitation.

In sum, there seems to be a vicious circle of "need dissatisfaction"; the PT's need for competence is undermined by her inability to connect with Terence, and Terence's needs for autonomy and relatedness are undermined by the PT's approach to his rehabilitation and self-care program.

### ***Practical implications***

Based on the above SDT interpretation, we might suggest the following practical implications for clinical professionals. Research (e.g., Rahman et al. Doust 2015) supports the importance of helping patients to feel self-determined and find purpose and enjoyment in their rehabilitation activities. Similarly, providing support for patients' needs of autonomy, competence, and relatedness has been identified as important for achieving positive rehabilitation outcomes (Farholm et al. 2017). One way to accomplish this may be to work toward a more collaborative process of goal setting between patient and physical therapist, with the emphasis on the *patients* setting their own goals (which may be small and incremental at first, if necessary) for what they want to achieve. This suggestion would align goal-setting practice with person-centered care (Lewin et al. 2001). Positive feedback and reinforcement have further been identified as important means of satisfying patients' need for competence (Ryan et al. 2008) and should not be overlooked by practitioners as part of the rehabilitation process. Finally, supporting patients' need for relatedness might be achieved by fostering opportunities for social support and interaction among patients as a key part of the rehabilitative process, thereby maximising opportunities for peer support and relationships.

In the following section, we use the concepts of embodiment (Csordas 1994; Merleau-Ponty 1962; Zaner 1971), embodied temporal disruption (Papadimitriou & Stone 2011), narrative (Smith & Sparkes 2008a), and web of significances (Weber 1949; Geertz 1973) to further analyse the data. In doing so, we show the socio-psychological and epistemic contexts within which the data excerpt may be located and interpreted. We explicate these contexts and expose taken for granted assumptions that may hinder an understanding of motivation that is person-centered, that is, one that appreciates Terence's life circumstances and that treats him with respect for who he is in this moment in time as he navigates learning to become en-wheeled (Papadimitriou 2008).

## A phenomenological interpretation

Scholars in the phenomenological tradition (Zaner 1971; Toombs 2013 1995) highlight the importance and complexity of experience within medicine. They focus on describing the experiences of chronic illness or disability (Toombs 2013 1995) as well as the ethical and embodied ways these experiences present themselves for persons (Zaner 1998; Winance, 2006a, 2006b, 2007; Williams 2000; Papadimitriou 2008). The phenomenological approach used in this article draws from hermeneutic phenomenology (Merleau-Ponty 1962; Merleau-Ponty 1968; Heidegger 1926/1968; Gadamer 1989).

Though there are many approaches to phenomenology (Spiegelberg 1978, 2012; Davidsen 2013), one key postulate of phenomenologically informed approaches is that people are embodied, that is, that we *are* our bodies (rather than *having* bodies). Embodiment refers to the physical (bodily) characteristics of the human body as well as to the meanings and values surrounding the body. The body is the centre of one's orientation to the world (it provides a point of view) and the locus of intention (it provides one's capabilities of action) (Merleau-Ponty 1962, p. 92). We will apply the phenomenological concepts of embodiment (Merleau-Ponty 1962; Csordas 1994; Zaner 1971) and temporality (Heidegger 1962; Stone & Papadimitriou 2010) to the data shared herein.

A second postulate is that embodied persons are immersed in an already meaningful world, that is, that we are always culturally embedded. Our behaviors and interactions in the world are always grounded in our experiences regardless of whether we are aware of those experiences. In the clinical encounter, Terence and Jean bring with them their habits, expectations, genders, ethnicities, educational training, previous experiences (in rehabilitation and trauma), politics, cultural norms, etc., all of which may be invisible to them. As such, Terence's and Jean's behaviors, actions, perspectives, and choices are a part of an intersubjective web of cultural meanings. This means there is a web of significances (Weber 1949; Geertz 1973) that is relevant in

this clinical encounter that forms *and* informs the ways in which Terence and Jean interact, and within which Terence's actions are interpreted as "hard to motivate." The reader should recognize in this instance that the concept of web of significances of this approach points to context-specific cultural factors to explain one's motivation, rather than internal or intrinsic characteristics of an individual person.

A third postulate is related to existential temporality (Heidegger 1926/1962) and the possibility of embodied and temporal disruption (Papadimitriou & Stone 2011) that persons come to terms with to understand their condition and situation as newly injured and newly abled after traumatic SCI. Scholars in sociology of health and illness have explicated the work it takes to come to terms with one's chronic illness and have described it as "biographical disruption," "loss of self," identity shifts, and "trajectory work" (Bury 1982; Charmaz 1983; Roth 1963; Corbin & Strauss 1988; Davis 1963). The disruption of traumatic injury and disability affects one's sense of being-in-the-world, that is, one's social, personal, existential, and relational ways of being. It takes a "re-embodiment of time" (Seymour 2002) to re-habilitate oneself, not least of which is to learn to incorporate the wheelchair as a "natural" part of one's body and "do again" as an en-wheeled person (Papadimitriou 2008).

If Terence is experiencing embodied temporal disruption, he may find himself disconnected from his past, such as who he was before the injury as a nondisabled man. As such he can't draw from his past experiences to understand his present circumstances, and he may be experiencing his immediate abilities and world as "I can't do that anymore." More importantly, Terence needs to relearn how to live his life anew without relying on his past in the ways that persons without traumatic injury generally do. During inpatient rehabilitation, he will learn to perform mundane and important physical tasks that will help him navigate his world, but the embodied disruption affects his personal aspects of his life, such as his self-image, sexuality, and future aspirations. These latter issues often remain unstated; they are not articulated by the patient or health provider, but are relevant nonetheless.

This notion of temporal disruption can be taken further in a hermeneutic-phenomenological direction (Heidegger 1926/1962; Stone & Papadimitriou 2010). In that approach it is recognized that human meaning-making requires persons to project themselves into the future. All meaning-making is fore-structured by intentions, purposes, and goals, whether individual, social, or historical. For ordinary individuals, those future states are best understood as their past coming back at them from the future, such that who they have been is what provides the horizon of possibilities that give rise to intentions and goals they may take up as their own. An individual experiencing acute spinal cord injury may no longer maintain a projection of the person they have been into the future that aligns with their current physical state. In this case, the temporal disruption amounts to an existential disruption; without that sense of where they

are going and what things will look like when they get there, individuals experiencing existential disruption struggle to make or find meaning in the present and make sense of difficult activities and exercises they are being asked to engage in (Stone & Papadimitriou 2010).

When Jean asks him to problem solve regarding his possible bowel accident (lines 1–9), Terence appears to not actively try to verify whether he has had an accident or not. During inpatient rehabilitation, bodily functions such as bowel movements and accidents are treated as practical matters, not as taboo subjects; they are tended to, like any other issue that needs to be problem solved. It remains unclear, however, whether Terence has accepted this particular bodily change as well as practical approach to bodily function: from someone who had intentional or could control bowel movements to someone who is unclear if he had a bowel accident. Though this is a practical problem in this instance for Jean, it may be much more than that for Terence. It can speak to his self-identity as a man and to his sexuality, and it is potentially embarrassing (perhaps especially so in front of two women). It may also more deeply reflect his incapacity to overcome the existential disruption confronting him such that he cannot fully appreciate or internalize the future self he is being asked to—or told he will—become. In light of Terence's upcoming discharge to the community (his mother's home), Jean is concerned he is not problem solving this practical problem. Jean is informed by her web of significances, thus expecting or wishing for Terence to show independence with this task so he can be discharged. The focus on preparing Terence to being discharged is part of her professional training and her work with him. It is frustrating to her that Terence appears not to know how to problem solve and tend to this task at hand.

Turning to lines 21–24 of the data extract, Jean is engaging in educating Terence by translating what his pain means, and why and how the two of them are working on relieving his pain (neck stretches to relieve elbow pain). Jean uses her clinical expertise and clinical reasoning to assist Terence to appreciate or contextualize the neck stretches as a response to his needs (the elbow pain). The practice of explaining to the person the reasoning of treatment is recommended practice within person-centered guidelines. Nonetheless, Terence seems to challenge the effectiveness or consequence of the neck stretches and treatment in line 24. It appears that he is expressing ambivalence or disagreement when he states, "I don't know if they [exercises] are working." This lack of agreement perhaps is what frustrates Jean (line 24) who in her turn now seems unable to understand Terence's statement and stands firm in her perception that her clinical decision to do neck exercises are the solution to Terence's pain.



### ***Practical implications***

Based on hermeneutic phenomenology, the work of interpretation is never ending. We focused on exposing the ways in which Terence and Jean may have been making meaningful their circumstances by using the concepts of temporal disruption, embodiment, and web of significances. In this way, we can observe that the meaning contexts that Jean and Terence are bringing to their encounter may be competing with each other (or he may simply lack the capacity to meaningfully take up the future she envisions for him). The practical implications that stem from this approach suggest to us that mindful clinicians could continue to ask questions that make explicit the cultural contexts within which clinicians and patients make sense of their lives together. Clinicians may ask: If for Terence many aspects of his therapy are still not meaningful to him because he is experiencing temporal disruption, is he letting Jean know that by responding to her in this way? What Jean considers so obvious/apparent/natural/normal is not for Terence. So we can continue to ask: How is it to be in this situation for both Terence and Jean? What makes it possible for Jean to see/treat Terence as someone who is “hard to motivate” rather than someone who is incapable of being motivated in the usual ways? These questions require that we reflect further upon the sociological and existential web of significances that may form the context in which the two participants are interacting. We offer the following sociological web of significances to our reader to promote continued exploration of these contexts. As such, consistent with this phenomenological approach, what we suggest herein are incomplete interpretations awaiting further fleshing out:

- (1) Practicalities of working within a U.S. health care delivery system: These are issues Jean has little to no control over but affect her work with Terence. For example, insurance length-of-stay requirements affect the remaining time Jean has with Terence; hospital policies about Jean’s productivity have implication on her performance (and as a result of billable hours, promotion, and reimbursement structures); and postacute care reimbursable or billable hours further influence Jean’s allotted time with Terence.
- (2) Discipline-specific habits: These habits are often invisible or taken for granted by clinicians (Papadimitriou 2008b). In this case, physical therapy guidelines foster a particular understanding of what a successful treatment looks like and how to work with patients with SCI that can influence the ways in which Jean experiences her interactions with Terence. According to Fleming-Castaldy (2015), allied health educators need to critique disciplinary pedagogy to determine whether they are preparing future clinicians to practice person-centeredness.

- (3) Rehabilitation culture: Uncritical acceptance of norms and assumptions within rehabilitation (such as measurement of treatment effectiveness using only a professional point of view) may impose a perspective on what is possible or expected within a clinical encounter. As patient reported outcomes are becoming more accepted and valid for use in rehabilitation assessment and treatment, we may experience a shift in accepting patient perspectives more and include the person served more actively in their treatment (Miller et al. 2015).
- (4) Social and cultural assumptions such as neoliberal cultural norms or unexamined ableism regarding the designation of the “responsible patient” may be uncritically accepted by Jean, thus blaming Terence as unmotivated. It is outside the scope of this article to explore how these assumptions may be taken for granted by clinicians (see *authors* for a critique; Grover & Soldatic 2013; Mitchell 2015; Mladenov 2015).
- (5) Gender norms: While we are unable to consider in detail the gendered implications of Terence’s new embodiment in this article (see, e.g., Shuttleworth, Wedgwood & Wilson 2012), it is worth noting the considerable challenges which Terence may encounter in embodying a new disabled masculinity (consider, for instance, Terence’s reluctance to check for a bowel accident in front of two women). Practically speaking, mindful clinicians and researchers do well to sensitize themselves to the gendered implications of traumatic injuries and to adapt their practice accordingly (e.g., respecting for patients’ modesty/dignity, offering a male or female colleague to assist with particular problem solving activities).

### **Motivation as narrative emplotment**

A narrative approach has previously been used to explore how men with spinal cord injury draw on a variety of cultural stories and narrative types to tell stories about their injury and recovery and to navigate their way into life with a disability (Smith 2013; Smith & Sparkes 2004, 2008b, 2011; Sparkes & Smith 2002, 2011). This research identified a dominant medical restitution narrative (see Frank 2013) which shaped the postinjury lives of men who became disabled through playing sport. The restitution narrative articulates the concrete hope that medical intervention will return the disabled individual to a former able-bodied self, and follows the basic plot of “yesterday I was able-bodied, today I’m disabled, but tomorrow I’ll be able-bodied again” (Smith & Sparkes 2004, p. 615). Alternatively, some disabled men foregrounded a quest narrative, emphasising disability as a journey of discovery and a transformed self rather than a hoped-for return to able-bodiedness and walking again. A third narrative (or *anti*-narrative) of chaos was also identified, wherein life is imagined as over and/or as never getting better. A narrative approach considers these different cultural storylines as *guides*, *maps*, or *resources*,

which individuals use to understand who they are and where their lives are going following the embodied temporal disruption (see above) of traumatic injury.

Crucially, what *motivates* someone depends on what kind of story they are caught up in. As Frank put it:

People do not simply listen to stories. They get *caught up*, a phrase that can only be explained by another metaphor: stories get under people's skin. Once stories are under people's skin, they affect the terms in which people think, know, and perceive. (Frank 2010, p. 48)

As well as affecting the terms in which we think, know, and perceive, stories call forth certain actions and motivate people toward certain goals such as performing rehab exercises or staying physically active (Smith 2013). A *good* story (from Jean's perspective) might thus be one that encourages commitment to reaching clinically defined goals. Thinking *with* the unfolding drama of Terence and his encounter with Jean, we suggest that Terence lacks a good story to guide his rehabilitation experience and his journey into life as a disabled man. Terence's altered embodiment calls for a new story that will help him make sense of the temporal disruption, yet none presents itself. Accordingly, how Terence appears to Jean in her interactions with him—unmotivated and disengaged—may simply reflect that Terence is lost in his attempts to come to terms with disability and has yet to find a narrative map that will provide him with some useful direction in life (Frank 2013).

While Terence may be lacking a good story to guide him (like a good *companion*; Frank 2010) through his rehabilitation and into his altered existence, there may be a number of stories competing for his attention (Frank 2006). As Frank (2006) suggested, many stories that circulate through culture and society call out to be taken on board, yet space can be found for relatively few. Some stories Terence might hear and find resonance with (perhaps these include the stories told by his new friend in the rehab setting), while other competing stories are left to float by in the river of “not for me.” At the same time, it may be that Jean is caught up in her own stories about rehabilitation and about what good, compliant patients are expected to do and these stories are resisted by Terence and his “refusal” to cooperate. Mattingly (1998), for instance, discusses “healing dramas” and “clinical plots,” which are co-created between patient and physical/occupational therapist as a way of engaging the patient in the rehabilitation process. Life is *emplotted* by a clinical story of healing from injury, and this emplotment calls upon the patient to perform certain actions, to be *motivated* to work toward clinical ends.

Yet rather than co-creating a healing drama, the interaction we present above reads more along the lines of a clinical narrative being *imposed* upon Terence by his physical therapist. We may surmise this is an institutional/clinical narrative driven along by targets, goals, measures of treatment effectiveness, and professional opinions, in which the ideal responsible patient is one who is docile and compliant with the therapist's requests. Following Robertson (2006) and Smith (2013), such institutional rehabilitation narratives are noticeably shaped by a cultural neoliberal

health discourse, which calls upon the patients as dutiful citizens to take responsibility for their own health, thereby becoming a morally “good” self. Or, as O’Brien (2012) put it, there is a “recovery imperative” imploring patients to work toward returning themselves to a high functioning norm, maximizing their own well-being and minimizing their burden on the health services. A “should care about health” approach is therefore *drilled into* spinal injury patients within rehabilitation settings, calling on them to work on the material body, to take responsibility, and to recover as much function as possible (Smith 2013). The clinical rehabilitation narrative leaves little moral space for manoeuvre or resistance on the part of patients, calling out as *the* story to be taken on board and acted on.

There are other cultural narratives, some perhaps complimentary and others contradictory to the clinical narrative, which may compete for Terence’s attention. One type of story (tied to the medical restitution narrative above) is drawn from powerful cultural norms of masculinity, whereby disability is constituted as a form of adversity to be dramatically and heroically overcome (Sparkes & Smith 2002). Such stories celebrate the heroically masculine individual who has fought and won the *battle* with disability and overcome his limitations. As Sparkes and Smith (2002) argue, however, the masculine hero narrative creates a compelling but mostly unattainable image for people to live up to. It may also direct the course of recovery in personally limiting ways (Robertson & Smith 2013; Smith 2013). For instance, societal pressure to adopt the hero narrative as one’s own limits access to other narratives and other ways of exploring disabled identity. Moreover, failure to live up to masculine ideals may leave newly disabled men feeling uncomfortable, embarrassed, or ashamed of their new embodiments (as Terence’s demeanour and responses surrounding his suspected bowel accident might thus indicate).

What story will Terence choose to tell about his life following his violent traumatic injury? And how might Jean help him to craft a creative response to his newly disabled body? Such questions illustrate the narrative *drama* of rehabilitation; a drama which presently appears unrecognised in the interaction between Terence and Jean. Here, we argue that a narrative approach adds significant value in addition to traditional motivational theories because it enables us to ask questions opening up new possibilities for understanding Terence’s life and experiences. Furthermore, whilst respecting the individual circumstances of Terence’s life story, a narrative approach also enables us to explore how wider cultural influences (such as masculine ideals, institutional norms, and dominant illness narratives) actively shape Terence’s experiences within and beyond the rehabilitation context (Smith 2013).

### **Practical implications**

A narrative approach encourages clinicians to imagine themselves as *storytellers* who help to co-construct a new narrative that their patient/client can live by. For

instance, Smith et al. (2015) demonstrated how narrative can be used as a tool for knowledge translation, “disseminating research-based knowledge in accessible, credible, and meaningful ways” (Smith et al. 2015, p. 304). These authors used stories (in this case, short written stories about the rehabilitation experiences of patients with SCI) to communicate information about the role of exercise and physical activity in rehabilitation. The stories were shared with 15 newly injured adults, along with their peers and health care professionals, who were currently going through SCI rehabilitation. These individuals were then interviewed about their perceptions of the stories they had read. Importantly, patients viewed these stories as an effective form of communication, delivered by credible messengers in the form of other disabled adults. Their responses in the interviews indicate the power of stories as a means of communicating with patients:

I obviously know it’s important to be fit for my health. But I didn’t know all of what was said. It [the story] taught me a lot, and, like how much exercise I should do, or to keep myself motivated. I’ll start doing more of that. (Smith et al. 2015, p. 309)

The whole setting is appropriate, the rehab center and where all those initial thoughts, fears, anxieties, and curiosities are pretty rampant. I think a lot of people can relate with that. That definitely struck me and pulled me back in a lot of ways ... The description of the rehab center was very good ... Those doors in the rehab that will swing open and the smells of the rehab center come wafting out ... I could certainly relate with all that. (Smith et al. 2015, pp. 307–8)

The stories of other spinal injured patients thereby acted as “maps” or “guides” for newly injured patients, helping them navigate their journey into disability. As Smith et al. (2015) further emphasized, “the stories open up dialogues between people that, in turn, become a useful resource for stimulating discussion about physical activity and perhaps persuading people to be more active” (p. 309).

Relatedly, narrative reveals the importance of both peer support and peer mentors as an integral part of the rehabilitation process. Informally, as part of the rehabilitation context, patients may share stories with each other about their lives and about their experiences in recovery from injury. Therein emerges the potential for *collective stories* (Richardson 1990) to develop among patients, shared narratives about injury and rehabilitation which help develop a sense of camaraderie and mutual identity among patients who find themselves in the same situation. As Caddick et al. (2015) argued, collective stories help to bind people together emotionally and gather up their individual stories into a shared narrative. Moreover, collective stories act as a crucial form of peer support by generating a shared commitment to supporting the wellbeing of others and by providing a sense of comfort that one is not alone in his or her experiences and challenges. As such, there is considerable potential for rehabilitation and health care services, which tend to be focused on the individual, to harness the power of narrative as a form of peer support to increase the therapeutic benefit that patients derive from their rehabilitation experiences (Horton-Salway 2001).

## Discussion/conclusion

Each of the three theoretical approaches we have explored provides us with a different focus for the position or place in which Terence finds himself. For SDT, motivation at its best is when it is the enactment of specific personal values and the joy produced through that enactment. For phenomenology, motivation is an unfortunately narrowly psychological term for the existential situation confronting those who can no longer project their past into their future and so struggle to make sense of what they are being asked to do in the present. From the perspective of narrative analysis, the presence or absence of motivation signals whether the individuals can locate themselves in a narrative that “works” for them and guides their actions, and it reveals the difficulties that ensue when competing narratives are at play. By adopting a methodologically pluralist approach, we hope to have clearly shown the value of drawing upon more than one approach to understanding the concept of motivation and the ways in which both practitioners and scholars can benefit from considering their own approach relative to the others presented. From here, however, we would like to press further into the opportunities presented by such an approach.

In the introduction to this article, we used perspectival language to frame the methodological pluralism we employed. But in closing the article, we reframe the basis for methodological pluralism away from the idea of one reality seen from multiple perspectives and toward the idea that as soon as we take a formal methodological stance, the reality we have access to is only that which is provided by the particular method we are using. In other words, not multiple perspectives on one ontology (world), but multiple ontologies. We are interested in exploring this option because methodological pluralism has a hermeneutic limitation. Across disciplines, methods (or approaches based on specific methods) cannot incorporate insights from other methods because, as we have shown, methods build in assumptions that are not simply epistemological but are also ontological; that is, they interrogate their object within the contextual world within which they operate and in ways that cannot be explained but only socialized into. But while methods have this limitation, experts (practitioners and researchers operating at the level of expertise) do not. As Dreyfus, Benner, and others have shown, expert-level practice transcends judgment based on methodologically driven understanding (Dreyfus, Dreyfus & Athanasiou 2000; Benner 2004, 2001). To take up the real potential inherent in a methodologically plural approach for informing and guiding practice and scholarship, we must take the next step to ontological pluralism so that we can free experts to negotiate across ontological boundaries and combine, at the level of expert understanding and practice, the insights made available by each of the approaches.

The most obvious parallel in the literature to what we seek to accomplish here is provided by Mol’s description of three different medical approaches to atherosclerosis of the leg (Mol 2003). In that work, the patency of multiple



ontologies is revealed through the efforts the physicians needed to make to negotiate cases in which their methods revealed different diagnoses (realities) for a given patient that had to be reconciled. Here, we will explore the value of multiple ontologies for permitting deeper levels of collaboration among rehab professionals and more robust understandings of matters such as motivation.

In this article, we have left the reader with the choice, based on their methodological predilections, to decide “what motivation really is.” This is the challenge presented by every multidisciplinary encounter, whether among researchers or practitioners, and the difficulty is that to choose one answer to the question of the reality of the situation is to deny the others. However, if we admit to ontological pluralism, we find ourselves in the position that to accept your reality is not to deny mine. The challenge in that event is to effectively “negotiate” motivation in both senses of that word: that we can come to a shared understanding of motivation that we can work with, and that we can work in, around, and through more of its nuances, meanings, and implications.

For example, we can see a point of intersection between the narrative and hermeneutic-phenomenological approaches. In previous work by two of the authors (Stone & Papadimitriou 2010; Papadimitriou & Stone 2011; Papadimitriou & Cott 2015), we advocated for the use of peer mentors in the context of inpatient rehabilitation to provide concrete cases for persons to use as the basis for forming their own new sense of what is possible for them. Seeing peer mentors arrive in their own cars and talking to them directly about their jobs and their relationships allow vague and seemingly unrealizable hopes to become concrete possibilities—possibilities that can be lived into and that provide meaning and motivation to the hard, incremental work that needs to be done today to realize those possibilities. But in the reality offered by the narrative approach, it seems entirely possible that the role of the peer mentor could be replaced by a suitably clear, strong, and articulate narrative that reveals a concrete sense of the person's future possibilities. Maintaining the link with the hermeneutic-phenomenological approach to temporality (Stone & Papadimitriou 2010), one could imagine helping persons develop such a narrative using traits from the client's past (e.g., stubbornness, past success in rigorous training environments, knowing oneself to be a quick study) that they can carry forward and embody as the character in a narrative that can point them toward a concrete future existence.

One could go further and embed the characteristics of autonomy, competence, and relationships provided us by the SDT approach into the narrative that serves to provide the concrete futural vision required by the phenomenological approach. In this way, one could imagine developing an intervention that builds upon all three of these disparate approaches in a manner that might prove more effective than any one of the approaches alone. But only if one were open to the prospect of multiple ontologies from the start.



Similarly, our understanding of what motivation is may also be enhanced through the process of negotiating across the realities offered by these approaches. Taking the term “negotiate” in the second sense described above—as the ability to work in, around, and through nuances, meanings, and implications—we can bring all three understandings of motivation together to provide a richer understanding. We can, for example, understand motivation as an individual mental state that expresses the innate tendencies toward growth, integration, social development and personal well-being, driven by the psychological needs for competence, autonomy, and relatedness. This, indeed gives us a basis for acting one-on-one with the person served. But it is also possible to see that the ways individuals make meaning for themselves (that is, understand themselves as moving toward integration and social development) are inherently temporal, contextual, and bodily without seeing those factors as in any way elements of external regulation. In this way, we uncover building blocks of motivation that were hidden within the psychological concept of innateness, and once uncovered, we have shown these building blocks can be worked with.

Multiple ontologies have not been a welcome addition to the scientific landscape (Musgrave 1970; Pickering 2017). But in cases of expert judgment and expert practice, where expert engagement already transcends the limitations of methodologically-driven understanding, multiple ontologies may provide permission for a deeper and richer engagement and greater prospects for truly person-centered care.

## Notes

- 1 We use the term person-centered term rather than patient-centered or client-centered care because a focus on a person includes a socio-cultural and thus more interpersonal approach to care. We follow CARF International’s lead to use person-first language. With the term ‘person’ we include the person-served’s family and caregivers. (CARF.org).
- 2 For a fuller discussion of SDT, see the recent review by Taylor (2015).

## Acknowledgements

The authors thank the participants of the study for their willingness to participate in the original study. We also thank the thoughtful remarks of Brett Smith, PhD on previous drafts of this manuscript.

## Funding

The data cited in this manuscript were part of an original research study funded by the National Institute on Disability, Independent Living and Rehabilitation Research (NIDILRR), H133F090053.

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