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WHERE THE ACTION IS: THE ENACTED DIMENSION OF ANALYTIC PROCESS

Enacted processes—variously addressed in the current literature by such terms as enactment, actualization, and interaction—represent the conceptual reuniting of Freud's concepts of transference and acting out. These various concepts include a recognition that transference may be represented not only on the verbally symbolized level but also on the enacted level, through psychic organizations and processes that use behavior, silence, and even speech as symbolic vehicles. Countertransference too finds representation within the enacted realm, in response to and in concert with the patient's enacted processes, though in more attenuated fashion. Enacted transference-countertransference processes are conceptualized as a continuously evolving second dimension of analytic treatment. This enacted dimension of analytic process exists alongside, and inextricably interwoven with, the treatment's verbal content, with characteristics unique to each analytic dyad. It occurs naturally and inevitably, without conscious awareness or intent, and is outside the domain of explicit technical interventions. The observable outcroppings or end points of processes within the enacted dimension are what are currently referred to as enactments. Attention to these unintended but meaningful and often elaborately developed characteristics of the treatment process furthers our understanding of the therapeutic action of psychoanalysis. The process of integrating the enacted with the verbal dimension of treatment enables the analysand to achieve higher levels of psychic organization.

The concepts of transference, acting out, and repetition were introduced together, early in Freud's writing (1905, 1912a, 1914).

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Despite their intertwined beginnings, psychoanalytic thinking about transference and action developed along separate paths, the latter in both neglected and disfavored fashion. In his review of action and acting out, Roughton (1996) notes that "from the very beginning of 'the talking cure,' there has been a strong tendency to exclude action, both in fact and in theory, from this mostly verbal process . . ." (p. 130).

Yet Freud linked the two concepts. He viewed transference both as a way of remembering and as a resistance to remembering (1912a). And he viewed acting out not only as a resistance to remembering, but also as a way of remembering (1914): "The patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as an action; he *repeats* it, without, of course, knowing that he is repeating it . . . . As long as he is in the treatment he cannot escape from this compulsion to repeat; and in the end we understand that this is his way of remembering" (p. 150). For Freud, acting out was a clinical concept directly related to transference: acting out was *always* transference, and the entire transference was an acting out, one that was essential for the treatment—"When all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*" (1912a, p. 108). Consider Freud's three examples of acting out:

> The patient does not say that he remembers that he used to be defiant and critical towards his parents' authority; instead, he behaves that way towards the doctor. He does not remember how he came to a helpless and hopeless deadlock in his infantile sexual researches; but he produces a mass of confused dreams and associations, complains that he cannot succeed in anything and asserts that he is fated never to carry through what he undertakes. He does not remember having been intensely ashamed of certain sexual activities and afraid of their being found out; but he makes it clear that he is ashamed of the treatment on which he is now embarked and tries to keep it secret from everybody [1914, p. 150].

Today we would more likely consider these to be examples of transference (or transference resistance) rather than acting out. Clearly, Freud did not sharply differentiate the two concepts. Both could constitute a resistance at one point and an indispensable tool for analytic work at another. Both seemed to be part of a conceptually broader category of repetition, but Freud did not make it clear how they differed from each other in this regard.

In discussing acting out, Freud (1940) also expressed concern that a patient's actions outside the treatment setting could seriously interfere

with the treatment and suggested that "the ideal conduct for our purposes would be that he should behave as normally as possible outside the treatment and express his abnormal reactions only in the transference" (p. 177). Analysts since Freud, overemphasizing this statement, have generally defined acting out as *motor* behavior, primarily *outside* the treatment setting, that served as a *resistance* to analysis (for thorough reviews of the concept of acting out, see Kanzer 1966; Boesky 1982; Abend 1993; Roughton 1996). Less attention was paid to Freud's statements linking acting out with transference in which he described forms of action *within* the analytic setting which, like free association, could also serve a *communicative* function.

Recent years have seen a reversal of this trend, resulting in two major changes in the concept of acting out. The first, a correction of the historical overemphasis on resistance, is by now well established and widely accepted: acting out is no longer seen simply as a discharge product opposed to transference and impeding the treatment. It is now understood as a product of the mind, the equivalent of other forms of unconscious communication and resistance. Ekstein's admonition (1965) over thirty years ago—"as we are impartial toward the *content* [of the patient's communication] we must also learn to be impartial toward the *mode of communication*" (p. 171)—is now a commonplace.

The second major change, a correction of the overemphasis on *motor* action, is more subtle and still evolving. Contemporary psychoanalytic interest has shifted away from the mostly external motor actions generally referred to by the term *acting out,* and is now attending to more subtle forms of action occurring *within* the analytic dyad. Concepts like "enactment," "actualization," "reliving," and "living out in the transference" have increasingly replaced "acting out" in psychoanalytic discourse (Boesky 1990; Chused 1991; Hurst 1995; Jacobs 1986, 1991; Johan 1992; McLaughlin 1991; Poland 1992a,b; Purcell 1995; Renik, 1993a,b; Roughton 1993, 1996). Not only do these newer concepts place less emphasis on motor behavior; they also return to Freud's point that acting out and transference are two forms of remembering and repeating, two vehicles for the expression of the patient's psychic reality.

Thus, these contemporary terms represent the conceptual reuniting of Freud's intertwined concepts, acting out and transference. They recognize that transference may be represented not only through verbal symbols but also through *enacted processes*—unconscious psychic

processes that use behavior, silence, and even speech as symbolic vehicles.[1] Many analysts now accept the idea that enacted manifestations of transference are integral accompaniments of the verbally symbolized transference and are intrinsic to the development of a fully analyzable transference (see Busch 1989, 1995; Loewald 1971, 1975).

With regard to the analyst's countertransference, broadly defined, it too may find representation through enacted processes, though generally in more attenuated fashion. Thus, in addition to the *verbally symbolized* interaction between analyst and patient, the bread and butter of analytic work, there is now considerable interest in *enacted* forms of interaction—unintended forms of transference-countertransference engagement in which the analyst's countertransference intersects with, and actualizes, the patient's transference. This *enacted dimension of analytic process*, as I will be calling it in this paper, occurs naturally and inevitably, without conscious awareness or intention. It exists alongside, and in concert with, the treatment's verbally symbolized content, an ongoing and evolving realm of analytic process with features unique to each analytic dyad. In these terms, the therapeutic action of psychoanalysis may be considered a function of two interwoven and inextricable treatment processes: transference experienced enactively and insight symbolized verbally.

I wish to emphasize that in this paper I am considering *standard* analytic treatment, treatment characterized by a reliance on verbally symbolized processes as the normative communicative mode and by a relative absence of gross behavioral action. I am not addressing analytic treatment characterized by a patient's chronic "acting out" or persistent demands for action and gratification from the analyst. With such

[1]By linking action with symbol formation I mean to emphasize, as I will discuss below, that a patient's capacity for verbal symbolization exists along a *continuum* of cognitive development that will vary with the vicissitudes of analytic regression. Thus, verbal modes of thinking will often be dominated by earlier, action-dominated modes of thinking and communicating—pre-stages of verbal symbolization—both of which may have unconscious symbolic value (see Busch 1989, 1995). I am not implying that verbal symbols and "enacted symbols" (Steingart 1995) are equivalent forms of mental development or that their place in analytic process is identical. The term *enacted symbol* can be likened to Freud's use of the term *dream symbol* and the concept of enacted processes to Loewald's concept (1976) of enactive memory. I intend the concept to highlight the role of enacted modes of psychic representation in standard analytic treatment, and thus to further redress the historical devaluation of action as an early developmental channel for the patient's expression of his or her psychic reality. Referring to these pre-stages of symbolization simply as "nonverbal" processes is insufficient, as enacted processes may also employ words as their vehicle.

patients, the enacted dimension of transference typically occupies the foreground of the treatment process, while its verbally symbolized dimension remains in the background.[2] What I am suggesting here is that in standard analytic treatment an ongoing enacted dimension—more than we may have realized or acknowledged—regularly forms an integral part of the process.

Following a review of early formulations that have addressed this dimension of analytic process without conceptualizing it as such, I will consider the contemporary concepts of enactment, actualization, and interaction. I will suggest that these concepts refer to interrelated and overlapping aspects of the larger, enacted dimension of analytic process, and may usefully be grouped under the umbrella term *enacted processes*. I will offer illustrations of the enacted dimension of analytic treatment, and will conceptualize interactive enacted process within an intrapsychic model of treatment. Finally, I will address the contemporary debate over technique in an effort to demonstrate that awareness of the enacted dimension of analytic process furthers our understanding, not of technique, but of the therapeutic action of psychoanalysis.

[2]Steingart (1995) considers the transference experiences of these patients to be primarily organized as "pathological play"—the outcome of psychopathology in the anal-rapprochement child's emerging awareness of the differences between the real and the "playfully unreal." In such cases, verbal symbols (language) are an unsuitable vehicle to realize the patient's psychic reality, which can only be expressed through "enacted symbols" and "pathologically playful transferences." A second group of patients whose treatments are typically characterized by a particular form of enacted transference process are those with a history of early object loss or significant early trauma. Such patients typically relive aspects of the experience through repetitive and often dramatic enacted transferences (Katz 1993; Roughton 1993)—which may take the form of repetition (acting out) in the transference or an unconscious identification with the object of memory—and remain unaware of the reproductive aspect of their behavior. From a psychoanalytic point of view this occurs as a result of a splitting of the ego at the time of the trauma, due to the immediate need for denial of a piece of external reality, followed by a continuing denial in one of the ego sectors that then remains frozen and fixated at the time of the trauma (Altschul 1968; Blum 1983). (This idea finds support in cognitive studies of perception and memory which demonstrate that "perceptual defense" [Erdelyi 1974] at the time of trauma interferes with the perception and processing of sensory stimuli.) As a result, the experience of the trauma does not get encoded into representational memory but is encoded instead on the sensorimotor level, what Dowling (1982) referred to as "motor recognitions," or in primitive forms of enactive language (Loewald 1975; Busch 1989, 1995) where it continues to organize psychic functioning. The analysis of such primitive enacted transferences in cases of trauma and early object loss may be seen as a *formative* psychic activity—one in which new representations and concepts are constructed and an ego split is gradually integrated—rather than one characterized by an undoing of a repression followed by the recall of a once conscious representational memory.

EARLY CONCEPTUALIZATIONS OF THE ENACTED DIMENSION OF ANALYTIC PROCESS

Transference and Acting Out

Over the past two decades many analysts, from both structural and developmental perspectives, have expanded our understanding of the enacted dimension of *transference*. One of the earliest and most influential contributors to this subject was Hans Loewald (1960, 1970, 1971, 1975, 1976), who legitimized and ultimately elevated its role. Loewald made the clarification that Freud's contrasting of remembering and repeating was meant to elucidate two different modes of psychic functioning, but not to imply that they were mutually exclusive. In Loewald's view, the conscious mental act of remembering—what he called "representational memory"—is a kind of repetition that occurs in the psychical field, and repeating in the form of action—what he called "enactive memory"—is an unconscious form of remembering. Thus, within the analytic setting, action, as an unconscious memorial activity, is a vehicle of communication and a useful form of transference.

Boesky (1982) argued for the formal integration of Freud's concept of acting out with the related concepts of transference, repetition, and working through. In his definition of acting out, Boesky emphasized the centrality of unconscious fantasy and compromise formation. He considered acting out to contain two components: an unconscious transference fantasy and a concomitant action or behavior. Building on discussions of "actualization" by Laplanche and Pontalis (1967) and Sandler (1976), Boesky maintained that when the ego experiences the imminent futility, or danger, of an unconscious fantasy's becoming actualized in the transference, action can facilitate a compromise formation that simultaneously carries out the wish and defends against it: "what becomes relevant . . . is the fate of the unconscious transference fantasy and its tendency toward actualization rather than the coincidental motor action or behavior which might or might not accompany it as an aspect of the compromise formation engendered by the fantasy" (p. 46).

To emphasize its status as a legitimate product of the mind, Boesky usefully compared acting out to dreams[3]: the day residue that prompts dreams corresponds to the transference residue that prompts

[3]For an elegant conceptualization of the transference neurosis as a waking dream, see Kern (1987).

acting out; the complexity of condensations in dreams corresponds to the complexity of compromise formations in acting out; the hallucinatory reality of dreams corresponds to the false reality created by acting out; the manifest content and the latent content of dreams correspond to the two components of acting out—the action itself and the underlying transference fantasy; the secondary revision of dreams corresponds to the patient's rationalizations about acting out; and both phenomena contain an adaptive potential—active, nonregressive components that are related to the process of working through.

Boesky summed up the centrality of acting out in psychoanalytic treatment as follows: "Psychoanalysis can not take place without acting out any more than psychoanalysis could take place without transference. Acting out is the potential of the transference neurosis for actualization and therefore expresses the psychic reality of the transference" (p. 52). Thus Boesky firmly linked acting out with transference. Steingart (1995) considers most acting out to *be* transference—a transference organization that "incorporates an urge for action of one sort or another in the psychoanalytic relationship" (p. 135). In the terms I am developing here, Freud's original concept of acting out would refer to the *enacted dimension of transference*.

While many have called for a general psychoanalytic theory of action (Hartmann 1964; Boesky 1982; Rangell 1989), the conceptualization of action as a dimension of transference puts action in a different light. As Roughton (1996) suggests, action per se is not in fact a psychoanalytically meaningful term, since action is ubiquitous in the clinical process and encompasses all motivated behavior from thinking, feeling, remembering, and talking at one end, to observable motor behavior at the other: "Action, thus broadly defined, by itself has no clinical psychoanalytic significance, just as the chemistry of an artist's paints is vital to his or her work but has nothing to do with the choice of subject or the experience of the viewer" (p. 141). In Roughton's view, the psychoanalytically meaningful questions about action in the clinical setting are about *which* actions are carried out and *why*—that is, they concern motivation, conflict, and psychic functioning.

I would add that the relevant questions about action also concern the very nature of transference—the nature of both its enacted and its verbally symbolized dimensions. For instance, what do enacted transference processes tell us about the nature of the patient's experience of the treatment, the depth of the analytic regression, the quality of the

patient's psychological orientation to reality, or the level of his or her ego development? Is transference expression in the enacted sphere inevitable, and are shifts between the two spheres an essential part of working through, as Freud suggested?

Both Busch (1989, 1995) and Loewald (1975) have added a developmental perspective to these issues, further explicating the nature of the enacted dimension of transference. In discussing forms of transference in which words and language are not used symbolically but rather are used as actions, Busch points out that while psychoanalysis considers the verbal period to begin at about eighteen months, words and thought are actually under the domination of action for a much longer period. Speech may thus constitute action that symbolizes something in addition to, or even entirely different from, its verbal content. Busch's concept of "action-thoughts" and Loewald's concept of "language action" designate forms of verbal repetition in action that originate in the early preoperational, concrete-operations stage of thinking (ages 2–5), when talk and action are not yet fully distinguished. During this stage the child is in the process of transforming the earlier action mode of thinking[4] into a new arena, the mental, in which reality can be represented internally. Mental experience in this stage, however, continues to remain closer to overt action. Since neurosis is formed during this stage, the central role of repression ensures that action-thinking and language action will continue into adulthood outside the patient's awareness. Thus, in Busch's view, the compulsion to repeat in action may be seen as a natural consequence of neurosis, and action-thoughts—"memories in action"—are viewed as an inevitable and necessary component of remembering. Interpreting action-thoughts allows repressed experiences under the domination of preoperational thought to be examined via higher-level thought processes.

Rather than saying, as I did above, that action-thoughts, or language action, are forms of transference in which words and language are not used symbolically but are used as actions, I am proposing that such forms of transference represent early pre-stages of symbolization that are ubiquitous and continuous in analytic work. Such enacted transference processes, utilizing the cognitive currency of the oedipal

[4]During this earlier sensorimotor period, thought and action are identical and awareness is organized around sensorimotor schemata. Anthi (1983) and McLaughlin (1987) discuss such primitive enacted transferences in the clinical setting, and the possibilities of their being analyzed.

and preoedipal periods, bring the infantile past into the treatment in an affectivly alive and immediate way. As Loewald (1975) describes:

> In the course of the psychoanalytic process, narrative is drawn into the context of transference dramatization, into the force-field of re-enactment. Whether in the form of free associations or more consciously, logically controlled trains of thought, narrative in psychoanalysis is increasingly being revealed in its character as language action, as symbolic action and in particular as language action within the transference force-field. The reference in regard to content and emotional tone of the communication through narrative, shifts more and more to their relevance as transference repetitions and transference actions in the psychoanalytic situation. One might express this by saying we take the patient less and less as speaking merely *about* himself, about his experiences and memories, and more and more as symbolizing action in speech, as speaking from the depth of his memories, which regain life and poignancy by the impetus and urgency of re-experience in the present of the analytic situation [pp. 293–294].

In the more reflective phases of treatment, "what was re-enactment, by reflection changes to that more objective repetition which Freud has called reproduction in the psychical field, as against reproduction by action" (p. 296). Effective clinical technique, according to Loewald, requires the analyst to maintain an optimal balance between what I am calling the enacted and the verbally symbolized dimensions of treatment.

In Loewald's view, the core of the transference neurosis consists of experiences understood and resolved in an action form in the psychoanalytic situation.[5] Thus, Loewald views repetition in the form of re-enactment as the sine qua non of the transference neurosis. Analyzing this enacted dimension of transference, as I am calling it, provides depth of feeling, meaning, and understanding that is not present in analyzing thoughts alone. This is similar to Poland's view (1992b) that it is the actualization of the patient's past in the present interaction with the analyst—what he calls an "original creation"—that is the essential subject matter of effective analytic process.

[5]Freedman (1994) demonstrated how motor action in the clinical setting, rather than constituting the outcome of unsymbolizable conflict, may at times be a precursor to the transformation of psychic structure into higher levels of symbolization. As such, he too views the transference neurosis not as the reactivation of the infantile neurosis, but rather as the actualization of the unconscious fantasy in the here and now. This view is also central to Kern's conceptualization (1987) of the transference neurosis.

Countertransference

Although I have been describing the enacted dimension of *transference*, I consider enacted processes also to be a dimension of *countertransference*. Like acting out, countertransference was at first viewed primarily as a resistance to analysis that the analyst needs to overcome (Freud 1910, 1912b, 1915a). Conceptually linked to abstinence, countertransference, again like acting out, became excessively tied to overt behavior. General acceptance of the broad, or "totalistic," conception of countertransference (Heimann 1950; Racker 1957)[6] has been instrumental in diminishing the exclusively negative/resistant connotation of countertransference, and has initiated a long-needed study of other facets of the analyst's subjective involvement in the clinical process.

To illustrate, I will summarize a vignette provided by Busch (1989, pp. 536–537). Mr. A was a "good patient" who had no difficulty supplying thoughts and feelings, and who generally responded to interpretation with confirmatory associations and memories. Nevertheless, little analytic progress was being made. Over time, the analyst realized that the content of the patient's words was not as important as the form they took: the patient was not really talking "to" the analyst, but talking "for" the analyst; he was not really "telling" the analyst his thoughts, he was actually "giving" them to him. The patient's *verbal action* was the symbolic equivalent of his childhood actions designed to please his mother, who, during his toilet training begun at the age of one, waited with him in the bathroom until he had a bowel movement.

This vignette offers a good example of an enacted transference process in which words were used not as verbal symbols but as enacted symbols. If we focus, however, on the analyst's side of the couch, we might ask why this interaction went on for the length of time it did. Let us assume, hypothetically, that the patient's enacted transference gratified an unconsciously determined infantile need in the analyst to "get" from the patient "good" material that in turn contributed to the reported transference resistance. Relevant to this discussion is that this hypothetical countertransference was not, initially, verbally symbolized in the analyst's mind but rather was *enacted* in the analytic interaction. Far from being disadvantageous for the treatment, however, it unintentionally provided the patient an analytic environment in which his

[6]For theoretical reviews of countertransference, see also Kernberg 1965; Abend 1989; Lasky 1993; Gabbard 1995.

infantile relationship with his mother was symbolically actualized—*remembered* in the enacted dimension of the treatment. For an unplanned and temporary period of time, it suffused the patient's infantile wishes and defenses toward his maternal object with an *analytic* reality, palpable and alive for both participants, in the "playground" of the transference (Freud 1914, p. 154). The patient's transference became an "original creation" with his analyst, thereby enhancing its analyzability following the analyst's return to a position of neutrality and abstinence.

Thus, like enacted transference processes, enacted countertransference processes contain the potential for advantageous impact on the clinical process. Boesky (1990) points out that conflicts in the analyst may lead not only to pathological countertransference but also to "creative subjectivity" through which analyst and patient gain understanding:

> Countertransference is too vague and abstract a concept to account for the myriad of interventions by the analyst which I am here indicating. It is not enough to say that lapses in technique are unavoidable. These lapses are highly valuable glimpses into the nature of the psychoanalytic process itself. Serious countertransference can destroy an analysis or stalemate it. All analysts must monitor their work throughout their careers with this in mind. But it makes little sense to refer to the ubiquitous minor intrusions of the analyst's unconscious as mere "lapses" of technique. There must be important reasons *why* these so-called minor lapses are universal and inevitable. It is time that they be removed from the category of forgivable but regrettable "countertransferences" and studied in careful and extensive detail to see what light they shed on the nature of the psychoanalytic process as the expression of an interactional experience [pp. 573–574].

Early object relations theories, psychoanalytic developmental theories, and, most recently, modern structural theory have all tried to take formal theoretical account of the complex interactions that occur within the transference-countertransference relationship. I will briefly summarize five concepts from diverse theoretical perspectives—each of which deals with some aspect of the enacted dimension of clinical process—in an effort to explicate their contributions to the thesis I am developing: (1) the Kleinian concept of projective identification, (2) Sandler's concept of role-responsiveness, (3) Tower's concept of countertransference structures, (4) Loewald's concept of a new object relationship, and (5) Boesky's concept of unconsciously negotiated

resistance. Following the review of these concepts, I will turn to a critical assessment of the contemporary concepts of interaction, enactment, and actualization.

Projective Identification. This term was coined by Melanie Klein (1946) to describe a primitive defense against paranoid/schizoid anxieties in which threatening parts of the ego are split off and projected into the object in an effort to rid the self of that which threatens to destroy it from within, and also to control and take possession of the object. Klein, however, addressed this process only as an intrapsychic fantasy in the patient. She did not address the patient's interactive process with the analyst, or any contribution the analyst might make to this process.

A dyadic, interactive dimension of this process was added by Bion (1959), who, using a developmental model, viewed the mother/analyst as the needed "container" of the primitive affective states that the child/patient could not yet regulate. The analyst, consciously or unconsciously, "contains" what the patient needs to project—holding it by temporarily deferring interpretation—until the patient is capable of experiencing it as part of the self.

Joseph (1989), focusing on the actual process of this analytic interaction, described the patient as attempting to unconsciously "nudge" the analyst into acting in a manner consistent with his or her projection, and the analyst as responding with internal, attenuated responses that can be used as data for interpretation. Joseph and other contemporary British Kleinians (see Spillius 1992; Schafer 1997) make substantial interpretive use of the analyst's psychic responses to the patient in the moment-to-moment flow of clinical process. However, Joseph stops short, as did Klein and Bion, of considering what contribution the analyst's own unconscious dynamics might make to this process, and so does not conceptualize the interactive process as unique to the particular patient-analyst dyad.

Role-responsiveness. In contrast to these concepts of projective identification, Sandler's theoretical formulations take the step of including the analyst's unconscious dynamics in an interactive process unique to each analytic dyad. "Role-responsiveness" is part of Sandler's broad, object-relational consideration of transference-countertransference phenomena. Sandler (1976) considered transference to refer not only to the displacement of libidinal and aggressive wishes, but also to all the patient's attempts to manipulate or provoke situations with the

analyst—through subtle verbal and nonverbal interactions—in order to *actualize*, within the framework and limits of the analytic situation, the intrapsychic self-object role relationship in which these unconscious wishes are embedded. This includes the role in which the patient casts him- or herself, and the complementary role in which he or she casts the analyst. Regarding countertransference, Sandler held that in addition to maintaining a "free-floating attention" to the patient, the analyst, within limits, responds to the patient with a "free-floating responsiveness" that includes not only thoughts and feelings but attitudes and behavior. In Sandler's view, these responses, important elements in the analyst's "useful" countertransference, are compromise formations between the patient's pressure and the analyst's own unconscious tendencies.

Behavioral role-responsiveness thus entails the unintended, attenuated actualization of an unconscious wish, or defense against the wish, on the part of the analyst that may contribute to the patient's experience of transference actualization. The analyst may become aware of this participation only after it has been carried over into action, thus enabling the patient to remain unaware of the infantile relationship he or she is trying to impose.

Sandler's concept of role-responsiveness overlaps with the Kleinian concept of projective identification,[7] but differs from it in three critical ways that are relevant to my thesis. First, it extends the idea of an interactive pull in the analytic relationship beyond the effects of a single primitive defensive maneuver on the part of the patient (projective identification) to the entire arena of multiply determined and layered transference phenomena from all levels of development and psychic organization. Second, it expands the concept of enacted psychic processes to include the *analyst's* unconscious processes. Third, behavioral role-responsiveness is seen as the product of a unique transference-countertransference fit that is an inevitable and unavoidable part of the treatment process.

[7]Within his own framework, Sandler (1993) conceptualizes projective identification as a defensive activity with two steps, one intrapsychic and one interpersonal: first is an intrapsychic process of splitting off and projecting (displacing) in unconscious fantasy some unwanted aspect of a self-representation onto an object representation; this is followed by the externalization of the object representation (now revised to include the unwanted aspect of the self) onto an external object (e.g., the analyst) via an actualization process in which the analyst is pushed, through unconscious verbal and nonverbal maneuvers, into playing a particular role vis-à-vis the patient. The analyst's participation constitutes a compromise formation between the patient's pressure and the analyst's own unconscious tendencies.

Sandler does not, however, explore these interactive processes as an important *ongoing dimension* of analytic process, parallel to the verbally symbolized dimension, nor does he ask whether they are *integral* to the development and working through of the transference.

Countertransference structures. While it predates Sandler's concept of behavioral role-responsiveness by twenty years, Tower's similar concept of "countertransference structures" (1956) goes further in the direction of my thesis.[8] Like role-responsiveness, a countertransference structure consists of the analyst's unconscious countertransference correspondence to the patient's particular transference—a unique pathological fit between transference and countertransference that is exploited by the unconscious pressure of the patient's transference:

> Every analyst of experience knows that as he gets deeper and deeper into an analysis, he somehow or other loses a certain perspective on the total situation. . . . it would appear that even under the most ideal circumstances there are bound to be certain drifts, so to speak, from the utterly straight direction of the analyst's performance and understanding of a case, and it is these very slow almost imperceptible drifts which develop in him in unconscious response to hidden pressures and motivations from his patient, which I think constitute the essence of the development of a countertransference structure in and of itself. . . . It is in the nature of the transference resistances as they are built up by the patient that they should ferret out and hurl themselves against the weakest spots in the therapist's armamentarium [pp. 233–234].

Going further than Sandler, however, Tower viewed the development of a countertransference structure, whether a large or small part of the treatment as a whole, not only as inevitable and unavoidable, but also as an essential component of the curative process. As the counterpart of the transference neurosis, its understanding by the analyst is a necessary vehicle for the emotional understanding and final working through of the transference.

> Perhaps the development of major change in the one, which is, after all, the purpose of the therapy, would be impossible without at least some minor change in the other, and it is probably relatively unimportant whether that minor change in the other is a rational one. It is probably far more important that the minor change in the other, namely the therapist,

[8]Tower's paper (1956) has been little noted, perhaps because her concept of countertransference structure became associated with the controversial concept of "countertransference neurosis," despite her explicit rejection of that concept (see p. 235).

> be that which is specifically important and necessary to the one for whom we hope to achieve the major change. These changes in the therapist would be compounded in my view from the ego adaptive responses and the unconscious countertransferences of the analyst, interacting upon each other in such a way as to expand his ego integrative powers specifically to cope with the particular patient's transference resistances [p. 234].

Tower's lucid and remarkably prescient formulations of interactive enacted processes—her depiction of the existence of inevitable, naturally occurring enacted transference-countertransference processes that are unique to each analytic dyad and essential to the therapeutic action of psychoanalysis—comes closest to the thesis I am developing in this paper. I will further suggest that these processes form an *ongoing dimension*—a second analytic text, if you will—that operates, without awareness, in concert with the verbally symbolized dimension of the treatment.

The new object relationship. The idea of an essential ongoing dimension of transference-countertransference process that remains largely unsymbolized on the verbal level is inherent in Loewald's concept of a "new object relationship" (1960, 1980, 1986). In Loewald's view (1986), the patient's transference to the analyst is not only a repetition of old object relationships, but also a new rendition that is "increasingly modified by the libidinally based transactions in the analytic encounter between patient and that special new object—the analyst" (p. 286). The ongoing juxtaposition, in the patient's experience, of both dimensions of transference provides him or her with the opportunity to reopen earlier lines of development within which new ways of relating to self and objects can be discovered.

Loewald (1986) thus situates transference and countertransference in a developmental context in which they are viewed not as separate issues but as "two faces of the same dynamic, rooted in the inextricable intertwinings with others in which individual life originates, and remains throughout the life of the individual in numberless elaborations, derivatives, and transformations" (p. 276). One of these transformations, Loewald (1980) observes, shows itself in the analytic encounter where, in deep unconscious layers, there coexists, along with more advanced levels of mental functioning and organization, "modes of *interpsychic* relatedness, of emotional ties that are active under the surface in both analysand and analyst, and thus in their relatedness, forming ingredients of the therapeutic potential" (p. 376; emphasis added).

Additionally, Loewald (1986) placed emphasis on the analyst's emotional investment in the treatment process, acknowledged or not by patient or analyst. He proposed that this emotional investment—what he calls the "rapport facet" of the countertransference—is a decisive factor, though by no means the only one, in the curative process. He observes that "if the capacity for transference . . . is a measure of the patient's analyzability, the capacity for countertransference is a measure of the analyst's ability to analyze" (pp. 285–286).

Loewald considered these features of the analytic relationship to be a nonexplicit background influence in standard analytic treatment, a relatively constant factor in the treatment process. In this paper I am highlighting an additional aspect of this ongoing analyst-patient interaction: unintended, enacted processes that result from the *unique* transference-countertransference fit of each analytic dyad.

Unconsciously negotiated resistance. Boesky's concept of "unconsciously negotiated resistance" brings the idea of inevitable, naturally occurring enacted transference-countertransference processes, unique to each analytic dyad and essential to the therapeutic action of psychoanalysis, squarely within the classical framework.

From his interactional perspective within modern structural theory,[9] Boesky (1990; Hurst 1995a) expanded the concept of transference resistance to include an interactive form wherein the manifest shape taken by the resistance is unconsciously negotiated by both parties. He considers the idea of a "pure" analytic treatment, in which all resistances are created only by the patient, to be a fiction. As do Sandler and Tower, Boesky considers the analyst's contribution to these "usable" patterns of transference resistance to be a compromise formation, between the analyst's understanding of the patient and the analyst's own unconscious conflicts, which is used creatively without conscious awareness.

Emphasizing the uniqueness of each such transference-countertransference interaction, Boesky (1990) asserts that since the analyst's compromise formation would not have been necessary for another analyst, the resulting manifest form of the transference resistance is unique to the particular analytic dyad:

[9]In Boesky's perspective, *interaction* is a descriptive term referring only to the locus of the process, still within an intrapsychic framework. He distinguishes his perspective from interpersonal, relational, or intersubjective perspectives that ascribe mutative aspects to the relationship with the analyst, rather than to interpretation.

> the transference as *resistance* in any specific case is unique and would never, and could never, have developed in the identical manner, form, or sequence with any other analyst. *In fact, the manifest form of a resistance is even sometimes unconsciously negotiated by both patient and analyst.* I am suggesting here a type of adaptive or benign iatrogenic resistance. . . . I have in mind complex and lengthy sequences of interaction which only gradually become evident to the analyst as a resistance in the patient and to which the analyst has in some more or less subtle way contributed by his or her own behavior [p. 572].

Going further than Sandler and, I believe, in essential agreement with Tower, Boesky considers these interactive forms of transference resistance, to which the analyst inadvertently contributes, to be a part of every successful analysis and an unavoidable expression of the essential emotional participation of the analyst. He states the matter baldly: "If the analyst does not get emotionally involved sooner or later in a manner that he had not intended, the analysis will not proceed to a successful conclusion" (p. 573).

THE CONTEMPORARY CONCEPTS OF INTERACTION, ENACTMENT, AND ACTUALIZATION

The past several years have witnessed an increased psychoanalytic interest in the transference-countertransference processes just reviewed, centering on the concepts of enactment, actualization, and interaction. Many contemporary analysts find the terms *transference* and *countertransference* too confining to capture the way in which meaning is generated in the process between patient and analyst. Although definitional consensus has not yet been reached, even by analysts working within the same theoretical model, the concept of enactment may be considered the *interactive form of transference-countertransference*, a dimension of treatment within which unconscious transference and countertransference fantasies achieve unintended actualized meaning. As noted by Smith (in Opatow 1996), "Transference and countertransference and their interactive form, enactment, operate ubiquitously and continuously both to generate and obscure meaning. The theory of compromise formation demands that the analyst's intrapsychic conflicts enter into his every technical decision. . . . We must interpret, in part, from countertransference. We cannot help it. What we always see when we look carefully is the simultaneous intertwining of the patient's and analyst's conflictual life.

This unique interaction in each analysis is the medium out of which meaning arises" (p. 643). Thus, the concepts of enactment, actualization, and interaction describe interrelated and overlapping aspects of what I have been calling the enacted dimension of analytic process.

Interaction

The term *interaction*, central to the concept of enactment, has had difficulty finding acceptance within classical analytic thinking. Despite the fact that the five conceptualizations of transference-countertransference interaction reviewed above come from analysts working within an intrapsychic framework, there continues to be reservation about its place within this model and a considerable lack of clarity about its meaning. Participants in two recent panels on interaction (Hurst 1995; Purcell 1995) could not agree on a meaningful definition that remained within an intrapsychic psychoanalytic framework, and contemporary discussion of interaction in psychoanalysis has come primarily from relational and intersubjective theorists, who hold to a different theory of human experience.

Part of the problem, I believe, derives from the tendency for discussions about interaction to become intertwined with the debate over theoretical models and their underlying assumptions (for an extensive and balanced discussion of the intersubjective and classical models, see Dunn 1995). Briefly, the intersubjective model views the patient-analyst interaction as creating the clinical data and driving the clinical process; the intrapsychic model views interaction as simply the locus of the analytic process at any given moment and considers the patient's core psychology, which has an existence independent of the immediate clinical interaction, to be what propels the treatment process. In the former view, interactions *are* the clinical data; in the latter view, interaction forms only the manifest layer of the psychic data—it is one route to the patient's intrapsychically derived core personality issues.[10]

This debate is predicated on the everyday meaning of the word *interaction,* an essentially behavioral/interpersonal definition. An intrapsychic, psychoanalytic definition could be achieved, however, by conceptualizing interaction not as an interpersonal or behavioral event but as a transference-countertransference process—what Loewald (1970,

[10]The theoretical distinctions are presented here in dichotomous form for the sake of expositional clarity only.

1980) referred to as *inter*psychic process—that achieves symbolic actualization within the enacted dimension of the treatment. Earlier, with regard to acting out, Boesky suggested that we conceptually divide the term into two components: (a) the unconscious transference fantasy pressing for actualization, and (b) the concomitant behavioral action, which may or may not accompany it. In similar fashion, the term *interaction* can be conceptually divided into an intrapsychic and a behavioral component: (a) an unconscious transference fantasy and an unconscious countertransference fantasy, each of which actualizes the other, and (b) their concomitant observable outcropping—their behavioral/interpersonal representation—in the analytic setting. Such a conceptual division would return our analytic focus to unconscious fantasy and compromise formation, thereby distinguishing an intrapsychically based, psychoanalytic concept of interaction from the everyday notion of personal interaction.

In analytic interaction so conceived, the interrelated wishes or defenses of patient and analyst need not be identical. Their genetic determinants, as well as the meaning of the interaction for each participant, may be different (Chused 1991; Smith 1993). In this intrapsychic model, neither the patient's transference nor the analyst's countertransference is "co-created," as described by relational and intersubjective theorists (see Dunn 1995; Hoffman 1991, 1992). This perspective conceptualizes separate sets of *intrapsychic* fantasy constellations, each of which finds symbolic representation in the enacted realm and confirms the unconscious fantasy of the other. While one can consider such a symbolic *interaction* to be co-created, the underlying transference and countertransference fantasies are not. On the clinical level, the essential treatment issue in such interaction is the patient's conscious and unconscious reactions to the fact that he or she has experienced the analyst's enacted countertransference process as an actualization of transference wishes.

To illustrate interaction from this intrapsychic perspective, I will summarize two clinical vignettes from the literature. The first is from Sandler's 1976 paper on role-responsiveness (pp. 46–47). There Sandler describes the treatment of a patient who had a need to "structure" her world so that she always knew exactly "where she was." From the beginning, she cried regularly in sessions, which elicited from the analyst the response of regularly handing her a box of tissues. Sandler states that he did not know why he did this (he did not do the same with

other patients), but decided not to alter it or bring it up until he understood it better. One day, two and a half years later, he found himself *not* passing her the tissues, again not knowing why. The patient upbraided him for callously abandoning her. The ensuing analysis of this interaction uncovered memories that further clarified the patient's underlying fear of soiling herself, which began at the age of two and a half following her mother's withdrawal upon the birth of her brother. Not only did the patient fear soiling herself, she feared soiling herself and there being no mother to clean her up. According to Sandler, the patient had unconsciously elicited in him an actualizing role enactment—initially, the mother who cleaned her up and then the mother who did not—which proved central to the recovery of this specific, but previously obscure, unconscious anxiety and fantasy.

In this vignette, an extended interaction formed an ongoing, perhaps sustaining, backdrop of the treatment. By "interaction," however, I do not refer to the interpersonal, behavioral act of passing the tissue box per se, but to the process in which the analyst's role-responsive countertransference (his countertransference structure, in Tower's terms; the rapport facet of his countertransference, in Loewald's; his creative subjectivity, in Boesky's) unintentionally provided the patient an actualized experience of her central intrapsychic conflict. For the entire two-and-a-half-year period of treatment reported, patient and analyst were engaged in subtle, unconsciously determined communications in the enacted dimension of the treatment, alongside and in concert with, the ongoing work in the verbally symbolized dimension more commonly considered *the* analytic process. The first part of this prolonged interaction—experienced by the patient as the transference actualization of the mother who cleaned her up—held in abeyance the transference reexperience of the traumatic infantile event. The second part of the interaction—experienced by the patient as the actualization of the trauma itself—took place at a point in the treatment when the patient had sufficiently experienced the analyst as a caretaking mother.

In what could be described as an assertion by spontaneous negation, Sandler parenthetically states that "it would be pure speculation to link the two and a half years of analysis with the age when her anxiety started" (p. 47). Sandler is thus suggesting that it was at this symbolic point in the treatment that the patient communicated, and the analyst unconsciously processed, subtle signals of a readiness to move on. The interpretation and working through of this new *analytic* experience of

the infantile trauma could then proceed within the treatment's verbally symbolized sphere. The phenomenon observable in some analytic treatments that there is a chronological recapitulation of important developmental events—that the patient actually has a temporal re-experience in the transference—is a clear example of the enacted dimension of the analytic treatment process.

My second illustration of an interactive enacted process comes from an extensive vignette provided by Renik (1993b, pp. 144–149). Renik describes the two-year treatment of an obsessional, timid, and inhibited man who was inwardly boiling with rage, particularly at women. One day he announced that he had not taken any sleeping pills, which he used occasionally, for a month. He complained that "it was like being weaned from the breast" and that the analyst could not know how difficult it was. Renik made the following comment: "It's as if you feel like the only person who was ever weaned from the breast." Renik reports that while the comment was accurate—calling the patient's attention to attitudes of entitlement and a sense of injustice that were central features of the transference—it was made in the context of conscious feelings of frustration with the pace of the treatment and impatience with the patient's whiny complaints, both of which had stimulated Renik's own grandiose self-pity. As a result, the interpretation was "not entirely kindly meant, and therefore was not put as gently as it might have been." Neither patient nor analyst addressed the hostility expressed in the interpretation. The patient merely acknowledged the truth of its content and compliantly associated to it. His warded-off unconscious experience of the interaction broke through, however, in a slip: he substituted the name "Gary" for the name of his son. When asked about this, he said: "The only Gary I can think of is the younger brother my parents told me about that was stillborn when I was a year and a half old." The patient had never before mentioned this fact. The slip led to the retrieval of early childhood memories not consciously available before: following the stillbirth, the mother had suffered a severe postpartum depression and the patient was sent to live with his aunt. In exchange for his not contradicting her fantasy that he was her son, she was unconditionally accepting of him, enabling him to ward off experiencing the traumatic rejection by his mother.

In his discussion, Renik describes what I would call the enacted dimension of the analytic process that had been taking place between patient and analyst from the treatment's inception:

> Initially we duplicated in many ways, without realizing we were doing so, his childhood relationship with his aunt. He construed my patient attention and therapeutic optimism as evidence of an all-accepting love for him; and I, in turn, saw in his eager cooperation the promise that I would be allowed to succeed with him where all others had failed. An early phase of progress confirmed both our fantasies; but then, as the pace of psychological discovery and symptomatic improvement slowed, mutual disappointment set in. In this context, my angry reaction to his complaining, which I expressed pointedly via my interpretation of his grandiose self-pity over discontinuing sleeping pills, evoked his rejection by his depressed mother. . . . When I made my deflating remark and the patient responded to it, neither of us recognized that he was experiencing me as punishing him in the same way and for the same reasons he thought his mother had punished him long ago [p. 150]. I was insisting on being an angry, rejecting mother instead of a gratifying aunt in order to punish him for the hostility and demands toward me that lurked beneath the surface of his good-patient pose. The childhood theory had been that his devastated mother had sent him away because his resentment of the frustrations he had to endure during her pregnancy and his jealous rage toward little Gary *in utero* had caused the stillbirth [p. 148].

I will take up other aspects of this vignette in the next section. At this juncture, I simply wish to emphasize again that the interaction in this vignette is not the act of making the hostile interpretation per se, but rather the entire treatment-long process wherein analyst and patient were engaged in unintended actualizations of each other's unconscious fantasy.[11] Through this interactive enacted process and its spontaneous correction, the patient's core conflictual object relationship was "remembered" in the treatment and ultimately integrated through interpretive work on the verbally symbolized level.

Enactment and Actualization

Contemporary Freudian consideration of this unconscious interactional dimension of analytic process has revolved primarily around the concepts of enactment and actualization, two concepts that have gained wide currency in the literature (Chused 1991; Jacobs 1986, 1991, 1994; McLaughlin 1991; Johan 1992; Renik 1993a,b; Roughton 1993).

[11]As in the Sandler vignette just discussed, the time period comprising this enacted process—two years—recapitulated the actual developmental time period of the childhood events (the patient was sent to the aunt at the age of one and a half, and lived with her for six months).

Actualization, the older concept, dates back to Laplanche and Pontalis (1967) and to Sandler (1976). As pointed out by Boesky (1982), it is a bridge term, like "tension" or "drive," that attempts to link subjective experience with the objective-abstract theory that tries to explain it. Thus the term *actualization* is useful because it describes both the patient's *subjective* feeling that an unconscious fantasy is being partially realized, and the *objective* process of the ego's attempt to revise compromise formations engendered by the conflict over the emerging transference fantasies. Sandler (1976) uses the term in both ways, but conceptualizes the process in object-relational terms: actualization is that process by which the patient attempts to recreate the infantile role-relationship that will actualize the transference wishes embedded in it. These include not only unconscious instinctual wishes but "the whole gamut of unconscious (including preconscious) wishes related to all sorts of needs, gratifications and defenses" (p. 45).

The concept of enactment, first used in a journal title by Jacobs in 1986, has been a generally useful conceptual addition to our psychoanalytic lexicon, one that has generated a considerable amount of productive discussion and debate. It has, however, also been a problematic term, easily given to misunderstanding and misuse.

First, despite the 1992 panel's agreement on a definition (Johan 1992),[12] the term continues to be used somewhat differently by each of the analysts participating, limiting its obvious advantage over the problematically conceptualized and negatively tinged *acting out.* Jacobs, for example, employs the term the least rigorously (or the most flexibly), applying it to any verbal or nonverbal behavior, by either patient or analyst, that actualizes an unconscious wish or defense. This usage is essentially Freud's original definition of acting out—remembering via action. With Jacobs's coinage of the term, enactment began to replace

[12]"Enactments derive from unconscious sources in both patient and analyst. Enactments are those moments, from brief and single moments to prolonged and/or multiple time periods, during which the patient's action, in the service of transference resistance, interacts with the analyst's resistance. The analyst's resistance subsumes those phenomena which have been called the analyst's countertransference, counter-identifications, or his transferences to that particular patient. The actions of both patient and analyst may vary from silent withholding and withdrawal to motor action of greater or lesser dramatic notice. While these phenomena have been observed, noted, and described for some time, those present at the panel regarded the term *enactment* as especially useful because it denotes a two-party interactional situation. That situation is the observable presentation of unconscious meaning residing in both analyst and patient" (p. 841).

acting out as a concept linking the enacted and verbally symbolized dimensions of transference. Jacobs's many evocative case vignettes, describing a wide range of both patient and analyst enactments, beautifully illustrate their ubiquity and their usefulness as analytic data. Chused's use of the term, closely followed by McLaughlin's, is the most specific and original. These authors restrict the term to interactional forms of enactment—that is, to events that actualize unconscious wishes or defenses in *both* patient and analyst (what I have been conceptualizing as the enacted dimension of analytic process). They, too, consider such phenomena ubiquitous and inevitable, but stress that only their retrospective interpretation is mutative. Still other analysts, for example Renik, tend to emphasize the analyst's contribution to enactments. This focus is an outgrowth of the recent interest in the subjectivity of the analyst and its impact on the treatment process. Renik believes that such phenomena at times have mutative value in and of themselves.

Second, while relatively free of the pejorative connotations of *acting out,* the word *enactment* still leaves the impression of a discrete behavioral event, whereas the essence of what needs to be conceptualized is a dynamic, evolving unconscious process. As Smith (in Opatow 1996) points out, descriptions of enactments in analytic writings, welcome for providing a more vivid interactive view of the analytic situation, do give the misleading impression that enactments are exceptional events rather than the "continuous background of the work of analysis" (p. 643).

A third problem with the term *enactment* arises from the mixing of intrapsychic and interpersonal frames of reference. On a theoretical level, the concepts of actualization and enactment could be defined, respectively, as the intrapsychic and the behavioral components of interaction, as I have defined it. That is, *actualization* would denote either (a) the intrapsychic, subjective experience of a transference (or countertransference) wish obtaining satisfaction through analytic interaction, or (b) the process by which this occurs. *Enactment* would denote the extrapsychic, observable, interpersonal-behavioral manifestation of the actualization.[13] On the clinical level, however, such differentiations do not actually exist, as these two aspects of interaction always occur

[13]With regard to levels of psychic reality, enactment would be comparable to the manifest content of a dream, while actualization would be comparable to the unconscious wishes of the dream's latent content and to the process by which they employ an enactment (the manifest content) to provide them with "real," observable, yet disguised expression.

together. As such, enactment, like actualization, has come to be used as a bridge term, subsuming both the overt patient-analyst interaction and the underlying unconscious fantasies being actualized.

This third problem—confusing the interpersonally observable and the dynamically unconscious aspects of the enacted dimension of analytic process—has generated misconceptions about how such interaction relates to analytic technique. For example, in calling for a revision in our basic theory of technique, Renik (1993a) suggests that "we discard a widely held principle of technique, which holds that countertransference enactment . . . is to be avoided" (p. 562). He makes this recommendation with reference to his extensive clinical vignette (Renik 1993b), summarized in the preceding section. The vignette, he states, demonstrates how "acting unselfconsciously on a wish to compete with and punish a patient was the basis for a very effective analytic intervention" (p. 563), and adds: "Sometimes it is useful for an analyst to accept the need to act under the influence of personal motivations *of which he or she has become aware* before those motivations can be thoroughly investigated" (p. 563; emphasis added).

Renik's suggestion to alter analytic technique arises, I believe, from his focus on the observably interpersonal, rather than dynamically unconscious, aspect of the interaction that took place in the vignette. His experience of a semiconscious intent while making the hostile interpretation leads him to consider how technique might accommodate the expression of the analyst's "personal motivations." I believe that this line of thinking is misguided for a number of reasons. First, it overlooks the fact that the *timing* of the comment, as well as the unconscious meaning it held for both participants, was influenced by factors beyond his control. Second, these factors were not simply his own "personal motivations," but *particular* personal motivations stimulated by the patient's enacted transference process, with which they joined in an unconscious process. Third, it was not the interpretation itself that initiated the therapeutic re-creation of the patient's core transference theme. The interpretation was merely the observable end point of the unconscious actualization processes he so cogently described. By the time this part of the "enactment" occurred, the underlying actualization processes had already been evolving, inherent in the fabric of the treatment, for an extensive, dynamically meaningful period of time. The very fact that it reached Renik's conscious awareness was actually an indication that further analytic transformation had just occurred. The

"countertransference enactment" was an unconscious adjustment or corrective to the actualization of transference and countertransference fantasies and defenses against them that had already taken place within each participant's unconscious experience of the treatment process. It was this unconscious analytic adjustment—perhaps initiated by subtle, unconsciously determined communications from the patient of a readiness to reexperience his infantile trauma—that ultimately enabled the two dimensions of the transference to be productively integrated. My point is this: while Renik's action did facilitate the analytic process, it did so *not* through a change in technique. As I will elaborate, not even the observably interpersonal, much less the dynamically unconscious, aspect of the enacted dimension of analytic process falls within the province of analytic technique. Rather, both should be considered under the rubric of the therapeutic action of psychoanalysis.

THE ENACTED DIMENSION OF ANALYTIC PROCESS

The concepts of enactment, actualization, and interaction, as well as the earlier concepts of projective identification, role-responsiveness, countertransference structures, the new object relationship, and unconsciously negotiated resistance, all address aspects of what I am conceptualizing as the *enacted dimension of analytic process*. They may be usefully grouped under the umbrella concept *enacted processes*. This term would provide conceptual organization to these interrelated and overlapping concepts, much as *internalization processes* organizes such overlapping concepts as introjection, incorporation, identification, and imitation. More important, as a process term, it better captures the evolutionary quality of unconscious fantasy as it plays itself out in the analytic setting.

I thus conceptualize analytic process as comprising two continuously interwoven and inextricable dimensions of experience: the verbally symbolized dimension, which makes use of free association, fantasies, dreams, self-reflection, and interpretation; and the enacted dimension, in which unintended actualizations of unconscious fantasy predominate.

Transference inexorably presses for actualization in the treatment setting. As Freud (1920) noted in his discussion of the repetition compulsion, "The unconscious—that is to say, the 'repressed' . . . has no other endeavor than to break through the pressure weighing down on it

and force its way either to consciousness or to a discharge through some real action" (p. 19). Thus, transference wishes continuously press to find contemporary satisfaction in the clinical setting. This process may be described as a relentless movement from repression to expression both in the verbally symbolized dimension (through thoughts and fantasies) and in the enacted dimension (through a variety of enacted processes).

The enacted dimension of transference is thus an ongoing and integral component of the treatment process. Unconscious fantasies, as transference potentials, gradually develop into a coherent, analyzable transference as they achieve, whether for brief or extended periods, some meaningful actualization in the enacted dimension of the treatment. The standard technical admonition to allow transference manifestations to develop and deepen before interpreting can be conceptualized as the desirability of allowing them to achieve some measure of symbolic actualization in the "interactive analytic space" of the treatment (Poland 1992a).

Analytic technique—including the analyst's optimal adherence to the technical principles of abstinence and neutrality, as well as his or her judicial use of interpretation—is the dialectical counterpart to the patient's press toward transference actualization. It is a balancing force gradually guiding the expression of transference wishes, with appropriate timing and tact, toward verbal symbolization. Optimal analytic technique maintains for the patient a delicate balance, in the "playground of the treatment," between the actualization of transference and the analysis of transference. As a result, the patient's participation in the treatment process continuously oscillates along a dynamic continuum between, at one pole, the enacted representation of transference fantasies and, at the other, their self-reflective verbal symbolization.

The analyst's subjective processes (i.e., facilitating and hindering countertransference responses) also find expression in the enacted dimension of the treatment. Their manifestations, however, are counterbalanced and ultimately attenuated by a number of factors inherent in the analyst's functioning: the analyst's different role responsibility in the analytic partnership, which requires the analyst to contain personal responses and needs and to subordinate them to the task of analyzing the patient; the boundaries circumscribed by the analyst's technique; the guidance provided by an analytic ego molded out of training, experience, and personal analysis; and the values and

standards contained in and monitored by an analytic superego and ego ideal.

The enacted dimension of the analyst's subjective processes does not necessarily have a hindering effect on the treatment process. Indeed, it often forms a facilitating counterpart to the patient's transference in the kind of *interactive* enacted process illustrated in the vignettes presented above. However, when conflicts in the analyst that are largely unstimulated by interactive processes find expression in the enacted dimension of the treatment, they generally *are* hindrances to the treatment. While some enacted countertransference processes of this kind may be benign, or are rendered benign by self-analysis, others have the potential to seriously compromise or even destroy a treatment, and must always be guarded against. Even if such an enacted process elicits and actualizes a patient's transference, it is generally of limited therapeutic potential because, in this situation, the patient's transference wishes are aroused by an external, environmental impingement—recapitulating the patient's experience of the fate of his or her wishes in the original object relationship—rather than arising out of the patient's own therapeutic creation in the enacted dimension of the treatment, where a disconfirming transference experience has the opportunity to occur.

The relatively unexplored *interactive* aspect of the enacted dimension of analytic process has been the primary focus of this paper. It exists alongside, and interwoven with, the verbally symbolized dimension of the process, a second dimension of therapeutic action. It is this interactive dimension that can create what is commonly referred to as good patient-analyst "chemistry," but it can also create blind spots in the analyst or result in a stalemated treatment. Its role in the treatment may appear relatively circumscribed and episodic, resulting in readily observable "enactments," or it may reveal itself as having been a silent, ongoing part of the treatment process for years and lead to the kinds of unique analytic achievements illustrated in the vignettes I have presented. But whether contributing positively and in easily discernible ways or problematically in more subtle and confusing ways, whether episodic or chronic, interactive enacted processes—as a dimension of transference and countertransference—are an inherent and inevitable feature of the analytic relationship, and a potentially critical ingredient in the therapeutic action of psychoanalysis.

TECHNICAL IMPLICATIONS

The enacted realm is part of all human relationships, and enacted processes contribute to all object choice (Sandler 1976). In the analytic situation, no alteration of technique, or addition to it, is required for their occurrence, and proper technique offers the analyst no immunization. Nonetheless, technical discipline is necessary if enacted processes are to have *analytic* meaning, and inconsistent or poorly conceptualized technique can make these processes difficult or even impossible to recognize, much less analyze. In other words, analytic technique and interactive enacted processes are dialectically related—each derives essential analytic meaning with reference to the other. Thus, enacted processes are simply real-life interpersonal events, even when occurring within an analysis, unless conceptualized within the context of analytic technique—that is, unless defined as unintended *departures* from the optimal analytic attitude that technical principles are intended to promote. And technique can be usefully conceptualized with reference to enacted processes. As Loewald (1986) puts it, "neutrality constitutes a resting point or mean around which . . . [transference-countertransference] dynamics oscillate with greater or smaller amplitude" (p. 281). Thus, while it is true that the analyst's "irreducible subjectivity" (Renik 1993a) makes technical ideals unattainable and ensures the inevitability of enacted processes, the analyst's subjectivity does not render technical principles obsolete or expendable. Enactments have no analytic meaning without them.

To illustrate this relation between technique and the enacted dimension of analytic process, I will use Casement's detailed and oft-cited case presentation (1982). Following is an extensive summary of the clinical process.

Casement describes the analysis of a young woman who had been seriously scalded in an accident at the age of eleven months. Six months later she was operated on to release the scar tissue from the surrounding skin. During the operation (performed under local anesthesia) her mother, who was present and holding her hand, fainted—falling to the ground and releasing her daughter's hand. The surgeon continued the procedure despite the mother's collapse.

In reliving this experience in the treatment, following a summer break, the patient reported a dream about a despairing ten-month-old child and requested that she be allowed to hold the analyst's hand

lest her anxiety become intolerable. In a Friday session, the patient threatened that unless she were able to hold the analyst's hand she would not continue the analysis. Casement managed this crisis by saying to her that some analysts would not contemplate allowing this but that he realized she might need to have the *possibility* of holding his hand if it seemed to be the only way for her to get through this experience. In this way he kept open the possibility of granting her request, as well as the opportunity for further analytic work.

Over the intervening weekend he reassessed the situation and realized that he was in part reacting to his own fear of losing the patient (he was about to present a paper about her to his society). More critically, however, he realized that to allow her to hold his hand would not help her to get through a reexperiencing of the original trauma, which had involved the *absence* of the mother's hand. As a result of this analysis of the situation, he decided to tell his patient that he would not permit her to hold his hand.

Over the same weekend, the analyst received a hand-delivered letter from the patient informing him that she had had another dream about a despairing child, but that this time the child was crawling toward a motionless figure with the excited expectation of reaching the figure. In Monday's session the patient explained that she had been afraid the analyst might collapse over the weekend if he had to wait until Monday to be reassured that she was feeling more hopeful. She then reported another image: when the child reaches the figure and touches it, it crumbles and collapses. At this point the analyst explained to her his rethinking—why he had decided that he should not hold her hand. The patient was devastated, assuming he could not bear to be in touch with what she was going through.

Casement then describes in sensitive detail the elaboration of the transference reliving, which hovered precariously for several weeks between delusion and workable illusion before its final resolution. At one point, the patient developed the delusion that the analyst was actually her mother and demanded to be held. Casement states that it was meaningless to her when he tried to interpret this "as transference, as a reliving of her childhood experience . . . there seemed to be no remaining contact with me as analyst" (p. 282).

At this critical juncture, Casement states, he finally became aware of the patient's projective identification—that he had been feeling her despair and helplessness and the impossibility of going on—and was

able to interpret from his countertransference feelings. He said to her, "I feel as if it could be impossible to go on, yet I feel that the only way I can help you through this is by being prepared to tolerate what you are making me feel, and going on" (p. 283).

Following this intervention, the patient began to speak to Casement as the analyst again, and actually had the sensation of smelling and feeling the hands of her pre-trauma mother's presence. She was able finally to accept his original interpretations—that her wish for him to concretely hold her hands was a wish for him to really be in touch with what she was going through and that, had he agreed, he would have become a collapsed mother/analyst. She expressed gratitude that he did not allow this to happen.

In his discussion of this material, Casement speculates on his technical handling of the abstinence principle:

> It is a matter for speculation whether I would have been so fully subjected to the necessary impact of this patient's experience had I not first approached the question of possible physical contact as an open issue. Had I gone by the book, following the classical rule of no physical contact under any circumstance, I would certainly have been taking the safer course for me but I would probably then have been accurately perceived by the patient as actually afraid even to consider such contact. I am not sure that the re-living of this early trauma would have been as real as it was to the patient, or in the end so therapeutically effective, if I had been preserving myself throughout at that safer distance of classical 'correctness.' Instead I acted upon my intuition of the moment, and it is uncanny how precisely and unwittingly this led me to re-enact with the patient this detail of the original trauma, which she needed to be able to experience within the analytic relationship and to be genuinely angry about [p. 284].

I will reexamine this skillfully managed and productive clinical process from the standpoint of its enacted dimension and then comment on its relation to analytic technique.

The clinical sequence begins "soon after the summer holiday," with a dream about a ten-month-old despairing child, and builds in intensity until the crisis about the request to hold the analyst's hand takes place during a Friday session, before a weekend separation. Thus, the transference reliving of the infantile trauma, utilizing the real separations in the analytic (hand-)holding environment (the enacted dimension of the treatment), brought about an intense transference evocation to actualize an *undoing* of the trauma. This took overt form in the patient's

demand to hold the analyst's hand. The analyst's initial equivocation was a compromise formation fashioned out of his role-responsiveness to this transference evocation and his own countertransference overidentification with the patient's fear of devastating separation and loss—in the analyst's case, fear over losing his relationship with his analytic society (connected, no doubt, to other issues at deeper levels). Over the weekend separation, the patient extended her hand to the analyst (the hand-delivered letter containing her hopeful dream) to prevent his fantasied "collapse"—an enacted attempt to undo her fantasied destruction of the analyst/mother during the weekend separation.

Upon being reunited in the Monday session, the patient reported that the figure in the dream crumbled and collapsed when the child touched it. Precisely at this point in the session the analyst decided to explain to the patient his rethinking of her request to hold his hand. The comment's inopportune timing—in part a reaction formation against the continuing countertransference wish to grant the patient's request—actualizes the patient's transference fear that her intense need had caused her mother's collapse/destruction. The analyst's attempt to interpret the ensuing delusional experience "as transference, as a reliving of her childhood experience," did not ameliorate the situation: "there seemed to be no remaining contact with me as analyst." I believe this was so because the analyst was still involved in the partial actualization of his own concordant countertransference (Racker 1957), which had interpenetrated with the patient's intense transference evocation (in Casement's terms, he had accepted the patient's projective identification).[14] As a result, the interpretation, though correct, was only a flat intellectual reiteration of a known historical event (the mother's fainting and dropping out of sight), rather than a living interpretation centering on the patient's actual(ized) experience of the analyst's withdrawal of the hand-holding possibility and his subsequent absences over the weekends—the interactive enacted process.

When the analyst finally realized that he had been overidentified with the patient's terror of experiencing catastrophic loss, he was able to effectively interpret within the "original creation" transference. The analyst's crucial comment—that he was prepared to tolerate what the

[14]Regarding this vignette, I believe the concept of interactive enacted processes has more explanatory power than the concept of projective identification, because it conceptualizes the unintended contribution of the analyst's unconscious dynamics to the analytic process and its therapeutic outcome.

patient was making him feel—repositioned him as the mother who could tolerate her terror without fainting (faltering in his analytic function), thereby affording her a transference experience that disconfirmed her unconscious expectations. This entire enacted process could then be brought within the verbally symbolized dimension of the transference—an aspect of working through—leading to the attainment of authentic insight and "higher psychical organization" (Freud 1915b, p. 202).

With regard to the interface of technique and the enacted processes just described, I would like to make three points. First, Casement's speculation about what would have happened had he "gone by the book," holding unequivocally to the no contact rule rather than approaching the question as an open issue, misses an important point: while another analyst might have had a choice, *he* did not. *The abstinence principle was only the verbally symbolized issue.* Casement's sense of the "uncanny," and his experience of relying on "intuition," reflect the fact that aspects of his involvement with the patient were not wholly rational, voluntary, or conscious. In other words, Casement's interactions with the patient *around* abstinence were shaped, in significant degree, by enacted processes. His conscious "decision" to hold the question of hand-holding in abeyance, as well as the timing of his conveying to the patient his reconsidered "decision" not to hold her hand, were each the only decision this particular analyst could make with this particular patient at those particular moments. These "intuitive" decisions were unconscious compromise formations, fashioned out of the patient's pressure toward transference actualization and the press toward actualization of the analyst's own interpenetrating countertransference, tempered by his work ego and his analytic conscience (see also Renik 1993b). It was not really uncanny how precisely and unwittingly Casement reenacted with the patient the original trauma. This is precisely what occurs in the enacted dimension of analytic process, and how it may be creatively utilized by sensitive and capable clinicians.

The second point is that despite the way in which the technical decisions about abstinence became enlisted in the service of enacted processes (see Jacobs 1986), abstinence remained a firmly established *principle* within Casement's work ego. This principle ultimately served him as the yardstick against which to assess his ongoing conduct of the treatment, enabling him to recognize the enacted transference process

that had elicited his impulse to stray from abstinence, and later to identify his enacted overidentification with the patient that had compromised his neutrality and his capacity to resolve the crisis. My point is that enactments are defined as processes that are *unintended but meaningful* deviations from abstinence and neutrality; they are not technical procedures in and of themselves. And, while such processes may ultimately provide a patient with a mutative emotional experience, they are not to be confused with the *consciously manipulated* "corrective emotional experience" advocated by Alexander (1950). Casement quotes Winnicott (1963) in this regard: "In the end the patient uses the analyst's failures, often quite small ones, perhaps maneuvered by the patient . . . and we have to put up with being in a limited context misunderstood. The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control, but that is *now* staged in the transference. So in the end we succeed by failing—failing the patient's way. This is a long distance from the simple theory of cure by corrective experience" (p. 258).

The third, related, point concerns the debate about the relative mutative value of verbal insight (via interpretation) as against that of experience (within an object relationship) in analytic treatment. The conceptualization of the dual dimensionality of the treatment process presented here supports the view that such dichotomies are simplistic and largely meaningless (see Loewald 1980; Eagle and Wolitzky 1986). Both verbally symbolized and enacted transference experiences are critical dimensions of analytic process, and analytic treatment is most effective during those periods, as demonstrated in Casement's case, when they can be brought together to create the kind of emotionally based, experiential insight that produces meaningful psychoanalytic change. Jacobs (1991, 1993) has consistently emphasized the value of such "integrative experiences" in psychoanalytic treatment, and this view is inherent in what Chused (1996) has recently called "informative experiences" and what Steingart (1995) has termed "insightful experiences."

SUMMARY

I have proposed that an enacted dimension of analytic process exists alongside, and in concert with, the verbally symbolized dimension.

Enacted processes—an umbrella term that encompasses such overlapping concepts as enactment, actualization, and interaction—form a continuously evolving, parallel text that is inextricably interwoven with the verbal content of the treatment.

The enacted dimension of analytic process—unconscious interactive processes wherein a patient's enacted transference process elicits a countertransference in the analyst that is experienced by the patient as an actualization of the transference—is considered an inevitable, naturally occurring, and ongoing part of analytic process that occurs without awareness or intent. Its particular features are unique to each analytic dyad. The observable outcroppings or end points of processes within the enacted dimension of the treatment are what are currently referred to as enactments.

Enacted processes are not a component of analytic technique, nor need analytic technique be structured so that they can occur (as in a consciously manipulated "corrective emotional experience"). Such processes continuously evolve, whether we want them to or not. Attention to these unintended but meaningful and often elaborately developed characteristics of the treatment process furthers our understanding of the therapeutic action of psychoanalysis. The process of integrating the enacted with the verbal dimension of treatment enables the analysand to achieve higher level of psychic organization.

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