Literature Review

Acceptance Motivation Inquiry (AMI)

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1. Introduction

Client engagement in psychotherapy is a dynamic process shaped by numerous interacting variables: motivation, readiness, emotional openness, external pressures, and the acceptance of a potential diagnosis. While extensive research has examined the mechanisms of change and the therapeutic relationship (Norcross & Lambert, 2019; Wampold, 2015), a notable gap remains: few assessment tools measure both a client's motivation and acceptance of diagnosis prior to the first session, nor do they sufficiently guide therapists in tailoring early interventions based on client orientation.

This literature review examines how psychology and psychotherapy have historically conceptualized and assessed motivation, readiness, and acceptance. Key theoretical models, including the Stages of Change (Prochaska & DiClemente, 1983), Self-Determination Theory (Deci & Ryan, 1985), Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999), and Motivational Interviewing (Miller & Rollnick, 1991), offer foundational understandings of internal drive, ambivalence, and the role of psychological flexibility in treatment. Motivational Interviewing, in particular, emphasizes client-centered, directive communication strategies to elicit and strengthen motivation for change, especially in ambivalent or resistant clients. Complementary clinical tools like the Working Alliance Inventory (Horvath & Greenberg, 1989), Readiness to Change Questionnaire (Rollnick et al., 1992), and the University of Rhode Island Change Assessment (URICA) (McConnaughy et al., 1983) primarily assess alliance and readiness after therapy begins, often missing critical insights about initial engagement.

Recent research has begun to probe more deeply into how clients conceptualize themselves in relation to therapy. The Perceived Acceptance Scale (PAS) (Brock et al., 1998) measures the degree to which individuals feel accepted by others, linking acceptance to psychological well-being and openness in relationships. The Illness Identity Questionnaire (IIQ) (Oris et al., 2016) assesses how individuals incorporate a diagnosis or condition into their identity, distinguishing between adaptive (e.g., acceptance, enrichment) and maladaptive (e.g., engulfment, rejection) identity styles. These instruments suggest that acceptance is not a simple yes-or-no state but a complex, identity-based orientation that may influence how one participates in psychotherapy.

Similarly, the Insight Scale (David et al., 1995) quantifies the extent to which clients recognize they have a mental health condition, accept this diagnosis, and believe in the need for treatment. This scale is particularly relevant for individuals navigating the early stages of diagnosis, offering clinicians a window into internalized attitudes that may predict resistance or openness. Additionally, Keyes' (2005) Complete State Model of Mental Health introduces a two-axis model, treating mental illness and mental health as distinct but correlated continua, thereby affirming that the absence of pathology does not imply the presence of flourishing. His work

advocates for a broader conceptualization of well-being that aligns with motivational and identity-based assessments.

Numerous tools have been developed to assess client readiness, motivation, insight, and acceptance, variables strongly associated with engagement and outcomes in psychotherapy. These tools vary in focus, timing, and theoretical underpinnings. Some are stage-based models of change, while others assess relational alliance or symptom distress. However, few instruments combine assessments of both motivation and diagnostic acceptance in a unified, pre-treatment format. This review considers factors such as what brought the client to therapy, their motivation to engage, perceived obstacles, and their overall congruence with the idea of therapy and diagnosis. The AMI positions these variables as central, not secondary, to therapeutic attunement and alliance. By making client motivation to be in therapy and acceptance of diagnosis explicit and observable from the outset, the AMI offers a fresh lens for engagement, helping therapists meet clients not only where they are, but who they are as they arrive.

2. Theoretical Foundations

Client readiness for therapy emerges from a complex interplay between internal motivation, acceptance of having a condition or issue that may benefit from treatment, and the perceived relevance or value of pursuing change through the therapeutic process. Foundational theories offer a scaffold for understanding these dimensions. Motivation is typically assessed by such systems as: the Stages of Change Model (Prochaska & DiClemente, 1983), which conceptualizes readiness as fluid, identifying phases through which individuals progress toward action; and Self-Determination Theory (Deci & Ryan, 1985), which underscores the role of intrinsic motivation and the human need for autonomy, suggesting therapy is most effective when clients feel self-directed. Building on both models, Motivational Interviewing (Miller & Rollnick, 1991; 2013) emerged as a client-centered, directive approach that helps individuals resolve ambivalence about change. Rather than imposing direction, MI evokes the client's own reasons for change, honoring their autonomy while gently guiding them toward insight and commitment. This makes MI especially effective in early engagement, where resistance, mixed motivation, or external referral are common. Finally, Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) introduces the concept of psychological flexibility, framing acceptance not as passive agreement but as active willingness to engage with difficult emotions in service of personal values.

Building on these models, mindfulness-based approaches such as Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002) and Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990) further emphasize the importance of present-moment awareness and nonjudgmental acceptance of thoughts and feelings. These approaches suggest that cultivating mindful attention can enhance psychological flexibility (Keng, Smoski, & Robins, 2011), reduce experiential avoidance, and promote openness to therapeutic work, particularly for clients struggling with internal resistance. A growing body of research affirms the role of mindfulness in helping

individuals navigate identity shifts associated with diagnosis or trauma (Strauss et al., 2014), encouraging clients to observe rather than fuse with their internal narratives.

Existential therapy and logotherapy add another critical dimension to this landscape. Rather than seeking to correct thought distortions, existential work invites clients to explore meaning, authenticity, and freedom in the face of suffering (Yalom, 1980; Frankl, 1985). Particularly for clients who are re-evaluating life purpose or facing a new diagnosis, existential therapy emphasizes the human capacity to choose one's response and reauthor identity through meaning-making. This orientation complements mindfulness and values-based approaches, creating space for clients to confront and transcend perceived limitations through deeper inquiry.

From a historical and sociopolitical lens, Michel Foucault's work reminds us that diagnosis itself is not a neutral act. In Madness and Civilization (Foucault, 1961/1965), he traces how modern psychiatry evolved as both a response to and a mechanism for managing those whose suffering could not be assimilated into post-war norms. After World War I, society struggled to make sense of invisible wounds, including shell shock, grief, and the psychic aftermath of modern warfare, and diagnosis emerged as a tool for rendering this suffering intelligible and governable. In this view, diagnosis served to both acknowledge and contain. It gave language to trauma while also placing individuals within institutional and moral frameworks. For many clients today, the ambivalence of diagnosis, its potential to validate or to stigmatize, remains central.

Social work's own history sharpens this point. The profession did not merely inherit diagnostic culture; it helped build one. Between 1890 and 1950, social work moved from Progressive Era environmental reform toward casework models that located problems, and their remedies, inside individuals, a shift systematized by Mary Richmond's (1917) model of social diagnosis and accelerated by the profession's pursuit of clinical legitimacy (Reisch, 1998). Bertha Reynolds warned as early as 1924 that the medical model builds an asymmetry into the clinical encounter, casting the practitioner as the knowing expert and the client as the object of expertise (Reisch, 1998). The descriptive turn in psychiatric nosology completed the arc. The DSM-III and its revision (American Psychiatric Association, 1987) reorganized clinical attention around categorical disorders, training clinicians to see clients primarily in terms of what they had rather than who they were, while studies of the system's reliability raised questions its authority outran (Kirk & Kutchins, 1992). Contemporary practice inherits the incentives. Reimbursement generally requires a billable code from the earliest sessions (Frances, 2013), surveyed clinicians report assigning diagnoses shaped by payer requirements (Braun & Cox, 2005), and practicing clinicians treat codes as administrative workarounds as much as clinical descriptions (Whooley, 2010). Training programs reward diagnostic competency, and institutional systems reward speed (Frances, 2013; Kirk & Kutchins, 1992; Whooley, 2010). The AMI is designed for exactly this environment: it asks the clinician to hold the categorical apparatus loosely for long enough to learn where the client actually stands.

The clinical literature on receiving a diagnosis complicates any simple account of acceptance. A diagnosis can orient treatment, unlock services, and give a client language for what has been happening to them, and the same diagnosis can arrive as verdict, stigma, or someone else's story about who they are (Perkins et al., 2018). The illness-identity research supplies the cautionary case: when diagnostic identity becomes engulfing, engagement can sustain identity rather than change (Charmaz, 1983; Yanos et al., 2010), while accepting a label alongside a sense of control over the condition predicts better quality of life than acceptance without it (Kravetz et al., 2000). Within social work, McCusker and Jackson (2016) argue that the profession's distinctive contribution to mental distress is relational rather than nosological, which is the register in which the AMI's acceptance axis operates. The clinical question the AMI poses is never whether diagnosis is good. It is where this client stands with it right now.

While these theories emphasize change processes, measures such as the Insight Scale (Marková et al., 2003) and the Illness Identity Questionnaire (IIQ) (Oris et al., 2016) provide valuable tools for assessing how clients integrate diagnosis or difficulty into their self-concept, what may be termed the "acceptance" aspect of the work. For instance, the Insight Scale measures awareness and acknowledgment of mental illness and the need for treatment, while the IIQ distinguishes between engulfment, rejection, acceptance, and enrichment as ways individuals relate to their condition. These instruments expand the lens beyond motivation, offering insight into how acceptance or resistance toward a problem itself shapes therapy readiness.

Together, these frameworks, including motivational models, mindfulness approaches, existential therapy, and diagnostic insight tools, guide the conceptual underpinning of the Acceptance Motivation Inquiry (AMI) by illuminating how clients locate themselves in relation to change, identity, and therapeutic possibility.

- The Stages of Change Model (Prochaska & DiClemente, 1983) conceptualizes readiness as fluid, identifying phases through which individuals progress toward action: precontemplation, contemplation, preparation, action, and maintenance. It has been particularly influential in addiction treatment and motivational interviewing, offering a non-pathologizing approach to ambivalence.
- Self-Determination Theory (Deci & Ryan, 1985) proposes that motivation exists on a continuum from extrinsic (e.g., compliance due to external pressure) to intrinsic (e.g., a desire for personal growth). It emphasizes autonomy, competence, and relatedness as core psychological needs fundamental to sustainable motivation.
- Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999) frames acceptance as an active process, a willingness to engage with difficult emotions in service of meaningful life goals. Core ACT processes include cognitive defusion, experiential avoidance, and psychological flexibility.
- Common factors theory (e.g., Lambert, 1992; Wampold, 2001; Norcross, 2011) emphasizes shared therapeutic elements, such as the therapeutic alliance, client hope,

empathy, and expectancy of improvement, as core contributors to treatment success, regardless of modality.

- Mindfulness, as developed by Kabat-Zinn (1990) and later integrated into clinical treatments like Mindfulness-Based Cognitive Therapy (Segal et al., 2002), emphasizes present-moment awareness and nonjudgmental acceptance. It has been shown to improve emotional regulation, reduce rumination, and enhance psychological well-being (Keng et al., 2011).
- Motivational Interviewing (MI) (Miller & Rollnick, 1991; 2013) is a client-centered, directive method for enhancing intrinsic motivation to change by helping clients explore and resolve ambivalence. Grounded in respect for autonomy and the stages of change, MI is especially effective in early therapy engagement where resistance or mixed motivation is common. It informs the AMI's attention to internal vs. external referral, client ambivalence, and the value of eliciting rather than imposing change. MI complements the AMI's dual focus on motivation and acceptance by operationalizing how clinicians can respond to where the client is, rather than where the system expects them to be.
- Existential therapy emphasizes human freedom, responsibility, and the search for meaning in the face of life's inherent uncertainties. Rooted in 20th-century European philosophy, this approach draws from existential thinkers like Søren Kierkegaard, who explored despair and the self's struggle for authenticity (1849/1980), and Jean-Paul Sartre, who viewed humans as radically free but burdened by the responsibility of choice (1945/2007). These philosophical foundations were adapted into clinical practice by figures such as Viktor Frankl, whose logotherapy emphasized the will to meaning as a core human drive, particularly in the face of suffering (Frankl, 1946/1985), and Rollo May, who integrated existential ideas into American psychotherapy, highlighting the role of anxiety, courage, and creativity in personal growth (May, 1983). Medard Boss, collaborating with Heidegger, advanced Daseinsanalysis, a psychotherapeutic method that reframes psychological symptoms as expressions of one's mode of being-in-the-world. Irvin Yalom later synthesized these ideas into a clinical model addressing four ultimate concerns: death, freedom, isolation, and meaninglessness (Yalom, 1980). In the context of therapy readiness, existential therapy helps clients confront core anxieties, reexamine their motivations, and find meaning, even in diagnosis, thus fostering insight, engagement, and agency.

Together, these frameworks provide a broad theoretical base for understanding how individuals orient themselves to the therapeutic process, including their ambivalence, resistance, and potential for growth.

3. Clinical Measures and Assessment Tools

Numerous tools have been developed to assess client readiness, motivation, insight, and acceptance, critical variables in predicting engagement and outcomes in psychotherapy.

However, few tools assess both motivational states and acceptance of care within a unified framework at therapy onset. This section summarizes several prominent instruments.

3.1 University of Rhode Island Change Assessment (URICA)

Developed by DiClemente and Hughes (1990), the URICA is a self-report measure that evaluates four stages of change: precontemplation, contemplation, action, and maintenance. It is widely used in addiction treatment and behavioral health but can be time-consuming and may not capture emotional or relational readiness for therapy.

3.2 Readiness to Change Questionnaire (RCQ)

Created by Rollnick et al. (1992), the RCQ is a brief, stage-based measure grounded in the same theoretical framework as the URICA. It is commonly used in health psychology and substance use contexts, offering a faster but more limited assessment of motivational readiness.

3.3 Working Alliance Inventory (WAI)

Developed by Horvath and Greenberg (1989), the WAI measures the strength of the therapeutic alliance through task agreement, goal alignment, and relational bond. While a robust predictor of outcomes, it is designed for use once therapy has begun and does not assess initial motivational or acceptance variables.

3.4 Treatment Motivation Questionnaire (TMQ)

Based on Self-Determination Theory, the TMQ (Ryan, Plant, & O'Malley, 1995) evaluates four motivational types: external regulation, introjection, identification, and intrinsic motivation. Though conceptually robust, it is primarily used in substance use settings and does not explicitly measure acceptance.

3.5 Illness Identity Questionnaire (IIQ)

The IIQ (Oris et al., 2016) identifies four ways individuals relate to a chronic condition: Rejection, Engulfment, Acceptance, and Enrichment. Initially developed for somatic illness, it provides insights into identity integration processes that are increasingly relevant in mental health settings.

3.6 Insight Scales

The Birchwood Insight Scale (Birchwood et al., 1994) and the Insight Scale (Marková et al., 2003) assess recognition of mental illness, attribution of symptoms, and treatment compliance. These instruments provide a cognitive perspective on diagnostic acknowledgment, though they may not fully capture emotional or identity-based dimensions of acceptance.

3.7 Therapist Attunement Scales (TASc)

The Therapist Attunement Scales (Talia et al., 2020) represent one of the most methodologically rigorous contributions to the empirical study of therapeutic attunement. Unlike self-report measures that ask clinicians to reflect on their relational behavior, the TASc is a transcript-based coding instrument that captures attunement as it manifests in the language of actual therapy sessions, utterance by utterance. Talia and colleagues argue that a therapist's attachment history, assessed independently through the Adult Attachment Interview (AAI), shows up in specific, observable patterns of clinical speech, whether the clinician is aware of it or not.

The TASc codes therapist speech turns across five scales: intersubjective engagement (tentative, correctable readings of the client's internal states, open to elaboration), empathic validation (objective affirmation of the client's experience from the therapist's own perspective), joining (expressions of warmth and investment in the relationship), detaching (moves that pull back from active attunement by minimizing or redirecting affect), and coercing (interventions that restrict the client's capacity to correct or elaborate, presenting interpretations as settled rather than offered). From these five scales, a global index of attunement security is derived. Talia et al.'s validation study demonstrated that TASc classifications of a single session matched therapists' independently obtained AAI classifications at a rate of ninety percent ($\kappa = .81$), suggesting that how a therapist narrates a client's inner world is not incidental to their attachment organization but a direct expression of it.

Each attunement pattern carries distinct clinical implications. The secure therapist holds interpretations tentatively, making space for the client to correct and elaborate, a posture Talia connects to what Keats called "negative capability," the capacity to remain in uncertainty without grasping after resolution. The dismissing pattern, captured by the detaching scale, deflects rather than deepens emotional disclosures, not out of hostility but through a reflexive smoothing over of affect that can produce misdiagnosis by omission. The preoccupied pattern, captured by the coercing scale, is particularly relevant to the clinical problem of premature diagnostic closure: these interventions present the client's internal experience as settled, foreclosing the client's agency in defining their own readiness or distress. As Talia et al. note, such eagerness to put forward a perspective may be rooted in genuine concern, yet it can end up restricting rather than supporting the client's self-authorship.

Crucially, TASc showed no significant association with the Working Alliance Inventory, providing preliminary evidence that attunement as operationalized here captures something distinct from alliance as traditionally measured (Talia et al., 2020). Where alliance tools assess the relational bond retrospectively, TASc locates attunement failures in the micro-level language choices that precede, and may determine, whether a meaningful alliance forms at all. This distinction is directly relevant to the AMI's clinical context: the assessment encounter itself is a site of attunement, and the clinician's communicative stance during intake shapes not only what is heard but what the client feels permitted to say.

3.8 Session Rating Scale (SRS)

The SRS (Duncan et al., 2003) is a brief, four-item tool used to evaluate the quality of the therapeutic alliance at the end of each session. It assesses relational bond, agreement on goals and tasks, and overall fit. As a post-session measure, it does not capture pre-treatment motivational or acceptance variables.

3.9 Longitudinal and Outcome Measures

Other commonly used measures include:

- Outcome Questionnaire-45 (OQ-45) (Lambert et al., 1996): tracks symptom change and interpersonal functioning.
- PHQ-9 / GAD-7: monitor depression and anxiety symptoms.
- CORE-OM: assesses psychological distress across multiple domains.

These tools are important for monitoring progress but are primarily symptom-focused. They do not assess clients' initial readiness or acceptance stance at therapy entry.

4. Gaps in the Literature

Despite a proliferation of theoretical models and psychometric tools aimed at understanding client behavior in psychotherapy, notable limitations persist in how the fields of clinical psychology and social work assess motivation and acceptance at the outset of care. These limitations have real implications for therapeutic alliance, treatment planning, and client outcomes.

4.1 Fragmentation of Constructs

Current assessment tools tend to isolate either motivation or readiness, rarely integrating both with a client's emotional acceptance of help or diagnosis. Instruments like the URICA and RCQ emphasize behavioral stages of change, while tools like the TMQ assess motivational origins (e.g., internal vs. external). However, few measures inquire into how the client feels about therapy itself: whether they believe in the process, trust clinicians, or feel emotionally safe enough to engage. This split between cognitive motivation and emotional/diagnostic readiness creates an incomplete picture of the client's therapeutic posture.

Even broader frameworks like Keyes' (2005) Complete State Model of Mental Health, which offers a valuable distinction between the presence of well-being and the absence of pathology, are primarily population-level constructs. While Keyes's model is useful in expanding the scope of mental health to include flourishing, it does not provide clinicians with micro-level, session-ready tools for assessing how an individual relates to therapy at the outset. Moreover, the model does not distinguish between a client's motivational state and their acceptance of diagnosis or therapeutic process, two dimensions that may diverge significantly.

Still, the complete state model matters to the AMI for a structural reason. Keyes (2005) demonstrated that collapsing two related continua into one conceals clinically meaningful states:

a person can be free of diagnosable illness and still languishing, or symptomatic and still flourishing. The AMI applies the same logic to the assessment encounter. Motivation to engage and acceptance of the diagnostic frame are correlated but distinct dimensions, and a framework that collapses them will miss the clients whose positions diverge, the motivated client who rejects the frame and the accepting client who cannot yet move. The complete state model therefore stands as precedent: the field has already accepted that two-continua thinking reveals what single-continuum thinking hides.

The AMI fills this theoretical and clinical gap by bridging internal motivation, diagnostic acceptance, and relational stance into a single framework, offering both conceptual coherence and clinical usability.

4.2 Post-Hoc Focus on Alliance

The bulk of alliance research, including widely used tools like the Working Alliance Inventory (WAI) and the Session Rating Scale (SRS), takes place after therapy has begun. While these instruments provide valuable insights into therapist-client dynamics, such as goal agreement, task collaboration, and relational bond, they are designed to assess the strength of the therapeutic alliance within or after sessions, not before, nor are they multi-dimensional. Yet the first sessions do decisive relational work (Hilsenroth & Cromer, 2007). As such, these tools offer limited predictive utility for initial engagement.

For instance, the WAI (Horvath & Greenberg, 1989) is often administered after several sessions and reflects retrospective perceptions of the working relationship. Similarly, the SRS (Duncan et al., 2003) is a brief, four-item tool completed at the end of each session to gauge client satisfaction with relational and task-based components of therapy. While both measures can strengthen the ongoing alliance and track rupture or repair, neither is positioned to identify motivational ambivalence or diagnostic resistance before the first session begins.

The alliance construct itself points to the gap. Bordin (1979) formulated the working alliance as agreement on goals, agreement on tasks, and the relational bond, all of which presuppose an engagement already underway. The rupture-repair literature shows that strains in the alliance are ordinary features of treatment and that their repair predicts outcome (Safran & Muran, 2011), yet repair research carries a survivorship blind spot: it can only study the clients who stayed. The clients lost before alliance formation never appear in the repair data at all.

This post-hoc orientation may help explain why early dropout remains a persistent challenge. Roughly one in five adult clients discontinues psychotherapy prematurely, and most who leave do so after only one or two sessions (Swift & Greenberg, 2012), with substantially higher rates reported in earlier estimates and in community settings (Wierzbicki & Pekarik, 1993). The attrition funnel is steep: of one hundred prospective clients who contact a mental health clinic, roughly fifty attend an initial evaluation, thirty-three reach a first treatment session, twenty remain by the third session, and fewer than seventeen by the tenth (Barrett et al., 2008). The

costs extend past the clinical dyad. Serious mental illness is associated with $193.2 billion in lost earnings each year in the United States (Kessler et al., 2008), and depression and anxiety disorders cost the global economy an estimated $1.15 trillion annually (Chisholm et al., 2016). Early termination concentrates precisely where predictive insight into a client's readiness and acceptance would be most valuable, before a strong alliance can form. By the time alliance tools detect a problem, the client is often already gone.

4.3 Overemphasis on Pathology and Technique

Traditional intake procedures often prioritize diagnostic criteria, risk assessment, and symptom inventories, leaving little room for evaluating a client's subjective experience of seeking help. This reflects a broader issue in the mental health system: the assumption that once a client arrives at therapy, they are "ready" for it. Yet many clients enter treatment ambivalently, pressured by others, or carrying negative prior experiences with therapists, medical systems, or authority figures.

By failing to explicitly assess these variables, clinicians may unintentionally misread a client's resistance or detachment as defiance, pathology, or lack of insight, rather than as a signal of unmet relational or motivational needs.

This problem is compounded when countertransference goes unexamined. Research on therapist pre-session emotional states suggests that a clinician's own internal experience, including anxiety, urgency, and a pull toward certainty, can shape the clinical encounter before a single question is asked (Abargil et al., 2024). When those internal states are organized around pathology-detection rather than genuine inquiry, the assessment process becomes less a conversation and more a confirmation exercise. The TASc framework offers a parallel account from the communicative side: therapists operating from a preoccupied attunement stance make interpretive moves that restrict the client's capacity to self-define, presenting diagnostic conclusions as settled rather than offered (Talia et al., 2020). In early clinical assessment, before any alliance has formed and before the client has had a chance to demonstrate their own complexity, these convergent pressures create the conditions for what might be called diagnostic premature closure: the clinician arrives at a formulation that fits their own frame, not the client's lived experience.

Fricker (2007) gives this failure its ethical name: testimonial injustice, the discounting of a speaker's credibility for reasons unrelated to the truth of what they say. When diagnostic criteria are allowed to outrank lived experience, the client's account arrives pre-discounted, and assessment becomes judgment without inquiry (Crichton et al., 2017). The stakes are professional as well as ethical. Client self-determination sits first among the commitments the field claims (National Association of Social Workers, 2021), and an assessment that overrides the client's self-account violates that commitment at the moment of first contact. The empirical record gives the concern teeth: clinicians are unreliable judges of their own read of a case,

routinely overestimating progress and failing to flag clients headed for deterioration unless measurement forces the question (Hannan et al., 2005).

The ethical and clinical costs of this failure are not evenly distributed. Racialized diagnostic bias is documented across the psychosis spectrum (Faber et al., 2023), dropout runs significantly higher among racial minority, less-educated, and lower-income clients (Wierzbicki & Pekarik, 1993), children of immigrants and refugees face compounded barriers to attuned care (Fazel et al., 2012; Pumariega et al., 2005), and sexual and gender minority clients carry a diagnostic history in which their identities were themselves classified as disorders (Drescher, 2015). Clients whose presentations do not fit dominant diagnostic narratives bear the greatest risk of being misread (Finn, 2007), and reading earned guardedness as low motivation repeats at the individual level an injury inflicted at the population level.

4.4 Inattention to Fit and Worldview Alignment

Little research exists on how value alignment, cultural worldview, and therapeutic orientation impact early-stage engagement. Clients may arrive open to support but skeptical of Western therapeutic models, suspicious of authority, or seeking spiritual rather than psychological guidance. Tools that fail to inquire about such preferences miss the opportunity to adapt the approach, refer appropriately, or co-construct a meaningful process.

The AMI addresses this directly by asking clients not only why they're seeking therapy but also how they feel about therapy itself, questions that can reveal critical mismatches before they derail treatment.

4.5 Lack of Clinician-Focused Application Tools

Finally, many existing assessments are created for research purposes or academic evaluation rather than real-time clinical utility. The language is often technical or inaccessible, requiring scoring and interpretation that do not fit easily into fast-paced outpatient, community, or private practice settings. There is a need for a brief, accessible, client-centered tool that offers immediate value to therapists without increasing administrative burden.

The gap is institutional as well as instrumental. Alliance quality is among the strongest predictors of whether any intervention succeeds (Flückiger et al., 2018; Wampold, 2015), yet training rarely addresses how alliance forms in the earliest encounters. The Council on Social Work Education's accreditation standards articulate nine core competencies, and alliance formation in early encounters is not among them (Council on Social Work Education, 2022). A tool that structures attention to motivation and acceptance at intake is one practical way to close a gap that curricula have not.

Summary

The absence of integrated, pre-treatment assessments for motivation, acceptance, and fit results in preventable alliance ruptures, premature dropout, and suboptimal treatment planning. By

addressing these gaps, the AMI aims to shift the field toward a more responsive, personalized, and human-centered approach to beginning therapy.

5. Contribution of the Acceptance Motivation Inquiry (AMI)

The Acceptance Motivation Inquiry (AMI) was created to fill a crucial limitation in mental health practice: the absence of a practical, pre-treatment tool that assesses both a client's motivation to change and their acceptance of their diagnosis. While traditional tools tend to focus narrowly on either stage of change, alliance strength, or internal drive, the AMI offers a more holistic view of the client's orientation toward therapy itself, before treatment begins.

Developed through years of clinical observation, feedback from supervisees, and iterative use in diverse therapeutic settings, the AMI reflects a grounded, practice-based contribution to the field. It integrates the most relevant insights from motivational, humanistic, and relational theories, while remaining brief, accessible, and scalable across clinical environments.

At the heart of the AMI is the recognition that motivation and acceptance are distinct but interrelated constructs:

- Motivation speaks to the desire to change, often shaped by internal readiness, external pressures, or urgency.
- Acceptance refers to internal identification with or resistance to the diagnostic label or concept of 'having a problem.'

The AMI allows for differentiated client profiles, recognizing that a person may be highly motivated to seek change yet struggle to accept that they have a mental health condition, or vice versa. Sample items that assess motivation include: "I feel ready to do the work of therapy," and "I am here mostly because someone else thinks I should be." Items reflecting diagnostic acceptance include: "I believe something is going on with me that needs attention," and "I'm not sure I really have a problem." This dual-axis clarity helps clinicians tailor their initial stance, whether that means validating uncertainty, exploring meaning around diagnosis, or pacing interventions in line with the client's internal readiness and self-perception.

Unlike longer instruments like the URICA or academically dense ones like the TMQ, the AMI is:

- Brief (30 items or fewer)
- Client-centered, using accessible language
- Self-administered, typically taking 5 to 10 minutes
- Immediately interpretable, offering therapists insight before session one

Its delivery format, whether online, paper, or verbal, makes it adaptable to settings from university counseling centers to private practice to telehealth platforms. It has been used in

intakes, group sessions, and training workshops to help clinicians avoid mismatched interventions or alliance ruptures.

In practice, clinicians may follow up AMI responses with reflective prompts based on client responses, such as: "I see you strongly agreed with the statement 'I'm unsure I even need therapy.' Can you say more about that?" These follow-ups are not part of the AMI itself but illustrate how it can spark collaborative dialogue. In this way, the AMI is not only a metric but a conversation-starter that empowers clients as co-creators of the therapeutic process.

The AMI also holds promise in supervision, training, and outcome research:

- In supervision, it helps early-career clinicians better attune to motivational and acceptance cues.
- In training, it models a relational and reflective stance.
- In research, it may predict early dropout, alliance ruptures, or mismatches between approach and client readiness.

Preliminary use suggests AMI data correlates with observed patterns in engagement, though further psychometric validation is underway.

In offering a brief, relationally attuned, and theoretically integrated tool, the AMI expands a clinician's ability to understand a client's internal state before formal treatment begins. It aligns with personalized, trauma-informed care and begins with a simple premise: each client enters therapy from somewhere, and understanding that starting point matters.

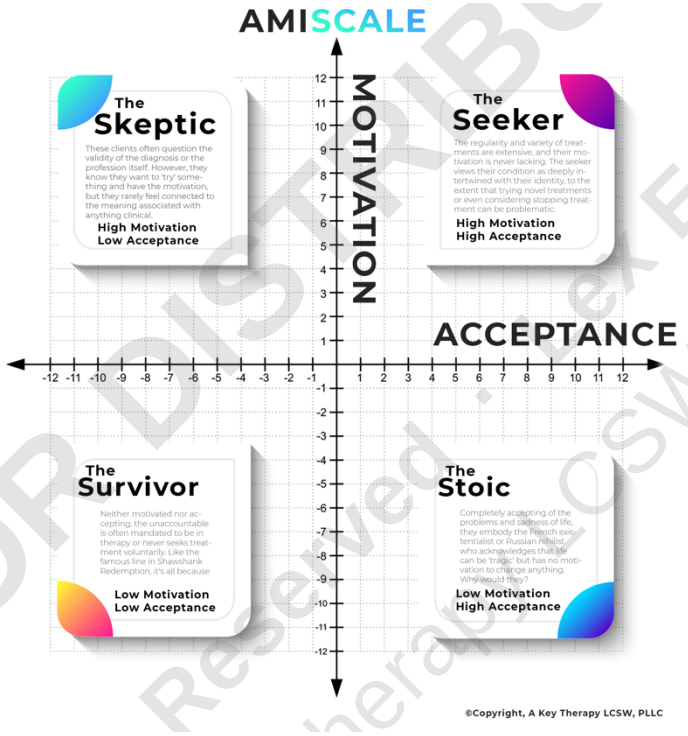
What the AMI also implicitly addresses is the clinician's side of the early assessment encounter. The TASc research demonstrates that attunement failures are not random; they follow from the therapist's own attachment organization and show up reliably in language (Talia et al., 2020). Countertransference research similarly finds that a clinician's pre-session internal states, particularly feelings of inadequacy or anxiety, predict reduced patient-rated helpfulness even when the therapist remains outwardly warm (Abargil et al., 2024; Hayes et al., 2011). The AMI functions as a modest corrective to both of these dynamics. By externalizing the client's motivational and acceptance stance into a concrete, visible profile before the first session, it reduces the clinician's reliance on in-the-moment inference, the kind of inference most vulnerable to countertransferential distortion. In this way, the AMI is not only a tool for understanding the client; it is a structure that invites the clinician to approach early assessment with more intentionality, less projection, and a posture closer to what Talia et al. describe as negative capability: remaining genuinely open, rather than arriving already certain.

6. The Four Orientations in Clinical Use

A common misinterpretation of the AMI visual framework is the assumption that the Seeker quadrant, high in both motivation and acceptance, represents the ideal or healthiest client profile. In practice, however, clients at any extreme of the scale, including Seekers, may be operating

from a rigid, identity-fused stance. For instance, a client who strongly identifies with their diagnosis and is highly motivated to pursue treatment may over-pathologize themselves, exhibit inflexibility, or become over-reliant on therapy as an identity anchor. Similarly, those at the extremes of skepticism, detachment, or philosophical resignation may resist relational engagement or meaningful experimentation with new patterns. In this sense, the AMI is not designed to celebrate typologies, but to illuminate where therapeutic work may be most needed: at the edges, where motivational and cognitive-emotional frames are more fixed. True growth often begins not at the poles, but toward the center of the matrix, where motivation and acceptance are held with curiosity and openness rather than certainty or resistance.

6.1 Embracing Fluid Identities, Not Fixed Types



At the heart of the AMI are four distinct categories that represent different client postures toward therapy:

- Seeker (high motivation, high acceptance)
- Skeptic (high motivation, low acceptance)
- Stoic (low motivation, high acceptance)
- Survivor (low motivation, low acceptance)

These categories are not diagnostic or prescriptive; they are reflective tools. They offer clients a chance to explore how they are relating to therapy at a given moment, and how that stance might shift over time. The AMI encourages clients to view these categories as fluid, not fixed; most people contain aspects of each depending on context, history, and part of self that is showing up.

Importantly, the goal is not to become a Seeker, nor is one category synonymous with wellness. Each stance has value, vulnerability, and meaning. A Stoic may offer deeply grounded insight but resist new behavior; a Skeptic may hunger for change while struggling to trust the process. And a Survivor may question or deny that there is an issue at all and, with time and alliance, grow toward change. Rather than judging these positions, the AMI helps make them visible, speakable, and workable.

6.2 Client-Led Reflection, Therapist-Facilitated Dialogue

Therapists are not encouraged to label clients as belonging to a category. Instead, clients are invited to view the AMI framework and self-reflect: Where do I see myself right now? What part of me feels aligned, or misaligned, with therapy? Sometimes a client identifies clearly with a category; other times, a therapist may gently offer a reflective observation that invites reconsideration. This process honors client agency while making space for relational honesty.

This approach also makes room for internal multiplicity and the nuanced interplay of parts within the self. Clients may express seemingly contradictory stances: "Part of me is a total Stoic about therapy, but another part really wants to be here." Such expressions reflect a broader therapeutic truth, that identity is not monolithic, but composed of layered voices, shaped by experience, habit, and longing. Within mindfulness traditions and Taoist thought, identity is seen not as a static construct but as a flow. This is formed by repeated responses and dissolvable through conscious attention. This aligns with the Internal Family Systems model (Schwartz, 1995), which views the psyche as a system of parts, each with its own perspective, bound together in patterns of protection and vulnerability. The AMI scale becomes a reflective mirror in this context, helping clients identify and soften the internal positions they hold toward therapy, without forcing premature resolution.

6.3 Relational Calibration

The framework's foundation is what the AMI's current development names relational calibration: the degree to which the clinician's understanding of a client's motivation and diagnostic acceptance matches where the client actually is. Calibration is not agreement, and it is not emotional resonance. It is accuracy, held mutually. A clinician can be warm, skilled, and well trained while operating from a read of the client that is simply wrong, and treatment built on an inaccurate read produces a familiar clinical experience: sessions that go nowhere, interventions that land on no one, effort without movement. Much of what presents as stuckness is uncalibrated treatment. Clinicians are unreliable judges of their own read of a case unless something forces the question (Hannan et al., 2005), and misalignment takes predictable forms: the client who performs engagement while privately rejecting the diagnostic frame (Safran & Muran, 2011), or the client who presents as withdrawn while holding more motivation than they reveal.

Calibration operates at two levels. In early sessions it functions silently: the clinician holds their read of the client as a hypothesis rather than a conclusion, tests it against what the client says and does, and adjusts. When treatment stalls, the map can be brought into the room explicitly, and the client is invited to locate themselves: where is your motivation right now, and what is your honest relationship to this diagnosis? Surfacing the misalignment collaboratively is itself an intervention, and often the one that restarts stalled work.

The quadrants exist to serve this calibration. They are reference points rather than a typology of clients, and each position carries implications for the stance a clinician should take:

- A Seeker may benefit from pacing and reflection on diagnosis as identity.
- A Skeptic might need transparency, consent-based processes, or cultural attunement.
- A Stoic may require motivational exploration and clear boundaries.
- A Survivor might need patience, creative modalities, or alternative frames.

The unit of clinical attention is never the label. It is the accuracy of the alignment between two people trying to do difficult work together. Rather than assume readiness, the AMI allows therapists to begin with humility and curiosity, using the client's own reflection as the foundation for clinical strategy.

6.4 Supporting Transformative Process

The AMI resists the medical model's binary of "ready vs. resistant" and instead offers a framework for meaningful transformation. It centers the client's subjective experience, making room for complexity, contradiction, and growth. Because it is brief, relational, and non-pathologizing, it can be used at intake, in supervision, or as a recurring check-in throughout treatment.

7. Limitations and Future Adaptations

While the Acceptance Motivation Inquiry (AMI) provides a novel framework for assessing client engagement at the outset of therapy, it is important to acknowledge its current conceptual limitations and areas for growth. Most notably, the AMI is built upon a two-axis model, motivation and acceptance, which yields four core categories: Seeker, Skeptic, Stoic, and Survivor. These categories serve as archetypal entry points, offering clients and therapists a language to begin exploring relational stance and emotional posture toward therapy.

However, such categorical frameworks inevitably simplify the diversity and fluidity of real client experiences. In clinical practice, individuals rarely fit neatly into one box. Clients may embody blended qualities, shift postures across sessions, or present contextually influenced resistance that does not align cleanly with a single quadrant. Moreover, cultural, systemic, or trauma-related barriers may shape a client's behavior in ways not fully captured by the current model.

The AMI is also intentionally non-pathologizing and reflective, but further research is needed to understand how clients across cultures, genders, and neurotypes interpret and respond to the scale. As it stands, the four categories offer clarity and usability, but may risk overgeneralization without space for dimensional complexity.

Future Adaptations

To address these limitations, several future adaptations are envisioned:

- Dimensional scoring: Rather than assigning clients to one category, a more nuanced profile could emerge by plotting scores along the motivation and acceptance axes, allowing for more personalized interpretation.
- Emergent subtypes: As validation studies progress, statistical analyses such as cluster or factor analysis may reveal natural subtypes or nuanced postures within each quadrant (e.g., "Defensive Skeptic" vs. "Hopeful Skeptic").
- Contextual overlays: Future iterations of the AMI may incorporate brief questions about systemic constraints, prior experiences, or cultural meaning-making that influence how a client relates to therapy.
- Visual tools and client vignettes: Supplementing the AMI with diagrams or sample profiles may help clinicians and clients better grasp its flexibility and avoid the misperception of static "types."

Ultimately, the strength of the AMI lies not in the precision of its categories, but in its ability to foster reflective dialogue, attuned strategy, and relational honesty from the start of care. Its continued development will rely on embracing feedback, exploring complexity, and remaining accountable to the diverse realities of those seeking therapy.

8. Conclusion and Future Directions

As the field of psychotherapy continues to evolve toward more personalized, trauma-informed, and collaborative approaches, it is essential to have tools that reflect the full complexity of how clients enter the therapeutic process. This literature review has highlighted a persistent gap: while theories like the Stages of Change, Self-Determination Theory, and ACT have deepened our understanding of motivation, and while tools like the WAI and URICA have expanded our ability to assess engagement, none fully capture the relational, emotional, and motivational state of clients before therapy begins.

The Acceptance Motivation Inquiry (AMI) offers a vital contribution to the clinical landscape by providing a brief, client-centered, and flexible assessment that integrates both motivation to change and acceptance of care. Its use of the four reflective categories, Seeker, Skeptic, Stoic, and Survivor, gives clients a language to explore how they relate to therapy and how that relationship might shift. It also allows therapists to adjust their clinical approach based on relational stance, not just symptom presentation. Its recent development names the underlying

construct relational calibration: the accuracy of the clinician's read of where the client stands, held as a hypothesis and revised in contact with the client.

Crucially, the AMI is not a tool for categorizing clients into fixed identities or measuring success by movement toward a particular type. Instead, it affirms that health and growth often emerge from a greater flexibility of position, an ability to inhabit different roles, and an awareness of one's own ambivalence or defenses. In doing so, the AMI aligns with the most humanistic and liberatory aims of therapy: to support people in becoming more fully aware, more fully empowered, and more fully themselves.

Future Directions

The potential uses of the AMI span several domains:

- Clinical Practice: Continued use in intake and early engagement to reduce dropout, increase alliance, and inform pacing.
- Supervision and Training: Helping new clinicians understand motivational dynamics and relational stance through client-centered reflection.
- Research: Validating the AMI's psychometric properties and studying correlations between category patterns and treatment outcomes.
- Group Work and Psychoeducation: Using the AMI categories to facilitate discussions about readiness, resistance, and relational patterns in group therapy or workshop settings.
- Program Development: Applying AMI data to inform service design, triage systems, or therapist-client matching processes.

As therapists and researchers increasingly recognize that how a client arrives to therapy shapes what is possible in treatment, tools like the AMI offer not only assessment but transformation, inviting therapists to ask not "What's wrong with you?" but "Where are you coming from, and how can we meet you there?"

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