CHAPTER

25 Motivation in Psychotherapy

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Abstract

Motivational issues are central to human life. Correspondingly, they are also central to the challenging endeavor of psychotherapy. Assisting patients to change involves motivational issues at various levels and at various stages of therapy. Patients might be more or less motivated to begin and to participate in the different stages of psychotherapy (therapy motivation). Besides these differences in therapy motivation, an understanding of the broader concepts of motivation in psychotherapy should mandate that motivational issues be considered in the treatment of *all patients* and not only in those with obvious deficits in therapy motivation: Motivational issues influence the therapeutic relationship, they should be considered in tailoring specific interventions, and they might be important factors for the onset and maintenance of psychological disorders. This chapter presents theoretical and empirical background information and illustrates therapeutic approaches for dealing with patients' motivation. Moreover, it summarizes the implications of basic and clinical research for a motivationally informed psychotherapy.

Key Words: motivation, goals, psychotherapy, treatment, psychopathology

Motivation in Psychotherapy

Motivation is central in life and governs most psychological processes. According to Heckhausen and Heckhausen (2008):

> the psychology of motivation is specifically concerned with activities that reflect the pursuit of a particular goal and, in this function, form a meaningful unit of behavior. Motivational research seeks to explain these units of behavior in terms of their whys and hows. (p. 1)

Consequently, motivational processes also have a central importance for the change of experience and behavior, which is the main purpose of psychotherapy. Psychotherapy patients seek help for the parts of their lives that they failed to cope with themselves. Therapists strive to optimally assist their patients to change behavior and experiences in order to enable them to live independently after therapy.

Because motivational issues are central to human life, they are also central to the challenging endeavor of psychotherapy. Assisting patients to change involves motivational issues at various levels and at various stages of therapy. First of all, patients might be more or less motivated to begin psychotherapy and to participate in the different stages of the psychotherapy process. Often, patients are willing to work very hard during the therapeutic process and to invest a lot to change their lives and their way of behavior. However, there are also patients who are ambivalent during different stages of the therapeutic process. They may be ambivalent about whether they should start therapy, whether they should frame a certain kind of behavior as a problematic behavior, or whether they should

take steps to change a problematic behavior. All psychotherapists are confronted with these variations of *therapy motivation* in their patients, and they know that it is useful to skillfully deal with the patients who show reduced therapy motivation.

However, a broader perspective on motivation in psychotherapy would indicate that it might be useful to consider motivational issues in the treatment of *all patients* and not only in those with obvious deficits in therapy motivation: Motivational forces influence the therapeutic relationship, and it may be wise to consider them when trying to build a helpful therapeutic alliance. Moreover, specific interventions might be tailored to the motivational background of the patients. For example, the specific situation patients are confronted with in exposure therapy might not only be chosen because of the nature of their avoidance behavior but also because of the important personal goals the patient strives for. On the most fundamental level, some authors have identified insufficient satisfaction of basic psychological needs as an important factor in the etiology of various psychological problems and psychological disorders (Grawe, 2004; Ryan, 2005; Ryan, Deci, Grolnick, & La Guardia, 2006). Accordingly, from this perspective, the overall goal of psychotherapy should be to increase the degree of satisfaction of motivational needs in order to reduce psychopathological conditions.

Therapists dealing with motivational issues in psychotherapy could profit from a deeper understanding of basic motivational principles in human life. Therefore, the first part of our chapter presents theoretical and empirical background information as well as selected methods of assessing motivational constructs that might be relevant for psychotherapy research and practice. The second part of the chapter reviews important theoretical and empirical literature from *clinical research* pointing to the relevance of motivational variables in psychotherapy and illustrating therapeutic approaches for dealing with patients' motivation. In the final part of this chapter, we will summarize the implications of basic and clinical research for a motivationally informed psychotherapy.

Clinically Relevant Motivational Constructs

We will briefly introduce the following motivational constructs: psychological needs, motives, personal goals, values, therapy motivation, and treatment goals. The concept of psychological *needs* implies that everybody has the same needs, everybody must satisfy them, and, if the individual fails to satisfy these needs, aversive outcomes such as diminished well-being or psychopathology might be consequences (Flanagan, 2010). Various lists of needs have been proposed, for example, self-enhancement, attachment, pleasure, and orientation/control by Epstein (1990), or relatedness, competence, and autonomy by Deci and Ryan (1985, 1995). Overarching metaneeds have also been suggested, such as a need for meaning (Heine, Proulx, & Vohs, 2006) or consistency as the most basic component of psychological functioning (Grawe, 2004).

Within the concept of *motives*, a general distinction can be made between *implicit* and *explicit* motives. Implicit motives are seen as enduring individual motive dispositions, whereas explicit motives refer to goals that are conscious or consciously accessible (Heckhausen & Heckhausen, 2008). The implicit motivational system consists of a relatively small number of motives (i.e., achievement, power, and affiliation motives) that are unconscious, holistically represented, and are more directly linked to emotional processes. It becomes apparent that the concept of implicit motives as used by Heckhausen and Heckhausen (2008) is very similar to the concept of needs described earlier, and the concept of explicit motives is very similar to the concept of high-level goals. Another general motivational construct is the construct of *values*. According to Rokeach (1973), "Values generally are defined as preferences for certain outcomes or modes of conduct" (as cited in Locke, 2000, p. 250). Such preferences can be shared by a whole community (cultural values) or be individual (personal values). The concept of personal values is also very similar to high-level goals.

A central and well-documented assumption of goal-oriented approaches is that, to a considerable extent, people's daily behaviors, thoughts, and emotions are linked to the pursuit of *personal goals* and are regulated by feedback regarding goal attainment (Austin & Vancouver, 1996; Carver & Scheier, 1996; Klinger, 1977). Personal goals can be defined as elaborate cognitive representations of what a person wants to achieve or avoid in his or her current life circumstances and are conscious, symbolically represented, and stored in a language-related manner (Brunstein, Schultheiss, & Graessmann, 1998). It is assumed that approach goals are developed to satisfy psychological needs, whereas avoidance goals are developed to prevent these needs from being hurt (Grawe, 2004; see also Elliot, 2008, for a review). People may pursue personal goals as diverse in content as, for example, making new friends, improving my professional situation, learning how to be more spontaneous, trying to be a better parent, or overcoming fear of rejection

(Chulef, Read, & Walsh, 2001). Grosse Holtforth and Grawe (2000) empirically identified the contents of personal goals that therapists considered to be especially relevant for their patients. Examples are to perform well, to be in a committed relationship, to avoid being humiliated, or to avoid showing weaknesses. The totality of all goals a person strives for (the person's goal structure) can be viewed as his or her individual future-oriented side giving purpose, structure, and meaning to life (Cantor, 1990; Emmons, 1986; Klinger, 1977; Michalak & Grosse Holtforth, 2006).

A patient usually seeks psychotherapy when he or she experiences an unbearable level of suffering being caused by unpleasant changes, experiences, and/or behaviors. Examples for such changes are psychopathological symptoms, unpleasant social interactions, inadequate performance at work, reduced enjoyment of leisure activities, or a general dissatisfaction with life. The person evaluates these experiences as problems because they are discrepant with his or her personal goals. When the person evaluates these changes as abnormal, believes that he or she is incapable of dealing with them alone, and has at least minimal hope that he or she will receive some relief from suffering through psychotherapy, the person may seek professional help (Schulte & Eifert, 2002). Apart from unbearable levels of suffering, other factors may also contribute to the person's decision to seek help, such as expectations or pressures by significant others or the wish to receive an absolution from guilt feelings by receiving a medical diagnosis, which may have been caused by a sense of burdensomeness to one's loved-ones (Schneider, 1990).

Therapy motivation is influenced by various experiences, including *(a)* suffering, *(b)* positive experiences (hope of relief), *(c)* fear of change, and *(d)* the therapeutic bond (wish to maintain the therapeutic relationship). Patient suffering may also be influenced by a multitude of factors, that is, *impairment* (psychopathological symptoms and negative affect), the experience of *being abnormal*, or the feeling of *helplessness* (Schulte & Eifert, 2002). Other factors may also be *gains from illness*, be they material (e.g., wish for a pension) or psychological (e.g., attention, support, protection; Schulte & Eifert, 2002).

Probably the most favorable approach that patients can bring to therapy would be one that is characterized by interest, curiosity, and commitment. The term *autonomous motivation* (Ryan & Deci, 2000) closely resembles this ideal kind of therapy motivation. For the purposes of psychotherapy, autonomous motivation can be defined as "the extent to which patients experience participation in treatment as a freely made choice emanating from themselves" (Zuroff et al., 2007, p. 137). If the patient has a favorable therapy motivation, he or she will cooperate with the therapist and the protocol, will disclose private experiences, will test out new patterns of behavior, will show low resistance to the therapist's intervention, and will unlikely drop out of treatment (*basic behavior*). The patient's *therapy expectations* may also influence the therapy process and outcome. Examples for therapy expectations are hope for improvement of well-being, hope for improvement of relationships, fear of adverse side effects, or fear of being ridiculed (Schulte & Eifert, 2002). The patient's motivation as well as his or her expectations may also be influenced by the patient's concepts of psychological illness and change (Calnan, 1987).

Treatment goals can be defined as "intended changes in behavior and experience to be attained by therapy, which patient and therapist agree upon at the beginning of treatment and on which successful psychotherapy should be instrumental" (Grosse Holtforth & Grawe, 2002, p. 79). Treatment goals have various functions in psychotherapy (Driessen et al., 2001). On an individual level, treatment goals focus patients' and therapists' attention, guide treatment planning, and provide criteria for outcome assessment (e.g., goal-attainment scaling, see earlier). In addition, treatment goals fulfill an ethical function by providing transparency for the patient, by balancing the power between the therapist and the patient, and by supporting the patient in giving his or her informed consent. Treatment goals also help to define similarities and differences between different therapeutic approaches. Finally, information on patients' treatment goals may support the optimization of treatment programs by providing feedback on the needs of specific patient groups (Uebelacker et al., 2008). Table 25.1 shows an empirically constructed list of patients' goals in psychotherapy (Grosse Holtforth & Grawe, 2002).

Assessing Motivational Constructs in Psychotherapy

As implicit motives are unconscious by definition, they cannot be assessed directly by self-report. Implicit motives have traditionally been assessed using projective techniques like the Thematic Apperception Test (TAT; Smith, 1992). During the TAT, respondents are asked to write fantasy stories in response to several pictures depicting motive-arousing scenarios. Several systems for deriving motive scores (achievement, power, and affiliation) from TAT stories have

Table 25.1 Bern Inventory of Treatment Goals (BIT-T)

Problem-/ Symptom- Oriented	Interpersonal	Well-Being/ Functioning	Existential	Personal Growth	Residual category (R)
Depression Suicidality Fears/anxiety Obsessions/comp. Traumatic experiences Substance use Eating behavior Sleep Sexuality Somatic problems Stress Medication	Intimate relationships Current family Family of origin Other specific relationships Loneliness, grief Assertiveness Contact/closeness	Exercise, activity Relaxation/ composure Well-being	Self-reflection and future Finding meaning	Attitude toward self Desires and wishes Self-control Emotion regulation	Regeneration Psychosocial rehabilitation Somatic rehabilitation

been developed (Smith, 1992). Although suitable for clinical research, these systems are not yet suited for routine clinical use due to missing norms, questionable or unknown test-retest reliability, and so on (Lilienfeld, Wood & Garb, 2000). Recently, several alternatives for assessing implicit motives (especially the achievement motive) have been introduced. For example, Brunstein and Schmitt (2004) developed an Implicit Association Test (IAT; Greenwald, McGhee, & Schwartz, 1998) to assess achievement motivation by evaluating the strength of association between achievement-related adjectives and the self-concept. However, such newer techniques are too time consuming for routine clinical use.

Explicit motivational constructs can be assessed efficiently using questionnaire methods. A sample questionnaire to assess various dimensions of therapy motivation is the Patient Motivation for Therapy Scale (CMTS; Pelletier, Tuson, & Haddad, 1997). Based on the self-determination theory proposed by Deci and Ryan (1985), the CMTS measures patients' intrinsic motivation, four forms of regulation for extrinsic motivation (integrated, identified, introjected, and external regulation), and a motivation for therapy. An example for the assessment of values in the interpersonal realm is the Circumplex Scales of Interpersonal Values (CSIV; Locke, 2000). The principle of a circumplex structure implies that variables that measure interpersonal relations are arranged around a circle in a two-dimensional space, with the dimensions being agency and communion.

Personal goals are most often assessed in basic research using a combined idiographic-nomothetic approach. The first step (the idiographic part) is to ask the participants to generate a list of personal goals. In the second step (the nomothetic part), patients rate these individual goals on various dimensions to allow for inter-individual comparisons. Goals can be rated by the participants themselves or by independent raters (e.g., categorization of goals by content or according to the approach and avoidance quality of the goals). Examples of this idiographic-nomothetic approach are the Personal Projects Matrix (Little, 1983), the Personal Concerns Inventory (Cox & Klinger, 2002), and its immediate antecedents, such as the Concern Dimensions Questionnaires (Klinger, Barta, & Maxeiner, 1980) and the Interview Questionnaire (Klinger, 1987). These instruments preceded and/or gave rise to other methods such as the Striving Assessment Scale (Emmons, 1986) and the Goal Assessment Battery (Karoly & Ruehlman, 1995). All of these approaches make it possible to assess theory-derived indices that seek to achieve a multilevel understanding of goals (e.g., goal importance, goal achievement, goal conflict, etc.).

Furthermore, various interviews to assess personal goals have been developed (e.g., AIMS; Wadsworth & Ford, 1983), allowing for an extensive description of the various goals and their mutual relationships. When standardized goal questionnaires (e.g., Ford & Nichols, 1991; Grosse Holtforth & Grawe, 2000; Grosse Holtforth & Grawe, 2003; Grosse Holtforth, Grawe, & Tamcan, 2004; Reiss & Havercamp, 1998; Ryff, 1989) are utilized, the participants are presented with goals that have to be evaluated with respect to dimensions such as importance, strain, progress, or realization. Compared to other methods, standardized questionnaires offer the advantage that the goal contents are comparable. Furthermore, goal assessment is less dependent on recall processes. However, the personal salience and ecological sensitivity of the idiographic-nomothetic

approach associated with the individual formulation of goals is diminished by the standardized goal presentation. Conflict matrixes are used to examine the interrelationship and possible conflicts among goals (e.g., Cox, Klinger, & Blount, 1999; Emmons & King, 1988). To measure the amount of conflict that exists between pairs of goals, participants compare each goal with every other goal and ask themselves, "Does being successful in this goal have a helpful, a harmful, or no effect on the other goal?"

A strategy to assess the person's clinically relevant personal goals is Plan Analysis (Caspar, 2007). According to Caspar, Grossmann, Unmüssig, and Schramm (2005), a "person's Plan structure is the total of conscious and unconscious strategies this person has developed to satisfy his or her needs" (p. 92). The patient's Plan structure can be derived from various sources of information (e.g., biographical information, behavioral observations, and the patient's impact on others). The main question guiding the assessment process is: What is the explicit or implicit purpose of this patient's behavior? In a simplified form, Plan Analysis can be done and used in collaboration with the patient to enhance his or her understanding of certain parts of his or her functioning (Caspar, 2007). The result of a Plan Analysis is a graphic display of the structure of the patient's most important approach and avoidance goals as well as his or her individual means (Plans and behaviors) toward pursuing these goals (see Fig. 25.1).

Treatment goals can also be formulated and assessed in a more or less standardized form. Various questionnaires and checklists for a standardized assessment of treatment goals have been developed (e.g., Driessen et al., 2001; Grosse Holtforth, 2001; Kunkel & Newsom, 1996; Miller & Thompson, 1973). The attainment of individually formulated therapy goals can be measured using, for example, the Goal Attainment Scaling (GAS) procedure (Kiresuk, Smith, & Cardillo, 1994). In the first step, GAS procedures define possible areas of change. Then, the patient and therapist join forces to explore and formulate as concretely as possible for each area what would constitute an improvement to, stagnation in, or a deterioration of the current state. The degree of goal attainment can be assessed in the course of treatment or after termination by patients, therapists, or independent raters. The goal-attainment scaling may then be viewed as individualized measures of treatment success (for a discussion of methodological limitations of GAS, see Hill & Lambert, 2004).

Personal Goals, Well-Being, and Psychological Problems

After considering methodological issues in assessing motivational constructs, we will now present research findings that underscore the importance of personal goals for well-being and psychological problems. We will focus on personal goals because most of the empirical research has used personal goals as a unit of analysis. In everyday life, humans pursue multiple goals in various areas, such as family, work, career, recreation, or spirituality using various individual strategies (Karoly, 2006). As there is a multitude of ways to pursue one's goals successfully, there are also many ways to fail in reaching one's goals. How effectively a person strives for his or her goals can be seen as key criterion for effective adjustment (Karoly, 2006). Succeeding or failing to reach one's goals not only has important consequences for the individual's happiness and well-being (for reviews see Brunstein, Schultheiss,

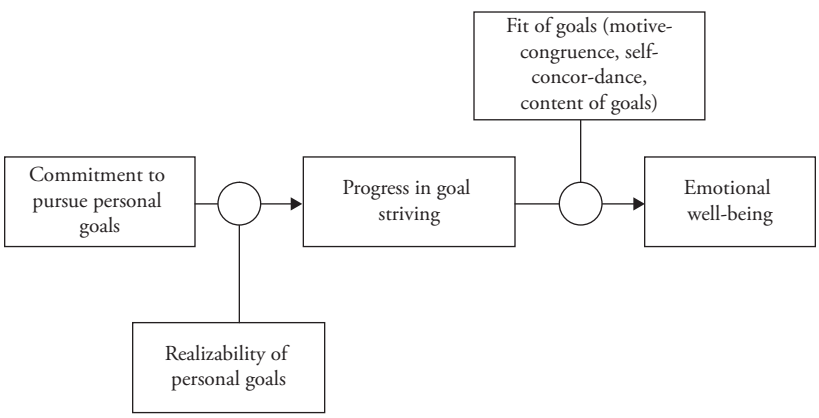

Fig. 25.1 Teleonomic model of subjective well-being (Brunstein & Maier, 2002, p. 163, modified).

& Maier, 1999; Emmons & Kaiser, 1996; Schmuck & Sheldon, 2001) but can also contribute to the development and maintenance of serious psychological problems and disorders.

In the following, we will highlight selected findings as pertaining to the associations of goal functioning to well-being and psychopathology. According to Pervin (1990), Karoly (1999), and Grawe (2004), psychopathology can develop when a person is unable to attain his or her goals over an extended period of time, when goal attainment is threatened by personal or external circumstances, or when dysfunctional processes occur in goal-oriented self-regulation. Concurrently, psychopathology can be seen as "disturbances to the normal processes and structures by which humans consciously and nonconsciously guide their actions, emotions, and thoughts in the service of achieving meaningful life goals" (Karoly, 2006, p. 367).

Brunstein and Maier (2002) summarized findings from basic research on personal goals in a *teleonomic model* of subjective well-being (see Fig. 25.1). In the teleonomic model, goal commitment, as well as goal realizability is assumed to causally influence well-being. If someone pursues his or her goals with commitment (i.e., he or she identifies with the goals and feels motivated to realize them), and if his or her life situation facilitates the attainment of these goals, progress in goal striving is more likely. Goal progress, in turn, is assumed to contribute to the person's emotional well-being.

The basic assumptions of the teleonomic model of emotional well-being have been supported by a multitude of research findings (Brunstein et al., 1999). For example, through longitudinal studies on various groups of participants (Brunstein, 1999; Maier & Brunstein, 2001, Wiese & Freund, 2005), it has been demonstrated that people who *(a)* are strongly committed to strive for their goals, and *(b)* who view their life circumstances as favorable for goal striving, achieved a greater degree of progress in goal attainment and greater increase in emotional well-being than people who were less committed to goals for which conditions were more unfavorable. In addition, people whose goals are in conflict with each other or are poorly integrated (Michalak, Heidenreich, & Hoyer, 2011) or who have goals that are abstract and not clearly formulated (Emmons, 1996) show lower subjective well-being and satisfaction with life. Furthermore, dysregulated goal/action identification seems to relate to various psychological symptoms and disorders such as depression or social anxiety in the sense that patients with these disorders identify negative events at a more abstract level than healthy subjects (Watkins, 2011). In addition, more goal progress can be also expected if the social network supports a person's goals (Brunstein, 1993; Brunstein, Dangelmayer, & Schultheiss, 1996; Ruehlman & Wolchik, 1988). However, which goals the social network supports and what the consequences for the individual's well-being are may also depend on the cultural context. For example, whereas independent goal pursuit (fun and enjoyment) increased well-being among European Americans but less among Asian Americans, interdependent goal pursuit (pleasing parents and friends) increased the well-being of Asian Americans but not of European Americans (Oishi & Diener, 2001).

A central assumption in the teleonomic model is that successful goal striving does not inevitably lead to happiness and well-being, but rather if the goals *fit* the person. Goals may be pursued for extrinsic or intrinsic reasons, and the various content of goals also seems to make a difference. Many studies have shown that the pursuit of goals is especially associated with a sense of well-being if the goals are well integrated into the person's self-system (*self-concordance*; Sheldon, 2001), that is, if goals are pursued because one has consciously accepted the values underlying such behavior as personally important and meaningful (*identified regulation*) or because the pursuit of these goals is in itself satisfying and rewarding (*intrinsic regulation*). In contrast, goals are not integrated into the self-system if they are mainly pursued because of external reward ("extrinsic regulation") or internal pressure (e.g., feelings of guilt or embarrassment, "introjected regulation"; for reviews see Deci & Ryan, 2002; Ryan & Deci, 2000; Ryan, Sheldon, Kasser, & Deci, 1996; Sheldon, 2001). Whenever goals correspond with a person's personal values and interests, or the pursuit of the goals is itself satisfying, he or she will—even in times when the pursuit of goals is fraught with difficulties or exertion—be more able to activate emotional resources and thus persist in the pursuit. Concurrently, in a meta-analytical review by Koestner, Lekes, Powers, and Chicoine (2002), the positive effects of self-concordant goals on goal attainment were consistently shown even after controlling for other relevant variables such as neuroticism, goal efficiency, and commitment.

A closely related, but not quite the same aspect as self-concordance (Kasser & Ryan, 2001) refers to the content dimension of goals. Kasser and Ryan (1993, 1996) have coined the term *external goals* for goals the focus of which is to increase one's status in the eyes of others, as compared to *internal goals*, which are geared toward the fulfillment of inherently personal needs,

such as competence, autonomy, and relatedness, and therefore fit people's deeper, psychologically fundamental needs. A series of studies (e.g., Kasser & Ryan, 1993, 1996; Schmuck, Kasser, & Ryan, 2000; Sheldon & Kasser, 1998) showed that people who mainly strove for external goals displayed a lower level of well-being than people who devoted their lives to the attainment of internal goals. Püschel, Schulte, and Michalak (2011) investigated associations between goal fit and psychopathology in a sample of 61 psychotherapy outpatients with heterogeneous diagnoses. In accordance with the teleonomic model, results showed that only motive-congruent goal progress was related to depressivity. Patients who made more progress at goals that matched their implicit motives experienced fewer depressive symptoms, whereas patients who failed to make progress at motive matching goals experienced more depressive symptoms. Motive-incongruent progress did not have any effect on depressive symptoms.

Several studies with student samples demonstrated associations between goal functioning and psychopathology. For example, in a study by Lecci, Karoly, Briggs, and Kuhn (1994) "negative" goal characteristics such as high stress and difficulty, low goal structure, low expectations regarding control, perceived insufficiency of own capabilities, and low expectations of success were associated with increased depression and anxiety. Correspondingly, Cohen and Cohen (1996, 2001) found in an extensive prospective longitudinal study that children and adolescents who set high priority on materialistic and hedonistic goals (i.e., external goals) showed a higher incidence of almost all Axis-I and Axis-II *DSM-III* diagnoses later in life. Furthermore, a number of studies found associations between goal conflicts, impaired well-being, and psychopathology (for a review, see Michalak, Heidenreich, & Hoyer, 2011).

Pursuing a high proportion of *avoidance goals* relative to approach goals is associated with less perceived goal progress and seems to be particularly detrimental to one's well-being and functioning (see Elliot & Friedman, 2007; Tamir & Diener, 2008, for reviews). Avoidance goals may exert this negative influence because the monitoring and management of goal process in harder for avoidance goals than for approach goals, because avoidance goals elicit more negative cognitions and emotions (Tamir & Diener, 2008), and avoidance goals hinder the satisfaction of important personal goals as well as associated psychological needs (Grawe, 2004). Particularly, an avoidance of aversive experiences may contribute to the development and perpetuation of mental problems (Grosse Holtforth, 2008; Hayes, Strosahl, & Wilson, 1999). Such negative experiences can relate to various types of events, such as abandonment, criticism, or failure (Grosse Holtforth, Grawe, Egger, & Berking, 2005).

Empirical research showed that psychotherapy patients pursue more avoidance goals than normal controls, and that the intensity of avoidance goals correlates with the decreased levels of goal satisfaction, poor well-being, severity of psychopathology, and other psychological problems in psychotherapy patients as well as in normal controls (Grosse Holtforth & Grawe, 2000; Grosse Holtforth & Grawe, 2003). However, avoidance goals do not have to be uniformly maladaptive but might protect individuals from being deeply frustrated and hurt in harmful environments (Grosse Holtforth, Bents, Mauler, & Grawe, 2006). Michalak, Püschel, Joormann, and Schulte (2006) examined *avoidance tendencies* in the explicit and the implicit modes. In a sample of students and psychotherapy patients, avoidance tendencies within the explicit system of personal goals as well as in implicit motives were associated with symptoms, even when controlling for the other mode.

Several studies examined goal functioning in specific mental disorders (Michalak, Klappheck, & Kosfelder, 2004; Pöhlmann, 1999; Stangier, Ukrow, Schermelleh-Engel, Grabe, & Lauterbach, 2007). Pöhlmann (1999) compared the personal goals of psychosomatic patients with the goals of a psychologically healthy sample. Psychosomatic patients generally pursued more goals than psychologically healthy subjects. However, the goals were formulated as avoidance goals rather than approach goals, and the scope of the goals was narrower. Compared to psychologically healthy subjects, goals expressing the desire to change oneself were mentioned more often, as well as health-related goals. Michalak et al. (2004) investigated the aspect of goal attainment as well as goal fit in a study with psychotherapy outpatients with anxiety and mood disorders. Both probability of goal attainment as well as the self-concordance of goals (intrinsically vs. extrinsically motivated goal striving) correlated highly with symptom distress. In addition, Stangier and colleagues (2007) found that depressed inpatients showed higher scores for inconsistencies among different goals/values as well as between goals/values and their perceived realization as compared with controls. Strauman (2002) proposed in his self-regulation model of depression that individuals who are unable to pursue promotion goals effectively are at risk for mood disorder because of their chronic inability to satisfy these goals. In this model, depression results from and

maintains disruption of the mechanisms of incentive motivation (Dickson & MacLeod, 2004; Strauman et al., 2006). Empirical studies indeed indicate that an inability to attain promotion goals is predictive of dysphoric mood and depressive symptoms (e.g., Scott & O'Hara, 1993).

In the motivational model of alcoholism by Cox and Klinger (1988, 1990), dysfunctional goal characteristics possess a central role as pathogenic factors in the development and maintenance of substance abuse and addictions. The model assumes that the balance between the expectation of positive and negative affective consequences of substance use determines the course and outcome of an episode of alcohol consumption. The satisfaction a person is able to draw from other areas of his or her life strongly contributes to the decision for or against the consumption of alcohol. When a person is unable to get satisfaction from other sources of reinforcement, the risk increases that he or she will use alcohol or other substances to find pleasure and emotional relief. In various studies with students with more pronounced alcohol-related problems Cox et al. (2002) showed that unfavorable goal structures were associated with the amount of alcohol consumed. Compared with students, alcoholic patients reported fewer goals and reported less average commitment to them but also reported less average commitment relative to the return they expected from their goal striving (Man, Stuchlikova, & Klinger, 1998). It might be that alcoholics need more expected rewards to become committed to goals. A recent study by Sevincer and Oettingen (2009) demonstrated that the relationship between goal striving and psychopathology is not unidirectional but a "double-edged causal sword" (Karoly, 2006, p. 369). Sevincer and Oettingen (2009) found in an experimental study that alcohol consumption creates strong commitments even in light of low expectations. However, in a longitudinal study, once sober again, formerly intoxicated participants with low expectations did not follow up on their strong commitments over a 3-week period. The authors interpreted the findings as showing that alcohol seems to produce "empty goal commitments," as commitments are not based on individuals' expectations.

Motivational Factors in Psychotherapy Research and Practice

In the following, we will examine various ways in which motivational factors are relevant in the practice of psychotherapy—either as *facilitators* of treatment process and outcome or as *targets* of psychological change. First, we will examine the role of motivational factors in psychotherapy as they occur *naturally* in the process of treatment, then we will outline therapeutic interventions that explicitly aim at changing motivational factors.

GOALS, THERAPY MOTIVATION, AND MOTIVE CHANGE

Zuroff and colleagues (2007) examined the role of autonomous motivation in a randomized controlled trial comparing interpersonal therapy, cognitive behavior therapy, or pharmacotherapy with clinical management for depressed outpatients. They found that autonomous motivation assessed at session 3 was a stronger predictor of outcome than therapeutic alliance across all three treatments. In addition, patients who perceived their therapists as more autonomy supportive reported higher autonomous motivation. Thus, it seems that fostering autonomous motivation in psychotherapy is a general facilitator of favorable treatment outcomes.

Certain goal characteristics might influence the therapeutic process by enhancing or decreasing the motivation to actively engage in treatment and to attain treatment goals. Ryan, Plant, and O'Malley (1995) found that alcoholic patients who were pressured to participate in a treatment program showed higher dropout rates compared to patients who experienced their participation as more intrinsically motivated. In addition, Michalak, Klappheck, and Kosfelder (2004) investigated the correlation of optimism about goal attainment and the intrinsic orientation of patients' general goals with session outcome. Optimism as well as goal fit (i.e., self-concordance of goals) correlated strongly with session success. This correlation was not mediated by the patients' psychopathological state, so it can be assumed that motivational aspects are responsible for the correlation. Klappheck and Michalak (2009), analyzing the same sample, found that only optimism to reach the goal of symptom relief was related to treatment outcome. However, self-concordance of goals failed to predict treatment outcome.

Various studies have investigated the question of whether conflicts between a patient's general goals and poor integration of the goal structure (i.e., the extent of mutual support or hindrance of goals) is associated with the motivation to become actively involved in therapy (for a review, see Michalak et al., 2011. For example, in a study conducted by Michalak and Schulte (2002), goal conflicts in patients with anxiety disorders were negatively correlated with patients' basic behavior during therapy as well as treatment success. Conflict was measured

using the Striving Instrumentality Matrix (SIM; Emmons & King, 1988). Moreover, basic behavior also correlated with some measures of treatment success (Michalak, Kosfelder, Meyer, & Schulte, 2003). However, Michalak et al. (2004) were unable to replicate correlations between goal conflicts and basic behavior in another sample of psychotherapy outpatients. In two studies with alcoholic inpatients and inpatients receiving treatment for drug addiction, Heidenreich (2000) showed negative correlations between the degree of conflict concerning the goal "personal change" and attitudes toward change-relevant topics. These attitudes were operationalized according to the transtheoretical model developed by Prochaska, DiClemente, and Norcross (1992): Willingness to contemplate changing problematic abuse ("Contemplation") and to actively cope with the abuse ("Action"; see also see Cox & Klinger, 2002).

MOTIVATIONAL INTERVENTIONS AS FACILITATORS OF CHANGE

Therapists can use motivational factors to facilitate change in at least two ways. Therapists can foster a good therapeutic relationship by tailoring the therapy to the patient's motives and they can try to formulate maximally helpful treatment goals.

Fostering the Therapeutic Relationship

One of the most important tasks of a therapist at the beginning of psychotherapy is to establish a good therapeutic relationship and productive working alliance (Horvath, 1995). From a motivational perspective, how well a behavior is received by another person depends on how effectively a behavior helps to satisfy the other person's needs and goals. According to Ryan and Deci (2000), a therapeutic relationship promoting the fundamental needs for competence, autonomy, and relatedness constitutes a prerequisite for a successful integration of goals into the self-system. However, a therapist can go beyond supporting generic psychological needs that are assumed to be shared by all human beings. For this, the therapist may individualize his or her behavior to accommodate the patient's individual goals. In their motivational attunement approach, Grosse Holtforth and Castonguay (2005) described ways to tailor therapeutic interventions to the patient's goals and motives in order to foster the therapeutic relationship and therapeutic outcome. By showing motivationally attuned behavior, the therapist attempts to satisfy important approach goals of the patient while activating avoidance goals no more than necessary. A motivationally attuned therapist behavior is assumed to foster each of the essential parts of the therapeutic alliance: therapeutic bond, agreement on therapeutic tasks, and agreement on therapeutic goals (Bordin, 1979). The Motivational Attunement approach is similar to Alliance Fostering Therapy proposed by Crits-Christoph et al. (2006), which is conceptualized as a supplement to existing empirically supported therapies. Among others, maximally informing patients about the indicated therapeutic procedures and discussing them with the patients until reaching an agreement will foster task agreement (Crits-Christoph et al., 2006). The therapist may also bolster motivationally unattractive techniques by putting the task into the service of other approach goals and by activating other resources. For example, the therapist might say, "This exposure exercise will finally enable you to spend relaxed afternoons downtown shopping with your daughter and enjoying life a little more." Motivational attunement may also help to prevent alliance ruptures (Safran & Muran, 2000). Empirical results show that potential precipitants of alliance ruptures occur as either "therapist does something that the patient does not want or need" or as "the therapist fails to do something that the patient wants or needs" (Ackerman & Hilsenroth, 2001, p. 183). Therefore, a therapist will be well advised to be aware of the patient's salient approach and avoidance goals in order *(a)* not to miss important expectations or needs or *(b)* commit interactional blunders that fit the patient's individual vulnerabilities.

Formulating Treatment Goals

Treatment goals may first come to mind when thinking about goals in psychotherapy. As patients and therapists may have different goals for therapy, it is important to distinguish treatment goals from *(a)* naïve treatment concerns presented by the patients and *(b)* from treatment goals defined exclusively by the therapist. An agreement on therapy goals is considered a central ingredient of the working alliance. Naïve treatment concerns are what a patient hopes to accomplish in the course of therapy and are usually closely connected to the problem the person suffers from. These naïve treatment concerns can be seen as a subset of the patient's general personal goals (Pöhlmann, 1999). Naïve treatment concerns may or may not parallel the goals for therapy that the therapist holds. On the other hand, what the therapist sees as the goals of treatment may be strongly influenced by various factors, including therapeutic orientation (Arnow & Castonguay, 1996; Dirmaier, Harfst, Koch, & Schulz, 2006;

Philips, 2009). Empirically, agreement between the patients' and the therapists' treatment goals seems to have positive effects on the process and outcome of psychotherapy (Tryon & Winograd, 2001; see also Orlinsky, Ronnestad, & Willutzki, 2004). However, the rather low correspondence between patients' goals and therapists' goals found in earlier studies indicates that it is necessary for the therapist to explicitly strive for this agreement (Dimsdale, 1975; Dimsdale, Klerman, & Shershow, 1979; Polak, 1970; Thompson & Zimmerman, 1969).

In the process of goal definition, the therapist helps the patient to translate the often vaguely worded treatment objectives and wishes into well-formed therapeutic goals, so that they optimally fulfill the aforementioned functions. Several characteristics of a well-formed therapeutic goal can be formulated (Michalak & Grosse Holtforth, 2006; Willutzki & Koban, 2004). Optimally, treatment goals are negotiated and agreed upon with the patient. In the goal selection process, those goals should be preferred that correspond with a patient's intrinsic (approach) goals so that they hold a maximum positive valence, urgency, and importance for the patient. The goals should describe a change, an increase in skills, or the preservation of facilitative conditions. Therapists should ensure that the goals a patient chooses or formulates are attainable. Complex and long-term goals should be divided into sufficiently concrete and feasible low-level goals, and they should be divided into steps small enough for the patient to be able to translate them into action. Goal attainment should be initiated and maintained by the patient. Goals should not be in conflict with one another, and goal formulation should entail simple, concrete, specific, observable, and detailed descriptions of the current problematic state as well as the aspired goal state. In addition, therapeutic goals should be formulated positively as approach goals ("to be able to go shopping by myself") as opposed to avoidance goals ("no longer scared when alone outside"). The goal-striving process should be supported by implementation intentions (i.e., specifications as to when and where the goal will be pursued and how obstacles will be dealt with; see Gollwitzer & Brandstätter, 1997) and the patient's social environment should be motivated to support the patient's goals. Finally, goals should be clearly measurable so the patient can see the progress and feel motivated to further engage in therapy.

Empirical studies show that patients' treatment goals differ depending on patients' diagnoses. For example, psychotherapy patients with eating or anxiety disorder show a higher proportion of explicitly symptom-oriented goals (e.g., "having fewer episodes of binge-eating," "being able to go shopping by myself again"; Faller & Goßler, 1998) than do patients with mood disorders. The latter show—in addition to disorder-typical goals (e.g., "being able to find pleasure in everyday activities")—many goals that focus on interpersonal or existential issues (e.g., "resolving my marital conflicts"). Similar diagnostic differences could be found in other samples of inpatients and outpatients (Berking, Grosse Holtforth, Jacobi, & Kröner-Herwig, 2005; Dirmaier et al., 2006; Grosse Holtforth & Grawe, 2002; Grosse Holtforth, Reubi, Ruckstuhl, Berking, & Grawe, 2004; Grosse Holtforth, Wyss, Schulte, Trachsel, & Michalak, 2009; Uebelacker et al., 2008).

So far, only a few studies have examined the association between the content of therapeutic goals and therapy outcome. In a study analyzing the treatment goals of 2,770 inpatients in psychosomatic rehabilitation, Berking et al. (2005) found that the level of goal attainment differed between goal categories. For example, goals such as "reducing my panic attacks" or "learning to accept myself better" had much better prospects of success than the goal "coping with my sleep problems" or "experiencing less pain." Such findings help to adjust therapist expectations and may serve as references for evaluating treatment progress in various disorders.

For patients experiencing difficulties formulating clear and self-concordant therapy goals, Willutzki and Koban (2004) introduced the *EPOS* intervention (Development of Positive Perspectives in Psychotherapy). In the imagination phase, the therapist guides the patient in activating positive perspectives beyond presenting problems (e.g., "When your life progresses fine within the next years, what will a day in 5 years look like?"). In the analysis phase, the therapist supports the patient in specifying the personally relevant goals and relates these more concrete goals to the patient's imaginary activation of positive perspectives. These interventions usually take two to three sessions.

CHANGING MOTIVATIONAL FACTORS BY PSYCHOTHERAPY

First, we will describe general models of psychological change that ascribe a central role to motivational factors for change in psychotherapy. Then we will demonstrate examples of interventions that have an explicit motivational focus. A fundamental assumption of attempts to change motivational factors in psychotherapy is that motivational change

will contribute to symptom change and improvement of well-being.

General Models of Change

We will describe three general models of behavior change that are particularly relevant to psychotherapy. These models are the Rubicon Model of Action Phases (Heckhausen, Gollwitzer & Weinert, 1987), the change model of General Psychotherapy (GPT; Grawe, 1997), as well as the Transtheoretical Model (TTM; Prochaska et al., 1992).

The Rubicon Model of Action Phases (Heckhausen et al., 1987) is a well-established psychological model for goal-oriented action that can be profitably applied to psychotherapy. Figure 25.2 shows the different phases of the model. In the *motivation phase*, a person contemplates on his or her goals, which is completed by the formulation of an intention, constituting the shift from choosing to wanting. From here on, all processes are directed toward the implementation of the decision, that is, toward the attainment of a particular goal. Subsequently, the person plans for how to reach the goal, screens out competing intentions, and ultimately executes adequate action. After realizing the action, the person evaluates the action consequences with reference to the pursued goal.

In General Psychotherapy (GPT; Grawe, 1997) the term generally denotes that rather than defining one's interventions by therapy *schools*, therapists conceptualize their interventions in terms of general *change factors*. The assumed general change factors are resource activation, problem actuation, motivational clarifications, and problem mastery. Whereas resource activation and problem actuation are considered catalysts for change, motivational clarification and problem mastery refer to specific types of corrective experiences (Alexander & French, 1946; Goldfried, 1980). Motivational clarification, which is of particular relevance for this chapter, involves becoming aware of the motivational background of unpleasant emotions and reevaluating negative primary appraisals of situations and events (Grosse Holtforth, Grawe, & Castonguay, 2006). The psychotherapist for each patient individually combines empirically supported interventions that correspond to these mechanisms of change based on a case formulation and treatment plan (Caspar & Grosse Holtforth, 2010). In an experimental study with heterogeneous outpatients, Grosse Holtforth, Grawe, Fries, and Znoj (2008) demonstrated differential effects for general psychotherapy depending on motivational factors. General psychotherapy, which combines motivationally clarifying interventions with mastery-oriented interventions, yielded stronger reductions of interpersonal problems for patients with high levels of avoidance motivation, as compared to a cognitive-behavioral condition that focuses on mastery-oriented interventions only.

Grawe (2004) adapted the Rubicon Model described earlier for the systematization of change processes in psychotherapy. In the Rubicon Model, the therapist's goal is to help the patient to move through the phases of action to enable the patient to realize an action that fulfils his or her psychological needs. As the Rubicon constitutes the difference between choosing and wanting, the therapist may help the patient on both sides of the Rubicon. The therapist may help the patient to form clear intentions (motivational clarification) or to realize his or her intentions (problem mastery), or both. By motivationally clarifying interventions, the therapist guides the patient's attention to the process of choice, raises awareness for the involved motivational *forces* (wishes, fears, expectations, standards, etc.),

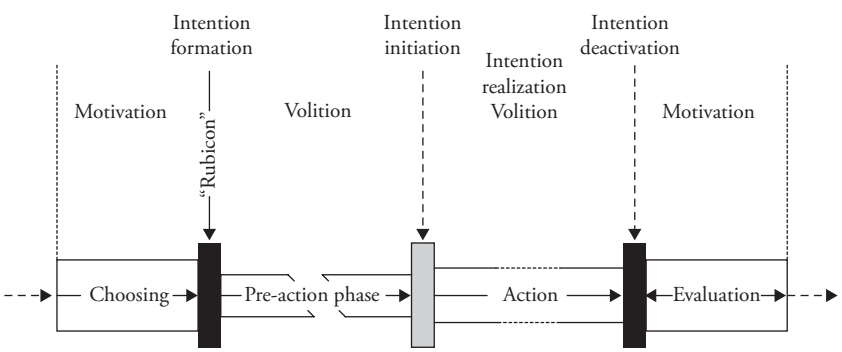

Fig. 25.2 The action phase model (Rubicon Model) by Heckhausen. (Adapted from Grawe, 2004, p. 50; reproduced by permission from Psychological Therapy by Klaus Grawe, ISBN 0–88937-217–9 ©2004 by Hogrefe& Huber Publishers www.hogrefe.com.)

and attempts to strengthen the patient's volition by changing the patient's intentions in clarity, direction, or strength. For example, psychodynamic therapies predominantly use interventions aiming at motivational clarification. To the *right of the Rubicon*, that is, when a patient has clear and strong intentions, the therapist's activities are geared toward supporting the patient in implementing his or her intentions. Behaviorally oriented therapies work predominantly on the right side of the Rubicon.

Perhaps the most testable of the general models is the Transtheoretical Model (TTM; Prochaska et al., 1992). The TTM describes the process of psychological change as going through six subsequent stages: *precontemplation, contemplation, preparation, action, maintenance,* and *termination*. Individuals may also return from action or maintenance to an earlier stage (relapse). Heckhausen et al.'s (1987) decisional Rubicon could be located between the contemplation and preparation phase. The authors also advise therapists to adjust their relational stance toward the patient to each individual's stage of change. Prochaska and Norcross (2001) proposed that in the precontemplation stage, the therapist should behave like an understanding parent, later morphing into a Socratic teacher in the contemplation phase. In the preparation phase, the therapist should assume the position of an experienced trainer, stepping behind again as a counselor in the action and maintenance phases. Research indicates that tailoring the therapy relationship and treatment intervention to the stage of change can enhance outcome, specifically in the percentage of patients completing therapy and in the ultimate success of treatment (Prochaska & Norcross, 2001).

Although the TTM has been criticized, for example, for inconclusive empirical foundation as well as unresolved assessment problems, the TTM, like the Rubicon Model and the change model of General Psychotherapy, possesses great heuristic value for practicing clinicians to conceptualize and structure their interventions.

Motivational Change as a Central Mechanism

Motivational factors may change in psychotherapy, even if motivational change is not explicitly part of the therapy rationale, or motivational factors may be the central mechanism of change that therapists explicitly try to implement. As an example of *naturalistic* motivational change, several authors found that unfavorable goal characteristics changed, even without an underlying explicit rationale for working on these goal characteristics. For example, motivational factors that were found to change in psychotherapy were strong avoidance motivation (Grosse Holtforth et al., 2005), goal conflicts (Heidenreich, 2000; Hoyer, Fecht, Lauterbach, & Schneider, 2001; Michalak, 2000), or goal satisfaction (Berking, Grosse Holtforth, & Jacobi, 2003; Grosse Holtforth & Grawe, 2002).

Even though motivation can change even in therapies that do not explicitly target motivational variables, several approaches have been developed directly targeting motivational change. Some interventions have been tested in studies with nonclinical populations that might be used as a heuristic for clinical interventions. For example, Schultheiss and Brunstein (1999) used guided *goal imagery* to foster motive-congruent goal commitment (goal fit). They found that those subjects who had used guided goal imagery were more committed to goals that corresponded with their implicit motive dispositions. In an extension of this research, Job and Brandstätter (2009) showed in a series of experiments that goal fantasies focusing on affective incentives that are specific to a given motive promoted motive-congruent goal setting. Sheldon, Kasser, Smith, and Share (2002) designed an intervention to improve self-concordance and integration of goals. In the intervention, participants are asked to reflect upon their goals and are taught four specific strategies for the regulation of goal-related experience, such as Own the goal, Make it fun, Remember the big picture, and Keep a balance (Sheldon et al., 2002). Empirical results indicate that participants already high on personality integration benefited the most from the program in terms of goal attainment, whereas participants with low levels of self-concordance did not profit from the program. Also the formation of *implementation intentions* specifying the where, when, and how of goal pursuit may further goal attainment (Gollwitzer, 1993; Koestner et al., 2002).

In the following we will highlight sample therapeutic approaches that attempt to influence goal processes at various levels. Whereas motivational change is at the core of psychodynamic approaches and these therapeutic approaches are rather well known (e.g., Luborsky & Crits-Christoph, 1998), we will focus here on more recent approaches for the treatment of emotional problems that explicitly target motivational change. First, we will describe Motivational Interviewing (MI; Miller & Rollnick, 2002), an approach that combines various motivational strategies to further treatment motivation and therapy outcome, as well as other approaches that aim at the resolution of patient ambivalence. Two approaches for the treatment of emotional disorders

that explicitly work on motivational factors are Self-System Therapy (SST; Strauman et al., 2006) and Well-Being Therapy (WBT; Fava & Tomba, 2009). Another approach that focuses on motivational change as a main change mechanism and has been explicated for several psychological disorders is the Acceptance and Commitment Therapy (ACT; Hayes et al., 1999). Finally, in the field of personality disorders, Clarification Oriented Therapy targets motivational change for changing patients' dysfunctional interactional behaviors (Sachse, 2004).

Motivational Interviewing (MI; Miller & Rollnick, 2002) is both a treatment philosophy and a set of methods employed to help people increase intrinsic motivation by exploring and resolving ambivalence about behavioral change. MI is highly compatible with the therapeutic goal of fostering autonomous motivation for therapy (Ryan & Deci, 2008). In MI, the therapist neither persuades nor coerces patients to change, but instead attempts to explore and resolve the patients' ambivalence, allowing them to decide for themselves about whether wanting to change or not (Ryan & Deci, 2008). When working with ambivalence and resulting resistance against change, the therapist supports the patient by confronting, exploring, and challenging introjected past experiences of conditional regard (Assor, Roth, & Deci, 2004). Such introjects may, for example, hinder a patient from disclosing his or her feelings to the therapist out of fear of disapproval. By providing an autonomy-supportive atmosphere, the MI therapist helps his or her patient find an internal source of motivation that guides and fuels his or her future change efforts (Markland, Ryan, Tobin, & Rollnick, 2005). The therapist tries to improve intrinsic motivation by helping the patient become the primary agent of change (Arkowitz & Westra, 2009). Initially, MI was established in the area of alcohol and other substance abuse (Miller & Rollnick, 2002), and more recently it has been used in the context of a wider range of clinical problems (see Buckner, 2009, for a review).

Patients may experience ambivalence not only regarding therapeutic change but also in other parts of their lives (e.g., the continuation of a marriage, finding a new job, etc.). Several methods are available to psychotherapists to help their patients deal with or resolve their ambivalences. A very pragmatic approach to this purpose is the work with the Decision Cube. More general interventions to change patient ambivalence are the Two-Chair-Exercise and the Decision-Fostering Intervention. The basis for the application of the Decision Cube is to assist the patient in making a deliberate decision for or against beginning psychotherapy. For this purpose, the intervention helps the patient to clarify the respective advantages and disadvantages of beginning psychotherapy (or not) using a 2 x 2 matrix. The therapist tries to activate the goals involved but takes an absolutely neutral stance toward the options. It is assumed that an autonomous decision to begin psychotherapy will lead to a greater commitment and endurance. The aim of the *two-chair-exercise* is to create awareness of both sides of an ambivalent experience and to prepare the two "split" sides for a later integration. As mentioned, this ambivalence may concern other ambivalences than starting a treatment. For this purpose, each of the two chairs used reflects one side of the ambivalence. The therapist actively guides the patient to activate and express the thoughts, feelings, and action tendencies of the different sides of the self by requesting the patient to switch chairs, whenever the patient assumes one respective side of the ambivalence. After some dialogue between the two sides, usually conflict/ambivalence weakens and the patient comes closer to a decision that integrates the two competing sides of himself or herself.

The Decision-Fostering Intervention (DFI) is a structured short group intervention aimed at motivating patients to actively participate in personal change. Central to the intervention is to frame the motivational problem as a decisional problem. DFI consists of the following successive parts: *Evaluation and Prioritization, Justification,* and *Planning*. In the *Evaluation and Prioritization* phases, patients imagine the change process, the range of possible outcomes, along with their own emotional reactions, the reactions of their significant others, and then subsequently prioritize their behavioral options. In the *Justification* phase, patients are asked to choose a decision and justify their decision in front of the group, while the therapist assumes the position of a (friendly) devil's advocate that the patient needs to convince. This dispute will lead to a *Decisional Statement* that the patient and therapist fixate in writing with the general structure: "I want to do X, because the consequence Y is more important to me than the consequence Z." To foster the *Presence* of the decision, the patients find a symbol for the decision (picture, posture, movement, etc.) and place it in a highly visible or noticeable position in their daily lives. In the *Planning* phase, patients plan the implementation of their decision by defining the where, when, and how of the associated actions, anticipate likely obstacles, and generate adequate

responses. In addition, patients plan the specifics of *coming out* with their decision to significant others, and write these plans down. The therapist in DFI closely monitors and guides the patient through the process of decision formation, up to the implementation of the formulated decision.

Self-System Therapy (SST) has been developed by Strauman and colleagues (Strauman et al., 2006; Vieth et al., 2003) based on a model of depression as a disorder of motivation and goal pursuit resulting from chronic failure to attain certain kinds of personal goals. In an earlier study, Strauman et al. (2001) had found that various empirically supported treatments (cognitive therapy, CT; Beck, Rush, Shaw, & Emery, 1979; Beck, 1995), interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984), and pharmacotherapy with selective serotonin reuptake inhibitors were less effective for depressed patients with chronic self-perceived failure in promotion goal pursuit than for other patients. According to Regulatory Focus Theory (RFT; Higgins, 1989), promotion goals are aimed at making good things happen, whereas prevention goals are aimed at preventing bad things from happening. If this subgroup of depressed patients was vulnerable to depression because of inadequate socialization toward pursuing promotion goals, then SST interventions to enhance promotion goal pursuit might help them recover from depression more completely. Strauman et al. (2006) summarized SST in four questions directed to the patient: "What are your promotion and prevention goals? What are you doing to try to attain them? What is keeping you from making progress? What can you do differently?" (Strauman et al., 2006, p. 368). To improve the patient's pursuit of promotion goals, SST flexibly combines techniques from other empirically supported psychotherapies, including cognitive therapy, interpersonal psychotherapy, and behavioral activation therapy in the service of improved goal pursuit. In a randomized trial comparing SST with cognitive therapy (CT) in a sample of 45 patients with depression, SST and CBT on average showed equal efficacy between treatments, but patients whose socialization history lacked an emphasis on promotion goals showed significantly greater improvement with SST (Strauman et al., 2006).

Well-Being Therapy (WBT; Fava & Tomba, 2009) is based on Ryff's cognitive model of psychological well-being (Ryff, 1989), which proposes six dimensions of psychological well-being: environmental mastery, personal growth, purpose in life, autonomy, self-acceptance, and positive relations with others. Although labeled as *dimensions of well-being*, these dimensions are very similar to other motivational constructs, for example, the dimensions of goal satisfaction (Grosse Holtforth & Grawe, 2003). A WBT therapist strives to help the patient achieve better well-being on all six dimensions to increase resilience (Fava, 1999; Fava & Ruini, 2003). To reach this goal, WBT integrates psychological techniques from various sources within a short-term format (8–12 sessions), that is, cognitive restructuring, scheduling of activities, and assertiveness training, and problem solving in addition to self-observation of positive experiences.

In early therapy the therapist helps the patient to develop skills to continuously attend to positive aspects of daily experience or positive emotions using structured diaries. Subsequently the therapist helps the patient to identify thoughts and beliefs leading to premature interruption of well-being by self-observation, and the therapist challenges these thoughts (Beck et al., 1979). In parallel, the therapist reinforces and encourages activities that are likely to elicit well-being by graded task assignments. In the final sessions, the therapist instructs the patient to self-monitor the course of episodes of well-being and optimize behaviors aiming at the attainment and preservation of well-being. WBT can be applied as a stand-alone therapy or as an addition to other forms of psychotherapy or pharmacotherapy. However, WBT is considered most appropriate for treating nonacute depression to address aspects that have been omitted by other approaches (Fava & Tomba, 2009). In an empirical test of WBT, 20 patients with depressive and/or anxiety disorders (major depression, panic disorder with agoraphobia, social phobia, generalized anxiety disorder, obsessive compulsive disorder) who had been successfully treated by behavioral (anxiety disorders) or pharmacological (mood disorders) methods were randomly assigned to either WBT or cognitive-behavioral therapy (CBT). Whereas both therapies showed a significant reduction of residual symptoms as well as increase in psychological well-being, WBT showed a significantly greater reduction of residual symptoms immediately after treatment (Fava & Tomba, 2009).

Acceptance and Commitment Therapy (ACT; Bach & Hayes, 2002; Hayes et al., 1999) focuses on reducing experiential avoidance, which is considered a pathological factor. Avoiding private experiences (i.e., certain thoughts, feelings, or body sensations) is assumed to result in failure to behave in a way that is in accord with one's values. As the acronym ACT indicates, patients learn to Accept their reactions and be present, Choose a valued direction, and Take action in order to develop more psychological

flexibility (Hayes et al., 1999). Patients are guided to face and overcome experiential avoidance by learning to perceive their inner experiences (thoughts, images, emotions, memories etc.) without any evaluation, by allowing and accepting them to come and go without resisting them, by experiencing the here and now with openness and interest, and by observing the processes within the self. The therapist focuses on values by helping the patient to discover what he or she considers most important in life, to set goals according to these values, and to carry them out. A characteristic of ACT that distinguishes it from, for example, CBT is that ACT focuses less on symptom reduction than on empowering patients to pursue their goals in accordance with their important values. ACT has shown significant effects with a variety of clinical disorders and problems; however, the body of well-controlled studies does not suffice yet to conclude that ACT is generally more effective than other active treatments (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). For example, Forman, Herbert, Moitra, Yeomans, and Geller (2007) found in a randomized controlled effectiveness trial of ACT and CT for anxiety and depression that patients in CT and ACT showed large and equivalent improvements in depression, anxiety, and other outcomes. However, the mechanisms of action differed between the therapies; in CT observing and describing one's experiences mediated outcomes for patients in the CT, whereas experiential avoidance, acting with awareness and acceptance, mediated outcomes for those in the ACT group.

Personality disorders can be characterized by the interpersonal problems the patients experience. According to the interpersonal theory of personality disorders, salient frustrated motives are the potential reasons underlying interpersonal problems (Horowitz, 2004). Accordingly in Horowitz's (2004; Horowitz et al., 2006) *model of interpersonal motives*, a person with a certain personality disorder is assumed to feel frustrated with respect to some salient motive. For example, for patients with a narcissistic personality disorder, the assumed organizing motive is the unrestricted admiration by other people. Consequently, narcissistic people may show behaviors like bragging about their exceptional achievements. As a result, they often appear rather arrogant and repel other people, so that the person reports characteristic recurring cognitions, fears, and interpersonal problems, which are described as the diagnostic criteria in the *DSM-IV-TR*. In response to failures to satisfy the predominant interpersonal motive, a person with a personality disorder may experience negative emotions, show maladaptive behavioral strategies (e.g., oversensitive counterattacks), or retreat to maladaptive coping strategies (e.g., abusing drugs or alcohol). Consequently, the goal of motivation-focused interventions for personality disorders according to Horowitz's model is to change problematic interpersonal behavior by changing the assumedly underlying motivational structure. This should lead to more adaptive interpersonal strategies and behaviors that, in turn, should lead to a better satisfaction of the full range of the person's goals.

Sachse (2010) proposed a conceptualization and treatment of personality disorders (Clarification-Oriented Psychotherapy, COP-PD) that is compatible with these assumptions. Like Horowitz (2004), Sachse (2010) assumed that over their lives, people with personality disorders have developed a preponderance of certain motives as well as dysfunctional interactional goals, strategies, behaviors, and cognitions for the satisfaction of these motives, which he calls *game structures*. These game structures (i.e., often manipulating and intransparent styles of interaction to force a partner to satisfy motives) constitute the characteristics of people with personality disorders. Thus, the actions of a patient with a personality disorder are governed by predominant motives as well as the developed game structures. In COP-PD, the therapist tries to help the patient explicate his or her interpersonal motives, change the associated dysfunctional interpersonal schemas (goals, strategies, and behaviors), and establish new need-satisfying motivational-behavioral patterns in real-life interactions. For example, with narcissistic patients, therapists attune their behavior to the assumed narcissistic motives by normalizing the patient's problems, maximally validating the patient's resources (but not the dysfunctional strategies), and cautiously directing attention to the discrepancy between the patient's self-doubts and his or her resources. This discrepancy in conjunction with awareness of the costs of the maladaptive behavior is assumed to fuel the patient's motivation for change. Subsequently, the therapist moves to reconstructing the schemas and to practicing new, more adaptive strategies and behaviors for motive satisfaction in real-life interactions with less adverse side effects. Clarification-Oriented Psychotherapy has been explicated also as a general strategy for other clinical disorders (Sachse, 2003).

Conclusion: A Motivationally Informed Psychotherapy

In the concluding section, we will try to summarize the implications of basic and clinical research

for a motivationally informed psychotherapy. In a motivationally informed psychotherapy, psychotherapists are faced with at least two tasks: to help the patient change the factors maintaining his or her psychological disorder(s), and to foster conditions that support the patient's treatment motivation (see Schulte & Eifert, 2002).

A primary goal of psychotherapy is to decrease psychopathology and associated suffering. From a motivational perspective, the overall goal of psychotherapy can be defined more broadly as helping the patient to better satisfy his or her psychological needs, which should go along with better well-being and life satisfaction. Under this perspective, psychopathology is considered the principal source of psychological suffering that psychotherapy is supposed to change. However, part of the therapeutic enterprise may also be to assist the patient in accepting and coping with problems that are unchangeable, such as losses of significant others or one's own limitations as, for example, caused by physical disabilities.

To optimally be aware of, use, and change motivational factors in psychotherapy, a therapist has various options for assessing motivational constructs. For reasons of practicality, the therapist will use observational, interview, or questionnaire methods of assessment most likely in conjunction with anamnestic information, rather than more stringent yet time-consuming methods of assessing implicit motives. Motivational constructs that the therapist may assess at intake are therapy motivation, values, personal goals, motivational conflicts, and treatment goals. If the therapist wants to use motive-related measures for quality assurance purposes, the improvement of goal satisfaction may be the central construct to assess (Grosse Holtforth & Grawe, 2004).

For a motivation-focused case formulation, it will be central to get a clear picture of which approach goals the patient deems important, which avoidance goals he or she dreads most strongly, how strong the suffering from goal dissatisfaction is, which goals the patient cannot satisfy enough, and what the sources of the dissatisfaction are. The sources of lacking goal satisfaction may be heterogeneous, such as marital problems, academic failure, and discrimination at work. Motivational sources of goal dissatisfaction may be approach goals that are too strong (e.g., very high standards for personal achievement) or too strong avoidance goals (e.g., being very easily hurt by critical remarks of others). Additionally, goal conflicts or ambivalences may be powerful sources of goal dissatisfaction (e.g., being ambivalent about ending the relationship to an alcoholic spouse may seriously hamper the patient's wishes to be in control of one's life). Goal satisfaction may also be hindered if the person has not developed adequate strategies for goal satisfaction (e.g., bragging behavior of narcissists). A motive-oriented treatment plan will then outline motive-related ways to improve the conditions for change as well as ways to change motivational factors that contribute to lacking goal satisfaction.

The therapist can create favorable conditions for change by fostering a good therapy relationship via motivational attunement and by formulating adequate therapy goals. As shown earlier, motivational attunement aims at strengthening the working alliance by attuning to the patient's most important approach goals, by avoiding to inadvertently activate avoidance goals, as well as using the motivational information to understand and resolve occurring alliance ruptures. The treatment goals that the patient and therapist agree on at the outset of treatment should concretize the directions the therapy should take for satisfying the patient's personal goals. If a patient experiences difficulties in formulating clear treatment goals, strategies of goal imagery and goal concretization (e.g., EPOS) may help the patient to get a clearer picture of what he or she wants to achieve with the help of the therapist. The therapist will focus goal formulation on positive outcomes associated with the planned changes and define goals that correspond well with the patient's values and motives and are compatible with each other.

Treatment goals should be formulated as approach goals ("I will be able to confront my boss assertively when I disagree") instead of avoidance goals ("I no longer avoid confronting my boss when I disagree"), should be controllable and attainable, should be formulated as concretely as possible, and the criteria for goal attainment should be explicitly stated. Well-chosen and well-formulated therapy goals will strengthen the patient's commitment and endurance in goal striving and participation in therapy. Goal attainment promises to be most likely if the patient develops clear intentions for goal attainment, as well as implementation intentions. Strategies like "Own the goal," "Make it fun," "Remember the big picture," or "Keep a balance" may help the patient in the process of goal striving (Sheldon et al., 2002, pp. 14–15).

To facilitate change, therapists may also question potential defensive justifications for preserving old goals and behaviors (Karoly, 2006). Another powerful force working against new goal striving

may be the influence of *automaticity*. Patients may make the experience that "old" maladaptive behaviors or feelings are automatically triggered by situational cues. Such reactions may especially arise in situations that the patient previously dreaded and avoided. The therapist will need to make these automatized associations consciously accessible to the patient and work with the patient on accepting (not avoiding) his or her own aversive experiences. The sequence of awareness, acceptance, and new reactions/new behaviors will have to be repeatedly run through with the patient to result in more sustainable change. Such a training of deautomatizing previously automatic dysfunctional reactions and behaviors will help the patient to recognize and override the effects of automaticity in service of pursuing more need-satisfying goals (Karoly, 2006). An important factor to consider is the context of goal striving. The more the patient's social network supports the patient's goals, the more likely the patient will reach them. Depending on how changeable patient and therapist perceive the level of support for his or her goals, either couple, family, or systemic interventions will be indicated for trying to change the level of support.

We have highlighted several therapeutic approaches that attempt to influence goal processes at various levels. Motivational Interviewing as well as other techniques (Decision Cube, Two-Chair exercise, Decision-Fostering Interventions) are suited to change patient ambivalence toward treatment as well as other forms of ambivalence. Both Self-System Therapy and Well-Being Therapy are designed to improve goal and need satisfaction in acutely or chronically depressed patients, respectively, with varying emphases. Acceptance and Commitment Therapy emphasizes overcoming experiential avoidance by accepting unpleasant experiences, developing clear values guiding one's actions, and trying to efficiently pursue one's goals. Clarification-Oriented Therapy for personality disorders intends to improve the patient's need and goal satisfaction by raising awareness for dysfunctional interactional strategies and behaviors and attempting to change these strategies and behaviors.

We hope to have demonstrated the centrality of motivational factors in psychotherapy, either as facilitators of change or as targets of change. Motivational considerations and interventions may be used in all kinds of psychotherapy and have a great potential for helping patients in overcoming their problems and living a happier and more satisfying life.

Future Research/Open Questions

As we have seen in this chapter, previous research on motivational factors in psychotherapy has already yielded findings that have great potential for advancing psychotherapy. However, as we have also seen, a multitude of questions remains to be investigated by future research. A few examples of such questions are as follows:

1. By which psychological mechanisms do motivational factors (treatment goals, motive satisfaction, conflicts, etc.) contribute to the development and maintenance of psychological disorders and problems? For example, how do the goals of patients with personality disorders influence their interpersonal behavior, and how does this behavior relate to the satisfaction of specific needs and goals?
2. Which motivation-focused interventions can foster motivational change, and how does this relate to therapy effectiveness? For example, is a treatment that fosters the formulation of well-formed therapy goals more effective than a treatment that does not?
3. Can therapists foster the quality of the therapeutic relationship by motivational attunement and does this improve therapy outcome? For example, do cognitive-behavioral therapists who try to tailor their interventions to the patient's motives attain better outcomes than therapists who do not?
4. What are the motivational mechanisms of change in psychotherapeutic treatments of various orientations? For example, how does the intensity of avoidance motivation change in cognitive-behavioral as compared psychodynamic therapies?
5. Which motivational factors predict the process and outcome of psychotherapy, and how is this prediction mediated? For example, do high levels of ambivalence over the expression of emotion predict collaboration in treatment, and worse outcomes?
6. Do various psychotherapeutic approaches change explicit and implicit motivation differentially? What are the consequences for outcome? For example, do motivation-focused treatments change implicit motivational conflicts more effectively, and is this associated with longer-lasting improvements?
7. Do ethnically and culturally diverse groups of patients differ in motivational factors (values, treatment goals, response to motivational interventions), how does this affect treatment,

and how should practicing psychotherapists tailor their interventions to the ethnical backgrounds of their patients? For example, can clarification-focused interventions be applied similarly with Swiss patients with Asian background as with Moroccan patients with sub-Saharan African background, and which adaptations are necessary?

8. Which brain areas are associated with motivational characteristics of psychotherapy patients and how do they change over treatment? For example, can intense avoidance motivation be localized in the brain, and is change in avoidance motivation over therapy associated with changes in these brain areas?

Generally, future research on motivational factors would profit from a more frequent use of experimental methods, as well as causal hypotheses using longitudinal designs.

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