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Review Article

Implicit and Explicit Motivation: Theoretical Approach and his Implication in Attention-Deficit/Hyperactivity Disorder and Personality Disorders Patients

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Abstract

Unlike motivation, implicit and explicit motivations and goal-seeking are psychological constructs that have received little research attention in recent years.

We have reviewed the updated literature on the topic and have attempted to adapt the concepts that involve two mental illnesses: attention-deficit/hyperactivity disorder (ADHD) and personality disorders, in particular, borderline personality disorder (BPD).

A relation is sought between motivational congruence and emotional well-being.

Keywords: *Implicit and Explicit Motives; Wellbeing; Competence; ADHD; Personality Disorders*

Introduction

An implicit motive is, per se, a competence that has to do with performing some kind of work that, in practice, takes place within a specific role, job, organization, or culture. In fact, implicit motivation is normally the intention, and competence requires a series of more limited behaviors related as much as possible to the motive on which it is based. Implicit motives are dispositional capacities to experience certain kinds of incentives as being pleasant and other kinds of disincentives as aversive. They are an important source of emotional well-being [1,2] and are relatively stable, unconscious needs [3] that represent the individual's affective preferences that gradually evolve through learning and experience [4]. These motives stimulate individuals when they participate in the corresponding courses of action. Examples are, the affiliation motive, that is stimulated when the individual interacts socially; the motive of achievement of difficult goals is activated more with challenging tasks, or the power motive, by influencing others. Belonging (being in a close, harmonious relationship), achievement (autonomous domain of challenging tasks), and power [5] represent capacities to experience incentives as pleasant or aversive [6]; that is, they orient the subject's attention, finally directing and holding their behavior.

These implicit motives are developed early in life, possibly before language development [6]. They tend to be poorly integrated into cognition and cannot be consciously accessed through introspection to make deliberate decisions [7].

Implicit motives are based on affective preferences; this is, on the capacity to experience the consummation of an incentive of a specific motive as reward or pleasure [8]. The effect of implicit motives on learning, attentional orienting, and energizing behavior is automatic and is not even represented or regulated by conscious awareness.

Difference between Implicit and Explicit Motives

The former motivate and the latter channel or regulate goal-oriented behavior. They also differ in the kinds of incentives they correspond to: implicit motives respond to intrinsic tasks or incentives (the pleasure of working on a challenging task, in the case of achievement motivation). They probably also respond more to keys of non-verbal incentives than verbal, symbolic stimuli [9]. Explicit motives develop later and are built around explicit norms that are acquired when a child develops an idea about the types of behaviors that the social environment finds important and valuable. The development of the implicit affiliation motive depends on parents' responsiveness to their crying infant [10]. In contrast, the development of the explicit affiliation motive depends on the extent to which parents explicitly teach their child to be nice to other people [10].

Explicit motives respond to extrinsic-social incentives (to major external demands and social norms). Explicit motives encompass self-attributed motives, representations of the individual's language-based beliefs about motivational orientations and their verbally represented personal goals. They are cognitive representations of what a person currently wants to achieve [8]. They are molded by social norms, tangible rewards, and individuals' beliefs about themselves [4]. Explicit goals affect conscious attitudes, choices, and decisions, but, unlike implicit motives, do not energize the individual.

Emotional well-being is greater in individuals who seek and achieve personal goals that suit their implicit motives (that are congruent with them) than those that do not align with them or are incongruent with them [2,7]. The process of committing to tasks that correspond to these motives is gratifying. A relation has been observed between severe or prolonged mismatches between motives and goals and clinical states of depression and mood disorders [11].

When decisions are made about what goals to pursue in daily life, people often trust self-reflection and introspection. This analysis probably orients attention about explicit rather than implicit motives, because they are consciously available and more strongly linked to the perceptions people have of themselves than implicit motives. Explicit motives tend to be good predictors of goals [6,7]. If goal-seeking is aligned with explicit motives, this does not guarantee that they will also match implicit motives, because there is low correspondence between both kinds of motives [9].

Implicit and explicit motive diagnostics

Implicit motives are not consciously accesible; instead, indirect methods are required, such as thematic perception: codifying specific kinds of images into imaginative stories that individuals write about ambiguous pictures:

1. The Picture Story Exercise (PSE) [7,12]
2. the Operant Motive Test [12]
3. or the Implicit Association Test (IAT) [13].

Self-attributed motives or personal goals are consciously accessible and are evaluated by self-report technique question naires, e.g. Personality Research Form (PRF) [14] or the Personal Goal Inventory (PGI) [8].

Implicit motives influence measures having to do with motivation procedure (about knowing how the person performs in his environment). Explicit motives and goals exert a greater impact on declarative measures of motivation (they appraise the what of the person or their attitudes, judgments, and decisions) [15].

Types of implicit motives and wellbeing

An implicit motive involves the desire for a specific affective experience and frequently experiencing this preferred affect can lead to satisfaction and well-being in a given domain. For instance, people with high affiliation motive will be more satisfied with the experiences of specific effects of tranquility and relaxation. Those who have a higher power motive will find greater satisfaction with the effect of strength and excitement in their relationships [16].

Satisfying the affiliation motive has been key to well-being [17]. The seeking goals that are incongruent can undermine emotional well-being and exacerbate symptoms of depression [8]. People with a strong implicit affiliation motive carry out tasks that provide them with social approval or that require cooperation with other people better [18].

People achieve high levels of well-being when they perceive themselves as being successful in their search. Progress in goal achievement is considered an immediate precursor of well-being. To reach high rates of progress, individuals need to be firmly committed to their personal goals and favorable conditions to achieve them.

Objectives in motivation

Integral affective resources must also be integrated into the implicit motivational system with the strategic capacities of effort of explicit goal-seeking systems to effectively regulate affect and behavior and in a self-determined way.

If the result is a lack of introspective insight about one's motivational needs, then helping people attain more congruent goals is achieved by educating them individually about their motives.

Objectives

1. To create awareness of one's implicit motivational needs and the degree to which they match committed goals.
2. To increase congruence when it is low and lower it if it is high.

But increasing congruence is not enough; it also has to do with the attainability of goals to be able to implement them [19].

The usefulness of considering individual implicit motives should be boosted by discussing their personal goals in therapeutic contexts.

How to close the gap between implicit and explicit motives?

Some are more concordant than others; this is beneficial because both motivational systems will be aligned and people's spontaneous behavior will match their planned behavior [20]. In cases in which the motives of system 1 and 2 are discordant, people can experience frustration with their efforts or decreased satisfaction with the product of their work. Discordance in motives reduces overall well-being while people pursue goals with one system that are not aligned with the other system [21].

To decrease the incongruence between both motives, the following have been proposed:

1. With experimental control of goal imagery [9]: mental simulation, such as the perception of the pursuit and availability of a potential goal, which acts as a means of connecting, setting activities as goals, and implicit motives.
2. Commit to more creative efforts, joyfully experimenting with original, innovative media to facilitate progress in relevant themes of their life; for example, sitting peacefully for a few minutes and clenching their left fist. This exercise makes it easier to be aware of implicit motives and fundamental values [22].
3. Fantasies focused on emotions about goal-seeking prospective: they are useful to close the gap between implicit motives and consciously chosen goals [16].
4. Mindfulness exercises reduce the motivation toward goals of social status and power, but increase and reinforce goals of affiliation [23]. This is in line with the afore-mentioned: in order to set goals that reflect the individual's implicit motives, they must have tools that increase access to affective signals that reflect the strength of their implicit motives. People who regularly practice mindfulness have greater congruence between implicit-explicit motives. This is based on the fact that mindfulness can increase access to unconscious processes [24] and acceptance of these processes [25]. In contrast, this access to the unconscious can be related to creativity [26] and enhance the ability to learn from mistakes (in studies on risk-taking) [27].

Other ways of seeking motivational competence, or the individual's ability to align and maintain their explicit and implicit motives in alignment [28]:

1. By means of flexible processes and strategies, as well as dispositional factors. Alignment is greater among people who score high for personality traits, such as
    A) Self-determination [20]; self-control could potentially compensate for the difficulties that accumulate when implicit and explicit motives diverge. Individuals with low self-determination have deficits in self-regulating affect; who tend to commit to unrealistic goals and with incongruent motives [29]. Motive incongruence acts as a general mechanism that contributes to making stress and psychosomatic symptoms chronic [22].
    B) Referential competence, or the stable, individual differences in the ability to rapidly name non-verbally represented information [30].
    C) Dedication and persistence, despite conflicting implicit motives. These motives do not necessarily converge with explicit motives, effort, and with progress [31].
2. Private body consciousness or sensitivity to internal body states. The implicit motives modulate affective responses to stimuli related to motives that manifest in the body [6]; they may be indirectly accessible by paying attention to one's bodily sensations while seeking and initiating goals [32].
3. Preference for consistency, behaving as consistently as possible; adopting similar behaviors and expressing the same values in different contexts, more than changing their behavior on the basis of opinions [32].
4. A stable, well-developed sense of self-identity [33].
5. Low tendency toward self-monitoring [32].

6. Factors that tend to relieve anxiety, such as self-disclosure and locus of control. From the perspective of the theory of personality interaction systems, when anxiety decreases, the individual's lasting goals and values are evoked. They could activate those values that are in line with their explicit motives, which would facilitate their dedication and persistence.

   None of these conditions exist in ADHD or in personality disorders.

7. Finding ways to increase motivational competence will help people to become more aware of and access their implicit motives and promote the development of motive-specific competences and well-being. However, at times, congruence is not enough and the person's will is limited [34]. Motive congruence does not always affect mood or well-being. Such is the case when activity inhibition levels are high or there is a tendency to constrain impulses.

Personality and Motives

Personality traits mediate the effects of motives [35]: they perceive motives as flexible impulses without a fixed object of expression; they are general desires or desires that seek to be expressed however possible. Other psychological variables channel or fail to channel these motives in satisfactory spheres of expression. However, Winter, John, Stewart, Kohen, Duncan (1998) [35] are of the opinion that introversion and extraversion traits could channel implicit motives: extraversion would facilitate the expression of motives and well-being, while introversion would inhibit the expression of motives and would negatively impact well-being.

According to the Theory of personality interaction systems [36], implicit and explicit motivational systems are congruent when they have free and easy access to each other; when they can exchange information. This exchange takes place without much difficulty, unless the person suffers affect regulation issues, particularly negative affect (stress) regulation. This interferes with affect regulation and information is not exchanged. The two motivational systems become incongruent. Kuhl's model finds no conflict between conscious and unconscious, but rather that stress can be environmental or internal and the outcome is the same. The lack of communication between both systems results in discrepancy between them, which has a negative bearing on well-being.

Motive incongruence as a general mechanism contributes to making stress and psychosomatic symptoms chronic [22,35]. Personality traits (pg., extraversion, with the need for power and affiliation), channel the expression of implicit motives (power and affiliation needs) and determine the specific way in which the motive is translated into goal-oriented behavior. Joining the effects of traits and motives predicts vital outcomes [37].

The cure is similar: opening up lines of communication, decreasing stress, and improving mechanisms of affect regulation. The personality characteristic of difficulty in regulating affect interacts with stress to increase motivational incongruence. This incongruence affects subjective well-being and symptomatology. The congruence of motives has to do with the ability to generate positive affect and reduce negative affect (strong mechanisms of affect regulation).

Competence

Competence can also be defined as the fundamental motivation that serves to help people develop and adapt to their environment. They learn to use tools to achieve competence in specific experiences and results [38]. Some authors propose achievement as competence and achievement motivation as motivation competence [39].

Competences can be looked at as a behavioral approach to emotional, social, and cognitive intelligence. Competence-building requires action (pg., a series of alternative behaviors) and intention.

Implicit motives are the primary source of motivational energy to truly develop the competence, whereas explicit motives predominantly regulate or channel behavior and determine the domain of life in which a person strives to become competent.

Competences and a holistic theory personality

McClelland DC [40] presents a theory of personality that comprehends the relations between people's unconscious motives, self-schemata, and observed models of behavior.

Boyatzis (1982) [41] proposes a diagram of integrated systems in concentric circles: unconscious motives and character traits are located in the center; these both affect and are affected by the next larger circle, values and self-image; the surrounding circle, abilities; the next larger circle, observed, specific behaviors.

Goleman D 2006 [42] adds a physiological level (neural circuits and endocrine (hormonal) processes; unconscious dispositions, motives, and traits; values and operant philosophy; separate, observed competences; clusters of competences to the previous model.

We can combine the models in this way: Unconscious relation motives and personality: with self-schemata and observed behaviors [40]; character traits and unconscious motives, values and self-image, abilities, specific observed behaviors; neural circuits, motives and traits, values and operant philosophy, observed separate competences, and competence clustering.

Attention-deficit/hyperactivity disorder (ADHD)

ADHD is a developmental disorder characterized by inattention, hyperactivity, and impulsivity, together with deficits in executive functioning, emotional regulation, and motivation [43,44].

However, individuals with ADHD have little capacity for introspection; consequently, they are largely unaware of explicit goals. They lack internal state language [45] and the ability to put themselves in another person's shoes [46]. Since working memory also fails them, goal-setting and long-term planning are difficult for them. They have trouble with behavior that is governed by rules or instructions [47], in the development, application, and self-monitoring of organizational strategies [48]. Likewise, self-directed language fails them [49]. Their private speech is slowed, with self-talk that has less of an influence on controlling their own behavior, difficulties in following rules and other people's instructions, and delayed speech internalization [50-52].

Patients with ADHD may have more creative thought [53] and a tendency to focus and maintain their attention on aspects on which they perform best (artistic creation, sports, etc.). These patients depend on context and situation for their motivation and due to the heterogeneity of their cognitive dysfunctions [54]. This means that the cognitive deficit should be investigated in certain motivations and contexts [55].

In ADHD, there is less consistency, a lack of motivation and persistence [53]. These individuals need someone to support and supervise them in those areas in which they have greater difficult. They are too consistent and overly focused on what they do well.

These patients exhibit a deficit in internally generated forms of representation of motivation needed to direct their behavior toward goals (in initiating and maintaining them). Also they have a difficult emotional self-regulation [56].

The efforts of self-regulation may lead to the temporary depletion of their limited resources or prolonged self-regulation may empty the pool of effort available. This flaw in self-regulation and resistance to immediate gratification is characteristic of these patients. The temporary emptying is reinforced with stress, alcohol, other drugs, and with low blood sugar.

This impairment in ADHD affects: decreased use of analysis and synthesis in forming verbal and non-verbal responses to events; reduced mental capacity to visualize and then generate multiple action plans (options) to serve goal-oriented behavior and select the ones most likely to succeed from among them. This impairment in replenishment is manifested in everyday verbal fluency to meet goals or complete a task. It is also evident when visual information must be held in mind in order to generate scenarios that help to solve problems [57]. In children, a deficiency has been observed in verbal and non-verbal fluency, planning, problem-solving, and in developing strategies [58,59].

Executive function is affected: inhibition, working memory, plans, and problem-solving, fluency, etc. [57]. They have impaired capacity to organize and execute one's own time-related actions; decreased retrospection and foresight [57,59]. Also, they have impaired capacity in:

1. Verbalization of internal states [45] Impaired internalization and self-direction of emotion affects them in the following ways: greater emotional expression in their response to events; guided behavior governed by rules or instructions [47];
2. Impaired sense of time [60]: The inability to regulate their behavior with respect to time. They respond or prepare only for relatively imminent events, more than those that are further in the future, and others are ready for the eventual event [48]. They are prone to risk-taking despite being informed of the consequences for others who do so [61].
3. Non-verbal working memory: self-directed visual imagery, hearing, concealed self-talk¸ without being sufficiently capable of controlling the behavior.

The affiliation motive is more important than the achievement motive for ADHD patients, if we go by the difficulty in organizing and directing themselves toward long-term goals. Their personality dimensions of low conscientiousness, self-discipline, and sense of duty hinder long-term motivation. They must be calmer to achieve affiliation (implicit other motive).

The delayed maturity of these individuals can lead to an associated delay of implicit motives.

How do ADHD patients become aware of their implicit motives and achieve well-being? We have previously seen that mindfulness (being cautious of the possible adverse effects), facility for creativity and imagination, and, perhaps, exercise, provide means by which to access implicit motivation, and a tendency toward greater well-being. The lack of motivation, given the previously reported difficulties in in executive functions, contributes to impeding the potential successful implicit access. On the other hand, self-control, dedication and persistence is low in ADHD. Because of the emotional dysregulation, there is less communication between implicit and explicit motives.

Insofar as goal accessibility or availability is concerned, we must distinguish between the short and long term; in general, they do not delay short-term rewards and have a harder time with long-term rewards.

In ADHD patients, emotional regulation and self-concept are flawed, and their cognitive dysfunction is heterogenous. Developmental delay and clinical comorbidity can affect motivational congruence.

Adverse effects in mindfulness-based interventions in ADHD

Enhanced awareness can result in an increase in self-reported symptoms or distress associated with these symptoms [62]. They become more objective observers of their behavior and the associated functional decline can play a role in the perceptions of being broken or deficient. These perceptions are already common among adult ADHD patients [63], and an increase in awareness of ADHD-related deficits could deepen the perception of brokenness. Mindfulness in these patients can also lead to increased insight into their behavior as developmentally positive thanks to their increased self-effectiveness. Other patients related increased insight with a sense of impotence or difficulties in managing their inner restlessness, loss of focus or noise during meditation, or exacerbation of depression [64]. The therapist must manage these latter experiences, because if not, they can accentuate adverse experiences, with a sense of failure, and patients drop out of therapy.

Those that are more affected by programming or planning conflicts [65] and challenges with organization and time management were more prone to taking less advantage of this tool.

Personality Disorders

In general, personality disorders entail an impaired ability to understand mental states [66]. Some patients tend to inhibit their emotions, which can lead to social dysfunction and distress, clinically express as a personality disorder (PD). Individuals who inhibit their emotions struggle to set personal goals and to a certain degree, are unaware of their emotional state or don't trust these states. This emotional inhibition has been associated more with avoidant, dependent, depressive, passive-aggressive, borderline, and paranoid personality disorders, and with the overall severity of the personality disorders [67].

Borderline personality disorder (BPD) also associates a deficit in working memory [68], planning, and sustained attention [69,70].

As a result, they have difficulties when it comes to goal-setting. BPD also presents an impaired ability to moderate affect, in contrast to their ability to display emotions. The suppression and expression of feelings are neither healthy nor pathological per se, rather they reflect a balance between expression and regulation [71]. Other authors have observed that BPD patients tend to suppress negative and positive emotions [72]. It can therefore be concluded that individuals with BPD are more emotionally unregulated than inhibited or over-regulated [73]. This abnormal emotional regulation seen in BPD is also observed in ADHD [43,61]. Lampe., *et al.* (2007) found that response inhibition was not typical of BPD but was only associated with ADHD. In 10 studies [70] observed impaired cognitive function: attention, cognitive flexibility, processing speed, learning and memory, planning, and visual-spatial abilities.

Patients with BPD do not properly regulate their emotions or form realistic representations of emotions, ideas, objectives, values, and intentions that underpin behavior and mold their own mental states, as well as those of others.

They have diminished mentalizing, which affects differentiation (distinguishing between internal and external representations of reality) and integration; i.e. they are less able to form a stable self-image and stable representations of interpersonal relations. Nevertheless, this difficulty in recognizing thoughts and emotions and creating mental states, is also seen in severe PD. BPD patients exhibited difficulties in two mind reading functions: differentiation and integration [74,75]. Moreover, they possess reduced emotional empathy in proportion to the clinical severity of their disorder.

For all these reasons, we find that both BPD patients, as well as those with other clinically severe PD display difficulties with their own self-image and those of others, with a lack of emotional regulation that hinders access to their implicit motives, not to mention the dissociative episodes they may display. If they do not coincide with their goals, they will not generate well-being, but will give rise instead to anxiety, depression, eating disorders, etc.

Conclusion

Implicit and explicit motives have been abandoned in recent bibliography.

We look for an update of these constructs and apply them to ADHD and personality disorders. It may be important to considerate these constructs when we see cognitive, forensic and personality dimensions, as motivation, competence and wellbeing.

Bibliography

1. Brunstein JC., *et al*. "Implicit and self-attributed motives to achieve: two separate but interacting needs". *Journal of Personality and Social Psychology* 89.2 (2005): 205-222.

2. Kollner MG., *et al*. "Meta-analytic evidence of low convergence between implicit and explicit measures of the needs for achievement, affiliation, and power". *Frontiers in Psychology* 5 (2014): 826.

3. McClelland DC., *et al*. "Stressed power motivation, sympathetic activation, immune function, and illness". *Journal of Human Stress* 6.2 (1980): 11-19.

4. McClelland DC. "Human Motivation Scott Foresman". Glenview, IL, USA (1985).

5. Atkinson JW. "Motivational determinants of risk-taking behavior". *Psychological Review* 1.6 (1957): 359-372.

6. Schultheiss OC., *et al*. "Implicit motives". In Handbook of Personality: Theory Research, 4th Edition (in press). eds John O P, Robins R W, editors (New York, NY: Guilford) (2008).

7. McClelland DC., *et al*. "How do self-attributed and implicit motives differ?" *Psychological Review* 96.4 (1989): 690-702.

8. Brunstein JC., *et al*. "Personal goals and emotional well-being: the moderating role of motive dispositions". *Journal of Personality and Social Psychology* 75.2 (1998): 494-508.

9. Schultheiss OC., *et al*. "Goal Imagery: Bridging the Gap Between Implicit Motives and Explicit Goals". *Journal of Personality* 67.1 (2001): 1-38.

10. McClelland DC., *et al*. "Sources of adult motives in patterns of parent behavior in early childhood". *Journal of Personality and Social Psychology* 44.3 (1983): 564-574.

11. Becker J. "Achievement related characteristics of manic-depressives". *Journal of Abnormal and Social Psychology* 60.3 (1960): 334-339.

12. Kuhl J., *et al*. "Der Operante Multi-Motiv-Test (OMT): Manual [Scoring manual for the Operant Multi-Motive Test (OMT)]". Osnabrück, Germany: University of Osnabrück) Applied Developmental Science (1999).

13. Brunstein JC., *et al*. "Assessing individual differences in achievement motivation with the Implicit Association Test". *Journal of Research in Personality* 38.6 (2004): 536-555.

14. Jackson DN. "Manual for the Personality Research Form". Goshen, NY: Research Psychologists Press (1974).

15. deCharms R., *et al*. "Behavioral correlates of directly and indirectly measured achievement motivation". Studies in motivation In DC McClelland (Eds) New York: Appleton-Century-Crofts 45 (1955): 414-423.

16. Job V., *et al*. "Are implicit motives the need to feel certain affect? Motive-affect congruence predicts relationship satisfaction". *Personality and Social Psychology Bulletin* 38.12 (2012): 1552-1565.

17. Schüler J., *et al*. "A high implicit affiliation motive does not always make you happy: A corresponding explicit motive and corresponding behavior are further needed". *Motivation and Emotion* 32.3 (2008): 231-242.

18. Atkinson JW., *et al*. "Neglected factors in studies of achievement-oriented performance: Social approval as incentive and performance decrement. A theory of achievement motivation". New York Wiley (1966).

19. Brunstein JC., *et al*. "Personal goals in college education: testing an intervention to increase students' goal effectiveness and satisfaction in college". *Zeitschrift Pädagogische Psychologie* 22 (2008): 177-191.

20. Thrash TM., *et al*. "Factors That Influence the Relation Between Implicit and Explicit Motives: A General Implicit-Explicit Congruence Framework". Implicit Motives New York: Oxford University Press (2010): 308-346.

21. Brunstein JC. "Implicit Motives and Explicit Goals: The Role of Motivational Congruence in Emotional Well-Being". In OC Shultheiss and JC Brunstein (Eds), Implicit motives New York: Oxford University Press (2010): 347-374.

22. Baumann N., *et al*. "Hemispheric activation and self-infiltration: Testing a neuropsychological model of internalization". *Motivation and Emotion* 29.3 (2005): 135-163.

23. Brown KW., *et al*. "The benefits of being present: mindfulness and its role in psychological well-being". *Journal of Personality and Social Psychology* 84.4 (2003): 822-848.

24. Strick M., *et al*. "Zen meditation and access to information in the unconscious". *Consciousness and Cognition* 21.3 (2012): 1476-1481.

25. Alberts HJ., *et al*. "Coping with food cravings. Investigating the potential of a mindfulness-based intervention". *Appetite* 55.1 (2010): 160-163.

26. Zhong CB., *et al*. "The merits of unconscious thought in creativity". *Psychological Science* 19.9 (2008): 912-918.

27. Wagar BM., *et al*. "Affective guidance in the Iowa gambling task". *Cognitive, Affective, and Behavioral Neuroscience* 6.4 (2006): 277-290.

28. Rheinberg F., *et al*. "Motivation and self-regulated learning: A type analysis with process variables". *Psychologia* 45 (2002): 236-248.

29. Brunstein JC. "Personal goals and actions versus state orientation: Who builds a commitment to realistic and need congruent goals?" *Zeitschrift fur Differentielle und Diagnostiche Psychologie* 22 (2001): 1-12.

30. Schultheiss OC., *et al*. "Referential competence is associated with motivational congruence". *Journal of Research in Personality* 45.1 (2011): 59-70.

31. Langan-Fox J., *et al*. "Incongruence between implicit and self-attributed achievement motives and psychological well-being: The moderating role of self-directedness, self-disclosure and locus of control". *Personality and Individual Differences* 47.2 (2009): 99-104.

32. Thrash TM., *et al*. "Methodological and dispositional predictors of congruence between implicit and explicit need for achievement". *Personality and Social Psychology Bulletin* 33.7 (2007): 961-974.

33. Hofer J., *et al*. "Motive congruence and interpersonal identity status". *Journal of Personality* 74.2 (2006): 511-541.

34. Langens TA. "Congruence Between Implicit and Explicit Motives and Emotional Well-Being: The Moderating Role of Activity Inhibition". *Motivation and Emotion* 31.1 (2007): 49-59.

35. Winter DG., *et al*. "Traits and motives: toward an integration of two traditions in personality research". *Psychological Review* 105.2 (1998): 230-250.

36. Kuhl J. "A functional design approach to motivation and volition: The dynamics of personality systems interactions". In: M. Boekaerts, P.R. Pintrich, & M. Zeidner (Eds.), Self-regulation: Directions and challenges for future research. New York: Academic Press (2000): 111-169.

37. Mark N., *et al*. "Integrating Implicit and Explicit Social Cognitions for Enhanced Personality Assessment: A General Framework for Choosing Measurement and Statistical Methods". *Organizational Research Methods* 10.1 (2007).

38. Gratz KL., *et al*. "Multidimensional Assessment of Emotion Regulation and Dysregulation: Development, Factor Structure, and Initial Validation of the Difficulties in Emotion Regulation Scale". *Journal of Psychopathology and Behavioral Assessment* 26.1 (2004): 41-54.

39. Elliot AJ., *et al*. "Client-Articulated Avoidance Goals in the Therapy Context". *Journal of Counseling Psychology* (2002): 243-254.

40. McClelland DC. "Personality". New York: William Sloane Associates (1951).

41. Boyatzis RE. "The competent manager: a model for effective performance". John Wiley & Sons, Nueva York. (1982).

42. Goleman D. "Emotional Intelligence". New York: Bantam Books (2006).

43. Barkley RA. "Deficient emotional self-regulation is a core component of ADHD". *Journal of ADHD and Related Disorders* 1.2 (2010): 5-37.

44. Martel MM. "Research review: a new perspective on attention-deficit/hyperactivity disorder: emotion dysregulation and trait models". *Journal of Child Psychology and Psychiatry* 50.9 (2009): 1042-1051.

45. Rumpf AL., *et al*. "Narrative competence and internal state language of children with Asperger Syndrome and ADHD". *Research in Developmental Disabilities* 33.5 (2012): 1395-1407.

46. Irastorza LJ., *et al*. "A cross-sectional study examining motivation and competence in adult ADHD patients". *Annals of Psychiatry and Mental Health* 5.6 (2017): 1118.

47. Danforth JS., *et al*. "Observations of parent-child interactions with hyperactive children: research and clinical implications". *Clinical Psychology Review* 11.6 (1991): 703-727.

48. Barkley RA. "The Barkley deficits in executive functioning scale-children and adolescents (BDEFS-CA)". New York: Guilford Press (2012).

49. Reck SG., *et al*. "Memory for object location in boys with and without ADHD". *Journal of Attention Disorders* 13.5 (2010): 505-515.

50. Berk LE., *et al*. "Development and functional significance of private speech among attention-deficit hyperactivity disordered and normal boys". *Journal of Abnormal Child Psychology* 19.3 (1991): 357-377.

51. Winsler A. "Parent-child interaction and private speech in boys with ADHD". *Applied Developmental Science* 2.1 (1998): 17-39.

52. Winsler A., *et al*. "Verbal self-regulation over time in preschool children at risk for attention and behavior problems". *Journal of Child Psychology and Psychiatry* 41.7 (2000): 875-886.

53. Irastorza LJ., *et al*. "Adult ADHD Patients: Emotional Dysregulation and Personality Dimensions". *Journal of Neurology and Translational Neuroscience* 4.3 (2016): 1071.

54. Nigg JT., *et al*. "An integrative theory of attention-deficit/ hyperactivity disorder based on the cognitive and affective neurosciences". *Development and Psychopathology* 17.3 (2005): 785-806.

55. Mostert JC., *et al*. "Cognitive heterogeneity in adult attention deficit/hyperactivity disorder: A systematic analysis of neuropsychological measurements". *European Neuropsychopharmacology* 25.11 (2015): 2062-2074.

56. Steinberg EA., *et al*. "A Developmental Psychopathology Perspective on ADHD and Comorbid Conditions: The Role of Emotion Regulation". *Child Psychiatry and Human Development* 46.6 (2015): 951-966.

57. Willcutt EG. "Theories of ADHD". In RA Barkley(Ed), Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment New York: Guilford Press. (4th edition) (2015): 91-404.

58. Clark C., *et al*. "Do executive function deficits differentiate between adolescents with ADHD and oppositional defiant/conduct disorder? A neuropsychological study using the Six Elements Test and Hayling Sentence Completion Test". *Journal of Abnormal Child Psychology* 28.5 (2000): 403-414.

59. Hervey AS., *et al*. "Neuropsychology of adults with attention-deficit/hyperactivity disorder: a meta-analytic review". *Neuropsychology* 18.3 (2004): 485-503.

60. Houghton S., *et al*. "Measuring temporal self-regulation in children with and without attention deficit hyperactivity disorder: Sense of time in everyday context". *European Journal of Psychological Assessment* 27 (2011): 88-94.

61. Barkley RA. "Health and related impairments in children and adults with ADHD". In RA Barkley(Ed), Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment New York: Guilford Press. (4th edition) (2015): 267-313.

62. Mitchell JT., *et al*. "The ADHD report 15". Guilford Press (2018).

63. Mitchell JT., *et al*. "Are negative automatic thoughts associated with ADHD in adulthood?" *Cognitive Therapy and Research* 37.4 (2013):

851-859.

64. Janssen L., *et al*. "The Feasibility, Effectiveness, and Process of Change of Mindfulness-Based Cognitive Therapy for Adults With ADHD: A Mixed-Method Pilot Study". *Journal of Attention Disorders* 1 (2017): 1087054717727350.

65. Haydicky J., *et al*. "Evaluation of MBCT for adolescents with ADHD and their parents: Impact on individual and family functioning". *Journal of Child and Family Studies* 24.1 (2015): 76-94.

66. Semerari A., *et al*. "Metacognitive dysfunctions in personality disorders: correlations with disorder severity and personality styles". *Journal of Personality Disorders* 28.6 (2014): 751-766.

67. Dimaggio G., *et al*. "The problem of overcontrol: Perfectionism, emotional inhibition, and personality disorders". *Comprehensive Psychiatry* 83 (2018): 71-78.

68. Hagenhoff M., *et al*. "Executive functions in borderline personality disorder". *Psychiatry Research* 210.1 (2013): 224-231.

69. Gvirts HZ., *et al*. "Executive functioning among patients with borderline personality disorder (BPD) and their relatives". *Journal of Affective Disorders* 143.1-3 (2012): 261-264.

70. Ruocco AC. "The neuropsychology of borderline personality disorder: a meta-analysis and review". *Psychiatry Research* 137.3 (2005): 191-202.

71. Chapman AL., *et al*. "Emotion suppression in borderline personality disorder: an experience sampling study". *Journal of Personality Disorders* 23.1 (2009): 29-47.

72. Beblo T., *et al*. "Increased attempts to suppress negative and positive emotions in Borderline Personality Disorder". *Psychiatry Research* 210.2 (2013): 505-509.

73. Carpenter RW., *et al*. "Components of emotion dysregulation in borderline personality disorder: a review". *Current Psychiatry Reports* 15.1 (2013): 335.

74. Semerari A., *et al*. "Metarepresentative functions in borderline personality disorder". *Journal of Personality Disorders* 19.6 (2005): 690-710.

75. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Association (2013).

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