Liveliness

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Objective: The objective of this study is to explore the significance of the experience of liveliness in psychotherapeutic interactions and its relevance to the practice of psychotherapy.

Method: Stern’s notion of ‘vitality affects’ and Emde’s concept of a ‘primary affective core’ are employed in developing a concept of liveliness, or an enlivening-deadening axis of experience. A critique of Freud’s ‘principles of mental functioning’ is made in the light of this concept. Clinical examples are provided as illustrations of the relevance of considering the ‘sense of liveliness’, and its sustainability, in psychotherapy.

Results and Conclusions: A sense of liveliness relates closely to activity within a system of interpersonal resonance with non-linear characteristics. The experience of, and responses to, vitality affects may be an important basis of a sense of liveliness. Sudden shifts towards experiences of deadness are a matter for concern in psychotherapy. This sphere of experience, although occurring largely outside verbal awareness, may constitute a distinct type of mental process. Three types of mental activity or process are postulated: (i) emergent, pre-representational activity characterised by the sense of liveliness; (ii) Play-related thought or activity typically experienced as enlivening; and (iii) work-related or adaptational thought or activity.

Key words: intersubjectivity, liveliness, resonance, trauma, vitality affects.

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. . . one is at a music-hall and on to the stage come the dancers, trained to liveliness. One can say that here is the primal scene, here is exhibitionism, here is anal control, here is masochistic submission to discipline, here is a defiance of the super-ego. Sooner or later one adds: here is LIFE. Might it not be that the main point of the performance is a defensive denial of deadness, a defense against depressive ‘death-inside’ ideas, the sexualisation being secondary.

– D.W. Winnicott, 1935

Medical training tends to characterise a linear, problem-solving approach as science and the doctor–patient relationship as important, but somewhat mysterious: the ‘art’ of medicine. Psychiatrists, in their effort to retain credibility for their medical discipline, at times tend to embrace the same dichotomy. We are encouraged, and often need, to come up with a diagnosis and preliminary management plan at the first meeting with a patient.

This expectation of finding an immediate answer, seems frequently discordant with the reality of clinical practice, especially in the domain of the therapeutic relationship. The development of human understanding and relatedness seem crucial therapeutic ingredients that, rather than being mysterious, require a different approach than the ‘solving’ of a particular diagnostic or behavioural problem.

I noticed, with a slight sense of guilt, when I began training in psychiatry that thoughts about patients, particularly ones with whom I was experiencing some difficulty, would come to me without my willing it, often while I was not at work. Moreover, comments
from patients suggested they at times underwent a similar process. Indeed, this process seemed to bring an additional depth to the interaction with the patient that at times contributed to a therapeutic process.

Case illustration

Bernice, a 52-year-old woman with a chronic depressive condition, was seen at a stage where she had been an inpatient in a private psychiatric hospital for 9 weeks. Her symptoms had not responded to a variety of antidepressants. I found myself thinking about Bernice and her situation. For some reason I thought of a character in a movie, *Scent of a Woman* [1]. This character used a self-affirming gesture and utterance when under pressure: he would clench a fist and say ‘hooya’. This struck me as relevant for Bernice. I presented some of these thoughts to her and felt that they made an impression on her. Within a week Bernice was discharged from hospital, with no pharmacological change. She continued to appear well when seen 6 months later.

This case seemed to indicate the importance of the interpersonal experience that arises out of a certain kind of engagement between therapist and patient. An experience resulting from an unconscious process, at least in the sense of not relating specifically to an act of will. In this type of engagement there is a sense of being alive for the patient, of being present in the moment, of the relationship feeling lively and, on occasions, of the patient ‘coming alive’.

Working in psychotherapy generally, particularly dynamic psychotherapy, depends upon a willingness to employ such forms of engagement and relatedness. To be there for the patient despite the many elements of uncertainty, including aspects of relatedness of which we can at most be partly aware. The interactional dimension of therapy demands levels of explanation in terms of complexity and defies reduction to a purely one-person or intrapsychic psychology. Although the emphasis in this paper is on dynamic psychotherapy, an awareness of the dynamic, evolving elements of the therapeutic relationship is broadly relevant in psychiatric practice.

When the focus moves to the experience of human relatedness as the domain of psychoanalytic study, a key level of understanding is associated with the experience of liveliness in interaction. This might be described by both patient and therapist as a sense of authenticity, of being ‘alive to each other’, or as a feeling of connection and goodwill: the interaction is felt to ‘have heart’, to be a human, as opposed to a purely technical or professional exchange.

In contrast to this interpersonal conception of a mental life which has at its core a (metaphorical) ‘sense of heart’ or a ‘sense of liveliness’, the dominant analytic ideology of this century has at its core the sense of pleasure and pain, as articulated in Freud’s pleasure principle [2]. Freud’s emphasis is particularly on the avoidance of pain and relief of tension. The accent on pain is further elaborated in *Beyond the pleasure principle*, where trauma takes centre-stage as the motive for the repetition compulsion [3]. It is of note, however, that Freud also invokes the life and death instincts in the same work, perhaps recognising a level of experience more fundamental than pleasure or pain or the demands of ‘external reality’.

Freud’s statement of the reality principle can be seen as the pleasure-seeking id being modified in the face of external reality, through the agency of the ego, towards appraisal of what can be achieved and the realisation that actions bring consequences. In this schema the subjectivity of id and the presumed objectivity of external reality are sharply contrasted, and the need for the sense of an autonomous self engaged in a world of other people, other subjectivities, does not figure prominently.

In a psychology of self and other, it is understanding the experience of living in a relational field that is central, rather than the definition or analysis of intrapsychic ‘structure’ [4]. The thesis of this paper is that such experience may be partly described by the sense of liveliness at any given time or, in other words, by an ‘enlivening–deadening’ axis of experience that is linked to the phenomenon of intersubjective resonance.

Notions of intersubjectivity currently inform both dynamic psychotherapy and developmental psychology [4,5]. Both refer to interpersonal transactions that have affect as the currency of shared feeling in a resonating system [6]. This can be understood as a form of communication, a system of thought and a level of experience that remains active throughout life. It is typified by play and has characteristics including an essentially interpersonal nature, non-linear dynamics and a correspondence to human feeling.

**The pre-representational self, vitality affects and the system of resonance**

In formulating the concept of a pre-representational self, Emde acknowledges that a paradox is
involved: how can there be a self without a mental capacity for representation? He resolves this by conceiving of ‘self as process rather than fixed attainment’ [7]. He maintains that a primary affective core allows an experience of continuity, despite many changes during the course of development. This formulation leaves us without a clear starting point for the emergence of self: the development of reflective and representational capacities merely subserve ‘increasing cognitive capacities for going beyond the immediate action-world of experience’ [7].

Although a capacity for representation, particularly verbal representation, takes us to a new realm of interpersonal and adaptive possibilities, we do not entirely leave the immediate ‘action-world’ behind. Present action remains compelling in the human condition throughout life. Jaspers’ concept of ‘lived reality’ [8], Lacan’s concept of ‘the encounter with the real’ [9] and Janet’s ‘function of reality’ [10] respectively, serve to remind us of the vitality of immediacy, the compelling challenge of encountering another developed subjectivity and the adaptive significance of being present in the moment. The ‘lived edge’ of reality implied in these concepts is always affectively toned, providing affective continuity in the manner proposed by Emde [7]. This is true even in the absence of any awareness of representations.

What is proposed is that there is a pre-representational component of experience throughout life. This is consistent with the notion of a primary affective core providing a thread of continuity throughout life and also with Stern’s layered model of self development, which starts with the emergent sense of self. Stern conceives of this as an un-integrated subjectivity experiencing shifting environmental stimuli and internal sensory changes with a bias toward the identification and encoding of patterns which allow a gradual emergence of organisation [11].

Like Emde, Stern gives affect a central place in this experience of emergence. However, he recognises the need to ‘flesh out’ the concept of affect beyond that of distinct emotions or ‘categorical affect’. Much of conscious experience does not conform to specific categories of affect, but rather to temporal qualities of shifting patterns, rhythms and intensities that are nevertheless ‘felt’. Stern suggests that this may be the dominant form of experience at the beginning of ‘life-in-the-world’, i.e. the first few months after birth. The expression used here – ‘life-in-the-world’ – is a paraphrase of Heidegger’s concept of ‘being-in-the-world’ [12,13] and suggests something fundamental about a sense of being alive-in-the-world. The expression makes explicit the importance of the connection between the person and the world. A world, most importantly, made up of ‘others’.

It is not possible to capture in words the nature of presymbolic, undifferentiated experience. However, if one accepts Stern’s idea that the emergent sense of self is a continuing aspect of experience, then we need to attempt to find words to communicate this aspect of mental life. It seems to me that the term ‘liveliness’ is used to describe the awareness of the temporal features of involvement with the world. What is implied is a sense of being lively rather than being alive, which would imply knowledge of mortality. This dimension of feeling varies along an enlivening–deadening axis.

Stern expresses the idea, after Werner, of ‘affect as the supra-modal currency into which stimulation in any modality can be translated’ [11]. Perhaps this is not surprising when one considers that, during embryonic development, sense perception must have developed from a state of less differentiation between sensory modalities, to a condition of greater differentiation. Stern highlights experimental evidence showing the capacity for cross-modal perception in neonates [11]. Such evidence supports the notion of some central organising principle (affect) that facilitates translation across modalities. For example, an object that has only previously been encountered by touch is recognised on visual presentation [11]. If similar affect is felt in response to stimuli from diverse sensory modalities, and if similar responses occur, then a form of perception somewhat independent of the mode of sensory perception is inferred. Stern terms this amodal perception.

However, the type of affect being referred to by Stern is not closely related to ‘categorical affect’. Rather he is referring to the continuous feeling state that accompanies living in interaction with the environment, the temporal qualities referred to above. He writes, ‘The experiments on cross-modal capacities suggest that some properties of people and things, such as shape, intensity level, motion, number, and rhythm, are experienced directly as global, amodal perceptual qualities.’ He considers these qualities are better captured by dynamic terms like ‘surging’, ‘fading away’, ‘bursting’. He coins the term ‘vitality affects’ to describe this aspect of experience [11].

Stern’s emphasis, of course, is on interpersonal development. He is, therefore, indicating the importance of vitality affects in interpersonal life. He
hypothesises that the mother speaking the words ‘there, there’ to a baby with the same rhythm, duration, surge and fade as the same mother stroking the same baby’s head would be experienced by the baby as having the same vitality affect, despite the difference in sensory stimulation [11]. Following other developmentalists, Stern posits that the infant ‘forms and acts upon abstract representations of qualities of perception. These abstract representations ... are not sights and sounds and touches and nameable objects, but rather shapes, intensities, and temporal patterns — the more “global” qualities of experience’ [11].

Understood in this way, vitality affects and amodal perception are links in a primitive form of communication and might be thought of as something of a barometer of the atmosphere experienced in interaction with others. I consider the term ‘liveliness’ congruent with Stern’s conception of vitality affects while conceding that it is a more complex construct. The sense of ‘liveliness’ or ‘deadness’ during interaction with others and the environment also involves the expressive side of a system of resonance. This involves the capacity to respond reciprocally in a matching, amplifying or extending way to the other.

The sense of an individual’s viability in an interaction and the feeling of expansion or diminution are plausibly related to the sense of liveliness and are arguably indicative of a level of mental organisation more fundamental than concepts of pleasure and external reality. Following the acquisition of language vitality affects, as part of a system of resonance, may continue to serve as an important indicator of the moment-to-moment state of a relationship, an important aspect of what we might refer to as intuition or ‘gut feeling’. By way of example, a colleague of Burmese origin reported the case of a man who used a Burmese word which translated as ‘the feelings are bursting out of my chest’ [14].

An apt description of experience dominated by vitality affect.

**Non-categorical feeling forms in psychotherapy**

With each person with whom a psychotherapist works there will arise a particular rhythm, pattern and characteristic form of engagement that becomes familiar, a signature of that particular therapeutic relationship. Within each session both patient and therapist are sensitive, in their own ways, to the tempo, flow of dialogue, strain, crescendos and diminuendos, the moments of stillness, chaos, focus, the disruptions, the general ebb and flow that reflects the emergence, development and growth of the therapeutic relationship. Effectively, the relationship has a ‘life of its own’. Equally, the therapeutic engagement is in constant danger of becoming inert or lifeless, of falling into languor, boredom, even disintegration. Both trends, of course, will be evident at the microscopic level of moment-to-moment interaction.

This is psychotherapy as directly experienced, part of a world of phenomenal experience. Balint, in formulating his concept of ‘primary love’, makes the analogy to our relationship to the air we breathe, drawing our attention to forms of relatedness that are everywhere interpenetrated [15]. This kind of relatedness is comparable to Merleau-Ponty’s conception of the inseparable, intermingled contact between the subject and the world that is ‘real’ and ‘given’ before the development of any second-order reflection: ‘The world is not what I think, but what I live through’ [16]. An implication of these notions is that, in working in relatedness, we need to notice the ‘atmosphere’ and be prepared for ‘changes in the weather’.

Ogden refers to ‘forms of aliveness and deadness of the transference/countertransference’. He gives examples of how, for instance, the experience of loss of curiosity about the patient was understood as a ‘nonverbally symbolised sense of deadness of the analysis’ that was capable of being transformed into a ‘living, verbally symbolised experience of the patient’s (and my own) deadness in the analysis ... Deadness had become a feeling as opposed to a fact’ [17]. He is referring to the potential to utilise the sense of aliveness in therapy in an integrative way.

Rather than focus on liveliness–deadness in relation to content in therapy, I will attempt to illustrate, in keeping with the emphasis on vitality affects, some aspects of therapeutic encounters that may have implications for therapy independent of the content of sessions:

1. A session flows freely, there is a sense of mutual responsiveness, a feeling of discovery and the creation of space. Time passes quickly. The session ends on time with no difficulty in closure. Therapist and patient feel lively and the therapy feels alive. The next session is anticipated with a degree of pleasure.

2. A session passes slowly. There is little to say. Responses are felt to be predictable and the therapist feels him or herself as predictable, stuck. There is a sense of boredom and of waiting for something to happen. When words come there might be a fading or downbeat inflection or tempo or a ‘petering out’. Sleep is a possibility. The end of the session is a relief.
3. A session ebbs and flows with moments of intensity and responsiveness, and of fading out. There is a lull, a little longer than the familiar pauses with this patient. The patient breaks a silence with a small voice, a voice slightly different, not heard before. The therapist is surprised and feels touched, feels the aliveness of the patient as a discovery, that the therapy has come alive.

4. A session that is like a minefield. Exploding forms and tension that cuts the air. Words are not being found readily, or spiral into darkness and chaos. There is the feeling of turbulence and comments from the therapist bring little relief, don’t reach the patient. Deadliness is happening. Closure is dangerous, a rupture. The feelings reverberate long after the end of the session.

5. A session where the patient shifts tempo and leaves the therapist behind. There is an upbeat flow and bounce to the patient’s language, but the therapist feels confused as if floundering in a backwash. Although the patient seems lively, the therapist feels deadened. There is little matching or connection and the therapist feels redundant, with no space to enter the dialogue. It is an effort to close the session at all.

While these descriptions may be recognisable, most sessions will be composites of these and other forms. The point I wish to illustrate, though, is that the first three examples are all compatible with a therapy that is proceeding satisfactorily. Even in the second example, the sense of deadness or dullness is sustainable and perhaps inevitable, even potentially therapeutic as part of an ‘optimal failure’ on the part of the therapist [18].

The latter two examples are of disconnection and mismatching between therapist and patient and are more alarming for psychotherapy. While such experiences do arise and may be safely contained in the course of a therapy, they are not sustainable and threaten the ‘life’ of the therapy, not to mention, on occasions, the lives of the individuals involved.

Although the vitality affects in the therapeutic situation can be reflected upon and usefully incorporated, at times, into the therapeutic conversation, it is inevitable that to a large extent the shifting forms of communication occur outside conscious awareness. That is what it is like when one is ‘in it’: in the therapeutic encounter, which includes one’s own shifting shapes and forms. Nevertheless, the sense of the aliveness, liveliness, deadness or deadliness of the interaction will be part of the reality of the encounter for both patient and therapist and will influence the viability of psychotherapy. Unless the attempt is made to reflect upon it, the influence will be ‘blind’.

‘Principles of mental functioning’ in an interpersonal framework

The system of resonance to which I have referred is inherently interpersonal in nature. It reflects in-built capacities in human beings for truly reciprocal interactions, perhaps epitomised by the form of interaction characterised by Trevarthen as ‘primary intersubjectivity’ [5]. The developmental observations are of a finely attuned interplay between infant and carer, a to-and-fro dance that appears to have vitalising properties for both participants [19]. Mismatches in this system are a basis for dissonant, traumatic experiences.

Case illustration: Leeanne

Vignette 1: ‘shifting reality’

Leeanne recalled an episode where her father, a teacher in the technical trades, was with her at a BMX event. She hurt herself and went to him seeking comfort. He became angry and shouted at her to get back on her bike and try to win. She was left feeling hurt and ashamed. She returned to the race, continuing with a dull inner sense of performing something that was demanded of her.

Vignette 2: ‘the adrenaline rush’

Leeanne remembered breaking away from the home where she often felt criticised, pressured and ‘stuck’ by getting on a horse and careering at breakneck speed down the mountainside. She would come to a stop breathless and exhilarated. The tension, the feeling of deadness inside was gone.

Vignette 3: ‘dream as motivator’

Leeanne, at the time of beginning therapy, felt trapped in a relationship characterised by denigration and criticism. She felt hopeless, yet also felt that separation would be catastrophic. Two months into therapy she reported a dream of herself flying as ‘superwoman’ who takes off, then comes back to earth in a succession of flying hops. Soon after she did separate from her pathological relationship. She was surprised at the extent to which she felt
supported by others and by an associated experience of enlivenment.

Vignette 1 illustrates how mismatching interpersonal responses may derail the sense of sustainable liveliness, transforming it to a deadness that in this case became internalised as a ‘trauma system’. The second vignette is illustrative of a host of behaviours that include risk-taking and fear as prominent features. They are not typically described as pleasurable so much as exciting and enlivening: the sense of aliveness that comes from living ‘on the edge’. In this case the activity served a function of freeing Leeanne from a sense of interpersonal entrapment and devaluation. The third vignette is of a dream that may reflect both a growth in autonomy and a motivating sense of liveliness. Without need for interpretation the dream portrays a sustainable form of liveliness that subsequently led to significant interpersonal developments.

Before considering ‘principles of mental functioning’, a consideration of ‘space for mental functioning’ is necessary. Winnicott was critical of psychoanalytic writing for dwelling on ‘either a person’s life as it relates to objects or else on the inner life of the individual.’ [20]. In other words on the purely subjective inner world or the objective world of external, shared reality. He felt that most of our time is not spent in either of these ‘spaces’, but rather in an ‘intermediate area of experiencing’, the ‘place where we live’, which develops through the interactions typified by play that, in health, originally occur between infant and caregiver [20]. He refers to the creation of a ‘potential space’ between infant and carer which offers room for illusion and the growth of a sustainable subjectivity.

Versions of this notion of a space between people are inherent in concepts like the intersubjective field [4] or systems of resonance [6]. Meares highlights the development of an inner world as an outcome, in health, of the interplay (occurring in a ‘playspace’) between infant and carers [21]. It is a paradox that the achievement of inner-ness is dependent upon a satisfactory area of interpersonal play. Meares also draws attention to another area of mental experience, that of trauma [21,22]. While it is nothing new to talk of trauma, it is significant in much modern analytic writing, informed by developmental psychology, that there is recognition of the differences in the way positive and negative affect is managed in the infant–mother dyad [23,24]. In the situation of healthy infant–other interactions the area of trauma does not necessarily figure prominently. When present it constitutes another area of mental experience involving the collapse or fragmentation of the sense of cohesion and continuity. A different type of experience is implied, not reversion to a supposed primitive state.

In classical drive-conflict-defence theory, Freud articulates two forms of thought: primary and secondary process [25]. Meares, coming from the perspective of psychological health and a psychology of self, reformulates two main systems of thought, that of play and that of adaptation [19,21,24]. There may be a need to add a third type of mental activity based upon the experience of, and responsiveness to, vitality affects in interpersonal situations. This level of activity may account for the experience of connection potentially facilitating growth of a mental ‘playspace’.

Schore’s comment on infant–mother interactions is illustrative: ‘the mother must monitor the infant’s state as well as her own and then resonate not with the child’s overt behaviour but with certain qualities such as contour, intensity, and temporal features. These, he felt, were not spent in either of these ‘spaces’, but rather in an ‘intermediate area of experiencing’, the ‘place where we live’, which develops through the interactions typified by play that, in health, originally occur between infant and caregiver [20]. He refers to the creation of a ‘potential space’ between infant and carer which offers room for illusion and the growth of a sustainable subjectivity.

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Schore’s comment on infant–mother interactions is illustrative: ‘the mother must monitor the infant’s state as well as her own and then resonate not with the child’s overt behaviour but with certain qualities such as contour, intensity, and temporal features. In physics a property of resonance is sympathetic vibration, which is the tendency to enlarge and augment through matching the resonance frequency pattern of another resonance system . . .’ [26]. What is implied is a system of interaction that proceeds largely outside conscious awareness. Indeed, it is liable to be disrupted if pointed out [7,26].

Freud, influenced by consideration of traumatic ‘war neuroses’, became unhappy with his original formulation of the pleasure and reality principles as the fundamental principles of mental functioning. He recognised, in the situation of ‘war neurosis’, material was occurring repetitively in dreams, symptoms and behaviour that bore no possibility of pleasure to the person and that was therefore not comprehensible in terms of the pleasure principle (no pleasure, no relief of tension) or the reality principle (external reality is not ‘demanding’ repetition). He reaches the conclusion that the individual’s need to ‘master’ trauma is the operating principle [3].

Trauma was seen as the primary principle and indeed Freud extends the notion of trauma as in ‘war neurosis’ to infantile trauma. His observation of a game played by an infant alone, involving throwing and retrieving a cotton-reel and making sounds approximating ‘fort-da’ (‘gone-there’), is seen as the repetition of the trauma of separation from mother, repeated in a way that turns ‘passive into active’ and contributes to a ‘mastering’ of the situation. He refers to the compulsion to repeat as ‘something that seems more primitive, more elementary, more instinctual
than the pleasure principle which it over-rides.’ [3].

Freud’s extension of the principle he invokes for war-related trauma to infantile trauma of the ‘fort-da’ (separation anxiety) type is questionable. Perhaps a distinction needs to be made between the normal challenges of development, which can be seen not only as having a distressing aspect, but also as providing opportunities for play and the development of thought, and trauma that is overwhelming or annihilatory in quality. It seems Winnicott is making this distinction in the quotation at the beginning of this paper: he is referring to the experience of deadness and (by implication) aliveness ‘inside’ as an organising principle that precedes erotic pleasures [27]. Freud’s concept of negation may help us understand why the recognition of such levels of experience may need to be denied by the ego/self [28].

This might be extended to indicate that such an organising principle precedes pleasure as a concept. The Freudian notion of the id seeking pleasure might be inadequate in understanding behaviours such as the second vignette of Leeanne’s case. It is rather the experience of a deadness inside that has arisen in an interpersonal context that drives Leeanne to risk life and limb to regenerate a sense of liveliness.

In an interpersonal psychology, the capacities to experience a basic sense of sustainable ‘going-on-being’ and varying levels of liveliness are likely to precede clearly defined experiences of pleasure or pain. This would be particularly so in the situation of ‘good-enough’ infant-mother care where the mother acts as an essential ‘affect regulator’ [7] for the child, or where cortical immaturity means that the mother effectively acts as the infant’s ‘auxiliary cortex’ [6]. In health the infant will be protected from extremes of affective experience at this stage.

Although the infant has powerful abilities to elicit responses in caregivers, there are obvious limits to the infant’s capacity to select an appropriate interpersonal environment that will provide optimal resonance and valuing responses. In Freudian meta-psychology the id is at odds with both its own ego and others, by virtue of the death instinct [3]. In terms of a psychology of self and other, the self has to deal with experiences of deadness or ‘death-inside’ that originate in the infant–carer dyad. The mechanism is not exclusively internal, but rather involves the containing, soothing and stimulating responses that are elicited from the environment. A basis for trauma lies in mismatches in this system of self and other rather than in conflict derived from the death instinct.

Case illustration: Sally

At the commencement of therapy Sally presented as a young woman with a severe borderline personality disorder. She had a history of multiple suicide attempts, some of which had been life-threatening, as well as a variety of self-harming behaviours. She had been alienated from her family for 6 years following disclosure of a history of an incestuous relationship with her brother. There was a background of an enmeshed relationship with a mother who had herself suffered severe abuse in childhood and a recurrent depressive illness. Sally had not lived or stayed with her mother since she left home following her disclosure. She was the youngest of five living siblings. A younger sibling had died in infancy. Her four older brothers and father all had a history of alcohol abuse and occasional violence. She gave examples of being subject, at an early age, to torments by her brothers that involved the experience of real terror.

Vignette 1: the killing scene

After a break in therapy and a dispute where she had not received money that was owed to her, Sally arrived at a session that became filled with a chilling sense of violence as she recounted sitting in a shopping precinct observing passers-by and deriving a sense of power from realising that she was capable of murdering ‘all of them’. Although she had not acted on these thoughts, any attempt to draw attention to this restraint or to seek contact with a more social part of Sally’s character was met with frank derision. There was no other reality than ‘the killing scene’.

Vignette 2: dream-murder

Three months later, after a period of more consistent attendance at sessions, Sally reported a dream where she saw a dead body, covered in blood and realised it was her body and that she was responsible. She had been taken into custody by police and was confused as to how she had committed this offence. Affects of fear, guilt and confusion were reported to accompany the dream, in contrast to the previously expressed affects of vehement, generalised hatred and the associated murderous impulses. Several weeks after this dream Sally resolved to move back to her parent’s home, a goal she had mentioned at the beginning of therapy.

This case is of a person who is caught up in an overtly traumatic system. In the first vignette Sally is
not reporting on a violent fantasy, but has become the aggressor perhaps as the result of a dissociative ‘reversal’, as described by Meares [21,22]. There is no potential interpersonal space, no room for experiencing others as human. The human world has collapsed into a world of things-to-be-manipulated. The experience in the room is one of deadliness. For the therapist this is felt as threat. For Sally it is felt as power that, paradoxically, seems to have an ‘alienness’ against which any social emotion is seen as pathetic. Fortunately, a remnant of her character that is not in evidence at this time restrains her enactment. In the second vignette the dream reflects a containment of evidence at this time restrains her enactment. This represents a step in the development of a potential interpersonal space that may have contributed to the reunion with a primary other.

It might be noted that this case illustrates the more ‘deadly’ of the two opposites of the state of ‘liveliness’. One of the opposites refers to a lack of stimulation and an associated sense of boredom and lack of vitality that constitutes part of everyday experience, although unsustainable if not relieved. The other opposite refers to the situation of immediate threat with the potential for violence or murder. This is the trauma space proper where horror or terror fills the mental space with annihilation of any sense of self. Content that is normally contained in fantasy becomes the only perceived reality. Meares describes a loss of reflective consciousness in the face of severe trauma so that, ‘In severe states . . . there is very little inner sense of life remaining’ [22]. The person may experience being ‘inhabited’ and even feel like they have become the ‘alien’ other [22].

There was some evidence in Sally’s case of the beginning of a capacity to integrate even the most stark and violent experiences. Developmentally a broad range of such affects (involving liveliness, deadness, even deadliness) can be integrated provided they are experienced at a level of intensity and a time in development where the person’s sense of self can accommodate, and respond to, the stimulus. Indeed being able to accommodate a broad range of vitality affects is likely to be adaptive: it would presumably equip the individual for a wider range of environments. However, where the stimulus is so intrusive as to induce a state of terror (as was the case in Sally’s development), the individual has entered a zone of trauma that is non-adaptive.

The experience of liveliness, particularly liveliness-in-relatedness, is motivating and relevant to understanding at an interpersonal level. It is also relevant to psychotherapeutic work. Emde reminds us that ‘moments of intense feelings of togetherness and of shared meaning are extremely important for psychoanalytic work’ [23]. He refers to ‘internalisation of an interaction process, not simply internalisation of objects’ as essential both to development and therapy [23]. The range of dead and deadly feeling, in contrast, is inhibiting, even paralysing.

Freud’s principles of mental functioning might be reformulated, using the concepts of liveliness and deadness:

1. The pleasure principle becomes a tendency to seek or continue experiences of liveliness and to seek escape from, or foreshorten, deadness.

2. The reality principle becomes the tendency to seek conditions that allow for a sustainable experience of liveliness.

The recognition of an enlivening–deadening axis of experience and ‘principle of mental functioning’, may provide a unifying framework which can extend to include traumatic experience. The experience of ‘deadliness’ dominates mental activity and behaviour until it can be integrated. Integration requires an interpersonal environment that contains the expression of negative affect and brings it into the realm of interpersonal, and later ‘inner’, space as opposed to action. Perhaps this is a useful revision of Freud’s notion of a repetition compulsion driven by a need to master trauma. Freud points out the primacy of the pleasure principle over the reality principle: ‘...the substitution of the reality principle for the pleasure principle implies no deposing of the pleasure principle, but only a safeguarding of it’ [2]. A principle of liveliness could also be seen as underlying all three of the principles of mental functioning elaborated by Freud [2,3].

The language Freud employs when discussing principles of mental functioning is the language of conquest and mastery. According to the reality principle the individual must either alter the environment or him- or herself through action which is prepared for in thought [2]. An interpersonal interpretation of the reality principle might emphasise the need for continuing connection and engagement with others. Freud saw day-dreams and fantasy as a source of pleasure, but as one radically split off from the reality principle. While he warns of the danger of ‘under-valuing the importance of phantasies in the formation of symptoms on the ground that they are not actualities’ [2], he may himself undervalue the role of fantasy and associative, non-linear thinking in engaging with reality, particularly interpersonal reality.
Freud’s idea of thought as an ‘experimental kind of acting’ which prepares for action in reality [2] emphasises preparation for the tasks of adaptation, that is the tasks of making necessary alterations in a more-or-less permanent way. He fails to consider the role of play in the creation of a personal reality where the experience of enlivening in relatedness engenders sustainability and harmony (an end in itself), as opposed to impingement on, or mastery over, some ‘fixed external reality’. The lively human response to external reality may depend upon the development of an inner life that can be shared and the imaginative elaboration of goals that will allow internalisation of a potential future and therefore facilitate movement or flow in that direction. Such a creation allows a sustainable experience in the environment: it facilitates an ongoing sense of liveliness. Such a sense of flow might be felt as a kind of ‘personally created vitality affect’.

Conclusions

To accept that an emergent or pre-representational self is a continuing aspect of experience throughout life may be to accept that shifting temporal forms and patterns represent an ongoing mental experience that colours lived reality. This may represent an unconscious mental activity important in systems of intersubjective or interpersonal resonance. Reflective awareness of this dimension of mental activity may require the development of an interpersonal mental space akin to Winnicott’s ‘intermediate zone of experiencing’ [20]. This relatively undifferentiated area of mental activity might be seen as a ‘background’ required for the systems of play-related thought and adaptational thought to develop.

On the receptive side, the experience of vitality affects is likely to be crucial to this area of function- ing. On the response side, processes of matching, amplifying and extending may be central modes of expression. In a clinical sense this aspect of experience may be described using the concept of liveliness, or thought of in terms of an enlivening–deadening axis of mental function. It is the liveliness felt in a situation that will determine its sustainability.

For therapist and patient this implies attention to the feel, as well as the content, of therapy. This ‘feel’ in a session extends beyond categorical affect to include the shifting rhythms and forms that constitute the vitality affects of the interaction. Where the intensity or mismatching of vitality affects is overwhelming, the area of emergent, undifferentiated mental process may be too chaotic to be therapeutic, and becomes traumatic.

In an ideal world the attunement of the therapist might be such as to always provide the containment that allows safe expression of affect. In the real world this does not always occur and trauma does occur in therapy. To the extent that it may be subsequently reflected upon and worked through, this is consistent with a good outcome. However, while it may be that there is a certain inevitability about the re-experiencing of trauma in therapy, it could be a mistake to think that this is an essential or therapeutic aspect of the process. The absence of liveliness, or the presence of deadness or deadliness, may serve as a key indicator of trauma in the moment-to-moment process of therapy.

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