Psychoanalysis and Motivational Systems
A New Look

Joseph D. Lichtenberg
Frank M. Lachmann
James L. Fosshage
Chapter 5

Inferences in clinical process

In this chapter we will develop and explore several proposals about the forming of inferences. First, making inferences about the emotions, intentions, and goals of others and one’s self are inherent aspects of empathic sensing into the state of mind of another and reflective awareness of one’s self. Second, inferences are commonly made in two stages: a blink-like intuitive rapidity, often out of awareness, and a more deliberate reflective process. Third, in clinical exchanges, inferences made by analysts about emergent themes and the status of the dyad with respect to motivation often occur in the same two-stage process—a rapid intuitive phase and a more deliberate articulated phase—both phases often occurring in intervals of three to five minutes. Fourth, the process of making inferences is the portal through which analytic theory enters and influences the understanding of the unfolding of affects, intentions, and goals.

EMPATHIC LISTENING AND THE MAKING OF INFERENCES

The importance of empathic listening or empathic perception in psychoanalytic treatment is well known (Kohut, 1959, 1977, 1982, 1984; Lichtenberg, 1981; Schwaber, 1981, 1983, 1992). It refers to sensing into the state of mind of the other and regarding experience from the perspective of the other. We typically speak of putting ourselves within the context of the other, resonating with his or her affect, calling up analogous experiences of our own, and reflecting on what we would be experiencing in that situation (what Kohut, 1959, 1982, referred to as “vicarious introspection”). In unpacking the process we propose that we always do more; that is, we make inferences from what we apprehend via empathic listening—inferences especially about the intentions and thought and relational patterns of the patient and about the characters portrayed in the narrative. The Webster’s New World Dictionary definition—“to conclude or decide from something known or assumed; derive by reasoning; draw as a
conclusion”—tilts toward conscious reflective mentation, while we include more immediate intuitive “sensing” or “knowing.”

We make inferences concerning all facets of our experience of the patient. As our attention flicks back to ourselves, we also make inferences about motives governing our feelings and our listening stance. At times the process is so fast and so out of awareness (implicit domain) that we don’t know we have made an inference that influences our subsequent experiences. At other times we can be more aware without reflection, or at other times we reflect on our inference. Inference making constitutes a particular individualistic unpredictable component of the analytic process (and all of our relational interactions). Yet, inferences that each analyst makes in the analytic encounter offer a certain predictability for inferences derived not only from the current events but also from previous conclusions based on prior experience in the dyad, knowledge of past experience, and formal and informal theories the analyst has learned. Tell an analytic candidate that all rivalries, desires, and triangular relationships are governed by positive or negative oedipal strivings and he or she repeatedly will infer motives as existing within that construct. Similarly, a medieval priest would infer a motive to reflect the input of God or the devil. Our theories, thus, along with the current input, shape the inferences we make on a moment-to-moment basis during the analytic process. The moment of inference making is the portal through which theory, generally nonconsciously, enters and influences the process.

Correspondingly, patients make inferences about all facets of their experience of the analyst. Their inferences are also based on conclusions emanating from current input from the analyst, prior experience in the dyad, other lived experience, and their theories and beliefs about people and relationships. Together patient and analyst form a complex interactive system, and each variably contributes to the inferences the other makes. A patient communicates implicitly and explicitly, verbally and nonverbally. As a therapist attempts to listen empathically to the patient, his or her initial emotional resonance and ever-so-fast implicit inferences likewise are communicated at times verbally and, more often, nonverbally. A therapist’s beginning smile, a slight startle, a questioning look will influence the patient’s affect and inferences. In these ways patient and analyst create a complex interactive communication feedback loop (see Coburn, 2000).

INFERENCES AND CHANGE

The inference process is central in the creation of meaning and organization of experience. Inference activity links past with present experience and often provides a source for creation of new meaning. Infant and mother, adult and adult, and patient and analyst, all of us on the basis of lived experience actively make implicit and explicit inferences about current experience, including inferences about our and others’ intentions.

How do we change undermining and devitalizing implicit and explicit expectancies and inferences? An important avenue for change is to become reflectively aware of implicit as well as explicit expectancies and inferences and their origins (Fosshage, 2010; Lichtenberg, Lachmann, & Fosshage, 2003). Reflective awareness of the origins of the assumptions undermines
“CHUNKING” CLINICAL PROCESS
AND THE ROLE OF THEORY

We believe that during clinical exchanges, the manner in which analysts process and experience the clinical process is commonly a two-step process. The first step is the analyst’s immediate awareness of the unfolding of the clinical process, its dynamic and often unpredictable nature. This awareness is not always conscious, and sometimes it is accompanied by an awareness of the analyst’s own emotional and psychological states. The second step is the analyst’s deliberate and conscious reflection on the clinical process, taking into account the analyst’s own experiences, feelings, and thoughts. This step is often called “chunking,” where the analyst breaks down the ongoing clinical process into manageable parts.

The role of theory in this process is crucial. It helps the analyst to ground their understanding in a framework that can help them to make sense of the clinical exchanges. Theory provides a context in which the analyst can place their own experiences, and helps them to see patterns and connections that might otherwise be missed. Theory also helps to clarify the analyst’s own role and goals in the therapy, and provides a means for the analyst to communicate their understanding to the patient.

In conclusion, the clinical process is a dynamic and ever-changing event that requires the analyst to be both aware of their own immediate experiences and to reflect on those experiences in a deliberate and conscious manner. Theory plays a key role in this process, helping the analyst to understand and make sense of what is happening in the therapy.
an observed person’s action or emotion is understood by inference mostly drawn from the context: “Once the inference is made, the brain generates the faint activation that nears the other’s affect” (p. 356). The more easily recognizable to liberate inferences about affects, intentions, and goals involve definable contexts and linguistic/imagistic/metaphoric processing.

In the clinical setting, many influences coalesce to form the implicit and explicit inferences that analysts make: prior experiences with the patient that are triggered by the current context, aspects of the analyst’s subjectivity arising from her life experience, all guided by the theory of mind and motivation the analyst holds.

Many analysts have voiced concern about the imposition of theory when listening to patients (e.g., Schwaber, 1981, 1983). A number of analysts (e.g., Bion, 1962; Jung, 1933), in turn, have suggested that we enter into the analytic arena with an open mind. We believe that listening is never theory free, and that theory significantly shapes the inferences we make. Our inferences and organizations of the data are what we offer to patients as interpretive understandings. Since we cannot, nor would we want to, escape theory shaping our inferences, the relevant issue becomes the need to assess theory for its explanatory value in the moment-to-moment understanding of the patient and therapeutic interaction.

We believe that motivational systems theory, with its emphasis on affects and intentions, helps orient us in listening to patients and their expressions of affect and unfolding intentions. Each motivational system has metaphoric value (Modell, 2003, 2005) with a background of easily generated stories to aid capturing similarities between affects, intentions, and goals as they unfold in the shared narrative.

**Tracking Clinical Process Chunks**

In this section we focus on brief illustrations of tracking the unfolding intentional process or shifting of motivational priorities, emergence of the implicit into the explicit, and inferences as they occur during the analytic encounter. Patient and analyst form a system and, as with all systems, asymmetrical or not, understanding of the system requires delineation of the various processes and their interplay as they take place within and between the two participants. In the clinical encounters that follow we focus exclusively on the verbal exchange; yet, the reader can rest assured that the verbal exchange was accompanied by all the nonverbal facial and gestural, that is, complex embodied, expressions. Lastly, these three- to five-minute chunks of clinical exchange are variously “messy”; that is, many trial and error inferences and responses are needed before a clarifying and meaningful communication (a moment of meeting) takes place.

**A clinical exchange: Daniel (JF)**

After an unhappy, emotionally disengaged, and almost totally sexless marriage of 17 years, Daniel, age 41, separated from his wife a year and a half before he began psychoanalytic treatment. He experienced his mother as anxious, “not present,” and overwhelmed with her five children. His father, a physician, was an extremely anxious, remote, schizoid man who worked at a large hospital. Daniel remembered asking his father questions and receiving monosyllabic responses that showed little interest in his questions and aborted further discussion. In response, Daniel retreated to his room and pursued his exploratory and intellectual interests. While he suffered from a chronic loneliness and low-level depression, he kept himself alive through his explorations and the use of his keen intelligence. He learned to expect and look for little from others. Not surprisingly, I experienced Daniel as warily seeking help, wanting help yet convinced (expectancy) that it would not be forthcoming.

On this particular day Daniel was having more difficulty than usual in getting started.

Daniel said, “I do not want to be here.”

I inquired, “Do you have some understanding as to why you do not want to be here?”

Daniel replied, “I can’t really talk to you.”

While his aversive intention was in the foreground, I inferred that he also desired to talk with me (his intention was certainly in the background and probably implicit). My inference was based on our experience together when his desire to be heard and understood was explicitly in the foreground. In addition, his very presence, in spite of his explicit aversive intention, indicated an attachment/exploratory goal.

Daniel continued with a sense of finality, “You really won’t understand me. You’re the doctor.”

I inquired, “Did I do something that contributed to your feeling?”

Daniel responded, “I don’t think so, but there is really no chance when you’re the doctor. We’re on different levels—you’re up there and I’m down here.”

His providing more detail confirmed my sense (inference) that he desired to communicate with me. The trigger of his aversive motivation, his expectation and inference that I would not understand, was now becoming more explicit. While Daniel was not aware of any actions on my part that had activated the “doctor theme” this particular time, the fact that I was a “doctor” (along with the many possible implicit and explicit cues) triggered these expectancies.

In the past when the doctor theme had emerged, we had understood that he saw me as elevated, emotionally unavailable, and unable to hear and understand him. At this juncture in treatment, Daniel anticipated and inferred that I was a belittling rejecter. I was implicitly influenced by theories of transference that led me to infer that his inference emanated from
A dispositional basis on past experience. I also knew from our past experience together that Daniel’s proclivity to experience a belittling rejection originated with his doctor-father, and that it was activated in the analytic encounter by a variety of implicit and explicit cues, not the least of which was the fact that I was a doctor like his father.

In contrast to his self-state of feeling deflated in his efforts to evoke a meaningful response from another, at other times Daniel shifted into animated states of mind and, with emotionally detailed depictions of his experience, touched me deeply. On those occasions when I shared my emotional response with him, affirmatively accenting his emotional access and capability of impacting the other in spite of a primary lack of parental responsiveness, he was surprised and touched. As yet, he was unable to retain an all too fleeting image of himself as an emotional person capable of impacting and eliciting an emotional response from another.

Continuing the exchange, I said: “When you see me as a doctor, you have me elevated, are on different levels, and there’s no possibility that I could understand you, like it was with your father. We have to find a way to get me off of the doctor’s pedestal, to put the doctor over there [gesturing with my hand to the right of me], to get me down to ground level, to a level playing field with you. It will not work as long as I am ‘the doctor.’”

Riding what I inferred to be the crest of the wave of his primarily implicit intention to activate in me responses for a wanted and developmentally needed experience of recognition and shared communication, I attempted (intended) to articulate my understanding of his and our situation, that is, for us jointly to find a way to get me off the doctor’s pedestal so that he could communicate and I could hear and understand him.

In response to my statement, Daniel nodded in agreement, deepening his conscious (explicit) understanding of the doctor theme. His mood lightened and, after a slight pause, Daniel said, “Well, let me tell you about my week.”

In this brief exchange, taking probably no longer than five minutes, we attempted to illustrate within each participant the complex interplay of the unfolding of shifting inferences and intentions about one another in the dyad.

A clinical exchange: Ms E (JL)

PATIENT (MS E): I knew I should go to bed. My health requires it. It was almost midnight but there I was opening my e-mail—the last thing I should be doing.

ANALYST: (Making a quick intuitive assessment of her state—she seems genuinely concerned and reflective. Both she and I are fighting off a shaming reaction, her saying and my listening to the same story over and over. I determined to make a fresh attempt.)

P: I had to go to a meeting that lasted all day. So I had to bring home the work I promised for today.

A: From your standpoint it looked like to be conscientious, to not risk criticism, you had to use your evening to get work done. (My empathic understanding is offered first, but my inference already made instantly was that she was performing an unconscious balancing act. From previous analytic work we had discovered that she first gives her after work evening time over to “others,” a submission to authority, and then rebels to steal time for herself, reading her e-mail. This inference was well supported by my knowledge of her frequent oppositional stances.)

P: Yes. I hate to look like I can’t do what I should. (She confirms having accepted the authority’s or her inner authority’s standards and intent to avoid a sense of having failed, being criticized, and rejected.)

A: (Thinking of her shame connected to an early failure in school.) You protect yourself from the shame of failure. You also protect yourself from feeling you are a submissive slave who gets nothing for yourself, but you lose sight of protecting your health—a less immediate consideration.

This four-minute opening segment of a session begins and ends with my attention drawn to a physiological dysregulation of inadequate sleep in a woman with hazardous health. I hold in the back of my mind a schema or map of the motivational system centered on the domain of physiological regulation and relevant information gleaned over the years of my contact with Ms E. Quickly, I assess my, and her, and our state of mind with respect to our immediate potential for joint exploration—and inferential assessment of the balance in the dyad between an exploratory and an aversive motivation on either or both of our parts. Ms E’s associations move me into her exploratory motivational system and the core dynamic related to her vulnerability to shame and the rigidity of her compensatory avoidance of humiliation through compulsivity and perfectionism to please her father and avoid his harsh criticism. Finally, I draw on my knowledge of the attachment motivational system, especially of insecure avoidant attachment to her mother “who gave up on guiding or helping her” except to shop, and a complex inclusion of aversive motivation. Ms E, like many avoidantly attached people who suppress their anger, maintained an unconscious internal bookkeeping in which submission to authority required payback in the form of rebellious oppositional entitlement. The immediate “secret” pleasure she gained from her transgressive stealing time for herself became an attractor state of irresistible strength. In this brief four-minute exchange, the inferences shifted between themes to be explored and assessments of each of our regulations of shame triggered by our limited success in helping Ms E to more openly recognize not just her oppositional behavior but the deep aversive wounded feeling that lay behind it.
A clinical exchange: Samantha (JF)

By the time of this clinical exchange Samantha, now 51, had been in psychoanalytic treatment with me for over 14 years. She was raised to be a “Swiss model child” with ubiquitous stifling “shoulds” and “should nots,” the core problematic issue. Over the course of our analytic work we had firmly established a reflective exploratory process and, at the time of this exchange, were operating with considerable reflective knowledge. This history between us helps account for the rapidity of the exchange that is presented in two five-minute segments. The first segment follows:

Samantha opens the session: “This is the first full-time job since 1991 and I am stressed.”

I inquire: “What’s the stress?”

Samantha responds, “Fear of being trapped.”

I ask, “In what way?”

Samantha answers, “It’s boring, unsafe, I don’t know what I’m doing. It’s like feeling trapped in school, bored and inhibited. With the freelance jobs, I could be in for six months and then out of there.” In a somewhat pleading tone of not wanting to be forced to do it, she reiterates, “Boredom, claustrophobia, and complexity of relationships.” (I infer that the theme turns on her negative expectation of coercion.)

I respond, “Yes, in a freelance situation, you can work six months and then get out of there and you’re fine.” (I infer that she needed me to resonate with her experience, communicating that I heard her negative expectancies and consequent antipathy to the upcoming job, followed by her aversive desire to escape.)

Samantha answers, “Yes, and I could continue to do that. Why should I have to face forced commitment? My commitment to you comes out of desire, need; I love you and, if we have difficulties, we work them out.” (She continues to explore and provides an alternative way of being—that is, to operate out of desire and openness rather than “forced commitment.”)

I respond, “That’s a new way of doing things, in contrast to what it often felt like at home.” (To further reflective awareness I contrast the new model with the old, referencing what we “know,” on the basis of considerable previous analytic work, to be the historical origins of the old.)

Samantha reflectively answers, “At home I felt driven to be something I’m not, I’m not fully myself, I had to perform perfectly at home” (deepening reflective exploration and connections).

I suggest, “Maybe you don’t have to be so perfect at work; maybe you could take some time to absorb, familiarize, get your footing.”

Samantha picks up the message, “I only need a pad and pencil until I figure out what I’m doing.” (She metaphorically applies the more effective way of being at work.)

In this example, the patient with an exploratory intention describes her conflict as she faces her new full-time job. The new job has activated old expectations of coercive performance. Based on previous analytic work, I infer and make the connection that these expectancies are related to dispositions carried over from her childhood experiences. She articulates the contrasting experience of her positive affect state and freedom from coercive expectation in the analytic relationship. I infer that she needs momentary help from me to apply this newly available freer way of being to the work situation. She gets the vision and describes it metaphorically.

The next three- to five-minute segment immediately follows. Samantha describes several interactions in which she was honest and “not perfect” (her new found freedom), and then says, “I feel like killing my father. The perfectionism came from him.” And with a slightly helpless tone, “I’m disappointed that it’s so deep.”

I infer that her aggressive intention toward her father bolsters her self-assertion and consequent rejection of her accommodative perfectionism. She then is reflectively sanguine about the depth of this configuration.

I respond, “Yeah, that’s the way it is. That’s what happens when these neural networks get activated” (something that we have discussed in detail).

Samantha reflects, “When I was a girl, I would sneak out of my window onto the roof, to be alone, smoke, and regain my equanimity.”

I say, “Yes, there you couldn’t solve it in the relationship; now, perhaps you can; perhaps you can just be, and then you can be at home wherever you go.”

Samantha answers with feeling, “That would be wonderful. We did it—thank you, I can breathe again. I love you.”

I respond, “It’s mutual.”

Samantha had entered the session feeling aversive to her new full-time job. Through joint exploration we understood that she feared the anticipated pressure of her Swiss model child’s perfectionism. Samantha, herself, offered an alternative way of being, that is, to simply be as she is, a way that she had experienced within the analytic relationship. Since she was in touch with an alternative, I inferred that we could use my making explicit applying the new model of being at work. I was also aware that she could experience the vision I was proposing as coercive, activating the negative expectation in our dyad. The unpredictability of potential responses contributes to the messiness of analytic work and the need to be flexible in the inferences we make. Fortunately, she was able to use my words to free herself from the old assumptions. She was then able to anticipate being free at work, where her motivational values of exploration and attachment could come into play.
A clinical exchange: Thea (JL)

Thea, a young talented designer, began treatment because of her distress about breaking up with Hugh. Although she was deeply in love with him, he was completely irresponsible. He cheated with other women, lied about it, and lied about anything large or small that she feared she would criticize. Even though she knew breaking up was for the best, she couldn’t stop her possessive thoughts about him and would cry whenever he came into her mind.

The example of inference making came in the last five or so minutes of a session six months into the treatment. Thea’s mood as the session had begun was upbeat after a success at work. The middle part of the session was taken up with Thea’s irritation at Katerina, a friend of Hugh’s, who had fouled up arrangements they had made for a trip. She compared her careful attention to detail with Katerina’s looseness. As an example of her thoroughness in researching she described having read about a current belief in the value of mothers bedding with their babies. She had tracked everything on the Internet about it.

The final segment of the session began with a dramatic shift of mood as Thea began to reminisce about Hugh. (I inferred that Thea had staved off for as long as she could her painful obsession with her loss of Hugh and that now, as the session was approaching the end, she was returning to it.) She couldn’t stop remembering activities they did together, the jokes, the teasing, the shared interests, even in silly things. (As some of the description of their playfulness was new, I inferred that Thea had returned to a shared inquiry we had been pursuing: What had made Hugh so special that she believed no other man could replace him?) I suggested that Hugh, with his immaturity, had become an ideal playmate, sharing a desire of hers to be playful and less serious. As the session was about to end, with unusual irritation, Thea said: “No! I miss having a companion!” (As she was leaving, I suddenly remembered the seeming incidental metaphor of the mother in bed with the baby and formed a new inference that the warmth of intense merger-like closeness, not playmate, was the correct metaphor. My earlier inference that the Internet hunt story was about a distraction now seemed a false lead. In my mind I revised the inferences about the incidental nature of the mother in bed with the baby and about Thea’s desire being for a playmate. Thea’s hesitance to talk about her family, especially her mother, other than “supportive,” now led me to another inference—that Thea had given an important lead in her obsessive tracking of mother-baby closeness.)

CONCLUSION

In this chapter we have proposed that as analysts attempt empathically to understand the experiential world of the patient, we make inferences implicitly and explicitly. Guided by the theories we hold, we make inferences based on a combination of all facets of our experience of the patient and ourselves, on input from the patient and on individual facets of our life experience. Correspondingly, patients implicitly and explicitly make inferences about all facets of their experience of the therapist. Patient and therapist form a complex interactive system, and each variably contributes to the emotional resonances and inferences the other makes.

We emphasize the inevitable role of psychoanalytic theories and their explanatory value in capturing patients’ experiences and informing the inferences we make. We have focused particularly on how intentions or motives are the “basic mental unit” for understanding human behavior. Tracking the shifting priorities of motivations or the intention unfolding process is central in understanding the wants, desires, and intentions that give meaning to a patient’s actions and plans. We believe that recognizing seven motivational systems provides analysts with a useful guideline for tracking a patient’s shifting motivational priorities on a moment-to-moment basis.

We concluded the chapter by suggesting that three- to five-minute intervals of clinical exchange typically provide optimal time for tracking the unfolding of themes and allow us to identify intentions and goals. We have provided examples of clinical exchanges that illustrate the analyst’s implicit and explicit inferences, the unfolding intentional process, and the emergence of the implicit into the explicit as they occur in a particular analytic encounter. Patient and analyst form a system and, as with all systems, asymmetrical or not, understanding of the system requires delineation of the various processes and their interplay as they take place within and between the two participants. While these chunks of the clinical encounter illustrate the complexity of the clinical exchange, we believe that focusing on inferences that help us to reveal the unfolding intentional process and the emergence of the implicit into the explicit orient us in finding our way. We also believe that motivational systems theory provides a detailed yet comprehensive view of the variety of intentions that further helps us in analytic focus and understanding of our patients.