

الدافعية للتدخلات العلاجية في الخدمة الاجتماعية الإكلينيكية في الكويت

هند المعصب

ملخص: نموذج الدافعية المقترح من قبل نظرية تقرير المصير يقدم تفسيراً لدافعية العملاء للتدخل العلاجي. هذه الدراسة تناولت العلاقة بين ثلاثة أنواع من المتغيرات الخاصة بالدافعية وهي الحكم الذاتي - السيطرة - اللادافعية على عينة تتكون من 78 من المدمنين المقيمين في مركز علاج الإدمان وبين المتغيرات التالية: العمر - الحالة الاجتماعية - مستوى التعليم - عدد سنوات الإدمان. بالإضافة تقوم هذه الدراسة باختبار ما إذا كان لدى المشاركين في عينة الدراسة دافعية لتلقي التدخل العلاجي. نتائج هذه الدراسة أظهرت أن هناك علاقة دالة إحصائياً بين متغير السيطرة وكل من المتغيرات التالية: العمر - الحالة الاجتماعية - عدد سنوات الإدمان. وأظهرت النتائج أيضاً أن هناك علاقة دالة إحصائياً بين متغير الحكم الذاتي ومتغير عدد سنوات الإدمان. كذلك هناك علاقة دالة إحصائياً بين متغير اللادافعية ومتغير مستوى التعليم. أوضحت النتائج أن المشاركين في عينة الدراسة لا توجد لديهم دافعية للتدخلات العلاجية.

المصطلحات الأساسية: الدافعية، الخدمة الاجتماعية الإكلينيكية، نظرية تقرير

المصير.

Motivation for Therapeutic Interventions in Clinical Social Work in Kuwait

*Hend Al-Ma'seb**

Abstract: The motivational model proposed by the Theory of Self-Determination provides an explanation for clients' motivation for therapeutic intervention. This study examined the relationship that holds between three types of motivation (Autonomous, Controlled, and amotivation) through a sample of 78 addicted resident inpatient in the Addiction Treatment Center, and each of the following variables: Age, Marital Status, Educational Level of Participant, and Number of Years of Addiction. In addition, the study investigated whether or not the participants are motivated to receive therapy. The results showed that there is: 1) a significant relationship between the Controlled Motivation variable and the following variables: Age, Marital Status, and Number of Years of Addiction; 2) a significant relationship between the Autonomous Motivation variable and Number of Years of Addiction variable; and 3) a significant relationship between the Educational Level variable and the amotivation variable. The results also demonstrated that the sample participants in this study were not motivated to receive therapeutic interventions.

Key words: Motivation, Clinical Social Service, Self-Determination.

Introduction

At the core of the profession of Social Work is the desire to help clients achieve appropriate changes in themselves and their lives so they can adjust to their environments. In order to fulfill this goal, social workers have used many tools to improve therapeutic interventions,

* Associate Dean Academic Affaris, College of Social Sciences, Department of Sociology and Social Work, Kuwait University.

especially in the area of Clinical Social work. Clinical Social Work is defined in the Dictionary of Social Work as “the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorder” (p. 74).

For various reasons, the therapeutic interventions that clinical social workers use with clients sometimes are not effective, and many researchers have concentrated on exploring the reasons behind this (Humphreys, Wing, McCarty, Chappel, & Galant, 2004; Humphreys & Tucker, 2002; West, Gorin, Subak, Foster, Bragg, Hecht, Schembri, & Wing, 2011). One of the important factors that may affect the effectiveness of interventions was found to be the degree of clients’ motivation for therapy, which may result in negative outcomes or may cause clients to drop out from therapy before the desired outcomes have been achieved (Ryan et al., 1995). Many studies found a significant relationship between clients’ motivation to seek and receive therapy and the outcomes of therapy in different populations (Buckner & Schmidt, 2009; Dean, Touyz, Rieger, & Thornton, 2008; Dunn & Larimer, 2006; Kennedy & Gregoire, 2009; McKee, Carroll, Sinha, Robinson, Nich, Cavallo, & O’Malley, 2007; Treasure, Katzman, Schmidt, Troop, Todd, & de Silva, 1999; Zuroff, Koestner, Moskowitz, McBride, Marshall & Bagby, 2007).

While numerous researchers in the West studied clients’ motivation for therapy, it is equally important to study the relation between motivation and therapy outcomes among clients from different cultures than Western culture. In particular, no studies that address this subject exist in the field of clinical social work in Kuwait. Social workers in Kuwait need to understand the various motivational variables that impact their clients’ choice to seek and receive therapy so they can work with them more effectively. This study will explore this new area in the field of clinical social work in Kuwait.

Theory Perspective and Literature Review

Self-Determination Theory (Deci & Ryan, 1985)

At the core of Self-Determination Theory (SDT) is the distinction between autonomous motivation and controlled motivation. Autonomous motivation is a form of behavioral regulation. Having autonomy means people are able to experience volition and choice. Gagne and Deci

(2005) explained that autonomy appears “when people engage in an activity because they find it interesting, they are doing the activity wholly volitionally” (p. 334). However, controlled motivation means that people experience pressure or compulsion when they perform an activity (Williams et al., 2002).

Self-Determination Theory suggests three types of motivation that regulate individuals’ behavior: intrinsic, extrinsic, and amotivation. Intrinsically motivated behaviors are exhibited when an individual engages in an activity that he or she finds interesting and enjoyable, so he or she performs it voluntarily and is interested in the activity itself. For example, a client may participate in therapy because he or she thinks it will be helpful (Pelletier, Tuson, & Haddad, 1997; Lynch, Vansteenkiste, & Deci, 2011). However, most clients do not enter therapy because it is an enjoyable activity for them; they participate in it because they believe it might help improve their lives (Ryan et al., 2011). Therefore, it is important that the social workers who work with such clients help them to discover the intrinsic motivation for the therapy. The intrinsic motivation is considered to be autonomous motivation, which is self-determined.

The second type of motivation is extrinsic motivation, which refers to “engaging in [an] activity to obtain an outcome that is separable from the activity itself” (Vansteenkiste & Sheldon, 2006, p. 67). If clients come to therapy only due to extrinsic motivation, then they derive no enjoyment from the therapy. Based on Self-Determination Theory, there are four different types of extrinsic motivation: external regulation, introjected regulation, identified regulation, and integrated regulation. According to Gagne and Deci (2005), each of these types of motivations varies in the degree to which it is autonomous or controlled (Gagne & Deci, 2005; Pelletier, Tuson, & Haddad, 1997; Ryan, Lynch, Vansteenkiste, & Deci, 2011; Vansteenkiste & Sheldon, 2006; Ryan & Connell, 1989; Deci, Eghrari, Patrick & Leone, 1994). As defined by previous studies, the first type of extrinsic motivation, external regulation, refers to the external sources that control the behavior of an individual. The clients enter therapy because they want to gain a reward or to avoid a punishment. The second type of extrinsic motivation, introjected regulation, means that the client has internal pressures because he or she feels guilty or ashamed. The third type of extrinsic motivation,

identified regulation, refers to clients' behavior that is congruent with their values and goals. The fourth type of extrinsic motivation, integrated regulation, means that clients believe that an individual's behavior is coherent with his or her values and is part of who he or she is.

Amotivation is the third type of motivation. It refers to an individual's lack of desire for the activities that he or she is doing because he or she is either feeling incompetent or has a sense of lacking control. Pelletier et al. (1997) illustrated that the clients do not recognize a relationship between the actions they are doing and the outcomes of this action. Finally, Gagne and Deci (2005) explained "Autonomous motivation and controlled motivation are both intentional, and together they stand in contrast to amotivation, which involves a lack of intention and motivation" (p.334). When social workers apply Self-Determination Theory in their work with clients, they are seeking optimistic changes in the clients' lives and that happens when there is both high internal and low external motivation (Zeldman et al., 2004).

Table (1) below shows the three types of motivation and their relation to self-determination. Intrinsic motivation is inherently self-determined. The four types of extrinsic motivation vary between low self-determined motivation and high self-determined motivation. Amotivation lacks self-determination.

Table 1: Taxonomy of the Self-Determination Continuum

Amotivation	Extrinsic Motivation				Intrinsic Motivation
Neither External nor Internal	External Regulation	Introjected Regulation	Identified Regulation	Integrated Regulation	Highly Internal
	Highly Ex- ternal	External	Internal	Highly In- ternal	
Lack of Motivation	Controlled Motivation	Somewhat Controlled Motivation	Somewhat Autonomous Motivation	Autonomous Motivation	Essentially Autonomous Motivation

Clinical social workers work with different types of clients with different degrees of motivation or resistance to therapy. As Ryan et al. (2011) explain, some clients appear to be extremely motivated for change; but in fact, they are opposed to change. Other clients appear compliant

during the therapy process not out of their own desire, but because they are seeking approval from the therapist or social worker or their family. Then there are some clients who are forced to enroll in a therapy, and they have no desire to make any changes (Bandura, 1996; Vandereycken, 2006; Zeldman, Ryan, & Fiscella, 2004).

One of the aims of clinical social work is to maintain helpful therapy with clients, associated with positive outcomes. The client's motivation for therapy is one of the most important elements of the success of therapeutic intervention. Ryan et al. (2011) provided evidence in counseling across a variety of settings and approaches that indicates a direct predictive relationship between patient motivation and the effectiveness of treatment. Therefore, it is desirable for clients to be motivated when they enter therapy. Many studies found that positive outcomes are more likely to occur when clients engage in therapy because they themselves are intrinsically motivated, which assures better outcomes (Overholser, 2005; Ryan & Deci, 2008; Philips, & Wennberg, 2014). Overall, motivational dynamics are critical in counseling processes and outcomes (Ryan et al., 2011).

Many social science research studies provide evidence that supports the assumption that autonomous motivation for therapy is associated with the best outcomes. Koestner et al. (2008) found a positive correlation between autonomous motivation and goal outcomes. Autonomous motivation has been linked to positive outcomes of the treatment of health problems, such as diabetes, drug addiction, obesity, alcoholism, and smoking (Ryan, Plant, & O'Malley, 1995; Williams, Freedman, & Deci, 1998; Williams, Gagne', Ryan, & Deci, 2002; Williams, Grow, Freedman, Ryan, & Deci, 1996; Williams, McGregor, Zeldman, Freedman, & Deci, 2004; Zeldman, Ryan, & Fiscella, 2004).

Williams et al. (1998) studied 128 patients with diabetes and found a relationship between autonomous motivation and glucose levels. They illustrated that patients who received autonomous support from their health care providers were able to control their glucose levels. Ryan et al. (1995) examined the relationship between internalized motivation and patient involvement and retention in treatment among a sample of outpatients who are addicted to alcohol. They found a strong association between internalized motivation and patient involvement and retention

in treatment, where the patients who had high motivation established high attendance and treatment retention.

Williams et al. (2002) studied the effect of autonomous motivation on smoking cessation. They found that “the more autonomy supportive the physicians were observed to be, the higher was the patients’ reported autonomous motivation for quitting” (p. 48). Another study conducted by Williams et al. (1996) tested the relationship between autonomous motivation and weight loss. The results of the study showed that clients who were motivated were more autonomous and therefore more likely to attend the program more often and lose weight. Zeldman et al. (2004) examined the relationship between motivation and treatment outcomes among a sample of opioid-dependent patients. The results of Zeldman et al.’s (2004) study showed that “Internally motivated individuals had lower relapse rates and indicated by fewer positive urine samples and better attendance, whereas those who were externally motivated for treatment had higher relapse rates and poorer attendance” (p. 691).

Philips and Wennberg (2014) examined the relation between clients’ pre-therapy and their characteristics and whether it predicted retention in therapy among 172 patients with substance use disorders. They found a significant difference between men and women with regard to therapy motivation. The results showed that women have higher levels of autonomous motivation, and lower levels of amotivation and controlled motivation. However, they found no significant differences between age and the three motivation variables.

The findings of the previous studies supported the conjecture between motivation and therapy outcomes. Therefore, it is important for social workers when they work with clients to understand the three types of motivation for therapy; moreover, it is also important to recognize the different types of clients with different degrees of motivation so they can assist the clients in a useful way.

The Research Questions

Based on the above literature and theory, the current study investigated whether or not the participants of this study are motivated for therapy. In addition, the study attempted to answer the following question: “What are the differences between the three types of motivation for therapy (Autonomous Motivation, Controlled Motivation, and

Amotivation) and the following variables: Marital Status, Age of Participant, Educational Level of Participant, and Number of Years of Addiction?”

Is there a positive relationship among the three variables, which comprise autonomous motivation (intrinsic motivation, integrated regulation, and identified regulation)? Is there a positive relationship between each of the two variables, which comprise controlled motivation (introjected regulation and external regulation)?

Methodology

This is a descriptive study. According to Rubin and Babbie (2001), “descriptive studies seek to portray accurately the characteristics of a population” (p. 247). A social survey approach was selected to address the research questions. The sample of this study was recruited on a voluntary basis from the Addiction Treatment Center in Kuwait. The author of this study selected this center to examine the research questions among its patients because there are many clients who either escape or drop out from the Addiction Treatment Center in Kuwait.

Data Analysis

Descriptive analyses were conducted to provide information about the sample and find the means, standard deviations, and range of scores. Also, Cronbach’s alpha was calculated to determine whether the instrument had adequate internal consistency. In addition, a univariate ANOVA analysis was used.

Participants

The population of this study consisted of drug addicts who are residents in the Addiction Treatment Center in Kuwait. Currently, there are 260 resident inpatients in the Addiction Treatment Center in Kuwait (Addiction Treatment Center, 2015). This study used a non-probability, convenience-sampling method to recruit the study participants. A total of 78 inpatients participated voluntarily in this research. Their ages ranged from 19 to 57 years old (mean = 33 years old). Females comprised 10.3% of the sample while males comprised 89.7%. The majority of the sample participants were single (51.3%), married participants formed (33.3%) of the sample, divorced (11.5%), and separated or widowed (1.3%). In terms of educational level, 73.1% of the

sample had a High School Diploma or less, 17.9% of the sample had a Bachelor's degree, and 5.1% had a Master's degree or higher. In terms of their places of residence, 21.8% of the sample reported living in Farwaniya, 21.8% in Al Ahmadi, 16.7% in AlAsima, 11.5% in Hawalli, 7.7% in Mubarak Al-Kabeer, and 7.7% reported living in AlJahra. In terms of their income, 70.5% were in the middle-income range, 15.4% had high income, and 12.8% had low income. Regarding their living arrangement, 76.9% of the participants reported living with their families and 20.5% reported living alone.

The Instrument

The participants in this study completed a questionnaire that included two parts. The first part asked about relevant demographic information, such as Marital Status, Age, Level of Education, Governorate, and Gender. The second part included the client's motivation for therapy, charted on the Client Motivation for Therapy Scale (CMOTS) developed by Pelletier, Tuson, and Haddad (1997).

There are many standardized measures of client motivation for therapy. However, these are in English. There are no standardized measures in Arabic to measure the client's motivation for therapy. Therefore, in this study, the author used Pelletier et al.'s (1997) CMOTS Scale. The CMOTS is a popular instrument used widely to measure clients' motivation for therapy. It is a 24-item instrument that requires respondents to rate their situation in response to self-descriptive statements. Responses were made on a 7-point Likert Scale, ranging from 1 = does not correspond at all, 4 = corresponds moderately, and 7 = corresponds exactly. The CMOTS is based on Deci and Ryan's theoretical perspective of individuals' motivation and self-determination. It has six subscales, with each subscale representing one type of motivation postulated by the theory. The first subscale represents intrinsic motivation, the second represents integrated regulation, the third is identified regulation, the fourth is introjected regulation, the fifth is external regulation, and the last one represents amotivation (Fischer & Corcoran, 2007). Pelletier et al. (1997) found the CMOTS valid and reliable. They explained that the alpha values for the six subscales were between 0.70 and 0.92 (Pelletier et al., 1997, p. 431).

The language of the questionnaire was English. A professional

Arabic language linguist translated the questionnaire and the covering letter from English into Arabic. A professional English language linguist translated them from Arabic back into English to make sure that the translation was accurate.

The researcher conducted a field test of the Arabic version of the questionnaire utilizing a panel of judges consisting of three professors from the Department of Sociology and Social Work at Kuwait University who are familiar with the study. This panel evaluated a draft of the questionnaire and the panelists gave their opinions. The panel found that all items were good and they did not require any changes. The internal consistency reliability of these subscales was found to be as follows: Intrinsic Motivation ($\alpha=0.81$), Integrated Regulation ($\alpha=0.61$), Identified Regulation ($\alpha=0.71$), Introjected Regulation ($\alpha=0.65$), External Regulation ($\alpha=0.64$), and Amotivation ($\alpha=0.60$). The autonomous motivation variable was formed to enhance the internal consistency by clustering the following three variables: Intrinsic Motivation, Integrated Regulation, and Identified Regulation. Cronbach's alpha for autonomous motivation was 0.71. The controlled motivation variable was formed by clustering the following two variables: Introjected Regulation and External Regulation. Cronbach's alpha for Controlled Motivation was 0.70.

Results

The researcher used correlation among Intrinsic Motivation, Integrated Regulation, and Identified Regulation to test the relationships among these variables which formed the Autonomous Motivation variable. The results show a positive correlation between Intrinsic Motivation and Integrated Regulation ($r = 0.44, p < 0.01$) and between Intrinsic Motivation and Identified Regulation ($r = 0.64, p < 0.01$). Furthermore, there is a positive correlation between Integrated Regulation and Identified Regulation ($r = 0.50, p < 0.01$).

A correlation test was conducted to test the relationships between the two variables that formed the Controlled Motivation variable. The results show a positive correlation between Introjected Regulation and External Regulation ($r = 0.34, p < 0.01$) (see Table 2).

Table 2: Correlation among the Client Motivation for Therapy Subscales

CMOTS subscales		1	2	3	4	5	6
1	Intrinsic Motivation	1.00	0.44**	0.63**	0.73**	0.32**	-0.11
2	Integrated Regulation	0.44**	1.00	0.48**	0.56**	0.53**	0.170
3	Identified Regulation	0.63**	0.48**	1.00	0.70**	0.43**	-0.06
4	Introjected Regulation	0.73**	0.56**	0.70**	1.00	0.34**	0.08
5	External Regulation	0.32**	0.53**	0.43**	0.34**	1.00	0.40**
6	Amotivation	-0.11	0.170	-0.06	0.08	0.40**	1.00

** Correlation is significant at the 0.01 level (2-tailed).

The main objective of this study was to investigate whether or not the participants were motivated to seek and receive therapy. A descriptive analysis was conducted to answer this research question. The lowest value was found for Intrinsic Motivation ($M = 7.31$; $SD = 5.43$), followed by Identified Regulation ($M = 7.85$; $SD = 5.58$) and Integrated Regulation ($M = 8.45$; $SD = 4.56$). The highest value was found for Amotivation ($M = 18.09$; $SD = 6.43$). This was followed by External Regulation ($M = 13.29$; $SD = 6.74$) and Introjected Regulation ($M = 9.01$; $SD = 5.36$). As a result, we concluded that the participants in this study were not motivated to seek or receive therapy (see Table 3).

Table 3: Means and Standard Deviations for the Client Motivation for Therapy Subscales

Subscales	<i>M</i>	<i>SD</i>
Intrinsic Motivation	7.31	5.43
Integrated Regulation	8.45	4.56
Identified Regulation	7.85	5.58
Introjected Regulation	9.01	5.36
External Regulation	13.29	6.74
Amotivation	18.09	6.43

One way ANOVA was conducted to test differences between groups in terms of Age, Marital Status, Number of Years of Addiction,

Educational Level, and the three clustered motivation variables (Autonomous Motivation, Controlled Motivation, and Amotivation).

The results of one-way ANOVA showed significant differences at $p < 0.05$ between Age of Participants and Autonomous Motivation and Controlled Motivation. The participants in the age category of 29 years old and less scored significantly higher on Autonomous Motivation than those who were in the age categories of 30 to 39 years old and 40 years old or older. In addition, the participants in the age category of 29 years and younger scored significantly higher on Controlled Motivation than those in the age categories of 30 to 39 years old and 40 years old and older. However, there were no significant differences at $p < 0.05$ in the relationship between Age of Participants and Amotivation (see Table 4).

Table 4: One-Way ANOVA between Age of Participants and Autonomous Motivation, Controlled Motivation, and Amotivation

	29 yrs old & younger		30-39 yrs old		40 yrs old & older			
	M	SD	M	SD	M	SD	df	F
Autonomous Motivation	28.51	14.3	22.72	11.9	16.73	8.1	72	4.64**
Controlled Motivation	25.27	9.8	20.73	10.6	15.93	7.4	73	4.67**
Amotivation	19.44	5.1	17.86	7.8	15.92	6.55	71	1.41

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$ (2-tailed)

Moreover, the results of one-way ANOVA showed significant differences at $p < 0.05$ in the relationship between Marital Status and Controlled Motivation. The researcher excluded the widowed and separated participants from the test due to their limited number.

The participants who were single scored significantly higher on Controlled Motivation than those who were married or divorced. However, there were no significant differences at $p < 0.05$ in the relationships between Marital Status and Autonomous Motivation or between Marital Status and Amotivation (see Table 5).

Table 5: One-Way ANOVA between Marital Status and Autonomous Motivation, Controlled Motivation, or Amotivation

	Married		Single		Divorced			
	M	SD	M	SD	M	SD	df	F
Autonomous Motivation	20.2	10.1	26.5	14.6	19.8	11.2	72	1.32
Controlled Motivation	18.4	8.5	24.0	10.5	15.0	7.5	73	3.72**
Amotivation	17.5	6.4	18.5	7.2	16.0	3.2	71	0.87

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$ (2-tailed)

The results of one-way ANOVA showed significant differences at $p < 0.05$ in the relationship between the Educational Level of the participants and Amotivation. Participants who have a Master's degree or higher scored significantly higher on Amotivation than those who have a High School Diploma or lower and those who have a Bachelor's degree. However, there were no significant differences at $p < 0.05$ between Educational Level and Autonomous Motivation or Educational Level and Controlled Motivation (see Table 6).

Table 6: One-Way ANOVA between Educational Level and Autonomous Motivation, Controlled Motivation, or Amotivation

	High School Diploma or Lower		Bachelor's Degree		Master's Degree or Higher			
	M	SD	M	SD	M	SD	df	F
Autonomous Motivation	22.6	12.8	30.0	14.0	16.2	6.2	70	2.58
Controlled Motivation	21.1	10.1	23.8	11.4	19.7	11.6	71	0.44
Amotivation	17.6	6.1	16.5	7.5	27.0	1.7	69	3.38*

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$ (2-tailed)

The Number of Years of Addiction variable refers to the number of years the participants used drugs. This variable has three categories:

using drugs for one to ten years; for 11 to 20 years; and for 21 years and more. The results of one-way ANOVA showed significant differences at $p < 0.05$ in the relationship between Number of Years of Addiction and Autonomous Motivation. Participants who reported having used drugs for one to ten years scored significantly higher on Autonomous Motivation than those who reported having used drugs for 11 to 20 years and those who reported having used drugs for 21 years or longer. However, we found no significant differences at $p < 0.05$ in the relationship between Number of Years of Addiction and Amotivation or Number of Years of Addiction and Controlled Motivation (see Table 7).

Table 7: One-Way ANOVA between Number of Years of Addiction and Autonomous Motivation, Controlled Motivation, or Amotivation

	1-10 yrs		11-20 yrs		21 yrs & above			
	M	SD	M	SD	M	SD	df	F
Autonomous Motivation	27.0	13.5	23.9	13.7	16.2	7.0	73	4.23**
Controlled Motivation	23.2	9.2	22.2	12.4	16.4	7.3	74	0.06
Amotivation	17.8	7.1	18.3	6.2	17.8	6.3	72	0.03

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$ (2-tailed)

Discussion

The current study focused on clients' motivation for therapy, based on self-determination theory. The findings of this study suggest that most clients fall under the category of Amotivation, where they lack any desire to undergo therapy. These findings explain the high rates of clients dropping out and discontinuing their attendance at the Addiction Treatment Center because they were not interested in the activities provided for them there. In addition, almost half of the clients (47%) did not enter the Center by their own choice, but were forced by their families or the police to enter therapy at the Center (Addiction Treatment Center, 2015). The findings here are consistent with other literature that suggests that patients who had low motivation established low attendance and treatment retention (Ryan et al., 1995). Therefore, it is important to

evaluate the activities provided to the clients to discover the weak parts of the program and develop new activities that can improve the clients' motivation for therapy. According to Ryan et al. (2011) "not all clients are motivated to enter treatment or to experience the changes that might occur if they did and that some clients, although they start therapy, might not be motivated to continue it" (p.119).

The findings of this study identify some of the correlates of Autonomous Motivation. They show that there is a positive correlation, that is, a positive relationship among the three variables: Intrinsic Motivation, Integrated Regulation, and Identified Regulation. For instance, when Intrinsic Motivation increases, Integrated Regulation increases as well, and Identified Regulation tends to increase. Furthermore, the findings of this study show a positive relationship between Introjected Regulation and External Regulation which form Controlled Motivation.

The results of this study demonstrate that clients who are 29 years old and younger displayed more Autonomous Motivation and more Controlled Motivation than those in the other age groups (30 to 39 or 40 years old and older). The findings of this study are consistent with the other literature that suggests that older high school students scored lower on intrinsic motivation than younger high school students and elementary school students (Digelidis & Papaioannou, 1999). This result could be explained by the fact that younger clients have more pressure from society than older clients because their parents still control their lives. Furthermore, Kuwaiti culture is part of Arab and Islamic cultures, in which people show respect for their parents and elders, and which makes them obey their parents. In addition, the younger clients have their lives ahead of them and they have plans and dreams for their lives. In contrast, the older clients may stop dreaming about their future or even have or make any plans.

The results of the current study show significant differences in the relationship between Marital Status and Controlled Motivation. The participants who were single had more Controlled Motivation than the participants who were married or divorced. The majority of the participants who were single in this study were in the age category of 29 years old or younger; therefore, they reported feeling more pressured by their families, especially if their families had high expectations from

them in terms of marriage and careers. It is important to concentrate on clients who are single to improve their motivation toward Autonomous Motivation instead of Controlled Motivation. In order to do that Vansteenkiste & Sheldon (2006) illustrate that therapists have to evoke and strengthen the clients' inner resources, which will help the natural change process in the clients to appear.

Another result showed significant differences in the relationship between the Educational Level of the participants and Amotivation. Participants who had a Master's degree or higher scored significantly higher on Amotivation than those who had a High School Diploma or lower, and those who had a Bachelor's degree. This result goes along with the above results because people who had a Master's degree or higher were the oldest participants, who showed more Amotivation, which means they had a lack of desire for the activities which they engage in.

In addition, participants who used drugs for one to ten years scored significantly higher on Autonomous Motivation than those who used drugs for 11 to 20 years and those who used drugs for 21 years and more. This result could be explained by the fact that the participants who used drugs for a few years had more desire to receive therapy because they might have wanted to stop using drugs, and they might have thought that if they participated in therapy, it could help them achieve their goals and make some changes in their lives. The findings of this study confirm Wahab's (2005) study which highlights "motivational constructs as key elements of the behavior change process" (p.46).

Implications for Clinical Social Work Practice

Social workers who work in the field can develop a better understanding of their clients' points of view based on the three motivational variables that clients develop through therapy. Moreover, in the field of clinical social work, there is always a need for effective interventions that can help social workers succeed in achieving positive change in their clients' lives and well being. Knowing the clients' motivation for therapy and the differences among the three motivational variables can help social workers develop appropriate therapeutic interventions for their clients.

Social workers do not have to focus only on an intervention without paying careful attention to the clients' motivations for therapy because

that would affect the outcomes of the therapy and cause clients to quit therapy. When working with clients, social workers have to increase their clients' Autonomous Motivation and decrease their Amotivation in order to improve the therapy outcomes.

Limitations of the Study and Future Research

Although this study is considered a pioneering research on clients' motivation for therapy in Kuwait, it has a notable limitation. In this study the scales were administered to a convenient sample which limits its generalizability. Future research needs to attend to this point and recruit a larger sample.

Many studies have been conducted in the area of clients' motivation for therapy in different parts of the world among different samples. The current study needs to be replicated using a different sample in Kuwait that represents different social problems such as divorce, alcoholism, eating disorders, and couples conflicts.

Another area for future research would be to study the effect of motivational interviewing, which is used as a tool to enhance the clients' motivation for therapy, on improving clients' Autonomous Motivation. In addition, further research is needed on clients' motivation as a predictor of retention in therapy and positive outcomes in the Kuwaiti population.

Recommendations for Practitioners

There are some recommendations based on the findings of the current study. First, social workers need to use the Client Motivation Scale before the intervention which will help them address whether or not their clients are motivated. Doing so would save social workers a lot of work and effort. Moreover, social workers in Kuwait need to be trained on how to enhance the clients' motivation for therapy. They need to understand the differences between Autonomous Motivation, Controlled Motivation, and Amotivation in order to be able to identify their clients' needs and devise an effective treatment plan.

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