LOVES AND LOSSES:
Enactments in the Disavowal of Intimate Desires

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As I have experienced it, the analyst's feeling and timely acknowledgment of the impact of the patient on him, and of the analyst's impact on the patient, can evoke in both parties powerful resonances of those oscillations of mutual influence and confluence that were central to our early relating. Such evocations lend particular intensities of immediacy and realness to the experience of being touched and touching, seen and seeing, moved and moving, influenced and influencing in the analytic dyad.
(McLaughlin, 2005, p.187)

I found myself a patient in a psychoanalyst's office as much by default as by choice. My previous psychotherapy had been terminated by unexpected, unwanted changes in external circumstances that required an abrupt termination of what had been a very productive, long-term psychotherapy. Living in a small city, it was difficult to find a therapist with whom I did not have some degree of professional or personal familiarity. I knew that the most likely choice would be someone within the psychoanalytic community, in which my involvement at that time was minimal. At my request, I was referred to Dr. D by my clinical consultant, a Jungian trained analytical psychologist. I knew only that Dr. D was one of the senior psychoanalysts in the city and that he had been classically trained.

My initial session was inaugurated by a dream the night before the session. The dream took place in Dr. D's yet unseen office and was of our initial session. The office of my dream was large, handsome, full of good and varied artwork, the ceiling strung with lines of illuminated plastic fishes, lights which in fact decorated the bedroom of my oldest son. The dream office was considerably more interesting

than Dr. D's actual office, which was rather nondescript. The dream analyst looked startlingly like my maternal grandfather, Grandpa Frank, a man I deeply loved. In the dream, I was immediately drawn to Dr. D and felt that he engaged me very directly, asking me questions that threw me back on myself. There was one anomaly in the office, a large curtain that covered most of one wall. When I inquired about the curtain, Dr. D seemed evasive. It continued to distract and disturb me. I finally left my chair and pulled back the curtain. There was a smaller office hidden behind the curtain, seated at the desk was my previous therapist and around him were several of my friends, all of whom had been listening intently to my session. I was stunned and enraged. The dream then seemed to end, at least my recollection of the dream ended there.

I began my actual initial session with a recounting of the disruption of my previous therapy and my marital conflicts. When I told the actual Dr. D that I had had an anticipatory dream the previous night, he said that he doesn't usually take up a dream in an initial session before a decision is made to work together, but that he was inclined here to make an exception. I told him the dream, and he asked for my associations. My first associations were to the termination of my previous therapy. The termination was the result of rather bizarre circumstances of my therapist being sued by a patient who had seen me in an earlier round of psychotherapy. I had had no idea that this patient, who had left me in a state of considerable mutual conflict, had then gone on into therapy with my own therapist. I did not know if she had somehow known that the therapist she then saw after our termination was my therapist. Unbeknownst to me, she had been seeing my therapist at the same time I was seeing him, and he had spent many hours listening to her talk about me. In her lawsuit, she had named me on her list of previous therapists and had planned to depose me. My therapist had tried to keep me out of the proceedings, but the lawyers persisted in their own way. It became clear that I would be required to write a report, be deposed and very likely called to testify in his malpractice case. Our therapy seemed suddenly filled with conflicts of interest and too compromised to continue effectively.

With deep mutual regret, we terminated. I was very worried about my therapist's well-being and quite frightened of the impending legal

proceedings, though they ultimately turned out in his favor. My therapy with this man had been marked by prolonged negative transferences, projections on him of my anger and distrust toward my father, who I had experienced as a remote and unreliable figure in my life. I had resisted depending on this therapist for years, keeping a wary, often sarcastic, distance. He met my reluctance and resistance with patient skill. As my transference gradually loosened, we had begun to establish a much closer and trusting relationship. The termination for me was decidedly unexpected, out of my control, premature. I was unable to acknowledge the loss of him or our work. Instead, I shifted to familiar stance of worrying about him, writing an incisive report to the court on his behalf, and went on my way.

Other associations to the dream were to my grandfather, my father, and others whom I had loved & who had died young – to myself as a father. There was, in fact, more than a passing resemblance between Dr. D and my grandfather who had pure white hair when he died at age 52, as did Dr. D who was in his early 70's when we began treatment. My grandfather's death from lung cancer when I was seven left deep wounds in the structure of my extended family. My maternal grandparents had been my primary caretakers until I was four, and the loss of their care with the onset of his advanced cancer was profound for me. In the face of her young husband's death my grandmother fell into a depression that consumed her through much of the remainder of my childhood. My grandfather, though not long in my life, was the closest I'd had to a loving, engaged father figure. As I began my work with Dr. D, I was filled with an unvoiced, anticipatory hope for the interest and engagement of an elder colleague.

My other association to the dream, to that of my previous therapist and friends in the hidden room, was of my struggle to make a decision to seek a divorce. All of my friends, and my previous therapist, were weighing in heavily with their opinions that I should get a divorce. I was desperate to talk with someone who did not know me, my wife or anyone else in my life, who could give me the psychological space to sort this out for myself. It felt essential to me that I understand both my motivations in the structure of the marriage as it had evolved and my reluctance to leave it before coming to a final decision.

There was no curtain and hidden room in Dr. D's actual office, but there was something he was clearly reluctant to say, something I immediately feared would be held out of view. With considerable hesitancy, Dr. D told me that the dream was uncanny. Just the day before my first appointment, Dr. D had agreed to be one of the expert witnesses to testify in my former therapist's case. This would mean, at the very least, that my former therapist would be an actual presence in the background of my work with Dr. D. He would be literally reviewing my report and testimony. We could even end up in a courtroom together. Dr. D presented three options: he could refer me on; we could agree to work together under these circumstances, in which case he would be bring his thoughts and experience of the court-related matters into our sessions directly; or he could withdraw as an expert witness. I chose the second option, expressing a desire to work with him and find some way to "manage the mess." He questioned my choice, observing that while he didn't really know me yet, he had the impression that I often paid a high price for managing other peoples' messes. He wondered if such an arrangement between us would create a parallel in our relationship to the kind of mess I was trying to address in my marriage. Dr. D chose to withdraw as an expert witness in my former therapist's case so as to preserve our therapeutic relationship. His decision had an impact on me at multiple levels. It was completely unexpected to me that a psychoanalyst (or anyone else for that matter) would act so decisively on my behalf. I felt secure in my privacy being preserved; no one would be listening in or intruding upon my psychotherapy. I felt deeply grateful. His intervention underscored a central theme in my personal defenses, very much relevant to my conflicts within my marriage, and we set to work. This intervention also underscored the immediate, external circumstances of my anticipatory dream. The more subtle and unconscious implications of the dream were lost for the moment. They would return.

The first three years of our therapy was twice a week, face to face. I was focused primarily on my marital conflicts and the severe financial pressures of being the sole financial provider for my family with one son in university, another soon to go, the third in a private school, and the possibility of divorce pending. Long an opponent of the intrusion of third party payment structures into psychotherapy, I had

always paid for my personal psychotherapy out of pocket. Refusing to use my insurance coverage, I could only afford Dr. D's fee for a single weekly session. Both of us thought that twice a week was necessary, and Dr. D offered to see my twice for the fee of a single session. I felt deeply grateful (and ashamed); we analyzed my gratitude and its possible consequences, but my shame passed unacknowledged and unanalyzed.

In the early years I constantly sought Dr. D's approval for my parenting, professional activities, and writing. I gave him copies of articles I was writing, eager for his thoughts and approval. He gave me his approval. We began to form what we sometimes nervously joked was a "mutual admiration society," which we both enjoyed rather than examined. Unconsciously I had yet again established a pattern of setting myself up (and to the side) as an object of idealization. We had fallen into what McLaughlin (2005), drawing upon Sandler (1976), refers to as a "transference actualization," in which "the patient views his analyst's behavior as having fulfilled his expectations," (p.188). Dr. D and I were ensconced in the "unobjectionable" (Stein, 1981) aspects of a positive transferential arrangement. McLaughlin argued that transference actualizations were a form of unconscious enactment involving both parties of the analytic dyad, thereby eluding identification and analysis. Dr. D and I were to pay dearly later on for the comfort of the moment.

Most powerful for me during this period of our work was Dr. D's comprehension of the centrality of losses in the foundation of my character. Both the paternal and maternal sides of my family suffered premature deaths of parents, creating intergenerational patterns of depressive and schizoid withdrawal. My mother, seriously ill with leukemia died suddenly as a result of a medical error when I was 18. Dr. D also lost his mother to cancer at 18, creating an area of deep, mutual identification between us, which informed and shaped our work in many important ways. Dr. D knew within himself the impact of early parental loss, and he understood something in me that had not been recognized in any of my previous therapy. He said to me in the midst of my internal conflicts about leaving my marriage, "Your entire character is founded in the determination to avoid unnecessary loss—be those losses of your sons, your wife, or your own. You cannot

discriminate, and you cannot think in the face of projected losses. Loss has always been unbearable to you, devastating to those around you." With that interpretation, I began to think. I was able to end my marriage and care for my sons. I felt profound gratitude to Dr. D.

Once I had separated from my wife, Dr. D and I decided to move from face to face to the couch in the hope of shifting my attention from coping with daily life to more intrapsychic reflection and a more purely analytic process. With the shift to the couch, I found myself going silent, mute really, for long periods during many sessions. At first, Dr. D seemed to reluctantly accept my periods of silence. I found myself in the familiar state of mind I fall into when I am alone, of silent thought with little sense of the presence or usefulness of others. It was a difficult struggle to remember to talk in session, to feel that there was any point in talking. Dr. D became a kind of ghost to me. I lost track of him. I would have a session with him in my mind as I drove to the appointment (an hour's drive) and then feel I had nothing more to say in the session, as though it had all already been said. In our face to face sessions, under the pressure of my needing to make a decision about my marriage, take care of my sons, and keep my life going, I was acutely aware of Dr. D's presence and concern. I was able to rely on him, unlike with my previous therapist. I accepted both his interpretations and his advice. On the couch, my attention turned more inward, I would lose track of him. I could not feel his importance or his function. I can see now, in retrospect, how hurt, helpless and angry Dr. D, having given me so much, must have felt in the face of my silence. Dr. D would sometimes encourage me to talk more, challenging my silence as a resistance, but any real understanding/analysis of the power and peculiarities of my muteness remained out of reach for a long time. I suspect that Dr. D did not have enough distance and understanding of his own reactions to my silence to effectively engage and analyze it. This, like our unexamined idealizations, were to have consequences for the two of us.

Unknowingly, I had set in motion again—this time with Dr. D-two rather paradoxical modes of relating, one of a silent, cut-off distancing and the other an idealized and idealizing engagement. Each kept the most vulnerable and lonely aspects of me out of view and reach. As I often felt deeply alone in my sessions (in the presence of my analyst), I

also felt deeply alone in my life (in the midst of many friends). I was, however, determined to at least find a sexual partner, if not a new life partner. I knew that with the ending of the marriage that I would be exploring sexual relationships with both women and men. As an adolescent it was clear to me that I was attracted to both women and men. I came out to my parents as possibly gay while in college. Both were supportive of either choice of sexual partner. I spent my college years experimenting with straight and gay relationships, though I found my relationships with women significantly more sexually satisfying. I lived with one woman for nearly a year and then lived my senior year with the woman who was to become my wife. At the point of separation from my wife I became involved with a man who lived in another state, hoping for some distance and privacy from my professional and home life. I fell into an intense and complicated relationship.

As issues of my sexual choices and activities came up in the sessions, I began experience what I considered to be countertransference reactions on Dr. D's part. When I told Dr. D of my sexual interest in men as well as women, he was clearly both taken aback and interested. I had little inclination to discuss issues of bisexuality, homosexuality, sexual preference, etc., as I had no particular conflict about it. I was very concerned that whomever I became involved with, male or female, I not repeat the symbiotic patterns I had created and was unable to break in my marriage. But throughout this process Dr. D would repeatedly inquire about my homosexual feelings, the history of my sexual activities, and my understanding of my same sex desires. These were, to me, clearly his needs and questions, not mine. I told him on several occasions that he seemed more interested in my homosexual life than I was. I told him that I had fantasies, frustrated and hostile, to add an additional, unpaid session each week to respond to his questions about homosexuality, so that it wouldn't detract from my time on the couch and my own concerns.

Finally, I asked Dr. D to talk about himself, what this was all about for him. Reluctantly, he told me of doing an analysis early in his career with a gay candidate in analytic training, with whom he made an agreement to hide the patient's homosexuality so that would not interfere with his accreditation as an analyst. He had had deep respect for this patient's professional skill and had long felt guilty

and conflicted about colluding with the hiding of his patient's sexual orientation. He was now trying to come to a better understanding of same sex relationships, acknowledging that he had had real questions about the capacity of two men to love one another. Dr. D told me he was on a national task advocating for gays and lesbians within the American Psychoanalytic Association and was a member of a small group of local analysts and psychotherapists discussing gay, lesbian and gender issues. It seemed clear to me that in the background for Dr. D were broader, vaguer issues of intimacy and passionate attachments between men. I continued to feel my familiar detachment and distance from him. I was losing track of why I was seeing him. I no longer found him so helpful. Quite to the contrary, I felt a growing irritation with him, which I lived in silence. We did not talk about what was happening between us.

One evening, as I was cooking a birthday dinner for my youngest son, I received a panicked phone call from a client of mine, who (unbeknownst to me) was a member of the gay and lesbian study group to which Dr. D belonged. In the meeting the night before Dr. D had discussed his work with a patient who she realized was me. She left the meeting as soon as she realized Dr. D was talking about me, but by then she had heard details of my sexual history and that I had recently become involved with a man. A bit later I received an awkward phone call from the clinical supervisor of the gay and lesbian counseling center, telling me that I had been outed by my psychoanalyst in the previous night's meeting. It was a surreal birthday party that night. I later learned that a supervisee of mine was also in that meeting and recognized that it was me Dr. D was talking about.

I was furious. I was confused. I called Dr. D's answering machine to tell him what had happened, telling him under no circumstances to contact me before our next session, that I needed time to think and I hoped he would have as miserable a weekend as I was anticipating for myself. I called my clinical consultant and went to see him at his home the next evening. He had known of my recent relationship with my male lover and was shocked at Dr. D's lack of judgment. He said I would probably have to terminate and suggested I consider bringing ethics charges against Dr. D. I saw no sense in either possibility. I was certain this was not an ethical lapse but something extraordinarily

stupid, unconsciously stupid, an acting out. I did not particularly care that Dr. D had "outed" me. Most people who knew me knew I identified myself as bisexual. The violation for me was that he spoke of the privacy of our work in a setting where I was almost certain to be recognized without elaborate efforts to disguise my identity. The curtain in my initial, anticipatory dream of Dr. D's office and my "first session" with him had indeed been ripped away.

In our first session after the mess, Dr. D explained that the discussion in the gay and lesbian study group had devolved into one of these classically intellectualized psychoanalytic discussions of the defensive functions of homosexuality. He had become intensely frustrated with the tome of the meeting and told the group that if the discussions continued in this vein, he would be leaving the group. He was not going to tolerate the pathologizing same sex love relationships. "Suddenly, " he told me, "I found my telling that group that I was learning a great deal about homosexuality and love between men from one of my patients. I went on to talk about our work without ever thinking of the consequences." Dr. D went on to suggest that we might have to terminate, that this was an error from which we could not recover. This was not acceptable to me. We needed to recover. I needed to understand how this had happened. I was suddenly revisiting familiar relationship issues with great intensity. I felt thrown back upon myself to take care of myself in a way so familiar from my earliest memories. How could I continue to rely on this man? If I worked to preserve this relationship, was I creating another horridly compromised relationship? I knew in my gut that I should not remove myself, withdraw — compromise and withdrawal were far too familiar defensive reactions. I needed to hold Dr. D on the hook to account for himself. Dr. D assured me that he was engaged in a self-analysis to understand what had happened. I was not the least bit reassured by this. I insisted he get consultation.

Facing the music

Among the ways of being that I value in the analytic setting…is the effort on the part of the analyst and the patient to face the truth, to be honest with themselves in the face of disturbing emotional experience. …In the absence of the effort on the part of patient and

analyst to "face the music," what occurs in the analysis has a shallow, desultory, as-if quality to it. (Ogden, 2005, p.21)

The following weekend I was having dinner with an analytic colleague from Great Britain. With visible distress I told him what happened with Dr. D. He began to laugh. He continued to laugh. He continued to laugh, occasionally muttering, "Oh, what a glorious fuckup. What a glorious fuckup." His reaction was rather unexpected, to say the least, but rather refreshing in an odd way. When he eventually settled down, he said quite simply, "We only fuck up this badly with patients we love. We are always learning from our mistakes. What we and our patients owe to each other is honesty and a willingness to learn from what goes wrong. If we do everything right, if we have to be right, no one is going to learn very much. But we do seem to save our biggest mistakes for the patients we love. It's the patients we love the most, want the most for, where we act without thinking. What you and he have to deal with is how much you love each other. You're very lucky to have each other. You know, Dr. D must be utterly in love with you. This was a rather clumsy way of telling you he loves you. You must talk to each other about your love for each other."

I took this dinner conversation back to session. We began to unravel what this enactment meant for each of us and between us. With considerable hesitation, Dr. D spoke more openly of his affection for me, his admiration of how I moved rather aggressively in my professional world, and his envy of my relations with other men, my male friends as well as sexual partners. He talked in more detail of his guilt for his collusion with his gay analytic candidate, the paradox of regret for his secrecy then and his inadvertent exposure of me now. He told me about an enlisted man he had grown close to while serving in the military. Dr. D, as a physician and an officer, was not supposed to interact personally with the enlisted men, but he was drawn to this one man in particular. Neither of them felt at ease with the hyper-masculine military environment. Both shared many interests, and they became close. The friendship was shrouded in secrecy—a double transgression of an officer and an enlisted man and of male affection. I did not see the relationship Dr. D described as homosexual in nature, but certainly deeply intimate and perhaps homoerotic. They did not maintain the friendship after their military service ended.

It became clear how much Dr. D hungered for male companionship and intimacy. He said it was not to be found within his psychoanalytic community, which he characterized as intellectual, competitive, secretly disdainful—men going though the motions of camaraderie but no true caring for one another. He told me he hoped our relationship would continue after termination. Perhaps most importantly, he talked of the complex meanings and feelings of my being his final analytic patient at the end of his career. His emotional charge around my gay relationships began to take on very different meanings for me.

I, in turn, had to acknowledge and examine my feelings of not deserving his attention (let alone affection) as the crises in my life were now past. I was taking care of my sons, working hard, earning college and school tuitions, and back fully into my distant, manic coping style. I was oblivious to Dr. D's care and concern for me. I did not give him the space or opportunity for him to give any voice to how he was feeling toward me. I realized that I had closed him out (as I had so many others) and could see how his complex feelings toward me and our relationship spilled out in a different context. As we now spoke more openly of our feelings for each other, I started to feel my reactions to his aging, my admiration for the way he was living his life, now past 80. My admiration had been held too often in silence, as his going on living vigorously was such a painful contrast to the resignation and ending of my young father's life. I wanted to know more about how he maintained his vitality and enthusiasm for life. I wanted to witness his growing older, how he coped with it. I wanted to be with him when he died. I was finally able to give voice to these desires. I felt my own envy of his happiness in his second marriage after the death of his first wife and the despair it engendered in me about ever finding love and companionship in a new relationship, be it with a man or a woman.

I was thrown back on the dream I had the night before my first session with Dr. D. I could not quite believe that we had somehow ended up living out that dream, my therapy suddenly exposed to colleagues and friends. I had to face that ways in which I had communicated an invincibility, even in the face of the depth of the work I had been doing my therapy. I had managed to convey a false sense resilience and

invulnerability that fostered both Dr. D's losing track of me as a patient and his feelings of being cut off by me, which I think contributed substantially to the spilling over of his feelings in an enactment.

Our enactment and potential rupture demanded that we consciously attend to the field of desire, love and intimacy opening between us. Dr. D and I began to grapple with the task defined for us by my dinner companion—the examination of our unacknowledged and feared affections and desires.

I would imagine that many readers, as you have watched this case unfold, could see the danger points, read the signals, recognize opportunities for intervention and analysis, or wonder, "Why doesn't he (one of them at least) say *something*?!" The fact that neither Dr. D nor I could see or say underscores the nature and the power of enactments. It was the behavioral manifestation that brought us to the surface, to the possibility of conscious recognition and exploration.

Ten years later

Arrested in their capacity to love, subjects who are under the empire of the dead mother can only aspire to autonomy. Sharing remains forbidden to them. Thus, solitude, which was a situation creating anxiety and to be avoided, changes sign. From the negative it becomes positive. Having previously been shunned, it is now sought after. The subject nestles into it. (Green, 1983, p.156)

Ten years has passed since the enactment I have described above. Dr. D regained his analytic stance and we continued for another four years of productive work together. I was his last patient, our work the end of his career. As we approached termination, I wrote up this incident for us to use as a reflection on the many layers of meaning about loss and anticipated endings embedded in our relationship.

Eigen (1998) cautions us that the "dread of environmental failure is the outer shell of a deeper dread of the failure of one's own [psychological] equipment. The environment tries to make up for what the individual can not do (and vice versa), but never with more than partial success. We rely on each other all life long for help with

agonies [and I would add passions] we can not handle" (p.97). I was in my late 40's when this enactment with Dr. D unfolded. I had been with and loved, within my limits, a woman for more than 25 years, but I had never truly relied upon her. I had wished for but never truly expected reliability. I had many friends, but there were limits to my engagement with them as well. Solitude remained my most faithful companion. I was by then having sex quite happily with a man, but I did not open myself fully or rely upon my sexual partners, none of whom had even lived in the same city as I. I had not yet learned to truly love a man or receive the love of a man. Dr. D was approaching 80 and the end of his career; the love and companionship of a man and his for a man had eluded him as well.

Andre green's brilliant essay, "The Dead Mother" (1983) afforded us particular insight into the process between us. Green describes mothers who are unable to metabolize and transform the losses in their own lives, living then in a profound deadness while still alive. For me, in my growing up, such an account characterized not only my mother but my extended family. Deadness and depressive withdrawal permeates my early object relations. Vitality seems impossible, even hostile to the "dead" parent. The infant/child cannot bring life to the parent's being, the child often identifies with the parent's lifelessness or imagines himself as the cause of it. What is most desired becomes the deepest threat. Gerson (2003) eloquently evokes the dilemma addressed in Green's essay:

> The baby's lips are made moist by the mother's milk even while the mother's tears dampen them both. It is a confused joining as the good and the bad are internalized simultaneously into a combined experience that occurs prior to splitting. …a whole object that is a product of the deadliness that was ingested together with life… In this scenario, where the source of life is mixed with its failure to sustain liveliness…the closer one gets, the more alone one feels…the more of life, the more of death. (p.14)

During this period of work with Dr. D, I began to recognize how profoundly I had turned away from others, forming a primary and solitary relationship with my own mind (Winnicott, 1965; Corrigan & Gordon, 1995). Dr. D and I had lived our lives in the shadow of "dead"

mothers (psychically dead and then tragically, actually dead) with fathers who were unable to bring vitality and passion into the lives of their sons or themselves. The wish for a man's affection and passionate involvement, for the love of and for a man, to bring each of us more fully to life was more than either of us could bear, even in the deeply committed relationship that we did have. We each unconsciously disavowed our loving desires for the other. Desire burst out unconsciously in the enactment at the gay and lesbian study group.

Dr. D needed to examine his breach of my privacy and the meanings of his outburst about male love, not to be punished or chastised for it. I needed to remain engaged with Dr. D rather than withdraw into myself, in spite of the breach, and examine my part in what was unfolding, though at that point I could not have understood this as an enactment. Gradually we were each able to comprehend our own contributions to this enactment, face our parallel fears of loss and rejection, and in so doing to begin to find the capacities for love that we each so dearly sought and could finally relish.

Perspectives on enactment

We both came out of this piece of analytic work with our own deep sense of having been changed by the impact of an intimacy with an other that was novel and disturbing, then acceptable and enhancing to us both. …In this core experience is a moving power, by and for the two participants, that I do not fully fathom. (McLaughlin, 2005, p.220)

The term "enactment" is still emergent and developing in our professional lexicon, and as such it is encumbered with a multiplicity of meanings that can render obscure what any particular author is meaning to convey. Beginning in the mid-80's a series of clinical papers began to explore the experience and meanings of countertransferential enactment and differentiate enactment from acting out (Boesky, 1982; Poland, 1984, 1988, 2005; Jacobs, 1986, 1991; McLaughlin, 1987, 1991a, 1991b; Chused, 1991; Elkind, 1992; Johan, 1992; Roughton, 1993; Renik, 1993a, 1993b). Over the past 20 years, the term "enactment" has evolved to gradually replace the concept of "acting out." Acting out was historically seen, within the psychoanalytic paradigm of free association and bringing everything

into words, as a patient's regressive use of *behavioral action* in a defensive refusal (or inability) to use language and cognition for self expression. Gradually it came to be understood that while acting out could well serve a defensive function, it wasn't quite that simple or unilateral. *Action* in therapy was coming to be understood as a form of implicit or procedural memory, a form of nonverbal communication for experiences that were not yet available in language. One could move from behavioral action toward expression through words, but it was coming to be understood that emergent, foundational experience was often neither available nor communicative in language (Bucci, 1997a,b, 2007). At the same time, the understanding of countertransference was undergoing a similar transformation of meaning, from that of a regressive/defensive emotional reaction of the part of the therapist, to an informative and communicative unfolding of emotional and unconscious communication.

Writing about enactment necessitated analysts being willing to write quite openly about themselves and their own intrapsychic conflicts, characterological blind spots, and unconscious vulnerabilities. These initial articles demonstrated courage on the part of their authors and began to introduce a personal frankness and self-examination to psychoanalytic writing seldom seen since Freud and Ferenczi. Elkind (1992) and Kantrowitz (1996) undertook self-report surveys of psychotherapists and psychoanalysts to study "therapeutic impasses" and ruptured terminations (Elkind) and the "impact of patients" on their analysts (Kantrowitz). While not writing specifically from the vantage point of enactment, these two studies offer a great deal of insight into the frequency of the phenomena, their developmental roots, and intrapsychic and interpersonal meanings.

Elkind distributed a questionnaire to 330 therapist members of the Psychotherapy Institute in Berkeley, California, inquiring about experiences of rupture in long-term therapy relations ending "in an impasse with accompanying feelings of rage, disappointment, or sense of failure" (p.4). Somewhat to her surprise, 87.5% of the respondents said yes with regard to patients and 53% said yes with regard to their own personal therapies. The respondents frequently reported their own vulnerabilities to being wounded by patients. The survey demonstrated that many of these irreversible ruptures were not a result of severe

psychopathology on the part of the patient or incompetence and lack of skill on the part of the therapist, but rather:

> The new perspective that I am emphasizing in this book views the unresolvable dilemmas—mismatches, impasses, and wounding—that can lead to ruptures, not as avoidable failures, but rather as *common, inevitable occurrences that present us with a special opportunity for new awareness and change as well as for the dangerous possibility of a wounding and disillusioning setback.* (italics in original, pp.6-7)

While not drawing upon the psychoanalytic conceptualizations of enactment, Elkind concludes that many impasses are the result of areas of primary (developmental) vulnerabilities on the part of both therapist and client. The recognition of these vulnerabilities and the understanding of their effects one on the other is "critically important if the wounding is to be worked through rather than allowed to disrupt the relationship altogether" (p.133). Her study is replete with detailed case studies and examples of her consultations with troubled therapeutic couples. For those concerned with the process of enactments, much can be learned from this volume.

Kantrowitz, a psychoanalyst, distributed anonymous questionnaires to 1,100 members of the American Psychoanalytic Association inquiring about the analysts' experiences of the impact of patients upon them professionally and personally; 339 responded. Kantrowitz followed up the written, self-report survey with in-depth telephone interviews with 26 of the respondents; these interviews and Kantrowitz' reflections upon them were written up and given to the interviewees, so that a second, often deeper discussion could ensue. Kantrowitz came to conclude that "the dividing line between what we define as a countertransference reaction and what we define as an enactment may at times be slim" (p.73). She characterizes "reactions" as those "in which the analysts described recognition of affective responses that were cognitively contained" (p. 73) while enactments were countertransference responses that took a behavioral form. Kantrowitz captures the nature of the enactment dilemma vividly:

> …the patient at this point is experienced as "the other," providing the stimulus for the recognition of some unwanted aspect of the analyst. Under these circumstances, the

> final jolt of recognition of being caught in an emotional reaction causes distress. The analyst sees that he or she is not in conscious control…and that reaction has had behavioral or distressing emotional consequences. (p.216)

It is not my intent here to offer the final and definitive definition of enactment but to be as concise and precise as I can be about how I am using the concept of enactment here. I am here indebted to the work of James McLaughlin (1987, 1991, 1994, 2005). No one has written more extensively or openly about transference, countertransference, therapeutic impasse, and enactment than McLaughlin (Cornell, 2005; Chodorow, 2007). McLaughlin (2005) conveys an understanding of the unconscious meanings of behavioral enactments in near poetic terms:

> Each has learned from infancy, long before the words were there for the saying, how to appeal, coerce, clarify, and dissimulate through the signals of body language, gestures, facial expression, and vocal qualities. …whether we are analyst or patient, our deepest hopes for what we may find the world to be, as well as our worst fears of what it will be, reflect our transference expectancies as shaped by our developmental past. (p.187)

We still tend to hope for the awareness and insight afforded by countertransference rather than the unconscious blindness of countertransferential enactments, but we seem to be coming to terms with the frequency and inevitability of enactments and seeing the challenge and opportunity embedded in enactment.

I do not think that the concept of enactment should replace that of acting out. Clearly there are times when actions on the part of the therapist or the patient are defensive and interfere with the course of treatment. I tend to think of acting out as a unilateral action on the part of either patient or therapist and reserve the term enactment for a bilateral process between therapist and patient. McLaughlin (2005) articulates the bilateral nature of enactments:

> When at work, we bumble, stumble, and get lost. …From this view of the analyst as an involved and not invulnerable participant, I suggest we use the term *analytic enactment* (italics in original)…to refer to events occurring within the dyad that both parties experience as being the

> consequence of the behavior of the other. …Implicit in this perspective of enactment in the clinical situation is the expectation that close scrutiny of the interpersonal behaviors shaped between the pair will provide clues and cues leading to the latent intrapsychic conflicts and residues of prior object relations that one has helped stir into resonance in the other, and between them actualized for both. (pp.188-189)

Yet, in his acknowledgement of the inevitability and necessity of analytic enactments and the mutuality of unconscious influences within the analytic pair, McLaughlin came to stress the recognition and articulation of the unique and quite separate subjectivities of the two participants, which Chodorow (2007) characterizes as "two-person separate". There is a necessary move from enactment to reflection, analysis and meaning-making, shifting from the unconscious merger and *mutuality of influence* to the developing capacity for *mutual recognition* and differentiation.

The enactment between Dr. D and I could be seen as an especially egregious error, an acting out on the part of Dr. D. That was certainly my first reaction to it, as I felt myself to be a victim rather than an unwitting participant. In our willingness to "face the music" Dr. D and I learned about ourselves and each other. In the rule-bound, litigious atmosphere of our current era, Dr. D's behavior could all too easily have been cast as a violation of my confidentiality (which it was), an irreversible ethical breach or even act of malpractice (which it wasn't). In my work as a consultant and trainer, therapists often bring me cases of impasse, countertransferential knots, failure, or enactment, usually accompanied by shame or anxieties of ethical charges or a lawsuit. What so often unfolds in the exploration of these therapeutic dilemma is some form of enactment between therapist and patient. When the enactment is unrecognized, I suspect it is all too often further acted out in the arenas of ethical charges, law suits, or premature terminations.

While I see the process of enactment as bilateral and as the expression of parallel patterns of unconscious disavowal, the resolution of enactments is not mutual and bilateral. The therapeutic relationship

is fundamentally asymmetrical with the onus of therapeutic responsibility on the mind and shoulders of the therapist. Kantrowitz (1996) captures the asymmetrical nature of the resolution of enactments:

> The analyst cannot resolve this just within the analytic hours. As elaborated previously, self-reflective efforts, along with talking to colleagues and sometimes friends or spouse about personal, emotional distress stemming from the situation with the patient, are employed by the analyst to regain perspective in the analytic work.
> …the actual process of work is not so different once the analyst becomes aware of what has been rekindled. When the patient represents some emotionally important firgure for the analyst in his or her countertransference, the reworking of earlier experiences is most parallel to the patient's reworking. The patient, however, unlike the analyst, has no reason to be empathically attuned or responsive to the personal meanings stirred in the analyst in reaction to him or her. (pp. 217-218)

While periods of enactment provide the occasion for deeper recognitions and more open communication between therapist and client, the undoing of an enactment does not mean a "mutual analysis" as exemplified in the radical experiments undertaken by Ferenczi (Dupont, 1988). It remains the responsibility of the therapist through self-analysis, consultation, ongoing supervision, or perhaps a return to personal therapy to undo one's own unconscious blind spots so as to re-open one's capacity for unconscious receptivity, direct communication and the capacity to observe, analyze, and find meaning.

The enlivening transference (and countertransference)

What I am sketching out here is how the enlivening transference facilitates the emergence of love for an other in patients who have cynically foreclosed and turned away from another's love and in the process have impoverished their own ability to love either themselves or others. (Gerson, 2003)

Gerson (2003), speaking of the continual and inevitable meshings of eros and thanatos within interplays of the transference and countertransference, observes that “the more overt expression of this [erotic] force may be most prominently at play in transferences of those patients who feel, or most frequently suffer from, a hollowness at the heart of their vitality.” This force was certainly at play in my transference to Dr. D. As can be seen in the enactment between Dr. D and me, this force can be at play, albeit disavowed, in the countertransference as well. Gerson expands the concept of the erotic transference to that of the “enlivening” transference, suggesting “this idea and terminology because I think it contains the advantage of highlighting the aim of the transference rather than its content or even its object. In the enlivening transference the motive is the evocation of desire itself rather than the object.” Desiring is not so simple; it is inevitably intertwined with the possibility, the likelihood of loss. This is especially true when one’s first and foundational loved ones are shot through with unresolved and unspoken grief.

What Dr. D and I most wished for and feared was the evocation of passionate attachment and desire, love--more simply stated, and a coming more fully to life with each other. It was the experience of myself coming more fully alive, not some exterior intrusion or disruption, that was traumatic for me, and so too for Dr. D. We are often too much for ourselves. For years, until the dam burst, neither of us could tolerate the force of that desire within ourselves and thus could not overtly seek it in the other.

My readings since the termination of my work with Dr. D on the analytic exploration of enlivening and deadening processes in therapy (Bollas, 1989, 1992; Bolognini, 1994; Eigen, 1996, 1998; Gerson, 2003, 2007; Green, 1980, 1983, 1995; Mann, 1997; Ogden, 1999) have deepened my understanding of what transpired not only in my therapy with Dr. D, but of the universality of these passions and vulnerabilities. What I hope most to have conveyed in this essay is the compelling, yet paradoxical interplay of the intensity of the wishes for enlivening and the forces of disavowal and deadening.

In conclusion

Dr. D and I decided that should the right circumstance arise I would publish an essay on enactment based on the narrative I wrote as part of our termination process. The invitation to contribute a chapter to this book seemed the right circumstance. We wanted to draw from our experience to explore both the disruptive impact of disavowed desires in both therapist and patient as well as the intimate and healing potentials of the emergence of such passions. This essay offers a rather unique perspective on enactment, written from the point of view of the patient rather than the therapist, centered on the disavowal and unmanageability of "positive" rather than "negative" feelings, and descriptive of the traumatic intrusiveness of internal experience and passionate attachment rather than the environmental intrusions and violations that we most often describe and relate to as traumatic.

Maroda (1991) has argued passionately that:

> One of the most important tasks of analytic treatment is to accept limitations, loss, and human frailty, but this does not mean that the patient should accept responsibility for the therapist's limitations as well as his own. …Many people believe that for the analytic therapist to admit her own pathology is dangerous. I believe that it is the need to preserve the mask of sanity that is dangerous" (p.107).

Those masks of sanity are, however, in our chosen profession idealized and deeply seductive. Over the course of many painful, bluntly honest sessions, my work with Dr. D again deepened, my self understanding grew, my capacity to sustain a passionate attachment in the face of severe disappointment became solidified. This was an opportunity for me to see Dr. D struggle with a serious error and come together more strongly and richly on my behalf. In so doing, he provided me with a startling contrast to repeatedly watching my parents (especially my father) disintegrate, withdraw and/or become avoidant in the face of conflict, disappointment and potential loss. With the challenge and understanding offered me by my dinner companion, I did not retreat into myself this time. I did not retreat but came at Dr. D again and again with the expectation that we understand what this meant for each of us.

I had broken ranks with my past and with my standard defenses of providing reason and comfort to others by sustaining this confrontation with Dr. D.

In my own practice, many of my clients are themselves psychotherapists. It is a complex business providing psychotherapy to psychotherapists, to provide a space within which those committed to sanity can experience and explore their areas of insanity. For Dr. D and I, our masks of sanity had fallen away. We had the guts and commitment to each other to face ourselves, talk to each other, and move through a period of intense denial, conflict, and vulnerability to reach for a more honest self-understanding.

I write here the story of myself as a patient, but what I learned for myself as a therapist was profound. I learned anew and at a more fundamental level through my experience of this enactment of the power of unconscious, disavowed desires and of passionate, loving engagement. I acquired a deep and abiding respect for the fundamental humanity of all of us in this practice of psychoanalysis, psychotherapy, counseling and human relations work. I internalized a deep and abiding regard for the unstoppable, and often disruptive, force of our unconscious passions. I learned a more realistic meaning of love and commitment. I still love solitude and still have access to my manic and idealizing defenses, but now other options for coping and closeness are more readily available. I remain forever seduced by my mind and the eloquent minds of others, but there is more compelling space in my experience of life and our work for the uncertain, for the mistaken, for human troubles, for needing and learning together, for honesty and self-scrutiny, for loving and being loved.

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