

## MOTIVATION FOR THERAPY: AN IMPORTANT INGREDIENT TO CHANGE?

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### ABSTRACT

We analyse the levels of motivation for therapy, as well as explore if there are significant differences between the group of clients who drop-out from therapy and those who continue. Is there a relation between the different dimensions of motivation and the way the client perceive the therapeutic environment? 39 dyads of therapist and clients from Portugal participated. The Client motivation for therapy scale, adapted from Pelletier, Tucson and Haddad (1997) and the modified HCCQ from Williams, McGregor, King, Nelson and Glasgow (2005) were administered to the clients in 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup> and 8<sup>th</sup> session. Significant differences in the intrinsic motivation and amotivation dimension and no significant differences were found, between those who give up/continue psychotherapy ( $p > .05$ ). Nevertheless it was found a positive significant correlation ( $r_s = .467$ ) between the level of perception of the therapeutic environment and integrated motivation, as well as a negative correlation with amotivation ( $r_s = -.521$ ), that is to say, the better the perception of the therapeutic environment, more motivated they are for therapy.

Keywords: motivation, psychotherapy, clients, therapeutic environment

### MOTIVAÇÃO PARA TERAPIA: UM INGREDIENTE IMPORTANTE PARA A MUDANÇA?

#### RESUMO

Analisa-se os níveis de motivação para a terapia, bem como explora-se se há diferenças significativas entre o grupo de clientes que desiste e os que continuam. Procura-se uma relação entre as diferentes dimensões da motivação e da forma como o cliente percebe o ambiente terapêutico. Participaram 39 díades de terapeutas e clientes de Portugal. O Questionário de motivação do cliente para a terapia, adaptado de Pelletier, Tucson e Haddad (1997) e o Questionário modificado do ambiente terapêutico de Williams, McGregor, King, Nelson e Glasgow (2005) foram administrados aos clientes na 1<sup>a</sup>, 3<sup>a</sup>, 5<sup>a</sup> e 8<sup>a</sup> sessão. Encontraram-se diferenças significativas na motivação intrínseca e na dimensão de amotivação e não foram encontradas diferenças entre aqueles que desistem/continuam psicoterapia ( $p > 0,05$ ). No entanto, verificou-se uma correlação positiva ( $r = 0,467$ ) entre a percepção do ambiente terapêutico e a motivação integrada, bem como a existência de uma correlação negativa com a dimensão da amotivação ( $r_s = 0,521$ ), ou seja quanto melhor a percepção do ambiente terapêutico, maior é a motivação do cliente para a terapia.

Palavras-chave: psicoterapia, motivação, clientes, ambiente terapêutico

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## Introduction

Psychotherapy, in general, can be beneficial. However, not everyone benefits to a satisfactory degree from it. One of the areas of psychology that seems to have particular relevance to the issues of drop-out, compliance, and maintenance of change is the study of motivation (Pelletier, Tuson & Haddad, 1997).

Self-determination theory (SDT) is a human motivation theory built upon the dialectical relation between people and the social environment in which they attempt to satisfy their basic needs (Deci & Ryan, 1985; 2000). It distinguishes the different types of motivation [intrinsic, extrinsic and amotivation] that can regulate the behaviour and consequently have distinct impacts on the maintenance and integration of therapeutic changes (Pelletier, Tuson & Haddad, 1997; Deci & Ryan, 2008).

Intrinsically motivated behaviours are those which are simply activated by the pleasure and satisfaction resulting from the activity itself. Such behaviours can occur voluntarily and even without any extrinsic rewards (Deci, 1975; Deci & Ryan, 2008). In contrast, extrinsically motivated behaviours are those which are basically stimulated by external reasons, in order to get a reward or to avoid a punishment (Deci & Ryan, 2008).

According to Deci and Ryan (1985) there are different forms of extrinsic motivation, namely extrinsic regulation, identified regulation, introjected regulation and integrated regulation, and consequently some of them can be self-determined. These forms of extrinsic motivation are proposed along a continuum of self-determination that gradually increases.

Extrinsic regulation refers to the behaviours which are controlled by specific external contingency, demands or regulation (Deci & Ryan, 1975; Ryan, Lynch, Vansteenkiste & Deci, 2011). While in the introjected regulation the behaviour is reinforced by internal pressures, such as guilt, anxiety or other emotions associated with self-esteem. Yet, identified regulation means that people identify with the value of the activity and consequently accept the responsibility for regulating their behaviour (Deci & Ryan, 2008; Ryan, Lynch, Vansteenkiste & Deci, 2011). Moreover, integrated regulation occurs when individual behaves consistently with his or her values but above all, with his/hers personal identity (Ryan, Lynch, Vansteenkiste & Deci, 2011). Note that, external and introjected regulations are forms of controlled motivation, whereas identified/integrated and intrinsic regulation are associated with autonomous motivation (Deci & Ryan, 2008). Autonomous motivation has been constantly associated with greater persistence, performance and psychological wellbeing (Deci & Ryan, 2008).

In contrast to others forms of motivation, amotivation is a lack of motivation and a lack of self-determination with respect to an activity (Deci, 2000; Ryan, Lynch, Vansteenkiste & Deci, 2011).

## Motivation for therapy as a promoter for change in the psychotherapy

Many efforts in motivation field have been focussed on studying the factors that influence the client's motivation for the therapy. Based on SDT, clients' motivation and engagement in the therapy is facilitated when an autonomy support atmosphere is

promoted by therapist. According to Williams, Lynch and Glasgow (2007) an autonomy supportive environment is associated with higher sense of self-competence, major changes and better outcomes in the therapeutic process.

Assuming that is important to establish clients' motivation as a reliable predictor of psychotherapy outcome and better understand the circumstances in which clients motivation may drop (Pelletier, Tuson & Haddad, 1997), an exploratory study has been conducted with two main goals:

(1) Provide a wider picture of the motivation levels for therapy throughout the therapeutic process, by answering: *“Is there a change in clients motivation across the four time periods of evaluation?”*, *“Do clients that continue in therapy or drop-out therapy differ in terms of their motivational levels?”*

(2) Enlighten one of the factors that may influence the motivational levels - the client's perception of the therapeutic environment: *“Is there a relation between the types of motivation and the client's perception of the therapeutic environment?”*

## Method

### Participants

A total of 39 dyads of therapists and clients (14 therapists and 39 clients), of the Northern Region of Portugal, have participated in this study. Of the clients' sample, 20 were women and 19 were men. The clients' age range from 19 to 47 years ( $M_{age}=28.7$ ;  $SD=6.9$ ). Thirty-two of them were Portuguese (82.1%), two were Angolan (5.1 %), one was Brazilian (2.6%), one French (2.6 %), one was from Luxembourg (2.6%) and one has Zimbabwean nationality (2.6%). With regard to clients' qualifications, 64.1% had the 12<sup>th</sup> grade, 15.4% the 9<sup>th</sup> grade, 15.4 % the 6<sup>th</sup> grade and just only 5.1% had the 8<sup>th</sup> year. Within the clients' sample, there were fifteen students (39.5%), seven unemployed (18.4%), three construction workers (7.9%), two secretaries (5.3%), two commercials (5.3%) and eight with others professions (20.8%)

For twenty-nine clients' it was the first time in therapy (74.4%). The remaining ten had previously been in therapy (25.6%), thus one of them is the fourth time in therapy (2.6%), two of them the thirty time (7.7 %) and three of them the twice time in therapy (5.1%). Just 18 dyads of therapist and client completed the all four periods of evaluations (1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup> and 8<sup>th</sup>). Overall, 21 clients gave up from therapy (54%). More specifically, 10 of them dropped from therapy after the 1<sup>st</sup> session, 6 of them dropped over 3<sup>rd</sup> session and just 5 cases dropped from therapy after the 5<sup>th</sup> session. Concerning the therapy motives, about 80% are linked to addiction problems and 21% to anxiety and depression.

Regarding the therapists' sample, thirteen were women and just only one man. The therapists age ranged between 27-59 years ( $M=32.9$ ;  $SD=8.5$ ). Therapists were predominantly psychologists (92.9 %) and just only one was psychiatrist (7.1%). Most of them were Portuguese (12, 85.7%), one Brazilian (7.1%) and one of Angolan nationality (7.1%). Just five of the therapists had masters degree and the rest of them hold a bachelor degree. The therapists' years of experience, was of an average mean of 10.5 years and standard deviation 5.3, ranging from 4 to 23 years. In terms of therapists' theoretical orientation, 33.3 % adopted a cognitive-behavioural approach, 25% a psychodynamic approach, 16.7% a systemic orientation, 7.1% a narrative orientation and 7.1% a client-centered counseling approach. In general, eleven of them worked in a Center for drugs addition, one worked in a hospital, one in a school/university and one in the clinical setting.

## Measures

In order to assess clients' motivation for therapy based on the SDT, it was used Client Motivation for Therapy Scale (CMOTS) from Pelletier, Tucson and Haddad (1997). The originally CMOTS was adapted and translate to Portuguese by Soares and Lemos (2003). CMOTS comprised 24 items, on a 7-point Likert-type scale, ranging from 1 (*not to true at all*) to 7(*totally*). It is composed by 6 subscales, namely: Intrinsic Motivation, Integrated regulation, Identified Regulation, Introjected, Regulation, External Regulation and Amotivation. Cronbach's coefficient alpha ranges between .682 and .896, which indicated good internal consistency.

Likewise, we applied the modified Health Care Climate Questionnaire – mHCCQ, adapted from Williams, McGregor, King, Nelson and Glasgow (2005) and translated to Portuguese by Soares e Lemos (2003). The mHCCQ, consists of six items on a 7-point Likert-type scale, ranging from 1 (*strongly disagree*) to 7(*strongly agree*). Cronbach's coefficient alpha is .704 which indicated a good internal consistency.

## Procedures

The questionnaires were administered to the clients, by the therapist, in the 1st, 3rd, 5th and 8th session of the therapeutic process, with the informed consent of the client and the institution where the therapist worked. Clients received free treatment. Participants' selection was based on their availability to participate in this study. All statistical analyses were performed using SPSS Statistics Program (version 17.0).

## Results

A descriptive analysis was initially conducted to explore the data linked to different subscales of CMOTS and mHCCQ. The motivational subscales with higher values were the Identified regulation ( $M=6.32$ ;  $SD=0.619$ ), Integrated Regulation ( $M=5.86$ ;  $SD=0.87$ ) and Intrinsic motivation ( $M = 5.41$ ;  $SD = 1.17$ ), subscales that suggest a high level of self-determination. The lowest values were in the Introjected regulation ( $M=4.88$ ;  $SD=1.25$ ), External regulation ( $M=2.29$ ;  $SD=1.64$ ) and Amotivation ( $M=2.2224$ ;  $SD=1.25150$ ). It seems like these clients are globally motivated for therapy. In addition, we compare the means of different scales of motivation across different sessions (see table 1).

**Table 1***Means and standard deviations for CMOTS in 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup> and 8<sup>th</sup> sessions*

	Intrinsic		Integrated		Identified		Introjected		External		Amotivation	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1 <sup>st</sup>	4.83	1.17	5.71	1.45	6.38	0.68	5.13	1.42	2.30	1.69	2.53	1.59
3 <sup>rd</sup>	5.38	1.17	5.91	0.83	6.41	0.63	4.82	1.45	1.99	1.66	1.41	0.59
5 <sup>th</sup>	5.63	1.18	6.08	0.82	6.66	0.52	4.76	1.43	1.69	1.45	1.43	0.60
8 <sup>th</sup>	5.61	1.06	6.32	0.67	6.47	0.48	4.75	1.23	1.99	1.46	1.71	0.78

Regarding the values obtained in the mHCCQ across the different sessions, we observed that those are slightly high (see table 2), which suggests that the therapeutic environment is perceived as autonomy support by clients.

**Table 2***Means and standard deviations for mHCCQ*

Session	Therapists		Clients	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1 <sup>st</sup>	6.34	.19	6.34	.15
3 <sup>rd</sup>	6.14	.10	6.14	.18
5 <sup>th</sup>	6.29	.18	6.29	.19
8 <sup>th</sup>	6.35	.18	6.35	.12

*Note.* The mHHCQ was adapted from Williams et al. (2005) and translated to Portuguese by Soares and Lemos (2003). Note that it was also created a therapist version of the mHHCQ.

Additionally, the assumptions for the use of parametric tests were checked. The variables were not normally distributed. To investigate the level of self-determination, in different moments of therapy, a *one way ANOVA* was performed (see table 3).

**Table 3**

*ANOVA Test Results for self-determination, concerning different session of therapeutic process*

		Mean Difference	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Session 1	Session 3	.02816	.21637	.999	-.5367	.5930
	Session 5	-.03014	.23199	.999	-.6358	.5755
	Session 8	-.13141	.25144	.953	-.7878	.5250
Session 3	Session 1	-.02816	.21637	.999	-.5930	.5367
	Session 5	-.05830	.24638	.995	-.7015	.5849
	Session 8	-.15957	.26478	.931	-.8508	.5317
Session 5	Session 1	.03014	.23199	.999	-.5755	.6358
	Session 3	.05830	.24638	.995	-.5849	.7015
	Session 8	-.10127	.27769	.983	-.8262	.6237
Session 8	Session 1	.13141	.25144	.953	-.5250	.7878
	Session 3	.15957	.26478	.931	-.5317	.8508
	Session 5	.10127	.27769	.983	-.6237	.8262

There was not found significant difference ( $p > .05$ ) between the overall levels of self-determination throughout the therapeutic process (1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup> and 8<sup>th</sup> sessions). However, when considering the different dimensions of motivation throughout the therapeutic process (1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup> and 8<sup>th</sup> sessions) there were found differences only in intrinsic motivation [ $F(3,104)=3.184$ ,  $p=.027$ ] and amotivation [ $F(3,104)=7.802$ ,  $p=.000$ ]. The actual difference in mean score between the groups was medium. The effect size, calculated using eta squared, was .08 for intrinsic motivation (medium) and of .18 for amotivation (large). It appears to exist an increase in intrinsic motivation throughout 1<sup>st</sup> session to 5<sup>th</sup> ( $M=-0.79$ ;  $SD=0.30$ ;  $p=.049$ ). The amotivation seems to have decreased after session 1, although with some fluctuations ( $M=1.11$ ;  $SD=0.27$ ;  $p=.000$ ).

Furthermore, to assess the differences in motivational levels between the clients who drop-out from therapy and those who continued in the therapy, *Mann Whitney's test* was conducted. Between the group of clients who drop-out from therapy (in 1<sup>st</sup>, 3<sup>rd</sup>, 5<sup>th</sup>) and those who continued (see table 4), no significant differences were found in the motivation scales ( $p > 0,05$ ). Therefore the levels of motivation for therapy could not explain the clients' drop-outs.

**Table 4**

*Man-Whitney Test results for the CMOTS*

Intrinsic Motivation	$Z = -0.634$ ; $p = 0.526$
Identified Regulation	$Z = -0.720$ ; $p = 0.471$
Integrated Regulation	$Z = -0.509$ ; $p = 0.611$
Introjected Regulation	$Z = -0.775$ ; $p = 0.438$
External regulation	$Z = -0.637$ ; $p = 0.524$
Amotivation	$Z = -0.989$ ; $p = 0.323$

Likewise, *Spearman's rho* was performed to test significant correlations between clients' perception of therapeutic environment and the subscales of motivation (see table 5).

**Table 5**  
*Correlation coefficients between CMOTS and mHCCQ variables*

Clients perception of the therapeutic environment	
Intrinsic motivation	.059
Identified regulation	.205
Integrated Regulation	.467**
Introjected regulation	.116
External regulation	-.124
Amotivation	-.524**

Note. \*\*P <.01

It was found a positive moderate correlation between the client's perception and the integrated motivation ( $r_s=.467$ ), and also a negative moderate correlation between the client's perception and the amotivation scale ( $r_s=.524$ ).

## Discussion

The current study focuses primarily on client's motivation for the therapy, based on SDT theory. Our findings suggest that most clients are motivated for therapy and showed higher levels of identified regulation, integrated regulation and intrinsic motivation, forms of autonomous motivation. In general, we do not observed fluctuations in levels of various forms of motivation across the therapeutic process, except in intrinsic motivation and amotivation. The fact that intrinsic motivation increased, is coherent with literature which states that behaviours that lead the client to experience feelings of competence and self-determination, like those seen, are intrinsically rewarding and are likely to be performed again (Pelletier, Tuson & Haddad, 1997).

Attending to the decrease in the amotivation scale it seems like clients' sense of purpose increases after the 3rd session. This could suggests possible influences of a somewhat compliance with therapist request, maintenance or even some integration of change in their lifestyle (Pelletier, Tuson & Haddad, 1997).

Additionally, we do not found any differences in the motivation scales between the group of clients who drop-out from therapy and those who continue in therapy. Therefore, the levels of motivation for therapy could not explain the clients' drop-outs. According to Bados, Balaguer and Saldanã (2007) there are several causes that may explain the drop-out from therapy, such as low motivation and/or dissatisfaction with the treatment or the therapist, external difficulties, and clients' feeling of improvement.

Moreover, it was found a positive correlation between the client's perception of therapeutic environment and the integrated motivation ( $r_s=0,467$ ), and also a negative correlation between the client's perception of therapeutic environment and the amotivation scale ( $r_s=0,524$ ). This seems to be consistent with the self-determination theory of Deci and Ryan (1985). Higher levels of self determination (like integrated motivation) are positively correlated with higher perceptions of therapist's behaviours that were autonomy supportive, caring, competence, and feedback providers, whereas non-self-determination (like amotivation) is associated with the perception of a more

controlling climate (Williams, Lynch & Glasgow, 2007; Ryan, Lynch, Vansteenkiste & Deci, 2011).

The present study has some limitations. Stands out two limitations that are very relevant and deserve a preliminary reflection: a) the use of instruments without adequate prior studies in Portuguese population to ensure their validity, including the Client Questionnaire Motivation for Therapy and modified Health Care Climate Questionnaire and b) the selection criteria and size of the sample, since it was one of convenience and therefore not representative of clients' and therapists' universe of the northern region of Portugal.

However, this study seems to stand important implications for the development of effective interventions in the therapeutic setting, considering that the client is a proactive agent in the development of knowledge, meanings, and experiences and that is why the therapeutic process is a creative process of sharing construction (Gonçalves & Henriques, 2005). It shows how important it is to evaluate the clients self-determination for therapy, which might increase the therapeutic success. Also, this study has shown some evidence that, when personal involvement is accompanied by autonomy support, it enhances individual's intrinsic motivation, self-determination, development and better mental health (Pelletier, Tuson & Haddad, 1997; Ryan, Lynch, Vansteenkiste & Deci, 2011).

Since, motivational studies in psychotherapy in Portugal are scarce, more research studies should be developed, given also their importance demonstrated in several previous investigations across the globe.

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