Patient Motivation for Rehabilitation

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The importance of motivation in the treatment-recovery-rehabilitation process has been cited by many authors. Many therapists have worked with two roughly similar cleft palate or facially disfigured patients, one of whom responded favorably to rehabilitation, while the other did not. In such an instance, unspecified differences in motivation have often been assumed to account for such disparities in progress. There is relatively little research or systematic writing on patient motivation for rehabilitation. This article is based in part on a review of reports in the literature on motivation concerning many types of patients for rehabilitation (*1*). While relatively few reports on patient motivation have dealt specifically with cleft palate, cleft lip, and facially disfigured patients, results from several studies have implications for this group.

In discussing patient motivation for rehabilitation, it is appropriate first to specify the meaning of these terms. The use of the word *patient* is meant to restrict this discussion to the patient's motivations (his interests, drives, and other behaviors) which have to do with his trying to improve his functioning and to realize his capabilities. The *rehabilitation* process connotes as complete as possible a restoration and/or habilitation of the patient, physically, mentally, vocationally, and socially, so that he may realize his potentialities to the fullest. In most cases, this will involve the assessment of present abilities, capacities, and functioning, then restoration and repair, then re-training, then reassessment, further repair when indicated, further re-training when indicated, reassessment again, etc. This rehabilitation cycle is a continuing one until rehabilitation is complete, that is, until the patient has achieved his best possible adjustment.

It is important to remember that physical management, whether surgical or prosthetic, is only one part of the rehabilitation process. Without guidance and training in the use of the prosthesis, without the very necessary training in communication skills, the patient may be only par-

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tially rehabilitated. Ideally rehabilitation of the patient should continue until he is functioning at his most efficient level. All of the members of the rehabilitation team help to orient the patient, and the parents, where appropriate, to the total rehabilitation task to be accomplished.

Theories and Research on Motivation

From a survey of the literature on motivation, it appears that the term *motivation* has been used in contexts so broad as to encompass all of psychology, all behavior, and perhaps all of life's activities. Certainly the use of a term in this broad a sense is not meaningful. Yet when two therapists talk about a patient's progress, they are very likely to mention the motivation of that patient either by implication or quite specifically. What are they talking about? What are they likely to mean when they mention motivation?

Motivation is a concept referring to a number of behaviors or characteristics which can be observed. For example, one might say about a patient that he comes for help because people laugh at his appearance or his speech. Yet, some theorists feel that use of the term motivation is too broad to be meaningful (*6*). Others, such as Kelly (*7*), have excluded the concept from their theoretical systems about behavior and life. Motivation has been variously described in terms of innate and internal drives or needs, in terms of inner stimuli and responses (both of which may at times be considered motivators), and in terms of the goals or the directions of the motivation. One might say, then, that motivation concerns the intrinsic and extrinsic conditions responsible for variations in the intensity, quality, and direction of on-going behavior.

Most personality theorists assume some innate biological activating force at the base or beginning of their descriptive motivational systems. The patient is alive, reactive to his environment, and invests varying amounts of energy in coping with his environment. Some theorists, such as Selye (*15*), believe that there are innate homeostatic processes which account for much of everyone's behavior. These theorists assume that a person's physiological and psychological sub-systems are in some kind of dynamic balance. When, in response to stress, these systems get out of balance, Selye believes that there is an innate automatic predisposition within the patient to compensate for and to try to correct the imbalance among the sub-systems.

Most theorists assume that some kind of hierarchy or family of needs with a highly refined and relatively central over-riding drive or need at the pinnacle of this hierarchy develops with maturation. Maslow's concept (*10*) of self-actualization is one such central, unifying need or drive. Rotter (*13*) believes that most behavior can be explained as security-seeking, although he specifies other rather specific kinds of needs which may be related to the need for security. Adler's concept of life style and

Freud's life and death instincts are other such central, integrating need concepts. Most theorists feel that need systems are organized around and relate to some such central integrating need.

At a more specific level, some think in terms of needs for love, affection, sex, dependency, exploration, and safety. Certain theorists, attempting to develop an all-inclusive system to account for all behavior, have arrived at relatively specific and exhaustive descriptive categories of needs, for example, Murray (*11*). The interrelationships and interactions of these specific needs, the prepotence of one or another pattern of needs in endless variations which differ at different times, allow the description of the unique individual characteristics of different people. The utilization of a common set of descriptive concepts and a common language system need not imply that the uniqueness of the individual must be obscured.

In order to understand a patient's motivation, one must also consider the environmental pressures which may act upon him. These pressures include the demands of his life-situation. In fact, there are environmental demands associated with most of the patient needs or drives referred to above. Research on motivation has tended to focus either upon the inner needs of the patient, or upon the environmental pressures and demands which seem to call forth the motivated behavior.

Research on the motivation for rehabilitation of the cleft palate and facially disfigured patient has not been extensive. There have been a few studies of the environment and other psycho-social context of these patients, (*2, 4, 9, 14, 16, 21*). Primarily, these studies have concerned children and surveys of the attitudes of parents about the problems of their cleft palate children. In one study (*18*), a control group of parents of children who did not have this particular disability was similarly surveyed.

Reported findings to date on the motivations of cleft palate patients have been very general, and not different, as nearly as could be determined, from the findings of studies of other patient groups. Parents in the American culture want what they feel is best for their children. Their feelings in this regard are influenced by the culture and subculture to which they belong. In addition, different categories of patients seem to be similarly motivated at all ages. They want to be happy, secure, and successful. They want to be unhampered by facial and speech deformities. Despite assertions to the contrary (*5, 19*), there is no clear evidence that there are peculiar innate personality or other characteristics of cleft palate patients. Several investigators (*10, 16, 17, 20*), have failed to find consistent and significant psychological test differences between children with cleft palates and control groups. There appear to be no early differences in the motivations of cleft palate children which cannot be accounted for by people's reactions to their appearance and/or speech. Of course, such reactions by others toward the patient may affect some of the patient's motivations and other behavior. But these reactions from

the environment may motivate the patient in positive directions, as well as encourage his withdrawal and disengagement from life.

Developing Patient Motivation

When one considers the handicapped patient and how his motivation for rehabilitation may be increased, the research literature, while far from conclusive, does yield several suggestions. Thus one might focus upon learning and reinforcement which many feel account for how needs are acquired or shaped. Imprinting, the very early learning of species-specific behaviors, is another concept related to the development of many personal characteristics, including those we call motivations. The expectations of others for the patient will certainly influence his behavior in many ways. Sources of satisfaction and gratification can be identified in the environment and usually can be related to some of the needs mentioned above. This essentially extrinsic vantage point for considering an individual's needs and drives is sometimes the most useful when one wishes to change, shape, or alter behavior by increasing the motivation of the patient and his parents. Also, of course, this is the vantage point from which therapists see the patient.

Regarding specific steps in the rehabilitation process, it is important in motivating the patient that physical recovery or surgical repair be initiated as soon as this is medically and psychologically feasible. The treatment activity is the beginning of rehabilitation and should not be delayed. Most rehabilitation specialists feel that there is a period of mourning immediately following the realization by the patient and his family that he may be or has become disabled. While this mourning period should be allowed to run its course (it rarely can be changed, even when it becomes pathological in intensity), one should start active rehabilitation efforts *before* the mourning period is over.

During this period of mourning, the patient and his family will come to realize that he is disabled. At this time, they must somehow begin to face the possibility that he will not be able to do all of the things he did before his illness or injury. Also during this period, the patient's psychological discomfort, and that of his family, increases. This discomfort is what the rehabilitation team may capitalize on in their work with the patient. The rehabilitation team provides *hope*. While they cannot guarantee over-optimistic outcomes to the patient, they can challenge the patient's and his family's imaginations with plans to help the patient compensate for his disability and cope with his new situation.

As indicated by Goldstein (3), successful rehabilitation is strongly influenced by patient expectancies on the one hand and the expectations of the significant people in the patient's environment on the other. Key people in the patient's environment include not only the patient's therapists, but also his family, his friends, and his associates in whatever

situation or setting he may live and work. Thus the expectancies of the family for the patient must become a consideration of the rehabilitation team.

A very important motivating factor noted from research with all kinds of disabilities is the use of the therapist's relationship with the patient as a means of bringing about the patient's recovery, readjustment, and rehabilitation. For example, the patient's relationship with his dentist is a tremendously important variable in predicting whether the patient will return for further treatment when needed, and whether he will follow the dentist's advice and prescriptions for appropriate self-care. After therapists learn the techniques of developing positive relationships with patients, they eventually come to use these rapport-developing techniques unconsciously (this is, without being consciously aware of their intention to use such techniques at a given time). Every therapist might well stand back occasionally and examine how he builds a relationship with a given patient, and how what he does and says influences that patient, sometimes much more than he realizes, or intends. Such relationships are used to build positive motivations for the recovery and total rehabilitation of patients and their families.

Only two other aspects of patient motivation for rehabilitation will be discussed here briefly. One involves external pressures upon the patient for his rehabilitation. The research literature is not clear regarding the effects of severe financial deprivation, or the threat of it, upon patient motivation for rehabilitation. Certainly the family intentionally or unintentionally often brings great pressures to bear which may influence the patient toward rehabilitation. These outside pressures in some instances are probably helpful by stimulating the patient's fear, discomfort, hope, and expectancies, and in this way, serve to further the patient's rehabilitation. Also, experience to date with the manipulation of external pressures including incarceration, for the rehabilitation of criminals, suggests that somehow one has to make the individual *want to change*, rather than just conform because he has to.

Another important aspect of patient motivation for rehabilitation is the availability of opportunities for treatment, re-training, and other kinds of rehabilitation. The availability of opportunities or resources for rehabilitation alone is not a sufficiently motivating force, but it is certainly an important consideration in trying to predict rehabilitation outcomes. This is one of the justifications for the impressive federal-state rehabilitation programs which last year rehabilitated over one hundred and nineteen thousand handicapped people. Some of these people probably would have recovered and gone to work without the help of the state-federal programs. However, there is every reason to believe that the present rehabilitation programs, facilities, and other resources supported by the Vocational Rehabilitation Administration, the Children's Bureau, the National Society for Crippled Children and Adults, the

Goodwill Industries, and many other similar public and private organizations and agencies play an important role in rehabilitation today (*8*). These programs provide available opportunities and resources for the rehabilitation of large numbers of people at a time when they are ready for rehabilitation and in a location relatively near the patient's home. The availability of such resources, while not a sufficient factor to account for successful rehabilitation, is an important one, and one which increases the probability of good rehabilitation.

Summary

Some of the current thinking about the basis and descriptive anatomy of motivation has been briefly described. Most theorists believe that given an active, moving energized organism (that is, a living patient), his motivations can be conceptualized in terms of some kind of hierarchy of needs or drives. Motivation should be considered from the vantage point of the patient and from the vantage point of the observer or the therapist. That is, one should be interested in what is going on inside the patient, what he thinks, feels, and does. Also one must look at the situation within which the patient lives now and will live in the future. One should try to identify the demands of the patient's life situation which call forth certain behaviors from the patient and thus motivate him. Finally, there are several important considerations in motivating the patient, which authorities suggest are universally important. These include the patient's acceptance of his disability, his feelings of discomfort and then hope, the patient's expectancies about rehabilitation and the expectancies of those in his environment, the extremely complex relationships between the patient and his therapists, the kinds and types of external pressures upon the patient, and finally the availability to the patient of adequate rehabilitation resources. Most of these consideraitons in greater or lesser degree are important in the rehabilitation of any kind of disability including that of the cleft palate and the cleft lip. Unquestionably a patient's motivation for rehabilitation can be improved and enhanced by an increased understanding of and attention to these considerations.

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