Unconscious Freedom and the Insight of the Analyst: Exploring Neuropsychological Processes Underlying “Aha” Moments

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Abstract: This article explores the insight of the analyst and the concept of unconscious freedom. By insight, the author is referring to those sudden bursts of realization, the “aha” phenomena. Arising from the unconscious of the analyst, these emotional insights can help break an impasse or curtail an enactment. Unconscious freedom is the analyst’s ability to function in the implicit or unconscious relational realm with empathy and sensitivity while relatively free of anxiety. This freedom facilitates the emotional “aha.” Clinical examples are given.

Recent research in neuroscience illuminates these processes, prominently the role of the right hemisphere. Although we are in the early stages of the integration of neuroscience findings and the actual practice of psychoanalytic psychotherapy, this article offers provisional commentary. The author posits that by understanding the neuropsychological aspects of insight and unconscious freedom, analysts will be better able to facilitate this process in themselves.

Reflecting the paradigm shift toward the importance of nonverbal, unconscious communications in treatment (Schore, 2007), this article explores insights of the analyst which rely mostly on unconscious processes, insights that are accompanied by a sudden “aha” experience. We have all experienced this, those moments when we spontaneously understand something new and significant about a patient and the intersubjective experience. This exploration of unconscious freedom and...
resultant insights is especially important for cases in which a sense of impasse has been reached. Although essential in all therapies, a sudden realization or flash of insight may be especially needed in these more difficult cases to bring previously dissociated or repressed material into consciousness and thus provide greater awareness and freedom for both patient and analyst. When these realizations happen relatively early in an enactment, they can shorten the duration of a transference/countertransference entanglement by serving as a form of signal anxiety, allowing the clinician to disengage. Several examples will be given.

I have discussed the ability to access this emotional “aha” as an embodiment of unconscious freedom (Domash, 2009) and similarly, Symington (1983) refers to the analyst’s inner freedom. In my view, unconscious freedom is the ability to function in the implicit relational realm, the nonverbal, frequently nonconscious or subliminal relationship between analyst and patient, with empathy and sensitivity while still remaining relatively free of anxiety. It is being able to receive the nonconscious, nonverbal communication of the patient and process it out of awareness so as to suddenly reformulate this emotional information in a new, surprising, and clear way.

In describing the analyst’s inner act of freedom, Symington (1983) writes that something within the unconscious of the analyst suddenly shifts or changes as he pulls out of a transference/countertransference entanglement. This gives him the freedom to respond to the patient in a new way which then leads to productive work. He describes this type of contact as revolutionary: a new reality develops and new growth begins. For Symington, this type of insight is the agent of therapeutic change.

My aim in this article is to get “underneath” this type of insight—whether it begins in the form of a thought, feeling, visual image or spontaneous act—to explore what happens as we suddenly “get” the patient. Not surprisingly, new advances in neuroscience about the nature of unconscious communication, the primacy of the emotional brain in psychotherapy, and the neurobiological aspects of insight can help us understand components of this emotional “aha” from a fresh and useful perspective. My hope is that by integrating psychoanalytic thinking with neuroscience, we can understand the nature of emotional insight more deeply and facilitate its development. Although this integration is in the early stages, this article offers provisional ideas for the reader’s consideration.

From a neuroscience point of view, the emotional “aha” is in part a right brain phenomenon, the intuitive, spontaneous, emotional, and imagistic aspect of mind that allows us access to our unconscious, that is, to bypass rational thought and in an instant, surprise ourselves with a
new or different idea. Although preceded by unconscious activity (Beeman et al., 2004), these insights arise suddenly, bursting into consciousness on the spur of the moment. Involving the paradoxical ability to be deeply emotionally engaged yet separate at the same time, unconscious freedom includes the ability to regulate affect (Schore, 2007), helping modulate the anxiety level of both members of the therapeutic dyad. As anxiety can easily drown out the neural signals necessary for insight (Beeman et al., 2004) and therefore interfere with focus, we especially have to regulate our own anxiety as well as the patient’s. Somewhat paradoxically, insight can arise either from a very relaxed state of mind which is able to block out anxiety and allow focus or from an intense, urgent state of mind which also drowns out extraneous stimuli and allows focus (Beeman et al., 2004; Lehrer, 2008). Simultaneously, our clinical empathy and sensitivity allows us to gather the nonconscious, nonverbal data frequently necessary for this type of insight. Our willingness to “court surprise” (Stern, 1997) and the unexpected allows for the possibility of the novel and the innovative. The totality of these freedoms is what allows us to “formulate the unformulated” (Stern, 1997) and suddenly make the implicit explicit.

Berns (2008) reminds us there are strong forces operating against insight. He describes a bias in the brain toward economy and efficiency. The brain is programmed to view the world in familiar, unoriginal ways. This uses the least amount of energy possible, and the brain needs to be energy efficient. Therefore, as analysts, we may need a counter-bias toward creativity and seeing things in new ways. Miller and Cohen (2001) have investigated how, on a neural basis, we use the prefrontal cortex as our orchestra leader, guiding which direction our neural activity will go, to the left for logical thinking or to the right for holistic, insightful thinking. We may need a bias toward creative thinking to initiate this latter activity.

THE IMPORTANCE OF EMOTIONAL INSIGHT IN PSYCHOANALYTIC INTERACTION

The work of Freud (1912) who advocated maintaining the analytic attitude of evenly hovering attention and Bion (1967) who instructed us to enter each session without memory or desire was prescient in terms of current neuroscience which has elucidated the suspension of judgment, the focus, and the relaxation needed for sudden insight and improvisational, creative bursts (Beeman et al., 2004; Limb & Baum, 2008). This is to remind ourselves that as much as there is a current
paradigmatic shift in psychoanalysis to a relational or intersubjective model, that emphasizes more emotional engagement/interaction with the patient (Atwood & Stolorow, 1984; Greenberg & Mitchell, 1983; Mitchell, 1988), we also have to be able to be neutral, quiet, and separate to receive the emotional communications of the patient.

This is to be distinguished, however, from the decades-long cognitive approach (Ryan, 2007) which preceded the shift to the more relational/intersubjective approach. The sudden insight I am describing is in the tradition of this relational/intersubjective tradition. The prior cognitive emphasis on verbal content and insight as the major change mechanism focused on improving the analytic processing of the left hemisphere of both analyst and patient, whereas Schore (1994) in placing affect and its regulation at center stage has emphasized the crucial importance of the right hemisphere to development, psychopathology, and psychotherapy. These insights are right brain phenomena.

In fact, referring to the more cognitive approach, many failed analyses have been discussed where the patient felt he had not benefitted from “insight” and that the entire process had been too intellectual; the term “pseudo-insight” has been used to refer to this, as opposed to mutative insight (McLaughlin, 1988). McLaughlin refers to the former as intellectual understanding, while mutative insight engenders a fresh perception of self, conscious or unconscious, which accompanies developmental advancements in the patient’s psychic organization. Such mutative analytic work involves very real struggles around old issues, replayed in new contexts of high emotional intensity, certainly for the patient and often for the analyst. The insight explored in this article is in this latter category as it emanates from emotional, unconscious processes and may help prevent intellectual “pseudo-insight.” This discussion also relates to Stolorow’s position that the distinction between insight and relationship is mute; he argues there can be no insight without relationship and no relationship without insight (Stolorow, 2003). The insight discussed is this article is precisely that: sudden unconscious, emotional insight arising from the therapeutic relationship.

A group of writers have addressed unconscious processes in the development of the “aha” insight which I also term emotional insight. As referred to above, Symington (1983) describes the analyst’s inner act of freedom, allowing him to pull out of a transference/countertransference entanglement and respond to the patient in a new way. Symington builds on the work of Bion (1962), who describes the analyst’s alpha function, whereby the analyst unconsciously processes and reworks the therapeutic material. Making this material his own, the analyst transforms the static beta functions of the patient and through these unconscious operations has emotional insight. Symington (1986, p. 286)
writes “that only those interpretations which result from the operation of alpha function are effective. It is only these that make contact with the patient.” D.B. Stern (1997) discusses the importance of perceiving and interpreting novelty rather than bringing to light preexisting truth. He stresses freedom of thought and curiosity. Courting surprise and the unexpected, the analyst takes the risk of exploring fleeting images that come to mind about the patient. When this occurs, there is more narrative spontaneity in the treatment and more possibility for new experience. D.N. Stern and the Boston Change Process Study Group (1998) describe “moments of meeting” in which the emotional connectedness between the dyad is paramount. It is an interpersonal communion where the analyst unconsciously responds to the patient in a very personal and improvisational manner; the patient feels understood and a new initiative becomes possible, one that alters the emotional landscape and allows something new to occur. Also included in this group is Wilner (1999, 2006) who discusses his playful engagement with the patient in a freely associative manner which opens the patient to more possibilities. Lichtenberg (2001, p. 445) discusses “disciplined spontaneous engagements” in an atmosphere of safety where “communications seem more to pop out than to have been planned or edited.” In a recent paper (Domash, 2009), I discuss how this unconscious freedom develops in the deep trust between patient and analyst where a play space for imagery is created. This helps lower the patient’s defensiveness and perhaps the analyst’s as well. Both analyst and patient are increasingly able to suddenly recognize new opportunities to explore.

**UNCONSCIOUS FREEDOM AND EMOTIONAL INSIGHT**

Back to the question: what gives the analyst the freedom to spontaneously feel or act in such a way that she can step out of a fixed way of thinking about a patient and spontaneously arrive at a sudden emotional insight? While there is now growing consensus that the therapeutic interaction is a result of the intersubjective field that is co-constructed by both participants (Stolorow, Brandchaft, & Atwood, 1987), the analyst also needs to have a well-defined “therapeutic self” and clinical expertise (Schore, 2007) so this co-construction does not drift toward unsettling, unproductive enactments, or even more disturbingly, into chaos.

Taken from the definition of unconscious freedom above, we need a relatively free emotional “therapeutic self” to develop these insights, that is the freedom to function in the unconscious, nonverbal realm which is the province of the right hemisphere. Our “therapeutic” self
might include the freedom to be “sloppy,” that is to allow paradox, uncertainty, and surprise in the therapeutic exchange (Nahum, 2005; Stern, 1997) to help in the creation of new insight. This is the freedom to function in transitional space, including suspending criticality and judgment. As mentioned, unconscious freedom also requires both considerable clinical empathy and sensitivity in order to grasp the patient on a deeply unconscious level. In addition, we need the strength and balance to contain affect and retain a sense of our own subjective self. From this point of view, to achieve insight, we as analysts need to be both “neat” with well-differentiated boundaries and a strong sense of self and also “sloppy” in order to tolerate relaxation of boundaries, sudden surprise, playfulness, ambiguity, uncertainty, and paradox—all at the same time. These are the ingredients of unconscious freedom.

1. “SLOPPINESS,” NOVELTY, IMPROVISATION

The Boston Change Process Study Group (Nahum, 2005) has identified a therapeutic attitude and process that promotes creativity and ongoing emotional insight in treatment. In applying dynamical systems theory to psychoanalytic process, the BCPSG has “come to the view that psychoanalytic therapeutic interaction is an inherently sloppy process. This sloppiness arises from the intrinsic indeterminacy of the co-creative process between two minds. Sloppiness here refers to the indeterminate, untidy, or approximate qualities of the exchange of meaning between patient and analyst” (Nahum, 2005, p. 693). In the sloppiness of the therapeutic process, the analyst joins directions with the patient through a process of dialogue, inference, evaluation, and negotiation. This inference and evaluation process is occurring all the time primarily at an implicit level, outside of consciousness, and leads to the emergence of a shared direction and the co-creation of something new, the “harvest from sloppiness” (Nahum, 2005, p. 707).

The more the analyst can accept the sloppiness of the therapeutic environment, that it is indeterminate and filled with fuzzy intentionality that requires redundancy to clarify, the more she will be able to operate in the open, fluid environment necessary for new discoveries. As Nahum (2005, p. 695) states, “Although the sloppiness of the exchange of meaning introduces substantial uncertainty into the interaction, creating what usually are viewed as errors or mishaps, it paradoxically introduces new possibilities for increasing the coherence of the interactive process between analyst and patient. Sloppiness is potentially creative.”

D.B. Stern discusses the importance of novelty and courting surprise to “break the grip of the field” (Stern, 1997, p. 25). This leads to creative
interpretation or, in my terms, emotional insight. He discusses the for-structures of understanding, those glimpses we have of unformulated or unconscious thoughts, and allowing them to emerge. For this, we need reflection that is both purposeful and spontaneous as well as a stance of uncertainty. Uncertainty is positive because it allows multiple traditions to contribute in unexpected ways to help formulate unconscious thoughts.

The ability to perceive novelty, an emphasis of D.B. Stern, is a function of the right hemisphere. Goldberg, Podell, and Lovell (1994) have explored the importance of the role of the right hemisphere for the perception of novelty and the ability to suddenly come up with a new approach. Goldberg et al. (1994) write that the two hemispheres are functionally different in ways not adequately captured by the classic distinction between linguistic and nonlinguistic processes. The right hemisphere is critical for the exploratory processing of novel cognitive situations for which none of the codes or strategies preexisting in the subject’s cognitive repertoire readily apply. The left hemisphere is critical for processing based on preexisting representations and routinized cognitive strategies. Therefore, although Berns (2008) chronicles how difficult it is for the brain to process new cognitive strategies, the role of the right hemisphere can greatly facilitate this possibility.

The specificity and suddenness (the “aha”) of emotional insight is supported by Beeman et al. (2004) who have extensively investigated the role of the right hemisphere in solving problems using insight. By studying the brain mechanism of insight and non-insight solutions, Beeman et al. found distinct patterns of performance and differential hemispheric involvement for insight and non-insight approaches. Beeman et al. describe the process of solving problems using insight as follows: (1) the subject consciously focuses on the problem, (2) comes to an impasse, (3) works on it unconsciously, and then (4) in a sudden burst, he becomes aware of the solution. This is the “aha” moment. Subjects solving problems using non-insight solutions report a gradual rather than a sudden process in coming to a solution.

Beeman et al. found two neural correlates of insight which were not present in subjects using a straight-forward, non-insight method of solution. On the fMRI they saw that a small fold of tissue on the surface of the right hemisphere, the anterior superior temporal gyrus (RH aSTG), became unusually active in the second before the insight. The activation was sudden and intense and likely corresponds to our feeling of “aha!” On the EEG they saw a spike of gamma rhythm in the same area 300 milliseconds before the insight. Gamma rhythm is thought to come from the binding of neurons, as cells distributed across the cortex draw
themselves into a new network, which is then able to enter consciousness. The area of the RH aSTG facilitates integration of information across distant lexical or semantic relations, allowing problem solvers to see solutions that had previously eluded them. By observing this area, the researchers could actually know before the subjects themselves who would have an insight!

This work on insight has proposed that due to the elongated shape and overlap of the neurons in the right hemisphere, it performs relatively coarse semantic coding (Beeman, 1998; Chiarello, Burges, Richards, & Pollock, 1990) which in turn produces large, weak semantic fields. The fact that the fields are weak accounts for the unconscious nature of this processing; it is not strong enough to be felt consciously until the insight occurs. These weak broad fields allow the processing of many concepts, even concepts distantly related to the input words and context. The cells are less precise but better connected. This is ineffective for straightforward language processing (at which the left hemisphere excels), but it does increase semantic overlap among multiple semantic fields which is useful when drawing parts of a story or conversation together that are only distantly related (Beeman, 1993; Beeman et al., 1994; Beeman, Bowden, & Gernsbacher, 2000), as we do in our work with patients. This may be related to the “sloppiness” described by the BCPSG which allows for imprecise, uncertain ideas to be considered to create new realities.

There is also research to indicate the role of the prefrontal cortex (PFC) in insight. Miller and Cohen (2001) theorize that the PFC is responsible not only for focusing on the task at hand but also for figuring out what areas of the brain are needed to solve the problem. Miller and Cohen (2001, p. 167) write:

The prefrontal cortex has long been suspected to play an important role in cognitive control, in the ability to orchestrate thought and action in accordance with internal goals. Its neural basis, however, has remained a mystery. Here, we propose that cognitive control stems from the active maintenance of patterns of activity in the prefrontal cortex that represent goals and the means to achieve them. They provide bias signals to other brain structures whose net effect is to guide the flow of activity along neural pathways that establish the proper mappings between inputs, internal states, and outputs needed to perform a given task.

This implies that if the PFC activates parts of the right hemisphere, we may end up with an insight. (Likewise, if the PFC activates the left hemisphere exclusively, we might end up with an incremental solution.) It is possible that when the circuitry in the right hemisphere (RH
aSTG) finally generates the correct associations and integrates the information into a new network, the PFC recognizes it, and the insight erupts into awareness (Lehrer, 2008). Before the insight, there has been considerable activity but it has been out of awareness.

In reviewing neuroscience research work on insight, Lehrer (2008) writes that it still remains unclear how simple cells can possess a code that helps filter through the chaos of incorrect ideas and produce the insight. To this, Lehrer (2008, p. 45) quotes Beeman, “At a certain point, you just have to admit that your brain knows much more than you do.” This might be another way of stating the power and breadth of our unconscious as opposed to our conscious mind, as the work on these insights proceeds mostly unconsciously until the moment the insights erupt.

Caveat: Beeman’s subjects were solving verbal problems adapted from a test of creative cognition, not problems posed from the dynamics of therapy. They used a set of compound remote association problems. For example, subjects saw three problem words, such as pine, crab, and sauce and had to supply the one word that can form a familiar compound word with each of the three problem words, such as apple to make pineapple, crabapple, and apple sauce. Since as clinicians we engage with another person in the intersubjective space, our insight necessarily involves grasping the intersubjective field between patient and therapist. We employ our clinical skills, such as empathy, sensitivity, and ability to tolerate affect in the service of emotional insight about these patterns. However, even though the task of Beeman’s subjects and the task of the analyst are vastly different, I suggest we can learn something about the process of insight which we can then apply to the therapeutic situation. What brings the analytic insight to consciousness may be the same process as for Beeman’s subjects. LeDoux (1996) writes that the same mechanism of consciousness brings both cognitive and emotional stimuli to consciousness, although the underlying mechanisms are different.

This is even more probable since this same area in the right hemisphere increases in activity when people comprehend complex, natural language (Beeman, 2005), during tasks that emphasize integration across sentences to extract themes (St. George, Kutas, Martinez, & Serno, 1999), and when subjects are asked to form more coherent memories for stories (Mason & Just, 2004). This is similar to our activity as clinicians listening to and comprehending people’s stories and extracting themes. As we see patients, we get continual practice developing our ability to understand complex stories, extract themes, and develop insight.
Beeman’s work suggests that to the extent we can allow our right hemisphere to solve problems, trust it to function out of awareness, and not rely on our left brain’s need to “solve” the problem logically, then we are more likely to have insight. In fact, Schooler, Ohlsson, and Brooks (1993) have shown how we can override insight solutions by asking participants to explain how they solve problems.

2. ANXIETY: THE ENEMY OF EMOTIONAL INSIGHT

For the most part, emotional insight requires a relative freedom from anxiety in the analyst. This is most clearly illustrated in more intense transference/countertransference interactions, when analyst and patient are relating with dysregulated right hemispheres, fear system to fear system. At these moments, each member of the therapeutic dyad has become caught in early implicit dysfunctional patterns and/or dissociated states that prevent reflective thinking (Bromberg, 1998; Ginot, 2007, 2009; Stern, 1997). These rigid patterns preclude thinking out of the “box” of the fixed patterns and literally prevent the emotional insight from occurring, both psychologically and biologically. In neuroscience terms, the anxiety caused by these dysfunctional patterns likely decreases the signal to noise ratio and disrupts the right hemispheric activation necessary for insight to occur (Beeman et al., 2004). LeDoux (1996) too discusses how strong emotions (such as those from intense transference/countertransference) can easily flood consciousness and displace or prevent other ideas from awareness.

Beeman et al. (2004) report that during the insight process, the brain lavishes the scarce resource of attention on a single problem. Once the brain focuses, it generates alpha rhythms, associated with a more relaxed mind. These rhythms inhibit visual inputs to the right hemisphere reducing the possibility of distraction. By attenuating bottom up activation that would decrease the signal to noise ratio for the actual solution, this allows the weaker processing of the right hemisphere to gain strength.

This need for a relatively relaxed state of receptive attention for sudden realizations is supported by a study by Limb and Baum (2008). They studied improvisation in relation to jazz musicians and found that the dorsolateral prefrontal cortex (DLPFC), responsible for monitoring one’s performance, including self-censoring and inhibition, shuts down completely during improvisation while the medial prefrontal cortex (MPFC) increases in activity, an area that manages functions of attuned communication, empathy, intuition, and self-expression and activities that convey individuality.
The authors posit that this deactivation of the DLPRC may be associated with the kind of free floating attention that permits spontaneous unplanned associations, and sudden insights or realizations. That is, creative intuition may operate when an attenuated DLPRC no longer regulates the contents of consciousness, allowing unfiltered, unconscious, or random thoughts and sensations to emerge. In this state there is a relative absence of anxiety. Limb and Baum explain that just as over-thinking a jump shot can cause a basketball player to fall out of the zone and perform poorly, the suppression of inhibitory, self-monitoring brain mechanisms helps promote the free flow of novel ideas and impulses.

This may be the neural equivalent of how patient and analyst feel as a result of the positive therapeutic alliance where there is a sense of deep trust in the process and affect is being well regulated. This allows for a relaxation of judgment and criticality and an opportunity to operate in transitional space to allow the emergence of new ways of experiencing the world.

It is interesting that Limb and Baum (2008) stress the role of a relaxed state of mind in promoting insight, similar to Freud’s instruction of evenly hovering attention (Freud, 1912). However, we also know that many of our insights in analysis arise from a feeling of impasse or urgency and it may be that intense pressure, if it is not overwhelming, also helps us with intense focus. The purpose of the alpha rhythms is to block distracting stimuli from preventing the weaker processing to come to consciousness. It may be when there is intense urgency, this is also sufficient to block competing imagery and allow intense focus. Perhaps both states create a blocking of interfering input (Beeman et al., 2004; Lehrer, 2008).

**Clinical Example 1: Relaxation and Insight***

Lehrer (2008) quotes Beeman as saying that early morning, when the brain is unwound, disorganized, and open to new ideas, is one of the ideal times for insight, possibly akin to the “sloppy thinking” of the BCP SG. The right hemisphere is also very active during this time.

The following may be an example of this. I will describe an insight I had about a patient on awakening. I was still in a relaxed state of mind before the stimuli of the day had a chance to intrude.

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*Names have been changed and personal clinical material in this article has been disguised.*
Mrs. R, in treatment for depression and anxiety, became more markedly depressed several years into treatment. She had achieved certain milestones in her life. These included successes as a lawyer and her recent election to local office. Prior to this episode of current intense depression, the patient had been preoccupied with and critical of her mother’s depression and helplessness, including her mother’s provocative “help rejecting” stance despite my patient’s numerous attempts to “help.” During this recent seemingly relentless depression, my patient described how she feels completely lost after work. Despite having two young children at home, she wandered aimlessly at a local mall for hours after work. I found myself feeling very critical of her. Although her children were being cared for by a nanny, I believe they needed her. I wondered why she couldn’t spend that time with them, creating a better atmosphere in the home. I said something to this effect and she understandably became quiet. When I asked her how she felt, she said I was yelling at her. I recognized that my tone was critical, stepped back, and tried to get her to talk more about how depressed she feels and acknowledged her helplessness.

However, right after I woke up the morning following this therapy session, I suddenly realized we were enacting some kind of “fight.” She was provoking me with her helplessness and seeming lack of gratitude for what she did have. I was being critical of how little she could or would do. I remembered the raging fights between her mother and father which were punctuated by empty still silences. Her mother also berated her for hours when she did something contrary to her mother’s demands. I realized this current depression was triggering intense feelings of emptiness, feelings she sought to avoid by not going home. She also wanted to protect her children from the escalating arguments she was beginning to have with them. This had not been the case prior to the depression. I felt, now, that I viscerally understood our enactment (and hers with her children). My critical statements to her about her not going home immediately after work to be with her children were an example of unconscious imprisonment—I was trapped in a pattern akin to the pattern she had with her mother as well as aspects of my own history, and I acted it out. The thoughts that came to me that next morning were closer to a feeling of unconscious freedom. They came quickly, seemingly with no preparation, and felt right. I was able to talk fruitfully with her in subsequent sessions about how she was manifesting some of the qualities of her mother with her children and how we were also mutually engaged in this enactment of provocation and criticism. As the patient became increasingly self-aware, she devised a method herself to stop the arguments with her children. When she would start to feel provoked, she would consciously conjure up how she felt when
her mother would berate her and she could then feel greater empathy for her children. She was able to reduce her irritability and feel closer to them.

In the above example, out of awareness my right brain was likely processing different explanations for what happened between us and testing each explanation until it came up with the right one (Beeman et al., 2004; Lehrer, 2008). Then without consciously thinking about the patient, the idea came to me. Relating this realization to Mrs. R felt easy. It was the time before when I was trapped in the pattern and trying to extricate myself that felt hard. Once the insight occurred, it felt effortless and free.

Schore (2009) discusses the dysregulation of the right hemisphere in disturbed interpersonal interactions and the regulating effect of a more ordered right hemisphere. As my right hemisphere became more regulated after sleep and not being immediately provoked by her, I was able to have a new idea. In the first instance, the patient dysregulated me. When I returned to her, I was able to regulate her. Although an everyday example, this is an act of unconscious freedom because I was able to release myself from the entrapment of the early emotional pattern of the patient and view what was happening in a new way.

3. ATTACHMENT, EMPATHY, AND SENSITIVITY

Schore (1994, 2003a,b, 2005, 2007, 2009) has made enormous contributions to our understanding of the importance of the right hemisphere in the therapeutic process. The analyst-patient dyad relate emotionally, right brain to right brain or unconscious to unconscious, to create the attachment bond. The right brain is dominant for the regulation of affect and bodily states, stress, empathy, intersubjectivity, self-awareness, intuition, and creativity (Decety & Charminade, 2003; Martindale, 1999; Rotenberg, 2004; Schore, 1994, 2007). This view highlights the clinician’s role as regulator of the patient’s dysregulated negative states, both psychological and physiological. As mentioned, with this regulation, there is a reduction in anxiety, allowing the spontaneity and focus needed for insight to occur.

Our ability to be empathic and sensitive is the bedrock of our clinical expertise (Bugenthal, 1987; Kohut, 1971, 1977; Meares, 2005; Mohr, 1995; Reik, 1972; Schore, 1994, 2003a, b, 2005, 2007; Watt, 2005). Schore (2007) defines empathy as the clinician’s ability to receive and express nonverbal affective communications; he defines sensitivity as the clinician’s right brain activity within the subjective field. We gather our
data for emotional insight from our clinical sensitivity and clinical empathy.

Schore (2005), Knoblauch (2005), and Bucci (2005) describe how implicit attachment communications are ongoing between patient and analyst, expressed in ultra-rapid transactions of nonverbal facial expressions, gestures, and prosody between the patient’s and analyst’s right brains. This reflects Reik’s (1972) earlier suggestions that the clinician must be ready to trust tiny stimuli and impressions that may be barely noticeable. Schore (2005, p. 845) discusses this from a neuropsychoanalytic point of view: “. . . the sensitive clinician’s oscillating attentiveness is focused on barely perceptible cues that signal a change in state, and on nonverbal behaviors and shifts in affects.”

When the therapeutic dyad is functioning well, the analyst uses her empathy to engage and contain her patient so there is more psychological awareness and narrative freedom for both. On a neural level, empathy within the psychoanalytic relationship reduces stress-induced affective arousal (Adler, 2002), creating a relaxed state of mind which may allow insights to burst into consciousness. When either or both members of the dyad become locked in an early fixed repetitive pattern, sensitivity and empathy are lost as the participants become overwhelmed and dysregulated by early memories, fixed repetition and anxiety (Bromberg, 1998; Ginot, 2007, 2009).

Also important is understanding the role of mirror neurons and their relation to empathy. Some neuroscientists have already advanced theories linking mirror neurons to our ability to inhabit the emotional states of others, although knowledge of mirror neurons is still in the early stages and caution is prudent (Gallese, 2006; Iacoboni, 2008).

Mirror neurons seem to underpin the complex web of interpersonal communication in or out of awareness. They will give rise to perceptions and projections that together may create an inevitable and ongoing mutual nonconscious influence. When conditions are favorable and differentiation, novelty, and empathy and sensitivity are present, it is likely that these mirror neurons may contribute, in ways we do not currently understand, to the seemingly sudden, nonconscious process of emotional insight.

Clinical Example 2: Disturbed Attachment/Crossover from the Implicit to the Explicit Domain

This is an example of a sudden realization, coming in a series of images, which brought previously dissociated or repressed material to
consciousness, making the implicit explicit and resulting in greater awareness. The thoughts and images I will describe come from my unconscious processing of the problem, similar to the process described by Beeman et al. (2004) in experiments designed to study how cognitive problems are solved with insight: there is a search for a solution, an impasse, and then a burst of an “aha” solution. When the analyst is able to do this for emotional problems in the treatment, the patient feels reached at a level beneath his familiar patterns.

The following is a brief, everyday clinical example, which I have discussed elsewhere (Domash, 2009). When Ms. T, a depressed 35-year-old woman, first came to treatment, she was in an abusive marital relationship. The patient’s history included a depressed mother who had died of breast cancer, and one of the patient’s main symptoms was an obsession with breast cancer. The marriage of the patient’s parents had been very unhappy; her father devalued her mother while at the same time elevating my patient. In sessions, the patient talked a great deal about her obsession with breast cancer, her terror and preoccupation, and her constant self-examinations and trips to doctors because she “felt something.” The patient did not give any history of abuse and portrayed her mother as remote and depressed. There was beginning to be a sense of urgency in me as I listened to what seemed to be a repetitive refrain with very little ability to reflect. After listening for a number of sessions to her obsession and starting to feel somewhat abused myself by the concreteness and irrationality of the repetition, I had an image of a little girl, very stern, attacking herself by being very self-critical and angry. Then, for the purposes of this discussion, I will add a horrifying image that then suddenly came to me. It was of a young teenager taking a sharp knife and anxiously but insistently trying to cut her breasts off. I said to the patient regarding her obsession, “This is a self-attack on your body. Your obsession with breast cancer is self-abuse.” This did surprise her enough to interrupt the obsession and make her think; it helped create a “gap” or space between herself and her symptom.

Then, fortunately, several weeks later, her sister spontaneously told her about an incident when she saw her mother beating her. The patient had no memory of this, but had internalized the pattern of abuse and was continuing to do this to herself. Her obsession had several levels of meaning. In addition to her internalization of her mother’s sadism, her guilt about her good relationship with her father compounded her need for self-punishment and contributed to her focusing on losing her feminine beauty so she would be less guilty. She was able to use her sister’s spontaneous story in a deep way and fight her masochistic tendencies more effectively. The obsession subsided, and she gradually extricated herself from her abusive relationship.
Although the memory of her mother’s attack became only partly conscious, that is the patient was not sure if it was a memory or a reconstruction based on her sister’s report, Ms. T was able to reorganize her experience of the world and not continue to subject herself to ongoing self-attack. Fosshage (2005) discusses the variability of implicit knowledge to explicit focus and under which conditions the implicit and explicit memory realms can inform each other. In this case, through her self-directed, hostile, repetitive, insistent, and concrete verbal and nonverbal expressions, the patient had communicated to me her unconscious knowledge of being beaten which I saw in the visual image. I, however, was more aware of her present self-abuse, and then her sister provided her with information about its origin. It may be that emotional insight occurs in the moment of “crossover” from the implicit to the explicit.

4. SEPARATENESS AND EMOTIONAL INSIGHT

To achieve emotional insight, we need to be able to embody both the patient’s early emotional patterns and then become conscious of them as separate from ourselves so as to use this information therapeutically. This implies an ability to connect very deeply emotionally yet be independent of the patient’s patterns as well. Clinical empathy requires both. Support for this can be found in the work of neuroscientists Gallese (2006) and Iacoboni (2008) on mirror neurons, seen by them as linked to our ability to inhabit the emotional states of others. Gallese (2006) writes that empathy is the capacity to experience what others experience while still attributing these experiences to others and not the self. Iacoboni (2008) also emphasized the ability of the observers to maintain their own sense of themselves separately from the subjects they observed.

However, in discussing Bion’s work, Symington (1986) relates how hard we have to struggle to become our own subjective self. There are powerful projective mechanisms operating in treatment that oppose this. Patients can put such pressure on us that we can forget whole sessions, lose our imagination, and have our thinking immobilized. It is our constant task to understand this, digest it, and emerge from it so as to offer insight to the patient, or allow the patient to offer insight to us. Part of unconscious freedom is to be, sooner or later, free from the projections of the patient. As indicated above, Bion used his constructs of alpha and beta functions to describe how, in his view, this is done.

There is evidence for the role of the right hemisphere in this self-object differentiation as well. Using techniques of transcranial magnetic
stimulation, Luber (2008) has identified a neural network for the sense of self. He has cited the right inferior parietal area as part of this network. In discussing Luber’s work, Solms has suggested this particular area may represent self/other differentiation (Luber, 2008).

This ability to be separate allows us needed balance and allows us to offset our identification with the patient; we can then better regulate the patient’s dysregulated states and contain affect, the importance of which is emphasized by Schore (2007). Without this separateness, we can easily become controlled/overwhelmed by our anxiety rather than using it to emotionally understand the patient. In trying to understand aspects of the “therapeutic self,” metaphorically, this ability to be separate means that the analyst knows where she ends and the patient begins—even though they are bound together in the intersubjective field.

Clinical Example 3: Beta Becomes Alpha

The following is an example of an insight bursting into consciousness that may have prevented an enactment from occurring with Ms. A, a 29-year-old woman who had entered treatment for depression and anxiety. I will report an image from my own dream that related to Ms. A’s session the day before. While analysts have long reported images from dreams regarding patients beginning with Freud (1900), Brown (2007, p. 835) writes, that

Until very recently, such dreams have tended to be seen as reflecting either unanalyzed difficulties in the analyst or unexamined conflicts in the analytic relationship. While the analyst’s dream of his/her patient may represent such problems, the author argues that such dreams may also indicate the ways in which the analyst comes to know the patient on a deep, unconscious level by processing the patient’s communicative projective identifications.

Other examples of writers who view the analyst’s dreams about the patient as having a diagnostic and/or important therapeutic function are Winnicott (1947), Bion (1959, 1962), Whitman, Kramer, and Baldridge, (1969); Zweibel (1985), and Rudge (1998). In explicating Bion’s work, Ogden (2004) views dreaming (and dream thoughts experienced as reverie) as unconscious psychological work with unconscious thought derived from lived emotional experience; put simply, dreaming is the primary form in which we do unconscious work with our lived experience. For Bion, dreaming is a form of alpha function,
that is a transformation of raw sensory data into units of meaningful experience (alpha elements). There is recent research (Goleman, 2003) that indicates that during dreaming the amygdala, the fear activation center, is very active and the frontal cortex relatively inactive. Goleman (2003, p. 347) writes “the amygdala plays a role in spawning the emotional reality of the subconscious as revealed in our dream life.” During dreaming we can get a glimpse of our terror without the regulating or inhibitory effect of the prefrontal cortex.

To use Bion’s terms, in the following example, I view the following dream image as an alpha function that transformed my amorphous feelings about the patient into a meaningful symbol. The insight began with the dream image which informed me in a very emotional way about the patient’s terror and possible enactments. Then I reworked this into information which I could use with the patient. The dream image began the “separateness” or ability to step back and take perspective necessary for the complete insight.

I awoke from a dream in which all I remembered was the chilling and dreadful image of a mermaid with the face of Joan Crawford. I associated to my patient who the day before had been discussing her mother as a seductive, yet periodically cruel woman. Although she had been discussing this a great deal in these first few months of therapy, I had been unable to feel it. Whether I was mirroring her detachment or it was my own defensiveness, or possibly both, I do not know. However, when I woke up from the dream, I was shaken and sweating, and felt a horror and dread about the image. I felt I knew then on a very visceral level what the patient felt. This gave me a sense of what could develop in the treatment, that is, how we could get into an enactment where either she or I could become the mermaid and have a sadomasochistic interaction. Instead, I was forearmed by the dream image and could move forward with more awareness of both her unconscious and mine. Of course, my feeling of detachment in the treatment was already the beginning of this enactment.

I can speculate about what happened to me here. Possibly the relaxation of sleep and the reduced activity of the inhibiting prefrontal cortex facilitated right cerebral processing of beta-elements into alpha-elements. As part of this, I embodied the feelings that the patient had about her mother mingled with my own life experiences. The insight burst through in the form of the visual dream image. In a condensed way, it described in “emotional language” the relational problems of the patient, my own issues, and what could happen between us. I was then able to reflect on this image and see how this related to my patient’s experience of her mother which she has also internalized as an aspect of her self. This unconscious insight (the image of the mermaid)
helped me understand the patient from “the inside out” (Bromberg, 1998) and be more free of the possibility of unconsciously acting this out. This is an example of tolerance for affect and apparently only in my sleep was I first able to tolerate the dread and horror of the experience of this mother.

This projective identification which I contained (Ogden, 1982) of a seductive, cruel woman was an important unconscious communication to me about the patient’s internal world. When I had the visual dream image, it began to stand out as something independent from me, something I could think about rather than unconsciously contain. This is an example of the importance of self-object differentiation in facilitating emotional understanding. The unconscious insight—the dream image—began this process.

This dream image may be an example of imagistic thinking or non-verbal symbolic processing from the implicit or nonconscious realm (Bucci, 1997; Fosshage, 1983, 1997). Fosshage (2005) describes this type of thinking as the earliest avenue for affective/cognitive symbolic processing. This image came from my unconscious, implicit memory occurring during sleep and connected with emotional data from the patient’s unconscious and may be a means of helping the patient bring to consciousness material previously out of awareness.

ENHANCING OUR CAPABILITY FOR UNCONSCIOUS FREEDOM

How does the analyst enhance her capacity for emotional insight, that sudden “aha” experience, and develop greater unconscious freedom?

Schore (2007) discusses how the clinician’s ability to handle the patient’s negative states involves the therapist’s capacity to auto-regulate these painful affects. He views the development of the right hemispheric functions of the clinician as crucial to effectiveness. Siegel (2007) addresses this in his discussion of mindfulness, that is, cultivating an attitude of attention to the present moment, to the fullness of our experience. It is a form of internal attunement, a special form of attention that helps promote insight and regulate emotion; this is essentially a form of auto-regulation. As Weber (2009) observed, it helps create a “spaciousness” within ourselves that allows us to bear suffering while decreasing our own as we do so. Mindfulness practices include the practice of prayer, Buddhist mindfulness, meditation, yoga, tai chi chuanm, and qui quong. These help regulate our body, balance our emotions, modu-
late fear, increase flexibility of response, and improve self-awareness, insight, and intuition. This facilitates emotional insight—possibly by a form of focus/relaxation which would allow us to block out extraneous signals which prevent insight because the signals may be weak and easily disrupted. As our flexibility and empathy increase and our fear decreases, we are more able to release ourselves from rigid patterns. Siegel explicates how as we practice mindfulness, we can enhance our own neural activity by strengthening the integrative functions of the medial prefrontal cortex (MPC), an area also identified by Luber (2008) as one of the five parts of the self system. By strengthening the MPC, we are stimulating the same area the jazz musicians did when they were creating. Analysts may have an opportunity to optimize their access to creative insights which rely on unconscious processes by mindfulness practice.

Siegel appears to stress integration of right and left hemispheric functions as important for fear modulation, empathy, attuned communication, and intuition whereas Schore stresses the importance of development of the complexity of the right hemisphere. An extensive discussion of this issue is beyond the scope of this article, but future research is needed to refine our understanding.

There is a bidirectional aspect to this process: the mind can change the brain and the brain can change the mind. Strengthening the psychological helps us neurologically as does strengthening the neural basis helps us psychologically. Siegel and colleagues (Cozolino, 2002; Schore, 1994, 2003a, b; Siegel, 1999; 2007; Siegel & Hartzell, 2003; Solomon & Siegel, 2003) have proposed that an effective therapeutic relationship between clinician and patient promotes the growth of the fibers in this prefrontal area, suggesting that the therapeutic relationship can strengthen the MPC. However, one can stimulate the MPC directly by mindfulness practice and also bring about positive psychological results. Patients and analysts can work this from both directions.

Pelled (2007) links Buddhists’ views, including mindfulness, with Bion. In both systems, mental growth is related to learning from experience. Comparing the concept of attention in Bion and the concept of mindfulness in Buddhism, Pelled states that for both systems, attention must be isolated from other mental processes in order to learn from experience. Pelled compares the reverie of Bion to the Buddhist state of equanimity. She argues that enhancement of the ability of reverie, that is, improving the inner container such that it can hold any content while unmoved by desire, is also the purpose of Buddhist practice. Both view the mind as capable of transcending its own restrictions through disciplined practice.
A more complete review of how we can enhance our ability to understand unconscious communication and stimulate our creativity is beyond the scope of this article, but as has been indicated, many writers have addressed this. The implications for training are also beyond the scope, but it is a direction for future exploration.

SUMMARY

This has been an exploration of unconscious freedom, the analyst’s ability to function in the implicit relational realm with empathy and sensitivity while relatively free of anxiety, and the emotional insight of the analyst. While provisional at this time, an integration of neuroscience research and psychoanalytic psychotherapy has been offered to understand the underlying issues.

Psychologically, unconscious freedom involves our ability to reduce anxiety and regulate affect, develop refined clinical empathy and sensitivity, have appropriate boundaries so as to make clear emotional distinctions between ourselves and the patient, and very importantly, be able to embrace novelty and tolerate paradox. The psychoanalyst must be able to be both “sloppy” and “neat,” to be emotionally engaged yet separate at the same time. Speaking neuropsychologically, we need to fine tune our self system and our right hemispheric functions.

This freedom facilitates the emotional “aha,” itself unconscious until the moment it bursts into consciousness. At the moment of insight, the analyst is released from a fixed way of thinking about the patient and sees something new. This then helps move the dyad toward greater analytic freedom, where new psychological realities are created.

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