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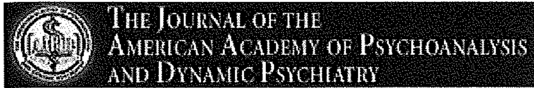

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A View From Riggs: Treatment Resistance and Patient Authority—X: From Acting Out to Enactment in Treatment Resistant Disorders

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Patients with treatment resistant disorders pose a major problem to clinicians of all theoretical perspectives, including psychodynamic therapists. Treatment of such patients often results in stalemates and impasses, and acting out is a frequent phenomenon. This paper addresses the value in work with such patients of looking beyond the concept of acting out, which is a one-person definition of a problem, toward the concept of enactment, which recognizes the roles both therapist and patient play in the phenomenon of treatment resistance.

As we have been noting in this series of papers, the problem posed by patients who fail to respond to state of the art biological and short-term psychotherapeutic treatments is increasingly recognized throughout our field. This series of papers reports what we are learning at the Austen Riggs Center on behalf of the larger field about working with such patients. This paper addresses the conceptualization of action defenses, which are a conspicuous part of the phenomenon of *treatment resistance.* Action defenses, often designated as *acting out*, pose serious challenges in treatment, leading to stalemates by creating an endless series of crises that derail therapeutic work, and evoking desperation in patients, families, and treaters. Worse still, these actions may end treatment and sometimes lead to the death of patients by suicide. Therapists are faced with the dilemma of how to formulate and approach these phenomena in a way that does not simply label them, but that also engages them in a way that can deepen and enhance the effectiveness of therapy.

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We propose that it is useful with difficult-to-treat patients to look beyond the notion of acting out toward the notion of enactment. The former is a one-person formulation, locating the action in the patient, while the latter is a two-person formulation that locates the action in both parties in the therapeutic endeavor. Recognizing the limitations of thinking about patients as acting out and reconceptualizing them as joining us in enactments is one of the major technical approaches that makes it possible to work with treatment resistant patients. This perspective is entirely consistent with and depends on the three core features of work with treatment resistant patients that we have followed throughout this series: the importance of relationships, of the exploration of meaning, and of recognition and engagement of the patient's authority as an agent in the treatment and in his or her life. Although the role of enactment in work with treatment resistant patients was noted in the first paper in this series **(Plakun, 2006)**, the current paper deepens the focus on this concept and its role in treatment.

From Acting Out to Enactment

The progression from acting out to enactment has been part of the evolution of our field. In 1945, Fenichel illustrated the "one-person" formulation when he **(Fenichel, 1945)** noted

> Neurotic acting out is an acting which unconsciously relieves inner tension and brings a partial discharge to warded off impulses. ... The present situation, somehow associatively connected with the repressed content, is used as an occasion for the discharge of repressed energies; the cathexis is displaced from the repressed memories to the present 'derivative,' and this displacement makes the discharge possible. (p. **197**)

In contrast to this intrapsychic formulation centered on concepts of drive, energy, and repression, some theoreticians were contemporaneously developing different ideas. **Johnson and Szurek (1952)**, who were working with patients prone to acting out, observed parallels between superego lacunae in the parent and the patient. They hypothesized that parents "may find vicarious gratification of their own poorly-integrated forbidden impulses in the acting out of the child, through their unconscious permissiveness or inconsistency toward the child in these spheres of behavior" (p. **323**), and asserted that the child was vicariously gratifying parents' "poorly integrated, forbidden impulses" (p. **342**).

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Bird (1957) agreed with this observation, stating that acting out is "a direct action response to stimulation by another person" that is motivated to "please or to influence another person, or perhaps to do both" (p. 630). He emphasized that this was an unconscious phenomenon using mainly behavioral channels of communication.

Contributions from International Psycho-Analytic Congress of 1968 sessions devoted to the topic of acting out crystallized these disagreements. On one pole, Anna **Freud (1968)** suggested about acting out that "excessive quantitative cathexis of the revived strivings is responsible for the *irruptions* from analysis which land the patient in repetitive *reality actions* of a psychopathic nature" (p. **170**). On the other hand, Grinberg (**1968**, p. **171**) asserted "Acting out, to my mind, can be regarded as a process that always calls for two participants."

Analysts working with patients with psychotic disorders were aware of the importance of the therapist as a central and ubiquitous "other" in analytic work. Margaret **Little (1951)** made references to the paranoid or phobic stance toward countertransference feelings that may impede the work: "I have shown above that unconscious (and uninterpreted) countertransference may be responsible for the prolonging" or "premature ending of analysis" (p. **38**). In 1973, Searles proposed the notion of "therapeutic symbiosis," which required an understanding "of the extent to which the patient is himself devoted to functioning as a therapist in relationship to his officially designated analyst, as well as in his relationships with other persons in his life" (Searles, **1973**, p. **248**). In another foreshadowing of the notion of enactment, **Boyer (1979)** discussed his treatment of a woman with whom he became sleepy in sessions. His sleepiness led to a chain of associations and to an analysis of his own dream

that led to awareness of the way his countertransference to the patient engaged conflicted issues from his own past. Boyer realized his sleepiness involved "expressing my anger by withdrawal and refusal to recognize her ... Such knowledge permitted me to regain my objectivity" (p. 361).

Writing from Riggs, **Cooperman (1983)** offered an innovative formulation: "Although the basic unit of biological functioning is the individual, the basic unit of psychological functioning seems always to be a twosome. That is, such behavior is always in relation to another person" (p. 22).

While therapists working with patients with psychotic disorders were elaborating on the vicissitudes of countertransference and paving the way toward the concept of enactment, within mainstream British psychoanalysis there was an inclination toward the evolution of a two-person psychology from early on. The Kleinians were instrumental in the development of two-person theories with their concepts of projection,

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introjection, and projective identification (Grotstein, **1994**, **1995**). Winnicott's **(1947)** observation that "there is no such thing as a baby" (p. 137) was a reference to the mother-baby twosome as an initially inseparable unit. **Sandier (1976)**, from the Anna Freud School, foreshadowed the concept of enactment when he suggested the analyst "will, unless he becomes aware of it, tend to comply with the role demanded of him, to integrate it into his mode of responding and relating to the patient. Normally, of course, he can catch this counterresponse in himself, particularly if it appears to be in the direction of being inappropriate. However, he may only become aware of it through observing his own behavior, responses and attitudes, *after these have been carried over into action*" (p. **47**, italics in original).

Mainstream American psychoanalysis, dominated by one-person ego psychology for decades, gradually incorporated the two-person approaches that came from work with patients with psychotic disorders and from the theories of the British school. In 1972 Bird, writing about analysts developing transferences and transference neuroses to their patients, suggested that the transference of the analyst was often the central obstacle in therapeutic stalemates. He **(Bird, 1972)** asserted that "stalemate in the analysis, an implacable resistance, an unchanging negative therapeutic reaction—anything of this kind should be suspected of consisting of a silent, secret, but actual destructive act engaged in by *both* patient and analyst" (p. 294).

Over time the field has seen a clear shift toward two-person formulations and toward recognition of the concept of enactment. Reporting on the work of a panel of the American Psychoanalytic Association, Johan (**1992**, p. **841**) defined enactment as a pattern of nonverbal interactional behavior between the two parties in a therapeutic situation. However, fully grasping the notion of enactment may require unpacking of this condensed definition. The link between enactment and projective identification is central (**Shapiro and Carr, 1991**, **Plakun, 1999**). Shapiro and Carr note eight components of projective identification (p. 24), including noticing that the analyst has "an attribute that corresponds" to that disavowed and projected by the patient, that the therapist is involved in "an unconscious collusion" with the process that sustains the projection, and that there is a "complementarity of projections—both participants project" aspects of their own life history into the other.

In an earlier publication **(Plakun, 1999)**, the components of enactment have been further elaborated as follows:

> One might think of enactment as a multistep process in which, first, there is the usual "reenactment" in the transference relationship of part of the patient's conflicted or traumatic past ... However, in an enactment, the

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> patient's associated unconscious self experience is next disavowed and projected into the therapist ... Enactment begins to become a unique concept, though, when the therapist then participates unwittingly by projecting back into the patient reciprocal and complementary unconscious conflicted countertransference material from the therapist's own life history. The therapist unwittingly colludes with the patient in a process of mutual and complementary projective identification organized around significant past events from the lives of both participants. Within such an enactment, the therapist is as much a participant as the patient. (p. 286)

Although some **(Chused, 1997)** view enactments as undesirable, others **(Renik, 1993)**, have argued that enactments are inevitable and useful. For example, Renik suggests "it is helpful to see countertransference enactment as the ever-present raw material of productive analytic technique" (p. 153). Based on our experience at Riggs, we agree with those who see enactments as inevitable therapeutic phenomena, particularly in work with "enactment prone" patients with primitive (e.g., action) defenses **(Plakun, 1998)**. Enactment is an integrative concept with connections to the central issues we have been emphasizing in this series: the importance of relationships, the elucidation of meaning and of the recognition of the authority of the patient in work with patients with treatment refractory disorders. The following further elaborates the notion of the inevitability and utility of enactment **(Plakun, 2007)**:

> The situation is a bit like that in skiing. In the complex interpersonal terrain of therapy, enactments seem as inevitable a part of the work as sliding downhill is on skis. In both situations one is pulled inexorably in a certain direction, either by the unfolding of the transference-countertransference relationship or by gravity. This is neither good nor bad, but part of the experience. A good skier learns the skill of finding and using his or her edges on the slippery slope, allowing control of the fall downhill. Similarly, a good therapist learns there will be enactments. The trick is to find the edge on this slippery slope that allows him or her to stay poised in a position of technical neutrality and abstinence as best one can. (p. 106)

Whether or not enactments are inevitable is in many ways a less compelling issue than learning to know when they occur, how to unravel what is going on in an enactment, and what to do with what has been learned. In an earlier publication **(Plakun, 2007)** steps in the detection, analysis and utilization of enactments were explored. Detection is an essential step; without detecting enactments the therapist is in danger of ongoing undisciplined acting out of the countertransference even to the extent of serious boundary transgression **(Plakun, 1999)**. Detection of enactments is facilitated by cultivating self-knowledge and awareness

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of one's thoughts, perceptions, bodily responses, and gut sense something may be different from the usual. Supervision and personal analysis are key to this kind of self-knowledge.

Analysis of enactments, that is, unraveling their meaning, is best carried out in a state of forbearance. This means stopping any acting out in the countertransference rather than simply continuing it or reporting it to the patient. This part of the analysis of an enactment is performed in a

way that observes the therapeutic dyad as if from the outside, that is, from a trans-dyadic perspective from the *third* **(Muller, 2007)**. Sometimes the therapist is able to complete the analysis of an enactment alone, but often it is necessary to seek supervision or consult with colleagues to concretize the perspective from the *third.*

Utilization of what has been learned in the analysis occurs in a range of ways. Utilization may take the form of an interpretation, an apology if the enactment has led to inadvertent injury of the patient with a sadistic remark or condescending tone, a new way of looking at things, recovery of an abstinent and technically neutral stance, a fuller elaboration of the formulation of the patient's dynamics, and/or emergence from a therapeutic impasse.

Acting Out and Enactment at Riggs

As we have described previously in this series, Riggs is a nonrestrictive, hospital-based continuum of care with a multilayered therapeutic structure that adds to state-of-the-art general psychiatric treatment four-times-weekly individual intensive psychodynamic therapy, family and group therapy, an elaborate therapeutic community, substance abuse services, and nursing care, in integrated ways summarized in previous papers (**Plakun, 2006; Fromm, 2006; Mintz & Belnap, 2006; Muller, 2007; Elmendorf & Parish, 2007; Schwartz, 2007**; Krikorian & Fowler, 2008; **Charles, 2008; Tillman, 2008**).

From the point of view of action defenses and their relationship to enactment, Riggs proves to be an ideal stage for these to be examined, explored and worked through. Action patterns that have been part of a patient's treatment resistance inevitably emerge in the community. These actions may manifest themselves in a wide range of behaviors, from coming late to or missing sessions, to more overt self-destructive behaviors, like cutting, burning, restricting food, threatening, or even attempting suicide. Although they may have no explicit conscious meanings for the patient, once the patient initiates these actions, they are understood as potential behavioral communications and will likely generate a complicated array of responses within staff and the patient

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community. In the environment of Riggs there is an opportunity to slow down these actions, "rewind" and examine them from different angles, including their unconscious meaning, their transference implications within therapy, the interpersonal implications within the therapeutic community, and their historical genesis within the family **(Plakun, 2006; Elmendorf & Parish, 2007, Schwartz, 2007)**. We believe much that we have been learning about at Riggs is directly applicable in outpatient and other settings.

Our experience at Riggs repeatedly reminds us that what may seem to be a counter therapeutic action initiated by a patient is generally co-created by therapist and patient. In other words, what might be understood as acting out in one-person terms is usually an enactment that, in two-person terms, involves the therapist as a main actor. The following case material constructed from composites of several cases will illustrate this. The first case example illustrates a potential enactment that is contained by the therapist's awareness of countertransference. The second illustrates an enactment that unfolds in the therapy.

The Case of G—An Enactment Forestalled

G was a man in his late thirties. Following graduation from college he began displaying serious difficulties, failing at graduate school and unable to hold a job. He would start a job enthusiastically, excel for a while, and then collapse into depression that was refractory to outpatient psychotherapy and medications. G would disappear from work, isolate in his home in a deeply depressed state, and stay in bed, often asleep, for days at a time. All through his life he vacillated between two self presentations. Whenever he was seen as a competent person who was able to take care of himself, G would collapse into depressed states that would evoke deep worries in his family members, who would intrude into his life to rescue him. The parents would vacillate between infantilizing him—giving advice on every decision he needed to make and rescuing him in the face of adversity—or insisting he was an independent, capable person who ought to be able to pull himself up by his bootstraps. G felt confused and ambivalent in his life and in relation to his family. He felt invaded and intruded upon, but also derived conscious pleasure from his family's caretaking and rescuing of him when regressed.

G began four-times-weekly therapy with a woman therapist at Riggs who was an eldest child with significant caretaking responsibilities for her younger siblings while growing up because her mother was ill and father largely absent. G's therapist had learned in the course of supervision

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and in her personal analysis, about the powerful pull toward rescuing and caretaking others that had been part of her choice of a career in psychiatry. She often struggled to contain therapeutic zeal with her patients while struggling to remain in a technically neutral, but compassionate and empathic stance.

The first several months of the treatment were uneventful. G developed an idealizing transference toward the therapist and explored his personal development. At the same time he began to function as an elected leader in the patient government. Around the sixth month, during a routine family session his parents asked G about the progress he was making. They were interested in learning whether their financial support of the treatment was proving to be a good investment. G was surprised, angry and frustrated with this inquiry, and deferred the question to his therapist, hoping she would help him out. The therapist was aware of strong wishes to offer a response to protect the patient and the treatment, but recalled a similar discussion had already occurred a month or so earlier, and contained her impulse, suggesting to G that he might have a point of view about what his parents were asking. In fact, G did offer a summary of what he thought he was learning in treatment.

In the next session G became angry with the therapist for the first time. He blamed her for not standing up for him and for making him do the work. He felt lonely, abandoned, and betrayed. The therapist acknowledged that G was feeling hurt and abandoned, but noted that G seemed to omit that he had handled the question competently himself.

Soon G began missing most sessions, staying in bed, and resigned from his position in the patient government. This evoked concern in the therapist and the treatment team. Now G was raising questions in their minds about how well he was using the treatment. There were team discussions about whether G was regressing and whether there was a need for an administrative intervention or a family meeting to report his absences from sessions. When G came to sessions the therapist was curious about why G missed sessions. G told his therapist that he was

avoiding some sessions because he felt overwhelmed. He asked the therapist whether he should come to or skip sessions when he felt overwhelmed. The therapist recognized a strong wish to suggest he come to the sessions, but, aware of G's parents' tendency to give such advice and of her own characterologic inclination to rescue and take care of him, recognized and contained her countertransference impulse. Instead of making a suggestion about G's decision to come to or skip sessions, she suggested that perhaps G might attend to what was going on in his mind during the moment of decision.

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The next week G missed the first session, but came to the next and reported to his therapist, "As you suggested, I paid attention to what was going on in my mind when I was struggling with the decision about coming. I recognized that if you told me I had to come, that would have made me mad and I would have opposed the idea. Since you gave no specific recommendations, I was conflicted. On the one hand I was thinking that I should go. But this thought made me angry and I opposed it. This in turn, made me feel good. Then I recognized I didn't want to go—that was what I wanted. The first sessions of the week are always too overwhelming for me so I needed an extra day off. When I made this decision though, I felt guilty about it." In subsequent sessions G and his therapist were able to elaborate the way G's life pattern of alternation between competence and collapse were being played out in his treatment at Riggs, as well as to note how G's "regression" seemed related to "aggression," that is, anger at his therapist for not taking care of him adequately. G's regression from competent functioning and from active participation in his treatment had a quality of revenge for failing him, and invited treating him as incapable, lacking both personal agency and the full authority to make his own decisions. He had found and recreated in his treatment the very issues he was grappling with in his life. Over time G took ownership of his role in initiating and evoking the very behaviors from his family that he found so intrusive and infantilizing, and was able to return to his therapy sessions and to competent functioning as a member of the patient community in a way that was sustained through discharge several months later.

The family therapy session was a critical moment in which G, in a familiar role, was unwittingly pulling the therapist into the position of doing something for him that he was perfectly capable of executing himself. The therapist's detection, analysis, and containment of her countertransference rescue fantasies, while remaining in a technically neutral stance, allowed the patient to practice his newly developing skills, while evoking negative transference anger in relation to the therapist for not rescuing him. It was a moment of separation and differentiation out of which the patient emerged with a sense of accomplishment and pride in exercising his budding sense of authority.

In the later issue involving missed sessions, G illustrates the process of internalization. What could have unfolded into a familiar action pattern if the therapist had made a suggestion, instead, turned into an internal conflict with which G could grapple. G's therapist's early detection and analysis of countertransference feelings and impulses led to their containment, and minimized the evolution of an enactment that would simply repeat the problem G had with his family in the transference

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and treatment, without either G or his therapist seeing what was happening or how the problem was being cocreated.

Early detection, analysis, and utilization of a potential enactment by a self-aware and self-reflective therapist who forbears acting on counter-transference impulses is a laudable goal, but it is not always achieved. The following is an example of such a situation.

The Case of W—An Enactment

W was in her thirties when she came to Riggs. The only child of a divorced musician couple, she had an extended history of a profound schizoid adaptation and social phobia. As a child she was frequently physically and emotionally abandoned while her parents rehearsed and performed in their demanding musical careers. During adolescence she was uninterested in developing friendships, attending social functions, or inviting friends to her home. She was deeply attached to her maternal grandparents and would spend most of her time with them. In her teens she dated a boy she eventually married. It became the one stable relationship in her life.

In contrast to the emptiness of her interpersonal life, W excelled academically, feeling this aspect of her life compensated for what she lacked in her interpersonal world. After college she applied for graduate studies but dropped these plans, married her boyfriend, who worked in a blue-collar job, and became a homemaker and mother when she discovered she was pregnant. W was deeply but guiltily resentful about her life. In her late twenties, not long after the death of both maternal grandparents, she became symptomatic, developing significant depression, restricting food, and losing large amounts of weight, often smashed her hands with a mallet and burned herself. She made several suicide attempts, was repeatedly hospitalized, and her marriage deteriorated. Several attempts at outpatient psychotherapy, including DBT, and numerous medication trials failed, leading to referral to Riggs.

At Riggs, W consciously tried to emerge from her schizoid cocoon. She gradually became more outspoken in various groups and tried to deepen and expand conversations with peers outside of groups. This was a wearing task. After periods of such attempts to reach out to people, W would isolate in her room, read books, listen to music, or paint to recuperate. While she struggled in the Riggs therapeutic community for several months, she filled the therapy hours with explorations of her lonely childhood and sense of abandonment by her parents.

The therapist was a man known for his relatively quiet and patient personality. The therapist's own parents had been distracted during his

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youth by the needs of his chronically ill younger brother. The therapist had been an inhibited adolescent who was seen as mature rather than shy. Unlike other adolescents, whose rebelliousness caused all sorts of trouble, the therapist was never a concern for his family. This created a conflicted self-image for the therapist. Although he longed to be less inhibited and felt shame about his reticence, he was also proud of the image of him as mature—as were his parents, who took pride in their mature, healthy son who was such a good boy.

As the therapist listened to W's themes of loneliness and abandonment he felt interested, but also left with an impression that he was an inanimate object in the room or at best a silent spectator of W's lonely explorations. In his work with W, the therapist had a clear therapeutic formulation and strategy that he shared with the treatment team. He saw himself as allowing the patient to expand and unfold into the therapeutic space. He was using interpretations sparsely to try to help W settle in and become accustomed to the presence of another person within the small

physical space of the office, but he was aware of difficulty feeling genuinely "with" W. Despite the therapist's experience of being a spectator, there was also evidence that the patient was revisiting important aspects of her past and sharing the narrative of her life.

After several months W began flirting with male patients and then engaged in brief sexual liaisons with a few of them. This behavior caused a stir in the patient community and in the treatment team since it was not consistent with behavioral expectations. Despite sharing some concern about these actions, the therapist also saw them as comparable to the developmental struggles of a teenager and as potentially useful for W. However, as often happens in splitting, what felt like developmentally appropriate mischief to the therapist felt like an intolerable flouting of rules to the larger community. W was referred by another patient to the patient group that examines and contextualizes, ideally in a nonpunitive way, worrisome behaviors carried out by members of the patient community (see **Elmendorf & Parish, 2007**). In the meeting with her peers she was angrily confronted about her promiscuous behavior.

This was a turning point for W, who felt her efforts to emerge from her schizoid cocoon had failed. W felt her efforts were seen as nothing but a performance, like the musical performances her parents would put on before audiences. She was confused, deeply hurt, humiliated, and angry. W severed her ties with the patient community and withdrew to her schizoid self. She had fantasies of hammering her hands or burning herself with cigarettes, but managed to contain these with the help of interpretive work about her humiliation and rage. Working on her paintings in the activities department and coming to therapy became the only spaces she attended regularly.

As she withdrew, W spoke of hopelessness, despair, and wishes to commit suicide. She became deeply resentful about her therapist's inability to help her emerge from the schizoid shell, demeaning the therapist's mind and technique, mocking his clothing and threatening to destroy his office. At one point she attempted to smoke in his office, evoking a strong sense of resentment, futility, and anger in the therapist. Nevertheless the therapist felt he was helping by keeping his composure and continuing to be present as a listening, empathic other in the sessions. From the therapist's theoretical perspective, it felt like the work was unfolding, with a negative transference emerging as he held to a technically neutral stance.

Several months passed with this intense, contagious sense of hopelessness and attacks on herself, the therapist, and others. During the therapist's two-week vacation, W overdosed on over-the-counter pills. She was immediately transferred to an emergency department and spent two weeks in an ICU being monitored for liver failure. The therapist, who was becoming increasingly hopeless about the work, had been relieved by his vacation and the break from the work, but was shocked to hear of her suicide attempt when he returned. For several weeks the patient and the treatment became the main topic of discussion in team meetings and larger clinical staff meetings. The therapist felt like he, his patient, and their work were under scrutiny and shamefully exposed. Colleagues confronted the therapist about his lack of affect and sense of numbness in his presentations of the work with W. They questioned his technique. Was he "addressing the aggression," "was W medicated enough"? W's actions evoked a strong response in the therapist compounded by responses from the patient community. The therapist felt enraged, exhausted, humiliated, and defeated. Even though she was now hospitalized elsewhere on a locked unit, W seemed to be invading all aspects of his life, even disturbing his sleep.

Once stabilized, W was readmitted to Riggs to review what had happened and whether the work could continue. In addition to exploration of what led to the suicide attempt, the therapist also renegotiated with W the terms of a viable treatment. He made it clear to the patient that there was one very definite requirement if they were to continue working together—the patient had to be open with him in therapy or with nursing staff about any wishes to die, instead of acting on them, so that they could determine if W's treatment could continue, and explore the meaning of suicide together. W agreed to this condition, reporting she was fearful of losing her treatment at Riggs and understood the implications of secrecy around suicidal wishes and plans. She gradually became aware of the link between the therapist's vacation abandonment

of her and her suicide attempt. From this perspective her attempt looked like acting out.

After W's suicide attempt, the therapist's colleagues were instrumental in helping him become aware of his own role in the process that had unfolded with her. They offered a sometimes difficult-to-experience but helpful perspective from the "third" to the therapist, who sometimes experienced shame about what he had not seen. This consultation helped him emerge from his place lost in the dyad during a regressed enactment. The therapist became more aware of unforeseen implications of his "technically neutral stance." In this instance he had been defensively avoiding the multiple negative feelings that W had evoked in him. Realizing this, he became more aware of and comfortable interpreting such motives as brutal, enraging, sadistic aspects of W. In response she felt, somewhat to the therapist's surprise, confirmed, acknowledged, and seen. Along with her negative transference, W also showed more caring and tender sides of herself to the therapist

Gradually, with consultation from colleagues and with self-analysis, the therapist was able to recognize how his countertransference led to his own role in the enactment. W developed transferences that were congruent with conflicted, narcissistic aspects of the therapist's self representation. This provided fault lines for the development of complementary countertransferences in the therapist, as described by **Racker (1968)**. The subsequent mutual and complementary regression organized around these fault lines became an enactment.

As the therapist consulted with colleagues about his work with W he realized several components of his role in the enactment. When W engaged in sexual relationships, the therapist realized he had silently colluded with her breaking of the Riggs behavioral expectation for abstinence from sexual relationships with fellow patients because of the way her behavior resonated with his own unfulfilled and inhibited adolescent sexual longings.

In addition, an aspect of the therapist's conflicted, grandiose self-image was engaged in the work with W. Both he and W shared the experience of neglect by their respective parents. As W complained about this experience from her own childhood, it hooked in the therapist his childhood and adolescent response of patiently enduring parental neglect in the service of being complimented as mature. What he experienced as being a mature and patient therapist, albeit without much emotional connection to W, she experienced as evidence of his neglect. While the therapist found in W someone to be patient with at a distance, waiting for the reward of being seen in a flattering way, W found in her therapist her neglectful, distant, and professionally preoccupied parents.

The therapist came to realize that the *acting out* of W's overdose was actually an enraged rejection of the absent father she found in him, and that his "patience" concealed his own emotional retreat from her, with previously unconscious wishes from him to be rid of her—wishes with which she unwittingly ultimately complied in her overdose.

Further Comments on the Case of W

As is so often the case in work with previously treatment refractory patients, what appeared from one perspective to be W's "acting out" was in fact an enactment involving therapist and patient. W, through her relentless, sadistic attacks on the therapist, had recreated a situation from her past, turning the therapist into the kind of "numb," passive and absent listener her parents had been. This time, though, it was the analyst who was a coactor and "enactor" of this old theme. Detection of the enactment, coupled with self analysis on the part of the therapist, with help from colleagues, allowed the work to deepen. Once conscious of his role in the enactment, the therapist was able to contain and metabolize his countertransference and return to a technically neutral analytic stance within which he could be emotionally more available to W and no longer numb.

It is also worth noting that W helped the therapist become aware of grandiosely held, conflicted aspects of his self-image. W's attacks on this image were clearly destructive—as she was being dangerously destructive with herself. On the other hand, they led to a moment of increased self-awareness for the therapist, thus offering a chance for reparation, reworking, and recreation of a less conflicted self-image. This is an example of the treatment resistant patient unwittingly becoming therapist to their therapist in the transference as part of moving toward a healthier adaptation (**Searles, 1973**; **Riviere, 1936**; **Chasseguet-Smirgel, 1984**).

Conclusion

Among the preconditions for optimal therapeutic handling of enactments are a good enough therapeutic relationship (as embodied in the working alliance), careful attention to the elucidation of meaning as a mutually agreed upon task of the therapy, and acceptance of the fallible humanity and legitimate authority of both participants. With these in place, the therapist's role is to carefully monitor the evolving transference

and countertransference in the service of early detection of enactments. Countertransference feelings, impressions, and fantasies are invaluable sources of data. It is imperative for the therapist to *hear* and to achieve understanding in words of the actions of both the patient and the therapist.

If the therapist can detect and make sense of countertransference feelings and the impulse to act, he has a chance to contain them, as illustrated in the case of G. However, since these feelings and impulses are often preconscious or unconscious phenomena, their recognition may only be possible retroactively or with the perspective of an outside third, as in the case of W. Once an enactment is detected, the therapist's task is to analyze it in a state of forbearance, and then determine how to utilize and bring it to the work.

The moment of enactment often brings therapeutic work to a crucial fork in the road. Down one direction lies stalemate or impasse, while down the other lies an opportunity to deepen understanding of the patient's struggles, strengthen the alliance, and advance the therapeutic work.

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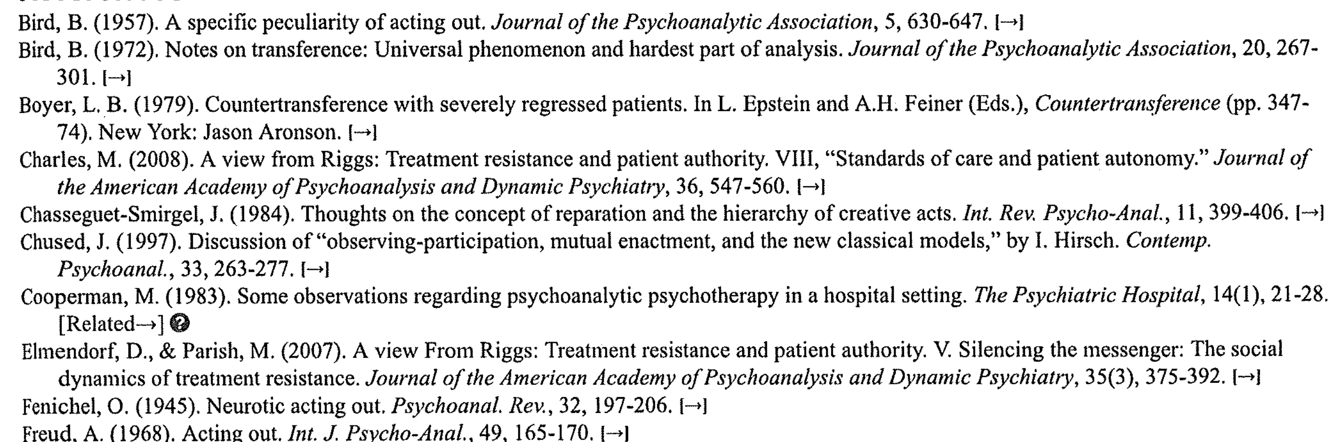

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