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Motivation and Autonomy in Counseling, Psychotherapy, and Behavior Change: A Look at Theory and Practice

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Abstract

Motivation has received increasing attention across counseling approaches, presumably because clients' motivation is key for treatment effectiveness. The authors define motivation using a self-determination theory taxonomy that conceptualizes motivation along a relative-autonomy continuum. The authors apply the taxonomy in discussing how various counseling approaches address client motivation and autonomy, both in theory and in practice. The authors also consider the motivational implications of nonspecific factors such as therapeutic alliance. Across approaches, the authors find convergence around the idea that clients' autonomy should be respected and collaborative engagement fostered. The authors also address ethical considerations regarding respect for autonomy and relations of autonomy to multicultural counseling. The authors conclude that supporting autonomy is differentially grounded in theories and differentially implemented in approaches. Specifically, outcome-oriented treatments tend to consider motivation a prerequisite for treatment and emphasize transparency and up-front consent; process-oriented treatments tend to consider motivation a treatment aspect and give less emphasis to transparency and consent.

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At the core of counseling and psychotherapy is the issue of motivation or volition, presumably because positive and lasting results most likely occur when a client becomes actively engaged and personally invested in change (Overholser, 2005; Ryan & Deci, 2008). Yet it is a common experience of counselors that clients are not always volitionally motivated to change. Indeed, many, if not most, clients display some resistance to change (Engle & Arkowitz, 2006; R. Greenberg, 2004; MacKinnon, Michaels, & Buckley, 2006). Some clients, for example, are superficially motivated, and yet underneath their motivated appearance, they actively defend against changing long-standing patterns of experience and behavior. Others exhibit compliance based on the desire for approval from the counselor or from significant others, rather than a true personal interest. Still others are not motivated at all. Forced by a system or by pressure from significant others to go to counseling or treatment (e.g., Zeldman, Ryan, & Fiscella, 2004), they either do not care about making any change or feel unable to do so (Bandura, 1996; Vandereycken, 2006). Because of such variety in client presentations, and because of its centrality in the processes of change, a key skill in counseling and psychotherapy is that of understanding and working with client motivation and resistance.

Whereas many clients initially manifest low or mixed motivation for engaging in counseling interventions, most counselors hope that their clients will display a strong motivation for therapy, and more specifically, they hope that the clients have considerable internal motivation—a willingness and desire for change that comes from "within." That is, they want their clients to *want* to participate in the processes of treatment, and they often assume this is the case (Sue & Sue, 2008). When this self-motivation is not present, some counseling approaches or programs exclude the client from therapy as lacking readiness, whereas others view the fostering of volition and a personal desire for change to be a central task of the therapist (Rappaport, 1997; Ryan & Deci, 2008). Beyond initial motivation, self-motivation or autonomy for change can become more critical over time as continued behavioral changes require overcoming obstacles (Ford, 1992; Jang, 2008; Sheldon & Elliot, 1998), persisting through rough spots, or sustaining action when the initial impetus and reinforcers associated with therapy and behavioral change are no longer available. Thus, motivation is an issue not only upon entrance but throughout the counseling process.

In this article, we review conceptions of clients' motivation and autonomy for engaging in the process of counseling and behavior change and for sustaining that engagement over time. We argue that theories or schools of counseling (e.g., cognitive behavior therapy, psychodynamic approaches, humanistic therapies, etc.) each contain, explicitly or implicitly, beliefs, interpersonal strategies, and practices concerning client motivation. These motivational beliefs range from approaches that exclusively locate the problem of low motivation in the client to those that consider motivation as a relational issue in which the therapist has a significant role. In accordance with those different beliefs, motivational practices span a full range from screening out nonmotivated clients from treatment to embracing low motivation itself as an important starting point in therapy. More generally, we see contrasting emphases on the role of therapists as actively persuading, shaping, rewarding, and training a client from without versus supporting, facilitating, or catalyzing change from within. At the same time, almost every modern approach to therapy shows evidence of valuing client volition and autonomy, although many approaches do not integrate that intuition within their theory of change.

Related to the issue of integrating motivation and autonomy into various theories, we note increasing trends toward the use of brief motivational enhancement interventions as a prelude to counseling and therapy interventions. That is, clinical models such as motivational interviewing (W. Miller & Rose, 2009), the Socratic method (Vitousek, Watson, & Wilson, 1998), the transtheoretical model of change (Prochaska & DiClimente, 1986), and motivational enhancement therapy (Treasure & Ward, 1997) have attracted considerable attention, among both scholars and practitioners, in part because these models are seen as modular additions to address motivation before treatment begins. Another trend is to attend to those *nonspecific factors* (Norcross, 2002; Wampold, 2001; Zuroff et al., 2007) in counseling relationships that are viewed as having motivational implications and are empirically associated with positive outcomes. Consequently, we discuss the meaning of considering motivation as a separable component versus as an ongoing concern in treatment and of integrating motivational strategies within practice through nonspecific factors.

Given both the importance of motivation in treatment success and the variation in how it is theoretically and practically addressed across counseling approaches, it seems timely to discuss the different positions on motivation implied within different schools and clinical models and implicated in our understanding of nonspecific factors in positive change. Such discussion will hopefully spur further interest in the issue of motivation within counseling and psychotherapy practices as a vehicle of clinical effectiveness.

The Importance of Motivation

> Certain types of therapy rely primarily on the healer's ability to mobilize forces in the sufferer by psychological means. These forms of treatment may be generally termed psychotherapy. (Frank & Frank, 1991, p. 1)

As Frank and Frank's (1991) classic definition suggests, counseling and psychotherapy involve mobilizing forces or energy within the client in the direction of healing or change. This is especially true in most counseling settings, where counseling represents a largely voluntary activity that may or may not engage the client.

Attending to clients' motivation and volition is an important theoretical and applied issue in psychotherapy and counseling for several reasons. First, although there are many effective approaches and treatments for optimally motivated clients, many clients are not motivated when they start therapy (R. Greenberg, 2004). Indeed, many, if not most, clients begin treatment with ambivalence and fear and, sometimes, even hopelessness and despair. Likely as a result of their poor motivation, many never come to their first appointments (Sheeren, Aubrey, & Kellett, 2007), whereas many others sabotage treatments or terminate before completion (Ogrodniczuk, Joyce, & Piper, 2005; Rappaport, 1997). Illustratively, Hampton-Robb, Qualls, and Compton (2003) reported that across 12 studies they reviewed, 40% of clients failed to attend even their initial appointments for therapy. Furthermore, having conducted a meta-analysis of 125 treatment studies, Wierbicki and Pekarik (1993) reported that nearly half of all patients dropped out, and nearly 80% of clients did not stay through 10 sessions. It seems that evidence like this can be found across counseling centers and treatment modalities, showing rates of attrition that, although multidetermined, implicate client motivation as an important concern.

A second reason to attend to motivational dynamics is that the effectiveness of any counseling technique likely depends on the clients' motivation for embracing the technique and persisting in the agreed direction. For example, Bastien and Adelman (1984) found that adolescents who perceived having a choice for staying at a private social rehabilitation facility made more treatment progress compared to adolescents who did not perceive having such a choice. Thus, moving clients to a place where they can volitionally engage effective techniques may be the most important movements of all. Yet in so many outcome studies, those who are not motivated or considered "ready" for treatment are "already gone," a screening luxury the typical practicing counselor or clinic staff member does not have (Westen, Novotny, & Thompson-Brenner, 2004). As a result, more homogeneous, well-motivated groups of clients

provide the evidence base for treatment, a selection bias that potentially obscures how counseling techniques may or may not be effective for initially less motivated clients.

Third, most counselors in daily practice outside of clinical trials do not begin therapy by addressing a focal problem with a set intervention. Instead, they start with an interpersonal exploration to identify what is wrong, whether one needs to begin treatment, and, if so, where to begin (Ryan & Deci, 2008; Yalom, 2002). These early stages in the encounter are critical for subsequent persistence. Even when clients report being motivated for counseling and adopt specific goals, energy for the process remains important. As Nix, Bierman, and McMahon (2009) concluded in their research on parent training groups, "From a clinical perspective . . . findings suggest that it is not enough to get parents to attend sessions; it is also necessary to facilitate their active engagement in the therapeutic process" (p. 429).

Fourth, changes in the current climate of counseling make a focus on motivation particularly important. Increasingly, pressure from agencies and third-party payers in many settings dictates a short-term approach to change, which makes motivation even more critical early on (Milner & O'Byrne, 2002). Furthermore, increasing pressure toward specific outcomes impacts both selectivity and therapeutic focus, which yield motivational implications (Ryan & Deci, 2008).

Finally, we notice a dramatic trend toward eclecticism or integration (Lambert, Garfield, & Bergin, 2004; Marquis, 2008; Norcross & Beutler, 2008). Many counselors and therapists today draw from numerous approaches in practice, both in an attempt to personalize treatments and interventions (Sue & Sue, 2008) and to address the wide variety of concerns they encounter with their clients, who rarely present with simple or discrete concerns (Rappaport, 1997; Westen et al., 2004). Different types of eclecticism can be distinguished in terms of how they integrate diverse practices into the therapist–client relationship. The potential for combining techniques with different, sometimes even incompatible, ways of motivating clients is thus of interest. In this respect, a comparative analysis of motivational dimensions of techniques may be informative, providing a framework for understanding, on a meta-technique level, how one is motivationally framing an intervention and thus the consequences likely to follow for treatment success.

Motivation as Energy and Direction

Motivation can be defined broadly as that which moves people to act. Etymologically, the word *motivation* derives from the Latin *movere*, "to move" or "be moved." More technically, motivation implies both the *energy* and *direction*

of action (Deci & Ryan, 2000; Ford, 1992). The analogy of a car may be illustrative. To move from Point A to Point B, a car requires fuel to provide the energy and a steering system to provide direction. Without steering the car's movements would be random (and short-lived), and without fuel there would be no movement at all. Of course the distinction between energy and direction is an analytic one, for in action they are inexorably intertwined. The type of goals that are set, for example, can impact the orientation of the motivation and therefore the energy behind the goal pursuit. Similarly, goals in counseling and therapy settings must be appropriate to the level of motivation a client brings, at least in the view of some current models (e.g., Prochaska & DiClemente, 1986).

With respect to counseling, we face both the issue of identifying the energy or fuel behind the client's efforts and the steering or directing of that energy. This first issue, energization, concerns the "why" of the client's behavior and includes both the impetus for engaging in counseling and then subsequently the reasons the client has for sustaining the process over time. The second issue concerns the steering of counseling. This includes the goals or the "what" of treatment and raises issues of both content and ownership of therapeutic goals. Toward what kind of goals does the counseling or therapy aim and who does the steering? The latter could range from the therapist to the client, or sometimes even significant others (e.g., legal or school authorities, insurers, spouses) who are not in the room.

Approaches to counseling embrace different assumptions regarding these energy and direction aspects of motivation, and they differ in how explicitly these assumptions are made. Most theories of counseling and psychotherapy derive from underlying theories of personality (Rychlak, 1977) and metapsychologies (Ryan, 1995), which in turn entail different claims about motivation and the appropriate methods for engaging clients in the activity of change and about how the goals of counseling are selected and implemented.

Counseling approaches also differ in the contents and scope of therapeutic goals, for example, in how much they are therapist- versus client-determined and how specified (e.g., symptom reduction) versus open-ended the goals are. *Outcome-oriented* therapies often have well-defined ideas about what the clients should do and aim for (e.g., Bricker, Young, & Flanagan, 1993; Hembree & Foa, 2003). *Process-oriented* therapies often explicitly avoid any quick focus on specified outcomes, engaging instead in a more open-ended exploration and search (e.g., Deurzen-Smith, 1997; Yalom, 2002). In discussing these different approaches and issues, our intentions are both to raise awareness of motivational formulations and practices that operate, whether explicitly or implicitly, within and across the varied techniques and

approaches and to specifically highlight how clients' volition and autonomy is implicated.

Motivation and the Continuum From Helplessness to Volition

Insofar as counseling is about creating conditions for positive change, it follows that motivation is deeply intertwined with such change. There is simply no change without movement and no movement without motivation. To conceptualize the reasons that underlie clients' movement (or lack thereof), we consider some classic forms of motivation. In doing so, we present a classification scheme drawn from *self-determination theory* (SDT; Deci & Ryan, 1985, 2000; Ryan & Deci, 2000b), which considers the multiple motives people have for enacting (or failing to enact) intended behaviors. Although later we shall present SDT in terms of its specific approach to counseling and psychotherapy (e.g., Ryan & Deci, 2008), we introduce this "taxonomy" of motivation now so as to have some common vocabulary for our comparative discussion of how different approaches think about and attempt to cultivate motivation.

Varieties of Client Motivation

Lack of motivation. We begin by recognizing that not all clients are motivated to enter treatment or to experience the changes that might occur if they did and that some clients, although they start therapy, might not be motivated to continue it. We argue that clients' resistance or unwillingness to pursue therapy and change is multidimensional in nature and, hence, can be underpinned by a heterogeneous set of client motives (Vansteenkiste, Lens, Dewitte, De Witte, & Deci, 2004) and addressed by a heterogeneous set of therapist approaches.

Broadly speaking, lack of motivation can be described as *amotivation*, a term that refers to a lack of energy or desire to act. Amotivation can stem from two general sources. The first type results from a lack of concern or value for the activity. An individual may be amotivated when he or she sees no gains of benefits in changing, when he or she simply does not see it as important or worthwhile. This type of amotivation can be observed in the satisfied spouse who does not see a need for couple's therapy, or the employee who disagrees with the need for an anger management intervention after his recent blowup. In these cases there is a clear lack of motivation to address the issue. A second, somewhat distinct type of amotivation stems from a lack of

perceived competence (Deci & Ryan, 1985) or positive efficacy beliefs (Bandura, 1996). One may not believe that counseling is reliably linked to positive outcomes, or one might feel that even if it were potentially helpful, one is not personally competent to use it in a way that would successfully make the change. For instance, a morbidly obese person may be advised by her counselor to change her diet and activity patterns, but she may believe that the treatments do not work and/or that she cannot follow the treatment plan.

Perceived competence or efficacy is a prerequisite for all intentional action (Deci & Ryan, 1985; Heider, 1958). One will not be motivated to act without a belief, however wavering, that the act will yield the intended results. But underlying intentional actions can be a variety of reasons or motives, from feeling coerced or compelled to act to feeling genuinely willing to act (de Charms, 1968; Kultgen, 1995; Ryan & Connell, 1989). We now turn to these motives, all of which can be operative to different degrees in counseling settings.

External regulation. Among the varied ways in which clients can be motivated for counseling is external regulation—when they are controlled or pressured from the outside to engage in behavior or attitude change. For instance, a man suffering from alcoholism may come to therapy and even make changes in behavior because of specific reward or punishment contingencies (e.g., to get his license back) or because his environment forces him to do so (e.g., his company mandates the counseling). Thus, a person may enter therapy because of external regulation. Beyond signing up for therapy, external regulation can also be used within treatment. For example, some counselors and therapists use reinforcement contingencies within the therapy to help control and sustain positive behaviors, such as allowing anorexic inpatients to go home on weekends only if they gain weight during the week. In such cases of external regulation, the individual's motivation is attributable to forces or persons external to the client that are controlling his or her behavior.

Introjected regulation. In addition to being externally pressured, people can also pressure themselves into action, using internal contingencies such as feelings of self-esteem and pride, on one hand, and guilt and shame, on the other. We group these motives that involve "shoulds" and seeking self and other approval or avoidance of disapproval under the heading of *introjected regulation*. With introjections, although the rewards and punishments are largely internal experiences, people tend to feel controlled. This control is buttressed by contingent self-esteem and ego-involvement, with implicit offers of pride and self-aggrandizement following success and implicit threats of guilt, shame, and self-derogation following failure (Assor, Vansteenkiste, & Kaplan, 2009).

For instance, when a college student comes to counseling because she feels guilty about her lifestyle, she would be displaying introjected regulation. Introjected regulation is deeply tied to the interpersonal experience of contingent regard (Roth, Assor, Niemiec, Ryan, & Deci, 2009). Introjected motivation for staying in therapy can often stem from the therapist's use of contingent regard for clients, which can evoke introjected regulations within the client.

Identification and integration. There are also clients who fully accept the importance of counseling and exhibit a sincere willingness to engage the process, a motivational state we label *identification*. The term is meant to suggest that the people identify with the value of the activity and willingly accept responsibility for regulating the behavior. When people perceive the personal relevance of the activity, they will have more fully internalized the regulation and will engage in the behavior with a greater sense of autonomy and thus do not feel pressured or controlled to do the behavior. To illustrate, a sex offender might pursue outpatient therapy because he has come to understand that his maladaptive behavior hurts others and interferes with building satisfying relationships and a meaningful life.

When people not only identify with the value of a behavior but also experience that value as fitting with other important life values and goals, then they are displaying integrated regulation for the activity. Integration represents full internalization and a very volitional state, because people are wholeheartedly behind the activity. From the standpoint of most clinicians this would be an ideal form of client motivation, because the client is fully behind the process of counseling.

Intrinsic motivation. When intrinsically motivated, a person is engaged in an activity because of its inherent satisfactions—because the process or activity is itself interesting and enjoyable. Most people are *not* intrinsically motivated for counseling. They are not coming because they think it will be interesting and fun but, rather, because they see it as instrumental to other valued outcomes, such as an improved career, marriage, or lifestyle. But there are exceptions: occasions when the counseling activities can be fun, or at least quite interesting. In many settings counselors can catalyze change through discovery exercises and experiential adventures. They can also present the change process as a challenging but interesting endeavor, such that clients can become intrinsically motivated in their self-explorations. Insofar as a person is intrinsically motivated in counseling, she or he has positive feelings about it and is very autonomous and volitional.

All of these forms of motivation are recognizable in the counseling setting. The motivational presentation of clients spans from amotivation and resistance, all the way up to a holistic endorsement of and commitment to the

Table 1. Taxonomy of Motivational Styles Relevant to Counseling and Behavior Change

Motivational Styles	Phenomenal Sources	Locus of Causality
Intrinsic motivation	Interest and enjoyment in acting, discovery, growth	Highly internal
Integrated regulation	Valuing of the activity and fit with other personal values and goals	Highly internal
Identified regulation	Conscious value for the activity	Internal
Introjected regulation	Motivated by self or other approval, avoidance of disapproval or guilt	Somewhat external
External regulation	Motivated by external reward and punishment contingencies	Highly external
Amotivation I: low value	Little or no perceived value or incentive for action	Varied, can be external or internal
Amotivation II: low efficacy	Little or no perceived competence for change	Impersonal

process. Thus, what we have described here is a continuum of motivation from a lack of volition to strong volition or willingness, what we call a continuum of *relative autonomy*. This continuum of motivations is displayed in Table 1.

A large number of studies in which these motives have been rated and compared have provided empirical support for the presumed continuum of autonomy underlying this taxonomy. Specifically, correlations between the subscales measuring these motives correspond with a *simplex pattern* (Ryan & Connell, 1989; Vallerand, 1997). A simplex is evident when the correlations between constructs expected to be adjacent along an underlying continuum are larger than those expected to be more separated or distant along that continuum. In this case, motives such as intrinsic motivation and identified motivation share high degrees of autonomy and should be more strongly related to each other than, for example, intrinsic motivation and external regulation. Thus, to the extent that external, introjected, identified, integrated, and intrinsic forms of regulation are ordered in terms of autonomy, a predictable pattern should emerge in which the sizes of the correlations are ordered as well, with larger correlations between those constructs most adjacent on this continuum. Measures of these motives have reliably produced this simplex pattern across multiple domains, in multiple cultures (Ryan & Deci, 2000b; Vallerand, 1997). Results using other techniques such as multidimensional

scaling and small-space analysis have also found evidence for these motives falling predictably along this ordered continuum of autonomy (e.g., Roth, Kanat-Maymon, Assor, & Kaplan, 2006).

It is important, however, to note that establishing a simplex pattern does not necessarily have any temporal or age-related implications; for example, it need not imply a stage theory or a developmental sequence (Ryan & Connell, 1989; Sutton, 2001). In this case, it also does not imply that behavior change moves from external regulation toward more autonomy. As we shall suggest throughout, different therapies attempt to tap different of these motives, with some therapies attempting to motivate with external regulations and others attempting to foster more autonomous motives such as identification. In fact, according to SDT, clients can have multiple simultaneous motives that vary in autonomy, resulting in an individual feeling more or less autonomous overall. In addition, individuals can move up or down in relative autonomy as a function of the therapeutic climate or other changes in social context or values.

We have suggested that this continuum of autonomy is applicable to understanding motivation for the counseling process. Empirical evidence for this claim was provided by Pelletier, Tuson, and Haddad (1997). In their study, adult outpatients reported the degree to which they entered treatment for external, introjected, identified, integrated, or intrinsic motivations and the extent to which they were amotivated. Results revealed that the correlations between the subscales measuring these motives fit a simplex pattern with clients' motives for entering treatment or counseling falling along a dimension from low to high autonomy.

More importantly, Pelletier et al.'s (1997) results revealed what most counselors intuitively know about motivation: The more volitional and autonomous the clients' motivation for therapy, the less distracted they were during therapy, the less tension they experienced about therapy, the more satisfied they were with the therapy, and the greater their intention to persist. In contrast, people whose motivation took the form of either external or introjected regulation reported greater tension and lower intentions to persist in treatment. The lowest satisfaction, importance, and intentions to persist were of course found among those who were amotivated for treatment.

SDT has also postulated that autonomous motivation—both the maintenance of intrinsic motivation and the internalization of extrinsic motivation—can be facilitated by the social contextual condition of *autonomy support*, in which the key others take the perspective of the target individual, support their choice, and minimize pressure and control (Ryan & Deci, 2008). This is an important point in comparing different approaches to counseling and therapy,

because supporting autonomy would logically follow from the assumption of autonomy being important.

Client Motivation in Major Approaches to Counseling and Psychotherapy

Insofar as motivation varies from amotivation to highly autonomous forms of motivation, and insofar as the latter type of motivation yields benefits, the question arises as to how to best facilitate more autonomous forms of motivation. In part, this is the question that counselors and therapists within each tradition of healing or behavior change ask themselves. The taxonomy in Table 1 provides us a vocabulary that can be used in our comparative analysis of how various schools or approaches to psychotherapy conceptualize or address motivation, alongside the specific terminologies within each school of thought that address this issue.

In this analysis, we select for review only a few representative and popular approaches to counseling. Given that there are literally hundreds of specific schools or techniques of therapy, we make no attempt to be comprehensive, and some schools and important techniques are left out. Instead, we hope the ones we examine are illustrative. We also address eclecticism as an approach to practice or a "school" of thought, and we attempt to highlight some of its implicit assumptions concerning client motivation.

We make no strong distinctions in this review section between counseling and psychotherapy. Although the professions of counseling and psychotherapy have different historical origins (Lambert et al., 2004) and some practitioners draw clear distinctions between them (e.g., "depth" of the interventions; types of cases), Corsini (2008) points out that the distinctions are becoming less and less meaningful. He argues that "counseling and psychotherapy are the same qualitatively; they differ only quantitatively," adding that "there is nothing that a psychotherapist does that a counselor does not do" (p. 2). Although one might disagree with that view, pressures from health care, organizational, and educational systems for greater efficiency and profitability have resulted in increasingly briefer interventions, resulting in a stronger convergence between the two endeavors. Therefore, in the present article, we will use the terms *counseling* and *psychotherapy* interchangeably, even while acknowledging their different historical origins and the often-cited differences in training, orientations, and processes between them. In addition, the fields of counseling and clinical psychology today are not limited to mental health, and our review draws on counseling within health care and educational situations as well.

Our focus will be on adult and adolescent clients, rather than younger children or other dependents. This is particularly germane because in dealing with issues of motivation, volition, and autonomy, we are assuming capacity for choice and decision making, both legal and functional. The nature of motivation and the place of volition and autonomy support in cases where adults (e.g., parents, guardians, agencies) assume responsibility for consent are layered and complex and beyond our current scope.

Behavioral Approaches

Behaviorism is a very broad school of thought with several rich strands of research and theory, and behavioral strategies and techniques have been applied in many counseling and therapy settings. Herein, we focus on *operant behaviorism*, which, although traceable to the work of Thorndike (1913), is most coherently and consistently articulated in Skinner's (1953, 1971) radical behaviorism. We focus on operant theory in part because space limitations prevent us from comprehensively reviewing the varieties of behaviorist thought and also because operant theory and methods have exerted considerably more influence on counseling and behavior change practices than the traditions of behaviorism associated with, for example, Hull's (1943) drive theory or Tolman's (1959) purposive behaviorism, each of which has its own perspective on the causes of psychopathology and human motivation.

Operant theory has, in a technical sense, offered an essentially nonmotivational account of the causality of human behavior (Moore, 2008). This is because behavioral theorists generally avoid discussing the source of behavior's *energy* and reject intentionality as an explanation for organized behavior. Instead behavior is understood functionally. Nevertheless, these approaches have been influential in the helping professions especially as they provide techniques to activate and sustain actions through contingency management (e.g., Petry, 2006), which, in lay terms, at least, makes them relevant to motivation.

Essentially, the operant perspective argues that behavior is the result of past learning experiences, including both classical (Wolpe, 1982) and operant conditioning (Skinner, 1974). *Reinforcement* is a central concept, defined as any event that is operationally separable from the behavior itself whose occurrence increases the likelihood that the behavior will be performed; a *punishment* is any event whose occurrence decreases the likelihood that the behavior will recur (aversive control). In clinical practice, problematic behaviors (not defined in canonical terms but in terms of their functional impact on the individual) are seen as maintained by a set of known or

unknown environmental reinforcement contingencies. Treatment then involves identifying those contingencies through a *functional analysis* and altering or replacing them with other contingencies, so that an undesirable target behavior is eventually extinguished or desirable target behaviors become part of one's behavioral repertoire. When applied to change behaviors, reinforcements and punishments could be *tangible*, such as the possibility to win monetary prizes (Petry, Alessi, Hanson, & Sierra, 2007) or vouchers exchangeable for desired goods (Higgins, Wong, Badger, Huag Ogden, & Dantona, 2000), or *social* in nature, such as praise or approval (Antony & Roemer, 2003). Reinforcements do not technically motivate behavior, but they function to control its occurrence.

Perhaps the technical construct closest to the concept of motivation within operant theory is that of *motivative operations* (Michael, 1993; Moore, 2008), defined as an environmental event, operation, or stimulus condition that affects either the effectiveness of reinforcements or the frequency of the relevant behavior. A classic example of a motivative operation is the deprivation of food for an organism, which would increase the organism's responsiveness to food-related reinforcements or activate a more frequent engagement in food-searching behaviors. The way in which motivative operations are defined is consistent with behaviorist meta-theory in situating the source of motivation in the external environment, where it might be directly altered, rather than within the organism. Yet it is also difficult to think of what controllable motivative operations might increase interest, participation, or adherence in behavioral counseling settings, in the sense that there are not ready targets for deprivation that would enhance behavioral engagement.

Using the taxonomy in Table 1, within operant treatments practitioners are typically focused on *external regulation* because the moving force behind behavioral change is located in the external reinforcements and punishments that control clients' behavior. When systematically and appropriately applied by counselors or therapists, external contingencies represent a powerful way to shape behaviors with considerable short-term effectiveness (e.g., abstinence during treatment; treatment attendance), as meta-analytically shown by Prendergast, Podus, Finney, Greenwell, and Roll (2006) and Lussier, Heil, Mongeon, Badger, and Higgins (2006). Those contingencies need to be appropriately applied to be effective; for instance, it is critical that the provided vouchers or monetary rewards are made contingent on, and directly available following, successful engagement in the requested activity (Higgins et al., 2000; Lussier et al., 2006).

Insofar as behavior is controlled by established contingencies, there is no expectation that the initiated behavior change will be automatically *maintained* and *transferred* once those contingencies are removed. *Maintenance*

refers to continued engagement in the behavior change once the contingencies are no longer being applied; *transfer* refers to the generalization of behavior change to a different social context from that in which the new behavior was learned. Operant theorists argue that technically behavior will not be maintained over time or will not spill over to new contexts independent of such contingencies. Indeed, operant theory does not technically acknowledge internalization of change and suggests that an absence of continued contingency management would lead changes to be extinguished (Deci & Ryan, 1985). It is less striking in this regard, then, that outcomes concerning maintenance are often not collected or reported in contingency management studies. For instance, in perhaps the most comprehensive meta-analysis on contingency management for the treatment of substance disorders to date (Prendergast et al., 2006), only 25% of the included studies yielded a follow-up assessment, with only 2 of the 47 studies including a 1-year follow up assessment.

This is not to say long-term outcomes are not of interest. In fact, to prompt maintenance of behavior change, operant theory provides several strategies that are theory-consistent. One is that new behaviors need to be occasionally or intermittently reinforced. Behavioral interventions can also be designed to establish or increase exposure to what are called "natural reinforcers," that is, contingencies that will reliably occur within one's everyday environment once a behavior is acquired (Bootzin, 1975). Still another approach entails concealing reinforcement contingencies so that their withdrawal is less detectable, thus delaying extinction (Stokes & Baer, 1977). Another solution would be to invite clients back into therapy to expose them to periodic booster sessions (Kingsley & Wilson, 1977) to reestablish the external contingencies. Finally, perhaps because of the problematic nature of maintaining purely externally driven reinforcements, behavioral practitioners are increasingly advocating getting clients to use *self-management* techniques. In this strategy, clients are taught to apply reinforcement contingencies to control their own behavior (Antony & Roemer, 2003; Kanfer & Gaelick-Buys, 1991). Across such techniques, the idea is to extend the behavior change acquired through therapist controlled contingency management, ensuring that contingencies of reinforcement are operative in everyday contexts that will ensure maintenance and transfer.

In addition to our focus on the techniques of behavior change themselves, concerning which there are many technical aspects (e.g., Stitzer & Petry, 2006), we are also interested in how behavioral therapists and counselors attempt to engage their clients in the process of change. That is, the techniques of goal setting and contingency management, which are techniques used to change behavior *within* treatment settings, do not speak to the clinicians' orientation

toward engaging their clients *for* treatment and supporting them through the process of planning and implementing contingency management or exposure treatments.

In this regard, behavioral therapists have traditionally been very articulate in discussing therapist attitudes and obligations. For instance, one important emphasis among behavior therapists is on the importance of *transparency*, *explicitness*, and *consensus* about the goals of treatment. As described by Antony and Roemer (2003), the therapeutic relationship should be *collaborative*, and there should be "repeated opportunities for clients to influence the course and direction of treatment" (p. 211). Similarly, Meichenbaum (1986) suggested that the first phase of treatment with adults involves helping clients to understand their problems and enlisting their active collaboration in formulating a treatment plan.

This emphasis on clients' volition, voice, and input in the context of therapy does not appear to us to be particularly theory-derived. Indeed, operant theorists have long argued that volition, self-determination, and other constructs related to autonomy are "fictional inner causes" or "epiphenomena" and are not consistent with a behavioral viewpoint (Moore, 2008; Skinner, 1974; Wolpe, 1982). Nonetheless, this emphasis on clients' experience of choice and self-endorsement of treatment goals seems strongly emphasized in practice manuals and in our personal interactions with behavior therapists. Perhaps because of the common belief that behavior therapy is potentially coercive, behavior therapists are often especially explicit about the centrality of clients' informed consent, choice, and involvement in treatment strategies and goals. As we shall see, this assumption, although it does not seem to be theory consistent, seems to be emphasized across this approach as well as many other schools of practice.

In discussing how behaviorally oriented practitioners can engage clients, Kanfer and Gaelick-Buys (1991) advocated a *participant model* in which the client accepts responsibility for change. They describe this as a basic foundation or "motivational requirement" (p. 306) for treatment. Yet within that, they further suggested that the therapist has a critical role in promoting favorable conditions for change. Thus, they see the early stages of treatment as involving the promotion of accepting responsibility for change and of encouraging participation in the setting of treatment goals. In this phase, Kanfer and Gaelick-Buys want the counselor to involve the client in anticipatory self-regulation, imagining his or her goals and discussing the strategies to get there, which will likely contribute to a more volitional engagement in therapy.

Along similar lines, the importance of the therapist–client *relationship* in behavioral treatments has been increasingly stressed. Keijsers, Schaap, and

Hoogduin (2000), for example, suggested that factors such as therapist empathy, warmth, and positive regard are important for treatment outcomes in behavior therapy contexts. In contrast, Woody and Adessky (2002) did not find evidence for the importance of relationship factors in predicting outcomes. As stated by Antony and Roemer (2003),

> The therapeutic relationship has been underemphasized in behavioral writings. . . . [R]esearchers have tended to focus more on examining the efficacy of particular behavioral techniques, with little discussion of the context in which behavior therapy occurs. (pp. 208-209)

These reviewers suggest that such factors are important, and they see this as consistent with behavioral theory insofar as these therapist factors represent forms of "social reinforcement."

In sum, behavior therapy is an approach that in theory emphasizes the external regulation of behavior. As we have noted, external regulations are often, when salient, experienced as controlling one's behavior and can engender an external perceived locus of causality for change (Deci & Ryan, 1985; Ryan & Deci, 2008). Maintenance of behavior change is therefore seen as dependent on continued reinforcement contingencies in the client's environment or periodic retraining.

Along with a focus on external regulations, behavior therapists in actual practice stress the importance of transparency, client choice over goals, and coparticipation in determining the course of treatment, suggesting that, whether theory based or not, they see autonomy and assent as important to engagement and positive change. This is also reflective of an ethical stance, as "behavior therapists place considerable emphasis on the development of therapeutic procedures by which the client might be provided with greater self-direction" (Goldfried & Davidson, 1976, p. 9).

Cognitive Behavioral Approaches

Among the most popular approaches applied in counseling today are those falling under the rubric of cognitive behavioral therapy (CBT). CBT is hardly a singular approach, and increasingly it has become an umbrella label used for the application of a wide variety of techniques from cognitive behavior modification (Salovey & Singer, 1991) to mindfulness training (K. Brown, Ryan, & Creswell, 2007; J. Miller, Fletcher, & Kabat-Zinn, 1995) to dialectical behavior therapy (DBT; Linehan, 1993), which eclectically incorporates multiple techniques from client-centered to operant schools of thought. Yet

despite the underlying diversity, two common elements in techniques labeled CBT are their emphasis on (a) the mediating role of cognitions such as beliefs and expectations in the linkage between environments and behavior and (b) basing practice on evidenced-based or empirically supported theory and practices. CBT treatments thus often emphasize the alteration of maladaptive beliefs and appraisals, which are assumed to underlie many emotional and behavioral problems, and the use of therapeutic strategies that have been empirically investigated.

In contrast to operant behavioral approaches, self-motivation and autonomy for treatment are more often explicitly recognized as important elements for treatment success and are actively debated within the CBT literature. For example, Michalak, Klappheck, and Kosfelder (2004) sampled outpatients receiving CBT regarding motivation and found that patients with greater autonomy for treatment reported better outcomes. Concern with motivation and autonomy has been heightened by concerns about selectivity (Westen & Morrison, 2001) and attrition in some CBT treatments. For example, in a study of cognitive interventions in depression in private practice settings, those who engaged in the therapy showed clinical improvement, but 50% of patients terminated prematurely (Persons, Burns, & Perloff, 1988). Similarly, Di Pietro, Valoroso, Fichele, Bruno, and Sorge (2002) and Steel et al. (2000) reported similarly high dropout from interventions for bulimia-related symptoms. Such numbers spark interest in the role of volition and motivation in attrition rates (Keijsers, Kampman, & Hoogduin, 2001).

One common and theory-consistent strategy for motivating clients within CBT is to focus on *expectancies*, or the client's confidence and optimism about the effectiveness of counseling and his or her own capacity to change. Indeed, motivation for change within CBT approaches is often seen to be a function of *self-efficacy beliefs*. Research on self-efficacy stems from the work of Bandura (1989, 1996), who has viewed efficacy as the core element in self-regulated action. Clearly, self-efficacy beliefs can play an important motivational role in counseling. Insofar as clients lack the belief that they are capable of successfully achieving an outcome, they are unlikely to put effort into behavioral change. In line with this, Westra, Dozois, and Marcus (2007), for example, showed that expectancy predicted early compliance with homework within CBT, which in turn mediated the relations between expectancy and symptom change. Thus, evidence suggests that expectancy is important to sustained involvement, motivation, and outcomes.

Given that theory points to efficacy perceptions regarding treatment as an important aspect of motivation, the cultivation of positive efficacy beliefs for participating in counseling has been relatively neglected in the literature

(Westra et al., 2007). Interventions would reasonably aim at enhancing the client's expectancy that (a) changes in behavior or thought will lead to positive outcomes and (b) the client is capable of engaging in that change. Within the cognitive-behavioral experimental literature, multiple techniques for enhancing client self-efficacy and motivation have been identified, ranging from modeling to persuasion to graded challenges, which are seen as having promise for clinical translations (Caprara & Cervone, 2000).

In light of how we have defined motivation as varying in autonomy or true willingness, we can see high levels of self-efficacy being accompanied by varied levels of autonomy. When related to the motivational taxonomy in Table 1, a lack of self-efficacy beliefs reflects one particular type of amotivation, namely, that associated with low competence as opposed to low value. Yet beyond amotivation, positive efficacy beliefs can sustain external, introjected, identified, or intrinsic forms of motivation. That is, one needs a sense of efficacy to be motivated to comply with external regulations, to live up to introjects, or to enact integrated values. Accordingly, positive self-efficacy beliefs can be accompanied by varied degrees of autonomy, and this means that whereas self-efficacy interventions can promote motivation rather than amotivation, they do not necessarily point to a particular type of motivation. Thus, self-efficacious actions in or with respect to counseling are not necessarily autonomous.

Engaging clients in CBT techniques. Again, our review is not focused extensively on therapeutic techniques per se but, rather, on the counselor's approach to engaging clients to apply the techniques. In this respect, motivational dynamics have again been widely recognized within the CBT literature. Indeed, numerous research studies within the CBT literature highlight the importance of clients' initial motivation by using it as a *predictor* of outcomes (e.g., Lewis et al., 2009). In such research it has typically been shown that low motivation is associated with more negative outcomes and is a negative prognostic indicator.

In some CBT approaches, clients are assessed before treatment for their *readiness* to change. Readiness has several components, for example, competency and means, but in common practice motivation and personal desire for change are seen as a big part of readiness. Within a number of CBT approaches the practice of transparency is seen not only as an ethical requirement but also as a way of assessing or gauging this readiness. Counselors explain the techniques to be used up front, and they then have potential clients either agree to the treatment or not, sometimes signing contracts to participate. Steketee (1993), for example, stated in her manual for treating obsessive compulsive disorder (OCD) that "motivation is best assessed by describing

treatment in sufficient detail . . . [that] Clients' reactions to this description will usually clarify whether they are willing to proceed" (p. 96). Linehan (1993) in discussing entrance into DBT said that therapists should fully explain the goals and ground rules of treatment, and those who do not agree to these aims and structures are not accepted into treatment. She added that in settings where legal or ethical constraints preclude rejection from treatment, "some sort of 'program within a program' is needed so that patients can be rejected" (p. 98). This emphasizes the DBT view of the *prerequisite* importance of volition and willingness, while also clarifying that the approach involves requiring it rather than working to explore and develop it.

Similarly, in discussing CBT group therapy, Bieling, McCabe, and Antony (2006) suggested that "motivation for CBT can be determined by explaining the treatment, as well as what will be required (e.g. weekly homework assignments), and asking about the individuals' readiness and openness to trying this treatment approach" (p. 139). They went on to argue that patients with "low motivation at the outset of treatment will not likely do as well, and their presence in the group may . . . detract from the therapeutic experience for the rest of the group, leading to contamination" (p. 139).

Beyond the transparency and agreement approach, CBT manuals and guidelines are expectably as highly varied in the manner in which they address client motivation for treatment as they are in their treatment strategies. Reflecting on this, Kanfer and Gaelick-Buys (1991) suggested that whereas in many behavioral modification programs the client's voice and participation in the strategy of change is limited, in some cognitive interventions there is "a basic presumption that the client is highly motivated to accept responsibility for changes" (p. 305). They thus suggest that such contrasts reflect a range from a passive recipient model, which assumes change is to be prompted from the outside, to an assumption that clients are eager to self-endorse change, which they see within some branches of CBT.

On the external regulation end of the autonomy continuum, Dryden and Branch (2008), writing about *rational emotive behavior therapy* (REBT; Ellis, 1984), suggest that therapists can apply what is called the *principle of rewards and penalties*. This basically involves getting clients to reward themselves when assignments or tasks are done and to penalize themselves for failures. Penalties and rewards are agreed upon in session, and patients and therapists sign a contract agreeing to their application outside treatment. The therapists can also discuss the risks of noncompliance and the benefits of compliance, using persuasion to foster engagement.

In addition to establishing external contingencies, some have also suggested that relationship contingencies can be used to motivate clients in CBT.

For instance, Linehan (1993) advocated a highly accepting and validating stance by therapists to establish a close relationship. Once established, the relationship could then be used as a contingent reward to catalyze change. Thus, a client might be told that "if she does not improve she will lose the therapist much more quickly," which, as Linehan admits, makes DBT a bit of a "blackmail therapy" (p. 98). In addition, appeals to others with power over the patient might also be employed. We see this as an example of contingent regard and, thus, a technique that can foster introjected regulation, in which the client's worth is implicated in failure or success.

Another increasingly prevalent tendency within CBT is the development of "add-on" components to traditional CBT techniques that are intended to promote personal identification with and value for engaging in treatment—in other words, to promote identified or autonomous participation. These are often labeled *motivational enhancement therapies* or MET components (e.g., W. Miller, Zweben, DiClimente, & Rychtarik, 1995; Treasure & Ward, 1997). The most widely used MET components are brief (e.g., three-session) *motivational interviewing* (MI; W. Miller & Rollnick, 2002) interventions, which are often delivered in the beginning of treatment. In W. Miller and Rollnick's (2002) terms, MI attempts to facilitate patients' intrinsic motivation for change, which Markland, Ryan, Tobin, and Rollnick (2005) clarified as concerning the promotion of *autonomous motivation*. We will discuss MI more extensively later in the article because, at least originally, MI was derived from a person-centered approach and embodied assumptions such as self-actualization tendencies that are inconsistent with the theoretical foundations of behavioral and cognitive behavioral schools of thought. Nonetheless, an increasing number of CBT practitioners have seen component interventions such as MI as a valuable addition to the often technique-driven practices in CBT (e.g., Brennan, Walkley, Fraser, Greenway, & Wilks, 2008; Treasure et al., 1999).

Noting that well-supported treatments in CBT are often compromised by poor compliance and dropout, Westra and Dozois (2006) compared normal CBT practice with a combined MI "pretreatment plus CBT" in therapy anxiety disorders. They found better within-treatment compliance (e.g., homework completion) in the MI plus CBT group and found that the MI pretreatment group had a significantly higher number of CBT "responders." McKee et al. (2007) similarly added an MI-based MET onto CBT and found better attendance and compliance within treatment, albeit no advantages on ultimate outcomes, which in their case was drug abstinence. Similarly, Buckner and Schmidt (2009) randomly assigned socially anxious individuals to an MET for CBT treatment condition or a control group. They found that the MET addition resulted in a significant increase in the probability of attending a

first CBT appointment and in a greater interest to be contacted by a therapist to schedule an appointment. Thus, it appears that adding MET as a "pretherapy" component may help to enhance engagement and may be especially important with groups with barriers such as shyness or anxiety.

The reason for MET "add-ons" to traditional CBT strategies is to enhance client volition and commitment. To use the terminology presented in Table 1, METs would be enhancing clients' identification with and integration of the values of treatment and, therefore, their more autonomous participation. Again this focus on autonomy, whether or not referred to by that name, is not systematically or theoretically connected with cognitive-behavioral models or their theories of change. For example, Bandura (1989), a theoretical leader within CBT, explicitly denied the utility of the concept of autonomy, because he defined it not as volition but as "independence" from all environmental influences. Few other cognitive behavioral theories address the conceptual importance of volition or autonomy per se. Nonetheless, almost every chapter reviewing the *practice* of CBT will highlight the need for clients to experience choice, volition, and value for the process, presumably because those without volitional motivation are not seen as good candidates for CBT treatment. Thus, as with behaviorism, one can find in the literature a strong value emphasis on client volition in clinical practice, without extensive grounding in the theoretical literature of social cognition.

Cognitive therapy. Closely related and often grouped with cognitive-behavioral perspectives is cognitive therapy as advanced by Beck and colleagues (e.g., A. Beck, Freeman, & Associates, 1990; J. Beck, 1995). The element of *cognition* in cognitive therapy refers to the subjective perception and interpretation of events and experiences, which in turn influences the behaviors that one performs. In its more recent formulations (e.g., A. Beck & Weishaar, 2008), cognitive therapy makes the somewhat broader argument that behavior is the result of the interaction of several systems: cognitive, affective, motivational, and physiological. Although the newer formulation of cognitive therapy names motivation as an important component in human personality, it does not articulate clearly or in a theoretically consistent way of what "motivation" consists. Cognitive therapy also acknowledges the important role played by the environment in shaping behavior. Yet despite its more inclusive and encompassing perspective on the systems that influence behavior, cognitions in theory play a decisive role in the emergence and treatment of pathology and, more importantly, represent a point for intervention.

In cognitive therapy, the relationship between therapist and patient is viewed as one of *collaborative empiricism* (A. Beck et al., 1990), in which patient and therapist work together to identify the patient's maladaptive cognitive

interpretations of events and experiences, to change those interpretations, and to test them "empirically," that is, to try out a new cognitive framework in the context of daily life and discuss its success or failure. Because Beck explicitly stated that his approach is eclectically based and draws from both psychodynamic and humanistic approaches, it is not clear what the specific theoretical justifications underlying this emphasis on collaboration and active involvement are, but his emphasis on cultivating client interest and identification with the process and goals of treatment is nonetheless clearly motivationally relevant. For example, A. Beck, Rush, Shaw, and Emery (1979) argued that the collaborative approach engenders a spirit of "exploration and discovery," which enhances motivation (p. 32). This suggests, therefore, that both relationships and process factors are seen as producing what we labeled in our taxonomy as intrinsic motivation for change. Similarly, A. Beck et al. (1990) stated that a therapeutic alliance is a necessary although not sufficient condition for positive change, and they emphasized that therapists need to demonstrate empathy, warmth, and other characteristics emphasized within "humanistic" therapies to be most effective. Regarding autonomy, they suggested further that when patients are noncompliant it is "rarely productive for the therapist to take an authoritarian role" (p. 198). They instead advocated that the therapist highlight the client's power to make choices and review the pros and cons of the noncompliance. This emphasis on empowerment, then, seems aimed at maintaining a sense of volition in the counseling process and keeping the relationship positive. This is important to highlight because, as Sue and Sue (2008) recently argued, a common difficulty for both new cognitive-behavior therapists and new cognitive therapists is insufficient attention to the therapeutic alliance, which some attribute to the often strong emphasis in training on techniques relative to client–therapist interactions and relationships.

At the same time that cognitive therapy emphasizes collaboration and consensus as positive motivators, this supportive focus is not infrequently combined with strategies that also seem more associated with external regulation or introjection. For example, when clients do not comply with homework assignments, A. Beck, Emery, and Greenberg (1985) advocated a host of potential intervention strategies that spanned from externally regulating, to approval-based, to directly controlling through admonition and authority. These included "getting the patient to make a verbal agreement," or contract to adhere, and even get it notarized; using contingency management, including "material rewards" as reinforcements; and using straightforward authority—"the therapist can tell the patient who is not improving that he *has* to do the homework if he wants to get better" (p. 269). Yet A. Beck et al. (1985) seem to prefer self-motivation and see these more controlling strategies as temporary until

success experiences become self-reinforcing. Thus, underlying the array of strategies appears to be the belief that experiences of efficacy, however energized, will ultimately supply the needed fuel for sustained motivation, presumably because internalization of regulations will have occurred.

In reviewing ideas about motivation within CBT and cognitive approaches, then, we see a high degree of variation in practitioners' strategies to enhance clients' motivation to participate in the counseling process. Nearly all CBT approaches embrace the need for self-efficacy, and some techniques actively promote it. Beyond efficacy, there is a lack of systematic conceptualization of low motivation and resistance in CBT, due in part perhaps to the fact that motivation or "readiness" for treatment is often considered a prerequisite to entry or is assumed. Add-on motivational enhancement packages preceding treatment are intended to help prepare this readiness.

As with behavioral approaches, within both CBT and cognitive therapy there is a background emphasis on and respect for client autonomy, albeit typically without a systematic theoretical justification. That is, the preponderance of approaches under the banner of CBT appear to value autonomous engagement by clients in processes of change, including the involvement of clients in the setting of goals and the direction of behavior change, even though the specific theoretical grounding for that emphasis is underarticulated.

Stages of Change and the Transtheoretical Model

The Stages of Change Model (SOC), which is part of the broader transtheoretical perspective on therapy developed by Prochaska and colleagues (e.g., Prochaska & DiClemente, 1986; Prochaska, DiClemente, & Norcross, 1992), was developed to address client motivation and has enjoyed considerable popularity. Dozens of studies have examined key tenets of the transtheoretical model (TTM), and the model has been used as a guiding framework to understand the change efforts related to both the cessation of high-risk behaviors (e.g., smoking, drug use, unhealthy eating) and the adoption and maintenance of healthy behaviors (e.g., exercising, healthy eating).

Heuristically appealing, the model suggests people can be located along a continuum of stages regarding readiness or motivation for behavior change. Specifically, in their movement toward lasting change, people are said to move from *precontemplation* (not considering change at all), to *contemplation* (weighing pros and cons), to *preparation* (getting ready to make the change), to *action* (making the change), and finally to *maintenance* (consolidating positive change). Quite often, specific time frames have been used to define the different stages of change (Prochaska, DiClemente, et al., 1992).

For instance, *preparers* are those clients who intend to undertake action in the next month and who failed to successfully undertake action in the previous year. In line with the claim that these stages describe clients' movement toward change, patients involved in a behavior therapy program for weight control have, as a group, been found to display a decrease in contemplation and an increase in action from the beginning to the middle of treatment (Prochaska, Norcross, Fowler, Follick, & Abrams, 1992).

This change process is considered cyclical in nature: Because relapse is an integral part of movement toward sustained change, patients are said to move repeated times through these five stages before achieving a state of sustained change. Thus, with each new change attempt, patients would move through the same five proposed stages such that, over time and with repeated attempts, their change pattern could be graphically best depicted by a *change spiral* (Prochaska, DiClemente, et al., 1992). Furthermore, it is assumed that these different stages are qualitatively different in the sense that each can be "regarded as reflecting a distinct motivational posture" (Velicer, Hughes, Fava, Prochaska, & DiClemente, 1995, p. 300). Because these different stages are mutually exclusive, individuals are said to belong to a single stage. Additionally, each stage is said to be characterized by a particular balance between the pros and cons of change, and in moving from the precontemplation to the action phase, patients' pros for change increase (strong principle), whereas their cons against change decrease (weak principle).

The concept of self-efficacy, or the belief one is capable of achieving desired change, is also incorporated within the transtheoretical perspective and is said to vary as a function of patients' stage. In line with these claims, DiClemente et al. (1991) found in a sample of smokers that in the latter stages of change the pros of smoking were less strongly valued, whereas the cons of smoking and the perceived self-efficacy with respect to smoking cessation were higher compared to the earlier stages of change. Studies in a variety of domains have further supported this pattern of findings, providing evidence that the later stages of change reflect greater self-efficacy.

DiClemente (1999) further argued that clinicians can help patients reach higher level stages by increasing their *internal* (or *intrinsic*) motivation as opposed to their *external* (or *extrinsic*) motivation to change. Thus, DiClemente adopts a dichotomous view toward clients' motivation, thereby suggesting that there is a nondesirable (i.e., extrinsic) and a desirable (i.e., intrinsic) type of motivation. When viewed from the provided motivational taxonomy in Table 1, we would reinterpret DiClemente in terms of controlled versus autonomous motives, with the latter including intrinsic motivation. Indeed, some empirical evidence suggests that as patients report being in later versus

earlier stages of change, they also report more autonomy or self-determination for change (e.g., Mullan & Markland, 1997).

According to the SOC framework, the promotion of optimal motivation and change is best achieved by applying the therapeutic principles, strategies, and tactics that *match* with the clients' particular stage (Prochaska & DiClemente, 1982). The proposed techniques in each phase are not rooted in one single theoretical framework or approach but instead represent a broad collection of diverse techniques taken from various approaches. These processes were derived from an analysis of 24 leading models of psychotherapy, which explains the term *transtheoretical*. Specifically, 10 processes are described that would be used by patients to pursue change, with 5 of these processes (i.e., consciousness raising, dramatic relief, environmental reevaluation, social liberation, and self-evaluation) being cognitive in nature and 5 of them (i.e., stimulus control, helping relationships, counterconditioning, contingency management, and self-liberation) being more behavioral in nature. Whereas the cognitive/experiential processes would be used by preference in the earlier, more motivation-oriented, stages of change, the behavioral processes would be applied by preference in the last, more action-oriented, stages of change. Rosen (2000), however, showed in a meta-analysis that the sequencing of change processes by stage is not consistent across all health problems. For example, the pattern of differences for smoking cessation and substance abuse was consistent with TTM, but cognitive/experiential and behavioral processes increased in tandem for exercising and diet change.

Although widely used by practitioners and advocated by some scholars (e.g., Spencer, Pagell, Hallion, & Adams, 2002), the SOC model and the TTM more broadly have been increasingly criticized (e.g., Armitage, in press; Sutton, 2001; Weinstein, Rothman, & Sutton, 1998; West, 2005; Wilson & Schlam, 2004). It is not our intention to provide an exhaustive overview of these criticisms but, rather, to highlight those that are relevant from a motivational perspective.

First, the idea that the proposed stages would form discrete categories, each characterized by a particular motivational mode of functioning (Velicer et al., 1995), has been criticized. Rather than belonging to one single stage, patients have been found to be in multiple stages at once (Sutton, 2001). Furthermore, stages of change measures have been found to be strongly positively correlated with behavioral intention measures (e.g., $r = .78$; Armitage & Arden, in press), suggesting a strong linear trend to the stages of change. Similarly, Kraft, Sutton, and Reynolds (1999) found that when discrete stage measures and continuous intention measures competed for variance in criterion variables, only the continuous measures explained significant variance.

Such results indicate to some that the stages of change algorithm, which is widely used in the literature to assess readiness, might better be replaced by a continuous dimension or metric (e.g., Dunn, Neighbours, & Larimer, 2006).

In other cases, multidimensional measures (e.g., the University of Rhode Island Change Assessment [URICA]) have been used to assess patients' stages; in such cases, a relatively consistent simplex pattern has emerged, with adjacent stages being more strongly positively correlated than are nonadjacent scales (Sutton, 2001). As we noted earlier, in our view such a simplex pattern supports, without contradiction, both the underlying continuum of motivation notion and the SOC-hypothesized ordered relations between the stage constructs. Both can be true. Such ordering, although suggesting an underlying psychometric dimension (e.g., of "readiness"), is not necessarily indicative of developmental or temporal sequences (see Ryan & Connell, 1989).

A second concern is that longitudinal studies have largely failed to predict patients' systematic movement through the different stages (West, 2005). For instance, Herzog, Abrams, Emmons, Linnan, and Shadel (1999), over a 2-year follow-up, found no evidence for the basic processes of change and the pros and cons of change to predict progressive-stage movement. Similarly, using a three-wave longitudinal study among adolescent smokers with 3-month intervals, Guo, Aveyard, Fielding, and Sutton (2009) reported that the observed changes only predicted stage transitions in 4 out of 24 possible cases. These issues have been noted by Prochaska et al. (1994), as when they wrote that "although some transitions, such as from contemplation to preparation, are much more likely than others, some people may move from one stage to any other stage at any time" (p. 1105). The very concept of a stage model, however, precisely implies that change occurs in a sequenced fashion.

Research reveals that especially the shift from the preparation to the action phase is difficult to predict (Armitage, Sheeran, Arden, & Conner, 2004; Lewis et al., 2009). These observations led Armitage (in press) to suggest that there exists a *disjoint* between the first three phases and the last two phases. Said differently, the transition from intention to engage in behavior to effective change is not well predicted by TTM variables. From a motivational viewpoint, this might be due to the fact that within the TTM not sufficient attention is paid to clients' qualitatively different reasons for pursuing change, which can be experienced as more controlling or as more self-endorsed, as indicated in Table 1. That is, to the extent that the intention to pursue change is undergirded by controlling motives, they are less likely to get translated into effective change, especially over time. If, on the other hand, clients' intentions to pursue change are self-endorsed or more autonomous, intentions might be better related to subsequent pursuit of change, especially when patients also formulate

implementation intentions (Armitage, 2006; Koestner, Lekes, Powers, & Chicoine, 2002).

A final observation is that, perhaps because the proposed stage transitions over time are not reliable, *stage matching* has largely failed to yield any greater change benefits over non–stage matching. Although practically appealing, the idea that therapeutic interventions need to be tailored according to patients' stage constitutes perhaps the most critical assumption of the transtheoretical model. A number of studies (e.g., de Vet, de Nooijer, de Vries, & Brug, 2008; Dijkstra, Connijn, & de Vries, 2006; see Armitage [in press] for an overview) have examined this stage-matching hypothesis, and the findings to date are at best "mixed" (Armitage, in press; Bridle et al., 2005; Lewis et al., 2009).

In sum, the SOC approach has been important in suggesting that clients differ in their types and levels of motivation for change and in stimulating considerable research on this topic. However, the descriptive model's actual validity has been questioned, especially the assumptions of a predictable sequence of stages of change and the need for therapy techniques to match specific stages.

Psychodynamic Perspectives

In clinical practice today, an increasingly smaller, but still substantial, subset of counselors and psychotherapists define themselves as engaged in a psychodynamic approach, and many others who are eclectically or cognitively oriented regularly draw on psychodynamic techniques to foster growth and self-understanding (e.g., Gibbons et al., 2009). Psychodynamic approaches place emphasis on the multiple forces, both conscious and unconscious, that motivate action and that people struggle to regulate in their everyday lives.

Psychodynamic approaches, much like CBT approaches, are not, however, uniform, and the term, as we use it herein, therefore refers to a variety of techniques with a common origin in psychoanalysis (Freud, 1923/1961). There are many motivational concepts in Freud's theory of personality that are not specifically focused on motivation for counseling and behavior change. Largely, orthodox psychoanalysis sees all motivated behavior as ultimately energized by biological drives, variously diverted into impulses and actions. There is also a core idea that the ego, or the "I" (*das Ich*), is synthetic or assimilative in nature (Freud, 1923/1961), attempting to regulate and modulate drives and use the energy adaptively. The therapist must ally with the synthetic function of the ego in the process of change, helping the clients to bring into awareness their true feelings and motives, so that they can experience

them and integrate them and, presumably, make better choices with respect to living (Meissner, 1981).

Since Freud, multiple approaches have emerged that used psychoanalysis as a theoretical springboard but that have developed in substantially different directions. These include *ego psychology*, *self-psychology*, *interpersonal psychoanalysis*, and *object relations* approaches. Despite their important differences, these approaches share a common appreciation for the role of the unconscious, the utility of understanding the transference relationship, and the importance of considering the role played by past experience on clients' present problems (Luborsky, O'Reilly-Landry, & Arlow, 2008). Each of these concepts has relevance for understanding and working with client motivation because the patterns of motivation from the past are likely to have continuity with the clients' attitudes and investment in therapy (Gabbard, 2005). As in our treatment of other theories, however, our focus here is mainly on how psychodynamic clinicians conceive of clients' motivation for treatment and how they practically address this.

First, it is important to underscore that psychodynamic therapies range from *supportive* to *insight-oriented* (Dewald, 1969; Wolitzky, 2003). Supportive therapy is applicable to clients with fewer intellectual and interpersonal resources and/or those with lower treatment motivation. According to this distinction, those requiring supportive therapy receive more direct support for their ego—from guidance to external regulation—whereas the insight-oriented end of this spectrum requires more careful attention to not usurping the patient's autonomous activity. As Dewald (1969) puts it, "the concept of 'reinforcement by rewards' involves reliance on an external authority for motivation control and judgment, and as such is opposed to one of the basic goals of insight-oriented therapy" (p. 109), namely, developing greater self-regulation. Therefore, to the extent the therapy is focused on insight and growth, "the therapist does not attempt to reinforce or actively reward specific types of behavior or change" (p. 109). We thus see that Dewald is in some ways titrating the degree of supporting autonomy to the level of ego-development of the client.

A second important construct related to motivation is that of *transference* (Gill, 1982). Freud posited that the feelings surrounding early, influential relationships carry over to new relationships, including, importantly, that with the therapist. From a motivational perspective, what this means is that people have a tendency to perceive and respond to others in their current situation based in part on experiences from their past. It is, however, the therapist's task within psychoanalysis to identify the transference in the context of the therapeutic relationship and then use this knowledge to separate present

reality from memories and expectations based in past relationships. The goal is one of liberating the client from past determinisms by bringing the unconscious to consciousness.

Early on, Freud saw transference as contributing to therapeutic motivation insofar as the transference was positive. *Positive transference* in the form of idealization was thought by Freud to allow the client to attribute to the therapist a sense of authority and competence and, thus, to more fully invest in his or her interventions and inputs (Horvath, Gaston, & Luborsky, 1993). Positive transference, to the extent it is built upon idealization of the therapist, would seem to fit best with introjected regulation (see Table 1). That is, to the extent that motivation is based on idealization, the client is motivated to follow the therapist's suggestions or live up to her or his standards in order to feel better about themselves, without necessarily understanding or integrating the "authority" or the rationale that instigates changes (MacKinnon et al. 2006; Meissner, 1981).

Clients are not always ready or willing to embrace the psychoanalytic process, and many demonstrate *resistance*. Resistances are often unconscious defenses, whose meaning and function can be brought to light (Kaner & Prelinger, 2005). Resistance can be related to transference, insofar as the client is sometimes reacting to attributes from a developmentally significant adult projected onto the therapist. It can also come from attempts to maintain or defend prior forms of functioning (Gill, 1982). Therefore, occasions of resistance do not reflect a failure in motivation on the client's part; instead, they emerge in interaction with a clinician whose presence activates previous encounters. The task of the therapist is to explore with the client the nature of her or his resistance and the purpose it is serving in the moment.

Gabbard (2005) stated that, in fact, "resistance is part of the bread-and-butter work of the therapist" (p. 100). By reflecting upon resistances with interest and curiosity, rather than devaluing them, the client too can become curious, interested, and ideally free to let go of the resistance. Similarly, Schafer (1983), in his classic work on psychodynamic techniques, argued that analysts should expect resistance to change to be ever-present. Accordingly, dynamic therapists create an interpersonal climate that is conducive to persisting through the difficulties of change, which Shafer described as an *atmosphere of safety*. Conveying a warm and respectful attitude, being nonjudgmental, and being interested in what the client introduces are elements that presumably decrease the intensity of defense and resistance and make room for insight. Kottler (1993) suggested that the dynamic view of patient amotivation and resistance reflects an understanding that they are "doing the best they can to keep themselves together. . . . [M]issed or chronically late

appointments are not part of a conspiracy to make us miserable, but rather the client's attempt to retain some control in a threatening situation" (pp. 126-127). Thus, dynamically oriented counselors seem to agree that patients tend to resist the counseling process and that such resistance is among the issues to be addressed.

This perspective that problems in motivation are among the issues to be treated is reflected across the spectrum of psychodynamic techniques. As Binder, Strupp, and Henry (1995) stated, dynamic treatments typically "offer therapy to all patients who are motivated to accept it and who seem at all suitable" (p. 55). Similarly, Kaner and Prelinger (2005) argued that resistances to therapy are inevitable and unavoidable and are integral to present forms of adaptation. They stated, "The therapist can rely on the assumption that when the patient resists, there are good reasons" (p. 172). Thus, unlike therapeutic techniques that expect clients to come to treatment highly motivated or to exhibit "readiness" or else be excluded, psychodynamic approaches see resistance and low motivation for change as symptoms.

Some newer dynamic therapies were developed especially to work with clients who might have trouble with developing a therapeutic alliance because of deeply maladaptive patterns in close relationships. For example, Levenson (2004) presented *time-limited dynamic psychotherapy* (TLDP) as an intensive, interpersonally focused approach for clients with dysfunctional ways of relating to others. Indeed, many contemporary dynamic perspectives draw attention to the important ways in which motivation for change is based in the desire to be related with another person (e.g., J. Greenberg & Mitchell, 1983). Important representatives of this tradition are provided by object relations theory (e.g., Fairbairn, 1954; Winnicott, 1965), attachment theory (Bowlby, 1969, 1988; Cicchetti, Toth, & Lynch, 1995; Lyons-Ruth, 1991), and self-psychology (Basch, 1995; Kohut, 1971). The key point here is that psychodynamic therapists after Freud have increasingly viewed clients as motivated by qualities in relationships. In this respect, the concerns with therapeutic alliance have, alongside consideration of transference, become even more central to the dynamic practitioners' methods of understanding motivation and fostering change.

Another interesting issue, concerning which psychodynamic treatments differ from more outcome-focused approaches, concerns *transparency*. Recall that transparency and up-front consent to procedures and goals are very salient features in many behavioral and cognitive-behavioral approaches where there is more likely a specified outcome or target for treatment. This is not always as clear in psychodynamic approaches, where the specific processes and techniques of the therapist (e.g., evocation of conflict areas, interpretation, etc.)

are not explicitly presented or made transparent upfront. Even questions about the process and its effectiveness may at times be interpreted as resistance. The idea, in fact, is that resistances may not be conscious or easily overcome simply through explicit consent or transparency. Thus, although there is value for assent to the process, the therapist, who is parrying with defenses and resistances, may not always be transparent in his or her specific methods or interventions (Gabbard, 2005).

For example, Kaner and Prelinger (2005) argued that, although some patients could benefit from an explanation of the therapy process, beyond spelling out the basic frame of therapy (e.g., meeting times) and some basic "consumer information" during initial contacts, there is no standard form that should be applied. They, and many other dynamic practitioners (e.g., MacKinnon et al., 2006), have advocated that any information, instead, should be introduced in response to clients' concerns or inquiries and should be minimal. This stands in contrast to the view espoused more frequently in behavioral and CBT approaches, in which transparency and explicit consent to procedures is emphasized both as an intrinsic valued and as a technique for motivational enhancement.

Interpersonal therapy (IPT). An increasingly popular evidence-based intervention is a time-limited dynamic approach called *interpersonal therapy*. Grounded in attachment theory (Bowlby, 1988) and originally developed by Klerman, Weissman, Rounsaville, and Chevron (1984) as an approach to treating depression, IPT is now applied to a broad spectrum of disorders and patient concerns (Stuart & Robertson, 2003). Unlike traditional relationship analyses within dynamic approaches, IPT does not focus directly on transference issues and interpretations or on the contributions of early memories and experiences. Its focus is on the resolution of interpersonal conflicts in here-and-now relationships. In contrast to cognitive therapies such as Beck's approach, IPT does not focus primarily on internal cognitions and beliefs but, rather, on interpersonal communications and functioning within the client's actual social network.

Again, our focus is on conceptions of how to motivate clients, here with respect to IPT. In discussing the therapist's role in motivation, Stuart (2004) suggested that IPT therapists must (a) be focused, (b) be supportive, (c) convey hope, and (d) reinforce gains. As laudable as these elements sound, one could imagine them being carried out in somewhat different ways. Stuart, for example, says the therapist "can control the transference reaction to a large degree by assuming the role of a benevolent expert" (p. 130). Also, as part of motivating clients, IPT therapists tell clients in the initial sessions what IPT involves and what can be expected, suggesting transparency and consent as factors. But beyond this, IPT counselors see that goals and time limits are negotiated

with the patients to help facilitate a positive working alliance. Violations of agreements are then viewed as interpersonal communications themselves and as providing valuable information about functioning. Thus, the transparency and agreement approach we discussed in some behavioral and CBT approaches is used here, along with the psychodynamic assumption that subsequent resistances are part of the material, or "grist for the mill," of counseling.

Existential and Humanistic Perspectives

Existential perspectives. Existential–phenomenological counseling draws on existentialist philosophies, particularly those of Heidegger and Sartre, and has its focus on human psychological freedom and helping clients to experience themselves at the center of their lives, responsible for who they are and what they do. Mental health is defined in large part by *authenticity*, the state that occurs when the individual acts as an integrated whole. To live authentically means to be aware of what is real and genuine (without distortion or defense) as well as to be the author of one's existence, taking responsibility and engaging one's freedom (Ryan & Deci, 2004; Wild, 1965).

Existential therapy is seen as a collaborative exploration of the barriers to authenticity, as experienced by the client, and of the possibilities of living. As Yalom (1980) put it,

> The therapist's goal then is engagement. The task is not to create engagement nor to inspirit the patient with engagement—these the therapist cannot do. But it is not necessary: The desire to engage life is always there within the patient, and the therapist's clinical activities should be directed toward the removal of obstacles in the patient's way. (p. 482)

In this light, existentially oriented counselors are inherently process-oriented and committed to open-ended goals, determined within the encounter between therapist and client. Given these background assumptions, it is clear that existentially oriented counselors would be focused on their clients' autonomy from the outset.

This cardinal orientation toward respect for patients' choice and autonomy is illustrated in the descriptions offered by Deurzen-Smith (1997) of her approach to existential counseling. In her practice she describes attempting to be as informative as possible about the nature of the work in the initial session, inviting as many questions as possible. The purpose of this brief session, for which she does not charge, is to inform and has the goal of transparency

and supporting authentic choice. She then asks potential patients to take time in making the decision before committing, asking them to recontact her if they desire to move forward. She stated that this insistence on freedom and choice in entering therapy is important, indicating a readiness to embark on the existential work. When related to the motivational taxonomy in Table 1, such an approach is likely to contribute to a personal endorsement of change or identified regulation, as clients are provided a structure for "owning" their decisions. If they ultimately withdraw from pursuing change, it is likely that this will also reflect their choice, thus signaling autonomous nonengagement in change.

Although the tasks of therapy are open-ended and client-determined in the existential approach, Yalom (2002) similarly advocated as complete a transparency as possible, both to alleviate anxiety and because it is consistent with the goals of counseling. In this view, to have an authentic relationship means to "forgo the power of the triumvirate magic, mystery and authority" (p. 84), and this is aided by pulling back the shroud of methods or focus wherever one can. It is worth noting, however, that although existential therapists, like many behavioral or cognitive behavioral therapists, advocate transparency, especially in the initial session, the focus of the conversation is likely to be rather different specifically because of the difference between the outcome focus of the latter approaches and the process focus of existential therapy. Stating the procedures of behavioral therapy or CBT is typically more precise and circumscribed than is stating the processes and foci of existential therapy.

More specifically, beyond initial commitment, existential approaches do not remain fixed in goals or strategies. Instead, there is a continual process in which therapists responsively attend to clients' concerns, in that the focus is on taking the frame of reference of the patients, while always highlighting the particular role and responsibility the patients have in their distress. As Yalom (1980) stated, "Readiness to accept responsibility varies considerably from patient to patient," and helping them assume responsibility for change, can become "the bulk of the therapeutic task" (p. 231).

Humanistic perspectives. Central to humanistic perspectives is the assumption of a self-actualizing tendency in personality development. The *person-centered* approach (sometimes referred to as the *client-centered* approach), developed originally by Rogers (1951), embraces this actualization assumption most explicitly; but this assumption informs a broader family of approaches increasingly referred to as *experiential* (Elliott, Greenberg, & Lietaer, 2004), which additionally includes Gestalt, existential, psychodrama, and expressive therapies. Despite important differences, these approaches all adhere to a central assumption that human nature is "inherently trustworthy, growth-oriented,

and guided by choice" (Elliott et al., 2004, p. 493). These principles have important implications for understanding motivation in counseling.

Rogers (1957) specifically argued that the therapeutic relationship, characterized by genuineness, empathy, and unconditional positive regard, could facilitate positive change and growth by creating an environment in which clients' inherent motivation toward actualization would be supported. Rogers assumed that these facilitating conditions for change—genuineness, empathy, and unconditional positive regard—were both necessary and sufficient in bringing about positive and lasting therapeutic change (Kirschenbaum & Jourdan, 2005). His assumption was that motivation in the direction of actualization will be catalyzed as long as these supportive conditions are afforded. Later we will discuss how that assumption has played an important role in the nonspecific factors movement that identifies counseling variables associated with positive change across techniques.

Another Rogerian concept with relevance for understanding client motivation concerns the self-concept. Rogers (1961) drew a distinction between how people actually think about themselves, what he called the *self-structure* or the *self-concept*, and how they would ideally like to be. Furthermore, the gap between the current or actual view of self and the ideal view of self serves as an important gauge of self-esteem: The larger the gap, the lower one's self-esteem, whereas the closer people are to their ideal, the better off they should be. He considered that awareness of a gap between one's current and ideal view of self often plays a major role in motivating people to seek counseling and psychotherapy. In support of this claim, in a number of innovative studies Rogers and colleagues provided empirical support for a link between self-concept discrepancies and well-being (Rogers & Dymond, 1954). Rogers speculated that the relationship between therapist and client, characterized by empathy, genuineness, and unconditional positive regard, plays a role in reducing self-concept discrepancies, thereby facilitating positive change. In line with this, Lynch, La Guardia, and Ryan (2009) recently showed that personal relationships characterized by autonomy support are associated with lower perceived gaps between actual and ideal functioning.

The focus on self-actualization and awareness in person-centered approaches is related to the principle vehicle of change—*reflection*. Reflection presumably helps clients clarify both reasons for change and the barriers in the way. Presumably, when clients experience low motivation, this itself would become an object of active interest and reflection, with a resulting movement on the part of the client in a direction of health (Engle & Arkowitz, 2008).

In sum, because existential and humanistic approaches are focused on authenticity and self-actualization, they are very prone to autonomy support as

a therapeutic style and strategy. There is an assumption that patients are inherently motivated, if obstacles can be removed and an atmosphere absent of threat can be provided. Existential approaches also value transparency, whereas this is less explicit among humanistic therapists, who vary in transparency and in the specific tools they bring to supporting clients' self-exploration.

Motivational Interviewing

Motivational interviewing (MI) is a clinical method that was originally applied in the domain of substance abuse but has expanded to be a motivational enhancement strategy alongside many specific therapies (W. Miller & Rose, 2009). MI has been shown to be effective in a number of domains such as addiction treatment, diet, exercise, hypertension, diabetes, bulimia, and smoking cessation (see Burke, Arkowitz, & Menchola [2003]; Hettema, Steele, & Miller [2005]; and Rubak, Sandboek, Lauritzen, & Christensen [2005] for meta-analyses). Improvements in clinical outcomes have been attributed largely to increased treatment retention and adherence (e.g., J. Brown & Miller, 1993).

MI recognizes that client ambivalence plays a central role in change and suggests that it is critical for clinicians to "roll with" rather than fight against the clients' resistance to change and focus on identifying and resolving discrepancies between desired behaviors and actual behaviors. The task for a clinician is thus to elicit or draw out clients' motivation and ideas about change. W. Miller and Rollnick (2002) labeled this approach "motivational interviewing, to denote 'a together looking at something'" (p. 25). Presumably, the reflective techniques and motivational inquiry are intended to spawn the client's willingness to talk about change, which W. Miller and Rose (2009) see as the mediating mechanism responsible for engagement in the process of change and, therefore, positive outcomes.

We positioned MI in this section of the review because MI was originally described as a person-centered, "directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (W. Miller & Rollnick, 2002, p. 25). By this, W. Miller and Rollnick (2002) intended to convey the importance of the client's having an internal locus of causality for change, or a sense of autonomy (Markland et al., 2005; Vansteenkiste & Sheldon, 2006). Indeed, Markland et al. (2005) argued that truly fostering autonomy was the essence of the MI spirit. Yet differing to some extent from the classical person-centered approach, MI is somewhat more directive. For example, W. Miller and Rollnick noted that "the interviewer elicits and selectively reinforces change talk and then responds to resistance (i.e., talk

that does not imply behavior change) in a way that is intended to diminish it" (p. 25).

More recently, W. Miller and Rose (2009) presented a new theoretical framework that put much more emphasis on change talk as the mechanism for change in MI, where *change talk* is defined as any speech that favors positive behavioral change. In making this change in emphasis, they appear to have shifted from ideas about autonomous or intrinsically motivated change toward a more cognitive perspective. Viewed in light of our taxonomy, change talk could take many forms and be underpinned by either controlled motives (e.g., wanting to comply with or please the therapist) or autonomous motives (e.g., actual interest or value in change). That is, whereas Rollnick, writing with Markland et al. (2005), emphasized the critical place of *client autonomy* as the basis of sustained engagement and integrated change, W. Miller and Rose's more recent formulation focuses on a concept that, in their words, could be enacted in a more or less honest way—or, in our words, in an autonomous way or a controlled way. That is, this increasing emphasis on the motivationally neutral construct of change talk as the key explanatory mechanism within MI (W. Miller & Rose, 2009) seems to put less emphasis on autonomy and on Rogers's (1957) humanistic concepts upon which MI was, at least in part, originally formulated.

We suspect that truly reflective and person-centered techniques are effective only insofar as they are fostering autonomous change talk (Oliver, Markland, Hardy, & Petherick, 2008; Ryan & Deci, 2008). Indeed, in a recent study of MI effects in counseling patients with Type 2 diabetes, Rubak, Sandboek, Lauritzen, Borch-Johnsen, and Christensen (2009) found that patients in their intervention group were significantly more autonomous (using an SDT measure based on Table 1's taxonomy) and more motivated in their inclination to change behavior at a 1-year follow-up compared with patients from the control group. Miller and Rose speculated, in fact, that MI is most effective when therapists embrace its "spirit" as well as technique. In support of this, they cited a study by Kuchipudi, Hobein, Fleckinger, and Iber (1990) in which a more authoritarian administration of MI failed to produce positive results.

On a related note, early formulations of MI, founded on a self-actualization view, suggested that clients know what is best for themselves and have the natural inclination to move in the direction of health and adaptation if sufficiently supported in their exploration of change. The recent formulation instead appears more parentalistic (Kultgen, 1995) in that its directive aspect has become stronger, and MI is being used as a technique to instigate change in a (therapist) predetermined direction (Amrhein, Miller, Yalne, Palmer, &

Fulcher, 2003). This is noteworthy given the previously discussed increasing use of MI as a pretreatment module for CBT and behavior therapies (e.g., Dean, Touyz, Rieger, & Thornton, 2008). W. Miller and Rose (2009) stated that MI can be considered a clinical tool "for use when client ambivalence and motivation appear to be obstacles to change" (p. 534). However, the spirit of MI appears to have changed if it is prejudiced in a certain direction of change regardless of the client's frame of reference.

The extent to which MI is practiced to be an instigator versus facilitator of change is an important issue within MI, and it also taps at the core of clinical concepts of motivation and whether optimally they come from within or from without. Hopefully the meaning of change talk and the appropriate balance between clients' choice and their ultimate wellness will be vigorously discussed within the literature of MI and in general, as it directly concerns the roles of autonomy support and transparency.

Self-Determination Theory

At the outset of this article we suggested, based on our reading of the different approaches, that most therapists and counselors appear to want clients to be self-motivated or to have an inner desire to engage in counseling and the process of change. Self-determination theory (SDT) is a long-standing research tradition in human motivation and volition increasingly being applied to counseling, psychotherapy, and behavior change settings (Lynch & Levers, 2007; Ryan & Deci, 2008; Vansteenkiste, Ryan, & Deci, 2008). More recently, SDT has been used as a guiding framework for a number of clinical interventions and randomized clinical trials (see Ryan, Patrick, Deci, & Williams, 2008).

SDT argues that interpersonal factors can foster or maintain autonomous forms of motivation or undermine them. Specifically, SDT posits the existence of three fundamental psychological needs as the basis for self-motivation and personality integration (Deci & Ryan, 2000; Ryan & Deci, 2000b). The first of these is the *need for autonomy*. *Autonomy* describes actions that are self-endorsed and volitional rather than controlled or compelled, and autonomy support includes methods that foster or encourage voice, initiative, and choice and that minimize the use of controls, contingencies, or authority as motivators. A second psychological need is the *need for competence*. This concerns the psychological need to experience confidence in one's capacity to affect outcomes. The third is *the need for relatedness*. This involves the need to feel connected with and significant to others. According to SDT, the development and maintenance of change over time and situations require that clients *internalize and integrate* values and skills for change, and SDT

further hypothesizes that by maximizing the client's experience of autonomy, competence, and relatedness in counseling settings, the regulation of new behaviors the client acquires is more likely to be internalized, and behavior change is likely to be better maintained (Williams, Deci, & Ryan, 1998).

Particularly germane to the issue of motivation in counseling settings is SDT's focus on *autonomy support*. Deci, Eghrari, Patrick, and Leone (1994) as well as Reeve, Bolt, and Cai (1999; Reeve & Jang, 2006) have examined specific behaviors associated with autonomy support that included (a) offering a meaningful rationale for engaging in a behavior, (b) minimizing external controls such as contingent rewards and punishments, (c) providing opportunities for participation and choice, and (d) acknowledging negative feelings associated with engaging in non–intrinsically motivating tasks. In autonomy-supporting contexts, pressure to engage in specific behaviors is minimized, and individuals are encouraged to base their actions on their own reasons and values. Thus, autonomy for behavior is facilitated insofar as actors are helped to identify their own reasons for changing their behavior and do not feel pressured or manipulated toward certain outcomes. In fact, the more the person "owns" the reasons for changing, the more autonomous and therefore the more likely to succeed is the behavior change. Even praise within SDT is seen as a double-edged sword—it is helpful when used informationally to support competence but undermining when applied to "reinforce" or "motivate" people toward a specified outcome (Ryan, 1982).

Along with a sense of autonomy, internalization also requires that a person experience the confidence and competence to change. In SDT, *competence support* is afforded when practitioners provide effectance-relevant inputs, feedback, and structure (Jang, Reeve, & Deci, in press; Sierens, Vansteenkiste, Goossens Soenens, & Dochy, 2009). This means that the client is afforded the skills and tools for change and is supported when competence- or control-related barriers emerge. In the SDT model of change, gaining a sense of competence is facilitated by autonomy. That is, once people are volitionally engaged and have a high degree of willingness to act, they are then most apt to learn and apply new strategies and competencies (Markland et al., 2005).

Finally SDT sees *relational support* as crucial both as a process and as a direct effect on well-being. Relatedness supports in the form of unconditional positive regard (Roth et al., 2009) and involvement (Markland et al., 2005) are ways in which a person both feels significant and safe to proceed. In SDT the positive regard and involvement must also be perceived to be authentic or genuine to have the functional significance of relational support. In this process, a sense of being respected, understood, and cared for is essential to

forming experiences of connection and trust that will allow for internalization to occur (Ryan, 1995).

An important distinction within SDT concerns the difference between autonomy and independence (Ryan & Lynch, 1989; Soenens, Vansteenkiste, & Sierens, 2009). In theory, the opposite of autonomy is heteronomy (being controlled), not dependence (relying on others). One can be autonomously or willingly dependent, insofar as one consents to, and trusts in, care or reliance (Ryan, La Guardia, & Solky-Butzel, 2005). One can also be controlled and dependent, as when one is made to rely on someone. Autonomy is also not inconsistent with following external guidance or even commands, provided the person receiving them self-endorses or authentically accepts their legitimacy and concurs (Chirkov & Ryan, 2001; Ryan & Deci, 2006).

SDT also differs from self-efficacy theories, arguing that simply feeling competent to engage in a behavior, or having self-efficacy, is not enough to promote sustained motivation (Deci & Ryan, 1985, 2000) and well-being (Vansteenkiste, Lens, Soenens, & Luyckx, 2006). One can feel competent about performing a behavior while having no internal motivation for enacting it, or alternatively one can feel fully volitional.

SDT has spawned experimental and field studies of how factors such as rewards, sanctions, use of authority, provision of choice, and level of challenge impact people's experiences and, in turn, their behavioral persistence and outcomes (Ryan & Deci, 2000a). A growing body of work has also applied SDT in studies of behavior change, including health counseling (Ryan & Deci, 2007; Williams, Deci, et al., 1998). Such work has examined how factors in treatment environments associated with patients' autonomy, competence, and relatedness affect both the initiation and maintenance of change (Sheldon, Williams, & Joiner, 2003; Williams, 2002).

The SDT process model shows that both autonomous motivation to change and feeling competent in carrying out the change independently predict a variety of outcomes, including higher treatment attendance, less dropout, less relapse, and enhanced well-being over the course of treatment. Such results have been obtained in various domains such as drug (Zeldman et al., 2004) and alcohol (Ryan, Plant, & O'Malley, 1995) dependence, weight loss and lifestyle change (Williams, Freedman, & Deci, 1998; Williams, Grow, Freedman, Ryan, & Deci, 1996), smoking cessation (Curry, Wagner, & Grothaus, 1990; Williams, McGregor, et al., 2006), general medication adherence (Williams, Rodin, Ryan, Grolnick, & Deci, 1998), HIV+ medication adherence (Kennedy, Gogin, & Nolen, 2004), eating regulation (Pelletier, Dion, Slovenic-D'Angelo, & Reid, 2004), and diabetes self-care (Senécal, Nouwen, & White, 2000). An added dimension of this line of research is

evidence that patient motivation for counseling and behavior change is influenced not only by the support for autonomy afforded by providers but also by the support for autonomy offered by important others such as spouses or friends (Williams, Lynch, et al., 2006). Interestingly, research has found that even a computer-assisted intervention can provide an autonomy-supportive context that has relevant impact on treatment outcomes (Williams, Lynch, & Glasgow, 2007).

Within SDT a sense of choice or assent is important to cultivate and make salient. For example, Vandereycken and Vansteenkiste (2009) studied an intervention that allowed eating-disordered patients to make an informed choice about whether to continue or to terminate treatment after the first few weeks of treatment. The implementation of this autonomy-supportive strategy reduced patients' dropout rate during subsequent treatment relative to the prior program in which such choice was denied. This choice implementation likely facilitated autonomous engagement in therapy among those who continued treatment, as well as autonomous disengagement from therapy among those who terminated treatment.

Recently Zuroff et al. (2007), drawing on SDT and its measures, suggested that autonomy should be considered a new common factor for effective brief treatments. They based this on a study of depressed outpatients who were randomly assigned to receive CBT, IPT, or pharmacotherapy with clinical management. Measures of depression severity were taken pretreatment and posttreatment, and the factors of therapeutic alliance, patient autonomous motivation, and therapist autonomy support were assessed in session three for each group. Results showed that autonomous motivation was a stronger predictor of improved outcome than therapeutic alliance across all three treatments and that therapist autonomy support was associated with greater autonomous motivation. They therefore suggested that the promotion of autonomy is an important factor in treatment across modalities and can be distinguished from therapeutic alliance per se.

Eclectic Psychotherapy and Counseling

The majority of counselors and psychotherapists practicing today describe themselves as *eclectic*. Beginning with Thorne (1950), eclecticism has grown from a small minority of therapists to be the predominant position in the field. Eclecticism derives from a number of important arguments, including that (a) no one theory has all the answers, (b) there are specific matches between theory-derived techniques and the varied problems clients present, and (c) the counselor must be responsive to individuals and personalize approaches rather than use a singular method with all. Sue (1992) also added

the perspective that counseling diverse populations may even require an eclectic approach to be responsive to differences. Eclecticism varies from *synthetic eclecticism* (Patterson, 1989) in which the counselor draws bits and pieces from many theories, techniques, and strategies, synthesizing them into his or her own personal blend, to *selective eclecticism*, in which the counselor applies different techniques on different occasions. Each of these has motivational relevance.

In practice, the synthetic eclectic counselor maintains a sense of harmony or unity in approach because incompatible theoretical points are not merged or incompatible techniques are not used simultaneously. Instead, various theories or models that have a common meta-theoretical foundation are meaningfully synthesized such that a more enriched and broader framework or set of techniques is deployed.

Multimodal counseling (Lazarus & Beutler, 1993) is a well-known approach to eclectic therapy that falls under the synthetic category. Multimodal therapy begins with a comprehensive assessment with the acronym BASICID referring to these categories of exploration: B—behavior; A—affect; S—sensation; I—images; C—cognitions; I—interpersonal relationships; and D—drugs, biology, and body, to get a well-rounded view of the client and his or her presenting issues. In multimodal counseling the therapist often selects multiple treatments to address multiple or complex problems. These are taken on within a framework of "flexibility and versatility" (Lazarus, 1989, p. 509) in which the counselor must always ask what will work for this person in this specific context or circumstance, but there is an overarching framework for organizing interventions.

Another example is the proposed marriage between traditional MI and self-determination theory. Both frameworks emphasize the issue of self-motivation and internalization of change: Autonomy is a central dynamic within SDT, and MI equally "emphasizes and honors client autonomy to choose whether, when and how to change" (Hettema et al., 2005, p. 93). Given their shared meta-theoretical foundation, the synthesis of the two seems straightforward and has been called for by various scholars (Britton, Williams, & Conner, 2008; Markland et al., 2005; Vansteenkiste & Sheldon, 2006).

In selective eclecticism, a therapist applies different specific systems of therapy with different clients or at different points in therapy; hence, the counselor is selective because the used techniques are matched with the client at hand. The adoption of selective eclecticism is then justified on the basis that the diversity of clients requires a diversity of unique methods. Thus, a counselor chooses different techniques but applies them with fidelity to different clients. It is also justified with the idea that clients need to be differently

approached depending on their stage of change or readiness status. This second form of selective eclecticism fits well with the attachment of motivational enhancement therapies as modular preludes to treatment. For instance, we reviewed how MI has been used as a pretreatment module, attached to a broad array of cognitive-behavioral treatments.

In both cases, the selective process involves techniques with varied motivational assumptions and practices. Yet whereas in client matching the client receives an existing technique and the assumptions it embodies, in the application of multiple techniques to the same client there is more potential for confusion. To illustrate, the use of a decisional balance sheet score, as suggested by MI, aims to facilitate a self-endorsed decision to pursue change, whereas, in contrast, the use of external rewards as a tool to reinforce positive change, as suggested within some CBT approaches, might lead clients to feel pressured to attain particular outcomes. Thus, when embedded within an eclectic approach, motivational strategies might sometimes be used in conjunction with strategies that are derived from theoretical viewpoints that are rooted in a different and even incompatible meta-theoretical framework.

This simply underscores the importance of thinking about the motivational underpinnings of different counseling approaches and the difficulty of synthesizing them with eclectic practice. Indeed, it is precisely because eclectic practice draws from the techniques derived by theories that this review of the relations of motivation to theory has import.

Nonspecific Factors and Empirically Supported Relationships

Discussion of eclectic practice is conceptually linked with another increasingly important trend in psychotherapy and counseling research and practice—namely, the recognition of nonspecific factors in effective treatments. Nonspecific factors are those elements of treatment or counseling practice that are not exclusive to any particular school or technique but are predictive of successful treatments. Understanding of these factors potentially impacts practitioners of every stripe and brand.

The idea of a set of fundamental nonspecific relationship-oriented factors stems in part from Rogers's (1957) assertion that therapist empathy, unconditional positive regard, and genuineness are the *necessary* and *sufficient* ingredients for catalyzing successful change through counseling. Since then, a consistent set of findings within psychotherapy research has indeed revealed that the quality of the relationship or *therapeutic alliance* predicts treatment outcomes (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). There is also evidence that poor alliances are correlated with unilateral termination

(e.g., Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995). Reviews of the counseling and treatment literatures (e.g., Horvath & Bedi, 2002; Wampold, 2001) have consistently shown empirical support especially for certain types of relationship variables over which counselors have considerable control.

For example, Hougaard (1994), Norcross (2002), Goldfried and Davila (2005), and numerous other authors have discussed the *therapeutic alliance* as a relational factor operating across types of counseling and therapy that is empirically associated with improved outcomes. Hougaard includes in the therapeutic alliance both the "personal alliance" (the quality of the dyadic relationship between client and therapist) and the "task-related alliance" (alliance concerning treatment planning and goals). Correlations between these two facets of alliance are high, presumably because they both bear on the clients' sustained motivation. Safran and Muran (2000) similarly highlight the importance of clients' assent to the therapeutic alliance, citing three components: (a) agreement on therapeutic goals, (b) agreement on therapeutic tasks, and (c) an interpersonal bond. In our view, the association of therapeutic alliance with more positive outcomes is due not only to the direct positive impact of caring relationships on clients' well-being but also to such relationship supports on clients' volition (Wolfe, 2006) and autonomy (Ryan & Deci, 2008).

Interestingly, although the importance of therapeutic alliances and other nonspecific factors (see Prochaska & Norcross, 2003) is broadly recognized across schools of therapy, that recognition may be either consistent or inconsistent with the underlying theories of change. Furthermore, there remains considerable variability in therapists' capacities to foster such alliances. Indeed, Baldwin, Wampold, and Imel (2007), using a multilevel modeling approach, isolated between-therapist and within-therapist variability in working alliances, thereby examining whether one or both of them are related to client outcomes. The former is associated with differences between therapists; the latter is associated with differences due to what clients bring to therapy. The researchers found that whereas the client variability was not predictive of outcomes, therapist differences were. This suggests that therapists relate, connect, and motivate in different ways, often independent of the theories or strategies they are presumably employing, and these differences bear significantly on treatment effectiveness.

An American Psychological Association (APA) Division 29 Task Force (Ackerman et al., 2001) that looked into nonspecific factors associated with treatment effectiveness indeed concluded that there were a number of both demonstrably effective, evidence-supported, nonspecific factors in effective

treatments and an additional number that were deemed promising or probably effective. Prominent among these identified nonspecific factors were a number related to issues of motivation and volitional support. These include the *therapeutic alliance* we have been discussing, which was foremost in this APA list. Another was *empathy*, which entails consideration and respect for the client's perspective. Still another was *goal consensus and collaboration*, which we have discussed throughout as intended to support autonomy and self-motivation across therapies. We see each of these as having importance in part, if not primarily, because of its impact on client autonomy and engagement in the counseling process.

Norcross (2005) described the meaning of identifying common factors for the field, highlighting that a focus on these factors can help identify the best practices across fields and some of the core elements of the healing process across time and cultures. Moreover, he argued that a focus on common factors does not preclude, but rather facilitates, the identification of *treatment-specific factors* that may add value above and beyond common-factor contributions. In our review we simply highlight that embedded in the common factors are elements of support for client autonomy and volition.

The Ethics of Autonomy Support

The concept of motivation and particularly of autonomy is critical in ethical thought, and as we saw, autonomy is valued even within theoretical frameworks with which it is logically or philosophically inconsistent. Within the context of this article, we consider it important to also call attention to the deep tradition of autonomy in ethical discourse and to its application to biomedical ethics and, to a lesser extent, counseling and mental health practices. Our treatment of this important topic will necessarily be brief and incomplete.

Respect for autonomy has a long tradition in philosophical discourse (e.g., Benson, 1983; Mill, 1869/1974) and fundamentally derives from Kant's formulation of the "categorical imperative," an aspect of which involves treating others as ends in themselves, rather than as means to an end (Kant, 1785/1964; see also Gillon, 1985, 2003). In this tradition, *autonomy* refers to the "capacity to think, decide, and act on the basis of such thought and decision freely" (Gillon, 1985, p. 1806), and it derives from the Aristotelian taxonomy that assigns reason to be a uniquely human faculty. For Kant, autonomy was the rational exercise of will, and the categorical imperative implies that as we ourselves are moral agents bound to the rational exercise of our will, we must grant this same right for the rational exercise of the will to all other moral agents. Put differently, respect for autonomy means respecting the rights of a

person to think, decide, and act, to the extent that such respect does not conflict with the right of others who might possibly be affected to think, decide, and act (Gillon, 2003).

The principle of respect for autonomy has been underscored in several important recent traditions that influence the practice of counseling and psychotherapy. The Belmont Report (National Commission, 1979) provided guidelines for the ethical conduct of biomedical and behavioral research with human participants. Three basic ethical principles underlie the report: respect for persons, beneficence, and justice. The first of these, respect for persons, is directly related to autonomy, as it entails two fundamental convictions: that each individual should be treated as an autonomous agent, capable of deliberation about personal goals and acting under the direction of such deliberation, and that those with diminished autonomy (for example, those not sufficiently developmentally mature or those incapacitated by illness, mental disability, or circumstances severely restricting their liberty) are entitled to protection.

Beauchamp and Childress (1989) proposed an approach to biomedical ethics similarly based on the principles of respect for autonomy, beneficence, and justice, with the additional principle of nonmaleficence. An important aspect of their approach is the claim that the four principles are universal, irrespective of one's cultural, political, religious, or philosophical point of view. In one form or another, these principles have been incorporated into the ethical codes that govern the practice of the various mental health professions. The principle of respect for autonomy is of particular relevance for us here.

The are numerous implications of respecting autonomy for counselors and therapists: consulting with clients and obtaining their permission before beginning treatment or intervention; maintaining the confidentiality of client communications; refraining from deceiving clients; and communicating with clients, that is, both listening and providing them with adequate information on the basis of which to make their own personal decisions about treatment.

Of course, when clients find themselves in a life-threatening situation or represent a danger for their environment, the clinician needs to intervene, particularly when actions are likely to be not reflectively considered and themselves truly authentic and self-endorsed. That is, intervention is justified to the extent nonautonomous processes may be at work that will ultimately preclude what the patient *would* choose if not compromised. Debates about the boundaries concerning when a clinician or counselor can interfere with a client's choices in the service of that client's ultimate welfare are the subject of important discussions in contemporary professional ethics (e.g., see Kultgen, 1995; McLeod & Sherwin, 2000).

More generally, autonomy does not just constitute an important *instrumental* process that contributes to therapeutic success, as indexed by less dropout, stronger therapeutic alliance, more therapeutic progress, and less relapse. For many, autonomy represents a valuable *outcome* of therapy in its own right, regardless of the beneficial effects that it engenders. For example, the exercise of autonomy is closely tied to what it means to be a "fully functioning" human being (Rogers, 1961) and to the Aristotelian understanding of happiness as *eudaimonia* or flourishing (Gillon, 1985; Ryan & Deci, 2001; Ryan, Huta, & Deci, 2008). Insofar as this is true, then not merely respecting but *facilitating* clients' autonomy becomes an important ethical responsibility for counselors and therapists. This enhanced autonomous functioning can take the form of a stronger personal endorsement (i.e., internalization) of change or a stronger endorsement of the decision not to change. The critical point is that—with the help of clinicians—clients are brought to a position where they can make more informed decisions to pursue change or to postpone the change attempts.

Multicultural counseling. Associated with the ethical call to respect autonomy is the application of this principle to diverse populations whose internalized cultural values and goals may be different from the therapist's. Counselors in contemporary practice must consider the implications of their preferred theoretical stances and interventions when working with members of other cultural groups (Leong & Lee, 2006; Lynch, 2002; Pedersen, 1991; Sue, Arredondo, & McDavis, 1992). In fact Baluch, Pieterse, and Bolden (2004) argue that multicultural movements within counseling represent "a fight for survival, freedom, and self-determination" much like other civil rights movements (p. 89).

Although to date there is no strong evidence of match between any particular approaches to therapy and specific cultural affiliations, perspectives on cultural counseling stress the importance of not imposing values or beliefs on people who may come from distinct cultural value sets. In cognitive and behavioral approaches, respect for autonomy is included within the emphasis on collaborative treatments, in which client and clinician work together toward agreed upon goals. In these regards, support for autonomy is an important aspect of culturally responsive counseling across schools of thought, although each engages this differently. Sue (1992) in fact suggested even more radically that cultural responsiveness may mean using different techniques rather than differentially applying any single one.

Although culturally responsive counseling requires flexibility in approaches, there may also be some common, technique-nonspecific elements that such counseling entails and that counseling research should increasingly detail

(Fouad, 2001). For us, a prime candidate is autonomy support. Not imposing goals, values, or agendas on the client requires, we believe, a deep respect for and support of her or his autonomy. This means working to understand and embrace the client's experiences, including culturally and socioeconomically embedded views of the world, and facilitating their expression. Such respect can be supported by person-centered styles of communication (Cooper et al., 2003) in which one empathically regards the other's experience. Similarly, within SDT, respecting autonomy means placing oneself as much as possible in the *internal frame of reference* of the clients, understanding the issues as seen by them, including their perceptions of their social, economic, and cultural contexts (Ryan & Deci, 2008). Beyond simply mirroring, support for autonomy also includes, however, an interest in empowerment and reexamination of the various forms of internalized oppression that may be shared with the counselor (McLeod & Sherwin, 2000).

We should wonder, however, whether autonomy support itself is of value across cultures or whether it is itself a culturally specific value. The issue is a controversial one (Ryan & Deci, 2006). It could just as easily be argued that autonomy is important only within those social contexts—including, importantly, the wider cultural contexts—that explicitly value autonomy (e.g., Markus & Kitayama, 1991). But here the meaning of autonomy becomes very important. Specifically, we believe that therapies that view development and positive change primarily in terms of *individuation* and *independence* may not be as fitting for individuals from groups or cultures that do not value such individualistic ideals. Many cultures do not share the Western emphasis on movement toward independence, or differentiation, or away from tradition, as a basic value. But when autonomy is interpreted in terms of facilitating volition, voice, and choice, we argue that that is relevant for all cultures.

When autonomy is defined in terms of the person's endorsement of her or his own actions, rather than in terms of individualistic definitions of autonomy as self-sufficiency or independence, autonomy can encompass relational and cultural concerns and, in fact, is the basis of enacting them. This awareness has been reflected in the reemergence of autonomy within feminist perspectives, where being both autonomous agents and deeply social selves are no longer seen as incompatible (Mackenzie & Stoljar, 2000). As Friedman (2000) argues, "To consider which particular attachments we should reshape, which to reject, which to choose, and which to promote, we need autonomy" (p. 68).

We think the same recognition of the universal value of autonomy and autonomy support is emerging within cross-cultural theorizing (e.g., Kagitcibasi, 1996). Indeed, research in SDT suggests that because autonomy is nonspecific

to the values embraced, but rather concerns the extent to which one can enact one's own values, autonomy support is beneficial across cultures (e.g., Chirkov, Ryan, Kim, & Kaplan, 2003; Jang, Reeve, Ryan, & Kim, 2009; Rudy, Sheldon, Awong, & Tan, 2007; Vansteenkiste, Zhou, Lens, & Soenens, 2005). This is so even though what people autonomously pursue (e.g., independence versus interdependence) varies (Chirkov, Ryan, & Willness, 2005; Lynch, 2002). Perhaps even more relevant for counseling is evidence that dyadic interpersonal autonomy support may be cross-culturally associated with greater authenticity and relationship satisfaction (e.g., Lynch et al., 2009).

In sum, regarding multicultural counseling, most ideal is having counselors with an understanding of the client's worldview and perspective (Baluch et al., 2004). But insofar as most counselors must stretch across economic and cultural differences, the value of supporting autonomy, and valuing the client's internal frame of reference and value system, becomes paramount. This of course fits in with the ethical frame that all clients warrant support for their autonomy in the process of counseling.

Summary and Conclusions

Evidence across a wide array of counseling settings and approaches has shown that patient motivation is predictive of treatment effectiveness. Although approaches to counseling are varied and the theories on which they are founded disagree on many issues, in the current review we find evidence across schools of counseling and therapy for the idea that motivation and autonomy are important concerns. Theories vary considerably, however, in how explicitly they address motivation and autonomy, both in terms of within-therapy techniques of change and in terms of the recruitment approach and methods of sustaining client engagement.

In particular, there is a relation between a theory's general view of behavioral causation and its explicit attention to client motivation. Theories that see external variables as the principal causes of behavior are more likely to see motivation as either a prerequisite for therapy (the patient should come with it as an aspect of "readiness") or as an "add-on" or component element that should precede behavioral change attempts in order to cultivate appropriate readiness. In contrast, theories of therapy in which internal causation and motivation are stressed are more likely to see motivation itself as an ongoing focus of treatment, with resistance or balking being treated as symptoms or issues to be processed. A similar argument could be made for the distinction between outcome-focused treatments and process-oriented approaches, with the latter seeing motivation as part of what is to be processed

and outcome-focused techniques more likely to see motivation as an aspect of readiness for engaging in treatment procedures.

Another issue related to autonomy is that of transparency and up-front consent to treatment. With regard to this dimension, more behavioral and outcome-focused treatments tend to place greater emphasis on transparency and on explicit informed consent to procedures. By contrast, more process-oriented therapies, particularly those that are psychodynamic in orientation, place less emphasis on transparency and up-front consent, in part because they see resistance as potentially unconsciously motivated and low motivation as a symptom or issue to be treated in the course of counseling.

Any such general comparisons of schools of thought are, however, strongly tempered by the fact that (a) clinicians are increasingly eclectic in their practice, and (b) there is increasing understanding that across schools of therapy there are nonspecific and relational factors that impact motivation and treatment effectiveness. We particularly explored the motivational significance of therapeutic alliance and the concept of autonomy support as such nonspecific factors.

We also suggested that there are ethical reasons as well as practical ones for making autonomous motivation a critical end value for therapy and counseling—that is, as an aspect of enhanced functioning. These considerations grow out of the philosophical stance that respect for and promotion of autonomy is an inherent and universal value, which has to be distinguished from issues such as individuation and independence that are more culturally specific. Given the importance and centrality of culturally responsive counseling in our increasingly intersecting world, autonomy support also becomes salient because it entails respect for the diverse backgrounds, viewpoints, and values of our clients.

Overall, we see motivational dynamics as playing a critical role in counseling processes and outcomes and therefore as deserving the increasing theoretical and empirical focus they are receiving. This is especially true as we move into an age of increasing eclecticism and multicultural applications. In the current review, in hopes of furthering the interest and inquiry in motivational dynamics in counseling and psychotherapy, we attempted to highlight motivational issues primarily by addressing the importance of autonomy and self-endorsed change and how they are fostered.

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References

Ackerman, S. J., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., Lambert, M. J., et al. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 taskforce. *Psychotherapy*, *38*, 495-497.

Amrhein, P. C., Miller, W. R., Yalne, C. E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology*, *71*, 862-878.

Antony, M. M., & Roemer, L. (2003). Behavior therapy. In A. S. Gurman & S. Messer (Eds.), *Essential psychotherapies* (pp. 182-223). New York: Guilford.

Armitage, C. J. (2006). Evidence that implementation intentions promote transitions between the stages of change. *Journal of Consulting and Clinical Psychology*, *74*, 141-151.

Armitage, C. J. (in press). Is there utility in the transtheoretical model? *British Journal of Health Psychology*.

Armitage, C. J., & Arden, M. A. (in press). How useful are the stages of change for targeting interventions? Randomized test of a brief intervention to reduce smoking. *Health Psychology*.

Armitage, C. J., Sheeran, P., Arden, M. A., & Conner, M. (2004). Stages of change or changes of stage? Predicting transitions in transtheoretical model stages in relation healthy food choice. *Journal of Consulting and Clinical Psychology*, *72*, 491-499.

Assor, A., Vansteenkiste, M., & Kaplan, A. (2009). Identified and introjection approach and introjection avoidance motivations in school and in sport: The limited benefits of self-worth strivings. *Journal of Educational Psychology*, *101*, 482-497.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*, 842-852.

Baluch, S., Pieterse, A. L., & Bolden, M. (2004). Counseling Psychology and Social Justice: Houston … we have a problem <http://www.albany.edu/counseling_psych/faculty_staff/pieterse/Baluch,%20Pieterse,%20&%20Bolden.pdf>. *The Counseling Psychologist, 32*, 89-98.

Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, *44*, 1175-1184.

Bandura, A. (1996). *Self-efficacy: The exercise of control*. New York: Freeman.

Basch, M. F. (1995). *Doing brief psychotherapy*. New York: Basic Books.

Bastien, R. T., & Adelman, H. (1984). Noncompulsory versus legally mandated placement, perceived choice, and response to treatment among adolescents. *Journal of Consulting and Clinical Psychology*, *52*, 171-179.

Beauchamp, T. L., & Childress, J. F. (1989). *Principles of biomedical ethics* (3rd ed.). Oxford: Oxford University Press.

Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias*. New York: Basic Books.

Beck, A. T., Freeman, A., & Associates. (1990). *Cognitive therapy of personality disorders*. New York: Guilford.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Beck, A. T., & Weishaar, M. E. (2008). Cognitive therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 263-294). Belmont, CA: Thomson Brooks/Cole.

Beck, J. (1995). *Cognitive therapy: Basics and Beyond*. New York: Guilford.

Benson, J. (1983). Who is the autonomous man? *Philosophy*, *58*, 5-17.

Bieling, P. J., McCabe, R. E., & Antony, M. M. (2006). *Cognitive-behavior therapy in groups*. New York: Guilford.

Binder, J. L., Strupp, H. H., & Henry, W. P. (1995) Psychodynamic therapies in practice: Time-limited dynamic psychotherapy. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy* (pp. 48-63). New York: Oxford University Press.

Bootzin, R. R. (1975). *Behavior modification and therapy*. Cambridge, MA: Winthrop.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. New York: International Universities Press.

Brennan, L., Walkley, J., Fraser, S. F., Greenway, K., & Wilks, R. (2008). Motivational interviewing and cognitive behavior therapy in the treatment of adolescent overweight and obesity: Study design and methodology. *Contemporary Clinical Trials*, *29*, 359-375.

Bricker, D. C., Young, J. E., & Flanagan, C. (1993). Schema-focused cognitive therapy: A comprehensive framework for characterological problems. In K. Kuehlwein & H. Rosen (Eds.), *Cognitive therapies in action*. San Francisco: Jossey-Bass.

Bridle, C., Riemsma, R. P., Pattenden, J., Soeden, A. J., Watt, I. S., & Walker, A. (2005) Systematic review of the effectiveness of health behavior interventions based on the transtheoretical model. *Psychology and Health*, *20*, 283-301.

Britton, P. C., Williams, G. C., & Conner, K. R. (2008). Self-determination theory, motivational interviewing, and the treatment of clients with acute suicidal ideation. *Journal of Clinical Psychology*, *64*, 52-66.

Brown, J. R., & Miller, W. R. (1993). Impact of motivational interviewing on participation and outcome in residential alcoholism treatment. *Psychology of Addictive Behaviors*, *7*, 211-218.

Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry*, *18*, 211-237.

Buckner, J. D., & Schmidt, N. B. (2009). A randomized pilot study of motivation enhancement therapy to increase utilization of cognitive-behavioral therapy for social anxiety. *Behaviour Research and Therapy*, *47*, 710-715.

Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology*, *71*, 843-861.

Caprara, G. V. & Cervone, D. (2000). *Personality: Determinants*, *dynamics and potentials*. Cambridge: Cambridge University Press.

Chirkov, V. I., & Ryan, R. M. (2001). Parent and teacher autonomy-support in Russian and U.S. adolescents: Common effects on well-being and academic motivation. *Journal of Cross-Cultural Psychology*, *32*, 618-635.

Chirkov, V., Ryan, R. M., Kim, Y., & Kaplan, U. (2003). Differentiating autonomy from individualism and independence: A self-determination theory perspective on internalization of cultural orientations and well-being. *Journal of Personality and Social Psychology*, *84*, 97-110.

Chirkov, V., Ryan, R. M., & Willness, C. (2005). Cultural context and psychological needs in Canada and Brazil: Testing a self-determination approach to the internalization of cultural practices, identity, and well-being. *Journal of Cross-Cultural Psychology*, *36*, 423-443.

Cicchetti, D., Toth, S. L., & Lynch, M. (1995). Bowlby's dream comes full circle: The application of attachment theory to risk and psychopathology. In T. H. Ollendick & R. J. Prinz (Eds.), *Advances in clinical child psychology* (Vol. 17, pp. 1-75). New York: Plenum.

Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M. & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine*, *139*, 907-916.

Corsini, R. J. (2008). Introduction. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 1-14). Belmont, CA: Thomson Brooks/Cole.

Curry, S., Wagner, E. H., & Grothaus, L. C. (1990). Intrinsic and extrinsic motivation for smoking cessation. *Journal of Consulting and Clinical Psychology*, *58*, 310-316.

Dean, H. Y., Touyz, S. W., Rieger, E., & Thornton, C. E. (2008). Group motivational enhancement therapy as an adjunct to inpatient treatment for eating disorders: A preliminary study. *European Eating Disorders Review*, *16*, 256-267.

de Charms, R. (1968). *Personal causation*. New York: Academic Press.

Deci, E. L., Eghrari, H., Patrick, B. C., & Leone, D. R. (1994). Facilitating internalization: The self-determination theory perspective. *Journal of Personality*, *62*, 119-142.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum.

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, *11*, 227-268.

Deurzen-Smith, E. (1997). *Everyday mysteries: Existential dimensions of psychotherapy*. London: Routledge.

de Vet, E., de Nooijer, J., de Vries, N. K., & Brug, J. (2008). Testing the transtheoretical model for fruit intake: Comparing Web-based tailored stage-matched and stage-mismatched feedback. *Health Education Research*, *23*, 218-227.

Dewald, P. A. (1969). *Psychotherapy: A dynamic approach*. New York: Basic Books.

DiClimente, C. C. (1999). Motivation for change: Implications for substance abuse treatment. *Psychological Science*, *10*, 209-213.

DiClemente, C. C., Prochaska, J. O., Fairhurst, S. K., Verlicer, W. F., Velasquez, M. M., & Rossi, J. S. (1991). The process of smoking cessation: An analysis of precontemplation, contemplation and preparation stages of change. *Journal of Consulting and Clinical Psychology*, *59*, 205-304.

Dijkstra, A., Conijn, B., & de Vries, H. (2006). A match-mismatch test of a stage model of behaviour change in tobacco smoking. *Addiction*, *101*, 1035-1043.

Di Pietro, G., Valoroso, L., Fichele, M., Bruno, C., & Sorge, F. (2002). What happens to eating disorder outpatients who withdrew from therapy? Eating and weight disorders. *Studies on Anorexia*, *Bulimia and Obesity*, *7*, 298-303.

Dryden, W., & Branch, R. (2008). *Fundamentals of rational emotive behaviour therapy: A training handbook* (2nd ed.). Paris: Lavoisier Librairie.

Dunn, E. C., Neighbours, C., & Larimer, M. E. (2006). Motivational enhancement therapy and self-help for binge eaters. *Psychology of Addictive Behaviors*, *20*, 44-52.

Elliott, R., Greenberg, L. S., & Lietaer, G. (2004). Research on experiential psychotherapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 493-539). New York: Wiley.

Ellis, A. E. (1984). *Rational-emotive therapy and cognitive behavior therapy*. New York: Springer.

Engle, D. E., & Arkowitz, H. (2006). *Ambivalence in psychotherapy: Facilitating readiness to change*. New York: Guilford.

Engle, D. E., & Arkowitz, H. (2008). Resistance as ambivalence: Integrative strategies for working with resistant ambivalence. *Journal of Humanistic Psychology*, *48*, 389-412.

Fairbairn, W. R. D. (1954). *An object relations theory of the personality*. New York: Basic Books.

Ford, M. E. (1992). *Motivating humans*. Newberry Park, CA: Sage.

Fouad, N. (2001). Dreams for 2010: Making a difference. *The Counseling Psychologist*, *30*, 158-166.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing*. New York: Basic Books.

Freud, S. (1923/1961). *The ego and the id* (Standard ed., Vol. 18, pp. 12-66). London: Hogarth.

Friedman, M. (2000). Autonomy, social disruption and women. In C. Mackenzie & N. Stoljar (Eds.), *Relational autonomy* (pp. 35-51). New York: Oxford.

Gabbard, G. O. (2005). *Psychodynamic psychiatry in clinical practice* (4th ed.). Washington, DC: American Psychiatric Publishing.

Gibbons, M. B. C., Crits-Christoph, P., Barber, J. P., Wiltsey-Stirman, S., Gallop, R., Goldstein, L. A., et al., (2009). Unique and common mechanism of change across cognitive and dynamic therapies. *Journal of Consulting and Clinical Psychology*, *77*, 801-813.

Gill, M. M. (1982). *The analysis of transference: Vol. 1. Theory and technique*. Madison, CT: International Universities Press.

Gillon, R. (1985). Autonomy and the principle of respect for autonomy. *British Medical Journal*, *290*, 1806-1808.

Gillon, R. (2003). Ethics need principles: Four can encompass the rest—and respect for autonomy should be first among equals. *Journal of Medical Ethics*, *29*, 307-312.

Goldfried, M. R., & Davidson, G. C. (1976). *Clinical behavior therapy*. New York: Holt, Rinehart & Winston.

Goldfried, M. R., & Davila, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 421-430.

Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.

Greenberg, R. P. (2004). Essential ingredients for successful psychotherapy: Effects of common actors. In M. J. Dewan, B. N. Steenbarger, & R. P. Greenberg (Eds.), *The art and science of brief psychotherapies* (pp. 231-242). Washington, DC: APPI.

Guo, B., Aveyard, P., Fielding, A., & Sutton, S. (2009). Do the transtheoretical model processes of change, decisional balance and temptation predict stage movement? Evidence from smoking cessation in adolescents. *Addiction*, *104*, 828-838.

Hampton-Robb, S., Qualls, R. C., & Compton, W. C. (2003). Predicting first session attendance: The influence of referral source and client income. *Psychotherapy Research*, *13*, 223-233.

Heider, F. (1958). *The psychology of interpersonal relations*. New York: Wiley.

Hembree, E. A., & Foa, E. B. (2003). Interventions for trauma-related emotional disturbances in adult victims of crime. *Journal of Traumatic Stress*, *16*, 187-199.

Herzog, T. A., Abrams, D. B., Emmons, K. M., Linnan, L. A., & Shadel, W. G. (1999). Do processes of change predict smoking stage movements? A prospective analysis of the transtheoretical model. *Health Psychology*, *18*, 369-375.

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology*, *1*, 91-111.

Higgins, S. T., Wong, C. J., Badger, G. J., Huag Ogden, D. E., & Dantona, R. L. (2000). Contingent reinforcement increases cocaine abstinence during outpatient treatment and 1 year of follow-up. *Journal of Consulting and Clinical Psychology*, *68*, 64-72.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York: Oxford University Press.

Horvath, A., Gaston, L., & Luborsky, L. (1993). The therapeutic alliance and its measurement. In N. E. Miller, L. Luborsky, J. P. Barber, & J. P. Docherty (Eds.), *Psychodynamic Treatment Research* (pp. 247-273). New York: Basic Books.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *38*, 139-149.

Hougaard, E. (1994). The therapeutic alliance: A conceptual analysis. *Scandinavian Journal of Psychology*, *35*, 67-85.

Hull, C. L. (1943). *Principles of behavior: An introduction to behavior theory*. New York: Appleton-Century-Crofts.

Jang, H. (2008). Supporting students' motivation, engagement, and learning during an uninteresting activity. *Journal of Educational Psychology*, *100*, 798-811.

Jang, H., Reeve, J., & Deci, E. L. (in press). Engaging students in learning activities: It's not autonomy support or structure, but autonomy support and structure. *Journal of Educational Psychology*.

Jang, H., Reeve, J., Ryan, R. M., & Kim, A. (2009). Can self-determination theory explain what underlies the productive, satisfying learning experiences of collectivistically oriented Korean students? *Journal of Educational Psychology*, *101*, 644-661.

Kagitcibasi, C. (1996). The autonomous relational self: A new synthesis. *European Psychologist*, *1*, 180-186.

Kaner, A., & Prelinger, E. (2005). *The craft of psychdynamic psychotherapy*. Lanham, MD: Jason Aronson.

Kanfer, F. H., & Gaelick-Buys, L. (1991). Self management methods. In F. H. Kanfer & A. P. Goldstein (Eds.), *Helping people change* (pp. 305-360). New York: Pergamon.

Kant, I. (1785/1964). Groundwork of the metaphysics of morals In H. J. Paton (Ed.), *The moral law*. London: Hutchinson University Library.

Keijsers, G. P., Kampman, M., & Hoogduin, C. A. (2001). Dropout prediction in cognitive behavior therapy. *Behavior Therapy*, *32*, 739-749.

Keijsers, G. P., Schaap, C. P., & Hoogduin, C. A. (2000). The impact of interpersonal patient and therapist behavior on outcome in cognitive behavior therapy: A review of empirical studies. *Behavior Modification*, *24*, 264-297.

Kennedy, S., Gogin, K., & Nollen, N. (2004). Adherence to HIV medications: Utility of the theory of self-determination. *Cognitive Therapy and Research*, *28*, 611-628.

Kingsley, R. G., & Wilson, G. T. (1977). Behavior therapy for obesity: A comparative investigation for long-term efficacy. *Journal of Consulting and Clinical Psychology*, *45*, 288-298.

Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 37-51.

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression*. New York: Basic Books.

Koestner, R., Lekes, N., Powers, T. A., & Chicoine, E. (2002). Attaining personal goals: Self-concordance plus implementation intentions equals success. *Journal of Personality and Social Psychology*, *83*, 231-244.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York: International Universities Press.

Kottler, J. A. (1993). *On being a therapist*. San Francisco: Jossey-Bass.

Kraft, P., Sutton, S. R., & Reynolds, H. M. (1999). The transtheoretical model of behavior change: Are the stages qualitatively different? *Psychology and Health*, *14*, 433-450.

Kuchipudi, V., Hobein, K., Fleckinger, A., & Iber, F. L. (1990). Failure of a 2-hour motivational intervention to alter recurrent drinking behavior in alcoholics with gastrointestinal disease. *Journal of Studies on Alcohol*, *51*, 356-360.

Kultgen, J. (1995). *Autonomy and intervention*. New York: Oxford.

Lambert, M. J., Garfield, S. L., & Bergin, A. E. (2004). Overview, trends, and future issues. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 805-821). New York: Wiley.

Lazarus, A. A. (1989). *The practice of multimodal therapy*. Baltimore: Johns Hopkins University Press.

Lazarus, A. A., & Beutler, L. E. (1993). On technical eclecticism. *Journal of Counseling & Development*, *71*, 381-385.

Leong, F. T., & Lee, S. H. (2006). A cultural accommodation model for cross-cultural psychotherapy: Illustrated with the case of Asian Americans. *Psychotherapy: Theory, Research, Practice, Training*, *43*, 410-423.

Levenson, H. (2004). Time-limited dynamic psychotherapy: Formulation and intervention. In M. J. Dewan, B. N. Steenbarger, & R. P. Greenberg (Eds.), *The art and science of brief psychotherapies* (pp. 157-188). Washington, DC: APPI.

Lewis, C. C., Simons, A. D., Silva, S. G., Rohde, P., Small, D. M., Murakami, J. L., et al. (2009). The role of readiness to change in response to treatment of adolescent depression. *Journal of Consulting and Clinical Psychology*, *77*, 422-428.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.

Luborsky, E. B., O'Reilly-Landry, M., & Arlow, J. A. (2008). Psychoanalysis. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 15-62). Belmont, CA: Thomson Brooks/Cole.

Lussier, J. P., Heil, S. H., Mongeon, J. A., Badger, G. J., & Higgins, S. T. (2006). A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction*, *101*, 192-203.

Lynch, M. F. (2002). The dilemma of international counselor education: Attending to cultural and professional fits and misfits. *International Journal for the Advancement of Counseling*, *24*, 89-100.

Lynch, M. F., La Guardia, J. G., & Ryan, R. M. (2009). On being yourself in different cultures: Ideal and actual self-concept, autonomy support, and wellbeing in China, Russia, and the United States. *Journal of Positive Psychology*, *4*, 290-304.

Lynch, M. F., & Levers, L. L. (2007). Ecological-transactional and motivational perspectives in counseling. In J. Gregoire & C. Jungers (Eds.), *The counselor's companion: What every beginning counselor needs to know* (pp. 586-605). Mahwah, NJ: Lawrence Erlbaum.

Lyons-Ruth, K. (1991). Rapprochement or approchement: Mahler's theory reconsidered from the vantage point of recent research on early attachment relationships. *Psychoanalytic Psychology*, *8*, 1-23.

Mackenzie, C., & Stoljar, N. (2000). Introduction: Autonomy refigured. In C. Mackenzie & N. Stoljar (Eds.), *Relational autonomy* (pp. 3-34). New York: Oxford University Press.

MacKinnon, R. A., Michaels, R., & Buckley, P. J. (2006). *The psychiatric interview in clinical practice*. Washington, DC: American Psychiatric Publishing.

Markland, D., Ryan, R. M., Tobin, V. J., & Rollnick, S. (2005). Motivational interviewing and self-determination theory. *Journal of Social and Clinical Psychology*, *24*, 811-831.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, *98*, 224-253.

Marquis, A. (2008). *The integral intake: A guide to comprehensive idiographic assessment in integral psychotherapy*. New York: Routledge.

Martin, D. J., Garske, J. P., & Davies, M. K. (2000). Relation of therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438-450.

McKee, S. A., Carroll, K. M., Sinha, R., Robinson, J. E., Nich, C., Cavallo, D., & O'Malley, S. (2007). Enhancing brief cognitive behavioral therapy with motivational enhancement techniques in cocaine users. *Drug and Alcohol Dependence*, *91*, 97-101.

McLeod, C., & Sherwin, S. (2000). Relational autonomy, self-trust, and health care for patients who are oppressed. In C. Mackenzie & N. Stoljar (Eds.), *Relational autonomy* (pp. 259-279). New York: Oxford University Press.

Meichenbaum, D. (1986). Cognitive-behavior modification. In F. H. Kanfer & A. P. Goldstein (Eds.), *Helping people change* (3rd ed., pp. 346-380). New York: Pergamon.

Meissner, W. W. (1981). *Internalization in psychoanalysis*. New York: International Universities Press.

Michael, J. (1993). Establishing operations. *The Behavior Analyst*, *16*, 191-206.

Michalak, J., Klappheck, M. A., & Kosfelder, J. (2004). Personal goals of psychotherapy patients: The intensity and the "why" of goal motivated behavior and their implications for the therapeutic process. *Psychotherapy Research*, *14*, 193-209.

Mill, J. S. (1869/1974). On liberty. In M. Warnock (Ed.), *Utilitatianism*. Glasgow, UK: Collins/Fontana.

Miller, J. J., Fletcher, K., & Kabat-Zinn, J. (1995). Three-year follow up and clinical inplications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. *General Hospital Psychiatry*, *17*, 192-200.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing*. New York: Guilford.

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, *64*, 527-537.

Miller, W. R., Zweben, A., DiClimente, C. C., & Rychtarik, R. G. (1995). *Motivational enhancement therapy manual*. Rockville, MD: NIAAA.

Milner, J., & O'Byrne, P. (2002). *Brief counselling: Narratives and solutions*. New York: Palgrave.

Moore, J. (2008). *Conceptual foundations of radical behaviorism*. Cornwall-on-Hudson, NY: Sloan.

Mullan, E., & Markland, D. (1997). Variation in self-determination across the stages of change for exercise in adults. *Motivation and Emotion*, *21*, 349-362.

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979). *Ethical principles and guidelines for the protection of human subjects of research*. Washington, DC: Federal Register.

Nix, L., Bierman, K., & McMahon, R. J. (2009). How attendance and quality of participation affect treatment response to parent management training. *Journal of Consulting and Clinical Psychology*, *77*, 429-438.

Norcross, J. C. (2002). Empirically supported therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 3-16). New York: Oxford University Press.

Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 3-23). New York: Oxford University Press.

Norcross, J. C., & Beutler, L. E. (2008). Integrative psychotherapies. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 481-511). Belmont, CA: Thomson Brooks/Cole.

Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2005). Strategies for reducing patient-initiated termination of psychotherapy. *Harvard Review of Psychiatry*, *13*, 57-70.

Oliver, E. J., Markland, D., Hardy, J., & Petherick, C. M. (2008). The effects of autonomy-supportive versus controlling environments on self-talk. *Motivation & Emotion*, *32*, 200-212.

Overholser, J. C. (2005). Contemporary psychotherapy: Promoting personal responsibility for therapeutic change. *Journal of Contemporary Psychotherapy*, *35*, 369-376.

Patterson, C. H. (1989). Foundations for a systematic eclectic psychotherapy. *Psychotherapy*, *26*, 427-435.

Pedersen, P. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development*, *70*, 6-12.

Pelletier, L. G., Dion, S. C., Slovenic-D'Angelo, M., & Reid, R. (2004). Why do you regulate what you eat? Relationship between forms of regulation, eating behaviors, sustained dietary behavior change, and psychological adjustment. *Motivation and Emotion*, *28*, 245-277.

Pelletier, L. G., Tuson, K. M., & Haddad, N. K. (1997). Client motivation for therapy scale: A measure of intrinsic motivation, extrinsic motivation, and amotivation for therapy. *Journal of Personality Assessment*, *68*, 414-435.

Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research*, *12*, 557-575.

Petry, N. M. (2006). Contingency management treatments. *British Journal of Psychiatry*, *189*, 97-98.

Petry, N. M., Alessi, S. M., Hanson, T., & Sierra, S. (2007). Randomized trial of contingent prizes versus vouchers in cocaine-using methadone patients. *Journal of Consulting and Clinical Psychology*, *75*, 983-991.

Prendergast, M., Podus, D., Finney, J., Greenwell, L., & Roll, J. (2006). Contingency management for treatment of substance use disorder: A meta-analysis. *Addiction*, *101*, 1546-1560.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, *19*, 276-288.

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 3-27). New York: Plenum.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behavior. *American Psychologist*, *47*, 1102-1114.

Prochaska, J. O., & Norcross, J. C. (2003). *Systems of psychotherapy: A transtheoretical analysis* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Prochaska, J. O., Norcross, J. C., Folwer, J. L., Follick, M. J., & Abrams, D. B. (1992). Attendance and outcome in a work-site weight control program: Processes and stages of change as process and predictor variables. *Addictive Behaviors*, *17*, 35-45.

Prochaska, J. O., Velicer, W. F., Rossi, J. S., Goldstein, M. G., Marcus, B. H., Rakowski, W., et al. (1994). Stages of change and decisional balance for 12 problem behaviors. *Health Psychology*, *13*, 39-46.

Rappaport, R. L. (1997). *Motivating clients in therapy*. New York: Routledge.

Reeve, J., Bolt, E., & Cai, Y. (1999). Autonomy-supportive teachers: How they teach and motivate students. *Journal of Educational Psychology, 91*, 537-548.

Reeve, J., & Jang, H. (2006). What teachers say and do to support students' autonomy during a learning activity. *Journal of Educational Psychology*, *98*, 209-218.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton-Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic change. *Journal of Consulting and Clinical Psychology*, *21*, 95-100.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton-Mifflin.

Rogers, C. R., & Dymond, R. F. (Eds.). (1954). *Psychotherapy and personality change*. Chicago: University of Chicago Press.

Rosen, C. S. (2000). Is the sequencing of change processes by stage consistent across health problems? A meta-analysis. *Health Psychology*, *19*, 593-604.

Roth, G., Assor, A., Niemiec, C. P., Ryan, R. M., & Deci, E. L. (2009). The emotional and academic consequences of parental conditional regard: Comparing conditional positive regard, conditional negative regard, and autonomy support as parenting practices. *Developmental Psychology*, *45*, 1119-1142.

Roth, G., Kanat-Maymon, Y., Assor, A., & Kaplan, H. (2006). Assessing the experience of autonomy in new cultures and contexts. *Motivation and Emotion*, *30*, 365-376.

Rubak, S., Sandboek, A., Lauritzen, T., Borch-Johnsen, K., & Christensen, B. (2009). General practitioners trained in motivational interviewing can positively affect the attitude to behaviour change in people with Type 2 diabetes. *Scandinavian Journal of Primary Health Care*, *27*, 172-179.

Rubak, S., Sandboek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: A systematic review and meta-analysis. *British Journal of General Practice*, *81*, 305-312.

Rudy, D., Sheldon, K., Awong, T., & Tan, H. (2007). Autonomy, culture, and well-being: The benefits of inclusive autonomy. *Journal of Research in Personality*, *41*, 983-1007.

Ryan, R. M. (1982). Control and information in the intrapersonal sphere: An extension of cognitive evaluation theory. *Journal of Personality and Social Psychology*, *43*, 450-461.

Ryan, R. M. (1995). Psychological needs and the facilitation of integrative processes. *Journal of Personality*, *63*, 397-427.

Ryan, R. M., & Connell, J. P. (1989). Perceived locus of causality and internalization: Examining reasons for acting in two domains. *Journal of Personality and Social Psychology*, *57*, 749-761.

Ryan, R. M., & Deci, E. L. (2000a). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary Educational Psychology*, *25*, 54-67.

Ryan, R. M., & Deci, E. L. (2000b). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*, 68-78.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. In S. Fiske (Ed.), *Annual review of psychology* (pp. 141-166). Palo Alto, CA: Annual Reviews.

Ryan, R. M., & Deci, E. L. (2004). Autonomy is no illusion: Self-determination theory and the empirical study of authenticity, awareness, and will. In J. Greenberg, S. L. Koole, & T. Pyszczynski (Eds.), *Handbook of experimental existential psychology* (pp. 449-479). New York: Guilford.

Ryan, R. M., & Deci, E. L. (2006). Self-regulation and the problem of human autonomy: Does psychology need choice, self-determination, and will? *Journal of Personality*, *74*, 1557-1585.

Ryan, R. M., & Deci, E. L. (2007). Active human nature: Self-determination theory and the promotion and maintenance of sport, exercise, and health. In M. S. Hagger & N. L. D. Chatzisarantis (Eds.), *Self-determination in sport and exercise* (pp. 1-19). New York: Human Kinetics.

Ryan, R. M., & Deci, E. L. (2008). A self-determination approach to psychotherapy: The motivational basis for effective change. *Canadian Psychology*, *49*, 186-193.

Ryan, R. M., Huta, V., & Deci, E. L. (2008). Living well: A self-determination theory perspective on eudaimonia. *Journal of Happiness Studies*, *9*, 139-170.

Ryan, R. M., La Guardia, J. G., & Solky-Butzel, J. (2005). On the interpersonal regulation of emotions: Emotional reliance across gender, relationships, and culture. *Personal Relationships*, *12*, 146-163.

Ryan, R. M., & Lynch, J. (1989). Emotional autonomy versus detachment: Revisiting the vicissitudes of adolescence and young adulthood. *Child Development*, *60*, 340-356.

Ryan, R. M., Patrick, H., Deci, E. L., & Williams, G. C. (2008). Facilitating health behaviour change and its maintenance: Interventions based on self-determination theory. *The European Health Psychologist*, *10*, 2-5.

Ryan, R. M., Plant, R. W., & O'Malley, S. (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement and dropout. *Addictive Behaviors*, *20*, 279-297.

Rychlak, J. F. (1977). *The psychology of rigorous humanism*. New York: Wiley.

Safran, J., & Muran, J. C. (2000). *Negotiating the therapeutic alliance: A relational treatment guide*. New York: Guilford.

Salovey, P., & Singer, J. A. (1991). Cognitive behavior modification. In F. H. Kanfer & A. P. Goldstein (Eds.), *Helping people change* (4th ed., pp. 361-395). Elmsford, NY: Pergamon.

Samstag, L. W., Batchelder, S., Muran, J. C., Safran, J. D., & Winston, A. (1998). Predicting treatment failure from in-session interpersonal variables. *Journal of Psychotherapy Practice and Research*, *5*, 126-143.

Schafer, R. (1983). *The analytic attitude*. New York: Basic Books.

Senécal, C., Nouwen, A., & White, D. (2000). Motivation and dietary self-care in adults with diabetes: Are self-efficacy and autonomous regulation complementary or competing constructs? *Health Psychology*, *19*, 452-457.

Sheeran, P., Aubrey, R., & Kellett, S. (2007). Increasing attendance for psychotherapy: Implementation intentions and the self-regulation of attendance-related negative affect. *Journal of Consulting and Clinical Psychology*, *75*, 853-863.

Sheldon, K. M., & Elliot, A. J. (1998). Not all personal goals are personal: Comparing autonomous and controlling goals on effort and attainment. *Personality and Social Psychology Bulletin*, *24*, 546-557.

Sheldon, K. M., Williams, G. C., & Joiner, T. (2003). *Self-determination theory in the clinic*. New Haven, CT: Yale University Press.

Sierens, E., Vansteenkiste, M., Goossens, L., Soenens, B., & Dochy, R. (2009). The synergistic relationship of perceived autonomy support and structure in the prediction of self-regulated learning. *British Journal of Educational Psychology*, *79*, 57-68.

Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan.

Skinner, B. F. (1971). *Beyond freedom and dignity*. New York: Knopf.

Skinner, B. F. (1974). *About behaviorism*. New York: Knopf.

Soenens, B., Vansteenkiste, M., & Sierens, E. (2009). How are parental psychological control and autonomy-support related? A cluster-analytic approach. *Journal of Marriage and Family*, *71*(1), 187-202.

Spencer, L., Pagell, F., Hallion, M. E., & Adams, T. B. (2002). Applying the transtheoretical model to tobacco cessation and prevention: A review of the literature. *American Journal of Health Promotion*, *17*, 7-71.

Steel, Z., Jones, J., Adcock, S., Clancy, R., Bridgford-West, L., & Austin, J. (2000). Why the high rate of dropout from individualized cognitive-behavior therapy for bulimia nervosa? *International Journal of Eating Disorders*, *28*, 209-214.

Steketee, G. S. (1993). *Treatment of obsessive compulsive disorder*. New York: Guilford.

Stitzer, M., & Petry, N. (2006). Contingency management for treatment of substance abuse. *Annual Review of Clinical Psychology*, *2*, 411-434.

Stokes, T. F., & Baer, D. M. (1977). An implicit technology of generalization. *Journal of Applied Behavior Analysis*, *10*, 349-367.

Stuart, S. (2004). Brief interpersonal psychotherapy. In M. J. Dewan, B. N. Steenbarger, & R. P. Greenberg (Eds.), *The art and science of brief psychotherapies* (pp. 119-156). Washington, DC: APPI.

Stuart, S., & Robertson, M. (2003). *Interpersonal psychotherapy*. London: Edward Arnold.

Sue, D. W. (1992). The challenge of multiculturalism: The road less traveled. *American Counselor*, *1*, 6-14.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*, 477-486.

Sue, D., & Sue, D. M. (2008). *Foundations of counseling and psychotherapy*. New York: Wiley.

Sutton, S. (2001). Back to the drawing board? A review of applications of the transtheoretical model to substance use. *Addiction*, *96*, 175-186.

Thorndike, E. L. (1913). *The psychology of learning*. New York: Teacher's College, Columbia University.

Thorne, F. C. (1950). *Principles of personality counseling: An eclectic approach*. Brandon, VT: Clinical Psychology Publishing Co.

Tolman, E. C. (1959). Principles of purposive behavior. In S. Koch (Ed.), *Psychology: A study of a science* (Vol. 2, pp. 92-157). New York: McGraw-Hill.

Treasure, J. L., Katzman, M., Schmidt, U., Troop, N., Todd, G., & de Silvva, P. (1999). Engagement and outcome in the treatment of bulimia nervosa: First phase of a sequential design comparing motivation enhancement therapy and cognitive behavioural therapy. *Behaviour Research and Therapy*, *37*, 405-418.

Treasure, J., & Ward, A. (1997). A practical guide to the use of motivational interviewing in anorexia nervosa. *European Eating Disorder Review*, *5*, 102-114.

Tryon, G. S., & Kane, A. S. (1995). Client involvement, working alliance, and type of therapy termination. *Psychotherapy Research*, *5*, 189-198.

Vallerand, R. J. (1997). Toward a hierarchical model of intrinsic and extrinsic motivation. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. 29, pp. 271-360). San Diego, CA: Academic Press.

Vandereycken, W. (2006). Denial of illness in anorexia nervosa—A conceptual review: Part 2. *European Eating Disorders Review*, *14*, 352-368.

Vandereycken, W., & Vansteenkiste, M. (2009). "Let eating disorder patients decide!" Providing choice might reduce early drop-out in inpatient treatment. *European Eating Disorder Review, 17,* 177-183.

Vansteenkiste, M., Lens, W., Dewitte, S., De Witte, H., & Deci, E. L. (2004). The "why" and "why not" of job search behavior: Their relation to searching, unemployment experience, and well-being. *European Journal of Social Psychology*, *34*, 345-363.

Vansteenkiste, M., Lens, W., Soenens, B., & Luyckx, K. (2006). Autonomy and relatedness among Chinese sojourners and applicants: Conflictual or independent predictors of well-being and adjustment? *Motivation and Emotion*, *30*, 273-282.

Vansteenkiste, M., Ryan, R. M., & Deci, E. L. (2008). Self-determination theory and the explanatory role of psychological needs in human well-being. In L. Bruni, F. Comim, & M. Pugno (Eds.), *Capabilities and happiness* (pp. 187-223). Oxford: Oxford University Press.

Vansteenkiste, M., & Sheldon, K. M. (2006). There's nothing more practical than a good theory: Integrating motivational interviewing and self-determination theory. *British Journal of Clinical Psychology*, *45*, 63-82.

Vansteenkiste, M., Zhou, M., Lens, W., & Soenens, B. (2005). Experiences of autonomy and control among Chinese learners: Vitalizing or immobilizing? *Journal of Educational Psychology*, *96*, 755-764.

Velicer, W. F., Hughes, S. L., Fava, J. L., Prochaska, J. O., & DiClemente, C. C. (1995). An empirical typology of subjects within stage of change. *Addictive Behaviors*, *20*, 299-320.

Vitousek, K., Watson, S., & Wilson, G. T. (1998). Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review*, *18*, 391-420.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. London: Taylor & Francis.

Weinstein, N. D., Rothman, A. J., & Sutton, S. R. (1998). Stage theories of health behavior: Conceptual and methodological issues. *Health Psychology*, *17*, 290-299.

West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addiction*, *100*, 1036-1039.

Westen, D., & Morrison, K. (2001). A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *69*, 875-899.

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, *130*, 631-663.

Westra, H. A., & Dozois, D. J. A. (2006). Preparing clients for cognitive behavioral therapy: A randomized pilot study of motivational interviewing for anxiety. *Cognitive Therapy and Research*, *30*, 481-498.

Westra, H. A., Dozois, D. J. A., & Marcus, M. (2007). Expectancy, homework compliance, and initial change in cognitive behavioral therapy for anxiety. *Journal of Consulting and Clinical Psychology*, *75*, 363-373.

Wierbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, *24*, 190-195.

Wild, J. (1965). Authentic existence: A new approach to "value theory." In J. M. Edie (Ed.), *An invitation to phenomenology: Studies in the philosophy of experience* (pp. 59-78). Chicago: Quadrangle.

Williams, G. C. (2002). Improving patient's health through supporting the autonomy of patients and providers. In E. L. Deci & R. M. Ryan (Eds.), *Handbook of self-determination research* (pp. 233-254). Rochester, NY: University of Rochester Press.

Williams, G. C., Deci, E. L., & Ryan, R. M. (1998). Building health-care partnerships by supporting autonomy: Promoting maintained behavior change and positive health outcomes. In P. Hinton-Walker, A. L. Suchman, & R. Botelho (Eds.), *Partnerships*, *power and process: Transforming health-care delivery* (pp. 67-88). Rochester, NY: University of Rochester Press.

Williams, G. C., Freedman, Z., & Deci, E. L. (1998). Supporting autonomy to motivate patients with diabetes for glucose control. *Diabetes Care*, *21*, 1644-1651.

Williams, G. C., Grow, V. M., Freedman, Z., Ryan, R. M., & Deci, E. L. (1996). Motivational predictors of weight loss and weight-loss maintenance. *Journal of Personality and Social Psychology*, *70*, 115-126.

Williams, G. C., Lynch, M. F., & Glasgow, R. (2007). Computer-assisted intervention improves patient-centered diabetes care by increasing autonomy support. *Health Psychology*, *26*, 728-734.

Williams, G. C., Lynch, M. F., McGregor, H., Ryan, R. M., Sharp, D., & Deci, E. L. (2006). Validation of the Important Other Climate Questionnaire: Assessing autonomy support for health related change. *Families, Systems and Health*, *24*, 179-194.

Williams, G. C., McGregor, H. A., Sharp, D., Levesque, C., Kouides, R. W., Ryan, R. M., et al. (2006). Testing a self-determination theory intervention for motivating tobacco cessation: Supporting autonomy and competence in a clinical trial. *Health Psychology*, *25*, 91-101.

Williams, G. C., Rodin, G. C., Ryan, R. M., Grolnick, W. S., & Deci, E. L. (1998). Autonomous regulation and long-term medication adherence in adult outpatients. *Health Psychology*, *17*, 269-276.

Wilson, G. T., & Schlam, T. R. (2004). The transtheoretical model and motivational interviewing in the treatment of eating and weight disorders. *Clinical Psychology Review*, *24*, 361-378.

Winnicott, D. W. (1965). *Maturational processes and the facilitating environment*. Madison, CT: International Universities Press.

Wolfe, B. E. (2006). Employing empirically supported treatments: A research informed clinical practitioner perspective. *Clinical Psychology: Science and Practice*, *13*, 171-178.

Wolitzky, D. L. (2003). The theory and practice of traditional psychoanalytic treatment. In A. S. Gurman & S. Messer (Eds.), *Essential psychotherapies* (pp. 24-68). New York: Guilford.

Wolpe, J. (1982). *The practice of behavior therapy*. New York: Pergamon.

Woody, S. R., & Adessky, R. S. (2002). Therapeutic alliance, group cohesion, and homework compliance during cognitive-behavioral group treatment of social phobia. *Behavior Therapy*, *33*, 5-27.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.

Yalom, I. D. (2002). *The gift of therapy*. New York: HarperCollins.

Zeldman, A., Ryan, R. M., & Fiscella, K. (2004). Client motivation, autonomy support and entity beliefs: Their role in methadone maintenance treatment. *Journal of Social and Clinical Psychology*, *23*, 675-696.

Zuroff, D. C., Koestner, R., Moskowitz, D. S., Mcbride, C., Marshall, M., & Bagby, M. (2007). Autonomous motivation for therapy: A new common factor in brief treatments for depression. *Psychotherapy Research*, *17*, 137-148.

Bios

Richard M. Ryan is a Professor of Psychology, Psychiatry, and Education at the University of Rochester. He is a widely published researcher and theorist in the areas of human motivation, development, and psychological well-being, having published over 300 articles and books. He is a Fellow of several professional organizations including the American Psychological Association and the American Educational Research Association. Ryan is a licensed clinical psychologist with a practice in psychotherapy and consultation to schools and organizations, and has served as Director of Clinical Training at Rochester. Ryan is also an award-winning teacher and educational researcher, and is currently Editor-in-Chief of the psychological journal *Motivation & Emotion.*

Martin F. Lynch, a clinical psychologist, currently serves as Assistant Professor in the counseling and counselor education programs at the Warner School of Education, University of Rochester. His research focuses on the effects of social context on human motivation, personality development, and well-being. His current research interests include cross-cultural issues in the role of autonomy support; the sources of within-person variability in trait self-concept, well-being, and life satisfaction; motivation for emigration; and adjustment of international students. He is also involved in applied motivational research in the domains of health care, education, work, and psychotherapy. Lynch, who has lived and worked in Russia, publishes in both western and Russian journals. Lynch is a member of both the American Psychological Association and the American Counseling Association.

Maarten Vansteenkiste is a faculty member in the Psychology Department at Ghent University in Belgium. A motivation psychologist, he has focused on expanding self-determination theory in new directions. For example, one thrust of his work has manipulated intrinsic relative to extrinsic goals on effective performance, social functioning, and psychological well-being. He has worked, both theoretically and empirically, on examining the differences and commonalities between self-determination theory and other well-established theories of motivation. His research and writings, which have been published in many top international journals, have also explored the effects of motivational regulations and goal contents in various life domains, including education, work and unemployment, psychotherapy, parenting, and sport and exercise.

Edward L. Deci is the Helen F. and Fred H. Gowen Professor in the Social Sciences at the University of Rochester. For 40 years Deci has been engaged in a program of research on human motivation, much of it with Richard M. Ryan, that has led to and been organized by self-determination theory. He has published ten books, including: *Intrinsic Motivation* (1975) and *Intrinsic Motivation and Self-Determination in Human Behavior* (co-authored with R. M. Ryan, 1985). A grantee of NIH, NSF, and IES, and a fellow of APA and APS, he has lectured at more than 90 universities around the world.