The role of chronic pain and suffering in contemporary society

Tidsskrift for Forskning i Sygdom og Samfund

Nr. 13, 2010

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Nr. 13: *The role of chronic pain and suffering in contemporary society*

Proof: Thomas Christian Mikkelsen.

Layout og prepress: Jens Kirkeby, Aarhus Universitet & Thomas Christian Mikkelsen.

Tryk: Werks Offset, Højbjerg.

Udgiver:
Foreningen Medicinsk Antropologisk Forum,
Afd. for Antropologi og Etnografi, Aarhus Universitet, Moesgård, 8270 Højbjerg.

Bestilling, abonnement, henvendelser og hjemmeside:
Tidsskrift for Forskning i Sygdom og Samfund.
Afd. for Antropologi og Etnografi, Aarhus Universitet, Moesgård, 8270 Højbjerg
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www.sygdomogsamfund.dk
ojs.statsbiblioteket.dk/index.php/sygdomogsamfund/index

ISSN: 1604-3405

Tidsskriftet er udgivet med støtte fra Forskningsrådet for Kultur og Kommunikation.

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Aims and scopes

The Journal for Research in Sickness and Society is an interdisciplinary journal which has a theoretical background in medical anthropology. The aim and purpose of the journal is to promote and develop research in the borderland between the health sciences and the humanities/the social sciences. The goal of the journal is to function as a forum in which these disciplines may meet and inspire each other – epistemologically, methodologically and theoretically. The journal conveys the debate and theoretical development which takes place in the growing collaboration and research initiatives emerging from this borderland. The journal addresses all with an interest in research in sickness and society and especially health professionals working with education and/or research in interdisciplinary institutions.

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Original research article

Lack of motivation as suffering

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Møller, J.E. (2010). Lack of motivation as suffering. *Tidsskrift for Forskning i Sygdom og Samfund, nr. 13, 89-107.*

This paper investigates how the concept of motivation functions in health promotion practice. It provides an analysis of the understandings and articulations of motivation at the levels of the state, health professionals, and citizens. It finds that motivation takes on different meanings and functions depending on the perspective; thus the general agreement on the importance of motivation in health promotion does not correspond to a mutual understanding of what motivation actually is: motivation works variously as technology, a statistically created collective informed consent, and a moral imperative. It is conceived of as an instrumentalized psychological entity but also expressed as a complex and context-bound phenomenon. The paper concludes by arguing that motivation must be seen as the latter: a relational concept, relating to concrete social and situational contexts rather than an instrumental psychological entity within the individual.

Why study motivation?

There seems to be widespread agreement among politicians, health researchers, and health professionals that motivation is a key concept in health promotion: surveys on citizen and patient motivation for changing their lifestyle are performed, methods and models of motivation are developed, health professionals are trained in the usage of these motivational models, etc. This current tendency in health promotion calls for analysis and clarification; Does the common agreement of the importance of motivation in changing health behaviour correspond to a similar common agreement of what motivation is? What do we actually mean by motivation?

Motivation as health promotion category - background

That the welfare state engages in the health and well-being of its populations is by no means a new phenomenon. Michel Foucault describes how 'the population' had already emerged as a political problem in the 18th century. The discovery of the 'nature' of the population (i.e., birth rates, rates of morbidity and mortality) involved the establishment of categories for surveillance, normalization, and state regulation (Foucault, 2006). The changes in the disease landscape throughout the 20th century brought along a change in the medical focus and state intervention strategies. Previously, the main problem area concerning the population's health and disease focussed on widespread infectious diseases, but from the mid-20th century, a new pattern of chronic conditions and civilization diseases replaced this earlier focus, and a 'health turn' in state politics took place (Jensen, 2006). The role of medicine transformed from a paradigm centred on 'the doctor treating the ill patient' to being a central theme in the development of the welfare state, or in the development of what has been called the 'therapeutic state' (Porter, 1999). Health and health promotion thus became central in the welfare state agenda (Lupton, 1995).

Although this interest in, and governance and regulation of, the population's health take many different forms, two main tendencies can be identified (Otto, 2009): On the one side, medicine shifts attention towards a systematic surveillance of apparently healthy people in order to identify risky behaviour. For example, screening programmes and health studies contribute to what has been named 'surveillance medicine' (Armstrong, 1995); here the object is 'the body' as a biological entity. On the other side, we find strategies that appeared later on in the century and have another aim. Instead of health policies being directed towards

the population as an object, they are now oriented towards the individual or the health subject. Through various types of appeals (e.g. appeals to responsibility or shame, etc.), the subject is called upon to choose a healthy lifestyle out of its own free will (Vallgårda, 2003). The inner will of the subject is thus called to life and worked upon (Foucault, 1988; Rose, 1999). Jensen (2006: 26) points out how broad concepts of health, as for example found in the WHO definition, entail a whole new space for state and professional intervention; rather than purely an absence of disease, health is defined as the personal management of or coping with disease (and other life circumstances), i.e., as a kind of personal strength or mental capacity. It is exactly the strengthening of this psychological capacity that is the aim of many health promotion activities: health promotion work is a work of creating will to health.

This article explores one single dimension of this last tendency, namely the will to health expressed as motivation. What function does the concept of motivation have in health promotion discourse? Do we share an understanding of the concept? On the different levels of the state, health professionals, and citizens, what role does motivation play and what understandings can be found?[1] The general historical development in national and international health promotion, as roughly outlined above, is also manifested in concrete local health promotion practices. One such local practice is the newly established health center in the municipality of Brønderslev. It is this local practice that will provide the empirical examples in the article.

The health centre in Brønderslev

Brønderslev municipality lies in the northern part of Jutland. Approximately 36,000 people inhabit the 663 km^2 of Brønderslev municipality, which makes it one of the most scarcely populated municipalities in Denmark with many small villages. This has influenced the way in which the municipal health center has taken shape, as it is geographically divided into four satellite functions in the two larger towns, Brønderslev and Dronninglund. The municipality[2] has a long tradition for health promotion; for example through the membership of the Healthy City Network since the 1990s and the participation in the HEPRO project, etc. In 2006, the municipality applied for and received funding from a state development pool for establishing and developing municipal health centers. The health center was opened in 2007. It offers a broad variety of health promotion activities, both patient- and citizen-oriented. The citizen-oriented activities include free individual counseling by physiothera-

pists and dieticians, physical training workshops, a cool kids project, different activities for older citizens, etc. Also 'prescribed physical exercise' and lifestyle teams are part of the health center activities. The health professionals in the center include nurses, dieticians, physiotherapists, and occupational therapists.

Method

The empirical scope of the analysis will be as follows: to describe the state perspective I will analyze the concept of motivation in policy documents and surveys of regional health. To explore the perspective of health professionals, I will combine an analysis of the key method and model in health promotion, namely motivational interviewing, with a group interview with the health professionals in the health center. Eleven professionals participated. Also, an observation of a lifestyle team session consisting of one instructor, a dietician, and seven participants is presented. I will investigate the citizen perspective through a group interview with six participants in a 'prescribed physical exercise' (PE) team. My aim is not a study of the characteristics of precisely the two types of activities as such (prescribed physical exercise and the lifestyle team), rather I see these activities as paradigmatic examples of general tendencies in health promotion.[3]

The state perspective: government through motivation

Lack of motivation is seen as a major reason for the rise in unhealthy lifestyle. The Public Health Programme 1999-2008, for example, states that "…the individual fails to transform knowledge to action in everyday life because of either lack of skills or motivation." (Regeringen, 1999: 110, my translation). Motivation is thus perceived as a condition of readiness for change, or a parameter of this readiness. The specific quantitative aspect of this perception is furthermore notable in the large number of surveys within the prevention field that try to identify the degree to which people are 'motivated' to change this or that unhealthy behaviour. The Health Profile of Northern Jutland, for example, states that "from a prevention perspective it is important to know the citizens' readiness and motivation to lower their alcohol intake, lose weight, be more physically active, and quit smoking…" (Region Nordjylland, 2007: 68). The profile will show "how important it is for the informants to improve their health habits. They can answer on a scale from 'not important' to 'very important', marked by a number between 1 and 10. The profile defines motivation as 'readiness for change' in the sense of identifying "indivi-

duals' needs for change and to what degree they have a will to and interest in changing behaviour" (Region Nordjylland, 2007: 68, my translations). This is a general tendency in current regional health promotion surveys. For example, the two other regional health profile surveys in Denmark, the Health Profile of the Capital Region (Region Hovedstaden, 2008) and that of Region Mid Jutland (Region Midt, 2006), also measure to what degree the population classified with unhealthy behaviour is motivated for changing their lifestyle.

Several aspects of interest arise from the measurement of motivation in the profile. First, the understanding of motivation is purely quantitative and instrumental. The focus of the surveys is not on the wills and needs of individuals in themselves, and no qualitative analysis is undertaken; on the contrary, motivation is a quantitative phenomenon; something we can measure by degree. Thus, the survey (as just one example among several) does not explore what makes people motivated, but rather how motivated (on a 1-10 scale) they are to change their lives. The survey's conceptualization of motivation can be seen as expressing a general instrumentalization of the health promotion field, which is criticized by, among others, the American health promotion philosopher David Buchanan. Buchanan argues that health promotion science asks the wrong questions (and gets useless answers) inasmuch as it does not ask

> why people pursue activities that may harm their health in an attempt to reveal what these activities may mean to them or why they might think the choices they have made are more or less fulfilling for them in the light of their circumstances. They ask instead how it happens… (Buchanan, 2000: 60).

So far, the definition of motivation and the status of this definition have been briefly considered. Yet another aspect demands attention inasmuch as a question concerning the function of the survey also arises. What, it can be asked, is the function of this sort of knowledge? Who is it produced for? Or more precisely, from which point of view does producing this type of lifestyle knowledge make sense? Would it, for example, help the health professional in her work to know that 34.1% of northern Jutland smokers are motivated to quit smoking? (Region Nordjylland, 2007: 68).

The answer seems to be 'no'. During any individual meeting, the health professional would still have to make use of knowledge concerning the individual "whys" of a person's lifestyle. Rather, the survey is more suited to generating material for an argument that might potentially be put to political use – albeit a political use and argument of a special kind.

The state legitimises lifestyle intervention in a twofold manner: one aspect is the idealistic search after improved health for all; another is an economic argument and promise to reduce the amount of resources spent by the state on medical treatment and hospitalization (Lupton, 1995). These two different lines of argument – an economic and an idealistic – thus function as the state's way of converting the interests of the individual and the interests of the state into one mutual interest. But neither rationale underlies the survey's concern with people's readiness for change. We may add a third legitimization argument, namely one concerning motivation and will of the population: The survey functions as a collective informed consent; from the state perspective it functions as an implicitly given permission from the population to move public/private demarcations in order to legitimize the state intervention in the individual lives of the population.

This is a mode of governing that provides the state with a legitimate way of changing the demarcation between the private and public spheres. It is a legitimization that renders it possible to open up life itself as a space of intervention for the state. The 34.1 % symbolizes the will of the people. Lifestyle is thus made 'treatable': 'treatable' here denoting the twofold meaning of being both public and pathological.

Health promotion methodology: the concept of 'motivation' in motivational interviewing

Let us now turn to the health professional level and investigate the concept of motivation from this perspective, both methodologically and as articulated by health professionals.Let me begin by quoting a health professional. The prevention worker is discussing the difference between initiating and working with, on the one hand, 'stop smoking' courses in the health center context, and, on the other, workplace initiatives: »*You're much further in your motivation - you know, when we're talking motivation circle, right (makes circular movement with her hands), then you're much further (in the health center, JM) in the process than when you get out (to workplaces). Out there, you actually have to start all down here (making circular movement with her hands, pointing at a low point of the circle) and you don't have the time then. You don't have enough time when you have to go all the way down where they need preparation for it (changing life style, JM)*« (interview health professional I: 14). The health professional is here referring to what has almost become a paradigmatic model in con-

temporary Danish health promotion, namely the Wheel of Change (Prochaska, 1995; Mabeck, 1999).

No previous mention of the Stages of Change model takes place in the interview, which suggests that the quotation illustrates its paradigmatic character. It has, in other words, become a standard reference for the health professional. In fact, it is reasonable to claim that it has this status for all members of staff at the health center, since no other informant questions her elaborations. How does this circular model of change find its way into the gestures of a health professional? What kind of status does the model attain on its travel from paper to body language?

First, it is necessary to investigate the rationale of the model at the level of definitions.

The model's conceptualization of motivation follows the definition in the Health Profile of the Region of Northern Jutland (Region Nordjylland, 2007). The concept of motivation used in the model can be summarized as 'a condition of readiness for change'. The arrows in the model mark the choice for change and the exercise of free will. They function as the engine or mechanism that makes the 'life style changer' move from phase to phase inside the wheel.

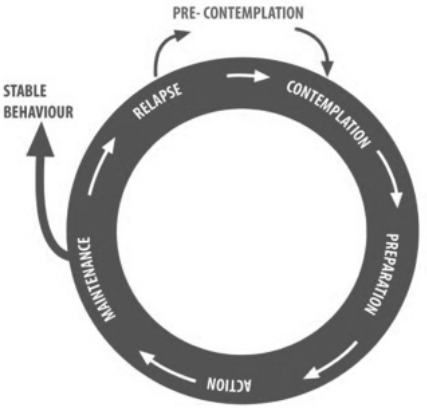

Figure 1: The Wheel of Change. Modified after (Mabeck, 1999: 11).

The model has an epistemological status: It serves as a diagrammatical organization of the phenomena of motivation. But the model does not only function at an epistemological level. It also bears an ontological meaning. Motivation is a circular psychological mechanism, it moves in stages, etc. The model thus attains a dual regulating function. This implies that the wheel of change is transformed

into the gaze of the prevention worker; a gaze that enables the health professional to see motivation as such. As an objectification it makes it possible for the health professional to identify the different phases of will definitive of the patient and citizens (Karlsen & Villadsen, 2008).

On this point, the analysis is in line with Lisa Dahlager who identifies how lifestyle both takes form as an external phenomenon, something that has to be learnt, as well as developing as an internal phenomenon, a psychological condition (Dahlager, 2005: 119). The authentic change of lifestyle must come from within. Similarly, other analyses of motivational interviewing and the wheel of change as a part of it claim that we are subject to two wills in an inner conflict: the potential external conflict between the health professional and the subject having been transformed into an internal conflict within the subject. The traditionally silent part of the prevention-dialogue is transformed into an active interlocutor (Karlsen & Villadsen, 2008)

Motivation – inclusion and exclusion

Furthermore, the health professional's quotation above points to another function of the wheel of change, namely an inherent inclusion and exclusion dynamic. It is possible for potential users of prevention services to be so far 'down-' in the wheel of change, e.g., the precontemplation phase, contemplation phase, or preparation phase, that time is too short for actually helping. Or even worse, the subject can be outside the wheel and therefore regarded as not motivated at all.

In a concrete organizational context, the health center practice in the municipality of Brønderslev can be seen as effecting the operations of this mechanism of inclusion and exclusion: An implicit selection of motivated subjects takes place inasmuch as the citizens must take the initiative of making contact to the center in order to receive citizen-oriented health services . As one health professional articulates this: *»The people here at the health center are quite motivated, simply because they have thought it over and made themselves ready for it (participation). They made the phone call and said I want to do it!«* (interview health professional I: 12).

The wheel of change can be seen as a metaphor for the concrete organization of the health center, as a convergence of in- and exclusion mechanisms. The phone call, or the door the individual opens to the 'healthy city shop', is also the way 'into the wheel'.

The quest for motivation - health professional practice

The following will attempt an analysis one step further into the health professional perspective/practice and explore the understanding and articulation of motivation at this level.

One empirical starting point is the "lifestyle team". An observation of a lifestyle team education session showed that the instructor began the first session of the course with a 'motivation assessment' round: each participant was asked to state to what degree, on a scale from 1 to 10, they were motivated for changing lifestyle. Also they were asked to elaborate on their reasons for choosing this or that number. This is an interesting example as it shows how the will of the individual is worked on and activated. The individual participant is addressed as responsible for making the lifestyle change happen. If no change in lifestyle is made, it follows that it is due to lack of motivation, a weak will, and a fault internal to the subject rather than a failure of the course itself.[4]

Furthermore, motivation plays a key role for the health professionals; the interview material shows how they conceive their prevention work as a 'quest for motivation': for them a central feature of prevention work is identifying the motivation in the individual. A health professional thus states that: »*The challenge for me is to find out "Ok there are many problems here, so where does the motivation lie to do something about them." So it has a lot to do with where the motivation of this particular individual lies because I want that person to take responsibility* (interview health professional I: 7).«

Motivation is in this way perceived as something within the subject, as a, perhaps latent, transforming mechanism for the health professional to identify and work on; it is the key for the health professional to unlock and solve the lifestyle problem. The professional must take an interest in the patient in order to find the motivation within; however, it is not an interest in the patient perspective in itself. Instead it is an interest in motivation as an instrument for change, or what one might call a pseudo-interest in the world of the citizen – an interest motivated not as an interest in the patient perspective in itself, but rather an instrumentalized interest (Buchanan, 2000).

The 'health pro-motivated' subject

Yet another dimension of the understanding of motivation is made visible in the last quotation, namely its moral dimension. Motivation is linked to responsibility.

A figure of triangularity between motivation, responsibility, and health is evident: being a motivated citizen includes being responsible, as well as being responsible includes choosing a healthy lifestyle. So motivation works as a moral imperative – a moral imperative to be healthy. With the words of Foucault: "The imperative of health: at once the duty of each and the objective of all" (quoted in Lupton, 1995:1). Government thus shapes a space for the morally healthy subject to take form. In this sense, what I will call the 'health pro-motivated' subject emerges in discourse.

As argued by Monica Greco[5], not being able to abide by the imperative of health invokes other subject categories, e.g., the irrational, the self failing to be a self, and, one might add, the incomplete individual.

> Each individual acquires a personal preventive capacity vis-à-vis the event of his or her illness… If the regulation of lifestyle, the modification of risky behaviour, and the transformation of unhealthy attitudes prove impossible through sheer strength of will, this constitutes at least in part a failure of the self to take care of itself – a form of irrationality, or simply a lack of skilfulness (Greco 1993: 361).

In addition this subject is framed in terms of the active citizen: »The citizens must be active. When we talk about training, they have to do something, they must give something. It is up to them if they want to be active. Some have the wrong understanding. They believe that they will get 'passive help', and of course that doesn't work. We cannot accept that. As therapists we cannot accept that the citizen just sits passively« (interview health professional I: 24-25). Being a 'health pro-motivated' subject not only involves making the healthy choice, but also making that choice in the right way, i.e., the active way. Being motivated is to be acting, do something, and actively participate in, for example, training sessions. It cannot take form as passivity; in other words a motivated subject cannot be motivated to passivity. Here the gaze of the health professional is characterized by inclusion of activity and exclusion of passivity.

Trust and confidentiality relations

The health professional's quest for motivation also involves establishing certain trust and confidentiality relations: »It is important that you try to meet the citizen where s/he is. In a way accepting that this or that is the quality of life for the citizen at the moment. (…) It is important to create that confidentiality because that enables you later on to move the citizen« (health professional interview: 26). The quotation paraphrases the famous (and in health promotion texts often quoted)

Kierkegaard passage concerning 'the secret in the entire art of helping',[6] although it is in a somewhat instrumentalized version. The following is in line with this: »It is important to build trust between the therapist and the citizen, right. (…) So that you can create an atmosphere where you can talk to them about other things than just health. About wind and weather; that is important. (…) You can motivate through that relation« (health professional interview: 14-15).

From these quotations it follows that the constant quest for identifying and awakening motivation in the patients and citizens instrumentalizes relations: health professionals aim at making use of trust-building techniques in order to awaken and build upon motivation. Relations of trust and confidentiality, therefore, are not understood and articulated within any deontological framework, as relations that are good or valuable in themselves, or, for example, as the ends of prevention work. Rather these are means to another end, namely motivation. Trust, for example, can motivate the 'health pro-motivated' subject.

Motivation can also be seen as a means to an end, since it is conceived as the transformation mechanism with regard to changing behaviour, e.g., to move from phase to phase in the wheel of change. To use an analogy: motivation is the start button to press in order to generate enhancement of physical activity. It is understood as an engine for change, and in purely mechanical terms.

This analysis is in line with what David Buchanan has defined as the instrumentalized view of health promotion. Motivation is conceptualized in a means-end chain and understood as such by the health professionals. It provides an illustration of how instrumental reason can result in treating people as a means to an end (Buchanan, 2000: 68). Also it is an example of a reduction of well-being to physical fitness (Buchanan, 2000: 67). The motivational button is to be activated for one purpose only, namely to enhance the physical fitness of the citizens.[7]

Motivational discourse

What types of conceptualization have we found so far? It seems that the unanimous voice in the various dimensions of discourse, including that of the state, of methodological theory, and the reflections of the health professionals, which states that motivation is the key for converting ill health into health, in no way involves an unanimous understanding of what motivation actually is. On the contrary, this first analysis shows how a motivational discourse involves a plurality of articulations of motivation, and the role it could or should play in health promotion work. The meaning and function of motivation thus takes on various

forms: a) The instrumentalized forms of motivation, e.g., 'a condition of readiness for change' – the mechanism that causes movement from one phase to another in the 'wheel of change'; b) motivation as a skill in active and rational action; and c) motivation as a moral imperative – related to taking responsibility for training, health, and life itself.

Aside from these differences, there seems to be one common core understanding, namely that motivation is something within the individual. It is viewed as an internal psychological entity, maybe latent, i.e., something to be found and activated by the health professional. This analysis is supported by studies of motivational theory documenting that the mutual assumptions shared in these theories are the following: that motivation is an entity residing with the individual, causing behaviour, which the health professional can affect, thus also affecting behaviour (Ahl, 2008: 154).[8]

Time and space as pre-conditions for the conceptualization of motivation

One step further into the concrete practice of the Health Centre in Brønderslev municipality allows us to explore yet another dimension of motivation through an analysis of a concrete citizen-oriented service/initiative, i.e., 'prescribed physical exercise'. In general, all citizen-oriented schemes are short-term. Prescribed physical exercise is no exception to this, its duration being 4 months. The participants meet for physical training for 1 ¼ hours twice a week. There are approximately 7-10 participants per team with varying diagnoses or reasons behind there participation.[9] The last month of the course is organized as a re-absorption phase where the team changes activity: once a week they train as usual and in the usual surroundings,[10] whereas the other training session of the week is situated around new training activities, for example water aerobics, Nordic walking, training in the private gym, etc.

This temporal demarcation is interesting analytically, as it serves as a precondition for the conceptualization of motivation. That is to say that the time limit shapes the way in which the health professionals understand and act upon motivation: the prevention worker perspective is oriented towards an 'after', towards motivating for 'after' the course of training is ended. The rationale behind the re-absorption phase is to motivate the participants to continue to do other forms

of physical exercise out of their own initiative when the PE course terminates. Not only is motivation meant to function 'now' but also 'after'.

Similarly, the spatial organization has a shaping and pre-conditioning function. A major part of the training program is designed around exercises that enable participants to do them also when they are at home. The health professional thus selects activities that are possible to do at home and calls attention to these whenever possible. A health professional articulates how he works to create the feeling in the participant that "this I can apply to my everyday life", and further he says, "well then, it's obvious that it can be a motivational factor that "if I can do this, then I can also do things better at home" (interview health professional I: 23).

A certain kind of 'in-out' and 'here-there' condition thus directs the way health professionals work. The spatialization and temporalization of the intervention become the conditioning possibility for the way motivation functions.

Motivation for prescribed physical exercise – participant dialogue

One perspective remains to be explored, namely the participant perspective.[11] In what ways can participant articulations of motivation be described? The following passages are from a group interview with a PE team by the end of their 4-month course of training. All participants agree that the course has been a success, and then the following theme is raised: »*I just think that it (PE) ought to go on because it is not enough that we only get twice a week. We should be allowed to continue, now where we have been given a team (…) because we have talked about the fact that we're afraid that we'll just go back to the sofa and sit there again*« (interview PE participants: 2). From a health professional perspective, the statement does not make sense; it is self-contradictory. The participant expresses being motivated to continue the activity in the same sentence as she tells us that she anticipates/expects to end up in physical passivity once the course has ended and she is back home. How can we give meaning to this? A starting point would be to consider whether the motivation from the participant perspective could be something yet again different from the health professional perspective (as well as the state perspective).

The quotation points out that for this participant (along with the team mate she has discussed this with) motivation relates to the specific situation and concrete activity. The PE activity (and the motivation for it) is seen as a particular event in a concrete historical and social setting. Motivation relates more to a 'here and now' than to the 'after', as is also seen in the following participant dialogue:

I1: "Now we're at a point where it's fun, I think, and we could easily take another month."

I5: "Yeah. we could take two."

I1: "Yeah, it's a bit of a shame that it ends now" (interview PE participants: 10-11)

Seen through the rationale identified in the previous analysis of the state and health professional perspectives a question arises: if all participants (as is the case) agree that they have fun and agree that they would like to continue, why do they not plan to continue to do physical activity after the course ends instead of simply noting that they wish it would continue? Finding an answer to this demands a rephrasing of the question. Underlying it, as it is, we find the presumption that the participants will act like what I have called 'health pro-motivated' subjects: that is to say that they will actively continue to engage in physical activity once motivated by the PE training course. However, it seems that this presumption is invalid, not to say that the participants are not motivated, because they clearly are. They are motivated, however, to continue with the concrete activity as a situated and sociological whole, not as physical activity alone.

This becomes clearer in the following dialogue concerning working out in a private gym:

I1: "It works. You can work out systematically, but my god it's boring!" (all laugh)

I5: "But that's also because you're alone, and with no one to talk to there."

I2: "Yes, you just go in, do the exercise and go home again" (Interview PE participants: 8).

For the participants it is not the physical activity in itself that motivates; on the contrary, doing physical exercise in a private gym is considered boring, and as the following dialogue shows it can be de-motivating as well:

I2: "You have to overcome yourself to go to other forms of exercise (than PE). You feel somehow alone and in a new context."

I1: "and, you're not as good as the others."

I5: "and then you have to mingle, but you can't, and then you just stand there and look stupid"(interview PE participants: 4).

Physical activity, as the participants have experienced it, is in itself neither pleasurable or necessary, nor motivating in itself. On the contrary, the social framing of the private gym creates feelings of loneliness, and both physically and socially inferiority. To this is contrasted the feeling or spirit of community the participants points out as a result of the PE training course in its particular context.

It seems as if motivation not only functions as an internal, latent entity within the individual, which must be awakened through all thinkable means, but relates to the concrete space and time of health promotional practice.[12]

Motivation in relations

Instead of an internal, latent psychological entity, motivation must be understood as basically relational:

> Motivation problems (…) arise only in the relationship between the recruiter and those who do not want to be recruited. If the recruiter's interest was not there to begin with, there would be no reason to talk about motivation problems" (Ahl, 2008: 158)

Categories such as 'motivated' or 'unmotivated' emerge only as a result of certain relational features, either as a relation between two people (e.g., a health professional and a citizen) or as a relation involving and internalizing others (e.g., the doctor, health campaigns) (Ahl, 2008: 169). 'The unmotivated' category, for example, does not make sense otherwise: a citizen in Brønderslev who does not want to change to a more healthy lifestyle and therefore does not participate in health center activities would not need to explain herself in terms of being unmotivated.[13] Only insofar as someone else wants her to change (the external other), or if she herself wanted to change but did not do it (the internalized other), does it make sense to label her as 'unmotivated'. In this way "motivation is all about discipline and power. It is easier to resist in the first case, when the 'other' is external and identifiable, than in the second case, when disciplinary power is internalized" (Ahl, 2008: 169).

In (Conrad, 1994) a nuance is added to this picture, as the empirical study shows how this kind of personal experience of being unmotivated can produce guilt and the feeling of letting oneself down in the individual (393-394). This stresses the fusion of morality and health, in this case linked specifically through motivation.

I believe that the analysis has illustrated in what way the health promotion focus on motivation is a sign of what has been called "institutionalized individualism" (Beck, 1998, quoted in Dean, 2007: 65). It shows us how government works through the powers of freedom (Rose, 1999: 90) – and provides an example at a micro-analytical level of what kinds of freedoms are at stake: motivation is institutionalized through policy papers, surveys, methodological models, and techniques; however, it is motivation understood in a very narrow instrumental sense. This conceptualization is not only theoretically questionable, as I hope to have shown, but it also fails to capture the variety of motivations that actually arise out of health promotion interventions from the participant perspective.

To suffer from lack of motivation?

There seems to be one feature of motivation shared by the state and the health professionals: lack of motivation is seen as 'the source' of health problems. Lacking motivation is a cause; it is the reason for people not engaging in healthy lives. Thus lack of motivation becomes the object for health promotion policies and interventions. A medicalization (Conrad, 2007) of the will takes place as the weak will is understood as a diseased will and lack of motivation as suffering. It follows that it is this suffering that should be treated; removing 'the lack', finding and activating the motivation within the individual will pave the way for a healthier society. However, this understanding is both theoretically questionable and at the same time does not correspond to the citizen articulations of what is found to be motivating.

The general agreement on the importance of motivation in health promotion by no means corresponds to a mutual understanding of the concept. There exists no one meaning of motivation but several. Motivation takes on a variety of different meanings and functions depending on the different perspectives. If we will try to understand what makes people choose a healthy or unhealthy behaviour - and this seems to be the general aim of health promotion practice - a starting point must be to incorporate this complexity of the concept of motivation in our endeavors.

Notes

1: Here I follow Uffe Juul Jensen's trichotomy of perspectives as an analytical strategy in order to grasp potential differences between the perspectives. I furthermore follow his definition of the three perspectives as such: The state perspective includes all state institutions at national, regional, and municipal levels. The professional perspective includes all levels of health professionals – 'the health collective'. The citizen perspective includes individual citizens and patients as well as patient organizations (Jensen, 2008).

2: Before 2007 it consisted of the two municipalities Dronninglund and Brønderslev

3: In Danish, prescribed physical exercise is known as 'motion på recept'. For a detailed study of PE, see for example Lone Friis Thing (2009). She identifies how PE can be seen as a medicalization of the gymnastics and athletics movement in Denmark.

4: This is an interpretation supported by Ole Dreier's critical study of psychological method and obesity intervention (Dreier, 1993).

5: This is also an argument put forward by Helene Ahl in "Motivation Theory as Power in Disguise (Ahl, 2008

6: The often quoted passage goes: " If One Is Truly to Succeed in Leading a person to a Specific Place, One must First and Foremost Take Care to Find Him Where *He* Is and Begin There." This English translation by Hong & Hong (1998). *The Point of View for my Work as an Author (*chapter IA, §2: 4). Princeton University Press.

7: Buchanan further identifies how the paradox of this take on health and health promotion is that we might be able to eliminate lifestyle diseases completely, although at the same time eliminating what make human life meaningful (Buchanan, 2000: 68).

8: Helene Ahl argues that all of these assumptions are not only invalid but also work as 'power in disguise'. Her focus is on adults' motivation for engaging in lifelong learning, but I see clear implications also for health promotion and prevention. I will return to her critique in more detail later.

9: In order to get included, one must obtain a prescription from the general practitioner or the health center employees.

10: For example the gym hall at Nordjyllands Idrætshøjskole.

11: On a methodological note: I understand the following participant's quotations as shedding light on the question of motivation even though they are not explicitly formulated as statements concerning motivation. So whereas the health professionals explicitly address the concept of motivation, the participants to a higher degree discuss what they enjoy or not. In this way the analytical scope here changes from what one may call 'what the health professionals say about motivation' to 'how the participants experience the PE-course'. It is quite possible to imagine that the participant dialogue, had it been framed by asking explicitly how they understand motivation, would yield answers quite different from the ones presented here.

12 C. Wright Mills already in 1940 identified how motives do not find an origin in something inner, but arise out of the situation in which people find themselves (Mills , 1940).

13 The category of the un-motivated is investigated in depth by Sam Paldanius (2002). Paldanius suggests 'the rationality of indifference and reluctance' as a basis for another understanding of what it means to be unmotivated.

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