The Integration of Self-Determination Principles and Scientifically Informed Treatments *Is* the Next Tier

Thomas E. Joiner, Jr., Florida State University
Kennon M. Sheldon, University of Missouri
Geoffrey Williams, University of Rochester
Jeremy Pettit, Florida State University

We agree with Schneider's claim (2003, this issue) that humanistic ideas and approaches are important for therapeutic change. However, we reiterate that their importance lies primarily in the "how" of therapy, not in the "what" of therapy. Available now are a variety of relatively simple treatments whose worth for mitigating psychological suffering has been empirically documented, in the same rigorous way and with the same standards that the worth of new medical treatments must be documented. Thus, we argue that psychotherapy's next "tier" involves the marriage of such proven techniques with the humanistically informed motivational prescriptions of self-determination theory.

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Schneider's commentary, which points to shortcomings in our approach in part by invoking his personal experiences as a clinician, illustrates the importance—and the pitfalls—of reference to personal experience. On the one hand, our self-determination theory approach prioritizes a patient's personal experience of autonomy, competence, and connectedness as of central importance, especially in motivating behavioral change. A person's experience *matters,* and clinicians would do well to pay close attention to that experience. On the other hand, relying on clinical experience as a data source regarding optimal treatment strategies is quite problematic. Indeed, as Meehl, Dawes, and others have repeatedly shown, clinical judgment is remarkably unreliable at predicting clinical outcomes, but clinicians remain remarkably resistant to this information (Dawes, Meehl, & Faust, 1989; Meehl, 1954, 1986).

Address correspondence to Thomas E. Joiner, 209–Psychology Building 1270, Florida State University, Tallahassee, FL 32306. E-mail: joiner@psy.fsu.edu.

Whose opinion is right—our assertion that conventional and scientifically supported treatment approaches have the most merit especially when clinicians attend to clients' motivational needs, or Schneider's response that the approach we outline goes nowhere near far enough towards full acceptance of the humanistic agenda? In fact, when the stakes involve the treatment of mental disorders (which kill people, and when they don't, impair and agonize them), someone's opinion—Schneider's, ours, whosever—is a petty matter. What matters is what *works,* and what works can only be discovered by careful quantitative measurement and by controlled clinical trials. Unfortunately, humanistically oriented clinicians have been reluctant to put their approach to either of these two tests.

Schneider implies that the conventional treatment approaches we discuss are simplistic and apparently intends this as an aspersion. On the contrary, the fact that something is both effective and simple is a crucial advantage. There is an urgent need for clearly articulated, systematic treatments for mental disorders to be developed and—even more urgent—to be transported from clinical laboratories in academic psychology and psychiatry to community settings. Training community clinicians to treat severe mental disorders with straightforward, accessible techniques is a national health priority, as shown, for example, by NIMH funding initiatives directed specifically to this issue. As we argue in our target article, the incorporation of self-determination principles into this agenda is likely to facilitate and accelerate progress on this topic.

Schneider questions whether the types of scientifically validated treatment programs we discuss produce "core" or "intentional" change. We can fathom no more crucial change than recovery from severe mental disorders. To imply that scientifically supported treatments do not produce such change requires a remarkable ability to distance oneself from reality; to suggest that humanistic approaches, *by themselves,* occasion such change borders on malpractice. Our view, as stated in our target article, is that humanistic approaches (specifically, self-determination principles), *when combined with scientifically supported treatments,* maximize patients' ability to achieve substantial and lasting recovery from mental disorders.

These disorders create mammoth public health problems. However, in his comment, Schneider puts "disorder" in quotations—a punctuational affront that we cannot let pass. Anyone who wishes to question the reality of mental disorders should take their quotation marks to a meet-

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ing of the National Alliance for the Mentally Ill (NAMI), where one will see the ravages of mental disorders in the tears, faces, and bodies (often wrists) of sufferers and their families. (One also sees compassion, hope, and strength at these meetings.) Look NAMI members in the eye and question the reality of mental disorders—there's a personal experience that should prove very informative.

For reasons like these, it is clear why some academic psychologists and psychiatrists are sometimes inclined to dismiss humanistic approaches altogether. Nevertheless, we insist that this is a mistake; there is merit in the approach. The specific merit, as explained by self-determination theory, has to do with humanism's *motivational* qualities, not its *technical* qualities. In other words, the humanistic perspective can help us to understand how to get people fully engaged in the treatments that work. Of course, there are many "new age" therapists who are very adept at motivating their clients to do things that, unfortunately, are unlikely to help them. As this illustrates, along with motivational ability clinicians also need up-to-date knowledge of the most empirically defensible therapeutic techniques and programs. This point applies not only to psychological treatments, but also to physical treatments, an equal focus of our 2003 book (Sheldon, Williams, & Joiner, 2003). Of course, physical health is an arena where rigorous empirical documentation of benefits for particular treatments is already the norm.

Schneider's final comment is that "Humanistic influences require humanistic investigative methods, and those methods can both inform and enhance mainstream instrumentation" (p. 317). We would state it differently. Humanistic influences (and therapeutic techniques) require sound quantitative methods to adequately demonstrate utility; that is, they should be held to the same standards that simpler treatment approaches are held to. For example, self-determination theory has taken up the empirical challenge within mainstream research psychology, showing that motivational approaches grounded in humanistic theory yield good results for both motivators and motivatees. In short, we are endorsing a marriage of humanistic sensibilities, empirically supported treatments, and quantitative documentation of claimed effects as the best of all worlds.

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