Sensory empathy and enactment

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The authors propose the concept of sensory empathy which emerges through contact between analyst and patient as they get in touch with an area concerning the primary bond. This area is not so much based on thoughts and fantasies as it is on physical sensations. Sensory empathy has to do with that instrument described by Freud as pertaining to the unconscious of any human, which enables one person to interpret unconscious communications of another person. The authors link this concept to that of enactment precisely because the latter concerns unconscious, early elements that find in the act a first meaningful expression. It involves both analyst and patient. In other words, the authors wish to emphasize the importance of the analytical process maintaining contact with that immense field of human interaction that can be defined as primary sensory area and which becomes intertwined with the evolution of affects. Clinical examples are provided to clarify these hypotheses.

Keywords: sensory empathy, kinesthetic empathy, empathic intuition, imitation, enactment

Psychoanalytic empathy

In this paper, we demonstrate how the concepts of enactment and sensory empathy are linked. They are both determined by a vast range of phenomena related to physical sensations, which we define as the primary sensory area. The latter constitutes the foundation of the developing psychic structure of a human being. The term ‘primary’ belongs to Freudian theory; authors of such schools as the French, Spanish, Italian, English and Latin American still refer to it. This term indicates an unconscious mental activity which does not follow the rules of conscious activity. There is no verbal language involved. Instead, there is a production of images that do not seem to follow any order and, even less, any system of logic. The primary process remains active in adult life and continues to be manifest in that part of the psychic apparatus that Freud called the id, ‘which is to say very close to the physiological sources of mental energy. This chaotic and primitive form of thinking tends to invade the superior areas, belonging to the secondary process, characteristic of the ego’ (Gaddini, 1960, p. 80), while the ego, as we know, will tend to protect its stability, so painstakingly achieved.

Not all authors have the same concept of the sensory. We cite here, as an authoritative example, the concept of ‘amodal perception’ suggested by Stern (1985).
According to him, children possess an innate ability to receive information through one sensory mode and somehow translate it into another. The latter is not a direct translation of the former, and might well be ‘an encoding into a still mysterious amodal representation, which can then be recognized in any of the sensory modes’ (p. 51).

As for us, when considering the contacts that can occur between individuals and more particularly between patient and analyst, we wish to stress the importance of acknowledging an early, unconscious form of sensory function, which is the foundation of the developing mental structure of an individual.

Empathy: why go back to this issue? Many authors have dealt with it. For a comprehensive review and, more particularly, for a study on the theoretical and clinical aspects of empathy we would cite the distinctive contribution of Bolognini (2004). For our part, we wish to look in more depth at the concept of sensory empathy. This is an unconscious way of perception which reaches the conscious levels from within, through the filter of preconscious elaboration (Gaddini, 1962). It is quite different from the more commonly understood concept of sensory modes.

**Sensory empathy**

The adjective ‘sensory’ preceding ‘empathy’ adds new meanings to the original phenomenological definition of *Einfühlung*. Gaddini (1969), through his concept of imitation and imitative identification, demonstrates that children’s perception of external stimuli happens firstly through the bodily sensations that they experience. Only later do these stimuli acquire a mental meaning. Gaddini’s concept of imitative identification (or primary identification) means, essentially, that a given object is not experienced as external to the self but is perceived as if one ‘were that object’. As such, it is a basic defence which, initially, like any defence, forms part of the normal developmental process. Subsequently, integration through introjections and oral mechanisms produces identifications of a structuring type.

As regards the analyst–patient relationship, the identification with the patient that we wish to discuss is the one occurring most immediately through empathic contact. It happens at the level of bodily sensations rather than feelings, fantasies and thoughts. This activates in the listening analyst something that we would define as sensory empathy (Zanocco et al., 1995). The latter has to do with a faculty defined by Freud as the instrument all humans possess within their unconscious, allowing the interpretation of another person’s unconscious communications. It is a faculty very close to that symbiotic nucleus which provides us with the ability to get in contact with another through physical sensations, phantasies in the body, harmony of rhythms, the ‘being together in the river’ (or any other expression which has been used to describe the primary bond). In effect, in their practice, analysts use the child’s ability of not being integrated, as suggested by Winnicott (1945). This ability seems to be an essential condition for achieving those modes of contact, characteristic of the primitive mind, that confer an extraordinary sensitivity.

The asymmetric quality of the analytic relationship creates for the analyst a certain isolation. The effervescence of sensations, the phantasies and the
quasi-hallucinatory perceptions of contact which are then activated to fill the void, are drained by the analyst in a sort of ‘mental suction’ and transformed into words. These words of the analyst will then be accompanied by processes of discharge in the patient (Greenacre, 1954). Now, thanks to these signs of verbal discharge, ‘internal thought-processes are made into perceptions’ (Freud, 1923, p. 23), acquire a reality and enter in the memory circuit.

Therefore, sensory empathy is the response of the analyst to the patient material—be it verbal symbols (signifiers), meaningful silences, or, on the contrary, enunciations that neither describe nor state anything. The last, which tend to be produced by the patient along with the performance of an act, can be considered as actual evacuations of the self which serve various purposes. On this subject, see the range of projective identifications described by Rosenfeld (1987).

Some clinical examples clarifying the nature of the exchange

A young neurotic man presenting autistic capsules (Tustin, 1990), in analysis four times a week, had seriously challenged the analyst in the first years of analysis. Because of his communication difficulties, he prevented the analyst from making any contact. This patient, who since his birth had had to relate to a mother affected by serious sensory disabilities, developed in his first year of analysis the peculiar habit of lying on the couch on his belly, as if in search of the analyst’s eyes and of a more reassuring contact. He would thus appear like an infant in his first attempts at turning over. This behaviour was suggestive of the patient’s need to recover, through analysis, an area of sensory contact denied to him in his early relationship with the mother.

During one session, this patient was trying to explain, with difficulty, how he was feeling. He was trying to convey to the analyst an image of ‘coiling’ which could not quite emerge clearly in his mind and even less be put into words. At that very moment, in the mind of the analyst there formed a highly focused image of a blow-out whistle—a long paper tube which unfolds with a sound when blown and, because of a steel spring, recoils in the absence of the air stream. In Italian, this is called a lingua di Menelicche [Menelik’s tongue] and children play with them at parties. At the very same instant in which the mind of the analyst formed this perfectly clear image, the patient found the words to say: ‘Do you know what I feel like? Like that party … lingua di Menelicche … that paper whistle which unrolls and recoils when you blow it!’ The patient was using this image to describe as clearly as possible the way in which he performed his ‘autistic withdrawal’ (his own words) from the world and social life, from affects and engagements. This peculiar way of rolling and unrolling was clearly reproduced by the patient in the analytic relationship, generating only too frequent oscillations in the transferential attunement. This rendered the analysis, during certain phases, very hard and almost sterile.

It was very useful that the patient could witness the analyst capturing the image of the lingua di Menelicche just a few instants before he himself was able to find the words. They had uttered it almost in unison: an image which was strongly thought, if softly murmured, by the analyst, and a loud, clear exclamation by the patient: ‘Lingua di Menelicche!’ This realization allowed the patient to perceive how much
the analyst was in tune with him, how close to him (present and attentive to a certain
depth of sensations) and how much the patient could experience with him the pos-
sibility of being understood. The patient had totally missed out on this kind of
experience in his limited, scarcely libidinal relationship with his parents.

In the silence between patient and analyst there was, therefore, a communication
of images and phantasies, even though almost or totally unverbalized. Sensations
felt in a state of ultraclear consciousness were employed by the analyst as the source
of images of body-part objects (Menelik’s tongue) and, at the same time, as the
source of acoustic messages, analogous to the sounding of foghorns ships exchange
when navigating through the densest nocturnal mist.

In the case of another neurotic patient with severe narcissistic disorders, in
analysis four times a week, a similar experience had helped break the monotonous
and repetitive situation that characterized the first years of analysis. One mode of
resistance used by this patient in the sessions was that of whispering so softly that
most of the time his words were incomprehensible. Cautious, if frequent, attempts
to make him speak louder were in vain. His voice was so soft that even the very
discreet tick of the table clock was an obstacle to the listening ear. Most of the
time the analyst was ‘resigned not to understand’. He did feel that the patient was
somehow communicating with him, but his communication was more akin to that
of an infant who has not yet found the use of language. In one session, during such
a ‘whispering silence’, the analyst experienced, to a greater extent than usual, a
painful sensation that seemed to indicate the possible death of the analytical rela-
tionship. Therefore, he was working hard to create a mental space within himself
where the phantasies of the patient could be received. He was thinking of something
that the patient might be saying next, sharing his phantasy, as it were, in a shared
space. He had something very precise in mind. At that moment the patient, as if he
had read the analyst’s mind, broke the silence exclaiming: ‘About that seminar, by
the way … I wanted to tell you …’. It was exactly what the analyst had in mind!

We can see how an increase of, and concentration on, sensory empathy on the part
of the analyst produced an intuition. This in turn had the effect of interrupting the
monotonous, deadly, whispering silence of the patient.

An empathic intuition is therefore followed, though unfortunately not always,
by an objective explanation of what happens between two people ‘close in a room’
(Nissim Momigliano, 1984). At this point, we need to reflect on the question of
affects and their particular status in relation to the mental representation of instinc-
tual impulses. Affects need to be acknowledged as the evidence of sensitive
experiences and as the immediate presence of feelings and emotions; they activate
sensations within the body (excitations, painful tensions). Affects are, by definition,
not mediated by image representations. As Green (1977) suggests, they are not the
result of a splitting of perceptions but rather are linked to primary identification.
Thus, we are back to the concept of sensory empathy, that process which is based
precisely on the ability to assimilate, through imitative identification, what another
person is feeling.

‘Identification is known to psycho-analysis as the earliest expression of an emo-
tional tie with another person’ (Freud, 1921, p. 105). As such it allows communications
from unconscious to unconscious, without the mediation of words. This is why we have to accept the presence of open wounds, of the ‘black hole’ described by our patients, the unspeakable pain (we think of the melancholic syndrome), the nameless dread, the unthinkable anxieties, which pose a limit to analysability. They will require instead the intervention of scientific theoretical models. This has nothing to do with a science-based utopian project, but rather with attention to a function which is largely related to the primary process and is not dissimilar from dreamwork. It is about giving form to painful affects through a process close to dreamwork. Aeschylus has already described this perfectly in *Agamemnon* (Parados, third strophe):

Zeus, whose will has marked for man  
The sole way where wisdom lies,  
Orders one eternal plan:  
*Man must suffer to be wise.*  
Head winds heavy with past ills.  
Stay his course and cloud his heart.  
Sorrow takes the blind soul’s part—  
Man grows wise against his will.  

(Dutta and Goldhill, 2004)

**Empathy and enactment**

At the very moment that from the organ loft the chorus started to sing Klopstoch’s *Auferstehung* [The Resurrection] … I was struck by a blinding flash and everything became clear in my soul. This is the kind of flash that creative people wait for: such is the holy conception (the Annunciation!). What I experienced that day was still not expressed in music. And yet, if I had not already carried in me this work of art, how could I have experienced such a moment? … It has always been so, in my case: it is only by experiencing the sensation that I can create through sounds and it is only when I am creating through sounds that I can experience the sensation. (Lebovici, 1995, p. 1788)

This is how Gustav Mahler described his difficulty in writing the *Resurrection* chorus in his symphony No. 2. We have here an example of a mental process in which so-called *enactment* has intervened.

Enactment is, along with empathy, another form of non-verbal communication: participation through a ‘shared act’ (Lebovici, 1995) shows how the creative ability described can be achieved through enactment in the context of a psychoanalytic session. He points out that enactment is not just an action or a piece of acting out but is something ‘achieved in the truly extraordinary moment in which the analyst feels in his own body an act which remains experienced and not acted out’ (p. 1788).

In summary, what exactly is meant by enactment? It is well known that this concept has been especially studied and debated by American authors, such as Renik, Jacobs, Stern, Hirsch, Friedman and Natterson, McLaughlin and Johan. However, it has also been a source of interest for authors of differing cultural background, see Filippini and Ponsi (1993) and De Marchi (2000, pp. 475–6), who stress the difference between acting out and enactment. De Marchi points out that acting out has to do with the patient putting into action what has been repressed and is not therefore
remembered. Enactment, on the other hand, is about the analyst accomplishing an act as a way of interacting with those patients who are not able to give representation to their instinctual impulses (p. 475). It is worth noting that the patient causes the analyst to act through posture or gesture rather than words. Even when action is through words, the way analysts expresses themselves is more important than what they actually say. Analysts will catch themselves making a gesture, changing posture or simply modifying the tone of their voice (p. 476). Enactment differs from projective identification and even more from acting out, in that the action involved is not aimed at persuading or forcing someone to do something in response. The dynamic of acting out is related to some repressed material and is a consequence of a lack of awareness. ‘Enactment, by contrast, is related to primitive unconscious elements which find in the act their first expression and which involve both analyst and patient, precisely because of the particular relationship that is formed between them’ (p. 482). Thus, the term enactment, as previously mentioned, is appropriate for describing a particular form of expression related to processes and dynamics originating in the primitive functioning of the mind, which maintains a necessary function even after the maturation of the mental apparatus. Enactment has to do with a part of the ego which has retained a primitive way of functioning. It is therefore possible to talk of an unconscious part of the ego (Freud, 1923) and also to hypothesize that it is precisely from this part that enactment emerges. As far as the analyst is concerned, enactment could consist of a counter-resistance (in defence of his own self) in relation to the patient’s material which is, at that given moment, not open to elaboration by either party.

Clinical examples of empathy–enactment linking and animation in an alternating dynamic

A non-psychotic patient (in analysis four times a week) found it very difficult to tolerate the restrictions of the setting. Whenever he had to go through the experience of being frustrated in his wish to be, as if by magic, the analyst himself, realizing instead that he was the patient in analysis, with his object (the analyst) keeping his distance, he would then feel ‘his brain squishing away’. He could not tolerate having to face anal–aggressive phantasies which he found very frightening. He would say that he felt like ‘a fish used to living in the high pressures of the deep-sea … that if brought to the surface feels like exploding’. By this, he clearly indicated that his exasperated demand for an object was in reality a hunger for stimuli. In other words, he was trying to elicit some active containment on the part of the external environment. However, this manoeuvre aimed at marking out an ill-defined boundary of the self, exposed him in turn to the claustrophobic anxiety of being confined, squashed and depersonalized. Another image of his was that of being stuck, head first, in a narrow underground passage. He would then defend himself against these claustrophobic anxieties of explosion or fragmentation by using the words of the analyst as if they were an extension of his body. It is worth noting that he never used expressions such as ‘penetrate’ or ‘inside/out’. The analyst had the impression that in these moments there was a defensive regression of his use of language and of his faculty
of symbolization. These were replaced by symbolic equations between words and things. It was as if the analytic relationship was transformed into an experience of concrete contact and fusion. Furthermore, it was possible to observe clearly that the patient was immersed in a dreamy state in which he made early fusional phantasies, largely illustrated in the clinical material. However, unlike the dream, which can be remembered, and unlike the ordinary production of phantasies, this dreamy state of the patient did not present any of the metaphorical, ‘as if’ qualities of representation.

As for the relationship with the analyst, in the first years of analysis the patient tried ceaselessly to reverse roles, in order to achieve a symmetrical and equal relationship in which one would be the mirror of the other. He could thus avoid actually relating to his object, and all the conflicts that this entails. One day he invented a dream to demonstrate that the analyst was an impostor and all his interpretations and hard work in the sessions had no foundation whatsoever. The analyst felt a great sense of impotence and experienced the physical sensation of being winded by a punch to the stomach.

In the course of a silence, this patient would often express the sensation of being in a physical continuum with the analyst. He would perceive the analyst’s breathing and movements of the chest as being within himself. He wanted the analyst to speak, but, when this happened, the patient would say that it felt traumatic, that his brain was ‘squishing’ away. This was because the analyst’s words caused in the mind of the patient a split between words–thought and the sensation of sensual physical contact in which he was absorbed. By then, the analyst’s words themselves would be quickly reduced to and assimilated as sensory events. The patient’s phantasy was that of physically incorporating the words of the analyst, as if they were a body part that he could keep in his mouth. They would become the ‘nipple-in-the-mouth of the baby’ which ensured a stream of sensations, held the self together and allowed for the focused attention that produced dreams during sleep.

On one occasion, the analyst was seriously challenged. It was in the first year, just before the summer break. As soon as the dates of the break had been stated, the patient increased his challenges and provocations by arriving late or early for the sessions, and starting polemical discussions of the terms of the contract. All efforts on the part of the analyst to contain the situation were in vain. He no longer felt able to maintain his inner freedom and his ability to think, and had the sensation of being paralysed. He then realized that the patient was repeating the scene of the separation from his primary object, which had occurred with excessive aggression. Instead of remembering this terrifying scene, the patient was trying to recreate the same situation in reality.

The analyst was able to resolve the impasse by inviting the patient to sit down in front of him and letting him know that in these conditions the analysis could not take place. He suggested that the patient should think about the situation and get in touch by phone later on. The patient did make contact after the break and the analysis returned to its regular course.

In the preceding example, regression is considered as a moment of dissolution of language and of the inability to make use of symbols. However, what we would
like to stress here is that the analyst elaborates the elements offered by this regression, which is to say by the most primitive transference. Through this, the patient re-experiences the need for physical support of vital needs, which characterizes the mother–infant relationship. As this patient once said, ‘When I think, I do it on your body’.

The question of how this search for the object on the body, as Tausk (1933) puts it, works in analysis, finds one explanation in the mother–infant relationship model. The analyst then functions as an extension of the patient’s self, as an auxiliary ego, such as that offered by the environment in the primary care of the infant. It is an environment which stands silent and reliable, a sort of background against which the imagination of the mother in touch with the baby’s phantasies can unravel. On this point, it is worth remembering what Greenacre wrote:

> It is my impression that this stage of perception of the outer world in terms of the own body may be the primitive forerunner of the ability to make tools and toys which are the prosthetic extensions or projections of the body parts, as indeed may be seen in the young child’s extended use of the transitional object. (1970, p. 454, original italics)

This is true not only for the patient, but also, to a certain extent, for the analyst, who is exposed to tactile, kinesthetic and visceral representations rather than symbolic ones. In such cases, it seems clear that all the fantasies that can emerge from this kind of physical impression can be used for transforming the latter into communication. Therefore, the analyst must be the body which can support the phantasies of the patient, the object which can think, verbalize and help thought to become transmissible.

Renik, in his critical revision of the concept of analytic neutrality, poses the question of how learning takes place in clinical analysis and of what allows the patient’s self-awareness to evolve (1996, p. 505). ‘More often, learning takes place through a series of inadvertent, corrective emotional experiences …’ (p. 506). Analyst and patient examine these experiences retrospectively, when possible, ‘the examination itself, of course, constituting in part a new enactment of the unconscious striving of both (see Renik, 1993)’ (p. 507). Renik continues by wondering whether affective interchange, which includes kinesthetic sensations, is not in fact the core of the analytic encounter (p. 511). In essence, he is in favour of a relationship which tends to be symmetrical, intersubjective and rich in empathy.

The last two very brief clinical cases corroborate the frequent coexistence of sensory empathy and enactment.

The first concerns a 40 year-old neurotic patient, in analysis four times a week, who suffered from a hereditary liver complaint which caused alterations to the metabolic balance, but was not otherwise particularly disabling for active life. This physical pathology, coupled with her scarcely libidinal family experience (hypochondriac mother, father with a serious heart disease) put this patient into the frame of the depressive psychological type. All her life had passed in an opaque way, with controlled, toneless moods. Her major inhibitions revolved around her relationships (with her husband and adolescent children) and her difficulty in acknowledging, as well as managing, her own aggression.
This patient, in order to allow her analyst make contact with her (of a somewhat psychophysical nature), had found a way of talking with her belly, through an intense usage of noisy gurgling. These noises would replace words for long stretches of otherwise silent sessions. The analyst, who initially experienced the situation with some embarrassment, eventually decided that he too would allow himself the use of his own belly, which came entirely naturally with this particular patient. The listening was therefore interspersed by the use of intestinal noises on the part of the analyst. These ‘belly exchanges’ seemed to be reassuring for the patient and allowed for a reactivation of the associative stream.

The last clinical case concerns a patient, in analysis four times a week, and presenting with a borderline pathology. Once, as he was reporting a dream focusing on some of the difficulties experienced in his development, this patient had triggered in the analyst’s mind (as if the latter was also dreaming during the session) a clear depiction of a difficult journey. This was represented by a car, driven by him with the patient at his side. This car was at risk of getting stuck, as it had to cross a narrow wooden bridge which was missing a few planks. This image formed by the analyst (concerning risk and danger) was superimposing itself on the story within the patient’s dream. The difficulty of the journey was probably to do with a difficulty of the analyst (concerning his own internal journey) which was colluding with the ones expressed in the patient’s dream. Such difficulty found its expression in an enactment: the analyst entered a dreamy state in the session, after the patient had told him his dream. Conceivably, the material brought by the patient had ‘disturbed’ the analyst by causing the emerging of ‘difficult’ passages of his own evolution. Presumably, the analyst’s enactment had not so much to do with countertransference as with the colluding disturbances caused by the patient’s material. Enactment could therefore be interpreted as a counter-resistance. As De Marchi puts it,

…enactment can be considered a turning point in an analysis in which the relationship is characterized by a mode of resistance/counter-resistance. An enactment, by patient or analyst, could be evidence of something which has not yet been ‘felt’ by them and, for this very reason, can sometimes be transformed into an act. (2000, p. 479)

All these clinical vignettes clearly show how intensely the analyst takes part, with his own body, in the patient’s communications.

**Empathy, enactment and neuroscience**

The notion of enactment has been reinforced by Gallese’s (2001) work on mirror neurons. These are found in an area of the visual cortex called V5 and respond to observations of goal-related hand actions, but only in the presence of the object performing them. Mirror neurons seem to confirm, on the one hand, the concept of intentionality and, on the other, to corroborate the concept of intersubjectivity at the most primitive levels of communication.

Gallese’s findings show that the observation of another person’s actions involves their imitation. It is an implicit, automatic and unconscious process, surprisingly similar to the one described by Gaddini (1969) concerning imitation. Imitation is a
phenomenon that occurs in the primitive mind (which imitates the object in order ‘to be the object’), but also in the mind of many patients with identity problems. As Gallese himself puts it,

My hypothesis is that many aspects of our ability to relate to others, and the facility with which we can mirror ourselves on other people’s behaviour, recognizing the similarities between us and them, stem from the same faculty: empathy. (2001, p. 90)

In conclusion, Gallese’s hypothesis is that sensations and emotions can be empathized and therefore understood by another person, through a mirror mechanism analogous to the one that regulates the reading of actions. To support his case, Gallese cites Jarviletho. The latter underlines how emotions constitute one of the most primitive ways of gaining insight into the state of our organism. In turn this information, obtained through relating to others, enables us to reharmonize ourselves. Thus, a strong link between emotions and actions seems undeniable. Finally, Gallese quotes Damasio, who states that the experiencing of emotions depends on the activation of a nervous circuit of an ‘as if’ kind, that is a circuit based on imitation. According to Gallese, therefore, this kind of circuit can be activated both within a person and through the observation of other people. In conclusion, he puts forward the hypothesis that ‘a lot of what we attribute to the mental attitude of other people when witnessing their actions, is in reality the result of what is evoked in us by “resonance mechanisms”, triggered by these very actions’ (2001, p. 96).

In other words, the ability to identify the intentions behind other people’s behaviours depends on the intersubjective bond that one is able to establish with them. Therefore, enactment could be considered as the consequence of the activation of imitative mechanisms functioning normally within us. These mechanisms do not necessarily become actions—in fact, because of our resistance mechanisms which protect ourselves from such imitation, they hardly ever are translated into actions. However, if against our conscious will, we happen to perform an enactment, it is because some sensory–empathic mechanisms activated by the patient, potentially disturbing for the analyst, have taken the upper hand and defeated the latter’s defences.

It is worth concluding with a quote from the ‘History of an infantile neurosis’: ‘The attention of children, as I have often noticed, is attracted far more readily by movements than by forms at rest; and they frequently base associations upon a similarity of movement which is overlooked or neglected by adults’ (Freud, 1914, p. 90).

Verbal acoustic image and motor image

In line with the above, it can be inferred that sensory empathy is based on the sharing, by two closely relating persons, of the same verbal acoustic image. Along with acoustic images, we also need to consider motor images, such as a slight gesture, a particular inflexion or tone of voice (so frequent, for instance, in the Hebrew language). Enactment might well be the expression of a shared motor image.

In the first canto of the Orlando Furioso, Ariosto (1998) describes a scene in which Angelica, hidden in a bush, sleeps and sighs, or rather dreams of sighing. Then, with a sigh, she wakes up. In reality, it is someone near by (Sacripante) who is sighing. There
are, therefore, two persons, next to each other, but unaware of each other. Angelica, wrapped up in her own intimacy, does not suspect a thing. She has withdrawn from reality, and while reason is asleep, her inner theatre, populated by phantasies and dreams, is lit up. She weaves a plot made of desires, anxieties and the protective strategies of sleep. Analysts call this ‘dreamwork’. The other person, Sacripante, a knight, is day-dreaming, murmuring senseless sentences (the young virgin … the rose … etc.) and his internal turmoil causes him to sigh. Angelica, asleep, is dreaming of sighing; in other words, she takes into herself the other person’s sigh. She is reproducing it as if it was her own in order to avoid (without success) being woken.

Then everything appears to happen in a moment. With just a sigh, the plot of a dream takes shape. The dream, probably, reflects what Ariosto tells us about the sexual longings of this menacing-looking knight lying next to Angelica. Thus, we have an explanation of why Angelica has woken up. She has come into contact with Sacripante’s fears and desires, which complement her own and threaten her virginity.

We can see how this scene represents the matrix of inner language in action: the process of implicit communication which goes back and forth in a couple, beyond the limits imposed by intersubjectivity and by the intrapsychic. One would say that in the scene described above, a motor acoustic image, conveyed by Sacripante’s sigh, has come into action. This menacing knight sighs his sexual desire and awakens Angelica by invading her intimacy, by touching, as it were, her erotic sensitivity.

Normally, words tend to convey not only a meaning, the content of a thought, but they also produce in the listener acoustic and motor images, experienced as sensations. We should consider too suggestive action (or message-supporting action) that usually accompanies a verbal statement and makes it more efficient than its written expression. *Vox significativa per se ipsa aliquid significans* [The voice expressing something is meaningful in itself] (Boezio).

On this point, one of us reports the words of a patient: ‘I firstly feel and then I can express with words what I am allowed to feel … Now I would like to sing [he is a singer] so that I will then be able to tell you something which is not yet clear to me … It is as if in that moment [singing] pulls the whole of myself together. This is the world I live in: firstly I feel and then I can express myself’.

Hautmann notes that along with the verbal formulation of an interpretation the analyst also conveys a small amount of ‘action’ (1974, pp. 187–8). This allows the analyst to maintain the contact with the patient, by actualizing the preconceptions and premonitions of the latter in a sort of creative framework. This is to say, the analyst’s words, the tone, pitch and rhythm of voice satisfy to a certain extent the patient’s primitive desires emerging in the situation of the analytic setting. A sensory contact is thus obtained: this is what primitive communication, or the first form of emotional bond, consists of. All this happens with a temporary interruption of symbolic language.

As in oral storytelling, the investment in sensory elements gives to the imagination the character of reality. As if by magic, a child who is listening to a story can ‘see’ the scene. There is something in between sensation and representation that has strong visual connotations (the French call it *la figuration*). It is as if emotions were
in search of a form and that it was offered by the possibility of visualizing through identification. Thus, while listening to the story, the child will identify with the characters in action: he will emulate them by actually tensing his muscles. He will go beyond the story with his own fantasies, will display anxiety and ask questions. It is the memory of such sensations that allows the introduction in the analytic relationship of a magical element (sensory magic). They reproduce, to a certain extent, that primary sensory contact of the infant at the breast. These kinds of sensations can be experienced by particularly sensitive people, for example artists. They bring about reactions analogous to the ones described in *The pied piper of Hamelin*. The rats had experienced the notes of the pied piper in a magic register; the result was the evocations of acoustic hallucinations concerning oral gratification: the noise of pickle tub-boards moving away, hoops of butter casks breaking … When the pied piper talks, the world is transformed into a vast grocery store:

At the first shrill notes of the pipe,  
I heard a sound as of scraping tripe,  
And putting apples, wondrous ripe,  
Into a cider-press’s gripe:  
And a moving away of pickle-tub-boards,  
And a leaving ajar of conserve cupboards,  
And a drawing the corks of train-oil-flasks,  
And a breaking the hoops of butter-casks;  
And it seemed as if a voice  
(Sweeter far than by harp or by psaltery  
Is breathed) called out, ‘Oh rats, rejoice!  
The world is grown to one vast drysaltery!  
So munch on, crunch on, take your nuncheon,  
Breakfast, supper, dinner, luncheon!’  
And just as a bulky sugar-puncheon,  
All ready staved, like a great sun shone  
Glorious scarce an inch before me,  
Just as methought it said, ‘Come, bore me!’  
—I found the Weser rolling o’er me.  
(Browning, 2001)

**One clinical evaluation**

Ultimately, all these observations on sensory empathy and enactment need to be validated by clinical experience. One direct clinical contribution comes from Friedmann and Natterson, who in work based on clinical experience, stress the value of enactment:

Enactments are interactions of analysand and analyst with communicative and resistive meanings that lead to valuable insight and can constitute corrective emotional experiences. Enactments that are recognized and defined become valuable dramatizing moments that have condensing, clarifying, and intensifying effects upon consciousness. (1999, p. 220)

In fact, the authors consider that they can show with clinical examples that ‘the term enactment enables us to understand the value of dramatization in analysis’ (p. 242).

Finally, ‘Enactments occur multiply and continuously … Thought and action are
intimately intertwined’ (p. 241). In summary, the authors state that, in the context of intersubjectivity, enactment is the intersubjective process in action.

To conclude, we would say that enactment and sensory empathy are some of the phenomena which characterize that very wide field of human interactions that we can call the primary sensory. This, intertwined in various patterns with the evolution of affects, remains the fundamental characteristic of each individual.

Translations of summary


Empatía sensorial y enactment. Los autores proponen el concepto de empatía sensorial, que se desarrolla mediante el contacto entre analista y paciente en la medida que estos se aproximan a un área relacionada con el vínculo primario. Esta área no está basada tanto en pensamientos y fantasías como en sensaciones físicas. La empatía sensorial tiene que ver con lo que Freud señalaba como el instrumento que todo ser humano posee en su inconsciente, y que le permite interpretar la manera en que se expresa el inconsciente de otras personas. Los autores vinculan este concepto con el de enactment precisamente porque este último está relacionado con elementos inconscientes precoces, que encuentran en el acto una primera modalidad expresiva y que implica tanto al analista como al paciente. En otras palabras, los autores desean destacar hasta que punto sea importante para el tratamiento analítico mantener el contacto con el inmenso campo de la interacción humana que puede ser definida como área sensorial primaria y que se entrelaza con la evolución de los afectos. Se presentan algunas viñetas clínicas para aclarar estas hipótesis.

Empathie sensorielle et mise en acte. Les auteurs proposent le concept d’empathie sensorielle, phénomène qui émerge dans le contact entre analyste et patient, au fur et à mesure qu’ils touchent à une aire concernant le lien primaire. Cette aire n’est pas tellement basée sur les pensées et les fantasmes, mais sur des sensations physiques. L’empathie sensorielle est en rapport avec cet instrument décrit par Freud comme appartenant à l’inconscient de tout humain, et qui permet à une personne d’interpréter les communications inconscientes d’autres personnes. Les auteurs relient ce concept à celui de la mise en acte (enactment) précisément parce que ce dernier concerne l’inconscient, des éléments précoces qui trouvent dans l’acte une première expression porteuse de sens. Le concept implique aussi bien l’analyste que le patient. En d’autres mots, les auteurs souhaitent mettre l’accent sur l’importance d’un processus analytique restant en contact avec l’immense champ de l’interaction humaine, qui pourrait être définie comme une aire sensorielle primaire qui s’intrique avec l’évolution des affects.

Empatia sensoriale ed enactment. Gli autori propongono il concetto di empatia sensoriale, che si sviluppa attraverso il contatto analista-paziente quanto più questo si avvicina a quell’area che riguarda il legame primario, e si nutre più di sensazioni corporee che di pensieri e fantasie. Essa ha a che fare con quello che Freud indicava come lo strumento che ogni uomo possiede nel suo inconscio che gli permette di interpretare il modo in cui si esprime l’inconscio altrui. Collegano tale concetto di empatia con quello di enactment proprio perché quest’ultimo riguarda elementi inconsci precoci che trovano nell’atto una prima modalità espressiva e coinvolgono sia analista che paziente. In altri termini vogliono sottolineare quanto sia importante, ai fini dello svolgimento analitico, saper cogliere l’importanza di quel campo così vasto delle interazioni umane che si può definire sensorialità primaria, embricata in vari modi con l’evoluzione degli affetti. Vignette cliniche vengono presentate per chiarire tali ipotesi.
References


Freud S (1914). From the history of an infantile neurosis. SE 17, p. 7–123.


