Psychoanalytic Psychology
1998, Vol. 15, No. 4, 517–535

0736-9735/98/$3.00

Enactment
When the Patient's and Analyst's Pasts Converge

Karen J. Maroda, PhD
Milwaukee, Wisconsin

As the emphasis on analytic treatment as a relationship continues to grow, all aspects of mutuality are being examined. Although much has been said regarding the analyst's emotional responses to the patient, enactment has been seen as a re-creation of some past event in the patient's life. Perhaps because of the threatening nature of the concept, analysts have not paid attention to the potential for recreating their pasts, sometimes in symmetry with the patient, at other times as an act of countertransference dominance that disrupts the treatment and may traumatize the patient. This article focuses on enactment as an inevitable mutual event beginning with mutual projective identification, followed by mutual, unplanned behavior, and culminating in a mutual sense of puzzlement and a certain sense of being emotionally out of control. The dangers of enactment are discussed, as well as its therapeutic uses.

As modern psychoanalysis continues to develop the two-person perspective, the issue of enactment inevitably draws one's attention. Formerly known as *acting out,* or *acting in,* the issue of enactment has researchers struggling to formulate a meaningful definition that does justice to the complexities of this unique transference–countertransference interplay.

Karen J. Maroda, PhD, independent practice, Milwaukee, Wisconsin.

Correspondence concerning this article should be addressed to Karen J. Maroda, PhD, 611 East Wisconsin Avenue, Milwaukee, Wisconsin 53202-4606. Electronic mail may be sent to kmaroda@compuserve.com.

Most authors (Aron, 1991, 1996; Chused, 1991, 1997; Gabbard, 1995; Hirsch, 1993, 1994, 1996; Jacobs, 1986; McLaughlin, 1991; Mitchell, 1988; Renik, 1993; Richards, 1997; Sandler, 1976) agree that enactment occurs unconsciously, that is, as an unwitting or inadvertent event on the analyst's part. The problem facing modern psychoanalysis regarding enactment is threefold. One, how should enactment be adequately defined, that is, what are its critical characteristics—motivation, emotion, behavior, or some combination? Two, what are the dangers of enactment and how can they be minimized? And three, because enactment is inevitable, how can its therapeutic potential be maximized?

Defining Enactment

Chused (1991) echoed Sandler's (1976) early definition of enactment when she said "Enactments occur when an attempt to actualize a transference fantasy elicits a countertransference reaction" (p. 616). Here the point of origin of the enactment lies within the psyche of the patient. Chused (1991) viewed enactment as the patient's attempt to recreate the past and gain gratification, which accounts for her belief that enactment is counterproductive. In another work, Chused (1997) went as far as saying that the therapeutic moment occurs when the analyst thwarts an enactment and provides a correct interpretation instead.

In Chused's (1997) view of enactment, the patient clearly initiates and the analyst participates only as a response to the patient's stimulus. However, she conceded that the American Psychoanalytic Association Panel on Enactment (1992), following disagreement as to the role of analyst and patient, concluded that enactment is "a *jointly created interaction,* fueled by unconscious psychic forces in both patient and analyst" (Chused, 1997, p. 265), a perspective that I share.

Hirsch (1994) definitively saw enactment as both inevitable and therapeutic, as did Renik (1993). Hirsch defined enactment as "a living out of affective experience, usually by both parties in the analytic dyad, within the strict boundaries of the analytic frame" (p. 172).

Gabbard (1995) noted the confusion that sometimes arises concerning the difference between mutual projective identification and enactment. Because mutual projective identification refers only to the mutual stimulation of repressed, intense affect, I think Gabbard is quite right in his distinction between the two. Although projective identification may inspire or inform behavior, by definition, it only requires the presence of strong felt

emotion. Gabbard noted that enactment "implies an action," a point also made by Hirsch (1994).

Most definitions of enactment, then, contain these two essential elements: the stimulation of strong, unconscious affect and some resulting behavior. Following this logical progression, a likely hypothesis states that enactment is necessarily preceded by mutual projective identification. One could say that the mutual stimulation of repressed affect is essentially the fuel for the engine of the behavioral event labeled as enactment. (See Aron, 1996, for a thorough historical overview of enactment as an analytic concept.)

Richards et al. (1997) noted that enactment may take any form; that it may be expressed through silence, action, or gesture, all of which qualify as observable behaviors. The defining characteristic of enactment, because virtually any behavior may qualify, rests on the presence of several essential elements. Richards attempted to define enactment by saying

> It is characteristic of an enactment that the analyst is not aware of his participation as it is happening. Only after the fact does the analyst become aware that he has acted in a manner that goes against his usual grain, and is a departure from the normal course of communication and behavior, discourse and relationship, of the analytic process. (p. 15)

Once again, it can be seen that enactment is universally defined as spontaneous, difficult if not impossible to control, unconscious, and affectively driven. Whether one believes that the analysand initiates the enactment (as Chused and Richards do) or that either party may be the initiator (as Hirsch, Renik, myself, and others do), who "started it" is probably impossible to determine and does not negate the consensus that enactment is a mutual event.

Enactment differs from other strong transference–countertransference interplays in that it is necessarily unconsciously motivated by the mutual stimulation of strong affect, with both persons usually stating that they felt out of control, or at least felt something come over them that was mysterious and powerful. Behaviorally, it may take the form of a heated argument, a sadomasochistic exchange, a spontaneous hug or other physical gesture, a shortening or lengthening of a session, a failure to collect the fees, an unexpected dissolution into tears, or a withdrawal into silent rejection.

Building on the work of those cited here, I would like to expand the definition of enactment beyond my earlier statement regarding the necessity of a mutual projective identification preceding an enactment. I think

the concept of enactment makes more sense, and serves to delineate the event more sharply from other affect-driven encounters between analyst and patient, if one takes the existing definition further. It is not just an affectively driven, unconscious, mutually acted-on set of behaviors. *Enactment is an affectively driven repetition of converging emotional scenarios from the patient's and the analyst's lives. It is not merely an affectively driven set of behaviors, it is necessarily a repetition of past events that have been buried in the unconscious due to associated unmanageable or unwanted emotion.*

Although one might prefer to believe that the enacted scenario is properly the patient's, it seems more likely that the enactment behaviors actually constitute an acted-out mutual scenario from both the analyst's and patient's pasts. Either party may initiate the enactment, but I would agree with those who would say that ideally the analyst's role would be a supporting one, not a starring one. This drama rightly belongs to the patient. It is his or her chance to relive the past, from an affective standpoint, with a new opportunity for awareness and integration.

The analyst's affective participation must be real, or the patient could not continue. The patient must be able to stimulate something in the analyst that is equally primitive and split off, so that they can relive the drama in a real way together. Enactment thus involves mutual stimulations of repressed affective experience, ideally with the patient taking the lead. Mitchell (1988) said that

> The analyst discovers himself a co-actor in a passionate drama involving love and hate, sexuality and murder, intrusion and abandonment, victims and executioners. Whichever path he chooses, he falls into one of the patient's predesigned categories and is experienced by the patient in that way. (p. 295)

If one acknowledges that the analyst can only truly "fall into" this drama when he or she is personally touched at a deep, unconscious level, when the analyst is stimulated to re-experience some portion of his or her own personal drama, then there is enactment. I think this split-off quality accounts for Richards et al.'s (1997) description, which stated that the analyst is typically quite surprised at his or her own behavior and finds it to be uncharacteristic. Formerly, this was accounted for by claiming that the patient forced some feeling into the analyst. But did the patient then force the analyst to behave in some way that was ego-dystonic and uncharacteristic? Hardly.

The analyst is shocked by these feelings and subsequent behavior because he or she does not know this part of himself or herself. It had been

buried long ago, and now this patient is threatening the analyst by stimulating something in the analyst that he or she does not want to see.

Regardless of who has initiated the enactment, it obviously has potency and therapeutic relevance only if it is mutual. If one side drops the ball and does not participate, no enactment occurs. In fact, one could argue that a major factor in a good analytic match is the ability of the analyst and patient to stimulate a therapeutic level of enactment between them, along with the ability to work through the accompanying strong affects. Too little enactment leads to stagnation; too much leads to premature termination, impasse, or unacceptable acting out (repeated sadistic encounters, sexual acting out, etc.)

The Dangers of Enactment

This definition, that enactment contains an element of uncontrolled unconscious impulses that are mutually stimulated between analyst and patient, brings us to the heart of the controversy surrounding it. Although Chused (1997) said that if there was an option to enact or not enact, analysts would be better off if they did not (I obviously disagree), there is a consensus that enactment is inevitable. The question remains, however, what action on the analyst's part is therapeutic? And herein lies the controversy. Addressing the dangers of enactment, Chused (1997) said

> Through my experience with the power of transference, the fervor with which patients maintain their psychic reality and actualize fantasies even without the analyst's behavioral participation (Boesky, 1982), I have learned there is no guarantee that the patient will understand an analyst's participation in an enactment, experientially, as the analyst does. Enactments are complex phenomena, with the power to inform as well as the power to impede an analysis. Neither Hirsch nor Renik seem to appreciate this complexity. Hirsch seems to believe in an enactment for what it reflects in the analyst (the myth of the omniscient patient). (p. 271)

Richards et al. (1997) shared Chused's (1997) concerns regarding the impact of enactments on the patient. He said

> Enactments, like transference actualizations and acting-out, can serve to advance the therapeutic process or to derail it. This fact is often lost. . . . I stress all this because there is of late a tendency for the concept of enactment to be valorized in discussions of the therapeutic process. (p. 7)

Richards went on to ponder the possibilities for the countertransference dominating the process. This comment by Richards is the first I have found

referring to the countertransference as a potential dominant force since my own mention of it in an earlier work (Maroda, 1991). There is no serious discussion in the analytic literature of the potential for the analyst's past, rather than the patient's, being re-enacted to the point of dominating the treatment, and even determining its outcome. Prior unrealistic expectations for the analyst's personal analysis are no doubt largely responsible for this oversight. How can the analyst possibly pollute the treatment in this way if he or she has already been "cured"? Somehow, even analysts who are aware of the inevitability of countertransference and of the patient's press to re-create the past neglect the fact that an analyst in the throes of a strong countertransference is under the influence of the same type of repetition compulsion as the patient—and has the power in the relationship to ensure that his or her reality prevails.

It seems not only possible, but highly likely, that when a powerful enactment between patient and analyst is not correctly identified and worked through, the patient's reality will be subjugated to the analyst's, resulting in *countertransference dominance.* Exactly how damaging this may be to the patient depends on many factors. These include when the countertransference dominance develops in the treatment and how long it persists, the extent to which the transference–countertransference conflicts are resolved during the ensuing enactments, the degree to which the patient blames himself or herself for therapeutic limitations or failures, the overall vulnerability of the patient, and the quality of the analyst's past experience in terms of its destructiveness. Analysts with less-than-average pathology and trauma in their backgrounds naturally have less that is seriously destructive to impose on their patients. However, this does not mean that harm will not be done by a relatively "healthy" analyst in cases where the countertransference dominates. Any significant diminution of the patient's experience caused by the analyst's need to replay his or her own past constitutes injury and a disservice to the patient, as well as a treatment failure.

Countertransference dominance also harms the analyst, who undoubtedly knows on an unconscious level that re-enactment of his or her past unduly influences a patient's treatment. Such an analyst is likely to be plagued with guilt and uneasiness over how a countertransference-dominated treatment is proceeding. Because countertransference-dominated treatments are usually characterized by excessive pleasure and gratification for the analyst, by excessive conflict and defensiveness on the part of the analyst, or by some pattern of alternating between the two, I think it is impossible for the analyst not to be haunted by an awareness that

things are not as they should be. Unfortunately, it can be easy to dismiss this recurring discomfort as either neurotic or as an understandable degree of distress incurred in treating a difficult patient. Countertransference-dominated treatments usually have one of two basic outcomes: either a prolonged, too-blissful treatment that ultimately is so nondynamic that it quietly extinguishes itself, or a stormy, passionate upheaval that culminates in traumatic acting out by the analyst or a precipitous termination of the treatment by either patient or analyst.

When a difficult patient leaves treatment in anger, the temptation is great to label that patient as untreatable. As hard as the analyst might try to say that the patient was impossible—that no one could have done better—she may be left with a nagging sense of failure and inadequacy that keeps the patient alive and present in the analyst's mind long after termination. In extreme cases of countertransference dominance, such as when an analyst engages in sexual relations with a patient, the damage to the analyst as well as to the patient is quite obvious.

The traditional ways of dealing with the countertransference, such as self-analysis, consultation, and return to personal analysis, often fail because they rely on the psyche of the analyst rather than addressing the interpersonal nature of persistent countertransference problems and the manner in which they are enacted. Only techniques that allow for constructive interaction between analyst and patient, including the appropriate expression of intense affect, offer the possibility for working through difficult, or even traumatic, enactments.

Sometimes the analyst is unaware of characterological problems that are most likely to lead to significant countertransference dominance. Building on the contributions of Miller (1981) and Kohut (1971, 1977), Finell (1985) documented the narcissistic problems of the analyst. She discussed the unique opportunities for narcissistic gratification that exist in the analytic situation, describing how both patient and analyst can collude and deny that such gratification is taking place in the treatment setting. Although Finell did not postulate the dominance of the analyst's pathology, she did acknowledge the potential for the harm that can be done by the analyst with unresolved narcissistic issues:

> The impossibility of processing denied and split-off feelings throws the burden of responsibility on to the analyst's personal analysis. If this fails to work through grandiosity, exhibitionism, aggression, and power, the potential for countertransference over and above a specific reaction to a narcissistic transference in patients is enormous. (p. 443)

Tower (1956) also noted how impossible it is for any analyst to control his or her own countertransference. Classical discussions of the countertransference, she said,

> presuppose an ability in the analyst consciously to *control* his own unconscious. Such a supposition is in violation of the basic premise of our science—namely, that human beings are possessed of an unconscious which is *not* subject to conscious control, but which is (fortunately) subject to investigation through the medium of the transference (and presumably also the countertransference) neurosis. (p. 225)

In another early contribution to the countertransference literature, Benedek (1953) hinted at the possibility of countertransference dominance, which occurs when the analyst attempts to defend against recreating the past with a patient:

> [Countertransference] is the analyst's projection of an important person of his past onto his patient. . . . The patient becomes . . . the feared "castrative woman" in the analyst's life, or he may become any person toward whom the therapist once felt helpless. Thus the patient, not only by the actual obligation, but also through the countertransference, becomes a partial representative of the therapist's superego; and then his inhibition in regard to that patient may grow beyond his control. (p. 206)

Benedek's (1953) statement illustrates that what analysts know to be true of their patients—that is, the harder they defend against awareness of their own unconscious or a repetition of their past, the more likely they are to repeat it—is also true of analysts. Benedek's reference to the analyst's helplessness is particularly relevant in that analysts typically, and understandably, aim for a sense of mastery and legitimate control in the analytic situation. Yet one need not look far to know how easily this desire for mastery can be transformed into a defense against the feelings of helplessness that patients can stimulate. This defense then serves to block awareness of the origin and meaning of the analysts's feelings of helplessness.

Racker (1968) was also aware of the possibility of countertransference dominance, but his discussion of *neurotic countertransference* was vague in terms of how this might be played out in the treatment and affect its outcome:

> A special danger involved in neurotic countertransference is what might be called *countertransference induction* or *countertransference grafting*. By this, I mean the well-known danger of the analyst's "inducing" or "grafting" his own neurosis upon the patient. (p. 125)

It is indeed frightening to consider how much self-destructive behav-

ior, including suicide, may actually be subtly encouraged or invited as a result of countertransference dominance. Although repetition of the patient's past, up to and including the same undesirable outcome, has long been considered by many as the worst possible occurrence in treatment, I do not agree. Patients are well-accustomed to reliving their pasts, as are most people. Thus, they are generally able to cope with this familiar event, no matter how painful.

However, when countertransference enactments pervade a treatment, resulting not only in inhibition of the transference but in the imposition of a significant degree of the analyst's past on the patient, it may well be traumatic. The patient may be completely unprepared for coping with an analyst's re-enactment, although this no doubt depends on the extent of shared history between patient and analyst.

An analyst who is significantly more disturbed than his or her patient—meaning specifically that the analyst's history includes conflicts, traumatic events, developmental arrests, or constitutional weaknesses that far exceed those of the patient—may unintentionally recreate harmful experiences that are novel to the patient and for which he or she has no defense. Also, countertransference dominance is more likely to occur during a period of mutual regression, which means that the patient's normal defenses would be disarmed, leaving room for serious damage.

The experience of being in control is an essential aspect of adequately defending or coping. When patients repeat the past, they do so at their own behest, and a measure of control makes the experience manageable. But when analysts re-enact their pasts with their patients, they remove control from the patient, which leads to confusion and anxiety at best and, at worst, to trauma, despair, and self-destruction.

The best example of countertransference dominance I have seen is the case of Joanne, which I first described in a previous work (Maroda, 1991). I am repeating it here both because it is was a consultation for referral, which leaves me freer to be nondefensive about the countertransference of the therapists involved, and because it so clearly illustrates the complexities of enactment and the potential for the analyst's past to determine the outcome of treatment.

Joanne, an attractive lesbian in her late 20s, consulted me regarding her two failed treatments. Both of her female therapists had gone to bed with her, in spite of the fact that they were both psychoanalytically trained (one was an an analyst, the other was not, but both had had a personal analysis).

Joanne told me that she had abruptly fled her first treatment after she

and her therapist, Dr. S., had ended up in bed fondling and kissing each other. Shortly after this incident, Joanne, suffering from an extreme anxiety reaction resulting from her sexual encounter with her therapist, was treated in a hospital emergency room by a young female psychiatrist, Dr. T.

Dr. T. was sympathetic and reassuring when Joanne told her what had happened with Dr. S. Dr. T. assured her that her anxiety was reasonably normal under the circumstances and concurred with Joanne that she should not return for any further therapy with Dr. S. Joanne felt very comfortable with Dr. T. and asked her if she would be willing to treat her. She agreed, and the treatment proceeded well and without incident for the next 18 months. They had developed a very good rapport and formed a close attachment to each other. What happened next was therefore very disturbing to both of them.

Dr. T.'s husband was offered an excellent position in another part of the country, which he accepted. As a result, Dr. T. informed Joanne that she would have to terminate the treatment within a few weeks. Joanne was naturally disappointed and upset, but she struggled to accept her therapist's imminent departure, understanding the circumstances. Dr. T. said she was sorry to leave Joanne when her treatment was really just getting going, which helped lessen Joanne's feelings of abandonment. They continued to see each other until the week of Dr. T.'s departure and terminated on good terms.

Within a few weeks of Dr. T's departure, however, Joanne received a letter from Dr. T., asking that they keep in touch by mail. Joanne was overstimulated and surprised by this request, knowing it was not appropriate, but she could not refuse her therapist's offer of continued contact. They corresponded on a regular basis. One year later, Dr. T. professed her love for Joanne and asked if she would be willing to see her, all expenses paid by Dr. T. Again, Joanne was reluctant because she knew this was wrong. She began to have small anxiety attacks, yet she was fascinated by her therapist's attachment to her and agreed to see her.

The relationship continued for the next 2 years. In the beginning Joanne was willing to fly anywhere to meet Dr. T., as they were in the throes of a love affair. (Dr. T.'s husband did not know about the affair, nor did Joanne's partner. Because all of them traveled frequently on business, the weekend meetings were disguised as conferences). As time passed, Joanne became less interested in seeing Dr. T. and began making excuses for failing to see her. She also wrote less and called infrequently. Joanne was feeling the stress of the affair, feeling guilty about cheating on her partner, and also experiencing anxiety and depression over her love affair

with her therapist. She was frequently despondent and having increasing problems being productive at work.

Dr. T. became agitated and seemingly desperate over Joanne's waning interest in maintaining the relationship. When Joanne did not return some of her phone calls, Dr. T. called in great distress, demanding to know what was going on. Joanne told her that their affair was getting in the way of both her personal life and her career. She was tired of jumping whenever Dr. T. called, wanting to talk or arrange to see her. Dr. T. responded to this complaint by saying she was bitterly wounded. Didn't Joanne know how much she loved her? How could Joanne withdraw from her so easily and sound so cold? Dr. T. finally offered to leave her husband and live anywhere Joanne desired. But Joanne begged off whenever this topic came up. Conversations of this type continued, often ending in a lovers' quarrel. During one of these quarrels Joanne ended the relationship.

Joanne sought me out for referral to another therapist, because she lived some distance from where I practiced. When Joanne presented this material she was pessimistic and discouraged. She said having an affair with her therapist was a terrible experience and one she regretted. Even though Joanne knew that both of her therapists had behaved in an unethical and irresponsible manner, she blamed herself for the traumatic sexual encounters with each of them. Joanne noted that both of these female therapists were married women with no homosexual history (she had asked and been told). Joanne could only conclude that she was at fault for her seductiveness, even though she was not the initiator of physical contact in either relationship. She desperately wanted more therapy but feared that she would only seduce her next therapist, too. (She did not feel comfortable seeking out a male therapist, feeling sure she needed a woman—but one she could not seduce.)

Joanne asked me what I thought about her situation. In interviewing her, I found her to be quite likeable, possessing an unusual degree of joie de vivre. Quick-witted, playful, and psychologically sophisticated, it was not difficult to imagine someone getting caught up with Joanne and her struggles. In addition to her charm, she possessed a tragic childhood history of parental loss and neglect that inspired pathos. Joanne was determined to overcome her adversity and expressed this through her intellectual and career ambitions. She seemed to inspire others to help her achieve her lofty goals.

When Joanne talked about others, however, there was more than a hint of opportunism as she spoke of dismissing people who "didn't want her to succeed." She spoke with contempt when discussing Dr. T., who I

actually began to feel sorry for as Joanne described Dr. T. pitifully begging her not to leave her. In spite of Dr. T.'s abuse of Joanne, it was Joanne who gradually took control as the relationship progressed—so much so that it seemed debatable as to who was more traumatized by the relationship—Dr. T. or Joanne. (My own reaction during these conversations with Joanne was that I ended up feeling very bad for both of them, even though I saw Dr. T. as responsible for what happened and unquestionably guilty of sexual abuse of Joanne.)

As I talked more with Joanne about her relationships, there appeared a pattern of her ambivalence toward anyone to whom she was strongly attached. She tended to idealize others and later discard them with contempt, although this was not true of all her relationships. However, most of the people she kept in her life were those whom she easily dominated. Joanne had a history of problems with intimacy, having had many lovers. It seemed that whenever anyone got too close, Joanne tended to withdraw.

Regarding Joanne's enactment with Dr. T., clearly she followed her usual pattern of seduction and abandonment. Unfortunately, this relationship could not be worked out because the frame had been broken—the relationship had literally been taken out into the streets. Had they continued in therapy, I have no doubt that some version of this scenario would have taken place. Joanne was very successful in her psychological seduction of Dr. T., leaving Dr. T. vulnerable to Joanne's inevitable withdrawal. Had therapy continued within the appropriate limits, this emotional situation could have been worked through. Instead, Dr. T.'s irresponsible behavior lead to an untimely and painful ending.

Although I am not privy to all of the information I would need to adequately discuss Dr. T.'s role in this enactment, I did ask Joanne some questions. Naturally, I asked Joanne if she had ever been molested. She said that although relations in her family had been sexually tinged, there had been no incest or molestation of any kind. Then she said, "But both of my therapists told me that they had been molested as children. Is that important?"

Given this startling information, it seems likely that both of Joanne's therapists were somehow re-enacting their own history of sexual abuse as a response to her. Perhaps being caught up in the pathos of Joanne's life and reliving their own painful childhood experiences became more than they could bear. (To what extent either of these women may have been suppressing or repressing a homosexual preference adds more to the drama.) Although it is impossible to determine exactly what took place in

the minds of these two therapists, they clearly became overinvolved with their highly intelligent, ambitious, talented, and wounded patient. They apparently denied their own vulnerability and neediness through their sexual enactment with Joanne.

After hearing how cold and rejecting Joanne could be toward these women, I imagined that both of them were frustrated and hurt by her and sought to magically restore the emotional merger they had previously enjoyed. Overstimulated and abandoned, they had taken the only route they knew to re-establish intimacy with their elusive patient. Yet they unquestionably repeated their own histories as they concluded their relationships with Joanne. In both cases the countertransference, rather than the transference, ultimately prevailed.

It is hard to know what could have happened differently to avoid the tragic consequences of the enactments that took place in both of these treatments. But given that both therapists had a history of being sexually abused, and the patient did not, it is easy to argue that the countertransference dominated and thus destroyed, both treatments.

Had both of these therapists been able to acknowledge their strong identifications with Joanne, as well as their intense attachments to her, the outcomes might have been different. Had they confronted Joanne with her cold and rejecting behavior, and helped her to experience and understand her fear of abandonment, some real therapy could have taken place.

When I interviewed Joanne, it was clear to me that she had no real understanding of her role in these relationships. The only sense of responsibility Joanne felt for the disastrous outcomes of her treatments revolved around grandiose visions of herself as evil, irresistible, and untreatable—all of which shored up her narcissistic defensive structure in the service of denying her underlying vulnerability.

(Follow-up note: For those who might be thinking that Joanne was indeed untreatable, I did refer her to an analyst in her area and she was successfully treated over a period of 9 years by this woman. In the follow-up conversations I had with Joanne, it was evident that this analyst was also quite taken with her, but in a much healthier way than the previous therapists. She idealized Joanne just enough to satisfy her narcissism, but was consistent, reliable, gave her good feedback and, most important, maintained the boundaries of the professional relationship. The resulting changes in Joanne were impressive, including an obvious reduction in her grandiosity, a more empathic and warm demeanor, and the ability to sustain an intimate relationship.)

Upon hearing about a case like Joanne's, where the therapists

committed what might be considered to be the "ultimate sin", it is easy to distance and say "I have never done anything like that and never would." As true as this may be, we all have had treatment failures that haunt us—situations where we felt too much and knew too little about how to manage it. And even our successful treatments are often marred by long stalemates motivated by the untoward inhibition of strong feelings. Frequently our fears of being out of control prevent us from working constructively with what we feel.

Therapeutic Uses of Enactment

Having described enactment as inevitable, as behavior emanating from unconscious affects and, therefore, being difficult to control, is it truly possible to manage enactment in a therapeutic manner? Doesn't the example of Joanne confirm Chused's (1997) and Richards et al.'s (1997) aforementioned fears that enactment can be dangerous? Certainly. But the point I want to make is an obvious one: any intervention can potentially go wrong, or be inherently dangerous and destructive. Enactment is a dynamic, naturally occurring manifestation of the transference and countertransference merging into a living entity, making the past alive in the present. This mix will always include some element of re-creating the analyst's past. In general, one can safely say that the goal should be that more of the patient's past be re-created than the analyst's, and even more important, that the patient have every opportunity to safely work through these events within the boundaries of the analytic relationship.

No analyst can control how he or she feels, only how he or she behaves. And even in the light of accepting that analysts are destined to re-create their pasts to some extent with their patients, they can still have a great deal of control over how they express themselves in these situations. (An analyst who finds himself or herself repeatedly unable to control his or her behavior should stop treating patients and seek additional personal analysis.) The difference between malpractice and successful treatment for Joanne centered not so much on her therapists' feelings toward her but rather on how those feelings were managed and expressed. Joanne told me that her final therapist was very forthcoming with her, letting her know when she was withdrawing, or being contemptuous, and how her therapist felt about it. As a result, they were able to work through these issues together. Concurrently, she let Joanne know that she cared about her and admired her, which Joanne loved once she realized that these feelings in her analyst would not lead to abuse.

Renik (1993) said that in order to appreciate the value of enactment, analysts must change the way they think about the therapeutic action of psychoanalysis. He made the point that Freud, in accordance with the widely held views of his time, believed that action and introspection were mutually exclusive processes. This belief produced an untoward emphasis on thinking rather than doing. I agree with Renik that analysts need to develop a better appreciation of the value of acting and expressing, as part of the process of working through and understanding, rather than viewing these vital emotional expressions as alien to the analytic endeavor.

Another anachronistic view of the analytic process states that the patient in the throes of the transference distorts reality and imagines that the analyst feels toward him or her in the present what some other family member had felt toward him or her in the past. I was taught this as a young therapist and believed it. Thus, I would wisely interpret to the patient that he thought I felt a certain way because he had experienced this in the past.

What I began to realize after many years of clinical experience is that quite often patients would effectively stimulate in me the exact emotions they had experienced with someone else in the past. (And I would do the same with them.) What turned out to be therapeutic was the constructive expression of these deeply felt emotions, as well as the mutual working through of the subsequent emotional and behavioral events.

We are now left to determine what action on the analyst's part is most therapeutic. The reader may be under the impression that, in spite of my warnings regarding countertransference dominance, I advocate free expression on the part of the analyst. This is both true and untrue.

The inevitability of enactment says more than a little about its therapeutic potential. Anachronistic advice about trying to avoid enactments seems senseless to me. Rather than downplaying the importance of enactment, I prefer an emphasis on greater awareness of just how ubiquitous it is and on how equally inevitable is the evocation of the analyst's past in terms of re-creating an emotional scenario. I want to emphasize that although it necessarily involves action, enactment is essentially an affective event. The action carries the purpose of fully expressing the intense emotion at the heart of the transference–countertransference exchange.

For example, someone who was sexually abused as a child obviously does not need to be sexually abused by his analyst, but he may need to stimulate intense anger, a desire to harm, or intense sexual feelings in the analyst. The more prepared the analyst is to experience these feelings as a natural event in the treatment, the less likely the analyst is to repeat the past in a literal, and traumatizing, way.

Failing to appreciate that the emotional intensity of enactment constitutes its inevitability, rather than a particular behavior, could lead to irresponsible acts on the part of therapists. What has happened to a small degree regarding self-disclosure, the tendency of some therapists to indulge themselves at the patient's expense, may also happen once analysts accept the inevitability of enactment.

The experience of unconsciously stimulated strong, or even overwhelming, affect is completely out of the analyst's control and is inevitable. His or her behavior is not.

Certainly one of the realistic outcomes of a personal analysis should be that the analyst is reasonably in control of how he or she behaves. And I say this with a full understanding of just how difficult it can be to manage intense countertransference feelings. I have felt murderous rage at patients. I have wanted to hit them. I have wanted to throw them out of my office, or even out of my office window. I have wanted to scream obscenities at them and tell them to get out and never come back. On the other side, I have wanted to make love to them, I have felt overwhelming grief upon witnessing their spontaneous heartbroken expressions and been tempted to hold and comfort them. And I have withdrawn into silence when I knew I should not. I have envied some of my patients to the point of shame. Worst of all, I have lapsed into a kind of deadness where I didn't care about anything and knew the patient was aware of it. None of these feelings were within my control.

Sometimes I deny them or try to minimize them. On a bad day, I can let myself off the hook by blaming my patients for what lies in my own heart. On a good day I accept what I feel, knowing it is useless to fight it and I will work better as a therapist if I just allow all of my feelings to wash through me and over me. Even if I am ashamed of them. And this gives me greater control over my behavior.

Knowing that I cannot control what I feel does not in any way let me off the hook for how I behave. Analysis is, by definition, a situation where both persons mutually inhibit certain behaviors in the interest of facilitating the therapy and maintaining the appropriate boundaries. Even very regressed and emotionally charged patients rarely act out in completely unacceptable ways. They talk about how much they would like to do it. They talk about how difficult it is to control themselves. Nonetheless, because they do not want to destroy the treatment, they usually do control themselves, or leave if they cannot. If patients are capable of such restraint in the face of their most primitive fears and desires, how can one assume that analysts cannot be? Both analyst and patient know that it is incumbent

upon them to control their own behaviors to the extent that the therapeutic limits are not seriously transgressed. Otherwise the treatment is over.

But within this small theater, where only certain acts can be played out, there is no such limitation on the world of emotion, which is at the heart of the therapeutic enterprise. All manner of emotions can be expressed, by both analyst and patient, even though the analyst must take greater responsibility for finding constructive and helpful ways to express himself or herself. For example, rather than simply disclosing every strong feeling the analyst has, feelings should be expressed at the patient's direction and behest, allowing him or her to be in control of the emotional action between them. If the analyst discloses primarily when the patient asks for it, either overtly or through repeated projective identifications, then the patient is less likely to be victimized by the analyst's need to relieve himself or herself at the patient's expense.

In the aforementioned case of Joanne, it seemed inevitable that all three of her therapists were destined to fall in love with her in some way, given who she was and what she stimulated. Two of these therapists succumbed to destructive acting out, whereas the third enjoyed her positive feelings toward the patient, and responsibly disclosed both positive and negative emotions that she experienced.

I am not saying that a good therapist is above being out of control with a given patient. Because therapists are human, this sometimes happens. But therapists who cannot control themselves to the point of violating the patient have no choice but to end the relationship and give the patient the opportunity to seek therapy elsewhere. (In an earlier work [Maroda, 1991], I outlined techniques for expressing strong countertransference emotion and for responsibly ending a treatment when the therapist cannot remain in control. And I believe it is both possible and desirable to formulate guidelines that delineate responsible behavior by the analyst. The notion of simply using one's intuition renders revelation of the countertransference unteachable and promotes a personality cult around analysts who do this well.)

Enactment now joins the discovery of countertransference and self-disclosure as ubiquitous and inevitable events. Once again, however, analysts are discovering an aspect of the analytic process that has always existed. Formerly ignored, partially defined, or neglected aspects of the analytic relationship are being described. Taking steps to further this understanding necessarily leads to a greater awareness of both the dangers and the therapeutic potential of these aspects of the analytic process.

The challenge for those who embrace a two-person psychology is to

examine, understand, and integrate these heretofore neglected aspects of the therapeutic relationship, such as self-disclosure and enactment. Many of the spokespersons for a theoretical perspective that places more of the emphasis on the patient, like Chused and Richards et al., wisely caution others not to become too enamored of relational discoveries. Although I differ with them in their views of enactment and general reluctance to embrace mutuality, I strongly agree with their belief that the object of the analysis is the patient, not the analyst.

If a patient observes that I seem to have "started" an enactment that occurs between us, and I intuitively know this to be true, I will admit it—but resist the temptation to analyze the analyst. It is one thing for me to know and understand how I am re-creating my past; it is quite another thing to make this the focus of the treatment. Believing as I do, that the therapeutic action of psychoanalysis centers on expressed affect, allows me to focus on admitting what I was feeling, and taking responsibility for it, while avoiding extensive forays into explaining my behavior. If some explanation is essential for the patient's understanding of the enactment, I try to keep it brief and return the focus to the resulting impact on the patient.

Believing that giving the patient an emotionally honest response, in the moment, is essentially therapeutic—provided that the analyst expresses herself clearly and responsibly the majority of the time—is at the heart of accepting enactment as inevitable and potentially useful. Accepting that patient and analyst are fated to move each other in mysterious and unplanned ways leaves room for accepting being both the recipient and the stimulator of intense, unexpected emotion. And this acceptance leaves further room for exploring the most therapeutic ways in which to work through the re-created scenes from the past.

References

American Psychoanalytic Association Panel on Enactment. (1992). Enactments in psychoanalysis, reported by M. Johan, M.D. *Journal of the American Psychoanalytic Association, 40,* 827–841.

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Quarterly, 1,* 29–51.

Aron, L. (1996). *A meeting of minds.* Hillsdale, NJ: Analytic Press.

Benedek, T. (1953). Dynamics of the countertransference. *Bulletin of the Menninger Clinic, 17,* 201–208.

Boesky, D. (1982). Acting out: A reconsideration of the concept. *International Journal of Psycho-Analysis, 63,* 39–55.

Chused, J. (1991). The evocative power of enactments. *Journal of the American Psychoanalytic Association, 39,* 615–640.

Chused, J. (1997). Discussion of "Observing-participation, mutual enactment, and the new classical models," by Irwin Hirsch, Ph.D. *Contemporary Psychoanalysis, 33,* 263–277.

Finell, J. (1985). Narcissistic problems in analysts. *International Journal of Psycho-Analysis, 66,* 433–445.

Gabbard, G. (1995). Countertransference: The emerging common ground. *International Journal of Psycho-Analysis, 76,* 475–485.

Hirsch, I. (1993). Countertransference enactments and some issues related to external factors in the analyst's life. *Psychoanalytic Dialogues, 3,* 343–366.

Hirsch I. (1994). Countertransference love and theoretical model. *Psychoanalytic Dialogues, 4,* 171–192.

Hirsch, I. (1996). Observing-participation, mutual enactment, and the new classical models. *Contemporary Psychoanalysis, 32,* 359–383.

Jacobs, T. (1986). On countertransference enactments. *Journal of the American Psychoanalytic Association, 34,* 289–307.

Kohut, H. (1971). *Analysis of the self.* New York: International Universities Press.

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Maroda, K. (1991). *The power of countertransference: Innovations in analytic technique.* Chichester, England: Wiley.

McLaughlin, J. (1991). Clinical and theoretical aspects of enactment. *Journal of the American Psychoanalytic Association, 39,* 595–614.

Miller, A. (1981). *Prisoners of childhood: The drama of the gifted child.* New York: Basic Books.

Mitchell, S. (1988). *Relational concepts in psychoanalysis.* Cambridge, MA: Harvard University Press.

Racker, H. (1968). *Transference and countertransference.* New York: International Universities Press.

Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly, 62,* 553–571.

Richards, A. (1997, July). *Interaction in the transference/countertransference continuum.* Paper presented at the meeting of the International Psychoanalytic Association, Barcelona, Spain.

Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psycho-Analysis, 3,* 43–47.

Tower, L. (1956). Countertransference. *Journal of the American Psychoanalytic Association, 4,* 224–255.