Reflections on the Clinical Utility of Motivational Systems Theory  
(With a Special Emphasis on the Aversive Motivational System)  
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I thank Joe Lichtenberg, Rosemary Segalla, and the Self Psychology Institute planning committee for their invitation to participate on today’s panel. My goal is to give you a sense of the enormous clinical utility I find in Joe’s theory and to share my particular way of using it. I begin my discussion with some historical context. Joe and I go back a long way – back to 1988 when I began supervision. Thus, I was first immersed in learning motivational systems theory from the inside, through my supervision with Joe.

From the first supervisory session, Joe taught me a method of therapeutic listening and communicating that began with sensing into what my patient was telling me in the present moment – an “experience near” approach (Kohut, 1982, p. 52). Intuitively, it made sense to me to go where a patient is as the beginning of an exploratory clinical engagement and I felt an affinity with Joe’s way of working that remains strong today.

From my viewpoint, motivational systems theory is first and foremost a comprehensive theory of development based on an appreciation of the intersubjective (interactive) experiences that begin in infancy and further develop throughout life. Joe’s theory focuses on interactions between children and their caregivers around intentions, goals and affects. Over time, these infant-caregiver interactions form the basis of expectations concerning how one will be responded to by significant others. These expectations are in a continuous process of being updated and reorganized during lived experience.
The way I think about this is that within each person’s experience, there are thousands and thousands of interactions between self and other involving intentions, goals and affects. During childhood, these interactions come to form developmental storylines (or narratives) which become organized into schemas (or representations) of self-alone and self-with-other. (Stolorow and his colleagues refer to these schemas as invariant unconscious organizing principles.) It is important to remember that during development, as well as during treatment, both child/patient and caregiver/therapist are continuously and mutually influencing each other in their ongoing interactions. This is the basis for the view that all experience, both individual and shared, is co-constructed and can only be understood within the relational context in which it emerges.

For example, let’s look at what happens when a child’s attachment system becomes activated. A 12-month-old baby in the strange situation experiment becomes distressed upon being separated from mother in the playroom, crying and searching for her. Upon mother’s return, the securely attached baby will scurry to her mother and hold up her arms to be picked up. The mother picks her up, pats and cuddles her and the baby becomes calm. In the reunion scene, the securely attached infant has already developed positive expectations that her mother will comfort her when she is distressed. Through this same interaction, the mother is reassured about her capacity to comfort her distressed baby, building positive expectations about herself and her baby. This is a good example of how we hope the attachment system will unfold – baby expresses intentions and affects directed toward seeking attachment and the caregiver reliably responds to the child’s emotional needs for connection and soothing.
As I mentioned earlier, each motivational system, is continuously being organized and reorganized in interactions with significant others. The human capacity to transform formerly rigid expectations of self and other into more open, flexible views can be linked to the possibility of change. Even for individuals who come into treatment with childhood neglect or maltreatment, the hope for transformation remains. New and more positive feelings about one’s self can develop in response to a therapist’s compassionate understanding. Especially important are instances of attuned responsiveness from the therapist during disruptive interactions when repair is necessary. These moments create opportunities for new, positive expectations about how one will be treated to take shape and grow stronger.

In teaching this theory, trainees can find it a bit overwhelming to get a grasp of all the motivational systems and can feel confused about which one may be most salient in any given moment. However, and I can not emphasize this point more strongly, once you look closely at the systems, study them, and think about them, the systems are so aligned with the human condition that they make very good sense. Also, once you master a basic understanding of the motivational systems and can grasp the way one or more of the systems may be operating at a particular moment, your understanding begins to operate at a procedural, non-conscious level even as you are able to reflect on the theory.

Let me give a brief example, a supervisee asked me if, as I listened to a patient, was I consciously thinking of the particular motivational system that seemed to be prominent. My answer was to say that I might be. For example, I might think, “now I am sensing an attachment motivation” or “now I am sensing an aversive motivation.” But even if I was not explicitly thinking about the patient’s specific motivation, I would be
processing what I am hearing and developing inferences about the patient’s particular intentions, goals, and affects. If I think it would be helpful, I put this into words and then listen to my patient’s response. If I have it wrong, which is always highly possible, my patient could set me straight. This speaks to an attitude of analytic engagement that is creative, open and flexible. It is also resonates with Donna Orange’s wise proposal to hold theory lightly in the back of your mind.

Directing my attention to my patient’s affective and motivational experience and connecting my in-the-moment impressions to the extensive developmental perspective of the theory are crucial to my efforts to empathically grasp my patient’s experience and put it into words. Patients tell me that this approach – using emotionally rich language to capture something specific about their experience – is very helpful. And, it helps me, too. As I suggested earlier, when a mother effectively comforts her distressed infant, she also builds confidence in her caretaking abilities. Similarly, feedback from patients that we have captured something essential in our understanding of their subjective worlds, builds our confidence that we can make a difference in their lives.

Now I am going to shift gears to highlight aspects of the theory that elucidates guiding principles of how to engage in exploratory therapies. In the brief time allotted to me, I am not able to do justice to Joe’s “user friendly” techniques in-depth. So, I will focus on two of them. Number one is empathic entry into a patient’s experience. What helps us gain an empathic appreciation of another’s experience?

Of course, we begin by accessing our own emotional experience to sense into the patient’s state of mind – this is vicarious introspection. Additionally, I propose that an understanding of development facilitates our ability to empathically enter a patient’s
experience. Sometimes we have a good sense of a patient’s particular developmental story (which helps us a lot) and, at other times, we only have a sense of the patient from our shared interactions (which can tell us something about a patient’s capacities to regulate affects, enjoy interpersonal relationships, engage in an exploratory process, be reflective, and so on). In either case, I believe a developmental perspective is crucial to empathy. Even in situations where information on the patient’s family and childhood is very limited, we can glean something important from what we know about development to sense into a patient’s in-the-moment experience and share that in way that promotes collaborative exploration. I find that an appreciation of the seven motivational systems facilitates a therapist’s ability to make inferences about a patient’s unfolding experience.

The second technique I focus on is following the sequence of therapeutic interactions. Of central importance is the discipline involved in tracking the patient’s responses to our interventions – does what we do and say open up an exploratory process or activate aversive responses? For example, a patient may directly express displeasure or anger. Or, in another instance, the patient may change the subject, potentially signaling an aversive response. Joe’s guidelines explicitly encourage us to notice a patient’s response and to inquire about the patient’s experience. I find that following clinical interactions in such a close way and speaking directly about them, especially when my actions have activated aversive responses, enhances a patient’s sense of safety and deepens the analytic process. For many patients, paying close attention to their unfolding emotional reactions as they emerge in clinical moments may be a new, positive relational experience.
I now turn to a discussion of the aversive motivational system in order to segue into David’s presentation. First, I present a brief overview of the optimal development of the aversive system and then discuss what happens when development goes awry.

Beginning in infancy, the aversive motivational system has two basic response patterns: antagonism and withdrawal. The affects associated with the aversive system include distress (crying), anger, disgust, fear, shame, and low-keyedness. In early infancy, aversive affects primarily serve to signal caregivers that some response is needed. When a caregiver reads the signal and successfully responds, the infant’s distress subsides and pleasure ensues. In the systems related to physiological regulation, attachment, exploration/assertion, and sensuality, it is desirable that these systems begin organizing early in infancy through positive exchanges between baby and mother. For example, when a hungry baby becomes satiated, positive affects are activated which provide a basis for the baby’s search to re-create the experience and build positive expectations about mother’s responsiveness. Thus, an adaptive gain is achieved through the early organizations of this system. In the aversive system, however, it is desirable for the system to become organized in late infancy and during the toddler period. Let me explain.

Optimally, the growing child comes in touch with having intentions and assertively pursues them in later infancy and the toddler period. When frustrated, the child learns to use instrumental anger to overcome obstacles in a very positive way if the caregiver is sensitive to the child’s state of mind. Caregiver acceptance of a toddler’s need to assert her position is crucial to this process going well.
Toddlers also need to learn, with caregivers’ help, to withdraw in the face of danger. Older infants and toddlers begin to learn to engage in and regulate controversy when they are able to build on their innate capacities for empathy and altruism. This ability helps them restore attachment intimacy even in the face of interpersonal conflict and personal disappointment.

From an adult’s perspective, what does this look like? An individual with a smoothly functioning aversive system will comfortably have access to a repertoire of effective responses regarding interpersonal situations that are of the “I don’t like this” variety. For example, one would be able to know when to withdraw in a dangerous situation. One would also be able to access instrumental anger to protest mistreatment or to press one’s agenda forcefully. Simultaneously, one would maintain the ability to recognize the other’s point of view and restore intimacy, if desired, through reciprocal, mutual empathy. Thus an individual with a smoothly operating aversive system is able to comfortably engage in and regulate controversy.

What happens when the aversive system is prematurely organized early in infancy? This unfortunate situation is usually related to a caregiver’s gross failure to respond to the baby’s aversive signals in order to relieve distress and soothe the child. Optimally, a caregiver’s attuned responsiveness, helps the baby recover from a disrupted state. However, when the infant is left alone to regulate prolonged states of dysphoric affects, the aversive systems usually becomes dominant. Over time, aversive states become familiar and the child seeks them out for the self-cohesive effect of having expectations met. The child may also begin to gain a sense of security and vitality from
the familiar affects of the aversive system and come to experience pleasure in the power of opposition or in the frustration of withdrawal.

When a genetic predisposition or some other factor contributes to a baby’s innate fussiness, how does this affect the organization of the aversive system? Not surprisingly, a lot depends on the caregiver’s ability to regulate the baby’s distress. The terrible situation in which a highly irritable baby (innately prone to strong aversive responses) has a mother whose capacity for sensitive responsiveness is impaired (usually because of her own encoded memories of rejection and by her current lack of support), can lead to the early, pathologic organization of aversive motives. In these cases, aversive affects and motives become dominant and may infiltrate and give an aversive tilt to all motivational experience.

Another complication in the unfolding of the aversive system relates to situations in which a toddler’s instrumental anger in the service of expressing intentions is met with a shaming or punishing attitude. Consequently, assertive motives may become combined with aversion, making it difficult for the child (and for others) to separate assertive intentions from antagonism.

In ending, I suggest that learning motivational systems theory, with its developmental underpinnings, enhances empathic engagement. Also, learning and following Joe’s “user friendly” techniques, has come to influence my way of being with patients – a way that facilitates an in-depth exploratory therapeutic engagement. Finally, and I think this is good news, using the theory to inform my clinical approach, which I initially consciously learned eventually began to operate at a procedural level, non-conscious level. I have taken the theory in, made it my own and it has become a valuable
part of my clinical repertoire, even as I hold it lightly in the back of my mind. I encourage you to discover this for yourself.

Thank you very much for your attention.