



MOTIVATION

This paper was prepared by the Encephalitis Society with advice from Dr Huw Williams Clinical Neuropsychologist, Lecturer in Clinical Psychology (University of Exeter)

Arousal

Arousal is with us all the time, to varying degrees. We are familiar with the extremes of arousal. When we sleep, arousal levels are low, we perceive nothing of the world around us. On the other hand, high arousal leads to distracted behaviour where we overreact to a minor occurrence and move about in a restless, purposeless way. If we are over-aroused, we are over-excited, over-active and easily distracted, with a racing heart and sweaty palms. Psychologists have long found that we are most efficient at performing tasks when we are in the middle range level of arousal. Arousal then is an important consideration to our prevailing state of mind. It is governed by distinct groups of different chemicals in the brain stem that predominate at different times of the day and night, or with emotions or illness.

Arousal maintains alertness and is therefore an important factor in rehabilitation, aiding the process of learning. Unfortunately, the improvements in cognitive functioning produced by increased arousal are maintained only for relatively short periods.

Drive

An extreme form of drive disorder which incorporates arousal problems is called an apathetico-akinetico-abulic syndrome. The person remains completely passive, expresses no wishes or desires, makes no requests and refuses to seek food, even in the case of extreme hunger. Less severe abulic disorders are often mistaken for depression, even when a person shows little evidence of emotional distress.

Drive disorders may be misconstrued as poor motivation. This stems from a misinterpretation of behaviours which accompany drive disorders. People often appear as "lazy", lethargic and disinterested, lacking both initiative and spontaneity. This pattern of behaviour is often interpreted as reflecting a lack of motivation, implying that the person is unwilling to engage in meaningful behaviour. However, when asked, people with drive disorders may express interests, desires, needs, etc., but seem unable to impel themselves to achieve the objects of their desires. The majority of people with drive disorders are happy to follow prompts and will co-operate with others in the pursuit of some interest, but appear unable to sustain such behaviour of their own volition. Consequently, many people with a drive disorder become much more purposeful when they enter a rehabilitation unit because their activities are structured and directed by others. Once support is removed, the individual with a drive disorder may revert to a lethargic, inactive or aimless, stereotyped pattern of behaviour. It is crucial, therefore, that rehabilitation is focussed on developing behaviours that will get practiced in the real world, and, therefore, reinforced. Also that various kinds of support is provided after rehabilitation to keep gains made, such as use of external prompting and reminding systems.

Motivation

In contrast, those with motivational deficits often react antagonistically to being prompted because they perceive this as pressure to achieve something for which they have no sense of need. Organic disorders of motivation can therefore be even more of an obstacle to social functioning than drive disorders. Whereas a person with a drive disorder is often willing to co-operate, if properly supported and encouraged, and capable of expressing ideas or interests which can form the basis of an activity programme, someone with a motivational deficit may have little or no interest in a constructive activity and will actively resist, or be disruptive if encouraged to participate.

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Neurobehavioural rehabilitation might be helpful in enabling the person to develop behavioural routines – such as self care - in small steps and at a pace they might be able to cope with.

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