INTERSUBJECTIVITY AND NEUROSCIENCE

Understanding Enactments and Their Therapeutic Significance Within Emerging Paradigms

Efrat Ginot, PhD
New York University Postdoctoral Program in Psychotherapy and Psychoanalysis

Evolving views of enactments as interpersonal manifestations of dissociated relational styles are increasingly finding support in attachment studies and neuroscientific research. Understanding enactments as an aspect of the intersubjective process and as the ultimate communicators of the patient’s neurally encoded early experiences, this paper examines what enactments convey, and explores their interpersonal and neural underpinnings. Unconsciously triggered and communicated within the intersubjective interaction, enactments reveal the participants’ implicit, neurally encoded relational and emotional patterns that inevitably come alive within the analytic dyad. It is suggested that the analyst’s eventual self-awareness of her own participation, followed by self-disclosure of her experience, promote a conscious, verbally articulated encounter with the patient’s unconscious relational styles, creating opportunities for emotional and neural integration.

Keywords: enactments, attachment styles, neuroscience, self-disclosure

Increasingly, enactments are understood as powerful manifestations of the intersubjective process and as inevitable expressions of complex, though largely unconscious self-states and relational patterns. This focus on enactments as communicators of affective building blocks also reflects a growing realization that explicit content, verbal interpretations, and the mere act of uncovering memories are insufficient venues for curative shifts. Rather, a growing emphasis has been given to the transformational power embedded in unconscious affective interactions that bring to life and consequently alter implicit memories and attachment styles (Bromberg, 1998; Fonagy, 1999; Kandel, 1999; Schore, 2005; Stern et al., 1998; Watt, 2000). As intense manifestations of transference–countertransference entanglements, enactments seem to generate interpersonal as well as internal processes.
eventually capable of promoting integration and growth. Recently, our understanding of the nature and role of enactments has been enhanced by attachment and neuroscientific studies, highlighting the ubiquity of unconscious communications in early life and the centrality of implicit brain functioning. Expressed and revealed through enactments are implicit, neurally encoded, early representations and relational patterns with all their affects, defensive adaptations, and behavioral manifestations. By setting the stage for direct and nonverbal access to the patient’s representational world, enactments take us beyond transference and interpretations and provide us with a new appreciation of what it means to know the other.

Construed of mutually reactivated dissociated memories and self-states, enactments contain within them entangled implicit relational schemas of both patient and analyst (Stern, 2004; Watt, 2000), and as such serve as a gateway to the patient’s relational patterns. In this article, I examine what enactments convey, through what possible mechanisms, and how the analyst’s self-disclosure of his or her own experience in the dyad contributes to the patient’s self-awareness and growth. Underpinning the discussion are recent and exciting data from attachment and neuroscientific research, two fields that are emphasizing the importance of neural and emotional integration (Siegel, 2001) and finding important links between brain and mind, between early experiences and enduring attachment styles, revealing how neurally encoded relational patterns come to life in an enactment.

Enactments, Implicit Memory Systems, and Relational Patterns

Often described as relational impasses, enactments create an intersubjective field in which both patient and analyst find themselves in an ongoing emotional entanglement that temporarily diminishes the likelihood of meaningful reflection (Chefetz & Bromberg, 2004; Chused, 1998; Goodman, 1998; Jacobs, 1998). What was a conscious collaborative effort seems in danger of collapsing under the weight of difficult, threatening, and seemingly inexplicable feelings and behaviors in both patient and analyst. At their most extreme, enactments threaten to halt the analytic process altogether or get out of control. Whether sudden or insidious, early or late in analysis, or long or short in duration, enactments are almost always a surprise. Whether resulting from a patient’s raw transference feelings and distorted perceptions that find conscious and unconscious emotional echoes in the analyst or from a pervasive, deadened atmosphere of being stuck and not moving, enactments indicate that something is out of sync. This “something” and its remarkable implications for clinical practice are the focus of the following discussion. To explore enactments within the context of both attachment and neuroscientific studies, the following vignette, which took place about 2 years into the analysis, highlights how unconscious intersubjective processes embody and reveal early relational styles and also introduces the important role of the analyst’s self-disclosure.

A professional, middle-aged woman, married with two children, Tina had been in analysis before and, according to her, learned a great deal about herself and her relationship with her parents, both Holocaust survivors, now deceased. Explaining her wish to begin analysis again, Tina said that she was aware of some recurring behaviors she wished to change. She did not like how oppositional she was and how easily argumentative she became in many situations. She suspected that her automatic opposition to others’ opinions was really hurting her ability to achieve more and have easier relationships. She
also wanted to further understand her difficulties with “needing others,” a lifelong problem she attributed to her need to take care of her emotionally devastated mother and “cure” her of feelings of grief and sadness.

Tina related all this with an earnest, optimistic demeanor, interspersed with cynicism and self-deprecating humor. She would give this process a trial, she said, adding that maybe what was behind her opposition “is something so dark and scary that we would not be able to deal with it.” This was not said with a warning tone or with hostility. It did not even feel like a challenge, but rather like a neutral, matter-of-fact statement. In any case, she said, “Not to worry, I’ll be a good patient.” Listening to her, I was surprised to find myself feeling both optimism and dread, reacting to what was said, but more so to some unuttered and unidentified feelings as well. I felt worried about future clashes and at the same time was aware of a wish to provide her with the opportunity to safely encounter what was clearly too painful to be integrated and become part of her conscious sense of herself.

Tina indeed started as a “good” patient. She easily talked about her past treatment, her overprotected and yet emotionally demanding upbringing, and her problematic relationship with her husband. Rather quickly, it became apparent that Tina was well rehearsed in telling her story. It’s not that her words did not resonate or lacked affect. She expressed feelings of anxiety and sadness, especially when recalling how miserable and grief stricken her mother always seemed to her. What seemed stale was Tina’s assured way of presenting her feelings and thoughts. It was as if she was not curious at all about any new possibilities or discovering something fresh about herself.

With time, Tina settled into a challenging and bantering way of relating, interspersed with being compliant and seeking recognition for it. When she was argumentative, Tina was not openly hostile or contemptuous, but rather playfully thwarting, needing to be smart, be right, and have the last word. At other times, she seemed eager to please, agreeing with me and complimenting me for my interventions. Tina’s compliments and compliance made me feel uneasy and anxious. I was vaguely aware of fearing retaliation, devaluation, and a pending attack. At the same time, I had the odd feeling that Tina’s flattering words were not really directed at me; they felt more like a generic, well-practiced brush-off, an attempt to keep me at bay. It became clear that even when she was agreeing with me, Tina was not really agreeing. She somehow molded and shaped any intervention to suit her own known frame of reference. When feeling frustrated and irritated, I would ask myself whether unconsciously I was somehow contributing to the growing staleness of our sessions.

When I discussed my experience with Tina, she quickly agreed with me. She said that she was again reverting to her “old habit of being in control” of herself and of the situation, a control that protected her from becoming vulnerable and needy. She acknowledged how guarded she was of letting anybody help her; it was “too unfamiliar” for her, and she did not really know how to do it. Tracing her behavior to her depressed mother, Tina felt that there was very little room in any relationship for her to be overtly needy. Being self-sufficient and feisty was most comfortable and natural for her. Her caretaking role as a child with both her anxious and sad parents again moved to the forefront. However, these discussions as well would quickly drift to known territories and, rather than opening up the inquiries to additional emotional memories and experiences, seemed to close them off.

As time went by, I realized that the core of our interaction was construed around a dance that Tina performed with great expertise. Somehow, using her abilities to analyze, explain, joke, and thwart, Tina exerted unwavering control over her emotional responses
and over the emotional atmosphere of our interaction. My various interventions were heard, examined, and then subtly dismissed. Tina, it seemed, simply could not take much from me in any meaningful way. Although I understood and could even empathize with Tina’s need to be self-sufficient, a topic that was frequently discussed in relation to her history with her parents, I still felt superfluous, diminished, and unimportant. Tina could do the analysis very well without me. She already knew it all, and what she needed of me was an ongoing validation of her insights and conclusions. Often I would catch myself drifting away, too reluctant to reengage, preferring my own private world, feeling that putting any real stamp on the process was mostly useless.

With a growing sense of anxious unease, I realized that the more Tina talked about her need to take care of her mother in that old familiar way, the more suffocated and stifled I felt. What I was not aware of yet was my growing inner rebellion against being so often thwarted and pushed away. Consequently, our interactions exceedingly reflected largely unconscious mutual communications that could not yet be reflected on and understood—in essence, an entanglement of implicit relational patterns emanating from both of us. Unaware, I became more active and verbal than ever before, repeatedly attempting to direct our interaction, in essence trying to wrestle some control away from Tina. Over a period of a few sessions, I relentlessly challenged Tina’s expressed feelings and explanations, deeming them too intellectual, rehearsed, and in the service of her defenses. It was not that my interventions were dynamically incorrect; some of the interpretations and observations had been discussed before. Rather, the emotional context of these interventions, my lack of felt empathy, my feelings of suffocation, and my overly active and controlling behaviors should all have alerted me to the fact that I was deeply involved in an enactment. At the time, however, although feeling uncomfortable and anxious with feeling suffocated and rendered useless, I was not aware of my actions.

After these sessions, Tina would leave the office angry, defiant, and visibly distressed. But when she described her feelings and reactions during the next session, what I heard, however, was not Tina’s vulnerability but more of the same; an unreflected-on, consuming need to fight me and thwart my attempts to help her. All through these few weeks, my feelings of suffocation and deadness became more and more palpable, lodging themselves in my body, which at times felt paralyzed and listless.

During one especially difficult session, when my behavior seemed to communicate to Tina that wherever she was, was not where I wanted her to be, Tina burst into tears, her face and body displaying great agitation. Amid sobs, she described how pushed and prodded she felt, how very anxious and alone. She said that she really wanted to please me, but did not know how, and now she felt deeply disappointed in both of us. Just as with her former analyst, she felt hopeless, lost, and misunderstood. I wanted something from her, and she did not know what it was. All she felt was pushed and coerced. My initial reactions were a mix of guilt, defeat, and a sense of failure. Not only could I not reach Tina, I utterly misunderstood her. At the same time, I also became aware of a growing feeling of sadness, a sadness that not only echoed Tina’s emotional state, but also seemed to have generated in some unnamed deep well of sorrow and despair. The more familiar feelings of being controlled and suffocated no longer seemed urgent or threatening. Becoming painfully aware of my insistent, pushy participation and feeling on shaky ground, I verbally acknowledged to Tina that indeed I had been blind to how I was behaving in the last few sessions and oblivious to how it made her feel. I also described the overwhelming sadness that I had just experienced, wondering aloud how I came to feel so intensely sad.
Tina felt deeply wounded and held me responsible for “totally missing the boat.” “Why is it so important to you to control what I need to say, to push your agenda?” she asked, with tears and bewilderment. Still feeling defensive, I answered that I was not quite sure what had taken place during the last few sessions, and for some time before, but I was certain that as difficult as the experiences between us were, we needed to understand what they meant. I apologized for my behavior again, for being pushy and hurtful, but also said that what had happened, our mutual emotional misses, had been building up for a while. They seemed to be part of something bigger than us, something that could teach us a great deal about her internal world and mine. As the session ended, I did not yet have a chance to describe the feeling that was most disturbing to me, the sense of deadening suffocation.

Tina left that session still feeling agitated. At the next session, she reported the following dream: We are both sitting in my office and she is asking me, “Why are we here? There are no windows in this office.” She feels a growing panic, and with dread realizes that I can’t help her, nobody can. She feels on the verge of suffocating and forces herself to wake up. While discussing the dream (noting that in reality the office has a big, light-filled window), Tina for the first time experienced and expressed her thoughts and feelings in direct and immediate ways. She was clearly and openly angry, sad, and frightened. All at once, she became fully aware of an intolerable sensation of being enclosed, held down, and suffocated. Her heart was racing, and her head felt light with panic. She felt like her chest and her head were going to explode.

While disclosing to Tina my own frequent sense of being controlled and suffocated by her and how closely these feelings echoed her own, Tina’s distressed intensified. But she was not running away from her frightening feelings and experiences this time. On the contrary, she desperately wanted to understand our tumultuous interactions. As we talked, it became clear to both of us that something very important was embedded in our seemingly mismatched communications. It was not only her need to take care of her mother that colored Tina’s interactions, nor was it her argumentative and evasive behavior. Fully dissociated was her enormous dread of being emotionally invaded and controlled. The painful, protracted enactment exposed core, unconscious relational patterns and affective memories that characterized almost all of Tina’s interactions with others—an intense fear of being emotionally violated and forced to adapt to the other and myriad automatic defenses all designed to preserve her sense of autonomy. Unaware, I came to embody both the emotionally invasive mother and Tina’s own dissociated self-state, one that could find its own voice only through creating a refuge in stubborn withholding and fighting back.

A growing visceral understanding of Tina’s tortured relationship with her mother brought into focus a relational pattern characterized by an intense desire to be a good daughter, to ease and erase the mother’s unbearable past, and concurrently also by a strong feeling that she was entirely taken over by the very despair she was attempting to release her mother from. It was not her mother’s verbal communications that made Tina feel taken over and suffocated, but rather what Tina felt to be an all-encompassing sense of sadness and despair that was constantly and nonverbally transmitted to her. Dissociated memories and experiences from her unmentioned traumatic past permeated many of the mother’s unconscious communications to her daughter. There was no place for Tina to hide; her mother’s unprocessed experiences resided in the basic modes of her interactions with herself and with the world. Having a close, loving relationship meant succumbing to and inhabiting her mother’s emotional life. At the same time, feeling increasingly suffocated, Tina also needed to carve out for herself her own sense of an independent subjectivity through defiance and argumentativeness that she was driven to use with others in her life.
Exchanging unconscious communications, we both simultaneously reacted to and triggered implicit affective memories, fantasies, and defenses. In our subsymbolic (Bucci, 2001, 2005) interchange, I was the one called on to enact what was most frightening, almost annihilating, becoming through my behavior the emotionally oppressing mother. And like Tina, in the face of her emotional control I also experienced an increasing pressure to resist the feeling of suffocation, to withdraw and preserve my own subjectivity. Unaware, I embodied Tina’s dissociated self-states, not fully recognizing their ferocious emotional depth and meaning until after the enactment took place.

The defensive control Tina exerted on the sessions was observed and talked about numerous times, but merely acknowledging and analyzing it did not create the interpersonal space in which to authentically experience and understand its multilayered meaning. On the contrary, talking only seemed to perpetuate and strengthen the oscillation between compliance and defiance. My introjection of Tina’s projected dread of being invaded by an oppressive emotional state that did not belong to her, and my participation in an enactment that conveyed both the fear of suffocation and the defenses against it, enabled us to become aware of dissociated self-states that often repeated themselves. The unarticulated sense that passive compliance was the condition for maintaining any relationship and the simultaneous fight to preserve her own sense of autonomy underpinned many of Tina’s close relationships, including the one with her husband. Maintaining an “optimal” distance from others, draining and unsatisfying as it was, became Tina’s unconsciously constructed compromise. Having an insight into her “tendency to oppose and argue” was not sufficient for integration and growth. Rather, an intersubjective stirring of Tina’s implicitly encoded early emotional and interpersonal attachment patterns gave voice to what was sensed but still not a part of a conscious sense of self. By being enacted and thus remembered, these early implicitly encoded patterns had the opportunity to be recognized, analyzed, and integrated.

Indeed, Bromberg (in Chefetz & Bromberg, 2004) spoke of enactment as the patient’s effort to negotiate dissociated self-states that, owing to traumatic experiences, are not verbally symbolized. Similarly, D. B. Stern (2004) viewed enactment as the interpersonal manifestations of unformulated dissociated self-states not allowed to conflict with conscious ones. Noting the inevitable relational impasses that accompany enactments, some clinicians see them as venues for communication whose real message to the analyst is to get engaged with the patient truly and authentically. Such an engagement, guided by the analyst’s countertransference, can help uncover and resolve painful attachment patterns originating from the patient’s implicit memories and fantasies that left unexplored are doomed to repeat themselves (Chefetz & Bromberg, 2004; Chused, 1998; Goodman, 1998; Jacobs, 1991, 1998; Pizer, 2003; Renik, 1998). By embodying inevitable repetitions of early learned and internalized emotional and defensive patterns, enactments are in essence an expression of the repetition compulsion process whose unconscious form needs to be made conscious and integrated (Freud, 1914/1958; Watt, 2000).

This theoretical and clinical view of enactments as interpersonal manifestations and embodiments of the patient’s dissociated self-states is increasingly finding a strong echo in both attachment and neurological research. Data from both these fields help further decipher what enactments communicate in such gripping and, at the same time, disowned and indirect ways.
Recent neuroscientific findings have provided convincing data that interactional patterns between infants and caregivers create lasting neural changes in the brain’s networks, resulting in enduring attachment styles, affect regulation patterns, and modulatory emotional set points that last from infancy through adulthood (Beutel, Stern, & Silversweig, 2003; Cozolino, 2002; Schore, 1994, 2005; Siegel, 1999, 2001). Although the exact neurobiological mechanisms that underlie neurodevelopment are not yet fully explicated, the role of the amygdala in establishing fear (LeDoux, 2002) and the emotional and interpersonal qualities of the right brain (Schore, 2005) are among the neuropsychological models extensively researched. Fulfilling an evolutionary function to detect and respond to threatening stimuli that may affect survival, the amygdala, active from birth, mediates the infant’s emotional responses to his or her environment (Cozolino, 2202; LeDoux, 1996, 2002). Encoding the visceral sensations and affective qualities that accompany early interpersonal events, the amygdala and its related neural pathways establish implicit memory systems, defensive adaptations, and attachment schemas.

As demonstrated by LeDoux (1996, 2002), fear conditioning by the amygdala is an implicit form of learning occurring without conscious awareness from early infancy. In addition to storing implicit memories pertaining to perceived danger situations in its own circuits, the amygdala also modulates the formation of explicit memories in the circuits of the hippocampus. An emotional environment that is primarily one of anxiety and misattribution results in the more frequent activation of the fear systems and of automatic defenses geared to deal with the felt anxiety (Cozolino, 2002; LeDoux, 2002). Consequently, parallel learning processes shaped by different emotional, cognitive, and memory storage networks are generated. According to Cozolino, in such an environment the developing neural systems become skewed toward creating and repeating self-states characterized by heightened interpersonal anxiety and poor affect regulation rather than by positive affect and openness. As a result, split and conflictual attachment modes develop, such as those I experienced with Tina. The degree of neural dissociation between these representational networks will determine which attachment state will be most often emotionally reactivated and repeated. Into adulthood, regardless of actual experiences, the amygdala networks, drawing on early fear conditioning, will continue to focus on what they perceive as interpersonally threatening and anxiety inducing (Cozolino, 2002; LeDoux, 2002; Schore, 1994; Siegel, 1999). These neurally encoded emotional and interpersonal patterns constitute, according to Lyons-Ruth (2003, p. 88), “enactive representations that are developed in infancy before the explicit memory system associated with consciously recalled images or symbols is available.”

The early-maturing right brain also seems to be involved in implicit emotional learning that precedes verbal development (Schore, 2005), and as such “represents the biological substrate of the dynamic unconscious” (p. 831). Unlike the more conscious and explicit processes tied to the left hemisphere, the right hemisphere has been connected to early implicit information processing and to emotional memories and experiences that underpin the self-schema and the individual’s sense of self (Happaney, Zelazo, & Stuss, 2004; Miller et al., 2001). Following these findings, Schore (2005) described how affective attachment interactions between mothers and children shape the neurodevelopment of the right brain limbic system, dominant for implicit emotional patterns.

Indeed, attachment studies have demonstrated strong connections between interactional patterns of mothers and infants and subsequent styles of secure, avoidant, anxious–ambivalent, and disorganized attachment (Diamond, 2004; Fonagy, 1999, 2001; Fonagy et
al., 2002, 1999; Hesse & Main, 1999; Main, 1993; Siegel, 1999). Recent longitudinal studies have found that disorganized attachment behaviors in infancy endured as dissociative symptomatology at age 19 and were related to patterns of parent–infant affective communication and interaction (Lyons-Ruth, 2003). Infants evaluated as displaying disorganized attachment showed conflictual and contradictory behaviors toward the mother, as well as frozen, disorganized, and undirected behaviors. The caretaking behaviors that were most consistently related to disorganized attachment and then to a dissociative structure were emotional unavailability, disruptive responses, and maternal self-absorption that overrode the infant’s needs. Consistent with previous findings (Fonagy, 2001), the study found that unmentalized and therefore unintegrated self-states in the caregivers themselves were also highly connected to disorganized attachment styles.

Paralleling LeDoux’s (2002) emphasis on amygdaloid fear conditioning and defensive reactions such as withdrawal, aggression, and submission and Schore’s emphasis on the right brain, Lyons-Ruth (2003) concluded that attachment strategies designed to deal with affectively stressful interactions are early defensive adaptations that develop due to the caregiver’s failure to provide soothing responses in the face of the infant’s stress or fear. Underlying the infant’s quick, automatic coping responses to nonverbal affective cues are preverbal implicit neural processes (Lyons-Ruth, 1999). Dovetailing with these observations, Siegel (1999, 2001) has also demonstrated that the quality of the early attachment relationships determines social and emotional development by affecting brain structures that mediate these experiences.

Of special significance is the realization that before the full development of higher cortical systems, when the emotional brain is the active entity, children seem to be especially vulnerable to misattunement of affect and gesture, to fear-inducing interactions, and to parental projections and attributions (Beebe & Lachman, 2002, 2003; Blatt & Levy, 2003; Fonagy et al., 2002; Lieberman, 1999; Siegel, 1999, 2001). Considering the role of the amygdala and its related neural networks in emotional learning, attachment patterns are essentially implicit procedural schemas containing sensory, motor, emotional, and cognitive memory systems. These multiple memory networks, dissociated from the conscious sense of self, but highly repetitious, are enacted in any relationship that triggers old emotional patterns and defenses that proved successful in dealing with them (Cozolino, 2002; LeDoux, 2002; Siegel, 1999, 2001). Tina’s repetitious but dissociated emotional conflicts and defenses come to mind. It is important to note here, however, that in further trying to understand the nature of enduring relational patterns, highly complex interactions between various predispositions and the environment should also be considered. Most likely, this will be the next frontier in neuropsychoanalytic research.

Enactments and Retrieval Cues

Embedded in the psychoanalytic relationship is the patient’s hope to be emotionally known and understood (Bromberg, 1998). Accompanying these wishes, however, are implicit affective memories, repeating conflicted and tortured attachment styles. This unique mix of promise, on the one hand, and the perceived threat triggered by it, on the other, seems to rekindle and reproduce the neurally encoded memory networks. Intersubjective by nature, but inherently asymmetrical at the same time (Aron, 1996; Lyons-Ruth, 2003), the analytic relationship, as well as the analyst’s unique personality traits, serve as retrieval cues (Carroll, 2003; Rustin & Sekael, 2004) for the early interactional patterns and schemas. Similarly, according to Bucci (2001, 2005), the therapeutic relationship
activates the dreaded, dissociated, maladaptive emotional schema that brought the patient into treatment in the first place. At the same time, these very same patterns are the ones “that he simultaneously wants to examine and to avoid” (Bucci, 2005, p. 861).

Frequently, however, retrieval cues cannot be readily identified as starting in or belonging to either of the participants separately; they develop in a complex but unconscious back-and-forth mutual communication. The analyst’s own emotional experiences with the patient are at once a reaction and a source. They may express the process of introjective identification, but at the same time they also constitute unconscious emotional triggers (Davies, 2004; Watt, 2000). My own personal resistance to being pushed and forced into an emotional stance was an unconscious echo of Tina’s reactivated emotional schema with her mother. But the more I unconsciously protected my sense of self by disconnecting from the emotional impact of her experience, the more insistent she became.

Here we encounter the heart of an enactment, in which the interaction that is being created contains within it unconscious relational elements of the two participants, consciously and unconsciously reacting to and affecting each other. And just as between parents and children, awareness of the experience is the remedy, creating in analysis the opportunity for meaning and symbolization (Bromberg, 1998; Lyons-Ruth, 2003). As is argued later, this awareness can be greatly helped through the analyst’s self-disclosure of his or her own experience, a process that can only occur once one of the participants realizes that an enactment has taken place. Having examined what enactments communicate, in the following segment I consider the role of unconscious communication in enactments.

Enactments as Mediators of Unconscious Communications

The ways in which neurally encoded attachment patterns are transmitted within an intersubjective interaction are relevant for both parent–child and patient–analyst dyads. An extensive body of infant research as well as clinical observations have documented unconscious communications embedded in facial expressions, gestures, and verbal and behavioral displays (Beebe & Lachman, 2002, 2003; Bromberg, 1998, Chefetz & Bromberg, 2004; Diamond, 2004; Fonagy et al., 2002; Freeman, 2000; Lyons-Ruth, 2003; Schore, 1994, 2000; Siegel, 1999; Stern, 1985). Projective identification and its complementary process of introjective identification have largely been considered as the intersubjective process capable of transmitting dissociated affects, expectations, and defensive strategies, in essence “forcing” the other to comply internally and behaviorally with the projected disowned (Davies, 2004; Lieberman, 1999; Ogden, 1986, 1994; Racker, 1968; Seligman, 1999; Silverman & Seligman, 1999).

Schore’s (1994, 2000, 2005) findings regarding the development of the social brain validate the process of unconscious transmission of parental self-states. Innately regulated by the attunement between the right hemispheres of both mother and infant, the mother’s self-states are transmitted to the child’s through myriad nonverbal communications. Being extensively connected to the limbic system and thus sensitive to interpersonal appraisal and emotional processing, the right hemispheres of both mother and child are especially active in the infant’s first 2 years. During this time, according to Schore, the mother’s right hemisphere is the child’s first reality. Her emotional preoccupation with the infant and her efforts at attunement are the bedrock for implicit memories and relational modes, projected to the child’s receptive right hemisphere (Cozolino, 2002; Schore, 2000, 2005).
Further supporting the role of the right brain in processing nonverbal communication is Schore’s (2005) conclusion that the development of the infant’s ability to efficiently process visual cues from the caregiver resides in the right hemisphere and not the left. A positron emission tomography study of 2-month-old infants looking at images of a woman’s face detected activation in the infants’ right visual area, the right fusiform gyrus (Tzourio-Mazoyer et al., 2002). Similarly, a functional MRI study (Ranote et al., 2004) of infants 4 to 8 months old demonstrated that mothers looking at videos of their infants showed activation of their right brain visual areas, the right anterior inferior temporal cortex responsible for processing facial emotional recognition and expression, and the occipital gyrus, involved in visual familiarity. LeDoux (2002) also maintained that facial misattunements register in the infant’s right hemisphere and are perceived as danger in the amygdala region.

Within the intersubjective interaction in the psychoanalytic dyad, similar implicit communication is constantly taking place. On the basis of recent neurobiological findings, Schore (2005) maintained that the ability to receive and process implicit communications is “optimized when the clinician is in a state of right brain receptivity” (p. 842). According to Adolphs, Damasio, Tranel, Cooper, and Damasio (2000) and Damasio (1994), the right hemisphere is involved in recognizing other people’s emotional expressions and is facilitated by internally generated bodily sensations interpreted by the right brain and not by the more analytical left hemisphere. Thus, the analyst’s right brain, according to Schore (2005), allows the analyst to know the patient in the most immediate and direct way. Schore concluded that the intersubjective field contains within it not just an emotional interchange but a bodily one as well.

Further understanding of the mechanisms underlying unconscious emotional exchange is provided by new research exploring mirror neurons found in the inferior frontal and posterior parietal cortex. Mirror neurons are activated not only when one participant is observing another, but also when the participant is engaged in an active relational interaction with the observed, such as an expressive imitation of the action or affect (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996; Gallese, 2003; Pally, 2001; Wolf, Gales, Shane, & Shane, 2001). Furthermore, mirror neurons in humans are involved not only in action recognition but also in grasping the intention of others and automatically inferring forthcoming new goals. This new finding broadens their perceived function from mere imitation and recognition to instantaneous understanding of goal and intent (Iacoboni et al., 2005).

Gallese (2003) proposed that a similar neural mechanism “could underpin our capacity to share feelings and emotions with others…sensations and emotions displayed by others can also be ‘emphasized’ and therefore implicitly understood, through a mirror matching mechanism” (p. 176). Mirror neurons in Gallese’s model can further explicate the relationship between affective interaction and empathy and between empathy and bodily sensation. Emotional links and sensory responses to others are activated through communicated gestures, vocal tones, postures, and facial expressions, creating an intuitive or an implicit knowledge of them and, according to Gallese, an expanded notion of empathy. Thus, mirror neurons, which have been found in both children and adults, create an actively shared intersubjective space where the other’s emotions can be implicitly perceived, and only then understood.

Indeed, mirror neurons have been implicated in the activation of limbic system networks such as the amygdala, which are critical to emotional learning and processing. Among those tested with functional MRI, the observation and, more so, the imitation of facial expressions significantly activated areas in the amygdala involved with emotional
behavior and the recognition of emotional expressions in others (Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003). Most likely engendering the dual processes of projective and introjective identification, unconscious communications mediated by mirror neurons give rise to enactments, eventually enabling the analyst to use his or her own emotional and bodily “sense” of the patient to identify attachment patterns.

Enactments as Intersubjective Ways of Knowing

The realization that the verbal content of an interaction constitutes only a part of a much larger whole is highlighted by the findings that most of the information encoded and used operates out of awareness (Cozolino, 2002; Edelman, 2004; LeDoux, 2002; Stern et al., 1998). The psychoanalytic echo of the mirror neuron studies can be found in the work of the Process for Change Group (Stern et al., 1998) that has explored the noninterpretive mechanisms of therapeutic change. Emphasizing the shared relationship, they see a powerful therapeutic action within implicit intersubjective communication and knowledge, termed a moment of meeting. The foundation of the “shared implicit relationship” is located in “the primordial process of affective communication, with its roots in the earliest relationships” (Stern et al., 1998, p. 918).

The implicit relational knowledge that is part of the shared relationship can be seen, then, as culminating in an enactment that by its enmeshed nature allows the analyst’s unmediated experience of the patient’s enduring relational patterns. Paradoxically, in spite of the inherent difficulties and uncertainties that accompany them, enactments can also provide the most significant and direct ways for both patient and analyst to connect with what needs to be known, recognized, and integrated as part of a developing sense of self. In this context, enactments contribute to an intersubjective mode of empathy based not only on an emotional echo of the patient’s explicitly expressed feelings, but on an unconscious experience that directly connects with the patient’s dissociated emotions, defenses, and attachment patterns (Bolognini, 1997; Chefetz & Bromberg, 2004; Ginot, 1997, 2001; Racker, 1968; Tansey & Burke, 1995).

The very immediacy that enables enactments to become an authentic encounter can also present the analytic process with potential pitfalls. A thin line may exist between successfully understanding and analyzing an enactment and succumbing to its destructive potential to derail the analytic treatment. Much further study is needed to better know how to navigate it. It is proposed here that the analyst’s self-disclosure of his or her own experience may constitute an important clinical aspect of enactments and may provide one of the most powerful tools toward conscious growth and integration.

Enactments, Self-Disclosure, and Integration

The importance of integrated self-states as well as of neural networks for the experience of well-being, self-awareness, and effective functioning is underscored both in clinical work and in the neurosciences. Paralleling the clinical observation of dissociative self-states and attachment styles is the notion of weakened neural integration. Both Siegel (1999, 2001) and Schore (1994, 2005) maintained that the emotional regulation established in the early mother–infant interactions contributes to the organization and integration of various neural networks critical to affect and self-regulation and explicit memory functions. Similarly, LeDoux (1996, 2002, Panksepp (2003), and Cozolino (2002) emphasized the centrality of integration between the emotional brain and higher cortical
functions, and in Bucci’s (2005) model the integration between the subsymbolic and the symbolic systems is enhanced in analysis through a connecting or a “referential” process.

From a psychoanalytic point of view, as well as from a neuroscientific perspective, the therapeutic endeavor seeks to strengthen integration between networks of affect and cognition (top, cortical/down, limbic system) and between networks of the right and the left hemispheres (Cozolino, 2002). Whereas the right hemisphere is more densely connected to the brain stem and the limbic system and mediates feeling, sensing, and understanding one’s own mind as well as others’, the left is more linked with higher executive functioning and is thought to be the “interpreter” or “explainer” of experiences. Impaired neural integration prevents the conscious recognition of overwhelming experiences of trauma or grief, resulting in a greater influence of the lower impulsive and emotional regions of the brain at the expense of reflective, more rational processes (Siegel, 2001). Enhanced integration of these various networks is essential for symbolization and acceptance of affect and experience, for affect tolerance, and for fluid connections between implicit and explicit memory systems. A growing integrative capacity, according to Siegel (2001), may enable the individual to establish a “coherent dyadic state” (p. 87), creating the capacity for compassion. Siegel further hypothesized that such a capacity is the basis of secure attachment.

The implications for clinical work are obvious and important. According to Cozolino (2002), integration is made possible through “the simultaneous or alternating activation of conscious language production (top and left) with more primitive, emotional and unconscious processes (down and right) that have been dissociated due to undue stress during childhood or trauma” (p. 31).

Paradoxically, it is the analyst’s subjective experience, gained through bypassing cognitive functions, that also enables the analyst to promote integration. The analyst’s realization that his or her part in an enactment is not entirely his or her own, that in some fundamental way it echoes, possibly through mirror neurons, the patient’s earliest attachment styles, gives the act of self-disclosure its transformational power. This stance can provide for both patient and analyst some missing links, some new understanding about buried memories and relentlessly self-defeating relational patterns. The mutual reflective examination enables the patient to become conscious of and integrate formerly implicit patterns stored and activated in pathways more closely related to the limbic system and link them to higher cortical functioning (Beutel et al., 2003; Bromberg, 1998; Cozolino, 2002; Fonagy, 1999; LeDoux, 1996, 2002; Schore, 1994, 2000, 2005; Siegel, 1999, 2001).

Neuroscientific findings have also confirmed clinical observations that without significant affective experiences, any analytical movement toward change is short lived at best. Indeed, neuroscientists have demonstrated that stress and emotional stimulation change neural connectivity and brain plasticity, most likely through a changed biochemical environment (Cozolino, 2002). Cowan and Kandel (2001) concluded that affective arousal results in the increased presence of neurotransmitters that consequently allow for neural relearning and cortical reorganization. Certainly, the raw emotional environment generated by an enactment provides the necessary emotional arousal conducive to neural changes. The analyst’s self-disclosure provides the other element contributing to growth, an authentic encounter through which difficult feelings can be experienced, verbalized, understood, and integrated.

Analyst self-disclosure is only one possible resolution to an enactment, but a potentially effective one. The analyst does not know better how the patient feels and what the patient needs; rather, through being part of an enactment the analyst inevitably feels what belongs to the patient as well. Containing the experience of the two participants as one unit
in the intersubjective space renders the analyst’s self-disclosure an interpersonal act providing a holding environment (Ginot, 1997, 2001). It is important to note at this point that the issue of the analyst’s self-disclosure is not considered here as a general analytical technique. Disclosure of general personal information is not encouraged, nor is it regarded as an acceptable way to promote a sense of intimacy. Rather, self-disclosure is seen here as an integral element in the resolution of enactments: It represents the essence of the collaborative efforts of both participants, giving voice to the hidden and dissociated.

Conclusion

No other aspect of the psychoanalytic process represents its enormous interpersonal complexity, its great opportunities for change, and its potential pitfalls and quagmires as does the presence of an enactment. And no other interpersonal event in psychoanalysis generates quite the same quality and range of affect, confusion, and unconscious behaviors in both participants. Capable of temporarily thwarting a mutual and reflective analytical exchange, an enactment can sometimes create an impasse that threatens to derail the analytic process. By embodying the most intense manifestations of the transference–countertransference interaction, enactments expose and repeat some of the fundamental building blocks of the patient’s earliest self- and other representations while simultaneously engaging some of the analyst’s own unconscious relational schemas. The ensuing complex and inevitable intersubjective processes within the psychoanalytic dyad provide both patient and analyst with enormous opportunity for reflective interpretive work based largely on interpersonal interactions that reveal the patient’s relational style.

The introduction of neuroscientific findings to further explore and understand intensely emotional intersubjective processes such as enactment opens up important new ways to integrate clinical work and the insights it provides with the growing information regarding the complex functioning of the brain. Using recent findings from the field of neuroscience and attachment studies, I have examined how implicit, neurally encoded attachment styles unconsciously find repeated expression throughout life and come to life in enactments. This article is a part of a growing body of work attempting to enrich our theoretical knowledge and clinical efficacy through an integrated clinical approach, taking into account how the brain forms its complex neural networks and how they, in turn, shape our human experience.

The newly created bridges between brain and mind will steadily and continuously contribute to the psychoanalytic endeavor, providing increasingly clearer, multilayered contexts for enhanced psychodynamic and clinical understanding. The discovery of mirror neurons, for example, has shed important light on the intersubjective process and the underpinning of empathy. Similarly, the proposition that enactments are intersubjective manifestations of neurally encoded attachment patterns acquired within the context of the primary relationships is an example of how seemingly unconnected areas, in this case intersubjectivity, attachment, and neuroscience, inevitably intersect with and illuminate each other.

References


