AUSTRALIAN CHILDHOOD FOUNDATION CONFERENCE TRUST, LOVE, AND BETRAYAL

MELBOURNE, AUSTRALIA
JULY 31, 2018

THE GROWTH-PROMOTING ROLE OF MUTUAL REGRESSIONS IN DEEP PSYCHOTHERAPY

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- Schore (The right brain is dominant in psychotherapy, *Psychotherapy*, 2014): **Paradigm shift** now occurring across a number of disciplines, from **left brain conscious cognition to right brain unconscious affect** (earlier plenary address to APA)
- McGilchrist (2009): "If what one means by consciousness is the part of the mind that brings the world into focus, makes it explicit, allows it to be formulated in language, and is aware of its own awareness, it is reasonable to link the **conscious mind** to activity almost all of which lies ultimately in the **left hemisphere**."

- In more recent work (2015) he concludes, "The **right hemisphere** both **grounds our experience** of the world at the **bottom end**, so to speak, and **makes sense of it, at the top end**," that this hemisphere is more in touch with both **affect and the body**, and that "neurological evidence supports what is called the primacy of affect and the **primacy of unconscious over conscious will**."
- Over last 3 decades I have offered clinical and research evidence indicating **right brain is the psycholobiological substrate of the human UCS, locus of the subjective self**.

- Schore (1994-2018): right hemispheric affective processes operating at levels **beneath conscious awareness** are dominant in development, psychopathogenesis, and psychotherapy.
- **Gainotti (2012): unconscious processing of emotional information** is mainly subsumed by a right hemisphere subcortical route;
- Gainotti (2006): **unconscious emotional memories** are stored in the right hemisphere.
- Schore (2003): RH stores implicit-procedural **autobiographical memory of early attachment trauma**.

- In 2012 I cited Krystal (2002) on "**traumatic memories:**" "It is not just because the past involved enforced passivity, submission, and surrender, but because **the emotional regression to certain infantile forms of relatedness causes an evocation of the infantile and childhood trauma** encapsulated within their memories of the major trauma."
- Raises clinical problem of regression, shift from dominance of later developing left CS mind to early developing right UCS mind, especially in context of psychotherapy. **Emotional regression = transient dominance of implicit functions of right brain.**

- **Schore (2012) chapter, "Therapeutic enactments: Working in right brain windows of affect tolerance:"** Krystal's "emotional regression" and "evocation" of infantile and childhood trauma occur not within a spoken objective verbal narrative between patient and therapist but within an intersubjective nonverbal bodily-based communication of intense negatively charged affect and sudden rupture of therapeutic alliance.
- That is, a **traumatic emotional regression occurs within a dysregulating (re) enactment of early attachment "relational" trauma**.

- Yet in **another chapter** (2012) I suggested the **therapist's interpersonal creativity within the regression of a regulated enactment can promote a corrective emotional experience**. Cited classical psychoanalytic work of Reik and Kris on an adaptive "**regression in the service of the ego**." Note that regression can be maladaptive or adaptive.
- Tuttman (2002): "The word '**regression**' is defined in the Oxford English Dictionary as **the act of going back; a return to the place of origin.** The process of returning or a tendency to return to an **earlier stage of development.**

- Tuttman asserts, "One implication of this definition concerns the **undoing of progress**, sometimes reflecting a possible deterioration. Yet there is a second possibility: **the return to fundamentals and origins that might facilitate a potential reorganization leading to better integration**.
- It seems paradoxical that we are dealing with a process often considered to be a central factor in the most serious psychopathology, and yet many acknowledge **regression to be a most potent therapeutic possibility**."

- Regression = process of returning or a tendency to return to an **earlier stage of development.**
- Regression as re-emergence of psychic activity of earlier development period (primary process thinking).
- Regression in moments of treatment to re-emergence of bodily-based **attachment dynamics**.
- Regression in therapeutic moments into re-emergence of affective **transference-countertransference dynamics** rooted in earlier stages of development.
- Regression from "higher" to "lower" levels represents a "taking off of the higher" and "at the very same time a letting go, or expression of the lower."

- **Functional regressions** reflect neurobiological structural regressions **between/within hemispheres**.
- Regression from **LH** conscious analytical mind to **RH** unconscious intuitive mind and bodily-based emotions.
- Regression from later maturing **LH** secondary process to early **RH** nonverbal primary process cognition.
- Regression from a **left brain mild/moderate emotion** (anxiety, pleasure, anger) to a **right brain strong emotion** (terror, elation, intense love, grief, rage).
- Regression from later forming **left brain-to-left brain** CS verbal communication vs early forming **right brain-to-right** brain UCS nonverbal communication**.**

- Schore (1994-2018): relational construct of right brain-to-right brain communication lies at the core of my therapeutic models of how a **shift from analytical left to intuitive right brain allows listening to the unconscious "beneath the words."**
- Schore (2003): How do we become perceptually receptive to what is outside CS awareness? "The therapist by means of reverie and **intuition**, listens with the right brain directly to the patient's right brain."
- Carl Rogers (1957): therapeutic change occurs when therapist and patient are in a special condition of **receptivity** to each other, outside of CS awareness, when both are in "psychological contact."

- "[T]he two people are to some degree in contact, that each makes some perceived difference in the experiential field of the other. Probably **it is sufficient if each makes some 'subceived' difference, even though the individual may not be consciously aware of this impact**…but it is almost certain that at some organic level he does sense this difference."
- In this **subconscious implicit open-receptive state** empathic therapist accesses a state of right brain wide-ranging "free floating attention." Therapist can now receive and send **emotional communications between patient's and therapist's synchronized right brains**.

- Hammer (***Reaching the Affect***, 1990):
- “My mental posture, like my physical posture, is not one of leaning forward to catch the clues, but of **leaning bac**k to let the mood, the atmosphere, come to me - to hear the **meaning between the lines**, to listen for the **music behind the words**. As one **gives oneself to being carried along** by the affective cadence of the patient's session, one may sense its tone and subtleties. By being more **open** in this manner, to resonating to the patient, I find pictures forming in **my creative zones**; an image crystallizes, reflecting the patient's experience.”

- “I have had the sense, at such times, that at the **moments** when I would pick up some **image** of the patient's experience, he was particularly ripe for receiving my perceptions, just as I was for receiving his. An empathic channel appeared to be established which carried his state or emotion my way via a kind of affective "wireless. **This channel, in turn, carried my image back to him**, as he stood **open** in a **special** kind of **receptivity**.” [both “openness to experience”]
- Meares (2012): refers to “a form of **therapeutic conversation** that can be conceived…as a dynamic interplay between **two right hemispheres**.”

- Right brain-to-right brain “state-sharing” represents a regression of both from LH CS mind to RH UCS mind. To access right brain clinician instantiates left-right hemispheric shifts that allow entering state of **“regressive openness and receptivity.”**
- In right brain state of evenly suspended attention empathic therapist can subjectively attend “**beneath the words**” to “barely perceptible cues that signal a change in state” in both patient and herself, and to intersubjectively detect patient’s “nonverbal behaviors and shifts in affects” including patient’s **preconscious affects just beneath conscious awareness**.

- **Clinical Applications of Neuropsychoanalysis: Therapeutic Synchronized Mutual Regressions**
- Kris (1952): emphasizes importance of moments in the treatment **“when the barriers separating unconscious from preconscious or conscious processes have been loosened…”**
- This occurs during a creative “**regression in the service of the ego**.”
- Arnold (2007) “**Reik** (1948) reformulated the analytic encounter as a **dialogue between** the Unconscious of the analyst and that of the patient.”

- “**Listening with the Third Ear** posits an unconscious process by which the [therapist] detects and deciphers clues to the patient’s unconscious dynamics: the so called ‘third ear’…This material is of a nonverbal, melodic character that expresses the **affective nuances of Unconscious mentation**.”
- “Reik has in mind the **primary process**, which he views as a level of mentation in which “**sounds, fleeting images, organic sensations, and emotional currents.”**

- “While secondary processes are abstract and logic-analytical, **primary process** cognition refers to states such as **dreaming or reverie**, but **also to abnormal states** observed in individuals suffering from mental disorders.” [Early **relational attachment trauma** imprinted in right brain UCS primary process]
- “If the [therapist] **surrenders to the regression required to access an uncanny insight**, a conscious **intuition** into the patient’s dynamics emerges. If insight originates in the UCS, then the only way to reach it is through some degree of **regression to the primary process**.”

- “Creative individuals are believed to be more capable of **shifting between secondary and primary** modes of thinking, or to ‘**regress**’ to primary process cognition which is necessary for producing novel, original ideas.”
- Reik (1956): “As rational consciousness gives way to the primary process, it may feel as if ‘the ground’ is threatening ‘to slip away.’”
- “It is critical that **transient regressions** be **tolerated**, as a rigidly **rational consciousness will stifle nonrational hunches**…you have to mistrust sweet reason and to **abandon yourself** to the promptings and suggestions emerging from the unconscious.’”

- **Regression** of **secondary** to **primary** process: Oxford, regression. “The process of returning or a tendency to return to an earlier stage of development.”
- Freud (*Interpretation of Dreams*, 1900): primary process functions, that are highly visual, tactile, auditory, develop in early stage before **secondary** processes, which “only take shape gradually during the course of life, **inhibiting and overlaying the primary** [processes].”
- Schore (1994): cites research showing **primary** process associated with functions of early developing **RH**, **secondary** process with later developing **LH**.

- Knafo (2002) cites Kris’ contrast between “an **ego overwhelmed by regression**” and a “**regression in the service of the ego**.” The latter form, according to Kris, is only a special case of the more general capacity of a well-integrated ego to **regulate** and control some of the primary processes.”
- Knafo: “There exists a difference between pathological and healthy, or adaptive, regression…If the move backward can open doors, why should it be viewed in pejorative terms? Yes, it is **risky**; but **new and original ideas are not born without risk**.”
- [Safe, but not too safe]

- Currently paradigm shift in construct of regression, just as with related concepts of trauma and clinical re-enactments. Over most of last century classical psychoanalytic position viewed it in perjorative terms, "pathological," "malignant" regression."
- **Balint** (*The Basic Fault*, 1968): Freud argued "**regression** during analytic treatment was considered a **dangerous** symptom and its value as a therapeutically completely, or almost completely repressed…it was a mechanism of defence difficult to tackle, it was an important factor in **pathogenesis**, and it was a formidable form of **resistance**…"

- In addition to studying the dangers of malignant regressions that "overwhelm the ego" **Balint** (1968) also emphasized **value of benign regressions**, suggesting these are beneficial when clinician provides an accepting atmosphere in which patient feels **safe enough to regress** "for the sake of recognition" and "understanding and shared experiencing." Describes the "**benign" form of regression as a "new beginning**."
- Sandor **Ferenczi**, first of Freud's disciples to formulate therapeutic principles of treatment of **trauma**, described importance of **mutual regressions**.

- Ferenczi: "It appears that patients cannot believe that a [traumatic] event really took place, or cannot fully believe it, if the [**clinician**], as the sole witness of the events, persists in his **cool, unemotional**, and as patients are fond of stating, **purely intellectual attitude**, while the events are of a kind that must evoke, in anyone present, emotions of revulsion, anxiety, terror, vengeance, grief, and the urge to render immediate help. . ."

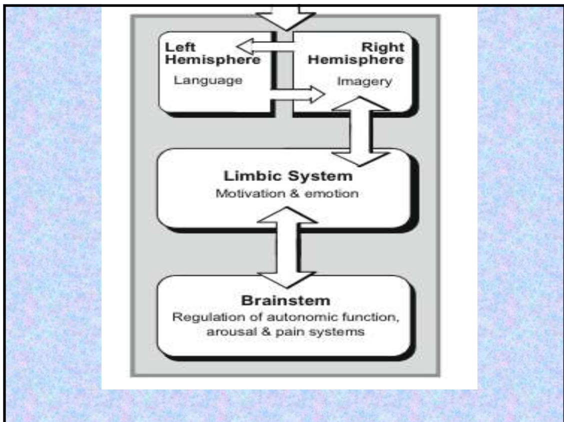
- “One therefore has a choice: to take really seriously the role one assumes, of the benevolent and helpful, that is, **actually to transport oneself with the patient into that period of the past** (a practice Freud reproached me for, as being not permissible), with the result that we ourselves and the patient believe in its reality, which has not momentarily transposed into the past.”
- “An abreaction of quantities of trauma is not enough; the situation must be different from the actually traumatic one in order to make possible a **different, favorable outcome**.”

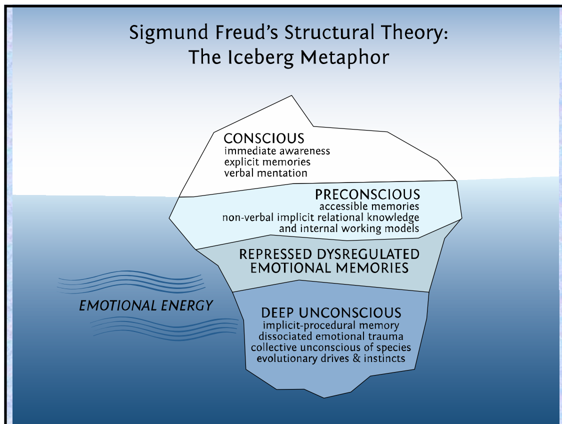
- **Tuttman** (2002): “**the skillful acceptance of regression to the traumatic developmental phases where something needed for growth was missing**, **and then facilitating understanding and growth from that point forward**, via an analytical relationship that has transitional, mirroring, nonautocratic, and synthetic qualities along with **play** and experimentation, are necessary steps in such treatment if healthy individuation is to occur.”

- This clinical conception is consonant with regulation theory’s formulation that both “**malignant**” and “**benign**” forms of regression reflect a return to respectively **dysregulated** versus **regulated** emotional events of an earlier stage of development.
- In updated clinical models **mutual reenactments** represent ‘traumatic repetitions” as well as “new beginnings” (and thereby a context for the expression of the right brain creative processing of novelty and a corrective emotional experience).
- Schore (**Right Brain Psychotherapy**, in press): reenactments occur within **mutual regressions.**

- **Clinical Topographic and Structural Regressions**
- Freud incorporated neurologist John Hughlings Jackson’s hierarchical concept of higher levels inhibiting lower levels of function into both his **topographic** model (1900) of stratified conscious, preconscious, and unconscious systems, and his **structural** model (1923) of a superego and ego which sit astride the id. These models describe two different mechanisms of regression.
- Clinical term of functional psychological regression derived from neurology’s concept of biological regressions within brain.

- In a further reformulation of Freud’s concept of regression I propose **two types of neurobiological regressions**:
- an **interhemispheric topographical** form (a horizontal state switch from conscious left prefrontal cortical to preconscious right prefrontal cortical system), and
- an **intrahemispheric structural** regression (a vertical hierarchical state switch from higher to lower right brain, downward cortical to subcortical, from preconscious to deeper unconscious levels right brain (see Figure horizontal and vertical arrows).

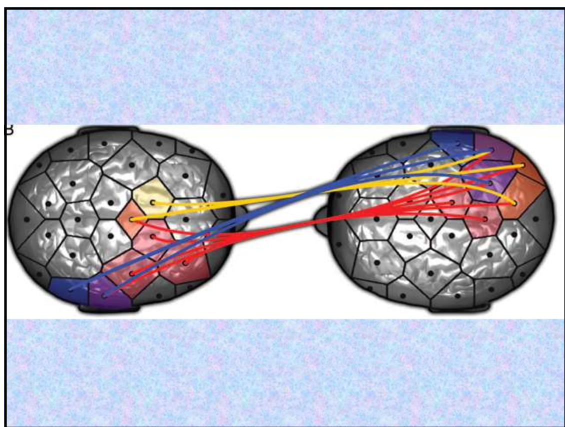




- **Topographical** regression thus represents an intrapsychic shift from later developing CS "left mind" to earlier developing UCS "right mind." **Structural** regression represents a shift from "higher right" to "lower right" levels of emotion processing UCS mind.
- With respect to "horizontal" topographic regressions, **Kane** (2004) states shift in hemispheric dominance in a creative moment involves a **callosal disinhibition**, "**a sudden and transient loss or decrease of normal interhemispheric communication, removing inhibitions placed upon the right hemisphere**."

- This hemispheric shift is described by clinicians.
- Heinz Kohut (1971): "The deeper layers of the analyst's psyche are **open** to the stimuli which emanate from the patient's communications while the intellectual activities of the higher levels of cognition are temporarily largely but selectively **suspended**."
- Carl Rogers (1986): "As a therapist, I find that when I am closest to my inner, **intuitive self**, when I am somehow **in touch with the unknown in me**, when perhaps I am in a **slightly altered state of consciousness** in the relationship, then whatever I do seems full of meaning."

- But even more so, this shift into the right allows empathic, intuitive therapist to **synchronize her structural regressions with the patient's**, and thus form a system of **mutual** topographical regression and right brain-to-right brain state-sharing.
- As a result of **right lateralized interbrain synchronization** (Dumas, 2011) during **heightened affective moments** both can **co-create a right brain-to-right brain system of spontaneous nonverbal communication** that can send and receive **UCS nonverbal emotional communications** (implicit face, voice, gesture) from one subjective self to another ("intersubjectivity," "making sense of another mind").



- Bromberg (2011): "Allan Schore writes about a right brain-to-right brain channel of affective communication…as 'an organized dialogue' comprised of '**dynamically fluctuating moment-to-moment state sharing**.' I believe it to be this process of state sharing that allows 'a good psychoanalytic match.'"
- Bromberg (2017): "The interface between my own thinking and his, when linked to the centrality we each place on the mind–brain–body interface, provides the core context that I believe will allow psychoanalysis as psychotherapy to become **most genuinely therapeutic**."

- **Mutual topographical regressions**, although unconscious, are ubiquitous in all but especially relational, affectively-focused psychotherapies. In synchronized left-right shifts, **each switches out of the conscious verbal left mind into** nonverbal affects and images of the **preconscious mind**.
- These events, outside conscious awareness, allow therapist's right mind to affectively empathize, synchronize, and intersubjectively resonate with the dysregulated or regulated subjective states of the patient's right mind.

- This is in **contrast to cognitive empathy**, an intellectual understanding of the patient's state, which represents a synchronization of the therapist's and patient's analytic left minds. In this type of work both are staying up in the rational left (mentalization), with no regression down into the intuitive right.
- **Structural regressions**, on the other hand, induce a **vertical shift** from the **higher preconscious to deeper unconscious levels of the right brain**. This intrapsychic regression can be regulated or dysregulated, adaptive or pathological.

- But when empathically resonating therapist remains psychobiologically connected to the patient and implicitly synchronizes with her dysregulating state **synchronized mutual structural regressions** facilitate co-creation of a deep UCS communication system that can detect and interactively **regulate** strong **UCS dissociated** (and **repressed)** affects.
- Neuroscience documents "right hemispheric dominance in processing of **unconscious negative emotion**" (Sato & Aoki, 2006) and "cortical response to **subjectively unconscious danger**" (Carretie, 2005).

- These interpersonal synchronized mutual regressions of UCS dissociated affects are activated in therapeutic re-enactments of attachment trauma.
- In line with current relational two-person model of psychotherapeutic change, this updated model of Freud's concept of regression reconceptualizes the phenomenon from a solely intrapsychic structural regression to an interpersonal **mutual regression** whereby both members of the therapeutic dyad experience a **synchronized interactively regulated regression**, thereby potentially transmuting a **pathological regression** into **adaptive regression**.

- **Dissanayake (2001):** "our original analogical, nonverbal, intersubjective mind **persists** after infancy, but it is usually consciously **overridden** by 'cognition' and language (which are necessarily coupled to the real world) so that we are generally unaware of it."
- **Regressions alter LH overriding of RH UCS mind. Allow us to enter into our own and our patient's intersubjective mind. Rapid right lateralized interbrain synchronization facilitates** spontaneous communications between **relational unconscious** of one individual and relational unconscious of another.
- Relational unconscious synchronizes, resonates with and is **expanded** by another relational unconscious.

- **Regression**, "the act of going back; a return to the place of origin" needs to be **re-integrated into the clinical literature**, not solely an intrapersonal solitary regression but also as an interpersonal mutual regression.
- Over time synchronized shifts in hemispheric dominance of patient and therapist from later maturing left hemispheric into early developing right hemispheric "origin of the self" allow for a **return to fundamentals and origins that can facilitate a potential reorganization** leading to better integration and therefore a **creative "new beginning**."

- **Clinical Applications of Mutual Regressions: Working with Dissociated Affect in Spontaneous Re-enactments of Early Attachment Trauma**
- Recall Kris's healthy regression in the service of the ego and Balint's **benign regression** describe output of an adaptive regulated right brain system.
- However, patient who experiences **pathological regression and traumatic re-enactments** in response to even mild to moderate relational stressors seeks therapy because of frequent painful states of affect dysregulation, a failure of integration of mental life, and chronic interpersonal difficulties.

- Bromberg (2011): "Therapeutic joint processing of **enactments**…allows [therapists] to use their expertise with a wide spectrum of **personality disorders** often considered 'difficult' or 'unanalyzable,' such as individuals diagnosed as **borderline, schizoid, narcissistic, and dissociative**."
- As a result of chronic relational trauma in infancy and toddlerhood these **early forming severe personality disorders do not attain** an **efficient right brain** system of emotional communication or implicit affect regulation.

- Also **fail to develop a "reflective self"** that can take into account one's own and others' mental states, as well as **affective empathy**, achievements that are essential steps in emotional development.
- Thus such personalities (e.g. BPD) don't developmentally **attain** a psychic organization which can generate complex **symbolic representations of self and other**.
- **Until recently**, due to the "primitive" organization of their regulatory structures these patients were seen to be unable to use cognitive insight, and were therefore **refractory to "the talking cure."**

- Also characterized as “**difficult patients**” due to the not infrequent expressions of pathological regressions within the therapy. These spontaneous therapeutic regressions were seen as “malignant” endogenous expressions of pathology. Until recently there was no model of early **“relational trauma” (Schore, 2001).**
- Schore (1994-2018): **etiology and developmental traumatology of pathological regressions** associated with early relational trauma: early growth-inhibiting social-emotional environment that induced severe arousal dysregulations and little interactive repair of frequent traumatic attachment ruptures.

- Psychotherapeutic **reenactments** of chronic attachment trauma in emotional regressions are expressions of **insecure (especially disorganized) working models** of attachment that encode UCS negatively valenced images of a dysregulated self as well as defenses against intense painful affect.
- These are **stored in patient’s right brain autobiographical implicit / procedural memory** that encodes strategies of affect regulation, including bottom-line defense against consciously re-experiencing early relational trauma, dissociation (Schore, 2003).

- These fragile personalities use **affect deadening defense of dissociation that defends against pathological regression of affect regulation.** Avoidance of relational threat at an UCS level, and implicit deficit in processing interpersonal novelty.
- These patients characterologically automatically trigger intense right brain stress responses at low thresholds of relational stress, frequently experience enduring states of high intensity negative affect for long times, and defensively dissociate to threat or novelty at lower levels of arousal, thereby **interfering** with access to emotionally **learning something new**.

- This brittle defensive structure too frequently **fragments under stress**, leading to a re-experiencing of the affective and interpersonal deficits of a **pathological regression**. This chronic dysregulating interpersonal neurobiological mechanism underlies what used to be called a traumatic **"repetition compulsion."** The resulting disorganization in turn increases the individual's **affective symptomatology**, which **brings the patient into psychotherapy**.
- Within the psychotherapy **both pathological and adaptive regressions may occur within regulated clinical re-enactments of attachment trauma**.

- The **psychotherapy** of early relational attachment trauma takes **two forms**, **short-term**, **symptom reduction /remission** and **long-term**, **growth-promoting** treatment of **deep psychotherapy**.
- Latter is uniquely suited to altering right brain cortical-subcortical dynamics that drive affect dysregulation and interpersonal deficits of pathological regression and directly reduce the dissociative defense.
- In the following I discuss the latter, although the basic clinical principles I outline here refer to both forms of trauma treatment (see Chapter 5 in Schore 2012).

- In this work **clinical focus** is not on an explicit reconstruction of infantile attachment traumatic context but on the **effects of early relational trauma on "character structure"** and deficits in adaptive right brain functions.
- Bromberg (2017) points out that in treatment "accessing early trauma is, at heart, **personally relational**: It does not free patients from what was **done** to them in the past, but from what they have had to do to themselves and to others in order to **live** with what was done to them in the past."

- **Meares** (2017) in developmental histories of various personality disorders **"the 'self'… has been damaged, distorted, and stunted by trauma**. In the case of relational trauma, at least, it must be the primary concern of the therapist. Such trauma is not approached by strategies, techniques, interpretations, and so forth, dictated by the agenda of a particular theory. Rather, it is through the establishment of a **specific kind of relationship**, which is not artificially imposed or manipulated but is allowed to emerge in **conversational interplay**."
- Meares (2012): **therapeutic conversation** between **two right hemispheres**.

- In the **early stages of treatment**, patient begins to share with empathic therapist the most emotionally salient experiences in the outside social world, including her subjective dysregulated emotional reactions to these experiences.
- In ongoing spontaneous psychobiological right brain-to-right brain nonverbal emotional communications, beneath the words, the **therapeutic dyad via right lateralized interpersonal interbrain synchronization establishes the development of the burgeoning therapeutic alliance, the major relational vector of psychotherapeutic change**.

- In a uniquely well-timed and sufficiently structured early stage of treatment, the patient and therapist begin to establish an implicit sense of **mutual familiarity**, to build the positive aspects of the working alliance, to begin to share mild to moderate affects, and to co-construct a system of **interactive regulation**, **core of the attachment dynamic**, thereby increasing possibility of therapeutic change.
- Important to note that this stage may take more time than in patients who begin treatment with more complex psychic structure and more efficient right brains (secures and organized insecure attachments).

- Over time due to developing co-created right brain-to-right brain affect communicating and regulating therapeutic alliance, the **patient's safety and trust**, **at implicit levels, begins to increase,** and this evolving therapeutic mechanism can **transiently, momentarily reduce** and alter the affect-blocking defense of **right brain dissociation**.
- Thus dyad can now shift into bringing **more intense negative affect in affectively tolerable doses** and traumatic experiences into the consulting room, including those that are intersubjectively experienced between them.

- In this work creative therapist's "deep listening" allows for an empathic grasp of experiential state of the patient. As a result the patient establishes an "**archaic bond**" with the therapist and thereby facilitates the revival of the early phases at which his psychological development has been arrested.
- The emerging emotional bond between patient and therapist promotes exploration of individual's internal experience and affective states. This strongly felt bond enables patient to **confront dissociated inner states associated with frightening or shamed aspects of the self**.

- Lessening of patient's **dissociative defenses** against affect allows for attachment trauma to be more easily activated and communicated in a mutual enactment, including "**unconsciously strong or even overwhelming, affect**" and states of "**subjectively unconscious danger**" embedded in the patient's right brain traumatic memory.
- **Defense of dissociation occurs not in just the patient, but also in the clinician**, where it determines the therapist's ability to receive (or block) the patient's unconscious intensely **painful** emotional communications associated with attachment trauma.

- Spontaneous regressions in re-enactments of dissociated attachment trauma represent **emergent property** of developing therapeutic **relationship**
- Maroda (2010): "To fit the definition of enactment, both therapist and client need to be **unaware** of what they are stimulating in each other **until some untoward event occurs**."
- This untoward event is frequently a **stressful breach in transference-countertransference relationship and rupture of therapeutic alliance, and thereby a mutual emotional regression**.

- Sands (1997) observes, "the **most empathic breaks** (when not the result of some blatant mistake on the part of the [therapist] and even sometimes when they are) also signal the reexperiencing of the transference of some important earlier traumatic failure. In this sense, **the empathic break, rather than signaling something is broken" may actually signal that the therapeutic relationship has reached a new level of safety, one that finally allows for the traumatic transference to be fully experienced.**

- Dyadic enactments thus occur in context of a moment of a synchronized **mutual regression** of both patient and therapist into a state of dysregulating emotional arousal. **Both are re-enacting a traumatic pathological object relation**, an internal interactive representation of a **dysregulated-self-in-interaction-with-a-misattuning-object**.
- This transferential traumatic **expectation** retriggers an implicit fear that **an emotionally close other will imminently trigger a stressful dysregulated intrapsychic pathological regression in patient**.

- In classic developmental psychoanalytic writings on regression, **Winnicott** (1970) discussed working with the patient's "**fear of a breakdown**," **one that has already happened in early development**.
- Recall Krystal (2002) describes affectively charged overwhelming early memornature of these ies: "It is not just because the past involved enforced passivity, submission, and surrender, but because the **emotional regression to certain infantile forms of relatedness** causes an evocation of the infantile and childhood trauma encapsulated within their memories of the major trauma."

- In the trauma literature Nijenhuis et al. (1998) observe,
- "The stress responses exhibited by infants are the product of an immature brain processing threat stimuli and producing appropriate responses, while the adult who exhibits infantile responses has a mature brain that…is capable of exhibiting adult response patterns.
- However, there is evidence that the adult brain may **regress** to an infantile state when it is confronted with severe stress."

- According to Loewald (1960) movement in treatment occurs by "the promotion and utilization of regression," but **the clinician must validate "the patient's regressive experience so that the patient is not left alone with it**." The therapist, also in the right brain, aligns herself with the patient's right brain, via an interbrain synchronization.
- But **what if the clinician does not shift "down right"** with the dysregulating patient and defensively remains "up left," that is uses more cognitive than affective empathy and offers interpretations while the patient is re-experiencing intense affect dysregulation?

- **Levine** (2010): "when therapists perceive that they must protect themselves from their clients' sensations and emotion, they unconsciously block those clients from therapeutically experiencing them. By **distancing ourselves from their anguish**, we distance ourselves from them and from the fears they are struggling with.
- To take a self-protective stance is to abandon our clients precipitately. At the same time, we also greatly increases the likelihood of their exposure to secondary or vicarious traumatization and burnout."
- This technique also **iatrogenically reinforces patient's dissociative defense**.

- An **optimal therapeutic outcome** of a spontaneous co-created enactment of dissociated attachment trauma **depends upon the therapist's creative ability to shift** from the analytic left hemispheric surface mind into deeper levels of right hemisphere, which specializes in "**intense emotions**." (Ferenczi)
- Can clinician creatively initiate an adaptive regulated regression into her own right brain in order to synchronize with patient's chaotic dysregulated state in order to receive patient's primary process communications and to **regulate patient's intensely strong unconscious affect**? ("take the transference")

- Can the therapeutic pair with a shared communication history retain a right brain-to-right brain interpersonal interbrain synchronization? In other words in this heightened affective moment will the clinician implicitly retain a system of "state-sharing" and remain **psychobiologically connected to the patient**?
- Can her right brain remain intersubjectively connected to the patient's in order to pick up the patient's dysregulated implicit emotional communications, especially during **rupture and repair**?
- **Can they both "hold in the right"?**

- At most fundamental level implicit change mechanism must include a CS or UCS affective experience communicated to an empathic other.
- Ginot (2009) on enactment: "As these interactions might give expression to dissociated **painful, angry, and defensive self-states**, the empathic aspects in enactments do not depend on the [therapist's] ability to experience empathy for the patient's difficulties. **The empathic component is found in the [therapist's] readiness and ability to resonate with what is not verbalized but nonconsciously transmitted nonetheless**."

- Therapist's affect tolerance and implicit ability to not dissociate from patient's communication of overwhelming negative affect is key. In this "heightened affective moment" of an "emotional regression to certain infantile forms of relatedness" the creative **therapist is able to retain an empathic resonance and an interpersonal right brain synchronization with the patient's dysregulation**.
- Note in this moment the emotionally connected therapist remains down right, and is not defensively shifting up left into a resistance interpretation.

- **Dyadic source** of therapeutic **mutual regression of the enactment** was the **unconscious alignment of both the patient's and clinician's dissociative defenses** to keep **experience** of dysregulated strong negative emotions out of the therapeutic relationship.
- Resolution of enactment involves **both** reducing affect blocking defense, simultaneously exposing **shame and vulnerability**, both right brain phenomena.
- Guntrip (1969): "Only when the therapist finds the person behind the patient's defences, and perhaps the patient finds the person behind the therapist's defences, does true psychotherapy happen."

- In this critical moment of an adaptive regression within a spontaneous enactment the expression of what Sands (1998) calls the therapist's "very being" is a creative open disclosure of "**affective honesty**" which according to Bromberg (2011) "is rarely communicated through content or through language per se. It is primarily communicated through a relational bond that Schore and others including myself believe is mediated neurobiologically by right brain-to-right brain state sharing."

- Therapist's creative left brain to right brain shift into an "authentic" self-revelation is described by Lichtenberg (2001) as a "**disciplined spontaneous engagement**." "Spontaneous" refers to the therapist's unexpected comments, gestures, facial expressions, and actions that occur as a result of an "unsuppressed emotional upsurge" that in generates "an ambience of safety."
- "These communications seem more to **pop out** than to have been planned or edited. **The therapist may be as surprised as the patient**."
- Bromberg (2009) describes critical role of "**safe surprises**" in enactments.

- In negotiation of a spontaneous face-to-face enactment **therapist's creativity** is expressed in an **authentic** right brain-to-right brain **novel interpersonal communication** which is instantly perceived by patient's receptive right brain, thereby contributing to "**an ambience of safety**."
- Lindell (2013): **creativity and openness (like emotion) expressed on left face**, and so the patient implicitly reads authenticity in the clinician's left face. In turn, the patient's instant right brain state switch from implicit danger to implicit safety is also expressed on the patient's left face (right brain-to-right brain).

- Kantrowitz (1999) when the **patient and therapist** are able to overcome resistance to engagement, an "**intense affective engagement takes place**."
- "When patient and [therapist] are affectively engaged, when the patient has come to trust in the analyst's basic benevolence, and when in this context **the patient feels safe enough to lessen defenses,** the **modification of intrapsychic organization becomes possible."**
- This intense emotional engagement is accompanied by a mutual disengagement of both of their dissociative affect-inhibiting defenses.

- Whitehead (2006) underscores an essential therapeutic principle of the joint processing of unconscious affects in a mutual enactment:
- "Every time we make **therapeutic contact** with our patients we are engaging profound processes that tap into essential life forces in our selves and in those we work with. . . **Emotions are deepened in intensity and sustained in time when they are intersubjectively shared. This occurs at moments of deep contact."**
- [**relational amplification** of negative or positive affect]

- Intersubjective context of mutual regression of a creative spontaneous enactment provides **not only** a **self-revealing** right brain implicit affective **communication** but **also** a right brain **interactive regulation** of a dysregulated intense affective-arousal state, the core of the attachment dynamic.
- Thus, **what was previously a dissociated unconscious overwhelming painful affect that was unbearable is now consciously experienced by both**, and can be consciously shared, interactively regulated, and relationally **repaired, and thereby bearable**.

- Bromberg (2011) describes “a core dimension of using enactment therapeutically is to **increase competency in regulating affective states**. Increasing competency requires that the [therapeutic] relationship become a place that supports **risk and safety simultaneously** – a relationship that **allows the painful reliving of early trauma, without the reliving being just a blind repetition of the past**…the [therapist] is communicating both his ongoing concern for his patient’s affective safety and his commitment to the **value of the inevitably painful process of reliving**.”

- This clinical model mirrors my own work in regulation theory where I assert “a **spontaneous enactment** can either **blindly repeat** a pathological object relation through the therapist’s deflection of projected negative states and intensification of interactive dysregulation and defensiveness, **or creatively provide a novel relational experience** via the therapist’s autoregulation of projected negative states and co-participation in interactive repair” (Schore, 2012).
- Note the allusion to the clinician’s triggering of an **iatrogenic** dysregulating pathological regression or a regulated adaptive regression.

- A key **psychopathogenetic mechanism** of early relational trauma is not only frequency, duration, and magnitude of painful ruptures of developing attachment relationship, but **lack of relational repair** with the caregivers. Encoded in unconscious working model is an implicit expectation that the other will not regulate but dysregulate the emerging self.
- If a stressful mutually dysregulating **rupture** of therapeutic alliance is a primary driver of a regressive re-enactment, then mutual **repair** of right brain emotional bond between patient and therapist is a central mechanism of resolution of mutual enactment.

- The relational rupture and repair mechanism within a regulated mutual enactment can **bring affects and motivations into consciousness on both sides of the alliance**, so that they can be used to negotiate the **mutual repair** of a stressed relationship in **new and creative ways**.
- Thus the **resolution** of a mutual enactment is **not** an intrapersonal **intellectual insight but** an affectively-charged **intersubjective negotiation**. **Creative adaptive regressions** within spontaneous mutual enactments thus represent an optimal intersubjective context of implicit therapeutic change mechanisms.

- Here I describe a **case example** which demonstrates the clinical principles outlined above. Listen with your clinical mind, visualize the intersubjective interactions, and feel the bodily-based affect in the description.
- This is a clinical vignette from the internationally recognized Jungian psychoanalyst Donald Kalsched. The patient, a 6 feet two inch 220 pound man would continue to report instances of his road rage, despite their work. The patient suffered from traumatic humiliation, shame, and helplessness in his early life, so that any frustration would trigger tyrannical rage as a defense to cover up his unbearable vulnerabilities.

- Kalsched (2015) reports a session of a spontaneous mutual enactment and emotional regression that occurred at a crisis of the treatment of this difficult "primitively defended" patient:
- "Mike came in and confessed superciliously (and with a guilty grin on his face) to yet another incident of road rage in which he had really hurt another man half his size. He was completely activated again and I could find no regret – no guilt or remorse in him, only the pumped up hyperarousal of this addictive violence. Sensing my discomfort, he changed the subject to some 'urgent' issue about his wife.

- I sat seething, trying to listen with that old familiar feeling of **helpless rage**. The thought that he was a psychopath crossed my mind – that he was simply too damaged for psychotherapy, etc. Recovering my senses, I suggested that he was avoiding the most important thing we had to talk about and **asked him what he was feeling**. 'About what?' he said with irritation. **At that point something snapped in me and I lost my mind – at least my analytic mind**. Somewhere from a far-off place inside, I heard myself say to him (with apologies to those of you who may be offended by the language):

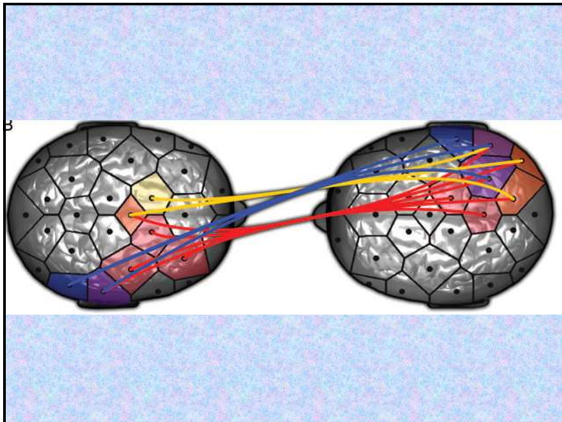
- Look, you are threatening everything you've created in your life – your profession, your family, your relationship with your wife, the boys, your relationship with me, and that new friendship with that little boy inside you – all for the temporary high of your little shit-fit rages. You think you're getting even or administering some kind of sick justice but the fact is you're simply indulging yourself like a two-year-old. You're just emotionally incontinent! That's your problem. You can't hold it! When are you fucking gonna learn to hold it?
- [Silence]

- 'Fuck you!' he said, turning his head away fuming. I'm outa here!' And he lurched out of his chair, slammed the door behind him and locked himself in the bathroom on the other side of the waiting room. (Fortunately there were no patients waiting.) I sat in stunned silence for a moment, then followed him and stood outside the locked bathroom door and said:
- Mike, I am really really sorry. You didn't deserve that outburst from me. It wasn't any better than yours on the highway! Let's not let this wreck our connection. Let me in so we can process this together. We've got too much going for us. There's a lot at stake.

- I heard the door unlatched from inside. I went in. He was seated on the toilet lid, head in his hands. I sat on the bathtub and put my hand on his shoulder. **Several minutes went by with both of us finally coming back into our bodies**. Then I noticed Mike' s eyes begin to tear up. I waited for him to say something but nothing came. 'What're you feeling?' I asked. He looked up at me and saw the tears rimming my eyes also. 'I don't know', he said, ' Sad… about my father I guess.' Then Mike really began to sob:

- Nobody ever cared! I had to take care of it all by myself . . . I was always crying out for help in my acting out, but nobody got it . . . Six felonies before I was 18 and my father never spoke to me about it! All they could do was make me bad. **You're not making me bad**.
- 'You're not making me bad.' Suddenly I felt a huge upwelling of relief and gratitude inside my chest – relief because I really had 'made him bad' in my mind, and I felt terrible about it. I had really hated him for a moment and it hadn't destroyed him. And it hadn't destroyed us. Both love and hate, the good and the

- bad, were held together in this moment for each of us but love was stronger, and hence the relationship was both preserved and deepened. Mike took my hand and **we just sat looking at each other** in this wet beautiful moment. It was like the Balm of Gilead – healing and reconciliation poured down on us both. Trauma repeated, acted out, but repaired, right there in the session…the little boy and the murderous protector (in both of us) present and getting to know each other."



- Note **therapist's creative rupture and repair: state-matching, authentic self-revelations, interactive regulation, synchronized mutual regression.**
- Before enactment, "Knowing that eruptive anger was a defense against the shame and humiliation he had experienced in childhood…I repeatedly tried to help these two dissociated self-states get together."
- In interactive repair of mutual regression of dyadic enactment, dissociated dynamics **beneath aggression, a "not-me" state of unbearable shame and helplessness**, able to come to the surface of consciousness and communicated to a valued other.

- Kalsched proposes relational trauma of unshared emotions of humiliation, shame, and helplessness with father was too painful for patient to remember, and so repeated and **re-enacted** in therapeutic relationship.
- Suggest source of shame in later paternal humiliation in 2nd year, but source of helplessness earlier, in 1st year neglectful insecure-disorganized mother.
- Although Kalsched provided no history of first year, he did describe patient's memories as a toddler of being driven in a highly dysregulated state to an orphanage where mother and father threatened to abandon him.

- On those occasions he'd have inconsolable temper tantrums for which he was intensely shamed, screaming until he couldn't breathe, and then blacking and going numb (dissociated).
- In mutual therapeutic dissociation preceding shame enactment therapist could not consciously tolerate his own dissociated hatred (helpless rage) and contempt for his patient, which broke through in a **creative spontaneous and authentic self revelation.**

- Kalsched observes, "Fortunately I did not dissociate my hatred for long. Once enacted, I could own it, and this made my apology possible. **That was the beginning of a negotiation towards a different outcome**."
- Note **dissociated** RH UCS helplessness and shame beneath LH CS predatory (not defensive) aggression. Emotional growth of enactment allows **integration** of **dissociated** self states of helplessness, shame and aggression, into a **new CS blended feeling** of shame and remorse about his aggressive road rage.

- Kalsched notes shortly after enactment there was "a **major shift in our work together**" and a major **integration** in patient's psyche. Negotiated enactment of mutual regression leads to **sudden change in nature of their relationship.** Right brain-to-right brain system becomes more complex, more intimate.
- Kalsched on enactments: "We get pulled in. Instead of sitting outside the process and providing insight or interpreting defenses, we will find ourselves participating in repeated rupture and, hopefully, repairs of our connections with the patient as dissociated pieces of the patient's experience get **knit together**…."

- “Communication is not linear and rational (mediated by the left hemisphere of the brain) bot non-verbal and experiential (mediated by the right hemisphere). Allan Schore calls this ‘**right brain-to-right brain communication**.’”
- Kalsched cites Schore (2015): ”When a therapist’s wounds are hit, can she regulate her own bodily based emotions and shame dynamics well enough to be able to stay connected to her patient? Can the therapist tolerate what is happening in her own body when it mirrors her patient’s terror, rage and physiological hyperarousal…Herein lies the **art of psychotherapy**.”

- Overall, general interpersonal neurobiological therapeutic **principle of working with relational trauma in a mutual regression of a clinical re-enactment** and indeed with any disturbance of affect regulation dictates that psychobiologically attuned empathic therapist facilitates the **patient re-experiencing overwhelming affects in incrementally increasing affectively tolerable doses in the context of a safe environment**, so that overwhelming traumatic feelings can be regulated, come into consciousness and adaptively **integrated** into the patient’s emotional life.

- **Right brain self integrates, dis-integrates, and creatively re-integrates in synchronized, interactively regulated mutual regressions.**
- Recall Tuttman’s (2003) characterization of clinical regressions as allowing for “the return to fundamentals and origins that might facilitate a potential reorganization leading to better integration.”
- Over time **therapist’s expanding expertise** in interpersonal creativity and in facilitating a patient’s self integration is expressed in her ability to implicitly enter into, monitor, and more efficiently co-regulate **spontaneous synchronized mutual regressions**.

- Ann Ulanov (2001) on “**deep psychotherapy**:” “Through…counseling…we may experience the safe holding that allows us to look into the **gaps of dissociation between our bodies and psyches**, into the terror of ground falling away beneath us, into the moments of unreality when we feel the flicker of our uniqueness as persons faltering.”
- “Looking into such gaps, we may begin slowly, carefully to knit together what was broken apart…**we must depend on someone holding us in being while we ourselves knit together our broken parts.”**

- But **we need someone present, holding the situation, while we undergo regression, the journey back to where we fell apart.** It is dependence that escorts us into emptiness, makes us hit the bottom of emptiness, and it is emptiness that opens us to our dependence.”
- “We are afraid that no one will be there calling our name, that we alone will know what we are going through. Such **regression** costs time, money, tremendous energy, and **courage** if attempted in therapy.”