A question of continuity: a self-determination theory perspective on "third-wave" behavioral theories and practices

Hayes and Hofmann[1] provide a sweeping history of behavioral approaches to clinical practice, from applied behavior analysis, through cognitive behaviorism, to contemporary "third-wave" approaches. Reviewing their history from my vantage points – as a clinician, a motivational researcher, and a psychological theorist – engenders different reactions, two quite positive and one more skeptical.

As a clinician, and former trainer of therapists, I laud the more "process-oriented" point of view represented by the "third wave", which conveys respect for individuals' perspectives and values, and greater flexibility regarding the directions of treatment. Both applied behavioral analyses and cognitive behavioral approaches (the first "two waves" of behaviorism described by the authors) have traditionally embraced an outcome focus to treatment – applying techniques and interventions to bring about pre-defined targets of behavioral change and involving therapist-directed activities such as teaching, training, shaping and rewarding.

Such outcome-focused approaches often either assume or select for motivation or "readiness" for change, such that patients can "fail the therapy"[2]. In contrast, process-focused approaches conceptualize both motivation and resistance as part of the change process, and are centrally concerned with the client's experience and volition with respect to change. Process-focused therapists emphasize activities of listening, reflecting, empathizing and facilitating. These are empowering, autonomy-supportive and relational activities.

Another important, and laudable, feature in Hayes and Hofmann's depiction of the "third wave" relative to prior behaviorisms is a focus not merely on behavior change, but rather on the "development and use of inner resources" for ongoing adaptive self-regulation. Highlighted is the person's relationship with events, cognitions and emotions, and developing a sense of awareness, value, and volition in reacting to them. A focus on facilitating such self-regulatory resources highlights new assumptions concerning internalized capacities and mechanisms of agency that prior waves of behavioral theory did not acknowledge, but which (in this clinician's view) are essential to maintained change and the enhancement of adaptive functioning amidst the ever changing environments people encounter.

As a researcher, I am particularly struck by the convergence of these "third-wave" ideas – particularly those embedded within acceptance and commitment therapy (ACT) and mindfulness-based cognitive therapy – with research accomplished within self-determination theory (SDT)[3]. SDT studies have, for example, shown that more self-endorsed or autonomous motivations are reliably associated with greater engagement, behavioral persistence, as well as more positive experience[4].

Clinical and applied research within SDT has also shown that a facilitating environment of acceptance and autonomy support enhances treatment motivation, engagement and success[5], offering a promising interface for applying SDT's research methods and concepts to ACT interventions in particular. Such theoretical iteration has been illustrated by work applying SDT to motivational interviewing[6]. Moreover, SDT models of change also suggest that mindful awareness facilitates greater autonomy in functioning, and in turn greater wellness. Indeed, a recent meta-analysis supports SDT's nuanced assumption of graded associations between mindfulness and more internalized and autonomous forms of motivation[7], suggesting that awareness supplies a foundation for improved self-regulation.

In parallel, we see the ACT concept of "psychological flexibility" as entailing both mindful awareness and autonomy, constructs that have been well researched within the SDT tradition. Similarly, ACT appears to converge with SDT in advancing integrative forms of emotion regulation, in which persons approach and understand the meaning of emotional reactions, rather than focusing only on down-regulating or reframing negative experience[8].

However positive my reactions as a clinician and researcher, I am a bit more skeptical regarding Hayes and Hofmann's claims concerning the philosophical coherence or conceptual continuity of the third wave's theoretical constructs with prior behaviorisms, as if they represent a logical next step rather than a leap to a new foundation. Finding a way from Skinnerian positivism to therapies cultivating awareness, choice, and inner resources recalls an old joke involving getting directions from a rural farmer who states: "You can't get there from here".

Classical behavioral theorists actively eschewed and often disparaged concepts such as awareness, volition and autonomy. And, although cognitive behavioral theorists accepted the reality of inner mediators between environments and behavioral outputs, their focus remained on leveraging these mediators toward behavior change, retaining an outcome focus[2]. For example, Bandura explicitly dismissed concepts such as autonomy and basic psychological needs as inconsistent with his views[9].

Hayes and Hofmann do establish some forms of continuity in that, like applied behavior analysis and cognitive behavioral theories, the new wave remains: a) evidence based; b) highly focused on contexts; and c) inconsistent with a medical model. But none of these general attributes is unique to behaviorisms and, more importantly, none establishes a deep theoretical or philosophical coherence of new-wave constructs with these old meta-theoretical foundations. This is not to say that connections cannot be established, but the question is whether these ideas and practices really fit well within such a procrustean bed. The core concepts underlying new-wave therapies involve authentically engaging clients, understanding their perspectives, and helping them build or access inner resources and capacities for reflective, value-based choices, concepts and practices that cannot be parsimoniously derived from earlier behaviorist worldviews.

Although doubtful of the congruence of many "third-wave" concepts with classical or cognitive behavioral theories, I am optimistic that the processes and models of the "third wave" can be both richly theo-

retically described and fruitfully studied within organismic perspectives such as SDT. Because the process-oriented issues of mindful awareness[7], integrative emotion regulation[8], autonomous treatment motivation[5], basic psychological needs[3] and other constructs relevant to new-wave behavioral interventions already have a coherent place within the system of concepts specified in SDT, research using this theoretical framework as either a primary or supplementary guide for research may help illuminate "active ingredients" in "third-wave" techniques.

Perhaps as importantly, the organismic meta-theory underlying SDT brings with it a person-centered sensibility and philosophy that is in itself important in effectively implementing new-wave clinical practices or, for that matter, any truly process-oriented approach. Process-oriented therapy approaches are not merely sets of techniques, but also entail an orientation toward perspective-taking, facilitation, and respect for autonomy. Part of the role of theory is to guide clinicians in developing, refining and implementing such orientations in their relationships with clients. The psychological principles and values forwarded within SDT seem, in this regard, well-matched with many of the "third-wave" sensibilities and values expressed by Hayes and Hofmann, and are integrated into a conceptual framework directly relevant to the innovations of this new movement.

Since the days of classical behaviorism, empirical models of human motivation have seen a "Copernican turn" – a movement away from models of people as pawns to external contingencies, toward a focus on the development and support of people's inner capacities for acting. From this view, it is nice to see this turn within behaviorism away from assumptions that Hayes and Hofmann describe as "too narrow", and toward a more person-centered point of view. Given SDT's past clashes with behaviorists, this openness of the "third wave" to a truly process-oriented perspective affords fresh opportunities for exchanging methods, findings and practices, and ultimately a more convergent clinical science.

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Variation, selection and retention: the evolution of process of change

Hayes and Hofmann[1] argue for the value of "third-wave" cognitive behavioral therapies (CBTs) – with which I heartily agree – and call for a renewed focus on targeting an expanded range of processes of change. They highlight five features of "third-wave" therapies: a) a focus on context and function; b) the view that new models and methods should build on other strands of CBT; c) a focus on broad and flexible repertoires; d) applying processes to the clinician; and e) expanding into more complex issues that historically were addressed by humanistic, existential and dynamic perspectives.

Variation is always to be desired and, if we have learned anything over the last century, it is that "one size does not fit all". We have made some marvelous strides in the field (we have doubled the efficacy of treatments for depression since the 1970s), but we are only about halfway to where we want to be. Midway through the second year of my "internship" at the University of Pennsylvania, in 1976, I was called into the office of the associate director of the training program and told "Steve, we have a problem". When I asked what the problem was, he told me that I was discharging my patients too fast. When I said that they were better, he told me that what I was observing was a "flight into health" and that I risked pushing my patients into psychotic decompensations if I insisted on treating their symptoms. We now know that any of several different types of psychotherapy are as efficacious as antidepressants for depression, and that both cognitive therapy ("second wave") and perhaps behavioral activation ("third wave") have enduring effects that medications lack.

Nothing works for everyone, and the more different "arrows in our quiver", the better for all. We now have tools at our disposal that can tell us what works best for whom, and the early indications are that some people will respond to one treatment who will not respond to another[2]. Hayes and Hofmann criticize the application of treatment packages to diagnostic categories, and I appreciate their critique. That being said, two-thirds of the patients meeting criteria for major depressive disorder in the trials that I do also meet criteria for other Axis I disorders, and half meet criteria for at least one Axis II disorder. While I do attend to the content of my patients' beliefs (more than their context) and often encourage them to use their own behaviors to test their accuracy, what I do and how I do it varies from one patient to the next. Most patients see themselves as either unlovable or incompetent, but precisely how that came to be and what tests they find compelling varies across patients. If Hayes and Hofmann can help lay that out, I am all ears.

I am a huge fan of D. Clark and his colleagues at Oxford and wrote a paper recently in which I speculated about how it is that they have been so successful in the approaches they have developed[3]. Clark essentially cured panic disorders, and a recent network meta-analysis found his approach to individual cognitive therapy to be the single most efficacious treatment for social anxiety[4]. He also found time to reshape the mental health care system in the UK to increase access to empiri-