Motivation and Success in Therapy

by

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Abstract

Motivation is essential to achieve success in therapy, and as such, a lack of motivation is a significant problem for clients as they work to meet their goals. In this dissertation, I describe two studies that sought to understand better the factors that affect client motivation in order to provide more information so researchers and therapists can improve support to their clients.

In the first study, I examined motivation from a self-determination theory perspective using a correlational survey design. One hundred and twelve individuals who had pursued one-on-one therapy completed a survey measuring their basic psychological needs and several therapeutic outcomes, such as motivation type (autonomous, introjected, and intrinsic motivation), effort, intention to persist, well-being, and perceived therapeutic improvement. I conducted a cluster analysis, which resulted in four combinations of the basic psychological needs: 1) needs met, 2) moderately met, 3) lower competence, and 4) needs unmet. The profiles were then tested to determine their association with various outcomes; specifically, I investigated whether the profiles were associated with the therapeutic outcomes listed above. In line with self-determination theory, the cluster with all the basic needs met was associated with the best outcomes. Participants in this cluster had higher autonomous motivation, effort, and therapeutic improvement than those in the other clusters. There were also some differences between the other clusters, and all results are discussed in light of practical implications for therapists, study limitations, and directions for future research.

In the second study, I examined client experiences of low motivation from a qualitative perspective. Much of the literature on motivation in therapy is quantitative, where researchers statistically test theoretical constructs in relation to outcomes, as was the case for my first study. Although there are benefits to this approach, a limitation is that it can be prohibitive of

determining whether motivational theories are missing key components of clients' experience of motivation. I interviewed six individuals and conducted thematic analysis to understand better factors that contributed to a lack of motivation for therapy. I generated the following themes: 1) client/therapist voice, 2) efficacy beliefs, 3) therapist abilities, 4) relationships with others, and 5) triggered by a low point. I examined these themes in light of current theory and found that many were consistent with factors used in self-determination theory (autonomy, competence, relatedness), although the theme of being triggered by a low point stands out as separate from motivational theory. I discuss how the results apply not only to theory but to other aspects of research and practice, and conclude by commenting on limitations and directions for future research.

Overall, through this dissertation, I illustrate that self-determination theory is valuable in improving our understanding of how therapists can foster autonomous motivation and other positive outcomes among clients by supporting their basic psychological needs. I highlight a summary of the most important results in the final discussion.

Preface

The projects presented in this dissertation have received research ethics approval from the University of Alberta Research Ethics Board: "Understanding motivation in therapy," No. Pro00060441 January 21, 2016.

Chapter 2 of this dissertation, "Motivation profiles and their relation to success in therapy" is under review at *Professional Psychology: Research and Practice.* I was responsible for design of the study, data collection, data analysis, as well as the manuscript composition. L. M. Daniels was the supervisory author and was also responsible for design of the study, data analysis, and manuscript composition.

Chapter 3 of this dissertation, "Unmotivated client's experiences of motivation in therapy: A qualitative study" is under review at *Canadian Journal of Counselling and Psychotherapy.* I was responsible for design of the study, data collection, data analysis, as well as the manuscript composition. L. M. Daniels was the supervisory author and also responsible for design of the study, data analysis, and manuscript composition.

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CHAPTER ONE: GENERAL INTRODUCTION

"No change without movement and no movement without motivation"

(Ryan, Lynch, Vansteeniste, & Deci, 2011, p.7).

A prerequisite to therapeutic change (Hanna, 1996), motivation is of central importance because clients are more likely to achieve permanent changes when they are actively participating and involved in the process of therapy (Ryan & Deci, 2008). Despite this, more often than not researchers neglect the role of client motivation and typically focus on other, more stable, factors that contribute to positive or negative outcomes (Schneider & Klauer, 2001). For instance, studies have regularly found demographics to predict client dropout – a negative outcome affecting anywhere from 20-60% of clients (Oruche, Downs, Holloway, Draucker, & Aalsma, 2014; Swift, Whipple, & Sandberg, 2012), and possibly indicative of low motivation. In a meta-analysis conducted by Barrett et al., (2008), younger individuals with low social-economic status and of a minority cultural group were more likely to disengage prematurely from therapy. Ribeirto et al., (2012) also found similar results, as low social-economic status predicted dropout. Other studies show evidence that, for certain disorders, motivation can be predicted through the match between client disorder and form of treatment (Swift & Greenberg, 2014). This type of research is limited in supporting clients because it focuses on static demographic factors, largely beyond the influence of therapists.

In this dissertation I argue that it is more useful for researchers and therapists to know whether there are malleable factors linked to client motivation than stable ones because this information would help therapists understand what they could do to enhance client motivation. Thus, in designing the two studies that comprise this dissertation, I gave priority to client motivation as a key component of the one-on-one therapeutic process and focused on factors

related to client motivation that are malleable to therapists. The dissertation has four distinct sections. In this General Introduction, I provide context and introduce prominent theories of motivation in therapy. I begin with motivational interviewing because it is the theory researchers and therapists commonly use to understand client motivation in therapy, and then discuss common factors because it provides a transtheoretical explanation of client change, and finally, I conclude with self-determination theory because these researchers have found excellent results in numerous arenas, but have under-utilized the theory's application within therapeutic contexts. Next, I present two free-standing manuscripts describing the two research projects I undertook to meet the requirements of this dissertation. Finally, in the General Discussion I consider the common results amongst the two manuscripts, give suggestions for theory, and examine the results in light of my practical experience working with clients.

Motivation in Counselling Psychology

One in five Canadians will have a mental health disorder at some point in their lifetime (Canadian Association of Mental Health, 2018), meaning that approximately 6.7 million individuals in the country live with a diagnosed mental health condition (Smetanin, Briante, Stiff, Ahmad, & Khan, 2011). These statistics only include individuals officially diagnosed with a disorder and thus likely underestimate the number of those seeking therapy, as this does not include individuals with subclinical levels or those with issues unrelated to a diagnosis (i.e., bereavement). As many as 67% of individuals in need of psychological services do not access them (Mental Health Commission of Canada, 2012). Additionally, once a client does initiate therapy, dropout is a common problem (Swift et al., 2012), as it is estimated that anywhere from 20-60% of clients prematurely end therapy prior to meeting his or her goals (Oruche et al., 2014; Jarret et al., 2013; Swift & Greenberg, 2014). In the discussion about mental health, researchers

and policy makers often fail to mention client motivation, even though it is a necessary factor for individuals to engage in treatment and achieve positive mental health outcomes (Ryan et al., 2011). Strategies to improve client motivation are needed (Swift & Greenberg, 2014), and I review three pertinent theories as an introduction to the subject of motivation.

Motivational Interviewing

Motivational interviewing is the leading theory therapists use to understand motivation. It grew out of clinical work with clients who had alcohol abuse disorders (Lundahl et al., 2013; Miller & Rose, 2009) and is considered a bottom-up approach because of its focus on applied techniques rather than theory (Miller & Rollnick, 2012; Teixeira, Palmeira, & Vansteenkiste, 2012). Miller and Rollnick (2012) recommend therapists use four processes to improve motivation: (1) relationship, (2) focusing, (3) change talk, and (4) a change plan.

Relationship. Miller & Rollnick (1991; 2013) posit that therapists should form a relationship with their clients based on trust, respect, and empathy. They specify that therapists use Carl Rogers' (1959) concept of accurate empathy, which he defines as when a therapist correctly perceives the client's inner world and then matches his or her emotional state. Clients who perceive their therapist as empathetic rather than confrontational are less likely to become "resistant" and disengage from therapy (Miller & Rose, 2009, p. 528). Therapists are also instructed to utilize core elements of interpersonal skills, represented by the acronym OARS: Open questions, affirming, reflecting, and summarizing (Miller & Rollnick, 2013).

Focusing. Focusing is the second process of motivational interviewing, and involves the therapist working with the client to establish goals and direction of therapy (Miller & Rollnick, 2013). To focus correctly, therapists must learn to tolerate uncertainty, which means he or she should not actively solve the client's problems, but rather allow the client to be ambivalent and

unsure about what they want without pushing him or her in a certain direction (Miller & Rollnick, 2013). If therapists put too much pressure on a client to act a certain way, he or she may become resistant, or "evok[e] further defences" (p. 526), which interferes with the change process (Miller & Rose, 2009).

Change talk. The third process is change talk, which the therapist does by having the client verbalize his or her reasons for change and reduce the amount of sustain talk, or the client's reasons not to change. Clinicians elicit change talk to help a client work through the uncertainty of deciding whether or not to modify a given behaviour (Killeen, Cassin, & Geller, 2014).

Change plan. A change plan is the fourth and final process of motivational interviewing, which involves helping the client prepare a concrete strategy whereby he or she moves from talking into performing the change (Miller & Rollnick, 2013). In this step, the client outlines how they will change and what this change looks like in his or her life.

Motivational interviewing criticisms. Despite successes, researchers' biggest criticism of motivational interviewing is that it lacks a coherent theoretical orientation. Patrick & Williams (2012) point out that well thought out and empirically researched interventions based on theory facilitate an understanding of the mechanisms responsible for behaviour change, such as mediators and moderators. Researchers have faulted motivational interviewing for failing to provide a firm understanding of mechanisms that explain how and why the interventions are effective (Atkinson & Woods, 2017; van der Kaap-Deeder et al., 2014). In trying to bring a theoretical foundation to motivational interviewing, researchers use the transtheoretical model, which Prochaska & DiClemente (1983) outline are six stages that individuals progress through as they work toward change. However, in addition to researchers criticizing motivational

interviewing for theoretical flaws, they also criticize the transtheoretical model for the same reason. Specifically, researchers argue that human behaviour typically does not progress sequentially in neatly arranged stages (Brug et al., 2005), and that the transtheoretical model does not adequately reflect such complexity (Littrell, 2002; Sutton, 2001). Thus, researchers argue the transtheoretical model does not strengthen motivational interviewing's weakness. Since motivational interviewing has this problem, researchers and practitioners alike have applied other motivational theories to therapeutic contexts (Teixeira et al., 2012). Two examples that are more theory-driven are the common factors model (Asay & Lambert, 1999) and self-determination theory (Ryan & Deci, 2000).

Common Factors Model

The common factors model emerged out of large meta-analytic studies of therapeutic outcome research. The model stipulates that client improvement can be attributed to a number of general factors that are not specific to one particular form of therapy, but rather are inherent to the therapeutic process generally and can be common across all types of therapy (Leibert & Dunne-Bryant, 2014). The four common factors are (1) expectancy and placebo effects, (2) relationship factors, (3) technique/model factors, and (4) client factors and extratherapeutic events (Asay & Lambert, 1999).

Expectancy and placebo effects. Expectancy and placebo effects refer to the client's beliefs and opinions about whether therapy will help him or her improve (Gaitan-Sierra & Hyland, 2015). Factors within this category account for approximately 15% of treatment outcome (Asay & Lambert, 1999). To support these factors, therapists seek to improve client's expectations for treatment by educating him or her about the benefits of therapy (Heins, Knoop,

& Bleijenberg, 2013). This research suggests that client expectancies are linked to feelings of efficacy of therapy, or the belief that therapy will help the client achieve successful outcomes.

Relationship factors. Asay & Lambert (1999) define relationship factors as the quality of the relationship between the therapist and client, commonly referred to as the therapeutic alliance. A strong alliance tends to occur when the therapist provides a safe atmosphere, where he or she treats the client with trust, genuineness, warmth, and positive regard in a non-judgemental manner (Leibert & Dunne-Bryant, 2014). The relationship factors are estimated to account for approximately 30% of counselling outcomes (Asay & Lambert, 1999). There is a vast amount of research on the alliance (Horvath, Flückiger, Del Re, & Symonds, 2011), and, compared to other common factors, the alliance has the most robust relationship with positive outcomes in therapy (Horvath et al., 2011; Smith-Hansen & Probert, 2014).

Techniques/model factors. Techniques or model-specific factors are the actual theory-driven skills utilized in sessions to treat the mental health problem (e.g., empty-chair, cognitive reframing; Laska, Gurman, & Wampold, 2014). These factors are estimated to account for approximately 15% of outcomes (Asay & Lambert, 1999). Just as there is a vast amount of research on the therapeutic alliance, there is also been a lot of studies on the techniques and models about what works best for specific subgroups and populations (Castonguay, Barkham, Lutz, & McAleavey, 2013; Weinberger, 2014).

Client factors and extratherapeutic events. Client and extratherapeutic factors include traits, such as the severity of symptoms, personality, motivation, strengths, and obstacles (Asay & Lambert, 1999). They are characteristics about the client, and operate outside the therapist's office (Leibert & Dunne-Bryant, 2014). These factors are said to have the largest impact on outcomes, at approximately 40% (Asay & Lambert, 1999). As already illustrated, researchers

studying client factors primarily focus on demographic characteristics influencing premature dropout, such as age (Edlunk et al., 2002; Jarrett et al., 2013), culture (Jarrett et al., 2013), type of disorder (Ribeiro et al., 2012), and socio-economic status (Barrett et al., 2008). Motivation is largely considered to be a client factor (Asay & Lambert, 1999).

Common factors model criticisms. Although attractive for the cohesion it could bring among the varied practices of therapy, researchers critique the common factors model because its proponents neglect other researchers who have found that treatment modalities do produce positive mental health outcomes, specifically when the modalities are matched with certain problems (Reisner, 2005). For example, family systems models improve family distress (Sexton, Ridley, & Kleiner, 2004) and cognitive-behavioural therapy improves anxiety (Deacon & Abramowitz, 2004). Thus, Reisner (2005) asserts that in an attempt to consolidate research across modalities, Asay & Lambert (1999) over-simplify and eliminate the impacts of specific factors that have proven to be effective in therapy. Additionally, Sexton and colleagues (2004) contend that Asay & Lambert (1999) do not consider the impact of moderating and mediating variables. They point out that such variables are important and can impact outcomes differently, depending on client and contextual characteristics. This limitation may be particularly relevant as it pertains to client motivation. If client factors account for 40% of therapeutic outcome, and motivation is a client factor, why do researchers do little to explain what client motivation is or how to leverage it to support change? Self-determination theory is an alternative theory that focuses on maximizing motivation and is also built on a strong empirical and theoretical base.

Self-Determination Theory

Self-determination theory initially grew out of researchers who examined malleable factors that contributed to intrinsic motivation. Its scope involves “the investigation of people’s

inherent growth tendencies and innate psychological needs that are the basis for their self-motivation and personality integration, as well as for the conditions that foster those positive processes" (Ryan & Deci, 2000, p. 68). While self-determination theory has six mini-theories, the basic psychological needs theory and organismic integration theory are most central to the studies in this dissertation and thus are explained below.

Basic psychological needs theory. Self-determination theory researchers stipulate that autonomy, relatedness, and competence are three basic psychological needs involved with optimal functioning, growth, and well-being (Ryan & Deci, 2018). When all three needs are fulfilled, their combination creates self-determined motivation (also referred to as autonomous or intrinsic motivation; Ryan & Deci, 2000). Autonomy refers to when a person performs an action because he or she wants to, not because others are telling him or her to do so. In other words, the action is conducted because of personal choice, will, and volition (Ryan, Lynch, Vansteenkiste, & Deci, 2011). Relatedness refers to the feeling of being connected within a relationship (Ryan & Deci, 2008). Competence refers to one's belief that he or she can achieve an outcome or perform a task successfully (Ryan et al., 2011). Overall, the basic psychological needs are central to motivation research because, when met, individuals achieve a higher level of well-being and become intrinsically motivated (Ryan & Dec, 2000). Thus, therapy clients are most likely to feel autonomously motivated when their options are actively incorporated in sessions, they feel connected with the therapist, and when they believe they can achieve their goals (Graham & Weiner, 2012).

Organismic integration theory. Intrinsic motivation represents one end of the motivation continuum in self-determination theory – an end that is highly adaptive. As described above, when basic psychological needs are met, autonomous and specifically, intrinsic,

motivation is most likely to occur. This motivation type is the most adaptive because it is autotelic, or "engaged in for [ones] own sake and enjoyment" (Schunk, Pintrich, & Meece, 2008, p. 251). It is regulated internally by the person. On the continuum, motivation becomes less intrinsic as it becomes more externally regulated.

Next, four other forms of motivation are to a greater or lesser extent externally regulated. As the regulation becomes more external, the form of motivation is considered more 'controlled' than autonomous. Integrated regulation is the least externally controlled type of motivation, and is when a person integrates information from other individuals into his or her own self-schema. This information becomes important to the person, and eventually becomes a part of their identity as well. In such a case, the person engages in the behaviour "because of its importance to their sense of self" (Schunk et al., 2008, p. 253). Integrated motivation is similar to intrinsic motivation and is often difficult to distinguish empirically from intrinsic motivation (Allan, Autin, & Duffy, 2016). Next, identified regulation is defined as when a person engages in undesirable behaviour that helps them obtain an outcome that they value. In this case, the individual "wants to do the task because it is important to him or her, even if it is more out of utilitarian reasons, rather than intrinsic interest in the task" (Schunk et al., 2008, p. 253). An example is a student who takes a high school course to be granted entrance into university. They value getting accepted into university, but not the course he or she must take to obtain the acceptance. Introjected regulation is another form of controlled motivation that occurs when a person does something out of an obligation because another person has said they should perform the behaviour. In this case, the individual does the actions to please others, which often creates feelings of guilt and a thought that one 'should' do what the other wants. Although "the feelings of guilt or 'should' are actually internal to the person, the source [of influence] is still somewhat

external" (Schunk et al., 2008, p. 253). Finally, external regulation refers to instances when an individual undertakes action to obtain a reward, such as when a child cleans his or her room to obtain candy. In this case, the person is motivated because he or she wants the reward and not because he or she desires the behaviour. In this case, the individuals "do not show high interest, but they tend to behave well and try to do the work to obtain rewards or avoid punishment" (Schunk et al., 2008, p. 253).

Finally, amotivation is a sixth regulation style, defined as lacking the interest to engage in a behaviour (Ryan & Deci, 2000). These individuals tend to have low self-efficacy, low beliefs about ability, and exhibit characteristics similar to someone with learned helplessness (Ryan & Deci, 2018).

Self-determination theory criticisms. Miller and Rollnick (2012) have criticized self-determination theory for its lack of practical interventions. Although self-determination theory has a well-established theoretical model, in an examination of commonalities and differences it and motivational interviewing, Miller & Rollnick (2012) argue that it lacks practicality. Other researchers have criticized self-determination theory for its lack of focus on mental health (Deci, Vallerand, Pelletier & Ryan, 1991; Grolnick & Ryan, 1987; Ryan 1982; Jochems et al., 2011; Ryan et al., 2011). For instanced, in an extensive theoretical article Jochems and colleagues (2011) question why, despite the theory's success in other domains, researchers and clinicians alike do not apply self-determination theory more widely, such as to therapy settings.

Purposes of this Dissertation and Relevance to Counselling Psychology

Ryan & Deci (2000) contend that the three basic psychological needs in self-determination theory foster autonomous motivation across many achievement settings (Dysvik, Kuvaas, & Gagné, 2013; Ryan & Deci, 2008). Despite the success of researchers' more recent

findings in applying self-determination theory to health-related behaviours, such as weight loss among diabetes patients (Ng et al., 2010), it is still minimally utilized in both the research and practice of therapy in mental health, such as improving the lives of those with symptoms of anxiety, or even those with full-blown anxiety diagnoses. In order to better understand client motivation, I designed two separate studies on motivation in one-on-one therapy for this dissertation.

Research Questions

My research questions for the two studies are:

1) Quantitative: How are naturally occurring combinations of autonomy, competence, and relatedness associated with type of motivation, effort, persistence, well-being, and perceived therapeutic improvement?
2) Qualitative: What is the experience of motivation in clients with low basic psychological needs?

In the first article I use the basic psychological needs portion of self-determination theory to identify clients' need satisfaction and test associations between profiles and indicators of success in therapy. Specifically, I conducted a correlational quantitative study using a cluster analysis to determine whether unique combinations of the basic psychological needs formed, and the effect these combinations had on autonomous motivation, introjected motivation, external motivation, effort, persistence, well-being, and perception of improvement. Overall, the results suggest that outcomes are best when clients feel that all three of their basic psychological needs are met.

In the second article, I undertook a qualitative analysis of clients' motivation in therapy. There are very few researchers who use interviews to ask clients about their experiences of

motivation and I advance the field in two ways through this study. First, I purposefully sampled participants who had scored low on a quantitative measure of basic psychological needs. My logic in doing this was to understand why participants may stay in therapy despite having low basic psychological needs with the possibility of identifying malleable factors to consider alongside autonomy, competence, and relatedness. After speaking with clients about their experiences of motivation I utilized content analysis to inductively identify themes related to their motivation in therapy. Although I did not seek to confirm any specific motivation theory in with my analyses, my expertise in motivation theory allowed me to frame the inductive results in relation to dominant theories of motivation and identify places of convergence and divergence with theory in the discussion.

Cumulatively, these two studies allow me to comment on the extent to which self-determination theory can be used to further our understanding of client motivation in one-on-one therapy and ways in which the basic psychological needs foster various types of motivation and outcomes. In each study, I discuss specific skills therapists can engage in to promote the basic psychological needs and am aware of my own professional experiences and how they may shape my interpretations of the study findings. It is my hope that these studies will provide information about how self-determination theory can be useful for researchers and therapists to view client motivation, and specifically, how the basic psychological needs affect motivation and related outcomes. Such information can inform therapists about why it is beneficial to support some, or all, of the client's basic psychological needs. While helpful for clinicians and practitioners, clients would ultimately benefit the most by feeling more engaged and achieving better outcomes in therapy.

Counselling psychologists aim to improve the mental health, well-being, and growth of those they work with, whether that be individuals, groups, or families (Canadian Psychological Association, 2009). In a discussion of values of counselling psychology, Gelso, Williams, & Fretz (2014) identify five central themes, which include utilization of strength-based work, a holistic perspective, social justice, the scientist-practitioner model, and preventative, educational, and brief interventions. My research is relevant to the field of counselling psychology in particular, because of its focus on strengths and the scientist-practitioner model.

Given counselling psychologist's emphasis on strengths, self-determination theory is relevant because it aligns well with the field's values. Ryan and Deci (2018) assert that self-determination theory is used to better understand optimal functioning in individuals. Indeed, the theory's basic psychological needs of autonomy, competence, and relatedness improve well-being and other positive outcomes in numerous populations, such as athletes (Gagne, 2003), geriatrics (Kasser & Ryan, 1999), dissatisfied employees (Ilardi, Leone, Kasser, & Ryan, 1993), and students (Sheldon & Niemiec, 2006). My research pertains to counselling psychology's strength-based approach because I seek to understand whether these psychological needs are associated with important factors in counselling, such as client motivation and success.

Additionally, my research is relevant to counselling psychology's value of utilizing the scientist-practitioner model. Gelso et al., (2014) maintain that one aspect of scientist-practitioners is to use science to inform practice. My research accomplishes this task, as I studied how certain factors (autonomy, competence, relatedness) impact client motivation and outcomes in counselling, where I ultimately sought to inform practitioners how they can maximize client success. This research directly applies to practical work with clients in a therapeutic setting, which provides information valuable to counselling psychologists.

CHAPTER TWO: MOTIVATION PROFILES AND THEIR RELATIONSHIP TO SUCCESS IN THERAPY

Introduction

More than 6.7 million Canadians meet the requirements for a mental health disorder today (Mental Health Commission of Canada, 2013). Of those, nearly half of those with anxiety and depression (49%) fail to seek professional help (Canadian Mental Health Association, 2018). Even when individuals do seek help, many encounter problems throughout the course of therapy (Choi, Adams, MacMaster, & Seiters, 2013) that can lead to either early drop out (Piper et al., 1999) or failure to achieve therapeutic goals, despite consistently attending sessions (Lambert, 2013). Estimates of dropouts alone vary widely, as researchers have reported rates ranging from 20-60% (Oruche, Downs, Holloway, Draucker, & Aalsm, 2014; Jarret et al., 2013; Swift & Greenberg, 2014). For those who choose to persist and complete all their sessions, approximately 20% do not meet their counselling goals (Asay & Lambert, 1999). As such, it is imperative to not only keep clients in therapy, but to maximize their motivation to achieve their goals.

Both dropping out and failing to meet goals have negative implications for the client, therapist, and even the economy. For clients, dropout is associated with worse mental health outcomes (Johansson & Eklund, 2006; Asay & Lambert, 1999; Reis & Brown, 1999), such as a worsening of symptoms (Simon, Imel, Ludman, & Steinfeld, 2012) and low satisfaction with counselling. For therapists, dropouts waste limited professional resources (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). For society, the cost of mental illness on the Canadian economy is estimated at $50 billion (Mental Health Commission of Canada, 2013). With ramifications so high, there is great need for clients to be motivated during therapy, and for therapists to understand why some persist and others do not.

Both theory and evidence suggest that clients who are motivated, particularly *autonomously motivated*, are more likely to persist and exert effort in therapy (Deci, Koestner, & Ryan, 1999; Lucas, 2012; Wade, Frayne, Edwards, Robertson, & Gilchrist, 2009). Likewise, environments that facilitate autonomy, competence, and relatedness tend to enhance intrinsic motivation (Ryan & Deci, 2000). Thus, the purpose of this study was to test how different profiles of autonomy, competence, and relatedness were associated with types of motivation and indicators of success in therapy including, effort, persistence, well-being, and perceived therapeutic improvement.

Motivation

In a therapeutic setting, clinicians commonly understand that clients need to be motivated to achieve behaviour change (Miller & Rollnick, 2013). One definition of client motivation accepted by therapists is the "engagement in the process of behavior change" (Drieschner, Lammers, & van der Staak, 2004, p. 1121). Another definition researchers commonly use is whether the client has intention to continue counselling (Deci, Vallerand, Pelletier, & Ryan, 1991; Lewin, 1951; Longo, Lent, & Brown, 1992). And of course, motivational interviewing, defined as the application of specific techniques to increase the client's motivation, is a common therapeutic practice. There are various conceptualizations of motivation, and such breadth in the literature and practice have created methodological problems that likely contribute to difficulties ascertaining a clear understanding of client motivation and ways to support it (Swift & Greenberg, 2014; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010). Seeking greater precision for this research, I sought a theory with a consistent definition of motivation. Thus, I expanded our consideration beyond motivation in the therapeutic literature to the achievement motivation context.

Achievement Motivation

Achievement motivation is a specific form of motivation, where an individual strives to achieve a goal (Niederkofler, Herrmann, Seiler, & Gerlach, 2015). The most familiar achievement context is school. In this domain, motivation research and theories abound with ways to help students achieve top grades, persist, exert effort, and learn. In these school settings, teachers successfully increase student motivation by incorporating practices derived from theories such as expectancy-value theory, attribution theory, and self-determination theory (DeCaro, Decar, & Rittle-Johnson, 2015; Pintrich, 2003). However, school is not the only achievement domain and thus these motivation principles and practices are relevant to other achievement contexts. For example, within the context of sports, motivational theories are frequently incorporated into coaching frameworks among high performance athletes (Cantón, 2014) and used to improve physical activity levels among inactive individuals (Deci & Olson, 1988). In the business context, theories of achievement motivation are used to understand environmental factors that improve employee productivity by "creat[ing] conditions where top performers can thrive" (Jones, 2014, para 2). For instance, studies have investigated what motivates individuals to achieve higher sales profitability based on their personality traits (Steenburgh & Ahearne, 2012).

Although the therapeutic environment may conjure up images of serenity and relaxation, I believe it is also an achievement context. Commonly, clients enter into therapy when facing some of their worst emotional pain (Frankl, 1984; Buhr & Daniels, 2018b). They enter into it also with the intention of overcoming this pain, which means making change and achieving goals related to personal flaws, relationship break-downs, or grief over the loss of a loved one (Corsini & Wedding, 2011). Commonly in therapy, clients are attempting to eliminate a problem and

achieve positive emotional functioning (Greenberg, Rice, & Elliott, 1993). In order to achieve these goals, they often engage in an emotionally demanding therapeutic environment that takes persistence (Lundblad, 2003) and effort (Cooper & Axsom, 1982). Thus, similar to school, sports, and business, therapy also involves elements common to other achievement environments and can be considered an achievement context as well.

Self-Determination Theory

One theory of motivation that researchers in achievement-based contexts regularly turn to when trying to enhance an individual's motivation is self-determination theory. This theory provides a framework to support "the investigation of people's inherent growth tendencies and innate psychological needs that are the basis for their self-motivation and personality integration, as well as for the conditions that foster those positive processes" (Ryan & Deci, 2000, p. 68). Researchers who adhere to this framework examine both an individual's type of motivation and ways to enhance autonomous motivation by meeting basic psychological needs.

Motivation Types

As opposed to most theories of motivation that include two polarized categories (i.e., intrinsic and extrinsic; Pintrich, 2003), self-determination theory is unique in that it includes a continuum of different motivation types. Understanding these motivation types is important because the therapeutic process is likely different depending on the client's type. For example, those who are in therapy because their spouse told them to attend may require additional and different techniques than a client attending therapy because they enjoy engaging in personal work.

There are six types of motivation. One is called *amotivation,* which describes an individual who lacks motivation. Those with amotivation tend to report low self-efficacy, low

beliefs about ability, and learned helplessness characteristics. The other five types fall along the continuum, with controlled motivation at one end and autonomous motivation at the other. The remaining types are described in order from those who are more controlled to those who are more autonomous. *External regulation* refers to performing an action to obtain a reward, such as when a child cleans his or her room in return for chocolate or candy. *Introjected regulation* is where the individual does something because someone else has told them to. In this case, the behaviour is typically performed to please others, often out of external pressure that evokes guilt if not done. An example is when an individual attends a fundraiser for a cause they feel they should care about, although they do not particularly want to attend. *Identified regulation,* where the individual performs a task because it is a means to an end that gets them a reward that they want. An example includes completing undesired coursework to obtain a degree. *Integrated regulation* is when information others give becomes integrated into the person's own self-schema and eventually becomes a part of the person's identity. An example is when a person enters a profession to help others because helping is consistent with his or her values. Marking the other end of the continuum, intrinsic motivation is truly autonomous, and occurs when individuals engages in an action because they actually want to do so. Those who are intrinsically motivated enjoy the activities they are performing.

Effects of different motivation types. A client's type of motivation is important because it can influence therapeutic outcomes. Autonomous motivation is generally associated with more positive outcomes in a number of achievement contexts (Ryan & Deci, 2000), including therapy. For instance, autonomous motivation predicted symptom improvements in clients with depression (Zuroff et al., 2007; Zuroff, Koestner, & Moskowitz, 2012), substance abuse (Ryan, Plant, & O'Malley, 1995), and eating disorders (Cater & Kelly, 2015; Thaler et al., 2016).

Specifically, higher pre-treatment autonomous motivation was associated with fewer eating disorder symptoms (Carter & Kelly, 2014; Thaler et al., 2016). Additionally, Zuroff et al. (2012) assessed depression levels, autonomous motivation, and controlled motivation for participants receiving one of cognitive-behavioural therapy, interpersonal therapy, or pharmacotherapy with clinical management. Consistent with their hypotheses, researchers found those with higher autonomous motivation were more likely to have lower levels of depression after therapy. In addition to autonomous motivation leading to improved mental health, it has also been found to have other positive impacts. For instance, autonomous motivation for therapy is related to interpersonal openness and willingness to receive help from others (Ryan et al., 1995), positive attitudes about mental health problems (Thaler et al., 2016), and self-compassion (Cater & Kelly, 2015).

Alternatively, the impact of controlled motivation on therapeutic outcomes is less straight-forward. Ryan et al., (1995) found controlled motivation was significantly and negatively related to depression, as well, that it was negatively related to confidence and help-seeking. Controlled motivation was associated with depression in another separate study as well (McBride et al., 2010) and has been related to other negative factors in clients such as shame (Thaler et al., 2016) and self-criticism (Zuroff et al., 2012). Other researchers have shown that controlled motivation had no effect on therapeutic outcomes. For instance, both Thaler et al., (2016) and Carter & Kelly (2014) found controlled motivation was unassociated with results for patients with eating disorders, and Franco (2012) uncovered that it was unrelated to client outcome in a study investigating participants in a university counselling centre. Interestingly, in a study on substance abuse, participants were more likely to remain in treatment when both controlled *and* autonomous motivation were high (Ryan et al., 1995).

A limitation of the research on motivation types in therapy is that it is unclear if controlled motivation negatively impacts outcomes, has no relationship with outcomes, or is associated with positive outcomes when combined with autonomous motivation. Additionally, a limitation of these studies is that most researchers have focused on contrasting the broad categories of autonomous motivation with controlled motivation (Carter & Kelly, 2014; McBride et a., 2010; Thaler et al., 2016; Zuroff et al., 2007), which fails to account for differences in outcomes because of variants of controlled motivation. Because clients are motivated for therapy for different reasons (i.e., personal development, the pressure from a spouse), it would likely be beneficial for researchers to examine the effect of these variants in motivation. Moreover, because actions taken by therapists can either support or thwart clients' basic psychological needs; thereby, influencing their type of motivation, it is also important to consider clients' basic psychological needs.

Basic Psychological Needs Theory

In addition to describing motivation types, Ryan and Deci (2008) stipulate that humans have certain needs that act like "nutrients" (p. 657), which facilitate autonomous motivation when met, and controlled motivation when thwarted. Ryan and Deci (2000) also identify autonomy, competence, and relatedness as the three basic psychological needs necessary for optimal functioning and autonomous motivation. In therapy, the more a clinician supports basic psychological needs, the more autonomously motivated the client is likely to be.

Autonomy. Autonomy refers to an individual performing an action because he or she wants to, and not because others are telling him or her to do so. In other words, the action is because of personal choice, will, and volition (Ryan, Lynch, Vansteenkiste, & Deci, 2011). Autonomy has been the psychological need that has attracted the most empirical research. A

closely related construct, autonomy support, refers to an individual who facilitates another person's autonomy by performing actions such as allowing choice, minimizing pressure, and taking the perspective of the other (Ryan & Deci, 2008). Autonomy support has also been a large focus of research in self-determination theory, particularly when applied to therapy. It has been found to facilitate autonomous motivation in those with depression (McBride et al., 2010; Zuroff et al., 2012), eating disorders (van der Kaap-Deeder et al., 2014), and in youth with emotional and behavioural problems (Savard, Joussemet, Pelletier, & Mageau, 2013). Thus, an individual is more likely to be more autonomously motivated and achieve better outcomes when the need for autonomy is met.

Competence. Competence refers to the belief that one can achieve an outcome or perform some task successfully (Ryan et al., 2011). Individuals are more likely to feel competent when they understand and believe they can master activities. Competence can be promoted by de-emphasizing evaluation and providing information on how the individual can master the task (Niemiec & Ryan, 2009). Minimal research in therapy has focused on competence. As an exception, Williams and colleagues (2006) examined the impact of autonomous motivation, autonomy support, and perceived competence on smoking cessation. They found that when accompanied by autonomy support and autonomous motivation, perceived competence reduced smoking in adults. Again, perceived competence is an important ingredient in helping clients feel autonomously motivated.

Relatedness. Relatedness refers to whether an individual feels connected to another person within a relationship (Ryan et al., 2011). Individuals are more likely to feel relatedness when they believe the other person thinks highly of them and genuinely likes them. Those who experience relatedness are more likely to internalize the values of the individual they feel related

to (Niemiec & Ryan, 2009). There has been very little self-determination theory research on relatedness in therapy even though the construct seems closely related to the notion of alliance. Insomuch as relatedness is similar to alliance, its importance in counselling cannot be ignored as therapeutic alliance is considered a basic standard of care (Asay & Lambert, 1999).

"Need" Satisfaction. A limitation of the studies on basic psychological needs is their focus on autonomy and autonomy support without consideration of competence or relatedness (McBride et al., 2010; Savard et al., 2013; van der Kaap-Deeder et al., 2014; Zuroff et al., 2012). Of the researchers who have examined competence and relatedness, the three needs are typically examined as a composite representing 'basic psychological need satisfaction' (Klag, Creed, & O'Callaghan, 2010; Ritholz, 2011). While there is ample research on self-determination theory illustrating that combined need satisfaction is important (Baard, Deci, & Ryan, 2004; La Guardia, Ryan, Couchman, & Deci, 2000), it is also possible that the three psychological needs might have their own unique effects. Indeed, Klag et al., (2011) found that perceived competence and relatedness mediated a relationship between autonomy support and motivation type in individuals with substance abuse disorders. In addition to this, it is also important to examine the relative *level* of need satisfaction. For example, previous research supports that individuals with more discrepant levels of needs have lower reports of general well-being than those with more balanced needs (Sheldon & Niemiec, 2006). Building on this, it may indeed be that high satisfaction of all three basic psychological needs in therapy results in the highest levels of intrinsic motivation and adaptive outcomes, or that combinations and levels of needs may also produce fruitful results. In one of the few studies to examine levels of basic psychological needs, Ritholz (2011) created a total basic psychological needs score and divided participants into 'high' and 'low' categories. A main limitation of this work was that the groups were arbitrarily

created based on high and low levels individually, rather than examining various levels and combinations of these levels. Thus, more person-centred research is needed to understand how naturally occurring combinations of needs relate to the type of client motivation and other outcomes related to success in therapy.

Operationalizing Success in Therapy

Trying to settle on a single indicator of success in therapy is nearly impossible. However, from a motivation perspective, because intrinsic motivation is regularly associated with wellness (Patall, Cooper, & Robinson, 2008), then outcomes associated with intrinsic motivation may be strong candidates for indicators of success in therapy. Thus, I suggest that along with intrinsic motivation, four indicators of success in therapy could be: effort, persistence, well-being, and clients' perception that therapy improved their symptoms.

Effort and Persistence

Effort and persistence are closely associated with intrinsic motivation (Skaalvik, Federici, & Klassen, 2015; Skaalvik & Skaalvik, 2005). Moreover, they increase the chances that individuals will work through obstacles (Graham & Weiner, 2012), making them prerequisites to success in therapy. Although not many researchers have directly studied persistence in therapy, many have studied dropout, an inversely related construct. Typically, those who are more likely to drop out are more likely to be younger (Edlunk, Wang, Berglund, Katz, Lin, & Kessler, 2002), ethnic minorities (Jarrett et al., 2013), have severe psychological disorders (Ribeiro et al., 2012), and have lower socio-economic status (Barrett et al., 2008). These characteristics of dropout are common demographic variables that are static and impossible to change. In contrast basic psychological needs are malleable person-centered characteristics that can be facilitated by the therapeutic environment.

Well-being. Subjective well-being includes satisfaction with life, feelings of happiness, and a sense of purpose (Steptoe, Deaton, & Stone, 2015). These are but some of the outcomes therapists strive to help their clients achieve in therapy. Perhaps it is good news then that there is a plethora of research illustrating that the basic psychological needs predict well-being (Gagné, 2003; Kasser & Ryan, 1999; Ilardi et al., 1993; Sheldon & Niemiec, 2006; Sheldon, Ryan, & Reis, 1996; Reis, Sheldon, Gable, Roscoe, & Ryan, 2000) as well as vitality and adjustment (Baard et al., 2004). There is preliminary evidence that the satisfaction of the client's basic psychological needs in therapy also positively impacts their well-being. For example Ritholz (2011) found the needs positively impacted a closely related construct called 'mental health recovery.'

Perceived therapeutic improvement. It is also important to understand whether the basic psychological needs impact therapeutic outcomes in terms of symptom improvement, as this is often the primary goal of therapy. Since symptoms, severity, and treatment plans vary by individual and therapist, it is difficult to determine 'improvement' rigidly. Sometimes researchers focus on therapist perceptions of improvement related to therapy (Bohart & Wade, 2013; DeFife, Smith, & Conklin, 2013) and other times, on client perceptions of improvement (Swift & Parkin, 2017). Because the general aim of therapy is to improve the clients' sense of well-being, it is important to consider client perceptions of symptom relief and belief that therapy helped them, as indicators of success.

Conceptual Framework with Person-Centred Analyses

Motivation in therapy is complex; however, I believe that self-determination theory provides the necessary structure to increase researchers and therapists understanding of clients' perceptions of the extent to which their basic psychological needs are met and how that relates to

their type of motivation and various indicators of success. Specifically, the purpose of this study was to determine the naturally occurring groups that represent different combinations of clients' basic psychological needs, and to ascertain if and how the groups differed on success in counselling. My research question was "how are naturally occurring combinations of autonomy, competence, and relatedness associated with: type of motivation, effort, persistence, well-being, and perceived therapeutic improvement?" (see Figure 2.1).

In contrast to many of the researchers who have used a linear approach, who prioritize direct relationships between variables, I used a person-centered approach to guide my research. Person-centered approaches use participant responses to create naturally-occurring groups. A benefit of this over a linear approach is that it maintains participants' unique scores rather than converting them into means where responses are 'lost' in the average of a group. Since motivation in therapy is complex, another benefit of a person-centered approach is that it allows for the complexity of how basic psychological needs may or may not be met to remain central in the analyses. In other words, person-centered analyses are arguably a better representation of how clients actually experience combinations of the three basic psychological needs rather than analyzing each need separately. I chose to focus on the basic psychological needs as the grouping variables because they are malleable, whereas, many other factors associated with client motivation such as demographics (i.e., age) are not. Thus, my results may provide information for therapists about the combination of basic psychological needs, and offer suggestions for ways that they can meet the client's basic psychological needs through the therapeutic process. I expected that the clusters (represented by the concentric circles on the left of Figure 2.1) would differ in regards to types of motivation and indicators of success (the columns on the right of Figure 2.1).

Researchers who have studied self-determination theory in non-therapeutic settings already demonstrate that fulfillment of all three needs impacts motivation type. Specifically, fulfillment of the three needs leads to autonomous motivation and when all three needs are unmet, autonomous motivation does not develop (Ryan & Deci, 2000). Thus, I expected a cluster to emerge that contained high satisfaction of all three basic psychological needs and that clients in this cluster would report high levels of indicators of success. I expected these outcomes because clients in this cluster will feel free, able, and supported in therapy and therefore, they will exert effort towards an important and achievable goal. I also expected a cluster to emerge that contained low satisfaction of all three basic psychological needs. As clients whose needs are thwarted, I expected more controlled motivation, such as external or introjected motivation, as well as lower levels of the other indicators of success. These outcomes would emerge largely because the pressure to change is external to the person and thus they will struggle to see the benefit of effortfully working toward goals. Lastly, I suspected a cluster high on relatedness compared to autonomy and competence would emerge because of the dominance of therapeutic alliance in the field of counselling psychology. I believe that therapists will build relationships and in doing so cultivate autonomous motivation and the other positive therapeutic outcomes (Asay & Lambert, 1999), but not to the same extent as when all three basic psychological needs are met.

Method

I used a correlational survey design. I utilized questionnaires to collect information from counselling clients about their satisfaction of basic psychological needs, types of motivation, and indicators of success.

Participants and Procedure

A convenience sample was recruited through community counselling clinics known to the researcher throughout Edmonton, Alberta. To be considered for the study, participants had to have been in therapy or currently be in therapy. Posters were put on the doors or in waiting rooms at Clinical and Counselling Services, Clinical Services, the Sexual Assault Centre of Edmonton (SACE), and the YWCA. The posters displayed weblinks to the survey on pull-off tabs the clients could take and complete on their own time. Additionally, clinicians at these centres were encouraged to tell their clients about the study. If the client wanted more information, the researcher's contact information was also provided on the tabs. Alternatively, if participants wanted to complete the survey in the clinic before or after their counselling session, they were provided with a paper copy. The study was also advertised on bulletin boards throughout the University of Alberta and at two local mental health events. The first event was a mental health conference called Jack.org, and the second was a campus mental health event called "Movies for Mental Health."

One hundred and three participants completed the online survey and nine participants completed a paper version (N = 112). See the Appendix A for the demographic questions, as well as all the questions I used in the survey. Participants were on average, 28 years old (SD = 4.5). Additional relevant participant characteristics are described in Table 2.1. Missing data ranged from 5-9% on items related to motivation. In order to retain the full sample, I used mean imputation to complete the data on the variables of interest. In terms of demographic information, however, there was some missing data that was not completed and subsequently, omitted.

Measures

Client motivation for therapy. To assess motivation type, I used the Client Motivation for Therapy Scale (CMTS; Pelletier, Tuson, & Haddad, 1997). This measure has 24-items and six scales. I included 12-items for three separate scales of autonomous, introjected, and external motivation. I omitted integrated and identified regulation because they are closely related to intrinsic motivation and factor analyses in other studies have found integrated, identified, and intrinsic regulation to represent one underlying internally regulated construct (Allan, Autin, & Duffy, 2016). All items I included used a 7-point rating scale (1= *Does not correspond at all to me* to 7 = *Corresponds exactly to me*) and I calculated mean scores for each motivation type. The CMTS has shown good evidence of internal consistency, convergent validity and discriminate validity (αs range from .70-.92; Pelletier et al., 1997). Higher scores on each subscale indicated higher levels of the type of motivation.

Basic psychological needs. I used the Basic Need Satisfaction Scale in Relationships to assess autonomy, competence, and relatedness. This is a 9-item measure with three scales. All items were based on a 7-point rating scale (1 = *Not at all true* to 7 = *Very true*). Although often used as composite of all three needs (α = .90; Felmet, 2014; La Guardia et al., 2000), the evidence of reliability and validity for individual scales is also adequate (autonomy α = .76, competence α = .84, and relatedness α = .88; Sheldon & Niemiec, 2006). I used the measure to assess the three basic psychological needs separately and modified the scale to reflect therapy; however, all other content remained the same. Higher scores indicated greater perception of autonomy, competence, and relatedness. Descriptive information including coefficient alpha for all variables is in Table 2.2.

Effort. I used the work intensity scale of the Psychological Climate questionnaire to assess effort in counselling. The scale has shown good evidence of reliability and validity in previous studies (α = .82; Brown & Leigh, 1996). Participants responded to 4 items on a 7-point rating scale (1 = *Strongly disagree* to 7 = *Strongly agree*). Higher scores indicate greater effort, and I used mean scores.

Intention to persist. To assess intention to persist in therapy, I asked if participants wished to continue with counselling using a 3-item Propensity to Leave measure (Lyons, 1971). Due to problems with wording the questions, this measure could only be used for individuals who were currently in therapy (approximately half of the sample). Correlations between items ranged from moderate to high in previous studies (Lyons, 1971). The items used a 5-point rating scale. I created a mean score such that higher scores indicated a stronger propensity to leave.

Well-being. I used a shortened version of a well-being measure called the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) by NHS Health Scotland (2007). The measure includes 7 items and uses a 5-point rating scale (1 = *None of the time* to 5 = *All of the time*) and has good evidence of validity and reliability (α = .90; Vaingankar et al., 2017). Higher score indicated greater well-being, and I calculated mean scores.

Perceived therapeutic improvement. Additionally, I wanted to capture whether participants felt therapy helped them improve and increase their sense of well-being. Therefore, I created two additional items and used the mean to generate a measure of how participants perceived therapy related to their well-being. Participants rated the two items on a 5-point rating scale (1 = *None of the time* to 5 = *All of the time*) and higher scores indicated a greater perception of therapeutic improvement.

Rationale for Analysis

Prior to analysis, I compared the participants who were currently in therapy with those who had completed therapy on our descriptive variables. I used a Mann-Whitney test and Omnibus ANOVA and found the groups did not significantly differ on age $F(1, 99) = .79$, $p = .38$, gender $U = 1248.00$, $z = -0.43$, $p = .70$, ethnicity $U = 1264.50$, $z = -0.46$, $p = .65$, income $F(1, 84) = .001$, $p = .98$, or setting $U = 1133.50$, $z = -1.25$, $p = .21$, but that the participants currently in therapy had attended more sessions than those not in therapy $F(1, 110) = 8.12$, $p < .05$ and had a higher prevalence of co-occurring disorders $U = 951.00$, $z = -3.02$, $p < .05$.

I conducted our main analyses in three steps. First, I ran correlations on the study variables. Second, I ran a two-step cluster analysis, which is recommended to account for researcher bias (Henry, Tolan, & Gorman-Smith, 2005). In the first step, I ran a hierarchical cluster analysis using Ward's method (Murtagh & Legendre, 2011) to identify heterogenous clusters (or groups) of participants according to their responses on measures of the basic psychological needs of autonomy, competence, and relatedness. Clusters were generated by the computer based on those who had similar scores within groups and disparate scores between groups. In the second step, I ran a *k*-means cluster analysis which is a nonhierarchical method (Huberty, Jordan, & Brandt, 2005) where I either confirmed or disconfirmed the number of clusters in the first analysis. To reduce bias, I compared these results with the number of clusters identified in the first step. I also examined the distribution of autonomy, competence, and relatedness across and within clusters prior to reduce bias. Third, after the cluster analysis, I used an analysis of variance (ANOVA) to compare clusters in terms of my indicators of success. I probed any significant omnibus group difference with post-hoc Bonferroni t-tests to identify specific differences between groups. I conducted the analysis using SPSS 22 (IBM, 2013).

Results

Correlations

Table 2.3 presents the zero order Pearson correlations for all variables in the study. I highlight several relationships that provide evidence of validity of my measures. For example, the correlations between the basic psychological needs were as would be expected: autonomy was significantly and positively correlated with competence ($r = .56$, $p < .01$) and relatedness ($r = .63$, $p < .01$), and competence was significantly and positively correlated with relatedness ($r = .58$, $p < .01$). External and autonomous motivation were also negatively correlated ($r = -0.20$, $p < .01$), supporting the notion that they are opposite ends of the motivation spectrum.

Relationships between basic psychological needs and types of motivation were also in line with existing literature. Specifically, autonomous motivation significantly and positively correlated with the basic psychological needs of autonomy ($r = .41$, $p < .01$), competence ($r = .40$, $p < .01$), and relatedness ($r = .42$, $p < .01$); whereas, external motivation significantly and negatively correlated with the basic psychological needs of autonomy ($r = -.24$, $p < .05$), competence ($r = -.26$, $p < .01$), and relatedness ($r = -.24$, $p < .05$). Interestingly, introjected motivation significantly and negatively correlated with competence ($r = -.29$, $p < .01$) and relatedness ($r = -.42$, $p < .01$), but was not correlated with autonomy ($r = -0.17$, $p = .08$).

Effort and therapeutic improvement were also strongly related to the basic psychological needs. Effort significantly and positively correlated with autonomy ($r = .37$, $p < .05$), competence ($r = .39$, $p < .05$), and relatedness ($r = .37$, $p < .01$), suggesting that a client who has their basic psychological needs met are more likely to exert effort in therapy. Therapeutic improvement also correlated significantly and positively with autonomy ($r = .55$, $p < .01$), competence, ($r = .54$, $p < .01$), and relatedness ($r = .61$, $p < .01$). This provides evidence that

clients with their needs met are also more likely to feel therapy helped them solve their problems, and feel better overall.

Cluster Analysis

Henry et al., (2005) recommend using a two-phased cluster analysis, which includes both hierarchical and non-hierarchical methods. For the first phase of the cluster analysis (Henry et al., 2005), I used a hierarchical cluster analysis with Wards method (Murtagh & Legendre, 2011). This is a 'bottom up' approach that creates groups with the furthest centroids (center) using the squared Euclidean distance as a distance measure (Huberty et al., 2005). In addition to being the centre, the centroids are the averages of scores within the cluster. The squared Euclidean distance is the space between two points, which in this case is how far apart the centroids are, and is calculated based on the maximum distance between the sum of squares when clusters are merged. This calculation results in a dendrogram and agglomeration schedule, which determined a four-cluster solution (see Figure 2.2). I then ran a *k*-means cluster analysis (Huberty et al., 2005) for a two-, three-, four-, and five-cluster solution. I considered existing theory and size of the sample needed to retain enough individuals within the clusters. There were not enough participants retained to allow for the five-cluster solution. I also considered the centroids within each cluster and relative to other clusters, and interpreted them within the context of theory. Based on all this information, I confirmed the four-cluster solution. Final cluster centroids are presented in Table 2.4 and are also described below.

The first cluster was characterized by participants who reported low levels of competence and relatedness. The level of autonomy was slightly higher than competence and relatedness, and I considered it to be at a relatively moderate level. Despite this, it was still the lowest level of autonomy out of all the clusters and because both competence and autonomy were clearly low, I

labeled this cluster as needs unmet. The second cluster was characterized by participants who reported similarly moderate levels of all three autonomy, competence, and relatedness, and thus, I labeled as moderately met. The third cluster had moderate levels of competence paired with high levels of autonomy and relatedness. Because relative to autonomy and relatedness, competence was lower, I labeled it as less competent. The fourth cluster was characterized by relatively high levels of autonomy, competence, and relatedness, and was then labeled as needs met.

Differences between Clusters

Motivation type. I examined the data to determine if the assumptions of ANOVA were met (see Table 2.5). I conducted an one-way ANOVA and found significant omnibus differences between clusters on the measures of autonomous motivation $F(3, 108) = 8.79$, $p < .01$. Specifically, the participants in the needs met cluster had significantly higher autonomous motivation than those in any of the other three clusters, namely needs unmet, moderately met, and less competent cluster (see Table 2.6 for pairwise comparisons on all outcome variables). These three clusters did not differ from one another on autonomous motivation. As well, the one-way ANOVA illustrated that external motivation was also significantly different between clusters $F(3, 108) = 3.12$, $p < .05$. Participants in the needs unmet cluster had higher external motivation than those in the less competent cluster only. There were no significant differences between clusters on introjected motivation $F(3, 108) = 2.60$, $p = .06$.

Effort. The one-way ANOVA also revealed that there were differences between clusters on effort $F(3, 108) = 7.10$, $p < .01$. Specifically, the participants in the needs met cluster had significantly higher effort than those in all the other clusters, which included the needs unmet,

moderately met, and less competent clusters. These three clusters did not significantly differ from one another on effort.

Intention to persist. There were no significant differences between clusters on intention to persist $F(3,45) = 0.68$, $p = 0.67$.

Well-being. The one-way ANOVA also revealed that the clusters differed between one another on well-being $F(3, 108) = 4.89$, $p < .01$. Specifically, participants in the needs met cluster had significantly higher levels of well-being than those in the moderately met cluster.

Perceived therapeutic improvement. The one-way ANOVA also illustrated that the clusters differed between one another on therapeutic improvement $F(3, 108) = 17.92$, $p < .01$. Similar to autonomous motivation and effort, participants in the needs met cluster reported significantly higher levels of therapeutic improvement than those in the needs unmet, moderately met, and less competent clusters. Additionally, I found that the less competent cluster had significantly higher levels than the needs unmet cluster.

Discussion

The purpose of this study was to identify naturally occurring combinations of basic psychological need satisfaction in clients engaged in therapy and to test for how such combinations differed in terms of types of motivation, effort, persistence, well-being, and perceived therapeutic improvement. I highlight four main findings. First, meaningful clusters of basic need satisfaction emerged, suggesting that not all needs are met simultaneously or equally in therapy. Second, cluster four, in which all basic psychological needs were well satisfied, was generally the most beneficial for clients' type of motivation and indicators of success. Third, the other three combinations of basic psychological needs supported certain components of success and thwarted others. Fourth, need satisfaction was unrelated to clients' intentions to persist. I

discuss how these findings could impact therapist behaviour in sessions with clients, study limitations, and directions for future research.

Psychological Need Satisfaction in Therapy

I found meaningful combinations of the three basic psychological needs resulting in four clusters (see Figure 2.3). The clusters were mostly in line with my expectations. First, as expected, there was one cluster of participants who reported having all their basic psychological needs met. This cluster was classified as needs met and had the most participants (36%), suggesting that the actions of therapists are meeting the basic psychological needs of many clients. As I did not know the theoretical orientations and skills the therapists used, I cannot comment on how therapists specifically may have met the participant's needs, so rather I discuss general skills and tools he or she may have used and could use to support the client's basic psychological needs. For example, commonly used strategies therapists might employ that would likely naturally facilitate basic psychological needs would include relationship-building skills (Ackerman & Hilsenroth, 2003), collaboration (Tryon & Winograd, 2011), and treating the client as 'the expert' in their lives (Berg & De Jong, 1996). In using these sorts of applications, the therapist is likely meeting the client's basic psychological needs without knowing that such actions achieve this function. Future research may want to consider examining the specific therapeutic skills that are related to need satisfaction in order to increase the specificity of our understanding.

Second, as expected, there was a cluster of participants who reported lower levels of need satisfaction. Consistent with our hypotheses, relatedness and competence were low; however, autonomy was at a moderate level, which was not what I had anticipated a priori. One explanation for this result could be because most participants reported being in community

settings (i.e., private practice, employee assistance programs) rather than institutions (i.e., hospitals, forensics), the participants were likely not mandated and had chosen to be in therapy, which could account for most participants feeling at least moderate levels of autonomy. This level of autonomy combined with low levels of relatedness and competence, suggested to us that, relative to other groups, this cluster of participants could be described as having their needs unmet. Reassuringly, this cluster contained the fewest participants (13%). Nonetheless, from a theoretical perspective (Deci et al., 1999; Ilardi et al., 1993) this cluster is problematic because individuals with low basic psychological needs are more likely to have low levels of autonomous motivation, less well-being, and poorer performance and satisfaction when performing tasks.

Third, because therapeutic alliance is such an important factor in therapy (Asay & Lambert, 1999), I had expected a cluster high in relatedness with low autonomy and competence to emerge. Indeed, 30% of participants fell into a cluster with high relatedness, however it was also paired with high autonomy. This cluster did have a lower level of competence relative to autonomy and relatedness, so I called this group the less competent cluster. When examining the results, I found that in most clusters, autonomy and relatedness were similarly endorsed by participants, suggesting that these needs may be met through similar behaviours. In one definition of therapeutic alliance, Bordin (1979) asserted that alliance contains elements of autonomy. His definition of alliance includes ‘bonds,’ which pertains more to the quality of therapist-client relationship, and also includes ‘goals’ and ‘tasks,’ of which the therapist and client must agree. Bordin (1979) stipulated that such an agreement means collaboration, where the therapist incorporates the client’s views and opinions to create the goals and tasks. Thus, this definition of therapeutic alliance supports our findings, illustrating a possible intertwinement of autonomy and relatedness within therapy.

Lastly, I called the remaining group the moderately met cluster, as participants had evenly moderate levels of all three needs, indicating that autonomy, competence, and relatedness were somewhat met. Twenty-one percent of participants fell in this cluster. This demonstrates that clients perceived therapists' skills as related to, but not strongly supporting, their basic psychological needs. This is a helpful reminder that just because a therapist undertakes a certain behaviour, it may not be received by the client as fully supporting their needs. The clients' perspective is critical to understanding their motivation.

Benefits of High Need Satisfaction

Our results support a main position of self-determination theory suggesting that meeting all three basic psychological needs contributes to the most optimal functioning (Ryan & Deci, 2000) in terms of autonomous motivation, effort, and perceived therapeutic outcomes. First, the needs met cluster had the highest mean level of autonomous motivation compared to the other clusters. Moreover, all three of the other clusters were equivalent in their levels of autonomous motivation. In other words, combinations where any single need was moderately met or unmet resulted in participants reporting autonomous motivation that was statistically equivalent to those in the needs unmet cluster. Therefore, for enhanced autonomous motivation, it was necessary for all needs to be met. Second, in addition to autonomous motivation, participants in the needs met cluster were higher than those in all three other clusters on effort. The relationship between motivation and effort is intuitive, however, client effort has rarely been studied alongside motivation. Nonetheless, effort has been associated with positive outcomes in behaviour change, such as in weight loss interventions (Axsom & Cooper, 1985), particularly when basic psychological needs were met (Sylvester, 2011). As such, motivation and effort are an important pairing for success in counselling, and my findings reinforce this.

Third, our findings are also consistent with other preliminary studies on self-determination and therapy showing that such interventions contribute to improved therapeutic outcomes (e.g., Carter & Kelly, 2014; McBride et al., 2010; Ritholz, 2011; Thaler et al., 2016; Zuroff et al., 2007). Ritholz (2011) ran a correlational analysis of participants classified into 'high' or 'low' levels of basic psychological needs and found that, regardless of mediating factors (i.e., quality of alliance), the basic psychological needs were significantly and positively associated with mental health recovery. Our findings are also consistent with this. Also, although I did not examine alliance, the high levels of relatedness, which I argue are an aspect of alliance, were associated with better therapeutic outcomes, which was inconsistent with Ritholz's (2011) results specifically related to alliance. Thus, I maintain that low satisfaction of basic psychological needs is not beneficial to clients and that alliance, in combination of the other two needs, is important to outcomes. Instead, I conclude that the focus of research and practice should be on how therapists can facilitate all needs in order to best position clients to be successful in terms of autonomous motivation, effort, and perceived therapeutic improvement.

Other Combinations of Basic Psychological Needs

In addition to finding that the needs met cluster was associated with many indicators of success, the needs unmet cluster had higher levels than the less competent cluster on both external motivation and perceived therapeutic improvement. There are a few distinct features of those in the needs unmet cluster that may help explain this comparison. First, remember that although I labeled the cluster needs unmet, in actuality clients reported a moderate level of autonomy alongside the truly low levels of relatedness and competence. Ryan and Deci (2000) argued that autonomy protects people from experiencing controlled motivation; however, our results suggest otherwise. Also, the moderately met cluster had moderate levels of all three

needs, yet was not associated with external motivation, thus the needs unmet cluster shows that the lower levels of competence and relatedness, combined with the moderate levels of autonomy, were sufficient to result in more external motivation reported by clients. Second, although those in the less competent cluster had lower levels of competence relative to autonomy and relatedness, their levels of external motivation were still lower than those in the needs met cluster. This suggests that much lower levels of competence and relatedness resulted in more external motivation. Specifically, although these clients were not mandated to be in therapy, it seems that without competence and relatedness, clients perhaps are only going to therapy if they are feeling some sort of external pressure.

Notably, the needs unmet cluster was significantly different from the less competent, but not from the needs met cluster on external motivation. This was unexpected, as I hypothesized that those who had all their basic psychological needs met would have the least amount of external motivation. Indeed, the needs met mean level of external motivation was lower than needs unmet mean, but was slightly higher than the less competent cluster and was not significantly different from needs unmet. As mentioned previously, research on external motivation does not always produce the predicted outcomes (Carter & Kelly, 2014; Franco, 2012; Thaler et al., 2016), and I found this as well. Alternatively, it is possible this effect could mean that autonomy and relatedness have a stronger effect on external motivation than competence.

In addition to differences in external motivation, the less competent cluster also varied from the needs unmet cluster in terms of therapeutic outcomes. Specifically I found that the less competent cluster reported better outcomes than those in the needs unmet cluster, thus it appears that the high levels of autonomy and relatedness were associated with improved outcomes.

Although this was the case, notably, the less competent cluster's mean was lower than the needs met clusters', indicating that perceived therapeutic outcomes were best when all needs were met. Also, autonomy was at moderate levels in the needs unmet cluster, yet it was not associated with perceived improved outcomes. Additionally, the moderate cluster's levels of autonomy, competence, and relatedness were not significantly different from needs unmet, but had lower levels of outcomes compared to needs met. This again provides further evidence that the moderate amount of autonomy was not enough to improve outcomes and that all three needs should be targeted rather than only emphasizing autonomy over and above the other two needs (Jang, Reeve, Ryan, & Kim, 2009).

Intention to Persist

Similar to autonomous motivation, effort, and therapeutic improvement, I expected that those with all their basic psychological needs met would be more likely to persist in therapy; however, I did not find this to be the case. There are several possibilities for this. One reason could be a methodological issue. The questions about persistence pertained to whether clients were feeling like they wanted to continue in therapy and whether they would continue therapy if there was a future disruption (i.e., they got sick). Due to methodological concerns about wording these questions for those who had already finished therapy, the questions were only asked to those currently in therapy (n = 49). Since the full sample did not complete these items, there may not have been enough power to properly test this association. A second reason why a significant association was not found could have been simply that supporting the basic psychological needs did not improve client persistence. In the correlations, only autonomy was significantly associated with intention-to-persist. Thus, there seems to be some relationship between autonomy and this factor, which shows that supporting client autonomy could somewhat

positively influence the client to stay, but that this is not enough for a significant association. A third reason could be that stigma plays a part. Seeking out and engaging in help for mental health problems is often associated with personal shame and stigma (Mental Health Commission of Canada, 2018), and shame and stigma is associated with client dropout (Choi & Gonzalez, 2005). It is possible that clients may begin sessions, but then feel uncomfortable and terminate early. Additionally, a fourth reason for the nonsignificant finding could be that clients benefited from some initial sessions and subsequently did not feel the need to return for additional ones. Indeed, Simon et al., (2012) found that the 34% of clients who did not return for a second therapy session reported both the worst and *the best* therapeutic outcomes of the entire sample (including clients who completed therapy). Thus, a subgroup of clients failed to continue therapy because they reported significant benefits and felt that they did not need to attend more sessions. Similarly, Dunn, Delfabbro, & Harvey (2012) found that early learnings in therapy may "faciliat[e] increased levels of [client] confidence and reduced perception of need for therapy beyond the initial few sessions" (p. 265). Thus, factors such as stigma and improvements may more fully account for reasons as to why clients fail to continue with therapy, than autonomy, competence, and relatedness.

Therapeutic Implications

The relationship between high levels of basic psychological needs and indicators of success suggest clinicians should be working with clients to support these needs. Although therapists' skills were beyond the scope of the current study, I draw on a strong body of evidence that suggests concrete strategies clinicians can use to support the basic psychological needs.

Autonomy-informed interventions include providing rationale for activities, acknowledging the importance of the client's perspective, identifying needs, minimizing

pressure, and facilitating choice (Ryan & Deci, 2008; Silva, Marques, & Teixeira, 2014). Examples of empirically-tested interventions in classrooms have found that when teachers ask for input from students and determine if the lesson is something the student would like, outcomes improve (Reeve & Halusic, 2009). In general, teachers using autonomy-supportive interventions such as supporting choice and considering the other's perspective have students who are more likely to be interested in the lesson (Deci et al., 1991), do better in the course (Reeve, Hyungshim, Carrell, Jeon, & Barch, 2004), and have less anxiety (Black & Deci, 2000) compared to teachers who do not support autonomy. In terms of health-related behaviour change, physicians who are more considerate of their patients needs, and viewed as supportive of autonomy had patients who are less likely to be depressed (Sultan, 2013). In therapy, processes that are autonomy-supportive include acknowledging the client's perspective. This is generally accepted as a common practice in therapy, although it is emphasized more in humanistic practice (Rogers, 1957). Signed informed consent is always needed when working with clients in general (College of Alberta Psychologists, 2013). While many therapists do provide rationale for activities and facilitate choice to the client as a part of therapy, not all do, and it is not required. Therapists may argue that it could be too time-consuming to provide rationale for all interventions or that their training and assessments should speak for themselves. Some therapists may also function from a perspective where they know what is best for the client and feel rationales are unnecessary. While there may be instances in which these concerns are valid, the power of explanatory rationales to support autonomy may outweigh the concerns.

To facilitate competence, researchers point to activities such as providing clients with feedback and supporting the development of mastery that is slightly above their current abilities, but not too challenging (Ryan, Patrick, Deci, & Williams, 2008). Evidence in the classroom

shows that providing students with a task that is slightly above their current abilities leads to better outcomes (Reeve & Halusic, 2009). Doing this is similar to scaffolding, whereby teachers get a sense of the student's skills and provide activities that are slightly more advanced than their current level (Mercer & Fisher, 1992). Additionally, competence is similar to self-efficacy (Bandura, 1994; Ryan et al., 2011) and the various means of fostering self-efficacy can also help foster this need. Specifically, self-efficacy is known to occur through enactive mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states (Bandura, 1997). Enactive mastery experiences are defined as learning from the consequences of one's behaviour (Schunk, 2004). One way the therapist could foster enactive mastery experiences would be by having the client engage in an 'experiment' outside the session where he or she tries new skills. For example, if there is a who client is socially anxious, the therapist could suggest that he joins a social activity and practices social skills with others. The client would experience the natural consequences of whether he could use the skills and the outcomes. Vicarious experiences involve learning by watching or listening to someone perform a skill (Schunk, 2004). If I continue to use the example of the socially anxious client, a therapist could use the opportunity of an upcoming meeting the client must attend and have him pay attention to how people at the meeting interact and the skills others use to initiate and engage in conversations. Verbal persuasion involves others communicating faith in the individual if he or she doubts they can master a task/skill (Bandura, 1997). To apply this and foster competence, a therapist could have the socially anxious client ask for encouragement from friends or family. Additionally, the therapist could encourage the client by providing positive feedback about how the therapist believes in the client's abilities. Lastly, physiological and affective states refer to the physical bodily sensations and feelings he or she has when attempting to gain competence, as

well as other internal states, such as energy levels and fatigue (Bandura, 1997). In the case of someone who is socially anxious, he is likely to experience a stress response whereby his autonomic nervous system would create panic-like symptoms (racing heart, shortness of breath, etc.). A therapist can help the client engage in relaxation behaviours (i.e., diaphragm breathing) and positive self-talk to temper the stress response when attempting social interactions.

Relatedness may be the most common basic psychological need from a therapist's perspective given its closeness to alliance (Ryan & Deci, 2008), and therefore I borrow from this field for my recommendations. Commonly utilized methods of improving the alliance can include the therapist conveying a sense of being trustworthy, affirming, flexible, interested, warm, and experienced (Ackerman & Hilsenroth, 2003). Additionally, Luborsky, Crits-Christoph, Alexandar, Margolis, & Cohen (1983) identified that the therapeutic alliance grew when therapists helped clients feel hopeful about overcoming their problems, remarked on progress clients had made, accepted and respected them, communicated about their competence, conveyed a sense of working together, noted common experiences between the client and therapist, and was enthusiastic about the client's work. Thus, therapists can facilitate relatedness by incorporating these skills in their therapy.

Limitations and Directions for Future Research

Limitations. I highlight four limitations that should be taken into account when considering my results. First, as there are many factors influencing the process and outcomes of therapy, it is nearly impossible to account for every opportunity to meet or thwart the basic psychological needs. Thus, some factors such as the theoretical framework of the therapist were not included because it was unknown whether the participant would be knowledgeable about frameworks or even be accurate in his or her report of identifying a framework. Secondly, I did

not include pre- and post-testing of outcomes because our sample was obtained from various locations where therapists may or may have not used such procedures. Thirdly, the intention-to-persist questions were only asked of those in therapy. The results from this variable approached significance and it may have been that the power with half the sample was not strong enough to fully illustrate the association. Finally, there was unexpectedly very few findings related to well-being. The well-being measure had evidence of good reliability and validity, however, I asked about current well-being (at the time of completing the study) to determine whether there was a relationship between this and the basic psychological needs. It could be that present well-being was unrelated to well-being at the time they were in therapy, and as a result, no relationship was found.

Directions for future research. I highlight three directions researchers should focus on for future research. First, the results of this study illustrate that self-determination theory is applicable to understanding client behaviour in therapy. Future research should continue testing this theory in therapy and examining how the aspects of it, in combination of consideration with the more predominant theory of motivational interviewing, impact motivation and therapeutic outcomes. Second, now that primarily high accounts of all three basic psychological needs were found to be associated with positive outcomes compared with other combinations of needs, future research should include whether autonomy support mediates this relationship. Third, future research should continue to test a model determining how forms of controlled motivation impact therapeutic outcomes. While the factors influencing autonomous motivation and outcomes are clear, I cannot say the same about controlled motivation. Our findings that the basic psychological needs did not have to be the highest to facilitate the lowest levels of external motivation illustrate that we still do not fully understand controlled motivation. In other words,

the basic psychological needs and therapeutic outcomes should continue to be further examined to understand their relationship with this type of motivation.

Table 2.1. Sample Characteristics

Characteristic	*N*	%
Gender[a]		
Female	86	77
Male	16	14
Ethnicity[b]		
Caucasian	84	75
Asian	7	6
Indigenous	5	5
Other	7	6
Reason for therapy[c]		
Anxiety	65	58
Depression	61	55
Stress management	41	37
Relationships	32	29
Posttraumatic stress disorder	26	23
Other	21	19
Completed therapy	63	56
In therapy	49	44

[a]Percentages do not equal 100% because some participants did not provide information for this question

[c]Percentages exceed 100% because participants could endorse multiple reasons for being in therapy.

Table 2.2. Descriptive Statistics of All Measures

	Sample item	Mean	SD	Range	Alpha
Autonomy	When I am in counselling, I feel free to be who I am.	5.42	1.34	1-7	0.78
Competence	When I am in counselling, I feel like a competent person.	4.61	1.44	1-7	0.80
Relatedness	When I am in counselling, I feel close with my therapist.	4.87	1.56	1-7	0.87
Autonomous motivation	I am in therapy for the satisfaction I have when I try to achieve my personal goals in the course of therapy.	5.42	1.34	1-7	0.85
Introjected motivation	I am in therapy because I would feel guilty if I was not doing anything about my problem.	3.49	1.77	1-7	0.71
Controlled motivation	I am therapy because my friends think I should be in therapy.	2.41	1.40	1-7	0.81
Intention to persist	If you had to stop counselling for a while, (i.e., due to illness), would you resume your current sessions.	3.42	0.43	2.33-5	0.91
Effort	I strove as hard as I could to be successful in counselling.	4.88	1.35	1.25-7	0.92
Well-being	I've been dealing with problems well.	3.38	.68	1-5	0.87
Perc. Therapeutic Improvement	"Therapy has helped me address my problems" and "My overall personal wellbeing improved because of therapy.	3.58	.98	1-5	0.87

Table 2.3. Correlations of Measures

	Autonomy	Competence	Relatedness	Autonomous Motivation	Introjected motivation	External motivation	Intention-to-persist	Effort	Well-being	Therapeutic Improvement
Autonomy	1	0.56**	0.63**	0.41**	-0.17	-0.24*	0.32*	0.37**	0.28**	0.55**
Competence		1	0.58**	0.40**	-0.29**	-0.26**	0.04	0.39**	0.33**	0.54**
Relatedness			1	0.42**	-0.20*	-0.24*	0.26	0.37**	0.17	0.61**
Autonomous motivation				1	-0.08	-0.20*	0.25	0.54**	0.22*	0.61**
Introjected motivation					1	0.24*	0.16	0.00	-.38**	-0.23*
External motivation						1	0.04	-0.27**	-0.19*	-0.23*
Intention-to-persist							1	0.29*	0.00	0.26
Effort								1	0.26**	0.61**
Well-being									1	0.41**
Perc. Ther. Improvement										1

Table 2.4. Cluster Centroids

Basic Needs	Cluster 1: All needs unmet	Cluster 2: All needs moderately met	Cluster 3: Competence need unmet	Cluster 4: All needs met
Autonomy	3.77	4.13	5.73	6.53
Competence	2.49	4.33	4.12	5.98
Relatedness	2.07	4.10	5.29	6.02
n	15	23	34	40

Table 2.5. Analysis of Variance: Main Effects for Clusters on All Outcomes

	df	Cluster		
Dependent variable		*M*	*F*	*p*
Motivation Type				
Internal	3	18.00	8.79	.00
Introjected	3	7.80	2.60	.06
External	3	5.71	3.12	.03
Indicators of Success				
Persistence	3	.12	0.64	.59
Effort	3	11.12	7.10	.00
Well-being	3	2.03	4.89	.00
Perc. Ther. Improvement	3	11.84	17.92	.00

Table 2.6. Means for Each Cluster and Significant Pairwise Comparisons

Cluster means and standard error													Pairwise comparison					
Variables	Cluster 1			Cluster 2			Cluster 3			Cluster 4								
	n	*M*	*SE*	*n*	*M*	*SE*	*n*	*M*	*SE*	*n*	*M*	*SE*	1 v 2	1 v 3	1 v 4	2 v 3	2 v 4	3 v 4
Aut mot.	15	3.33	.42	23	3.60	0.27	34	3.73	0.24	40	5.03	0.23			1.70		1.43	1.30
Ext mot.	15	3.30	0.50	23	2.55	0.28	34	2.06	0.16	40	2.29	0.22		1.24				
Effort	15	4.40	0.41	23	4.22	0.24	34	4.71	0.21	40	5.57	0.19			1.17		1.35	0.86
Wellbeing	15	3.26	0.18	23	3.07	0.17	34	3.29	0.10	40	3.67	0.09					0.60	
Ther imp	15	2.57	0.29	23	3.10	0.16	34	3.65	0.13	40	4.18	0.12		-1.08	1.70		1.43	1.30

Figure 2.1. Conceptual Model Guiding the Research

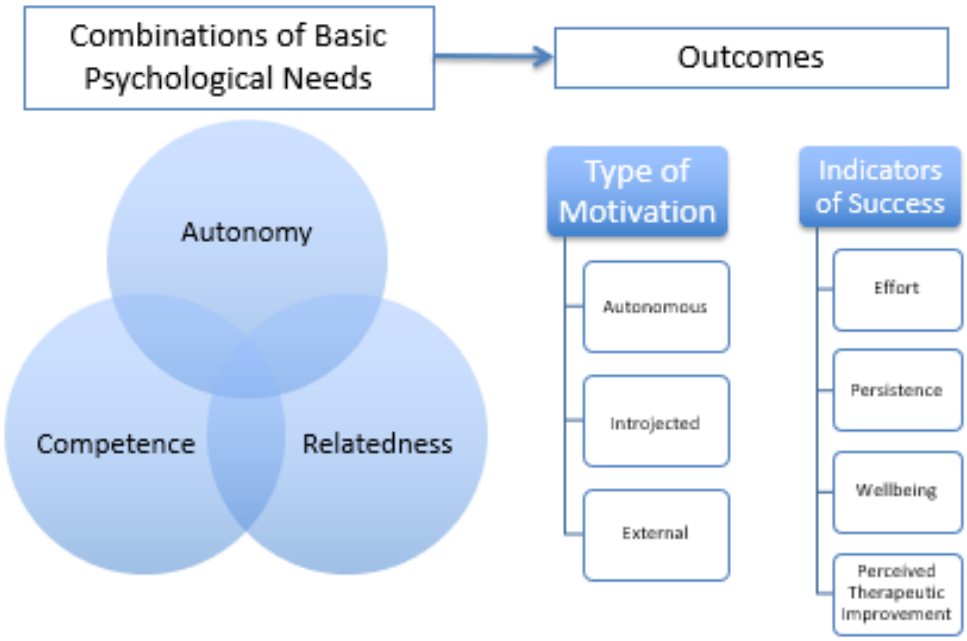


Figure 2.2. Dendogram

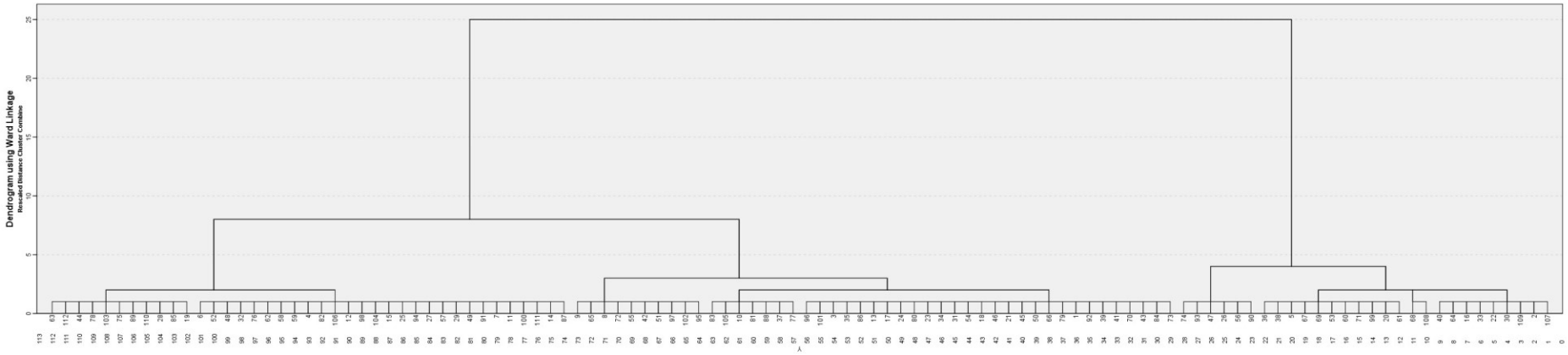
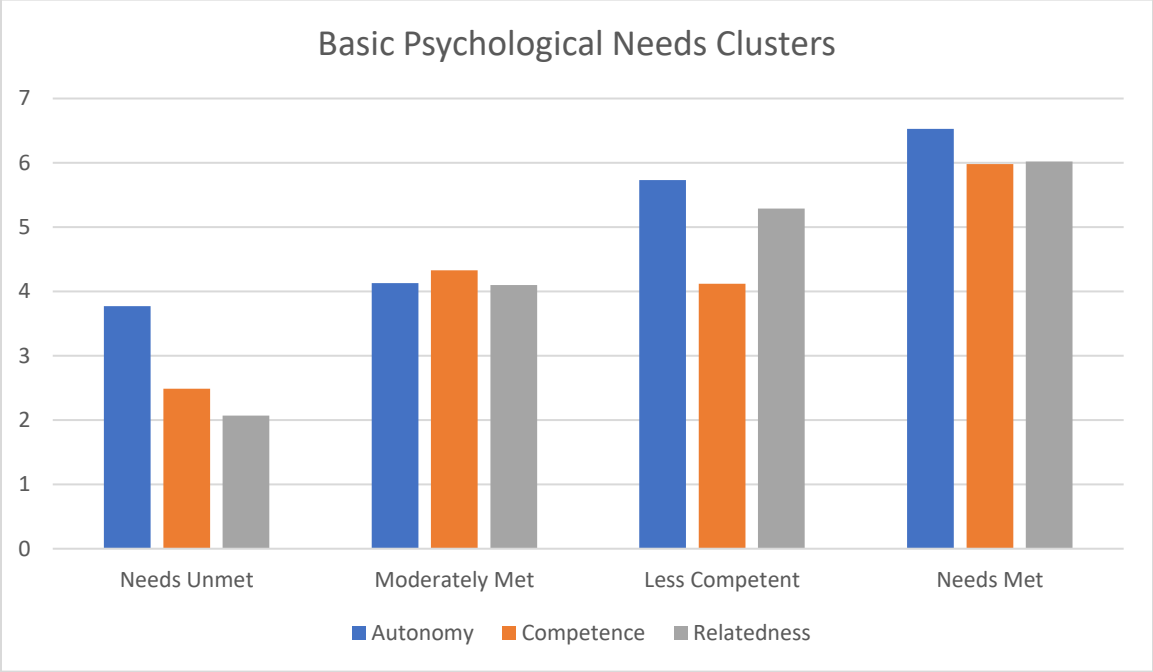


Figure 2.3. Basic Psychological Needs Clusters



CHAPTER THREE: UNMOTIVATED CLIENTS' EXPERIENCES OF MOTIVATION IN THERAPY: A QUALITATIVE STUDY

Introduction

Just because clients book their first counselling appointment does not necessarily mean they will remain in therapy until their goals are met. Unfortunately, many clients frequently discontinue therapy prior to achieving their objectives (Swift & Greenberg, 2012). Researchers suggest that the number of individuals who drop out of therapy varies from 20-60% (Oruche, Downs, Holloway, Draucker, & Aalsm, 2014; Swift & Greenberg, 2012). Regardless of the precise number, client dropout is a problem because these individuals are at risk of poorer mental health outcomes than those who complete therapy (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). Although there are many factors that support an individual's ability to persist in therapy, one that may be underrepresented is the client's motivation.

Current Theories of Motivation

Individuals are motivated for many different reasons: some by external rewards such as praise (Covington, 2000), performance or mastery goals (Rolland, 2012), personal expectancies (Pintrich, 2003), or interest (Naceur & Schiefele, 2005). When studied empirically in therapy, researchers look for evidence of motivation in several ways. For example, motivation has been operationalized as whether or not people persist or drop out of therapy (Swift & Greenberg, 2014), the extent to which they adhere to their treatment recommendations (Gibson, Brand, Burt, Boden, & Benson, 2013), and their intentions to continue therapy (Deci, Vallerand, Pelletier, & Ryan, 1991). Although these are potential indicators of motivation, they do little to either describe the quality of client motivation or to suggest how therapists can support it. To gain this sort of information, qualitative research with clients themselves is needed. Thus, the purpose of

this study was to explore clients' experiences of motivation in therapy in order to understand what they perceive as supporting or impeding their motivation.

Supporting Client Motivation

Stereotypically a motivated client might be described as someone who is exerting effort, processing problems, and perhaps even enjoying the personal development – all desirable outcomes. In attempts to bring about desirable outcomes such as persistence and treatment adherence, therapists seek to maximize client motivation. One of the most common strategies therapists use to do so is motivational interviewing. The fundamental processes of motivational interviewing have shifted throughout time; however, Miller and Rollnick (2013) outline that it is based on four main processes which include (a) forming a therapeutic relationship using empathy, (b) tolerating uncertainty, (c) using change talk to bring about different behaviour, and (d) a plan to move from talking to action. In addition to these processes, motivational interviewing is guided by promotion of client efficacy (Miller & Rollnick, 2002). Interventions using this theory have been successful in helping clients achieve goals related to alcohol abuse (Killeen, Caasin, & Geller, 2014), smoking cessation (Karatay, Kublay, & Emiroğlu, 2010), and diabetes (West, DiLillo, Bursac, Gore, & Greene, 2007). For instance, in a randomized clinical control trial of women with type II diabetes, researchers compared weight loss among women who had five sessions of motivational interviewing with a control group who did not. They found that the treatment group lost more weight, suggesting motivational interviewing was successful. Although it is commonly used, it is criticized for lacking a theoretical base and oversimplifying behavioural change (Armitage, 2009; Teixeira, Palmeira, & Vansteenkiste, 2012). Moreover, it does very little to help describe the client experience of motivation.

Self-determination theory (Ryan & Deci, 2000) overcomes the theoretical shortcomings of motivational interviewing and provides a framework to understand different types of motivation. It describes a continuum of motivation ranging from completely extrinsic, with the reasons for behaviour resting outside the self, to intrinsic, with the reasons for behaviour originating from within the self. Intrinsic motivation tends to result in better outcomes than other, more external, forms of motivation. For example, intrinsic motivation is associated with good outcomes in academic settings (Ratelle, Guay, Vallerand, Larose, & Senécal, 2007), physical activity (Ryan, Frederick, Lepes, Rubio, & Sheldon, 1997), wellbeing and therapeutic improvement (Buhr & Daniels, 2018a), and other health behaviours such as eating and weight loss (Teixeira, Carraca, Markland, Silva, & Ryan, 2012).

Moreover, according to self-determination theory intrinsic motivation is maximized when people feel that their basic psychological needs of autonomy, competence, and relatedness are met (Ryan & Deci, 2000). Thus, just as with motivational interviewing, self-determination theory offers ways for therapists to increase client motivation – in its case focusing specifically on intrinsic motivation brought about by three basic psychological needs. Autonomy refers to a self-determined action, such as when an individual makes their own decision about him or herself; competence is when individuals perceive themselves to have the ability to perform a certain action; and relatedness refers to the connection with others. When therapists support their clients' basic psychological needs, a host of adaptive outcomes have been found, including less depressive symptoms (Zuroff, Koestner, & Moskowitz, 2012), more self-compassion and support (Carter & Kelly, 2014), and improvement in general mental health and autonomous motivation (Buhr & Daniels, 2018a).

Despite the commonness of motivational interviewing and richness of self-determination theory, both literatures have relied largely on quantitative designs, thereby failing to produce a rich picture of clients' lived experiences of motivation in therapy. Additionally, there are no qualitative studies examining clients with low basic needs in therapy. Thus, the purpose of the current research was to add depth to the current broad perspectives of client motivation. My research question was: "What is the experience of motivation in clients with low basic psychological needs?"

Clients' Perspectives on Motivation

Qualitative methods include interviews and focus groups, which allow participants to provide in-depth explanations (Roshan & Deeptee, 2009) and lengthier responses to questions. This can lead to participants identifying novel factors not yet included or tested within a theory (Pope & Mays, 1995). These qualities also help researchers attain greater understanding of complex issues, such as motivation. However, qualitative studies are shockingly underrepresented in the literature. There are eight qualitative studies on client motivation in therapy between 1987-2018. From these studies, I extracted four common findings related to clients' descriptions of motivation.

First, across studies participants described that experiencing positive outcomes such as reduced substance abuse, employment, or even self-awareness increased their motivation in therapy. Specifically, Francis and Abel (2014) showed that individuals with alcohol abuse problems were more motivated if they stopped or even just reduced the number of times they drank. Participants also felt more motivated when they became employed or began attending school (Francis & Abel, 2014). Positive outcomes, however, did not always have to be tangible. For instance, participants who learned more about themselves, their anxiety, or reasons for their

anxiety felt more motivated (Marcus, Westra, Angus, & Kertes, 2011). This increased awareness of themselves and the nature of their problem helped them engage in therapy more and work harder towards obtaining their goals.

Second, participants described ways in which relationships increased their motivation (Dunn, Delfabbro, & Harvey, 2012; Hughes & Rasmussen, 2010; Priebe, Watts, Chase, & Matanov, 2005). They broadly defined relationships to include not only therapists but also their family and friends. Having relationships with individuals who were supportive and warm, active listeners, and caring increased their motivation (Priebe, Watts, Chase, & Matanov, 2005). For instance, in Dunn and colleagues' (2012) study, participants explained that relationships were helpful because they contributed to developing an awareness about the gambling problem and provided the social support to stop. Participants were also more motivated when they felt autonomous in their relationships. For instance, Priebe et al., (2005) studied participants who had already withdrawn from treatment and were not open to engaging with service providers. They were more likely to engage if their service providers allowed them to make important decisions.

Third, participants felt more motivated when they had a personal desire to improve and felt confident that they could change. For instance, as part of an opioid substitution trial, those who were attempting to break an addiction reported being more motivated when they shifted from ambivalence to desiring change (Ayres et al., 2014). These participants were randomized into a treatment condition where they received either a same-day prescription for opioid substitution, or a control condition where they were told how to contact a physician for a prescription at a later date. Individuals who felt ambivalent about breaking their addiction even upon enrolment in the study, began to feel a desire to improve as they were recruited and completed self-evaluation questionnaires. In addition to this, individuals also reported that their

motivation increased when they felt more confident (Hughes & Rasmussen, 2010). Those who received a motivational interviewing intervention for domestic violence were more motivated to change because they felt better about themselves and had more confidence. Participants also felt more motivated when *others* had confidence that they would change. For instance, when those with a substance abuse problem engaged in therapy, and later reported that their friends and/or therapist also had confidence they could change, the participant themselves reported feeling more engaged in the change process (Francis & Abel, 2014). Thus, both perceived confidence in themselves and from others improved their motivation for therapy.

Lastly, clients described several factors that impeded their motivation. Among those who had dropped out of gambling treatment, participants stated that they were less motivated when logistical problems interfered, including moving away from the therapist's office and family responsibilities (Dunn et al., 2012). They found that high costs of treatment interfered with their motivation (Francis & Abel, 2014). Additionally, they felt a decrease in motivation if they did not engage in homework between sessions. Researchers suggested that in these instances where clients do not completed homework, motivation may be compromised because participants "feel that they are letting their therapist down if they do not comply with difficult tasks or if they relapse during therapy and prefer to withdraw from treatment, as this seems preferable to disclosing 'failure' to a therapist" (Dunn et al., 2012, p. 267). In other words, not completing homework may have been related to a perception they would disappoint the therapist, thus reducing motivation. Lastly, some participants felt shame and stigma by seeking help, which made it difficult to stay motivated for treatment (Dunn et al., 2012).

Limitations and the Current Study

The existing qualitative research on client motivation has three limitations, all of which are related to prioritizing research on a specific mental health problem rather than on client motivation specifically. First, researchers have focused on specific problems including addictive behaviours (Dunn et al., 2012; Ayers et al., 2014; Francis & Abel, 2014), psychosis (Preibe et al., 2005), or domestic violence (Hughes & Rasmussen, 2010). While it is important to understand these issues, clients battle motivation while managing many other mental health problems that are arguably more common. For instance, approximately 3.5 million Canadians accessed mental health services because of a mood or anxiety disorder each year (Statistics Canada, 2016), and yet there is little research of motivation on this large group. Second, the existing studies often include clients dealing with therapy related to medication (Priebe et al., 2005; Ayers et al., 2014) rather than psycho-social interventions, even though the latter is more common (National Counselling Society, 2018). To improve these two limitations, I undertook an in-depth exploration of client motivation across a range of common disorders treated in one-on-one therapy; thereby, increasing the applicability of the results.

Third, the existing studies tend to focus on all participants regardless of their motivation or assume that clients who dropped out did so because of low motivation without actually measuring motivation. Keeping with our prioritization of motivation, I was interested in understanding clients who previously scored low on measures of motivation. In other words, my sample consisted of clients who had reported not feeling that their basic psychological needs of relatedness, competence, and autonomy were met in therapy, and yet attended for some duration of time nonetheless. This is counterintuitive to self-determination theory and the group provides a unique window into client motivation.

Researcher as Instrument

Prior to undertaking any analyses, I sought to identify and make explicit my beliefs and biases (Pietkiewicz & Smith, 2014). The first author is a registered psychologist completing her PhD in Counselling Psychology and her supervisor is an Associate Professor of Educational Psychology and motivation researcher. As the first author, I conducted all interviews and was responsible for the original analyses. Thus, prior to undertaking the analyses I wrote a bracketing statement that reflected my assumptions including that (a) clients are motivated to participate in therapy, (b) therapy helps clients achieve their goals, and (c) therapists can influence their clients' motivation. I shared this bracketing statement with my supervisor and over time it evolved to include an additional assumption, namely, that the results would converge with self-determination theory – an assumption shared by the second author – and one both of us actively worked against as I undertook the original analyses, but then returned to for the purposes of discussion.

Method

Research Design and Participants

The purpose of this study was to understand client experiences of motivation among those whose basic psychological needs were not being met in therapy. I used a constructivist lens with the aim of capturing in-depth information about client's experiences of motivation. Constructivism is based on the premise that meaning is created through the interpretation of people's experiences (Creswell & Plano Clark, 2011). I sought the participants' experiences of motivation to gather their subjective view, and used thematic analysis to generate results (Aronson, 1995).

I interviewed six participants for this study and used pseudonyms to protect their identity. The participants ranged in age from 23-34 years (M = 28, SD = 4.5). They identified varied reasons for attending therapy such as stress, anxiety, depression, eating disorders, bipolar disorder, workplace stress, and relationship problems. They attended counselling at a private practice, at a university/college setting, or at a hospital and had attended anywhere from 2 to 72 or more sessions (M = 22; SD = 33.4). The exact range of sessions was impossible to determine because two participants had been in counselling on and off throughout their lives and could not give an accurate number as to the number of sessions they attended. Four participants discontinued therapy without having their issues resolved, whereas one participant discontinued after meeting her goals, and one participant was engaging in ongoing therapy at the time of the interview. See Table 3.1 for additional participant information.

Recruitment & Procedure

The individuals in this study were purposefully sampled from a larger quantitative study in which they scored low to moderate levels on measures of basic psychological needs in therapy (La Guardia, Ryan, Couchman, & Deci, 2000) and had consented for follow-up. I used a random number generator to decide the order in which to contact individuals, and asked him or her if they wanted to be interviewed. If they declined, I contacted the next person.

Each participant completed an in-person interview that lasted approximately 60 minutes. All interviews were conducted by the first author and took place at a university clinic. The interviews were audio-recorded and transcribed verbatim. The interviewer followed a semi-structured format with open-ended questions designed to gain an understanding of the participant's experience of motivation in therapy. See the Appendix B for the interview questions.

Rationale for Analyses

I analyzed participants' responses using an inductive thematic analysis to identify subthemes and themes (Vaismoradi, Turunen, & Bondas, 2013), which had three steps: immersion, main analyses, and enhancing rigour. First, I engaged in immersion because it assists the researcher in seeing the data as a whole and obtaining a clearer sense of the interviews (Polit & Beck, 2004). I listened to the interviews while reading the transcripts several times until I was immersed in the data. Second, my main analyses followed the procedure outlined by Aronson (1995) in which I identified patterns in the interviews through open-coding, elaborating on patterns, creating sub-themes, creating themes, and then providing rationale for themes. I did this by looking within individual transcripts and then across transcripts during the analysis. I first put the participants' similar experiences together to create subthemes. I next placed related subthemes together to develop larger themes. The themes represented the broad expression of the participants' experiences and captured the smaller details of the subthemes. Throughout the analysis, I kept a journal, consulted with a research team, and returned to my bracketing statement. Third, I used member checks and inter-rater reliability to enhance the rigour and build confidence in the results. Rigour refers to the demonstration that the researcher has not created findings in a qualitative study that reflect their own biases by using several strategies to allow for replication and confirmation of the results (Pope & Mays, 1995). For member checks, I sent the themes from their interviews to the participants and then sought their feedback. For inter-rater reliability I conducted two separate rounds of matching with members of my research lab until an acceptable level was reached.

Results

Data Transparency and Rigour

My initial analyses resulted in six themes which described elements that supported or impeded clients' motivation. The results were subjected to an inter-rater check (de Witt & Ploeg, 2005) to ensure consistency of our coding. I asked two members of the research team to match two to four quotes from the interviews to the themes. One team member matched 92% of the quotes to the themes correctly but the other matched only 73% of the quotes to themes correctly. Because we do not consider 73% of a match as adequate inter-rater reliability, we undertook a conversation to identify the mis-matches. Two themes appeared to be the source of confusion and after discussion I decided to combine the two overlapping themes and related codes. Once the results were adjusted to five themes, I undertook another reliability check with a third team independent researcher. This rater correctly matched 99% of the quotes. I sent these final five themes to all six participants who unanimously agreed the themes reflected the main points of their interviews. One participant requested a minor change, which was incorporated into the feedback; however, this change did not alter the results in any significant way (see Table 3.2 for an overview of the themes, which are then expanded on individually).

Voice

I classified statements that dealt with participants' perceptions of who controlled the direction of therapy under the theme of "Voice." One of the participants, Sean, identified the problems he encountered after feeling the therapist's voice dominated his sessions.

> Sean: "It seemed like [the therapist] was pretty set on that I needed to immediately jump into some prescription medication, and that really was like, 'wow, I spoke to you for an hour when I was extremely distressed, and now I'm talking to you again.' The person doesn't really know me… it seemed pretty instantaneous…it freaked me out."

Although Sean could understand the therapist's concern for his well-being, he felt medication was such a big decision and that he wanted the therapist to know him better before deciding if medication would be right for him. Thus, when the therapist did not consider Sean's voice his motivation was reduced to the point that he no longer continued in therapy. Other participants also similarly explained that their motivation for therapy decreased when they felt the therapist was not considering their voice. For instance, although Eva had experienced some success in therapy, she ultimately discontinued counselling and has never returned because she felt like her voice was not taken into account:

> Eva: My mom came in one day for the appointment…I just felt like I was saying all of these things that bothered me to my mom and she pretty much denied them and then my psychiatrist looked at me and said, "she's really nice I don't know what's wrong with you." And that's when I left.

In contrast, motivation seemed to be enhanced when the direction of therapy was described as a mix between the voice of the participant and therapist. One participant, Abigail, described how the therapist listened to her goal and collaboratively brought in strategies to help. She felt her therapist took her opinion seriously and let her needs direct aspects of the sessions. Similarly Faith explained the collaborative process as such:

> Faith: "I think that therapy is a really collaborative process. Like there is an equal influence from both people. So in that sense I have at least a 50/50 influence on shaping the process"

When asked to explain the reason it felt collaborative, she elaborated:

> Faith: "When something comes up [the therapist] ask questions. A lot of the time [it] is me…answering her questions rather than just listening to her talk about stuff…I am not usually the one who sets goals. I think as far as goals and strategies, that is something that I am looking for from the therapist...yeah I don't think the goals really come from me, which is okay."

Efficacy Beliefs

Participants' beliefs in their ability to be successful in counselling and about the effectiveness of therapy in general were important for their motivation. When efficacy beliefs in self or process were low, motivation was impeded and when they were high, motivation was enhanced. In some cases, participants like Faith focused on belief in their own abilities.

> Faith: "I was really skeptical of my own ability, I think to put into words what I was feeling, and so a lot of the time when I was first at the very beginning [of therapy] I would like write down notes and I would spend time before a session writing things out because I wanted to make sure that what I said was accurate, and was true to myself, and over time, I got past that…I talked about how I was feeling nervous about not being able to say things properly…then I guess I got more comfortable and more familiar with therapy as a whole and conversations would just take their own form and eventually I didn't feel like I needed them."

In other cases, participants described their beliefs about the therapeutic process itself. Faith and Tracy had low efficacy beliefs about the therapeutic process and discussed not knowing if it was something that could help them. For example, Faith shared:

> Faith: "…I wasn't really sure about [therapy] and it felt like a big process and I knew I was having some feelings and I was trying to get through it myself, but I never really felt like therapy was something that was for me or that I needed it…it was this feeling that my problems weren't bad enough to warrant going to therapy. So I felt kind of weird about doing that. Like it wasn't something that I ever was like, 'oh I wish I could do this.' It wasn't something like, 'why don't you try this to solve your problems?"

Sean and Tanya both engaged in therapy because they felt it would help them but then found the process ineffective. Despite this, Tanya shared she was contemplating going back to therapy with a different therapist because she felt confident the process could help her.

Therapist's Abilities

Participants shared that confidence in the therapist's abilities was important for their own motivation. When the therapist's abilities resulted in positive change, clients' motivation increased, but if they did not bring about desirable change, clients' motivation decreased. For

instance, Tanya and Eva felt uncertain about the direction of therapy, but continued to engage in the sessions because of the therapist's expertise:

> Tanya: "Well, I think that partially, [I'm] trying to rely on the [the therapist's] professional expertise and maybe she has some kind of long-range vision that I'm not seeing here…"
>
> Eva: "…that's why I thought to myself, 'I've got to go back to the therapist. Maybe they know something that I don't know, obviously."

In addition to general expertise, many participants stated that receiving the therapist's techniques and tools motivated them. For example:

> Abigail: "[S]o I went in basically for tools or, I call tools, like strategies or approaches… I kind of felt like…I want some new things, if they exist because, you know, you get very in your head and then you forget that, oh you might be able to do something completely different."

Abigail identified that she had been going primarily to get the therapist's suggestions. Other participants such as Tracy echoed this, as she identified her therapist taught her a specific strategy that was very helpful.

However, when the strategies were ineffective clients' motivation would decrease. For instance, although Tanya continued with sessions, she described how her motivation faltered because the suggestions were not effective for her.

> Tanya: "it was kind of unpredictable whether a session would feel helpful to me or not, so beforehand, being like, "is it worth it for me to haul out and go to this and take all this time when it's not necessarily going to feel that helpful?"

Others shared a similar sentiment, explaining they would try suggestions, and if their problems were not addressed, they became less engaged, some disengaging completely. This was the case for Abigail, as she was no longer motivated to engage in therapy when she found out that the tools did not help.

> Researcher: "And then the conclusion of your therapy had been…did you feel like you reached that goal?"

> Abigail: "No, but that was okay…I felt like I went to some guy who…gave me a few different things and I got him to explain his rationale behind those things, so it was kind of like, 'okay I tried that, good, we're done."

It is important to distinguish that although participants described instances in which they did not try the strategies because they did not like them, only strategies they tried but found ineffective seemed to decrease client motivation.

Clients view their therapists' abilities as consisting of more than just their 'clinical skills.' For example, the therapist's interpersonal skills were also viewed as part of their overall ability. This included skills such as being empathetic, non-judgemental, likeable, directive, professional, compassionate, and a good listener.

> Faith: **"**I think there's some different language…I've talked to therapists for a long time, and I feel that there's a certain way of talking that's, it's quite kind."

Likewise, participants also commonly shared that their motivation increased when the therapist facilitated space for them to work through their issues. Space refers to the therapist being open and taking the time to process issues the client felt were important. Tanya brought up this topic.

> Tanya: "I think in that instance [my therapist] gave me the space to just talk about the things that I had not really verbalized a lot before, and it was super-helpful just to create space and take that time to unpack the things I was worried about."

This sentiment was echoed by Faith:

> Faith: "So just having a safe place to talk openly and not having to worry about the kind of consequences that you have to when you are talking to people that are in your life…"

Comments referring to the time a therapist took to get to know the client, explore issues, and work through problems also constituted giving space. For example,

> Eva: …[therapy became] more like just tell me…she was just like, 'I want to know,' it kind of felt like she just wanted to know what I was going through. I wanted them to, maybe it was to get it off of my chest and I don't know if that was it. But it was just to say, 'this is happening and I don't know why I can't stop [the disorder] anymore. I don't know why it's just so hard for me to just stop.' I just wanted to tell them and I wanted to show them…"

Conversely, Sean did not feel like his therapist gave him enough space. For him, not having the space caused him to feel less motivated in therapy and seek conversations with friends:

> Sean: "…You're sorta a different person when you're in school, and sorta a different person when you're at work, and a different person at a family event. So I kinda knew that I was sorta a different person at that time [in school]. Who I am in school, that isn't who I've been for the x number of years, because your personality is going to shift and do different things...So how I would have handled stuff [while working], I'm trying to learn a new piece of my personality while I'm at school...And I wasn't quite sure that that part of me needed to go on antidepressants or any type of medication. I was experiencing a lot of new aspects about myself for the first time. And all of a sudden I have this counsellor that's like, "you need to go on medication." I'm like, 'wow hold on here. I'm only a few months into this, you know what I mean?'...There were still a lot of moving pieces in my life that I hadn't had the chance to really fully investigate…"

Participants continually referred to these aspects of listening in order to help them participate fully. It was clear participants valued the therapists' abilities and found that this improved their motivation. Clients who perceived their therapists as not having these skills reported that it negatively impacted their motivation.

Relationships with Others

Finally, participants described how their relationships with people outside of therapy influenced their motivation in either adaptive or maladaptive ways. Relationships with other people were important, not necessarily because participants wanted to talk and share with them, but because they often came alongside and increased their motivation throughout therapy. Tracy, Faith, and Eva, all had others support them to go to therapy.

> Tracy: "I'll tell my aunt I'm going to therapy and it's no big deal and she'll check up on me every once in a while…it's good to have support…"

Relationships were also important to Sean, but in his case, he was using his relationships outside of therapy to supplement what he was not getting in therapy. In his case, he had many people in his life who he could talk with, so when he found therapy unhelpful, he turned to his friends:

> Sean: "Of course the close people in my life, they're pretty supportive, they were like, 'hey if you need to go talk to this counsellor, then you go do that. But if there's something else that you need to go do, figure out whatever that is.'"

Additionally, the participants identified the quality of relationships with others in their life as important for how much they engaged in therapy. Qualities included interpersonal skills such as being warm, kind, and providing a safe space where they could talk. Tracy, in particular, spoke at great length that how the attitudes of people in her life affected her, as she found most people in her family would judge her and had stigma towards mental illness. These attitudes simultaneously kept her from therapy while also propelling her towards it:

> Tracy: "…I didn't want to tell anybody about anything that was going on and if I was [in area by counselling centre] and I saw somebody I knew, I just cancelled my appointment like that."

Lastly, some discussed how comparisons with others was important. Comparisons affected Eva's motivation, as when asked about motivating factors that propelled her, she said she engaged because:

> Eva: "I got pissed off at seeing everyone having a normal life…I have a really good friend…and I just remember I thought 'wow she is so confident'…she doesn't think about stupid crap like I do, you know she's moving forward and doing all these great things and so are all of my other friends. I felt like I was just stuck in a bathroom and no one ever knew about it because I was too afraid to tell anyone I went back to it."

Triggered by a Low Point

I defined "Triggered by a Low Point" as when a participant's problem was bothering him or her so much and they did not know how to get better. Some reported that the low points interfered with their ability to function, such as go to school, work, or engage with friends. For example, one participant described that her eating disorder affected her life:

> Eva: "and then at a certain point it [my disorder] got so bad I couldn't study…because I was hungry, but I was too afraid to eat…and [I] was just sitting…every minute of my day thinking about how I was going to feed myself and how was I going to get rid of it [the food] and then how I was going to feed myself again and it just became this cycle. And I

> just, I just couldn't do it anymore. Mentally and emotionally I remember it was just draining me so badly, like I had come to that point where I just didn't want to go to school anymore, I didn't want to wake up anymore… and then I thought there is no way that I can live like this forever….That's when I decided, "okay I'm going to have to crawl back [to therapy]".

The problems also resulted in intense, negative feelings that spurred participants into therapy. They described that the intense emotions exhausted them and forced them to admit the feelings were so severe that they sought help. For instance, Tracy discussed how she could handle the sadness on her own, but that she recognized the sadness was not healthy and that she should go to therapy to change it.

> Tracy: "…but once I got older I realize that I do need to change my ways or my actions or my feelings…I think I was just trying to figure out that the way I'm living isn't the way I should be living…I don't know if that makes sense, but being depressed all the time is not how it should be living even though I'm used to it, I shouldn't have to have it."

Lastly, these low points were compounded by feelings of isolation and participants' realizations that they were unable to handle it on their own. Many participants shared that they reached a tipping point. It was at those times that they were motivated to pursue therapy. For example,

> Faith: "I ended up withdrawing a lot from people and I don't really talk to my parents about things and I still haven't and so having someone that I can talk to openly and regularly has really made a big difference...outside my [one] friend, I don't really talk about anything at all. So very quickly I was starting to feel really stressed out."

Overall, most participants felt extreme stress, confusion, dysfunction, or an inability to manage the problem that compelled them to seek help through therapy. They attributed confusion or extremely negative emotions as the main reasons they continued to book sessions.

Discussion and Implications

The purpose of my study was to understand client experiences of motivation in one-on-one therapy. I conducted qualitative research with participants who had experienced low motivation in therapy. Based on the results from thematic analysis, I highlight three key points.

First, the themes of client voice, issues related to efficacy, and relationships are analogous to self-determination theory, as well as some aspects of motivational interviewing. Second, the theme of clients being motivated by a low point in their lives has not been included in these motivational theories, but should be considered in our understanding of motivation in therapy. Third, I discuss study limitations and directions for future research.

Themes Consistent with Motivation Theory

Participants reported that having their voice heard, beliefs pertaining to themselves, therapy, and their therapist, and as well, supportive relationships with others impacted their motivation. These three themes were all consistent with motivational theories' concepts of factors that support motivation.

Client voice as autonomy. The participants reported a need for therapists to incorporate their opinions into therapy, which is not only consistent with a few of the qualitative studies (Priebe et al., 2005; Ayers et al., 2014), but also with self-determination theory's concept of autonomy. It has been illustrated time and time again that autonomy is a key ingredient of autonomous motivation in classrooms (Reeve, 2006) and other achievement contexts. In therapy, Zuroff et al., (2007)'s quantitative study utilizing self-determination theory as a framework revealed that clients reporting more autonomy also experienced more autonomous motivation and were less depressed after the intervention. Drawing on the roots of one's sense of self, Ryan & Deci (2017) suggest that a person expresses him or herself through volition and self-determined action. Thus, autonomous acts are central because they "allow us to reflect on, organize, and prioritize our inclinations, aversions, and values" (Ryan & Deci, 2017, p. 54). Given that therapy has direct implications for how a client behaves in his or her life, a therapist providing an environment that supports client autonomy would be very important. It would also

mean a client is more likely to engage in therapy and subsequent behaviour change. Motivational interviewing also involves supporting client autonomy (Miller & Rollnick, 2013); however, the founders describe that autonomy is promoted using a "directive method" (Miller & Rollnick, 2002, p. 25). They define such a method as reducing client resistance using other parts of their theory such as developing discrepancies and change talk to encourage the client to proceed in the direction of change (Miller & Rollnick, 2002). My results illustrate that client autonomy is more about the client's direction, needs, and even who they are as people. Thus, my findings are more consistent with a notion of autonomy as outlined by self-determination theory rather than motivational interviewing. When clients felt their own voice was respected their motivation was increased and when their voice was disregarded their motivation was tested.

Therapists can support client autonomy by acknowledging perspectives, using non-controlling language, identifying client values and interests, and providing rationales (Ryan, Patrick, Deci, & Williams, 2008). Acknowledging client perspectives and using non-controlling language are some of the most fundamental skills of basic counselling skills (Gladding & Alderson, 2012). Paraphrasing and reflecting back content allows the client to feel heard. Non-controlling language refers to speaking in a manner that does not pressure someone to comply with another's agenda, but helps them identify their own inner resources (Reeve, 2006). Providing rationale for therapy is not always a focus of intervention. While therapists are encouraged to be collaborative, textbooks do not state that therapists should explain why they are working they way they are (McLeod & McLeod, 2011). While it may not always be realistic or needed to outline the reason behind all theories and interventions a therapist applies, the strategic application of rationales, such as when a client may doubt the effectiveness of a certain practice could bolster autonomy.

Competence: In the client and of the therapist. The role of competence in supporting clients' motivation was three-faceted. Clients described needing to believe in their own skills, the general process of therapy, and in the abilities of (a competent) therapist. Clients' beliefs in themselves is consistent with self-determination theory (Ryan & Deci, 2000) and with the qualitative research on the topic (Ayers et al., 2014; Dunn et al., 2012; Hughes & Ramussen, 2010). Specifically related to self-determination theory, our findings were analogous to its concept of competence, which refers to belief in one's ability to achieve success (Deci & Moller, 2005). Competence is often overlooked in self-determination theory research, with autonomy and autonomy-support attracting more interest. However, in one study that did focus on competence, Williams et al., (2006) used a quantitative methodology and found that clients who perceived themselves to be competent engaged in smoking cessation behaviour while in treatment. Our findings expand on this behavioural outcome to show that competence beliefs impacted motivation. This finding is also consistent with motivational interviewing, which posits that practitioners should work to increase client competence in their ability to change (Miller & Rollnick, 2002).

In addition to beliefs about one's own competence, beliefs about the effectiveness of therapy in general impacted their motivation. In other words, those who believed therapy could help reported being more motivated. This is consistent with Lucas (2012), who found that clients who completed therapy were more likely to believe in its effectiveness than those who prematurely dropped out.

Therapists can support client competence by providing structure and feedback, as well as tasks that are slightly more difficult than the client's current level of knowledge (Ryan et al., 2008). Structure can be facilitated by discussing client goals and ensuring targets are identified

so the client is working towards something. Feedback can be facilitated by taking time out of a session to discuss the client's work and provide information about progress. Providing slightly more difficult tasks is similar to a concept called scaffolding, whereby a task is somewhat more advanced than the individual's current skill level, but not so difficult that they have great difficulty in attaining it (Mercer & Fisher, 1992).

Our results highlight though that belief in self and process must be paired with a competent therapist. In this vein, participants described competent therapists as possessing certain knowledge, allowing for space, using effective strategies, and using certain interpersonal skills. In other words, participants were looking for services that would help them with their problem and subsequently allow them to get better. This finding that the therapy needs to produce some sort of change reinforces the need for standards and quality training programs where therapists can learn how to effectively and efficiently help clients. The subtheme of interpersonal communication is something that is regularly taught in courses on basic therapeutic skills (Gladding & Alderson, 2012). My finding that clients are more motivated when the therapist allows for space to work through problem and provides strategies points to the importance of knowing one (or more) theoretical orientation to help clients. Different orientations provide clients with various means of allowing for space to work through problems, some with more of a process-oriented approach (Greenberg, Rice, & Elliot, 1993; Lambert, 1992), and others with more of a focus on providing clients with concrete tools and strategies (De Shazer & Coutler, 2012). Regardless of orientation, my findings illustrate the importance of therapists becoming skilled in applying their knowledge successfully in order to meet the client's need of facilitating change.

Relationships with therapist and others. Participants reported that when relationships with the therapist and others were warm, friendly, and empathetic, their motivation was enhanced. This is the type of adaptive relationship described in self-determination theory and in motivational interviewing. Moreover, therapeutic alliance is a core principle of counselling (Asay & Lambert, 1999). Thus, each of these approaches offers suggestions for how therapists can build relationships with clients. For example, motivational interviewing encourages empathy towards clients (Miller & Rollnick, 2002). From an alliance perspective, Asay and Lambert (1999) identified that therapists should be warm, convey understanding, and create a place where clients feel safe to discuss their goals. Indeed alliance continues to prove to be an important therapeutic factor in outcomes (Lambert, 1992).

While the therapist-client relationship is undeniably important, when asked open-ended questions about relationships impacting their motivation, my participants talked about relationships with friends and family, as well as the therapist. This is consistent with the few qualitative studies on motivation as well as research on social connectedness and mental health (Saeri, Cruways, Barlow, Stronge, & Sibley, 2017). For example, Dunn et al., (2012) found that some participants shared their mental health concerns with a significant other in their life and those who did subsequently received increased support and motivation for treatment. Considering that participants reported supportive relationships with friends and family improved their motivation, therapists should also encourage clients to connect with other healthy individuals. They could do this by exploring whether clients have supportive relationships and helping them address any barriers preventing them from connecting with at least one person in their lives.

Beyond Motivation Theory: Triggered by a Low Point

The findings unfortunately reinforce the old adage that individuals with mental health disorders need to hit 'rock bottom' (Sremac & Ganzevoort, 2013) before seeking help. Certainly, many participants identified this as something that propelled them to therapy, some even after previously dropping out. The participants expressed that they were in some of the worst psychological pain they had ever been in before they were motivated in therapy. This factor is not considered in either self-determination theory or motivational interviewing. My finding is consistent with Dunn et al., (2012)'s results described under the theme of "recognition of problem gambling and help-seeking" (p. 263). Comments united under this theme dealt with how clients were motivated because they were fired from their place of employment, suicidal, or had lost a relationship – things that our clients might have described as a 'low point.' Clearly an important factor in client motivation is their life functioning (or dysfunction); however, I argue that this is not a 'good' motivator. To help people be motivated towards therapy prior to dire need, therapy needs to move into a preventative space.

Three levels exist within healthcare: *primary,* prevention; *secondary,* reducing the impact of a problem; and *tertiary,* addressing a problem once it has developed (Institute for Work and Health, 2018). There have been recommendations that primary interventions should be created to prevent mental health problems from developing (World Health Organization, 2004). The findings suggest that individuals are seeking help at the tertiary care level. Clients would likely be better served if agencies, governments, and other mental health care providers utilized preventative efforts and education aimed at informing the public of benefits to accessing services before their life was in dysfunction. Such efforts could provide information including warning signs of mental health disorders, consequences of waiting longer to seek help, strategies for

addressing their problems, and resources about how to access therapy, should the individual desire more help.

Limitations and Directions for Future Research

The results of this study need to be considered in light of three limitations. First, because participants were drawn from a pre-existing study only those who agreed to be contacted for interviews could be recruited. This could mean there was a self-selection bias, and it is possible that motivation experiences of the participants who did not want to be interviewed may have been different than those who agreed to be interviewed. Second, although I focused on general mental health issues, my participants were somewhat homogenous in terms of cultural background and employment status. My intention was never to have a representative sample, but these characteristics may have shaped the motivational experiences of these individuals. Finally, this study was designed to explore clients' experiences and did not include accounts from the participants' therapists. Although the therapist perspective would be informative, it was beyond the scope of the present study, which solely sought to prioritize client experiences of motivation.

My research provides evidence that the majority of the experiences influencing client motivation can be described by existing motivational theories. However, participant descriptions suggest ways that these elements are broader than the theories perhaps suggest. As a case in point, clients view relatedness as stemming from multiple individuals, not just the therapist, and competence as being both their own competence and that of the therapist. Thus, future research may want to focus on generation of a theory of motivation in therapy specifically. Grounded theory would be a good approach to this important undertaking. The purpose of grounded theory is to use inductive research that identifies participant experiences in order to create and build

theory (Charmaz, 2009). I believe this would be an important step in advancing motivational theory to more accurately apply research to therapeutic practice.

A second direction for future research would be to create and study therapeutic interventions aimed at increasing client motivation. Interventions aimed at increasing client autonomy, competence, relatedness, as well as therapist interpersonal and practical skills should be examined to determine whether they improve motivation. While many studies incorporate outcome measures to track improvement, interventions incorporating these factors are studied much less, despite motivation being a common problem for participants.

Finally, I proposed that interventions should also be preventative in nature, in order to help clients access therapy before their problem becomes too overwhelming. Future research should focus on whether such interventions improve potential client's access to therapy and whether this saves resources in the mental health field in the long run.

Table 3.1. Frequency and Percentages of Participant Demographics

Variable	Frequency	Percent
Gender		
Female	5	83
Male	1	17
Ethnicity		
Caucasian	4	67
Asian/European	1	17
Canadian	1	17
Occupation		
Undergraduate	2	33
Professional/Graduate	3	50
Human Services	1	17

Table 3.2. Themes and Subthemes

Theme	Subtheme
Voice	Participant's voice
	Therapist's voice
	Collaboration
Efficacy beliefs	Belief in self
	Belief in performance
	Belief in therapy
Relationship with others	Presence
	Quality
	Comparisons
Therapist's abilities	Knowledge or experiences
	Strategies
	Interpersonal skills
	Space
	Effectiveness
Triggered by a low point	Ambivalence or confusion
	Capacity to manage
	Emotionally distressed
	Interferes with functioning

CHAPTER FOUR: GENERAL DISCUSSION

The overall purpose of my research was to understand client motivation in one-on-one therapy better. I designed and executed two studies to accomplish this goal. First, I used a quantitative methodology to determine whether certain combinations of the basic psychological needs were associated with outcomes in therapy. Second, I used a qualitative methodology to understand experiences of motivation in therapy for clients who had previously reported low basic psychological need satisfaction. In this section, I extrapolate and discuss findings from both studies. First, I draw from both the quantitative and qualitative results to discuss how consistent support of the three basic psychological needs is necessary, whereas 'moments' of basic psychological need support is not enough to sustain client motivation or adaptive outcomes. By 'moments' of support I mean any instance or combination in which basic psychological needs were only partially met. This could be a lower endorsement of just one basic psychological need or low levels of more than one need. Second, I describe the implications of the results for motivation theories in the counselling field. Last, I raise the issue that there was only one finding from the qualitative study that theorists do not have included in motivational theories, and consider how the results of the two studies fit with my experiences of working with clients in therapy, both as a practicum student, and for the past year, as a Registered Psychologist.

Consistent Compared to Moments of Basic Psychological Need Support

When I reflect on the results from the quantitative and qualitative studies, I land on a picture that distinguishes the benefits of consistent support of the basic psychological needs from moments of support of the basic psychological needs. The former appears to be ubiquitously

better for client motivation, outcomes, and persistence than the latter in both the quantitative and qualitative results.

In the quantitative study, participants in the cluster with all their basic psychological needs met had significantly higher autonomous motivation, effort, and perceived improvement compared to those in the three other clusters. Even the participants in the clusters where one need was lower (i.e., less competence cluster), or where all three needs were consistently moderate (i.e., moderate cluster) were not associated with autonomous motivation or other adaptive outcomes. In the survey, I asked participants to endorse the extent that the therapist met their basic psychological needs *throughout therapy*. Those who felt their needs were strongly supported most of the time would have given high responses, whereas participants who felt the therapist supported their needs only to a low or moderate degree, or who felt the therapist supported their needs only some of the time would have given lower responses. Those in the moderate and needs unmet clusters, as well as those in the less competent cluster, had some psychological needs met to some extent, and yet this was not stable enough for them to experience as positive outcomes as participants in the needs met cluster. In other words, participants maximally benefited when they endorsed that their therapist consistently supported high levels of all three basic psychological needs.

The importance of meeting all basic psychological needs and risks of only providing moments of support was reiterated in the qualitative study: Participants provided numerous examples where they became motivated if the support was consistent and where they lost their motivation if need support was not consistent – even in just one domain. In these instances, I believe the participants were describing moments of basic psychological need support which were simply not enough to sustain their motivation. For example, Faith's story illustrates how

motivation increases as a therapist meets one's basic psychology needs. She was very unsure of whether to attend therapy in the beginning, because she did not know how to explain her thoughts and feelings. However, over time, she described that she trusted and liked her therapist (relatedness), felt therapy was collaborative (autonomy), and that she developed the confidence to speak freely in therapy (competence). Once Faith's needs were consistently satisfied, her motivation was increased and she explained that "I have never missed a session." In contrast, both Eva and Sean described moments of need support and yet ultimately stopped attending therapy when even one of the basic psychological needs dropped below a certain threshold. Although Eva developed a positive relationship with her treatment team (relationship), explained that her team implemented interventions at a pace she was comfortable with (autonomy), and that she was successfully applying the strategies to her life (competence), she chose to discontinue therapy when they insisted that she track her weight gain stating "they have totally taken over me" and "they're telling me what to do" (loss of autonomy). Likewise, Sean found that despite support for the relationship and self-efficacy, he lost his motivation and left therapy when his autonomy in one specific area – medication - was not supported or respected.

These findings reinforce results from studies in different achievement-based contexts on importance of satisfying all three basic psychological needs (Markland & Tobin, 2010; Ryan & Deci, 2017). However, in regards to therapy specifically, researchers have prioritized autonomous motivation without much consideration of the basic psychological needs (Ayers et al., 2014; Carter & Kelly, 2014; Thaler et al., 2016; Zuroff et al., 2007; see van der Kaap-Deeder et al., 2014 for an exception). Thus, my study is one of the first to show that all three of the basic psychological needs must be consistently supported in order to produce perceived improvement and autonomous motivation, and the first to show that all three of the basic psychological needs

must be consistently supported to produce effort and to ward off drop out. In light of this, recommendations for practitioners to focus on improving autonomy and autonomy support (Gagné, 2003; Chatzisarantis & Hagger, 2009; Reeve & Halusic, 2009) or building alliance (Asay & Lambert, 1999) fall short by not addressing the importance of supporting all three basic psychological needs. My two studies should serve to move the research in the area of counselling psychology forward by reinforcing the importance of studying and applying all three basic psychological needs from both quantitative and qualitative perspectives.

Connections with Motivation Theories

The results from my studies illustrate that self-determination theory is a good theoretical model to support researchers', therapists', and even clients' understanding of motivation in one-on-one therapy. In my opinion and based on these findings, the parsimony and strong theoretical and empirical history of self-determination theory position it to be more influential than either motivational interviewing or the common factors model.

First, self-determination theory provides a clear position on what type of motivation is most effective: intrinsic motivation is argued and empirically demonstrated to be more beneficial than other forms of external motivation (Deci & Ryan, 2008). Thus, self-determination theory sets a clear direction about what type of motivation therapists want to support in their clients. Alternatively, the instructional books for motivational interviewing focus on techniques rather than theory (i.e., sustain change talk). Since motivational interviewing appears to offer some effective techniques (Miller & Rollnick, 2012), perhaps its techniques could be aligned with the constructs in self-determination theory, amalgamating it within self-determination theory.

Second, although each of the basic psychological needs has a presence in motivational interviewing and the common factors model, they are not adequately defined and have to

compete with many other constructs to be effectively operationalized. For example, although autonomy and self-efficacy are officially included in motivational interviewing, they are not emphasized in practice as much as other factors such as change talk and relationships (Miller & Rose, 2009; Miller & Rollnick, 2013). Similarly, in common factors, client characteristics (i.e., motivation) and therapeutic techniques are not emphasized in practice as much as alliance, despite client characteristics and techniques still accounting for a large amount of the outcome (55% cumulatively).

Third, self-determination theory is not redundant and its constructs do not overlap (Ryan & Deci, 2000). On the other hand, motivational interviewing has multiple factors that may be a part of one construct. For instance, proponents of motivational interviewing discuss the importance of 'communication styles,' which outlines that therapists should reduce the amount of directing and guiding, and rather place a priority on supporting the client's opinion (Miller & Rollnick, 2012). This construct is akin to how motivational interviewing defines autonomy, which is also another, separate construct defined within their theory (Miller & Rose, 2009). Alternatively, self-determination theory does not have multiple terms representing the same construct, but rather is more concise (Ryan & Deci, 2017).

While the themes from the qualitative results mostly supported constructs already identified in their theories, the theme 'triggered by a low point' was the only new theme to emerge. This serves as a reminder to therapists that, when beginning therapy, clients may be experiencing dysfunction in their lives and may be very vulnerable.

Professional Experience & Therapeutic Applications

In this section, I reflect on the highlights from the findings and how they relate to my clinical experiences with clients in my practica and work experience. I discuss what I do to

support clients' basic psychological needs, some challenges that arise when doing so, and how I resolve these challenges.

Since beginning my dissertation research on self-determination theory, I have become personally committed to trying to meet my clients' basic psychological needs of autonomy, competence, and relatedness. This is a big task and yet one that my personal experiences and empirical results reiterate as critical for client success. To meet basic psychological needs, I ask clients their opinions and for feedback about sessions, I create steps they can manage when the goals are large and difficult for them to achieve, and I use humour to build relationships and strengthen my therapeutic alliance with clients. In reflecting on my professional experiences, I have found there are more challenges to support client's autonomy than their competence and relatedness, but that these challenges can be overcome.

In practice, I am mostly able to support client autonomy. Often I easily explore the client's opinion, and most of the time, we agree on the direction in therapy, and begin mutually working on achieving goals. I have occasionally found it difficult to support their autonomy – or in one instance even necessary to directly oppose client autonomy. For example, as a doctoral practicum student I was working with a client who in the last session gave indicators of suicide ideation. When I asked him whether he was thinking of committing suicide, he confirmed that he was and that he thought it would be better to end his pain by taking his life. Upon further discussion, he disclosed a plan he would carry out after getting home from the therapy session. I went through the ethical decision-making process in the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 2017) and include a short summary here in order to demonstrate how to manage occasions when a therapist may not be able to support a client's autonomy.

The Canadian Psychological Association (2017) maintains that the first ethical principle, Respect for the Dignity of Persons and People's, which reflects the client's worth and right to choose, and is closely tied to self-determination and autonomy. It has the highest priority of all four of the ethical principles. The second principle, Responsible Caring, reflects that clients should benefit from care and that psychologists should be competent in their practice area (Canadian Psychological Association, 2017). Although Responsible Caring is the second principle and officially comes after Respect for the Dignity of Persons and People's, in exceptional circumstances, it can be put above the first principle. Exceptional circumstances include if the client is choosing not to take care of him or herself, i.e., by expressing he or she wants to commit suicide. In such a case, ethically the therapist can put the second principle (care for the client) ahead of the first principle (client autonomy). This points out that within a therapeutic context, there may be exceptions when it is not beneficial (or ethical) for the therapist to support client autonomy. In the case with my client, prior to actually insisting he go to the hospital, I engaged in a conversation about him that explored his perspective. I asked him more about his pain and about how we might be able to address it. In my conversation, I realized my client did not really want to commit suicide, but rather that it seemed like the only option at the time. When I proposed another option of going to the hospital, he agreed that it would be a bad idea for him to be at home alone, agreed that he should go to the hospital, and we made a plan together for him to go to the emergency room. Thus, I have found that when I am challenged to support client autonomy, I am able to do so in a collaborative manner by having deeper conversations.

Taking a less extreme example than suicide to discuss competence, I make decisions about how much information to share about the process and efficacy of therapy prior to

beginning my work with clients. At first glance, these discussions may seem more like a frivolous detail, but I have learned that such discussions may be the difference between a client returning for a second session or not. Additionally upon reflection on my study results, I see now why these subtle decisions are important for clients. When beginning therapy, I spend more time asking questions about whether clients have been to therapy before, what their beliefs about therapy are, and whether they feel therapy will help. When a client tells me he or she doubt that therapy will be helpful, I will spend time discussing their assumptions and expectations of treatment. For instance, I had a client who had never been to therapy before and was very unsure about what therapy was and whether it would work. I spent the first three sessions with him discussing the process and the different studies on its effectiveness. I went at a pace that was comfortable for him. I also went into more depth about the approaches I used, and we had discussions about his feelings regarding the process throughout therapy. This individual was a great client and I believe it was these conversations about his assumptions that allowed him to stay in therapy. Although at the time I did not necessarily realize I was addressing an aspect of competence, I see now that is what I was doing. Presently, I continue to check in with clients about these issues, with the understanding I am helping address competency beliefs.

Regarding the third need, relatedness, I focus on creating a working alliance between myself and clients. The importance of doing so has been a main component in my training. Using Bordin's (1979) definition of alliance, which includes goals, tasks, and bonds, I feel fairly confident in my abilities to create agreement on goals and tasks with clients. In terms of bonds, Bordin (1979) more clearly defines it as two individuals "liking or disliking each other" (p. 254), which consists of trust and attachment, facilitated by time, self-disclosure, and focus of client responsibilities. To me, the relationship in therapy is much more illusive than goals and tasks,

and oftentimes has been summed up by the statement: “there just needs to be a ‘fit.’” This can occasionally be difficult to hear because it implies there is some ‘mystical’ element that cannot be explained (or overcome). To try and improve relationships with those where it does not seem we have a ‘fit,’ I use humour and self-disclosure in attempts to have the other person hopefully relate to me better. I do find this is an area where doing so works well, and I work hard to ensure my clients feel connected, all as a part of satisfying the basic psychological needs.

Conclusion

The purpose of this research was to develop a better understanding of client motivation in therapy. Specifically, I sought to extend the quantitative research on the topic by identifying participant profiles based on the basic psychological needs, and then testing if the profiles were related to various indicators of success in therapy. I found four participant clusters, where the participants in the cluster with the highest level of basic psychological needs also had higher levels of positive outcomes. I also sought to extend the research by conducting an exploratory qualitative study of clients’ experiences of motivation in therapy. In this study, I found that client motivation was primarily influenced by five key findings, which included participant voice, efficacy beliefs, relationships, therapist’s abilities, and being triggered by a low point. The findings in the quantitative and qualitative studies were complimentary. My experience with clients echo most of the study findings. Overall, both the qualitative and quantitative findings suggest therapists should utilize strategies aimed at addressing autonomy, competence, and relatedness in order to increase client autonomous motivation, effort, and positive therapeutic outcomes.

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Appendix A: Demographic Questions and Surveys

1) What year were you born?: _____

2) What is your occupation?: _____

3) What is your gender?: □ Female □ Male □ Other

4) What is your ethnicity?:
□ African American
□ Asian/Pacific Islander
□ Hispanic
□ First Nations
□ Caucasian
□ Other *(Please specify):* _____

5) What was your approximate average household income for 2015?_____

6) What setting was/is your therapy in? *(Please check only one):*
□ Public mental health clinic (i.e., Primary Care Network, CHMA, hospital)
□ Private practice
□ University (or university-related) clinic
□ Other: _____

7) When did you begin therapy? (e.g., May 2009) _____

8) What is the reason you attended therapy? *(Please check all that apply):*

□ Anxiety-related disorder
□ Depressive-related disorder
□ Substance abuse (alcohol and/or drugs)
□ Body image/eating-related disorder
□ Anger
□ Personality disorder
□ Parenting (help with raising child)
□ Problems related to post-traumatic stress
□ Personal growth
□ Romantic relationship problems
□ Other relationship problems (i.e., friend, family)
□ Workplace issues (i.e., problems with boss)
□ Health (i.e., weight-loss, recovering from an injury)
□ Grief/bereavement
□ General stress management
□ Problems related to the law (i.e., assault)
□ Career/vocational problems (i.e., vocational guidance)
□ Other *(Please specify):* _____

Client Motivation for Therapy Scale

	I am in therapy…	Does not correspond at all			Corresponds moderately			Corresponds exactly
1.	because other people think that it's a good idea for me to be in therapy.	1	2	3	4	5	6	7
2.	for the pleasure I experience when I feel completely absorbed in a therapy session.	1	2	3	4	5	6	7
3.	for the satisfaction I have when I try to achieve my personal goals in the course of therapy.	1	2	3	4	5	6	7
4.	because I would feel guilty if I was not doing anything about my problem.	1	2	3	4	5	6	7
5.	because I would feel bad about myself if I didn't continue my therapy.	1	2	3	4	5	6	7
6.	because I should have a better understanding of myself.	1	2	3	4	5	6	7

7.	because my friends think I should be in therapy.	1	2	3	4	5	6	7
8.	because I experience for the pleasure and satisfaction when I learn new things about myself that I didn't know before.	1	2	3	4	5	6	7
9.	for the interest I have in understanding more about myself.	1	2	3	4	5	6	7
10.	because it is important for clients to remain in therapy until it's finished.	1	2	3	4	5	6	7
11.	to satisfy people close to me who want me to get help for my current situation.	1	2	3	4	5	6	7
12.	because I don't want to upset people close to me who want me to be in therapy.	1	2	3	4	5	6	7

Basic Need Satisfaction Scale in Relationships

When I am in counselling…	Not true at all			Somewhat true			Very true
1. I feel free to be who I am.	1	2	3	4	5	6	7
2. I feel like a competent person.	1	2	3	4	5	6	7
3. I feel cared about.	1	2	3	4	5	6	7
4. I often feel inadequate or incompetent.	1	2	3	4	5	6	7
5. I have a say in what happens and I can voice my opinion.	1	2	3	4	5	6	7
6. I often feel a lot of distance between myself and the therapist.	1	2	3	4	5	6	7
7. I feel very capable and effective.	1	2	3	4	5	6	7
8. I feel close with my therapist.	1	2	3	4	5	6	7
9. I feel controlled and pressured to be certain ways.	1	2	3	4	5	6	7

Psychological Climate

When I am in counselling…	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1. I devote all my energy to achieving my goals**.**	1	2	3	4	5	6	7
2. I engage in it with intensity**.**	1	2	3	4	5	6	7
3. I work at my full capacity.	1	2	3	4	5	6	7
4. I strive as hard as I can to be successful**.**	1	2	3	4	5	6	7

Propensity to Leave

1. If you were completely free to choose, would you prefer to continue counselling, or would you prefer not to?

   1 = I would prefer very much to continue to counselling

   2 = I would prefer to continue counselling

   3 = I would not care either way

   4 = I would prefer not to continue counselling

   5 = I would prefer very much to continue counselling

2. How long would you like to stay in counselling?

   1 = I would like to attend as many sessions as I can

   2 = I would like to attend sessions for quite a while longer

   3 = I would like to attend sessions for a little while longer

   4 = I would like to be done sessions soon

   5 = I would like to be done sessions as soon as possible

3. If you had to stop counselling for a while (i.e., due to illness), would you resume your current sessions?

   1 = No, I definitely would not come back here

   2 = No, I probably would not

   3 = Perhaps, but I would look around for other counselling options first

   4 = Yes, I probably would

   5 = Yes, I definitely would come back here

Short Warwick-Edinburgh Mental Well-being Scale

		None of the time	Rarely	Some of the time	Often	All of the time
1.	I've been feeling optimistic about the future,	1	2	3	4	5
2.	I've been feeling useful.	1	2	3	4	5
3.	I've been feeling relaxed.	1	2	3	4	5
4.	I've been dealing with problems well.	1	2	3	4	5
5.	I've been thinking clearly.	1	2	3	4	5
6.	I've been feeling close to other people.	1	2	3	4	5
7.	I've been able to make up my own mind about things.	1	2	3	4	5

		None of the time	Rarely	Some of the time	Often	All of the time
1.	Therapy has helped me address my problems.	1	2	3	4	5
2.	My overall personal well-being improved because of therapy.	1	2	3	4	5

Appendix B: Semi-Structured Interview Script

1. Everyone starts therapy for some reason, what prompted you to start?
    a. What would you say was the most motivating?
    b. Where did this motivation come from?
    c. Over the course of therapy, motivations and reasons for therapy change. How did your motivation change over time? How, if it all, did your reasons for therapy change? Sometimes, motivation can be low. Please tell me about 'low motivation' times, if you had any. How did these experiences shape your time in therapy?
2. In what way were you personally involved in shaping the course of therapy?
    a. To what extent did the therapist incorporate your needs in therapy?
    b. To what extent was the process collaborative?
    c. How much of a voice did you have in your therapy sessions?
3. How did people influence your time in therapy?
    a. Who influenced your progress in therapy?
    b. How did he or she make such an important difference?
    c. What characteristics did he or she have that were important to you?
    d. Whom do you wish had been more influential on your time in therapy?
4. How did you feel about your ability to be effective in therapy?
    a. How confident did you feel you could be successful? What affected this?
5. How did your motivation change over time?
    a. Describe whether your motivation was consistent or whether it waxed and waned?

Is there anything else that impacted your motivation that we have not discussed?