# COUNTERTRANSFERENCE ENACTMENTS IN COUPLES THERAPY

Sid Aaronson

# COUNTERTRANSFERENCE ENACTMENTS IN COUPLES THERAPY

A dissertation submitted to the
Sanville Institute
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in Clinical Social Work

By

SID AARONSON

June 23, 2007

THE SANVILLE INSTITUTE

DISSERTATION APPROVAL PAGE

We hereby approve the dissertation

COUNTERTRANSFERENCE ENACTMENTS IN COUPLES THERAPY

by

Sid Aaronson

Candidate for the degree of

Doctor of Philosophy in Clinical Social Work

Doctoral Committee

Sylvia Sussman, Ph.D
Chairperson

Signature: Sylvia Sussman, Ph.D. Date: 3/13/07

Cynthia O'Connell Ph.D.
Committee Member

Signature: Cynthia O'Connell PhD Date: 03/09/07

Jan Mill Ph.D.
External Member

Signature: Jan Mill, PhD. Date: 3/5/07

Gareth Hill Ph.D.
Dean

Signature: Gareth Hill Date: 6/6/07

# ABSTRACT

## COUNTERTRANSFERENCE ENACTMENTS IN COUPLES THERAPY

By

SID AARONSON

This qualitative study explored how therapists experience, think about, and deal with countertransference enactments in couples therapy. The study examined situations when therapists get caught up in and/or act out their countertransference while working with couples; these types of reactions are referred to as countertransference enactments.

Open-ended, semi-structured interviews were conducted with ten experienced psychodynamically-oriented therapists who specialize in couples therapy and who come from varying professional fields and theoretical orientations. Data from the interviews were analyzed using the constant comparative method as developed by Glaser and Strauss (1967).

A primary finding of the study showed that, while the concept of enactment was not well understood among most participants, all were able to reflect upon times when they were caught up in an enactment and reported several examples of such occurrences. Common countertransference affect themes were present during enactments, such as frustration, anger, ineffectiveness, helplessness, dread, and anxiety. However, what best captured the essence of couples therapists' countertransference experience during an enactment was the experience of pressure. Therapists experienced the build up of pressure with couples in a

variety of ways including: the couples' high expectations, triangulation pressures, the sheer amount of clinical material to track and the pressure to stop hurtful and destructive dynamics between partners.

After becoming aware of the enactment, therapists attempted to work it through while managing their countertransference reactions. Therapists attempted to understand why the enactment occurred by analyzing their countertransference triggers as well as exploring the case dynamics. Some therapists interpreted the transference-countertransference dynamics of the enactment and how it played out among the threesome in an effort to facilitate a deeper understanding of its meaning in the treatment. Therapists also often had to deal with clinical issues related to repairing the rupture or break in the therapeutic relationship. They also used a variety of coping strategies to help them manage and contain their countertransference reactions, such as self restraint, self supervision and consultation.

# ACKNOWLEDGEMENTS

I could not have written this dissertation without receiving the support and encouragement from the many caring people in my personal and professional world. For that, I am grateful, and have many people to thank. First, I appreciate the members of my committee. As the dissertation chair, Sylvia Sussman, provided the right combination of qualities to guide me through this project; she was focused, optimistic, held me to the task, and I always felt re-energized after speaking with her. Cynthia O'Connell, as a committee member, carefully read my work, supported and discussed ideas with me, and helped move my work along. I am deeply indebted to my external committee member, Jan Mill, who was fundamental in helping me think through the conceptual aspects of my dissertation. She graciously gave her time to my project.

I wish to express my sincere thanks and gratitude to the psychotherapists who participated in my study and who so generously volunteered their time. Their willingness to be candid in sharing their countertransference enactments added depth and richness to my research.

I thank the faculty and Dean of the Sanville Institute, especially my mentors Judith Schiller and Mary Coombs who helped guide me through the Doctoral program. I also thank my fellow students who, along with the faculty, provided a lively culture for learning and growth at the institute. Special thanks are extended to Tina Casenza and Angeleen Campra for always being there to hold down the fort.

The support and caring of my friends and family was very important to me. Special thanks to my best buddy Ken Miller, my loyal friends in my Men's group (Murray, Kevin, Barry, Lance), my brother Les and his wife Karen, my sons Brendan and Ruben, Kate, Lieba, Michael, Gina, Stephany and Pearl. They believed in me and cheered me on throughout the process. I am especially appreciative of my friend, Cheryl Jern. We began and ended the Doctoral program together and were best school buddies. We supported and spurred each other on; complaining, competing, discussing ideas and talking about all the knit-picky things that go into making a dissertation.

Finally, I am eternally grateful to my wife, Corisa. She was excited about my subject and always willing to talk out ideas. She read my drafts and gave excellent suggestions, often helping me think through the rough patches. She listened to my endless kvetching and encouraged me when I was ready to give up. She is also an excellent editor and provided those skills to my final drafts. She was truly always there for me and was invaluable. She is precious.

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# CHAPTER 1: INTRODUCTION

This qualitative study explored how therapists experience, think about, and deal with situations in which they get caught up in and/or act out their countertransference in couples therapy; these types of reactions are referred to as countertransference enactments.

## The Problem and Background

While much has been written in the psychoanalytic literature about transference and countertransference in individual therapy, the concept of enactments has only recently been more fully explored, particularly in relational psychoanalytic theory (Aron, 2003; Black, 2003; Chused, 2003; Jacobs, 1986, 2001). Almost all the accounts of enactments are descriptions from long-term intensive individual psychotherapy. In contrast, comparatively little has been written about transference and countertransference in couples therapy, most of this work coming from an object relations approach (D. Scharff & J. Savege Scharff, 1991; Sharpe, 1997, 2000; Slipp, 1984). While countertransference is often recognized as being important, many of these clinicians, in general, give surprisingly little attention to the enormous difficulties the couples therapist faces in sorting out, containing, and dealing with strong countertransference reactions and the enactments that may result. This study addresses that gap by investigating therapists' experience and handling of countertransference enactments that occur while working with couples.

Transference and countertransference dynamics are different in couples

therapy than in individual psychotherapy. In couples therapy, while each member of the couple has his or her own transference to the therapist, partners are more likely to be focused on their feelings towards each other; thus, the transference to the therapist is probably more diluted (D. Scharff & J. Savege Scharff, 1991; Willi, 1984). However, depending on his personal history, the therapist's countertransference is often stirred up powerfully in couples work; it can provoke specific and intense kinds of reactions that do not necessarily occur in individual treatment (Siegel, 1997).

Since the dyad of the couple is probably the nearest equivalent in adult life to the early bond between parent and baby, the couple brings these charged, primitive emotions to therapy potentially making countertransference more potent, chaotic, and unruly (Siegel, 1997). The therapist is not only asked to respond to a wide range of volatile emotional conflicts, some of which may mirror his own relationship conflicts, he must also contend with the raw expression of these conflicts. Being in the middle of a ferocious fight provokes far more intense reactions than hearing about it in individual treatment, and further, the therapist's own unresolved conflicts about anger may be activated. Often the therapist must assertively intervene to stop anger from becoming destructive to the therapy, and this can be difficult for a therapist conflicted about anger. From informal discussions with colleagues who work with couples, I have gathered that most feel overwhelmed, flooded, confused, and ineffective quite often in working with couples; many have wanted to give up doing couples therapy altogether. Thus, the emotionally loaded scenarios of couples therapy provide the perfect medium for

countertransference enactments to occur.

What are enactments? Enactments are generally viewed as the behavioral playing out of the therapist's and patient's most fundamental internalized object relations in the transference and countertransference (Hirsch, 1998). Enactments are usually motivated by the mutual stimulation of strong affect between therapist and patient, resulting in an action or behavior on the part of the patient and/or therapist. Becoming argumentative or excessively silent are examples of an enactment. During an enactment, the patient and/or therapist may feel out of control, or at least overcome by something that feels mysterious and powerful, similar to what therapists describe when they feel taken over by a projective identification. In fact, an enactment is usually preceded by projective identification, and for this reason, is often a repetition and a reenactment of some core vulnerability or unresolved conflict from both the patient's and therapist's lives (Maroda, 1999).

Controversy surrounds what constitutes an enactment since there is no agreed upon definition. Although the history of the meaning of the concept of enactment can be traced back to Freud (1914), who called it "acting out," the current usage was re-introduced into the modern psychoanalytic literature by Theodore Jacobs (1986). Since then, clinicians have struggled to formulate a definition that does justice to the complexities of this unique transference-countertransference interplay (Maroda, 1999).

Some believe that every moment of the therapeutic process is an enactment because everything a therapist and patient says and does constitutes an action; by

this definition all of therapy is one ongoing enactment (Aron, 1996; Bass, 2003). These clinicians assert that to isolate one transference-countertransference event and call it an enactment risks obscuring the fact that every interaction between therapist and patient may be usefully viewed as an enactment. For example, should the moment a therapist becomes argumentative be considered the enactment, or did the enactment begin earlier when the therapist began to feel irritated with the patient?

Others believe that while everything that occurs in the therapeutic relationship can be seen as an enactment, some enactments have more importance (Black, 2003; Chused, 2003). Bass (2003) called these "capital E" enactments; they are more dramatic and require the full and heightened attention of the therapist. They can take hold of the therapeutic process for periods of time and are frequently fundamental to psychic change. Sharpe (1997, 2000), one of the few couple therapists who writes about countertransference enactments, agrees, claiming that the couples therapist is often unwittingly triangulated into the couple's system whereupon the therapist's core conflicts are activated. The therapist is swept into the triadic enactment occurring among the three participants.

While not calling these situations triadic enactments, systems marriage and family therapists have long recognized how triangulation occurs in family life. For example, Minuchin (1974) and Bowen (1988) concur that one way a family resolves its conflicts is through the process of triangulation. This may occur, for example, when a two-person system in conflict, (for example, a couple) pulls a

third person in (a child) to reduce their conflict. This tends to temporarily stabilize the system.

Psychoanalytic family therapists see triangulation as a process through which intrapsychic conflicts of family members are externalized through projective identification; one family member (usually the child) often becomes the scapegoat or identified patient and acts out the conflict of his parents, bringing about a homeostasis in the family (Zinner, 1989). These descriptions of triangulation as they occur in a family also occur in couples therapy; they can be viewed as a triadic enactment. However, while many clinicians agree this process occurs, they seem to give short shrift to exploring countertransference enactments in couples therapy.

Why is this? Perhaps one reason less is written about countertransference and countertransference enactments is that many of the clinicians who treat couples come from a behavioral or systems approach where paying attention to one's countertransference is not normally considered. The realistic aspects of the therapy situation are assumed to be predominant, and the therapist is viewed as an objective agent of change rather than being the object of any unrealistic expectations or fantasies by the couple (Guttman, 1987). The therapeutic alliance is therefore considered to be much more significant than transference or countertransference (Minuchin, 1974).

Another possible reason is that a couples therapist is normally confronted with the arduous task of monitoring the complex dynamics that occur between partners; he often has to spend an immense amount of time and effort actively

intervening in order to help the couple contain their emotional volatility. This could potentially sidetrack the therapist from attending to his countertransference. In addition, attending to one's countertransference in couples therapy is a more complicated endeavor. The therapist is faced with having different feelings about each partner individually and also towards the couple as a pair. This could make it more difficult for him to get a clear read on what he is feeling because so much is going on among all three participants; not only are the partners fully enacting out their conflicts with each other, but the therapist's own conflicts and vulnerabilities are also often triggered, creating situations rife for enactments to occur.

Here are a few examples. Since couples often come to therapy in crisis and in despair about their marriage, they may feel this is their last chance to save the relationship and could secretly yearn for a magical solution, "tools" that will suddenly turn their marriage around. Each partner may have impossible expectations, such as fixing their mate, or quick answers. Such pressure could trigger a therapist's unconscious need to be the savior, which could result in an enactment such as excessive advice-giving or being the know-it-all.

The triangular format of couples therapy sets the stage for other enactments to occur. In individual psychoanalytically-oriented therapy, the therapist does not get the opportunity to experience how the real objects in the patient's life match the patient's fantasized internalized objects. The therapist can only get a sense of the patient's real objects from the patient's accounts. But in couples therapy, the therapist, as participant and witness, experiences how partners view each other

and sees how these match his own perceptions of the partners.

Because each of the three participants have his/her own subjective reality, the potential for certain types of enactments are perhaps more likely to occur. For example, if the therapist finds one partner's perceptions more plausible, compelling, or in greater alignment with his own, he may repeatedly side with that spouse's point of view, perhaps resulting in a misalliance type of enactment. Or, if the therapist has unresolved conflicts, he may project those onto the spouse that irritates or triggers him. For example, if the therapist has a core vulnerability about being victimized and bullied, he may become overly controlling or aggressive towards the bullying mate, which may be a way of counteracting feelings of powerlessness.

The triangular format of couples therapy may also set up the potential for oedipal countertransference enactments. As compared to individual psychotherapy where the therapist develops an intimate connection with the patient, in couples therapy he stands outside the circle of intimacy (Gerson, 2001). The therapist is like an outsider/voyeur, privy to the intimate secrets of the couple, who sometimes let the therapist in and sometimes not. This situation shares many similarities with the way a child may feel excluded from his parent's relationship. Should the therapist have conflicts about feeling excluded, he may enact his conflict by becoming overly intrusive with the couple. Or perhaps he might withdraw into silence, feeling rejected. Another oedipal enactment could occur when one or both partners pressure the therapist to take sides against their mate; they may be like two siblings fighting for parental attention. If the therapist grew

up in an oedipal triangle similar to this, he might, for example, feel compelled to compete with the same sex partner for the other's sexual attention.

## The Research Question

The purpose of the study is to explore how therapists experience, think about, and deal with situations in which they get caught up in and/or act out their countertransference in couples therapy; these types of reactions are referred to as countertransference enactments. The following questions are addressed in my research: Are there typical countertransference reactions provoked in couple therapy, and do therapists reveal an awareness of the emotional conflicts and/or vulnerabilities being activated in themselves in the course of their work? What kinds of couples and/or situations do therapists describe as activating their countertransference? How do these therapists describe countertransference enactments, and do they differentiate these from countertransference? What are some of the ways couple therapists get caught up in and/or act out their countertransference? Do countertransference enactments help therapists recognize their vulnerabilities or emotional conflicts? How do couple therapists think about the enactment and work with it in the therapy, either within themselves or with the couple?

This qualitative study focused on the subjective experience of the therapist, using a Grounded Theory approach (Glaser & Strauss, 1967). The data consisted of in-depth interviews with ten psychodynamically-oriented therapists who were asked to consider their experiences of countertransference enactments while

working with couples. Psychodynamically-oriented therapists were interviewed because of their orientation towards recognizing transference and countertransference dynamics. The "constant comparative method" of qualitative data analysis as described by Strauss and Corbin (1998) was used to analyze the data from the study.

## Significance of the Study

Why is it important to understand enactments? Many clinicians believe enactments provide vital information about both the transference and, perhaps more importantly, the countertransference (Black, 2003; Ellman & Moskowitz, 1998; Jacobs, 1986; McLaughlin, 1991). Renik (1993) said that countertransference enactments are not only unavoidable, but are also the vehicle by which the therapist comes to recognize his countertransference. The enactment, if acknowledged and worked with, either within or outside the therapy, can help facilitate an understanding of transference-countertransference dynamics and provide a means of furthering the treatment.

The same advantages hold true for couples therapy. If the couples therapist can recognize the ways he is getting caught in his enactments, he can become aware of his blind spots with a particular partner or couple; this may help him get in touch with those unresolved conflicts that prevent him from understanding a partner or couple. The therapist can become familiar with the types of couples or particular emotional issues with which he tends to have the most trouble or which are more likely to result in an enactment. This awareness could help the therapist

resolve a therapeutic impasse or prevent the early terminations that are so prevalent in couples therapy.

Along the same lines, by bringing attention to the way countertransference enactments occur in couples therapy, much can be learned about how couples therapists think about and deal with their enactments; this could facilitate a further understanding of several aspects of triadic enactments. For example, what kinds of couples, in general, tend to provoke enactments. Similarly, what particular types of unresolved conflicts in the therapist might tend to result in an enactment. For example, a therapist who is having marital problems or an extra-marital affair might be challenged by similar issues in the couple. It also might be interesting to discover what types of enactments tend to result in therapeutic progress or impasse. Of course, this may depend on the different ways therapists handle the enactment, which in itself is an important aspect of this study.

While not all couples who come to couples therapy are highly conflicted, most are, and this tends to make the therapy very stressful. This might make it more difficult for the therapist to become aware of his countertransference enactments for several reasons. Couples therapy usually requires the therapist to be more active than he is in individual therapy; this activity could make it harder to differentiate an enactment from a normal intervention. In many instances, the couples therapist educates, advises, gives homework, teaches communication exercises and applies other techniques in order to help the couple. But therapeutic techniques may disguise what is in fact a countertransference enactment. For example, with an argumentative couple, a therapist usually needs to assertively

intervene to make therapy safe; getting the couple to stop fighting so they each feel heard and understood takes persistent effort. Most of the time this is a typical and important strategy and is not necessarily an enactment. If, however, the therapist is conflicted about his own expression of anger, he might unconsciously enact his countertransference by overly suppressing the couple's anger; this could actually hinder the couple's ability to express anger constructively.

Another reason why it may be difficult for the therapist to become aware of his enactments has to do with the conflictual nature of couples therapy. Because the couple is already fully enacting their conflicts, it may be difficult for the therapist to get a read on his own contributions to the process. He is perhaps more likely to disown or minimize his own conflicts and vulnerabilities and project them onto the struggling couple. Couples therapists coming from a behavioral or systems approach already tend to minimize their countertransference reactions and instead see themselves as the active agents of change. But even some object relations couples therapists tend to minimize countertransference, focusing more on the couple's transference to the therapist. For example, in one text on the treatment of the borderline/narcissistic marriage, a type of couple who usually stirs up overwhelmingly negative feelings in the therapist, the author relegated relatively few pages to the therapist's countertransference (Lachkar, 1992). This is not uncommon in the literature.

Another way object relations couples therapists minimize is that they tend to see the therapist's countertransference as diagnostic of the couple's system rather than as indicative of the therapist's own conflicts (D. Scharff & J. Savege Scharff,

1991; Sharpe, 1997; Ruszczynski, 1993). They believe the therapist's countertransference is an attunement to the projective identification processes occurring between the partners, and is thus the royal road to understanding the couple. While this may very well be true, the therapist also needs to see that not all of what he is feeling is about the couple, but is also an indication of his own conflicts and projections. Because of these tendencies, my sense is that couples therapists do not pay enough attention to their countertransference enactments, which is why my study has the potential to bring more awareness to this important subject.

# CHAPTER 2: LITERATURE REVIEW

The focus of this study is on how therapists experience, think about, and work with their countertransference enactments in couples therapy. The literature review is divided into two sections. In the first section, I will review the concept of enactment as discussed in the psychoanalytic literature in relation to individual treatment, since it is in this body of work that the concept was most richly developed. I will begin with a brief definition of the term and then reviewed the history of the concept, tracing pivotal psychoanalytic ideas on countertransference, transference and countertransference enactments, and the nature of analytic interaction. I will then discuss some of the therapeutic pitfalls that may occur during an enactment. Finally, because projective identification is thought to precede an enactment, I will end the section with a discussion of that concept.

In the second section, I will discuss countertransference in couples therapy. Since most of the work on countertransference in couples therapy comes from object relations practitioners, the review primarily focuses on their contributions. These include topics such as oedipal enactments, countertransference as diagnosis, concordant and complementary countertransferential identifications, countertransference with difficult couples, misalliances, and ethical and moral dilemmas. I will then discuss an intersubjective perspective on countertransference in couple therapy, highlighting the differences between this perspective and an object relations perspective. Finally, I will summarize how some couples therapists work with their countertransference.

## Enactments

An enactment refers to the interactional and behavioral aspects of the transference-countertransference dynamics between therapist and patient; it describes the ways in which a patient and therapist act upon one another through unconscious communication and interpersonal influence (Jacobs 1986, 2001); these actions are intended to persuade or pressure the other in the interactive field. As a process of mutual influence, enactments continuously operate in both directions.

An enactment differs from other strong transference-countertransference interplays in that it is usually unconsciously motivated by the mutual stimulation of strong affect, with both persons often stating that they felt out of control, or at least overcome by powerful emotions. Enactments seem to provoke core conflicts or vulnerabilities in both therapist and patient and can manifest in various behaviors, for example, a heated argument, a shortening or lengthening of a session or an unexpected withdrawal into silent rejection (Maroda, 1999).

While an enactment may be initiated by either the patient or therapist, I primarily examined countertransference enactment; this is defined as the patient's unconscious efforts through unconscious communication, both verbal and nonverbal, to pressure the therapist to play out a particular role from the patient's internalized object relations; it is an actualization of the transference (Johan, 1992). If these interactional pressures stimulate an unconscious conflict in the therapist, a countertransference enactment can occur (Chused, 2003).

*History of the Concept of Enactment*

The term enactment, a refinement of the original term acting out, was only recently introduced to the psychoanalytic vernacular by Theodore Jacobs (1986) and has since stimulated considerable interest among progressive classical analysts (Boesksy, 1990, 1998; Chused, 1991) and contemporary relational psychoanalytic writers (Aron, 1996; Hirsch, 1993, 1996, 1998; Mitchell, 1997; Renik, 1993). It has led some classical analysts to re-conceptualize the basic nature of the psychoanalytic process and, perhaps more significantly, the role of transference and countertransference. To understand the concept of enactment, and more particularly, countertransference enactment, I briefly summarize evolving psychoanalytic notions of transference, countertransference, and psychoanalytic interaction, which are related to the concept of enactment, beginning with how Freud understood acting out.

Freud (1961) introduced the idea of acting out in his extraordinary paper "Remembering, Repeating, and Working Through." Freud described how acting out, the repetition compulsion and working through are interconnected in the psychoanalytic process (Boesky, 1998). He believed that acting out is related to the transference, and particularly, to the patient's resistance to experiencing the transference. Instead of being able to access the transference through words, the patient unconsciously acts out the transference behaviorally. The patient repeats his past with the analyst in the form of an action instead of remembering it and expressing it in language; in this way acting out is a form of communication. Freud (1914) wrote:

> 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. For instance, the patient does not say that he remembers that he used to be defiant and critical towards his parent's authority; instead, he behaves in that way to the doctor. . . . As long as the patient is in the treatment he cannot escape from this compulsion to repeat. In the end we understand that this is his way of remembering. What interests us most of all is naturally the relation of this compulsion to repeat the transference and to resistance. We soon perceive that the transference is itself only a piece of repetition. . . . The greater the resistance, the more extensively will acting out (repetition) replace remembering." (pp. 150-151)

Later in this paper, Freud spoke of the necessary cautions to be observed if dangerous actions spill outside of analysis and threaten the analysis or the patient's safety. To avoid the risk of acting out, new patients were discouraged from taking significant actions or making major life decisions during analysis.

Like Freud, Fenichel (1945) believed that acting out is a special form of remembering in which the old memory is reenacted in a more or less organized and often only slightly disguised form. He defined acting out as "an acting which unconsciously relieves inner tension and brings partial discharge to ward off impulses" (p. 197). These impulses express instinctual demands. Any situation closely linked with this repressed content has the potential to discharge them. Part of the purpose of acting out behavior is to reduce neurotic anxiety; acting out

one's impulses reduces anxiety by relieving the pressure which the id exerts upon the ego. The patient is usually not aware of what is making him act out. Greenacre (1950) believed that acting out occurs more frequently in analysis because the transference, by provoking repressed impulses, stirs up more neurotic anxiety. She also felt that certain patients are more prone to acting out, such as those with severe neurosis or poor ego structure.

Over time, the term acting out became over-burdened with meanings and, in some situations, loosely applied. For example, besides describing a wide range of patient's behaviors during psychoanalytic treatment, acting out was also used to depict criminal behavior, delinquency, drug additions, severe character neurosis, sexual perversions, and other behaviors considered to be irrational. At a symposium on "Acting Out and Its Role in the Psychoanalytic Process," Calef (1968) reported that clinicians concurred that the concept is confusing and could not agree on a specific definition. However, most agreed that some level of acting out occurs in every treatment.

Normally, acting out was thought of as something the patient did, not the analyst. The concept of countertransference acting out or countertransference enactment had its roots in the work of Ferenczi who was perhaps the first analyst to regard the reciprocal nature of the analytic relationship; he promoted a view of the analyst's participation as far more active, central and mutual than Freudians had believed (Dupont, 1988). The analyst is not a blank screen to the patient; rather, the patient "detects from little gestures the presence of affect which may reveal to the patient more about the analyst than the analyst may himself know"

(p. 84). This suggests that the analyst may be unconscious of his subtle actions and ways of being with a patient that impact the patient.

After Ferenczi, countertransference became a topic of discussion in both the classical psychoanalytic writings of Winnicott (1949), Heimann (1950), Tower (1956), and Bird (1972) and in the interpersonal psychoanalytic writings of Sullivan (1953), Thompson (1950), and Wolstein (1975). These two schools of thought developed in separate but parallel tracks, although their perspectives on countertransference were remarkably similar. In addition, their ideas recently converged in current relational psychoanalytic theories. While countertransference is a vast subject about which much has been written, I reviewed only a few of the most salient authors who addressed aspects of countertransference most relevant to the concept of enactment.

Interpersonal psychoanalysis, as developed by Sullivan (1953), emphasized the ostensible interactions between patient and analyst. Rather than focusing only on verbal communications, Sullivan looked at what patients and analysts do to and with each other; that is, he examined behaviors between analyst and patient as well as the transference. Sullivan, whose scientific background included familiarity with Heisenberg's concept of uncertainty and Einstein's relativity theory, attempted to counterbalance Freud's notion of the analyst as a blank screen. Rather, Sullivan asserted that absolute truth and objectivity are not possible; like the scientist, the psychoanalyst interacts with, and thereby influences, what is observed and cannot be neutral. Sullivan named this the principle of participant-observation because the analyst is an observer as well as a

participant in the psychoanalytic process. These ideas established interpersonal psychoanalysis as a forerunner of today's intersubjective and relational theories (Aron, 1996).

Though Sullivan introduced the idea that the therapist is an observing-participant, he ironically avoided looking at his own countertransference. In this way, he is similar to the classical psychoanalysts of his day, who viewed countertransference as something to be eliminated. They thought this necessary so that the patient's pure projections could be objectively studied. In this country, Sullivan's followers broadened the view of countertransference, seeing it as a natural and central part of understanding the patient. The analyst had to become emotionally engaged with the patient. This engagement was inevitable and necessary for productive analytic work and was the means through which the analyst became aware of his countertransference, including his actions.

For example, Thompson (1950) believed the analyst must become skillful at observing himself even while being a part of the analytic system; in this way, he could become conscious of the effect of his participation and better control his influence. Wolstein (1975) viewed the analyst and patient as having equal influence over each other, both being full and equal co-participants in the therapeutic relationship. From his perspective, it is difficult to distinguish between transference and countertransference since it is impossible to determine who is reacting to whom; the analyst reacts to the patient as much as the patient to the analyst.

Levenson (1983), a contemporary, interpersonal psychoanalyst, does not see

the analyst and patient as equal co-participants, but views the patient as more influential. Because of this, the analyst is, sooner or later, unwittingly pulled in by the patient to live-out the patient's internalized interpersonal dramas. The analyst must allow himself to be used by the patient and lose himself in the process. Further, each analyst enacts the transference in his own idiosyncratic way, making it even more important that the analyst be vigilant about his countertransference.

For Levenson, analysis is not just talk therapy; it is an active and interactive process; that is, analysis is not only talking about experience but a living-out of that experience. Levenson suggests that what is central to psychoanalysis is a detailed inquiry of the here-and-now transference-countertransference interaction as a co-creation of patient and analyst. He states, "The language of speech and the language of action will be transforms of each other; that is, they will be, in musical terms, harmonic variations on the same theme" (1983, p. 81). This notion precedes current ideas of enactment, which views both the words and deeds of the analyst as equal expressions of the analyst's countertransference.

While the interpersonal psychoanalysts saw countertransference as a vital part of the interactive process, most classical psychoanalysts prior to the 1950s had viewed countertransference as intrusion to be eliminated. This began changing in the late forties and early fifties when several traditional psychoanalysts moved toward a more interactional view of the therapeutic relationship. Winnicott (1949), Heimann (1950), Little (1951), Tower (1956), and Racker (1957) were among the first classical analysts to emphasize the value of using countertransference feelings to understand clinical data.

Winnicott (1949) expanded the traditional definition of countertransference to include all the reactions of the therapist to the patient. He believed that with the more disturbed, non-neurotic patients, countertransference difficulties are often based on so-called objective reactions to the patient, and not simply on subjective intrapsychic conflicts within the therapist; that is, most analysts would have similar reactions when working with these types of patients. Such patients are repeatedly compelled to evoke certain responses in the therapist as an attempt to gain omnipotent control over him, and this represents a maturational need to recreate the early symbiotic relationship to their mother. Thus, countertransference is not a resistance that interfered with progress in treatment but is an important source of information for the therapist about the developmental needs of the patient.

Heimann (1950) similarly thought that countertransference is a valuable way to understand the patient's unconscious processes and is therefore an important therapeutic tool superior to one based purely on conscious intellectual judgments. She decried the fact that many analysts attempted to control their countertransference because this led to them becoming emotionally detached, which impeded therapeutic process. On the contrary, strong emotions such as hate, love, anger, etc., are typical countertransference reactions which help the analyst stay involved. However, these same feelings could at times erupt and impel the analyst towards action (enactment) rather than towards reflection, blurring his capacity to objectively view the therapeutic interaction.

Little (1951) thought countertransference feelings are unavoidable and

omnipresent. Patients, especially disturbed ones, frequently provoke reactions and behaviors in the therapist, and these, in turn, provoke responses in the patient. The patient might induce the therapist to behave in a manner similar to the patient's parents, but if the therapist denies the patient's perception of this, it can potentially perpetuate the patient's pathology and disrupt the possibility of a genuine relationship. Thus, Little felt that the therapist's responses needed to be openly revealing so the patient's perception of reality and sense of trust could be bolstered. Only then could the distorted transference responses in the patient be explored and worked through. Otherwise, treatment might reach an impasse. Little's notions of the therapist being self revealing were revolutionary at the time and are remarkably similar to post-modern concepts of countertranference.

Racker (1957, 1968) elaborated on Little's ideas, claiming that the analyst is induced to play out the roles from the patient's internalized object relations through the process of projective identification. According to Racker, the analyst is induced to experience a complementary identification with the patient's object representations. He is induced to feel like the patient's parents (e.g., critical, rejecting); this he called a complementary identification. Or, the therapist experiences a concordant identification with the patient's disowned self representations and is induced to feel like the patient's split-off self aspects (e.g., victimized, rejected). Racker elucidated ways in which the therapist might get caught up in his countertransference. For example, the therapist may over-identify with the patient's persecutory parental objects, becoming judgmental, and, in this way, the patient's past trauma is re-enacted in the therapy.

Tower (1956) likewise acknowledged that countertransference could overcome the therapist and result in a countertransference neurosis. Because of the deep nature of the analytic relationship, she admonished that no analyst can control his unconscious nor be completely free of disturbing emotional patterns. Like Levenson, Tower believed that the analyst must become as lost in the analytic process as the patient and must be pulled into a countertransference neurosis to match the patient's transference neurosis. Inevitably, the analyst will make mistakes and failures, and these will impact the patient. However, Tower thinks that patients often forgive the analyst's limitations and failures; she believes that these limitations are incorporated into the transference-countertransference dynamics and become an essential component of therapeutic change.

Bird (1972) reflects a similar perspective. When the transference neurosis begins to reach its peak in terms of emotional intensity, the patient's most destructive impulses surface, often creating an adversarial situation with the analyst. The result may be a stalemate, a negative therapeutic reaction, or a struggle between patient and analyst. The analyst may feel lost, out of control, or irrational. For analysis to be productive, the analytic interaction must feel like it is on the brink of dissolution. The patient's transference neurosis cannot be worked through without this sort of unwitting participation by the analyst.

This unwitting participation by the analyst is called the actualization of the transference by Sandler (1976); the therapist, in a free floating reverie, allows himself to be used by the patient. The patient makes active, but unconsicous

efforts to provoke, manipulate, and impose an interaction between himself and his analyst by prodding the analyst into behaving in a particular way. As a result, the therapist is induced to live out the roles of significant others in the patient's internalized object world. The patient then unconsciously scans and adapts himself according to his perceptions of the analyst's reactions.

It is not only the analyst's reactions, but his personality as well that influences the patient (Lipton (1983). Lipton suggests that analysts need only look back to Freud to recognize this influence. Freud, who clearly enacted his personality with patients, was far from the ideal of the neutral blank-screen analyst; rather, he had a spontaneous interactional style. Lipton criticizes American psychoanalysts for abandoning Freud's ways and adopting a method which over-emphasized silence and emotional distance. Instead, he believes analysts need to be more fully themselves with patients. Either form of participation has as much an effect upon patients, and both are acceptable as long as the particular interaction is analyzed for its effects and meanings to the patient.

Since the analyst is not able to hide his personality from the patient, McLaughlin (1991) persuasively argues for an increasingly mutual view of analysis. The analyst is no more objective than the patient and is as capable of influencing the patient as the reverse. In fact, because both analytic parties are equally primitive and infantile in their participation, McLaughlin asserts that the term countertransference is a misnomer and should be called the analyst's transference. Countertransference incorrectly implies that the analyst is reacting only to the patient's transference and not, just as likely, the reverse. Co-

transference is a more apt depiction. McLaughlin's views were radical for their time and presaged more recent relational ideas of mutuality.

### *Current Views on Enactments*

The analyst most responsible for the introduction and acceptance of the term enactment within the modern, mainstream psychoanalytic community is Theodore Jacobs (1986). Though others before him were thinking along similar lines, Jacob's article on countertransference enactment stimulated a groundswell of discussions among many progressive classical and relational analysts about the role of the analyst in the psychoanalytic interaction (Boesky, 1990; Chused 1991; McLaughlin, 1991; Renik, 1993). Jacobs (2001) explores the nature of conscious and unconscious communication, both verbal and nonverbal, between patient and analyst. He suggests that both patient and analyst unconsciously enact certain subtle transference-countertransference interactions.

Believing that the analyst's personality is more important than either the analyst's theory or technique, Jacobs (2001) says that extensive countertransference participation and enactments are inevitable. This occurs through subtle metacommunications between analyst and patient, communications that are usually nonverbal in nature and have considerable mutual influence. In fact, according to Jacobs, every aspect of the analytic interaction entails a potential countertransference enactment, even when the analyst believes he is applying standard technique, as in asking questions or making an interpretation.

Boesky (1990) agrees that countertransference enactments are common, but

more than that, they are necessary for analysis to succeed. He states, "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 analyst must regress in a manner similar to the patient; he must become an unwitting participant in the patient's world, playing out the patient's core internalized schemas. Mitchell (1988) says the same thing, only more poetically:

> Unless the analyst affectively enters the patient's relational matrix or, rather, discovers himself within it – unless the analyst is in some sense charmed by the patient's entreaties, shaped by the patient's projections, antagonized and frustrated by the patient's defenses – the treatment is never fully engaged and a certain depth within the analytic experience is lost. . . . The analyst discovers himself a co-actor in a passionate drama involving love and hate, sexuality and murder, intrusion and abandonment, victims and executioners. Whichever path he chooses, he falls into one of the patient's predestined categories and is experienced by the patient in that way. (pp. 293, 295)

Thus, if the analyst can truly let himself fall into this drama and is simultaneously stimulated to re-experience some portion of his own personal drama, a countertransference enactment occurs. That is why the analyst is often quite surprised at his own behavior and finds it to be so uncharacteristic of him.

Chused (1991, 2003) does not go as far as Boesky or Mitchell in claiming that enactments are necessary for analysis to be effective, but does state that they are inevitable and urges the analyst to capitalize on them. Analysts should not dwell

on their own guilt for being drawn into enactments or making mistakes but, rather, view this error as an opening for potentially productive analytic engagements.

Of all the classical analysts, Renik (1993) takes the concept of countertransference enactment to its logical extreme. Fully embracing both the inevitability and necessity of countertransference participation, Renik believes that countertransference awareness comes only after it is expressed in action and in post-enactment analysis of what these actions say about the transference and countertransference dynamics. According to Renik, it is impossible for the analyst to be objectively focused on the patient's inner reality even for an instant because the analyst is constantly acting on the basis of personal motivation of which he cannot be aware until after the fact. Just as analysts expect patients to act out their transferences before becoming aware of the meaning of their actions and motivations, so too, should analysts expect they will enact their countertransference before becoming aware of its meanings and motivations. Renik says that to eliminate countertransference enactments is not only unattainable as a goal but is also misconceived, since it is this awareness which contributes to authentic encounter. Thus, Renik encouraged a technique that left more room for the analyst's spontaneity, which in turned helps facilitate a corrective emotional experience (Aron, 1996).

To many relationally-oriented clinicians, virtually every moment of the analytic process potentially constitutes an enactment. Further, because the psychoanalytic interaction is mutual and continuous, it is difficult for the analyst to sort out those psychic elements that belong to the patient from those that belong

to him; thus, it is almost impossible to ascertain who initiates a particular sequence of an interaction. For example, when describing a clinical case in which an enactment took place, Aron (1996) ponders the following questions: At what point can an analyst say that an enactment is taking place; when did the enactment begin; and when did it stop? Who is nudging whom? Who is evoking a role in whom and who is being asked to play a part in whose script? Are not the patient and analyst always enacting their internal sets of self and object relations, using each other as characters in the internal scripts that they are playing out and acting out? Aron contends that the analyst and patient are always enacting, just as transference and countertransference are always occurring.

If every aspect of the psychoanalytic interaction is an enactment, how is the concept useful in understanding countertransference? Bass (2003) addresses this concern, claiming that the analyst needs to discern the difference between the ordinary enactments that occur in the daily ebb and flow of the analytic process and those that are a bigger event; these he called capital E enactments. They are:

> . . . highly condensed precipitates of unconscious psychic elements in patient and analyst that mobilize the analyst's full, heightened attention and define, and often take hold of, the analytic activity for periods of time. These processes frequently are fundamental to psychic change. (p. 660)

Bass views big E enactments as having the potential for psychological growth because they provide opportunities for the analyst and patient to discover new inner resources and levels of self awareness.

*Potential Therapeutic Pitfalls of Enactments*

As reviewed above, enactments are an inevitable part of the therapeutic process and can be quite useful in helping the therapist understand his countertransference. But enactments can also be detrimental to the therapeutic process. Richards (Richards, Bachant & Lynch, 1997, as cited in Maroda, 1999, p. 126) states:

> Enactments, like transference actualizations and acting out, can serve to advance the therapeutic process or derail it. This fact is often lost. . . . I stress all this because there is of late a tendency for the concept of enactment to be valorized in discussions of the therapeutic process [p. 7]. (as cited in Maroda, 1999, p. 126)

Maroda contends that there is little written in analytic literature about the potential for the analyst's past, rather than the patient's, being re-enacted to the point of dominating the treatment and even determining its outcome. This is especially true of therapists who tend to be unaware of their countertransference or countertransference enactments. Further, analysts may neglect the fact that they might be in the throes of the same type of repetition compulsion as the patient, but because they hold the power in the analytic relationship, they can insure that their reality prevails.

This last point is crucial, according to Maroda (1999), because usually when a powerful enactment occurs that is not correctly identified and worked through, the patient's reality can be subjugated to the analyst's, resulting in a countertransference enactment that can potentially damage the patient and/or

derail the treatment. The damage depends on many factors, including how long the enactment persists, the vulnerability of the patient and the degree to which he blames himself, and the extent of the analyst's pathology. If the analyst is unaware of his own pathology, is more characterologically disturbed than his patient, or comes from a very harsh traumatic past, countertransference enactments can potentially pervade the treatment and result in the patient experiencing confusion, anxiety, depression, and even despair and self-destructive acts. The patient's defenses may not be completely prepared to cope with the analyst's re-enactments. For example, Finell says that the narcissistic problems of the analyst, if unresolved, can lead to grandiosity, exhibitionism, aggression and power in the countertransference, especially if the patient is prone to narcissistic vulnerabilities (as cited in Maroda, 1999, p. 128) .

### *Projective Identification*

Since most clinicians who write about enactments concur that projective identification often precedes an enactment, a discussion of enactments would not be complete without addressing this phenomenon; in fact, at times, projective identification and enactment seem to be describing the same psychological process. What might differentiate a projective identification from an enactment is that projective identification refers only to the mutual stimulation of repressed, intense affect, while an enactment implies an action or behavior (Aron, 1996). Although projective identification may result in or inform behavior, by definition, it only requires the presence of strongly felt emotion. Thus, in a projective

identification, the analyst may experience and contain a set of affects that feel "not his own," while in an enactment, he may unconsciously act out on these affects behaviorally.

While it is beyond the scope of this study to provide an in-depth evaluation of the projective identification literature, I will discuss the concept and describe how it is viewed from the perspective of more relationally-oriented psychotherapists; they generally see it as an interpersonal/intersubjective process as compared to many traditional Freudian and Kleinian clinicians, who view it as primarily an intrapsychic one. For the purposes of my study, I view projective identification as an intersubjective process, because conceptualizing it in this way helps illuminate not only how countertransference enactments may occur, but also aids in understanding an object relations perspective on marital dynamics.

Projective identification was first described by Melanie Klein (1946). Since that time, the concept has fostered many controversies among clinicians. While most clinical writings describe how projective identification occurs in the transference and countertransference, this process can also occur in any intimate relationship and is therefore helpful in understanding unconscious communication between two people. In general, projective identification can be viewed as a defensive, intrapsychic, unconscious process in which an individual splits off from consciousness intolerable (or valued but internally threatening) intrapsychic aspects (impulses or parts of self or internal objects plus associated affect) and projects them onto another person (Moore, 1995). These projected aspects are then assumed by the projector to lodge and belong to the personality of the other.

The projector may believe (in fantasy) that he possesses the other (object), or controls him/her from within, and, in this way, maintains a tie with the disowned parts. The process becomes intersubjective when the projector attempts to induce the recipient to enact these disowned parts.

Klein (1946) originally coined the phrase projective identification to depict how an infant, terrified of imminent annihilation and abandonment (the paranoid-schizoid position), handles the intolerable anger and anxiety of inner destructiveness by fantasizing its expulsion into the object (mother); this occurs through the defenses of splitting and projection. These split-off parts are now located in the mother from the perspective of the infant's unconscious fantasy. This permits the infant to perceive her as the "bad mother" (i.e. the "bad breast" as part object) because it is less dangerous for him to experience the badness outside himself in an object from which he could escape rather than inside himself from which there was no escape. Klein assumed the infant also projects good parts of himself into his mother creating the "good breast." The good breast serves as a refuge from the threat of the bad breast and is important for ego integration. Klein saw projective identification as a crucial organizer of mental life in the paranoid-schizoid position, an early phase of development in which the infant oscillates between experiences of goodness and badness. Klein left further elaborations of projective identification to her followers (Bion, 1959; Ogden, 1979; Racker, 1968).

As the concept developed, analysts began exploring how projective identification is an interpersonal process and a form of unconscious

communication between two people. Bion (1959), an expert in group therapy and a Kleinian analyst, made important contributions in this regard. His work grew out of experiences with very disturbed patients in which he found himself having intense feelings that seemed to correspond to the patient's affective life. He believed the patient's intention is to project parts of his mind into the analyst's mind, where, if they are allowed to repose long enough, they would undergo modification by the analyst's psyche, allowing them to be safely re-introjected by the patient in a metabolized form. In other words, the analyst became a container for the patient's intolerable split-off aspects and through tolerating them, made them more manageable.

Bion (1961) believed this process originates in the relationship between mother and infant. The mother, in a state of loosely flowing reverie, allows herself to be responsive to the infant's various affect states, especially those which are noxious. The mother holds and, in a sense, organizes the experience for the infant, making it bearable. The mother is able to contain the disturbing anxiety without damage to herself. The infant then identifies with his mother as container and develops a secure self capable of thinking through. In short, the mother responds to the infant by reflecting, holding, and modifying his primitive raw intolerable experience. Over time, the infant gradually develops an increased capacity to tolerate, think through, and contain his original experience (Seligman, 1999).

In contrast, less healthy parents might not be able to tolerate the child's raw and primitive communication and, as a result, they respond to the child in distress

with equally raw and primitive affect. The child becomes more anxious when the parent fails to take in and contain his distressed feelings and thereby misses the opportunity to develop increased integration and the capacity to tolerate his experiences (Barbera, 2001). Children form their internalized worlds around these interactions, which, left in their original dangerous, hateful, and disintegrative forms, can result in pathological organizations in the personality. In adulthood, these painful, unmetabolized experiences often need to be projected because they cannot be tolerated, and this can result in the adult recreating repetitive, painful interpersonal experiences.

Bion's concept of valence is also crucial to this process. Valency is "the capacity for an instantaneous, involuntary combination of one individual with another for sharing and acting on a basic assumption" (1961, p. 136). Valence is the part of us that automatically and instinctively resonates with another in positive and negative ways. Valence explains how the recipient of the projection in projective identification identifies with the projection and introjects it. Through interactional pressure, and through behavioral and communication patterns that tend to elicit certain responses, the projector induces the recipient into playing out (enacting) his disowned aspects.

In treatment, projective identification captures important elements of the patient-therapist experience, particularly those vexing moments when the therapist feels pressured, consciously or unconsciously, to take on feelings or entire roles that seem inauthentic or unacceptable (Seligman, 1999). The patient, who projects and identifies disowned aspects of himself in the analyst, subtly pressures

the analyst to get him to behave in ways that fit with the projected image. The analyst as the recipient of this interpersonal pressure begins to feel or act in ways consistent with these attributions (Alvarez, 1999). The analyst will not usually react to the pressure unless the projection connects with some psychic element in himself; that is, the projection requires a hook in the recipient to make it stick. Even if the analyst feels he is being manipulated into feeling something that is not his own, clearly some repressed aspect is being activated.

The power of any projective identifications depends on the forcefulness of the projector's insistence on getting the other to accept the identification even when he resists (Alvarez, 1999). Countertransference enactments are most likely to occur at these times, especially if the therapist's core vulnerability or unresolved unconscious conflicts are triggered in such a manner that he is not able to contain the affect.

## Countertransference in Couples Therapy

### *Introduction*

In this section, I will review the literature on countertransference in couples therapy. After a brief overview of the subject, I will introduce a few important family therapists' contributions to the topic, followed with an in-depth discussion on countertransference from an object relations perspective. As a prelude, I will provide an overview of how mutual projective identification occurs between partners in an intimate relationship. This is important to understand because most object relations therapists believe this is the basis for how the therapist's

countertransference gets triggered when working with a couple. I then look at the D. Scharff's and J. Savege Scharff's (1991) important contributions to object relations couple therapy, examining how the projective indentificatory system of the couple affects the therapist.

Related to the D. Scharff's and J. Savege Scharff's (1991) ideas are how object relation couples therapists think about oedipal enactments. Many think these reenactments are quite common but overlooked. Object relations couples therapists have also used the concept of projective identification as a way to understand their countertransference and what it tells them about the couple. This part includes an examination of the concepts of concordant and complementary countertransferential identifications and the use of countertransference as a means of diagnosis.

The sections that follow elaborate some of the specific situations which are unique to couples therapy and are prone to activate countertransference. This includes a thorough consideration of how easily countertransference misalliances can occur. Next, I will elaborate the various types of countertransferences encountered in working with difficult couples, especially with partners who are severely traumatized or characterologically disturbed. I will end the object relations section with a review of how specific moral and ethical dilemmas that are unique to couple therapy are likely to provoke countertransference.

Lastly, I will consider intersubjective approaches to couples therapy and countertransference; I will begin with a brief discussion of how intersubjectivity differs from an object relations perspective and then elaborate how this approach

views transference and countertransference as it unfolds in the intersubjective field between therapist and the two partners. Surprisingly, although the relational psychoanalytic perspective is closely akin to an intersubjective one, there was no literature on couples therapy from this perspective, even though that theoretical approach had some of the most fruitful discussions on how countertransference enactments occur in individual treatment. Perhaps what accounts for this lack is that relatively few relationally-oriented psychoanalytic therapists are writing about their work with couples. I will end with a summary of how some clinicians work with their countertransference in couples therapy. Because the couples therapists' countertransferences were primarily elaborated through case vignettes, I will present numerous case examples to elucidate a particular point.

Almost the entire body of work on countertransference in couples therapy comes from a psychoanalytic perspective. Systems and cognitive-behavioral approaches, which tend to dominate the field of couples therapy, neglect transference and countertransference phenomena primarily because they do not perceive that it exists in any visible or easily identifiable manner. Nor do these theorists think that the therapist is not seen as a transferential object by the couple. Nichols (1988) states that the therapeutic relationship in couples therapy is de-centered in favor of the partner's relationships with each other.

Similarly, Bowen (1988), one of the most influential pioneers in family therapy, makes no references to transference and countertransference. He dismisses the transferential aspect of the therapeutic relationship, positing that patients are coached to deal with the actual parents, siblings, or partners;

therefore, transference of their unresolved or unconscious feelings from childhood onto the therapist does not occur. Likewise, Minuchin (1974; see also Minuchin & Fishman, 1981), the founder of strategic family therapy, makes little mention of transference/countertransference dynamics in his works, although he does discuss the concept of enactment. Minuchin thinks that rather than having the family talk about their conflicts, the therapist should attempt to get them to enact their struggles in the consulting room so that the therapist has greater leverage to effect change in the family interaction through an intervention. However, Minuchin does not talk about how the therapist gets pulled into the enactment. Flaskas (1996), a systems therapist, thinks that system theorists have failed to examine the therapeutic relationship in couples and family therapy; yet, except for a cursory examination, she has not considered the subject of countertransference.

Other popular approaches to couples therapy fail to cover countertransference in any significant depth, including well-known clinicians such as Bader and Pearson (1988), Gottman (1999), Haley (1973), Jacobson and Gurman (1986), Johnson (2002), Papp (1984), Stuart, (1980), and Wile (1981). Take, for example, Johnson (2002), an attachment-oriented therapist who developed the well-established approach, emotionally-focused couples therapy, and who writes about working with trauma survivors. She mentions how crucial the attachment to the therapist is for healing so that a corrective emotional experience can occur. She acknowledges that marital partners with a history of trauma often experience intensely negative affect states, crisis, suicide attempts, and self destructive acts, and that, as a result, the therapist must deal with intense rage, sadness, and

despair. In fact, she says that the therapist may be overwhelmed and have to deal with his own areas of trauma, depletion, and burn out when working with such clients. While Johnson affirms that the therapist must be aware of his countertransference, she does not provide any detailed examples about the specific ways in which negative countertransference reactions or enactments can derail the therapy. Similarly, Bader and Pearson (1988) and Gottman (1999), both of whom are towering figures in the couples therapy field, give countertransference issues short shrift. This is typical in the literature.

What is also very common in the literature, even from a psychodynamic perspective, is the view that the clinician is the active change agent, who applies certain techniques and interventions to the couple; these include interpretation, clarification, empathic responses, communication training, anger management techniques, and so on. In addition to the therapist's activity, alliances and sympathies are continually shifting in couple work, requiring that the therapist be much more spontaneous and improvisational in order to stay in touch with the fast-moving dialogue. This tends to makes the therapist's own style and character more visible and less neutral (Ehrlich, 2000). Yet, despite the increased activity of the therapist, most non-analytical clinicians have little regard for how countertransference reactions play a major role in the treatment (Seagraves, 1982.)

### *Influences From Family Therapy*

While an in-depth review of family therapists contributing to the topic of countertransference in family treatment is beyond the purview of this study, I will

mention a few important figures who have discussed the subject. The first therapist to discuss countertransference in couple and family therapy from a psychoanalytic perspective was Nathan Ackerman (1958). Although he mainly wrote about family therapy, his ideas are applicable to couples as well. Ackerman disagreed with the prevailing psychoanalytic practice to see a patient alone without the family; he believed this did not allow the therapist to have direct observation of the patient interacting with his/her significant others. Since the roots of transference emanate from these very early and continuous interactions, the real people involved in the relational conflicts should be part of the therapeutic dialogue.

Napier and Whitaker (1978), experientially-oriented psychotherapists, recommended that the therapist be involved emotionally in the family so that he could identify empathically with each member of the family. To facilitate the process of identification, they suggested that the therapist think about experiences he had had that were similar to those of the family members. If the therapist had a strong countertransference reaction, he suggested sharing it openly with family members in order to mitigate against potential destructive acting out. Like Napier and Whitaker, Boszormenyi-Nagy and Krasner (1986), the developers of contextual family therapy, believe that countertransference can be used as a resource for deepening the therapist's capacity for engagement in the treatment through empathizing with each family member.

*Object Relations Couples Therapy*

Among the most important contributions to the subject of countertransference in couples therapy come from the object relations clinicians. To gain a better understanding how countertransference arises in couples work, it is important to see how object relations theorists conceptualize couple dynamics, especially the process of mutual projective identification. Object relations theory posits that each individual's internalized object relations contain both negative and positive self-in-relation-to-others aspects (D. Scharff & J. Savege Scharff, 1991). In an intimate relationship, these positive and negative internalized object representations are reciprocally played out through a process of projective and introjective identification. In this process, each partner denies and splits off intolerable negative aspects of self and projects them onto the mate who is now viewed as containing these split-off traits. Partners attempt to induce their mate to act in accordance with the projections. Because partners usually have a valence for the projection, they begin behaving in such a manner that confirms the original projection. This process helps explain the unconscious fit that occurs between partners and, further, why partners can feel set up to respond in a particular way, only to feel criticized for doing so. For example, if a wife disowns her anger and induces her husband to act this out, she may then criticize him for behaving this way.

Among the first to study this process in marriage was Henry Dicks (1967), who worked with couples at the Tavistock Marital Studies Institute in England. Drawing heavily on the object relation theories of Fairbairn's (1952) model of

psychic structure and Klein's (1946) concept of projective identification, Dicks explored how partners develop a marital joint personality based on mutual projective identifications. Marriage affords each partner the opportunity to rediscover parts of him/herself which had been split-off or repressed (Caruso, 2003). This rediscovery is what initially contributes to partners falling in love and to their feeling of aliveness with each other; each holds (in fantasy) a valued (though denigrated) aspect of the self.

In healthier couples, projective identification can add vitality to a relationship, but in severely distressed marriages, it becomes a primary mode of defense. In the latter scenario, each partner's hated intrapsychic contents are dumped into the interpersonal sphere and acted out (Slipp, 1988). Each attempts to transplant his/her bad self onto the mate and manipulate him/her to collude with it. Marriage becomes an unconscious collusion based on mutual projective identifications. Zinner (1989) writes:

> Projective identification is an activity of the ego that modifies perception of the object and, in a reciprocal fashion, alters the image of the self. . . . Through projective identification, the individual may locate the object not inside the self, but as if it were inside the other partner in a relationship. (p. 156)

Zinner goes on to discuss how the process not only alters how the self perceives the object, but actually evokes a collusive response in the object. Both spouses are involved simultaneously in projecting and introjecting, such that the marriage becomes a mutually gratifying collusive system.

Soloman (1989) adds that unconscious collusions are attempts to avoid dreaded affects. One's most hated aspects – too awful to acknowledge in oneself – now reside in the spouse who is perceived as dangerous and must be defended against. Each partner in the unconscious collusion has an investment in maintaining it because the spouses' defensive structures are aimed at protecting the individual and the partnership from those remnants of early experience perceived to be potentially destructive (Willi, 1982, 1984). The expression, "You can't live with them and you can't live without them" typifies the feeling of such relationships.

When projective identification processes become entrenched, partners, unable to tolerate the feelings engendered by the projections, send the projections back and forth to each other in their original toxic forms (Barbera, 2001, Morgan, 1995). The original projector is left with little relief from the intolerable experience that caused him to project in the first place, so he attempts again to rid himself of the noxious experience through projection (Barbera, 2001). When neither partner can do anything different with the expelled, toxic experience, it remains a constantly moving hot potato, creating more pain with each toss.

A vicious cycle of destructive interactions ensues, in which partners blame and counter-blame, resulting in painful, vulnerable feelings such as abandonment, helplessness, anxiety, shame, guilt, fear, and fragmentation. Unconscious guilt and unproductive self protective strategies contribute to the entrenchment, reinforcing the negative behaviors (Berkowitz, 1999). Sander (2004) understands this vicious circle as the mutual enactment of the couple's transference neuroses.

Other clinicians view it as a cycle of interlocking vulnerabilities (Jenkins, 1999; Scheinkman & Fishbane, 2004) or as interacting sensitivities (Wile, 1981). Middelberg (2001) labels five typical projective identification systems that occur, what she termed "couple dances," each having a particular constellation of defenses and vulnerabilities that help regulate the interpersonal closeness and distance between partners.

The therapist is not only an observer of the projective identification system of the couple, but also participates in the process; through introjective identification, he is stimulated to experience aspects of both partners' internalized representational worlds (Siegel, 2004). He acts as a container for the couple's disavowed feelings, and should these feelings resonate with something in the therapist's own history, strong countertransference reactions may be stimulated. Such reactions can be used to inform the therapist about the nature of each partner's internalized self and object representations so that he can better understand the couple.

The therapist can feel pulled into the couple's projective system. Slipp (1988) states that a major difference between a systems approach and object relations approach to couple therapy is that the systems therapist is trained to keep himself detached in order to remain experientially outside of the couple system, while the object relations therapist allows himself to enter into the couple system and have certain responses evoked through projective identification. The therapist can be "sucked" into the couple's dynamics in a similar way that he is in individual treatment through projective identification, except that in couples

therapy, the induction comes from two individuals and, further, it is essential for the defensive equilibrium of the couple (Slipp, 1984). Sometimes the therapist may carry such disturbing projection for some time and feel threatened with the loss of his identity and sanity (Skynner, 1976). This may cause him to react with his own projections onto the couple, and the collusive interaction already existing within the couple will be reinforced. Gurman (1978) thinks it is easy for the therapist to project onto the couple because often the therapist's relationship problems are similar to those of the partners. This can make it difficult to avoid unconscious collusions.

Enactments occur regularly in couples and family therapy, according to Gerson (1996), who says,

> In all schools of family work there is significant concern about induction into the system, which is essentially worry about the therapist being swept off the reef and washed into the family's customary tidal patterning. (p. 211)

She adds that enactments are more likely to occur when dissociated aspects of the therapist's history impact how he works with the family or couple. For example, if the therapist defended against abandonment in his family of origin by becoming the peacemaker, that is, he became needed, he might have difficulties working with a fighting couple that stimulates this very response; the therapist may try to force a peace between the partners when what they really might need is an improved ability to fight. In fact, one of the common complaints of couple therapists is they cannot bear watching partners abuse each other hour after hour, or tolerate the chaotic destructiveness of their uncontrolled rage (Willi, 1982).

Freedman (1998) eloquently summarizes the countertransferential quandary of the couples therapist:

> Countertransference to a couple therapist is like a three dimensional lens to a photographer. As she observes, zooms in, and interprets a blend of two sets of internalized object relations, a portrait of the couple's world evolves. The therapist experiences and sharpens the images of the world as they interface with her own emotional interior. She filters out and discerns what seems to be her own struggle from the backdrop of the subjects' projections, projective identifications, and split-off self and object representations. In an attempt to sustain past distortions, the partners try to draw the therapist into their film of joint reenactment; a moving portrait which intrinsically strives to include the therapist as a major character. The couple therapist must identify her role and what it feels like to have the role as compared to one in her love life, and finally relay what she considers to be the meaning of the role for the couple. She has to accomplish all of this while dealing with possible onslaughts from often narcissistically damaged individuals, blaming each other for their condition of despair and, at times, vilifying her as a way of protecting themselves and each other from emotional truth. (p. 50)

### *The Scharffs*

The Scharffs (J. Scharff, 1989; D. Scharff & J. Savege Scharff, 1991; D. Scharff, 2001) are among the important representatives of the object relations approach to couples therapy and make countertransference the center of their

technique. Because they are leaders in the field of object relations couples therapy, I will go into some detail about their work. The Scharffs (D. Scharff & J. Savege Scharff, 1991) elaborate how transference and countertransference occurs in couple therapy. The couple, already transferring their individual conflicted past onto each other, brings a shared transference to the therapist. The Scharffs call this a shared contextual transference which is built around the couple's shared hopes and fears about the therapist's capacity to provide them therapeutic holding; this helps them shore up their ability to provide holding for each other. Couples often feel deficient in this regard.

When each partner's transference and the combined transference reactions of the couple reverberate in the therapist, countertransference occurs. Countertransference refers to the totality of the therapist's affective responses. The Scharffs (D. Scharff & J. Savege Scharff, 1991) especially highlight those reactions occurring whenever the couple challenges the therapist's capacity to contain affect. When this happens, the couple's object relations system reaches an area of the therapist's own repressed object relational conflicts, such as previously unexplored areas of the therapist's life, or more problematically, areas of pathology. Training and personal therapy hopefully prepare the therapist's psyche as a fertile ground in which these internal experiences can take hold and facilitate an understanding of the couple.

The Scharffs (D. Scharff & J. Savege Scharff, 1991) describe two forms of counter transference: contextual and focused. Contextual countertransference relates to the therapist's capacity to provide holding for the couple in a similar

way a parent provides holding for a child. Focused countertransference relates to the idiosyncrasies of the therapist's object relations and unresolved conflicts, and reveals the manner in which the therapist resonates, avoids, or clashes with the individual projective identifications of the members of the couple towards each other or the therapist.

The Scharffs (D. Scharff & J. Savege Scharff, 1991) view the couple as a group of two, the smallest of all groups, and countertransference is best understood as a response to the couple as a pair. This means that fundamental resonance is between the couple and the therapist's "internal couple," that is, how the therapist has internalized a sense of "coupleness" from his own history (1991, p. 73). This internal couple is derived from the therapist's experiences with couples who have been or currently are primary in earlier and current life, including parents, prior relationships with partners in adolescence and adulthood, former marriages, and current relationships with spouses or loved ones. Therapists carry many versions of "couples" inside them, including angry couples, loving couples, idealized, and feared couples. At different points in the transference/countertransference interplay, various aspects of the internal couple constellation are activated.

Breaching the couple dyad is not an easy task for the therapist. The couple as a two-person group is designed to have a tight, often impregnable, closed system since both husband and wife are devoted to each other and their commitment is reinforced by the powerful pleasure of the sexual bond. Though actively seeking help, spouses may be unconsciously worried that the therapist will come between

them. Fearing that their bond is too fragile, they unconsciously make a pact to exclude him in order to protect their relationship. This may leave the therapist feeling frustrated and rejected, and may trigger unresolved oedipal feelings of a child being excluded from his parent's relationship. The Scharffs (D. Scharff & J. Savege Scharff, 1991) call this the "rejecting couple countertransference" (1991, p. 73). They give an example of a therapist who felt excluded from the emotional life of the couple and felt bored and deadened in her work with them. The therapist enacted her countertransference and withdrew from the couple.

Gerson (1996) has a similar notion. She thinks one of the tensions in working with couples comes from the awareness of their undeniable shared reality. Partners are implicated in each other's lives and cued to each other's mood and cognitive states in myriad ways. They become attuned to each other's body language, mood states, and nonverbal messages. Because partners tell their stories to and with each other, the couple therapist often feels removed from the epicenter of the engagement (what Gerson refers to as being outside the circle of intimacy). Thus, the therapist can feel like an outsider. In addition, couples commonly collude to keep secrets from the therapist, such as not to talk about shameful aspects of their sex life or other aspects of their marriage, and the therapist may feel excluded as a trustworthy agent of change.

The Scharffs (D. Scharff & J. Savege Scharff, 1991) recommend the therapist access his countertransference by reacting to the unconscious messages of the couple, including what the members of the pair verbalize, how they say it, what their bodies express, and what their silences and glances communicate. These

reactions become crucial data to understanding the dynamics of the couple system and are considered the primary guide to navigating through the couple's therapy. In order to listen for unconscious meanings, the therapist must first clear his mind so that it can act as a receiving field and allow the client to register messages on the relatively clear slate. The Scharffs (D. Scharff & J. Savege Scharff, 1991) use the concept of "negative capability" to describe this type of listening (1991, p. 82); this refers to an open state of mind in which the therapist absorbs the patient's affects and unconscious projections in order to grasp them without actively searching for a concise definition of these phenomena. The therapist must be willing to be taken over by these various states, which he will find foreign to his own personality and will have therefore arisen in unique response to each couple. Donovan (1999, 2003) uses a similar method in opening up to the couple; he does not look directly at the couple, finding that this allows him to listen for the metacommunications without being drawn into the immediacy of the fight and of the present drama of the couple's interaction.

If the unconscious field is encumbered by the therapist's unanalyzed personal assumptions and projections, or if the therapist is unable to acknowledge his countertransference, therapy can quickly go off track. Jill Scharff (D. Scharff & J. Savege Scharff, 1991) gives the example of becoming irritated by an overly aggressive, foul-mouthed, unsophisticated wife. Scharff continually attempted to tone down the wife and defend the calmer, more sedate husband. This countertransference enactment made her miss the fact that the wife carried all the aggression for the couple and eventually led to a misalliance with her (1991, p.

111).

### *Oedipal Countertransference*

Closely related to several of the Scharffs' (D. Scharff & J. Savege Scharff, 1991) ideas is how oedipal transferences and countertransferences get reenacted in couples therapy. In order to more clearly understand this dynamic, I will give a brief description of the oedipal complex. The oedipal complex occurs between the ages of three and five during a time when a child competes for his parent's love; he views the opposite-sex parent as the desired love object and the same-sex parent as a rival for that love (Sharpe, 2000). The child experiences a conflict between the longing to gratify his yearnings to possess the love object, even in fantasy, and the fear of consequences should that occur. Among other things, this conflict stirs up anxiety and guilt.

How the parents handle the child's aggression and sexuality will determine how the child negotiates the developmental tasks of the oedipal phase. The oedipal complex is never wholly resolved but is continually worked through, especially during adolescence and in adult love relationships (Fisher, 1993). Each individual carries an internal model of the oedipal complex, and this results in a multitude of complex unconscious oedipal feelings such as idealization, envy, competition, sexual longings, incest taboo, rivalries, aggression, primal scene fantasies (universally held images of parental intercourse), contempt, fear of retaliation, hostility, oedipal victory, and the associated guilt and/or the excitement of success (Frank, 1997). How one negotiates this important

developmental phase helps determine adult object choice and how an individual loves and hates.

Oedipal conflicts continue to be stirred up in any love relationship, especially when an emotionally intense triangular situation arises (Haldane & Vincent, 1999). Even though winning the love of one's chosen mate may represent the longed-for oedipal victory, oedipal feelings, such as competition, jealousy, and aggression, are not so easily laid to rest, particularly when a third party threatens the individual's position of being first (Grier, 2001). This frequently occurs to a couple during the birth of a child who often disrupts the husband's relationship to his wife. Even more damaging is an extra-marital affair. But any third element can upset the security of the relationship, such as a demanding work schedule, extra-familial duties, friendships, etc. In short, it can occur anytime one partner experiences another person or thing as a rival for their love (Ruszczynski, 1998). Throughout the life cycle, couples are continuously challenged to regulate the incorporation of a third element into their relationship.

According to Ruszczynski (1998), when a third element enters the relationship, the couple needs to be able to reflect jointly on its impact and meaning for the relationship and on each individual partner. By their very nature, psychological triangles are unstable (Guerin, et al, 1996; E. Wachtel & P. Wachtel, 1986). The health of the couple's relationship is determined in part by their capacity to reflect on the needs of the relationship and hold a space for this third element; if partners lose their reflective capacities, Ruszczynski thinks that the third will be experienced as a threat, resulting in intrusive and persecutory

projections which are more likely to disrupt the couple.

How a couple incorporates a third element is important in couples therapy because the therapist is experienced as another third. Systems theory explains how the therapist becomes the third leg of the triangle and can be used by partners to stabilize their conflict. (D. Goldberg, 1985a). Frank (1997) suggests that oedipal themes are active from the beginning of treatment. Because the therapist immediately enters the privately shared culture that exists within the couple, it is as if he "is suddenly born into a preexisting structure within which communication codes and private cues abound" (p. 90). Thus, it is essential for the therapist to understand how derivatives of the oedipal complex are enacted in therapy, including sexuality, aggression, incest, guilt, jealousy, envy, competition, and/or obsession with triangular entanglements.

However, Frank (1997) believes that marital therapists too often fail to explore oedipal issues, focusing instead on alleviating problems of narcissistic injury and rage, identifying fears of abandonment, or exposing the pathological projective identifications that drive and distort a marriage. He thinks such avoidance often has its roots in countertransference anxieties unique to marital therapy – namely, oedipal countertransference anxiety. Because of this anxiety, therapists are less likely to examine their feelings of competitive rivalry, sexuality, and envy towards the couple.

Hill (1999) thinks oedipal dramas take on a powerful impulse to be enacted rather than understood. Due to the immense pressure that is placed on the couple therapist stemming from the couple's and therapist's oedipal conflicts, Hill

believes these oedipal reenactments manifest in what she calls the "wipe out" factor, a condition in which the therapist feels wiped out, inadequate, and impotent (p. 36). This occurs when the therapist is unable to tolerate the unbearable conflicts that arise in couple therapy, such as the couple's pain and anxiety over the loss of expectations, acceptance of differences or the limitations in the relationship, and decisions to break up, etc. In the face of such pain, the therapist becomes acutely aware of his limitations and sense of failure and the intense feelings that such experiences evoke. The wipe out phenomenon could be thought of as a numbing defense against these painful feelings. However, Hill also believes there can be a developmental aspect to oedipal dramas in couples therapy. If couples therapists are able to hold and tolerate the pain of the couple's attacks and disappointments, they can help the couple mourn the loss of their omnipotence and narcissism so that a mature relationship can develop (Ruszczynski (1998).

While countertransference enactments are never desirable, they are inevitable and can be clinically useful, according to Hill (1999). Enactments create a shared experience among all three participants which cannot be ignored, especially if they mobilize the therapist's efforts, either alone or through consultation, to understand their meaning. She concurs with Carpy (1989), who suggests that the therapist's struggle to recover from an enactment can help bring therapeutic change.

Haldane and Vincent (1998) also think that due to the triangular format of couples therapy there may be a powerful impulse for the oedipal drama to be

enacted. They hypothesize reasons why these enactments are so common. One reason is that the pain and intensity of the couple's dynamics and the furious pace of therapy can overwhelm the therapist's capacity to think and reflect; when this capacity is lost, an enactment is more likely to occur. Further, the therapist may feel ashamed that he acted out, potentially extending the enactment. Second, they believe that the dilemma in any intense three-person interactions is that, at any one time, one person in the triangle is likely to feel left out while the other two are more intimate. When the therapist feels excluded, he may feel rejected, and this, too, can block his ability to reflect. Lastly, a couples therapist might experience oedipal guilt when he forms a close alliance with one partner, even if only in fantasy.

This latter is a common oedipal theme in couples therapy because it is typical for partners to compete with each other to win the therapist's favor; they may vie for the therapist's attention with impressive displays of charm, wit, reasonableness, knowledge, and insight (Sharpe, 2000). Spouses may assume the role of competitive siblings fighting for their parent's attention (Guttman, 1987). Various enactments can result. For example, if both partners are trying to ingratiate themselves to the therapist, the therapist, in his wish to sustain the gratification, may not want to do the hard work of uncovering the underlying oedipal problems because it could destroy the idealization. Therapy stays superficial, perhaps at the level of improving communication, while everyone basks in the gratification of the oedipal romance, similar to how a doting parent encourages and allows the child to experience an oedipal victory (Sharpe, 1997).

If therapy stalls at this superficial level, the couple may terminate treatment.

If the partners are more aggressively competing with each other to win the therapist, oedipal reenactments can play out in other ways. For example, Solomon (1997) discusses erotic transferences and countertransferences in couples therapy. Sometimes the opposite-sex partner can become seductive toward the therapist, attempting to draw him into an oedipal enactment in which she becomes the oedipal victor, claiming the therapist as her own. In this scenario, the therapist is induced into feeling an erotic attraction because of his own oedipal history.

Solomon (1997) gives a case vignette of a couple in which the husband had grown up with a seductive mother who triangulated him between her husband and herself. He learned to sexualize intimacy, becoming seductive towards women when he and his wife were having problems. In therapy, he turned his charms on the therapist. He requested individual sessions, and the therapist agreed. The therapist realized she was feeling seduced and had an intensely sexual dream of him penetrating her. The wife got angry because she felt abandoned by the therapist, who had obviously gotten caught in the oedipal enactment by allowing herself to be triangulated by the husband.

This scenario can play out in another way. For example, a male therapist may be especially threatened, but also titillated by an acting out seductive wife; he may feel guilty because he sees that this stirs up competitive, hostile, and anxious reactions in the husband (Appel, 1966). If the therapist still carries guilt from his own childhood oedipal victory, he may attempt to ingratiate himself to the husband. This may parallel how the threatened oedipal child defended against his

aggression toward his father, and, fearing retaliation, aligns with him. In this enactment, the therapist aligns with the husband and rejects the wife.

Another variation of this theme can occur when the therapist competes with the same-sex partner (whom he views as a rival) to win the approval of the opposite-sex spouse. He may try to appear better, more understanding, or more attractive, etc. (D. Goldberg, 1985b). For example, if a female therapist is especially empathic and emotionally available to the husband, the wife may feel jealous and competitive. Or, a male therapist may try to compete with the husband for the wife's attention. If the husband already feels ashamed to be in therapy and reveal his vulnerability, this competition could heat up and end in an enactment (Willi, 1982).

The therapist may also identify with being the oedipal child and relate to the couple as if they were his parents. If his parents had a difficult relationship, a countertransferential wish to repair the couple (parents) may emerge (Frank, 1997). While the therapist is already naturally prone to conscious and unconscious identifications with being the helper/savior, Frank thinks this natural reparative urge is more likely to occur in couples therapy, perhaps resulting in the therapist wanting to save the marriage at all costs. The therapist might be still trying to work out his oedipal guilt that he contributed to his parent's marital woes. When the sway of such feelings becomes strong, the therapist might enact his countertransference by offering the couple advice and rules to live by.

If the therapist is treating a couple who are always arguing, this experience can arouse feelings of being a helpless, overwhelmed child caught between

warring parents. This can provoke excessive silence, inactivity, or withdrawal on the part of the therapist (Guttman, 1987). A variation of this occurs when the therapist becomes the intruding child trying to get his parents distracted so they will stop fighting (Dare, 1986).

Similarly, the couple may induce the therapist to play the role of the parent to two quarreling siblings, appealing for him to become both referee and judge (Hill, 1999). If the therapist's own history includes that of being a parentified or peacemaking child, he may take on the projection and set himself up as the wise settler of disputes and giver of perspective (Frank, 1997). The therapist may want to become a surrogate parent to the couple especially if the therapist is older (Bockus, 1980). Playing the role of the good parent can be dangerously seductive for the therapist because there can be a strong pull to compete with and denigrate the partners' actual parents; the worse the real parents are, the greater the tendency for the therapist to want to compensate for the couple's bad upbringing (Ehrlich, 2000).

Even though the couple might see the therapist as a surrogate parent and is actively soliciting advice, Frank (1997) thinks most couples covertly undermine this stance by rendering the therapist ineffective, for example, by not following the advice. This could lead the therapist to intensify his efforts to assert his expertise and authority, continuing the enactment. Or, the therapist may defend against his frustration and inadequacy by blaming the couple, seeing them as impossible to treat. It is not uncommon for a countertransfenrence-based impasse in marital therapy to develop when the therapist gets stuck blaming one or both

marital partners. Sometimes the opposite occurs; the therapist defends against this kind of blaming and instead continually strives to balance every bit of pathological behavior evenly between the partners.

One last type of oedipal countertransference I will describe is the re-emergence of primal scene anxiety, which can manifest in a variety of ways. For example, a therapist may feel inhibited from openly exploring the couple's sex life because of his own childhood prohibitions against sexual curiosity about his parent's sexuality. Similarly, he might avoid other topics that provoke his anxiety. On the other hand, the therapist may become a voyeur and develop a compulsive curiosity to explore sexual or other very intimate issues, more for his own sake than the couple's (Siegel, 1997). This could potentially lead to the couple's premature termination due to the stimulation of too much anxiety.

### *Concordant and Complementary Countertransference Identifications*

Another way object relations couples therapists view countertransference is via concordant and complementary identifications. As mentioned previously, Racker (1968) described how the therapist may have a countertranferential identification with the patient's projections in two ways. A concordant countertransference identification occurs when the therapist is induced to identify with the patient's projected internalized self representations. For example, if the therapist is working with a couple and the wife blandly describes her husband's abuse, but does not seem angry about it, the therapist may experience anger at her husband for her. In a complementary countertransference, the therapist identifies

with the patient's internalized parental objects. For example, the therapist may be induced to express criticism toward the husband similarly to how his mother treated him. In couples therapy, there are more possibilities for identification than in individual therapy because there are two sets of self and object representations as well as those representations shared by the couple as a unit. The experience of concordant and complementary identifications can be quite overwhelming and confusing (Siegel, 1997).

As an example, Francis (1997) elucidates the common concordant and complementary countertransference reactions a therapist experiences with a physically abusive couple. Because the dynamics of the abusive couple in domestic violence are among the most intense and provocative, the therapist often becomes entangled in the gripping drama of the couple. The mental cruelty of the emotional and physical abuse forces the therapist to manage intense countertransference reactions, including anger, disdain, disgust, and chaos. There is rarely the space for the caring therapist to feel comfortably neutral.

Francis (1997) states that these countertransference reactions can manifest in various enactments. For example, one possible concordant countertransference reaction is that the therapist may identify with the abused partner's disowned self representation. If the abused partner (the wife, in this case) feels guilt that she is responsible for her husband's abuse, the therapist might identify with her disowned innocence; that is, he might believe that she is taking on guilt needlessly, believing her to be innocent. Should the therapist have a history of unresolved conflicts around being victimized, he may attempt to get the abused

partner to give up her guilt. This could result in a countertransference enactment in which the therapist does not get the abused individual to explore her part of the responsibility for the abuse. Thus, by differentiating one's countertransference in this way, the therapist is able to get a clearer idea about what aspect of the self the patient is projecting.

### *Countertransference as Diagnosis*

Sharpe (1990, 1997, 2000) is another object relations therapist who uses her countertransference reactions to help her understand the couple; she tunes into the couple's projective identifications as a way to diagnose the couple. She proposes that the nature and intensity of the countertransference cues the therapist to the stage of development of the couple's object relations. Though difficult, if the therapist is able to distinguish between what part of his countertransference belongs to his own unresolved conflicts and those evoked by the couple, he can use his impressions to understand the couple. In this way, countertransference can be employed to get a sense of the central conflict of the couple (Sharpe, 1997).

Sharpe (1997) identifies four basic kinds of couple relationships. The four types are: (a) the symbiotic couple, whose object relating reflects basic trust and primary dependency conflicts (longings for merger and fears of abandonment and engulfment); (b) the oppositional couple, whose interaction is dominated by dependence-independence conflicts; (c) the gender competitive couple whose competitive interaction reflects conflicts over feelings of inadequacy, especially in regards to gender identity; and (d) the oedipal couple, whose competitive

interaction reflects unresolved negative oedipal conflicts. Sharpe thinks that the therapist will have distinctive countertransference reactions and enactments with each type.

For example, the symbiotic couple usually suffers from profound deficits in attachment. Their emotional issues often center around dependency conflicts and fears of abandonment and/or engulfment. In a relationship, these conflicts are often split between partners; one expresses the fear of abandonment and pulls for merger while the other expresses the fear of engulfment and pushes away for distance. A typical type of symbiotic couple is the hostile-blaming couple, characterized by ferocious fighting, blaming, sadomasochistic exchanges, and physical and emotional abuse. Borderline and narcissistic pathology are common.

Sharpe (1997) believes that at first, the desperate neediness of this couple, combined with their tendency to initially over-idealize the therapist, can activate the therapist's own omnipotent, grandiose fantasies, especially if the therapist is prone to rescue fantasies. Each partner may view the therapist as a narcissistic extension and expect him to magically fix the marriage and their mate. This may induce the therapist to act out the role of the omnipotent all-giving, all-wise, constantly available mother who can fulfill all the couple's needs.

As the couple's hostilities escalate, the therapist often feels increasingly confused, overwhelmed, and repulsed. Since this type of couple is usually highly demanding and equally devaluing of the therapist's valiant efforts to persevere, the couple may begin attacking the therapist for therapy being a waste of time. The therapist can end up feeling used, exploited, and enraged. He may take on the

role of the abused victim, which could make him want to flee from working with the couple. This, in turn, can evoke guilt for abandoning the couple, especially if the therapist is over-identified with being the savior.

Consequently, the overwhelmed therapist may swing back and forth from wanting to save the couple to wanting to retaliate and abandon the couple by tuning out. The therapist is thus pulled into enacting the couple's most feared expectations of rejection, which may be a reenactment of both the couple's and the therapist's earliest object relations. The therapist could also pulled into a masochistic triangulation (Glickauf-Hughes & Wells, 1995).

Oppositional couples also stir up strong countertransference reactions (Sharpe, 1990). Oppositional couples are typified by a predominant style of interaction in which partners oppose, defy, thwart, or in some way openly combat or covertly resist the other who is often experienced as critical and controlling. In extreme instances, the oppositional stance invades almost all aspects of the couple's life. The couples therapist may have a difficult time establishing a position of authority with the couple, finding it hard to feel heard and/or validated by them. This often provokes frustration and anger in the therapist. He may even respond in the same oppositional mode, becoming the third person in the room competing to be heard, insistently arguing for his point of view, or stubbornly refusing to collaborate or compromise. In such an enactment, the therapist might rationalize that he needs to show who is boss. Other potential countertransference enactments with such a couple include wanting to respond as a benevolent, all-knowing parent who will fix the problem with advice, or as a punitive parent who

must scold the couple for their bad behavior. The therapist may also feel the urge to side with the more rational, receptive or compliant partner against the more "impossible" one.

While Sharpe and other object relations therapists use their countertransference to diagnose the couple, Lander and Nahon (1995) offer a cautionary voice. They think that, more often than is recognized, therapists are too quick to label their countertransference as a projective identification coming from the couple, when actually it has more to do with the their own conflicts. In addition, Lander and Nahon believe that a reverse projective identification often occurs: the therapist's unresolved conflicts get projected onto and played out by the couple. For example, a therapist who does not own personal anger may get the couple to act this out. Or, this same therapist can reframe and distort a partner's anger, and its potential healing powers, into sadness; the partner then becomes a sad person whom the therapist feels he can now help; this legitimizes the therapist's professional narcissism. They state: "If you are basically sad and dysfunctional, I can help. But if you're functional, but engaging in bad behaviors . . . well, it's a different ballgame" (p. 85). The reframing of anger into sadness may end up making the client feel guilty or ashamed of his/her anger and may result in a sense of powerlessness.

### *Countertransference in Working With Difficult Couples*

Among the most frequently described intense countertransference reactions come from working with partners who are severely traumatized or who have

personality disorders. Often the intensity of the therapist's reactions reflects the degree of character pathology (Siegel, 1995). According to Siegel, the reactions experienced with difficult couples would most likely be activated in any therapist who worked with these kinds of couples.

*Borderline and Narcissistic Disorders*

McCormack (2000) thinks that treating borderline states in marriage is daunting because the couples therapist is triggered to feel the most repellent affect states of childhood, such as persecution, deprivation, abandonment, and hatred. These couples are infamous for their oppositional, ruthless aggression, ability to get under the skin of the therapist, and resistance to treatment efforts. Because of their reliance on primitive defenses such as splitting and projective identification, the therapist often feels attacked, leading to confusion, flooding, and hopelessness.

The couples therapist often defends against this emotional onslaught by becoming overly concrete and directive. He may try to superimpose upon the patient simple, concrete solutions to complex human dilemmas which are not only beyond the patient's capacity, but also disrupt his ability to learn to work through his conflicts. The therapist's wish to fix the couple only supports their magical fantasy that things will get better without their having to change. McCormack (2000) believes when the therapist attempts to assume responsibility for fixing the couple, it may lead to a countertransference enactment because when solutions do not work, this often spurs the therapist to greater activity in order to defend

against failure and despair. Eventually, both patient and therapist reach exhaustion, each faced by an overriding sense of impotence. When this occurs, the therapist frequently blames the couple.

Lachkar (1992), concurs, stating that the directive approach (e.g., assigning homework or communication exercises) in working with borderline/narcissistic couples may be a way for the therapist to feel he is doing something concrete to relieve the couple's anxiety. This "doing something" may be a way of alleviating the therapist's anxiety about the mess and confusion in working with such difficult couples. However, this will not help the couple develop an understanding of why they got into the mess in the first place.

Lachkar (1992) also thinks the therapist must contend with many difficult countertransference feelings such as inadequacy, guilt, anxiety, despair, failure, and, especially, abandonment. These couples often let the therapist know about their experience of abandonment through projective identification. Or, they can disrupt the treatment through a premature flight into health: "We decided to take a break. We don't need treatment anymore" (1992, p. 99). The fantasy that now they can do it on their own is often a defense against intimacy and the fear of abandonment. One possible countertransference enactment that can occur in this circumstance is that the therapist colludes with the couple, feeling guilty that he is trying to keep them in therapy; thus, he lets them go, and the marriage may decompensate.

A variation on this theme can occur when narcissistic partners make the therapist feel devalued while simultaneously demanding total involvement and

confirming responses (Solomon, 1989). Comments – "We don't think you can help us. We've been coming for six months and it's a waste of time. We're going to someone else." – can make the therapist feel worthless, possibly resulting in the therapist finding a way to terminate the treatment prematurely rather than explore the couple's hopelessness and disappointment (p. 100).

Lansky (1986) believes that the therapist may also become averse to feeling devalued with such patients by impulsively attempting to control or shame them. Or, the therapist may rationalize his need to withdraw. Many therapeutic errors are made by therapists who do not recognize such dangers as characteristic of the narcissistic individual. Therapists who cannot tolerate feeling empty, depressed or helpless will tend to act out their countertransference in ways that are, at best, neutral and, at worst, disastrous.

*Partners Who Have Been Severely Traumatized*

With severely traumatized partners, therapists need to be aware how partners fluidly reenact victim, victimizer, and bystander roles (Basham & Miehls, 2004). Depending on the context, each of these roles may be enacted in therapy by all three participants. The couple is likely to project one of these roles onto the therapist, who, because of his own trauma history, may take on the projection.

The authors highlight seven common countertransference themes that are frequently enacted in couple therapy: aggression, passive indifference, detachment, boundary violations, eroticized feelings, helplessness, and reaction formation. The authors relate case vignettes highlighting how these themes turn

into countertransference enactments. For example, a wife who had been sexually abused as a child became enraged at her husband because he demanded she become more emotionally available; this was after the couple had spent a lot of time discussing how difficult this would be for her. The therapist, growing irritated, harshly confronted the husband about this, leaving him feeling shamed and vulnerable. The therapist realized she was caught in an enactment having played out the role of rescuer toward the wife and the role of victimizer toward the husband. The therapist experienced the husband as excessively needy and believed this partially stemmed from her own unconscious ambivalence about dependency needs and the feeling that men should be independent. The therapist also thought she was induced to experience a complementary projective identification from the husband in that she acted towards him similar to how his sadistic father had.

A therapist may also enact the bystander role. An indication this may be occurring is when the therapist begins to feel detached, bored, or sleepy while listening to the partner's trauma history; this could be the result of the dissociative manner in which the patient tells his/her story, or could come from the therapist's inability to tolerate hearing the suffering of the patient's brutal history. In either case, the therapist may be induced to enact the bystander role of someone who is ignoring the abuses.

Countertransference enactments can also occur with couples who minimize or deny the significance of their childhood traumatic experience of abuse. Should the clinician be overly intrusive in interpreting or suggesting the existence of

childhood trauma without getting the confirmation from the partners, he might be enacting a judgmental, victimizing stance, overwhelming them. On the other hand, if the therapist turns a blind eye toward the abuse, he might be seen as an ineffectual bystander, colluding with the abuse.

The therapist may have his own history of sexual abuse, and if he has not worked through his own trauma, he might not be receptive to hearing about incest from the couple; he might block its emergence, fearing that it will stir up his own rage or other dissociated affects (Kaslow, 2001). Other countertransference reactions in working with trauma victims include becoming over-stimulated by the material in a voyeuristic manner, blaming the patient for not stopping the perpetrator, or expressing rage at the perpetrator before the client is ready.

*Domestic Violence*

Domestic violence also triggers strong countertransference. In these couples, abuse and coercion, love and hate, blame and over-responsibility, hyperbole and minimization, remorse and cynicism are all part of the confusing clinical picture (Goldner, 2004). This can provoke countertransference extremes in the clinician such as taking sides, refusing ever to take sides, exaggerating or minimizing danger, dealing with gender and power inequities, and insisting on one particular clinical paradigm while rejecting all others. Goldner asserts that the therapist's capacities are tested in domestic violence work because he must help clients develop an understanding of the abuse-reconciliation cycle without blaming or shaming the victim or perpetrator.

According to Goldner (2004), this complex agenda entails combining clinical acumen with zero tolerance for violence and a bottom-line focus on safety, equity, and accountability. In other words, she sees the potential for enacting rather than containing the pathologies of splitting. To avoid a countertransference enactment, the therapist must be able to contain contradictory truths and multiple perspectives rather than choosing among them. This includes the therapist holding the perpetrator accountable, which might mean that the therapist has to hold a moral clarity in the face of psychological ambiguity, certainly a difficult challenge for the therapist.

### *Misalliances*

The urge to side with one partner over the other is perhaps the most pervasive countertransference dilemma occurring in conjoint therapy. Since the tendency for the therapist to be triangulated into misalliances occurs so regularly in couples therapy, this concept is discussed throughout the literature review, but will be further highlighted here. Any conflict has the potential to result in a misalliance, particularly if the therapist's unresolved conflicts come into play. For example, difficult issues, such as alcohol and substance abuse, often trigger intense countertransference (Levin, 1998) as do eating disorders (Woodside, D., Shekter-Wolfson, L., Brandes, J., & Lackstrom, J., 1993)

Broderick (1983) discusses how therapists must attempt to continually balance his attunement in order to protect the therapeutic alliance with both partners. He even points out how the therapist has to sit equidistant between

partners. But Broderick believes there are many pitfalls that can skew the therapeutic alliance and lead to potential countertransference enactments. Broderick gives several examples of how misalliances can occur. If the therapist has an abusive, violent background, he may find it especially difficult to deal with violent or bullying clients, responding in old familiar ways; he may become intimidating, placating, or rebellious. The therapist may also disagree with the way the abused spouse deals with the abuse, and pressure that spouse to adopt the therapist's solution.

A therapist who was neglected as a child may readily over-identify with an unloved, neglected partner and feel judgmental toward the neglectful spouse. A therapist who is competent and well-organized may get frustrated by incompetent, unreliable, or passive-aggressive partners. They may too easily join forces with the more competent spouse in trying to reform the irresponsible or passive-aggressive one.

*Secrets*

Sometimes misalliances are caused by one spouse sharing a secret with the therapist; this may be revealed during an individual session with the expectation that it will not be shared with the spouse (Siegel, 1992). There are many reasons why partners keep secrets from each other. It may be an attempt to create more distance or feel more autonomous. Or, partners may keep secrets about their fantasies, wishes, feelings, or behaviors, fearing that their revelation will result in emotional catastrophe (Freedman, 1998). Commonly, this latter pertains to the

existence of an extra-marital affair or plans to end the relationship. The secret revealed may be an attempt to seek the support of the therapist; this forces an alliance with the therapist, but also makes the therapist less powerful. If the therapist colludes to protect the secret, it may weaken the therapist's position, making him an ineffectual accomplice. Because the spouse feels supported, he may begin acting in a punitive or demeaning way toward his partner (Siegel, 1992).

Caught in a bind, the therapist may feel protective towards the unsuspecting, innocent spouse by covertly trying to alert him or her that all is not well. The therapist might also lose his empathy for the spouse with the secret. As a result, the therapist's capacity to provide a safe holding ground for the couple may be permanently damaged (Freedman, 1998). Freedman advises the therapist in this situation to confront the spouse with the secret and discuss its impact on treatment.

A partner can also keep a secret of an affair from both the partner and therapist. When it is revealed, the partner can feel devastated and the therapist duped and disrespected. The therapist may feel incompetent as he wonders why he could not see through the lies; his values concerning marital fidelity usually surface, especially if parental or marital infidelities were part of his history. In these scenarios, the impartiality and effectiveness of the therapist is severely compromised and can result in the therapist acting out.

*Polarized Couples*

Polarized couples, particularly those who have different agendas or motivation levels to work on their relationship, can also draw the therapist into a misalliance. It is common for one partner to be more motivated to work on the marriage and seek therapy, and it is often this partner who attempts to enlist the support of the therapist in confirming his/her perception that their mate is the source of the problems (Nadelson, Polonsky, & Mathews, 1984). Since it is harder to work with a resistant spouse, the therapist may align with the more motivated partner to see the resistant one as the identified patient. Sometimes the willing partner and therapist team up to get the other motivated (Willi, 1984). For example, if the therapist exhorts the unwilling partner that he has got to be willing to try, that partner may feel criticized (Ables & Brandsma, 1977). These situations are rife for misalliances as the ganged-up on partner can end up feeling like a scapegoat.

Another type of polarization occurs when one partner wants out of the marriage and the other wants to save it (Crosby, 1989). In these situations, the partners' respective agendas for therapy and expectations of the therapist are, for the most part, contradictory; this can place the therapist in a double bind (Everett & Volgy, 1989). If the therapist holds a strong value that marriage is forever and spouses should try to work out all their difficulties no matter what, the spouse wanting divorce may not feel recognized by the therapist for his/her desire to leave the relationship (Jurich, 1989). On the other hand, if the therapist tries to maintain a neutral stance, the spouse wanting to save the marriage may perceive

the therapist's neutrality as support for the exit of the partner and believe the therapist does not possess the power to talk the spouse into staying. If the therapist falls into either of these traps, the result is escalation of the polarizing dynamics and the potential for the offended spouse not to return to therapy.

Along the same lines, Solomon (1989) feels that while most couples therapists try to stay neutral, she has rarely heard therapists acknowledge that their personal views have any bearing on whether or not a couple stays together, separates, or divorces. Once trust is established with the therapist, partners often want to have faith in the therapist's ideas and may even act in ways that will meet with his approval. For example, if the therapist is overwhelmed by the enormous problems with which the couple is struggling, he might tell them they are no good for each other and that they should get a divorce. Despairing, the couple may blindly follow the advice, which may in fact, be a countertransference enactment. Even if the therapist never shares his own viewpoint, Solomon believes the therapists views on divorce or staying together will somehow be communicated and influence the couple.

A divorcing couple can also provoke strong countertransference reactions, especially if divorce or severe marital rupture are part of the therapist's history (Wallerstein, 1997). This may interfere with the therapist's ability to help the divorcing couple. The therapist may even fear that the couple's divorcing is contagious and want to distance himself to avoid losing control. In addition, the therapist can have strong reactions about the impact of the impending separation on the children. Because therapists are usually quite sensitive to the suffering of

children, Wallerstein thinks the therapist may go all out in his attempt to save the marriage in order to rescue the children.

The therapist may also have a personal stake or pride in saving the marriage; if he can save the marriage, he is competent; if he can not, he is a failure. This can result in the therapist pressuring the couple to stay together (Guerin et al., 1987). Also, the therapist may act out his frustration toward the spouse seeking divorce, viewing him as the villain.

*Parenting Disagreements*

Parenting disagreements can pull the therapist into a misalliance. Couples frequently polarize over how to parent their children; this can trigger the therapist when it clashes with the his own values about how to raise a child (Mark, 1997). Mark gives the example of a countertransference enactment that occurred when a couple wanted parent education to control their child who was acting out. The therapist, who yearned to have her own children, was placed in a position of power as the expert who presumed to know the right and wrong way to raise children. The therapist, basking in an idealizing transference, relished the role of providing the couple with answers. When therapy stalled, the therapist realized her deep desire to raise her own children was being done by proxy. This contributed to keeping the couple insecure and dependent on her.

Because of his own unresolved conflicts, a therapist might also disagree with the way parents are raising a child . For example, the therapist may not be able to tolerate a belligerent father because his own father was verbally abusive. In over-

identifying with the child as victim, he might insist the father change his ways and, as a result, lose his alliance with him. Mark (1997) gives another example of a therapist who tried to get the parents to recognize that their sixteen year old son was a severe drug user and needed tough love. He suggested that the parents put the boy in residential treatment. The parents, who did not want their son to feel rejected, resisted following the therapist's suggestions. The therapist, feeling exasperated, wanted to scream at the parents to shake them out of their denial. Through consultation, the therapist was able to see how his own parents had neglected him during his troubled adolescence, making him feel abandoned. He enacted these dynamics with the parents.

### *Countertransference from Ethical and Moral Dilemmas*

Some clinicians think couples therapy places the therapist in ethical and moral dilemmas, some of which provoke strong countertransference reactions. For example, Finkelstein (1991) suggests that marital discord regularly involves important issues of moral responsibility, since couples are dealing with right and wrong, good and bad, honesty and dishonesty, and trust and mistrust. Couples often regard treatment as if it were a sort of court session in which the therapist, as judge, determines who is more guilty for breach of proper marital conduct (Willi, 1982). Since the therapist becomes intimately involved in evaluating the couple's moral and value system, he is often given a lot of power by the couple over important moral problems and must therefore decide how to deal with such problems therapeutically.

According to Finkelstein (1991), superego transferences and countertransfererences are common in couple therapy. For example, the therapist may be perceived as an overly harsh, punitive parent, or he may perceive one or both partners in this way. Or the partners may project onto the therapist a wished-for parent who can provide a more humane, just, and moral guidance to them than they received as children.

Whatever the superego transference/countertransference interplay, the therapist may at times inadvertently impose his value system on the couple, doing more harm than good (Wylie & Perrett, 1999). For instance, since most couple therapists bring a set of values about what they consider to be a good relationship, they might occasionally be directly confronted by a couple who presents issues that go against the grain of what is considered a normal marriage. The authors present a case in which a husband, bored with his sex life, began pressuring his wife to join a swingers group. The wife was disgusted by the idea, as was the couple therapist. As a result, the therapist found it difficult to understand and support the husband's position.

Finkelstein (1991) says that therapists can be put into a bind when they take a strong stand on moral issues or attempt to remain neutral. An example of the latter occurred when a therapist treated a couple in which the wife was righteously angry due to her husband's ongoing insulting, derogatory behavior towards her. When the therapist suggested that they take a "no fault" attitude towards the behavior and try to understand why the husband behaved the way he did, the wife was outraged. As a lawyer, she was accustomed to dealing with questions of right

and wrong. She confronted the therapist, "Don't you believe in right or wrong?" (p. 55). The therapist replied that he did not want to sit in judgment. This angered the wife because, while she was interested in exploring underlying reasons for her husband's behavior, unless he showed remorse, she could not forgive him. The therapist felt pressured to give up his neutrality in order to prevent a misalliance with the wife, but also wanted to remain true to his own guiding principles of how to do therapy.

Some therapists freely judge the couple's behavior as good or bad and accordingly, offer praise or blame. If the therapist believes it is his job to hold the standard of good and righteous behavior, he may feel a bind when having to address the bad behavior of one partner without making that partner feel criticized. Many couple treatments have failed because of the therapist's moral rigidity, according to Finkelstein (1991). Even in more subtle forms of moralizing, such as when the therapist tells the couple to show kindness, consideration, and fairness, the implication is that the opposite behavior is bad; this may result in one or both partners feeling judged for not behaving this way.

In fact, some couple therapists embrace the moral high ground. For example, Boszormenyi-Nagy and Krasner (1986) stress that marital partners who wish to be happily married must adhere to strong moral standards such as fairness, equal sharing, and responsibility for each other's welfare. They consider "the ethic of due consideration and merited trust" based on personal responsibility to be the foundation of trustworthiness and personal health in a good marriage (p. 61). While it would seem to go without saying that couples would strive to act in this

manner, the fact that many do not raises important moral and ethical concerns for the therapist.

A particular thorny ethical issue with which the therapist might have to struggle arises when a partner has an extra-marital affair. In a survey, Constantine (1986) found that only a minority of counselors indicated they would be professionally supportive of clients desiring to have a sexually open marriage, to engage in an affair or to try swinging. Finkelstein (1991) writes about a husband who had multiple extra-marital affairs. The husband reluctantly apologized and felt that his wife should forgive him and move on. He experienced her harassment as overkill. The therapist, like the wife, felt irritated with the husband's lack of guilt and atonement and got caught up in attempting to get the husband to address the seriousness of his behavior. Eventually, the husband quit therapy.

According to Goldner, (2004), the therapist should claim his moral authority. Since the therapist has direct social consequences on the practices of the couple's personal life, (how they should love, fight, make love, raise children, stay together, etc.), the therapist must develop ways to enhance his sense of responsibility about that authority. This can be accomplished by cultivating a stance of moral engagement in the work by discussing these dilemmas with clients.

*An Intersubjective Approach to Countertransference in Couples Therapy*

In this section, I will review an intersubjective approach to couples therapy

and countertransference. One important distinction between an object relations perspective on countertransference and an intersubjective one is that the object relations therapist often views the countertransference in terms of projective identification, while the intersubjective clinician views it in terms of mutual influence. In intersubjective thought, the therapist does not hold the objective view of the patient; rather, his subjective reactions are an intrinsic part of the intersubjective field in which no one individual holds the correct view of reality (Siegel, 1997).

Intersubjective theory, especially as proposed by Stolorow and Atwood (1984, 1992) and Stolorow, Brandchaft, and Atwood (1987), philosophically has its roots in phenomenology and a commitment to an experience-near perspective. From this perspective, the therapist, through empathy and introspection, immerses himself in the patient's subjective world. The only reality relevant and accessible to psychoanalytic inquiry is subjective reality – the patient's, the therapist's, and the psychological field created by the interplay between the two. The term intersubjective describes the relational field formed by the interplay between the differently organized subjective worlds of two or more persons.

In couples therapy there are multiple intersubjective fields. The therapist investigates the interaction between the differently organized subjective worlds of the two partners as well as the meanings that occur at the interface of the interacting subjectivities of the therapist and each partner (Trop, 1997). The therapist is not considered the objective observer who will be able to ascertain the "truth" of what is really going on between the partners, but rather, is there to

investigate and understand each partner's subjective experience of the relationship, and how each of their unconscious organizing principles contributes to their perceptions of the other (Ringstrom, 1994; Shaddock, 2000; Trop, 1994). Thus, each partner's perceptions become something to be explored rather than corrected.

Organizing principles are the ways an individual comes to uniquely pattern and schematize his personal reality and perceive his world and relationships; they develop out of the matrix of early child-parent configurations (Stolorow & Atwood 1992). The authors state:

> The organizing principles of a person's subjective world are themselves unconscious. A person's experiences are shaped by his psychological structures without this shaping becoming the focus of awareness and reflection. . . . in the absence of reflection, a person is unaware of his role as a subject in elaborating his personal reality. The world in which he lives and moves presents itself as though it were something independently and objectively real. The patterning and thematizing of events that uniquely characterize his personal reality are thus seen as if they were properties of those events rather than products of his own subjective interpretation and constructions. (p. 36)

*Transference*

From the perspective of intersubjectivity, transference is conceptualized as the way a patient assimilates the therapeutic relationship through the lens of his or

her organizing principles. There are multiple dimensions of transference, but two in particular stand out, the selfobject dimension and the repetitive dimension (Stolorow & Atwood, 1992). First, it is important to point out that selfobjects do not refer to people, but to a class of psychological functions which a person provides another to help maintain and restore that individual's self-cohesion; they refer to how an individual subjectively experiences and uses another (an object) for the purpose of regulating, repairing, and consolidating his self experience. Thus, in the selfobject dimension, the patient longs for the analyst to provide healing selfobject experiences that were missing or insufficient during formative years, such as mirroring or idealizing selfobject functions. This will enable him to resume and complete an arrested developmental process. In the repetitive dimension, the patient expects and fears the therapist will repeat the developmental failures of childhood and re-traumatize him. These two dimensions of the transference continually oscillate between the foreground and background depending on how the patient experiences the therapist's varying attunement to his emotional state and needs.

Transference between marital partners can be conceptualized in the same way. Partners assimilate each other through their organizing principles. Each long to have the other provide those selfobject experiences that they cannot provide for themselves (Goldstein, 1997). When the partner does not meet the selfobject need, developmental failures and traumas from childhood are reawakened, resulting in emotional injury, rage, depression, and at times, fragmentation. Thus, the repetitive dimension of the transference is activated

between the partners and usually lead to mutually frustrating interactions. Partners utilize self protective strategies to guard themselves from narcissistic injury and preserve self cohesion, but usually these defensive responses trigger further selfobject failures. This can create an intersubjective collision course in which the selfobject needs of neither spouse are fulfilled (Ringstrom, 1994).

*Countertransference*

Countertransference occurs when the unconscious organizing principles shaping the therapist's experience in relationship to the couple and to each partner are activated in treatment. Rather than viewing the patient as responsible for inducing reactions in the therapist through projective identification, a concept Stolorow and Atwood (1992) eschew, intersubjective theory views both therapist and patient as shaping all aspects of the therapeutic interaction through mutual influence. From this perspective, every facet of the therapist's life informs his response to the couple. For example, a therapist whose parents divorced may have strong beliefs about keeping couples together, while those who experienced their parent's relationship as stifling or abusive may be more inclined to sponsor separation. Since the intersubjective perspective advocates that the therapist fully own his contributions to the intersubjective field, the goal is not neutrality but awareness of one's own organizing principles (Shaddock, 2000).

Therapists working with couples can easily become enmeshed in the complexities of an intersubjective field that involves partners striving to make up for selfobject deficits and competing for the empathic understanding of the

therapist (Dasteel, 1994, Goldstein, 1997). The therapist faces the daunting task of trying to understand both partners simultaneously; he feels an on-going pressure to balance his exploration of each partner's viewpoints fairly (Shaddock, 2000). Partners often demand the therapist see their positions as right and their mate's position as wrong. If they can get the therapist to agree, they will feel vindicated in their belief that their partner is the cause of all the problems.

Every response of the therapist to one partner can have an immediate effect on the other. As one member of the couple feels calmed, appreciated, vindicated, or affirmed by the therapist, the other may feel disapproved, overlooked, abandoned, or attacked (Dasteel, 1994). Empathic understanding to one partner might make it seem that the therapist is condoning that partner's perception as correct and valid, and that he is taking that partner's side. This can make the other spouse feel invalidated. Or, it can make the partner feel that the therapist is supporting their mate's acting out behaviors. For example, if a husband has problems with anger, and the therapist tries to empathically understand his anger, the wife might feel the therapist is condoning the rage (Shaddock, 2000). This can lead to a therapeutic disjunction, which can occur anytime the therapist assimilates the patient's material in a way that significantly alters its meaning for the patient (Trop, 1994). Stolorow and Atwood (1984) state,

> Repetitive occurrences of intersubjective disjunction . . . are inevitable accompaniments of the therapeutic process and reflect the interaction of differently organized subjective worlds. (p. 47)

Therapeutic disjunctions can potentially lead to enactments. They occur

regularly in couples therapy, according to Shaddock. Because the therapist has his own family of origin issues, relationship preferences and experiences, communication style, gender, age, ethnicity, values, personality and selfobject needs, he will probably be better able to empathize with one partner than the other (Shaddock, 2000). He may find one spouse's point of view more plausible, interesting or seductive.

When the therapist's preference becomes an enduring impression, he must investigate how his organizing principles influence his therapeutic understanding and responses (Ringstrom, 1994). This is compounded by the fact that the therapist has his own selfobject needs and yearnings as well as fears and dreads, which might lead him to compete with the couple over whose selfobject needs will be met (Ringstrom, 1998). Trop (1997) gives the example of working with a couple where the husband was a workaholic. The wife wanted more time with her husband and asked that he work less. As the wife became more insistent, Trop increasingly experienced her as shrill and immature and thus felt more empathy for the husband. Trop soon came to realize he was caught in a countertransference disjunction with the wife because he pathologized her as excessively needy and dependent. He over-identified with the husband, whose attitude towards work closely matched his own unconsciously organized beliefs; he himself was ambitious and hard-working. This led him to assimilate the husband's point of view as healthy and normal.

Because one or both partners are usually acting out their conflicts, Shaddock (2000) thinks this presents the therapist with a difficult task. On the one hand, the

therapist must explore the perceptions and behaviors of the spouse who is acting out, while also protecting the other mate from the effects of that acting out. The line between acting out and emotional expression is highly subjective, and there are likely to be three differing views in the consulting room of where that line is. In addition, containing the acting-out behavior can make the acting-out partner feel ganged up on. Also, if the therapist works for a long while with one partner, it may convey the notion that he or she is the problem.

Ringstrom (1994) thinks that most therapists have an "Achilles heel" that can lead to a misalliance (p. 317). For example, Ringstrom has a strong aversion to one partner bullying the other, claiming his or her reality is the correct one. Since Ringstrom advocates that neither spouse has a more correct version of reality than the other, a basic supposition of intersubjective theory, he regularly challenges the couple about this because it is a difficult issue for most partners.

Ringstrom discusses a case of a highly reactive couple with whom he felt he "was constantly walking a tightrope over two pits, each holding a potentially voracious alligator" (1994, p. 319). In one incident, the husband was angry that his wife did not greet his news of a promotion at work with more enthusiasm; she claimed she was just too depleted after an incredibly hard day at work. Discussing this in session agitated the husband even more because he was certain his wife meant to spoil his good feelings despite her excuses. He demanded a confession and an apology. She refused, disagreeing with his perceptions. Ringstrom identified with the bullied wife; he tried to get the husband to see an alternative explanation for her behavior. As a result, the husband exploded in

anger, and Ringstrom got angry in return. Ringstrom realized his vulnerability about being bullied led to his enactment. In exploring this with the husband, he discovered in the husband's family of origin, bullying one another was a way to survive. Ringstrom believes the awareness of one's Achilles heel will not necessarily prevent disruptive therapeutic disjunctions, but will help in working through the enactment.

### *How Therapists Work With Countertransference*

I have discussed how some clinicians, such as the Scharffs (D. Scharff & J. Savege Scharff, 1991), work with the countertransference; in this section, I will examine how several other clinicians work with it. In general, most psychoanalytically-oriented couples therapists work with their countertransference, but perhaps to lesser degree than they do in individual psychoanalytic psychotherapy. Rothstein (1992) thinks this is because psychoanalytic couple training is less formal than training in psychoanalytic psychotherapy, and therapists are not taught to examine their countertransference to the same degree. Most psychoanalytically oriented couples therapists try to become aware of and get a handle on their countertransference through self examination, consultation, psychotherapy, and discussions with colleagues. Some also discuss their countertransference reactions with the couple if they think it will be therapeutic. Intersubjective approaches to couple therapy especially advocate the latter. For example, when a therapeutic disjunction occurs, Ringstrom (1994, 1998), Shaddock (2000), and Trop (1997) think that the therapist needs to explore

the partner's experience of the therapeutic rupture and validate the patient's feelings. The therapist can relate his experience of the interaction, including his countertransference. This in itself can be curative.

Greenberg and Johnson (1988), though not intersubjective in their approach, agree. The therapist must deal directly with the partner with whom the alliance has been breached by exploring the rupture, validating and legitimizing the client's experience, while also taking responsibility for causing any unnecessary pain by being judgmental. However, while they might discuss their reactions, they do not discuss their personal conflicts directly with the couple.

Dasteel (1994) thinks that the therapist's self disclosure of countertransference must be done judiciously. This serves as a model for how to work out conflict. For example, if the therapist is feeling angry toward one partner, the other spouse may have similar feelings but is unable to articulate them. If the therapist can express his feelings diplomatically, it not only clears the air but also exemplifies how the partner may express anger. Livingston (2001, 2004) adds that the therapist's self disclosure models for the couple how to be open, calling this the vulnerable moment. This can deepen the therapeutic process and the partner's intimacy. Siegel (1995) concurs, but also thinks the therapist should explore the meaning of his countertransference reactions in order to understand how the dynamics might be playing out among all three participants.

Goldberg (1985b) has different view; he believes the therapist should not discuss his countertransference with the couple, but that, as much as possible, try to be in control of his reactivity. A therapist can do this by examining his pattern

of over-involvement and under-involvement. Over-involvement can occur when the therapist attempts to take too much responsibility for the couple's difficult decision-making. It also occurs when the therapist focuses almost entirely on the manifest content of the couple's arguments, missing the latent process, such as the couple's sense of connection. The therapist is also over-involved if he dominates the interactions with lots of feedback or interpretations about the couple's dynamics, leaving less room for the couple to engage each other. This may dilute the intensity of the couple's interaction. Under-involvement may occur when the therapist is overwhelmed by the emotional intensity of a couple's conflicts or by their style of fighting and begins to withdraw as a way to modulate his anxiety. Clockwatching, dreading sessions, withdrawing, or starting late may be a symptom of under-involvement.

Lander and Nahon (1995) conclude that it is critical the therapist never cloak himself behind neutrality or irreproachability. Rather, the therapist must always make any countertransference feelings part of the working dialogue of therapy. He must become responsible and accountable for his contributions to the here and now of the therapeutic encounter, being open to both self-examination and challenge by the couple. The therapist's willingness to acknowledge personal faults and vulnerabilities models for the couple personal responsibility. Goldstein (1997) concurs, stating that scrupulous honesty is needed in order to process any reactions that depart from the typical treatment stance. These authors' ideas have many similarities with the intersubjective perspective.

Willi (1982, 1984) thinks it is almost impossible for the therapist to not

become enmeshed in the couple's conflicts, a process he calls collusion. Willi's depiction of collusion seems to be describing a process similar to that which occurs in enactments. He concludes that while the therapist needs to try to be as unbiased as possible, it is inevitable that he will not feel equal empathy. Rather than trying to be neutral, the therapist should attempt to make conscious use of his personal idiosyncrasies, reactive tendencies, and conflicts.

When a conflict with one partner occurs, and it has become problematic in the treatment, the therapist must not deny his antipathies and tensions, but face his conflicted feelings about a partner head on. He should not blame the partner but communicate clearly that he himself is affected by the conflict and genuinely wants to clarify and resolve it. For example, some things he could say are:

> I feel some tension between us. I see that I'm having trouble relating to you and imagine you're feeling the same about me. I'd be glad if we could get a clearer idea of what's going on between us . . . . I feel that right now I am annoyed with you because . . . . But it's very important to me to understand your reactions and my own. (1984, p. 74)

By entering fully into this emotional process with the partner, the therapist conveys a trust that, sooner or later, he will find a way to resolve the conflict. This sets in motion a process that is highly significant for successful treatment.

The spouse witnesses the therapist and his partner working out the conflict and might experience a variety of feelings. Initially, the spouse may feel a satisfaction in seeing his partner get into same difficulties with the therapist that he does. He may also feel guilty for leaving his partner all alone to fight it out

with the therapist. The spouse may even feel left out of the intensive confrontation between the therapist and his partner. Thus, it is important for the therapist to check in with this partner about his experience. Willi (1984) concurs with Dasteel (1994) that the therapist working out his difficulties serves as a model for dealing with marital conflict; the couple discovers that it is a worthwhile experience to face and resolve conflict because it enables them to find solutions and brings them closer together.

Many of Willi's (1982) ways of working with the countertransference parallel how the relational psychoanalysts work with enactments. He fully allows himself to be drawn into a collusion (enactment) with the couple and expects, and even embraces, the fact that conflicts will arise. When this occurs, Willi confidently engages the couple, knowing that in working through the conflict the therapy will deepen, the therapeutic relationship gets back on track, and the couple grows.

It should be noted that the literature reviewed was comprised of the observations and experiences of practitioners as well as their theoretical approaches to the subject, most of which was derived from a psychoanalytic perspective. I did not find empirical investigations on countertransference in couples therapy other than those described.

# CHAPTER 3: METHODS AND PROCEDURES

The purpose of this study is to discover how couples therapists experience, think about, and deal with the countertransference enactments that occur when working with couples. The central questions, as presented in Chapter 1, are: Are there typical countertransference reactions provoked in couple therapy, and do therapists reveal an awareness of the emotional conflicts and/or vulnerabilities activated in themselves in the course of their work? What kinds of couples and/or situations do therapists describe as activating their countertransference? How do these therapists describe countertransference enactments, and do they differentiate these from countertransference? What are some of the ways couples therapists get caught up and/or act out their countertransference? Do countertransference enactments help therapists recognize their vulnerabilities or emotional conflicts? How do couples therapists think about and work with the enactment in the therapy, either within themselves or with the couple? In this chapter on methodology, I move from what led up to the research questions and perspectives gleaned from psychoanalytic literature on couples therapy to the processes and techniques that guided my study of the phenomenological data.

## Methodological Approach and Research Design

My approach to the research was qualitative and based on Grounded Theory (Glasser & Strauss, 1967; Strauss & Corbin, 1998). Qualitative research relies on interpretive rather than statistical procedures. Data collection is designed to preserve context; therefore pre-established categories which reduce the data prior

to interpretive analysis are avoided. The research process is designed such that explanatory concepts emerge from the data. Thus theoretical concepts are "grounded" in the data. This approach to research is particularly appropriate for analyzing data derived from participants' personal experiences, allowing the quality of those individual experiences to be retained in the analysis and interpretation. As Strauss and Corbin state: "Qualitative methods can be used to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods" (p. 11). Qualitative research is also appropriate for understanding a neglected or insufficiently elaborated theoretical area of thought, such as the concept of countertransference enactments occurring during couples therapy. Since the focus of this study is therapists' subjective experiences as reported in open-ended interviews that invited their thoughts and feelings about countertransference reactions while conducting couples therapy, the qualitative approach is most appropriate for this exploration.

As compared to quantitative research, qualitative research does not rely on statistical or quantifiable procedures to collect, code, and analyze data and to generate theory from the data. In quantitative research, the researcher sets out to prove or disprove a hypothesis and approaches the participants with a pre-set, structured set of questions asked in an identical sequence and manner. According to Mishler (1986), this method suppresses discourse and discourages spontaneity. Instead, he recommends an interview style that generates a more organic process, one in which the interviewer and interviewee co-create the context in which the

data emerges and the researcher becomes an instrument in the data collection process.

This method fits very well into the Grounded Theory approach developed by Glaser and Strauss (1967) and further described by Strauss and Corbin (1998). Grounded theory means "theory that was derived from data, systematically gathered and analyzed through the research process" (Strauss & Corbin, 1998, p. 12). They describe a theory as "a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological . . . or other phenomenon" (Strauss & Corbin, 1998, p. 22). These "categories" are derived from the data through the analytic process.

Using an open-ended, semi-structured interview guide, I allowed each participant to tell his/her own story as it unfolded. By employing the "constant comparative" method of data analysis (Strauss & Corbin, 1998), each participant's responses were individually analyzed and interpreted for contextual meaning and compared with the responses of the other participants. The analytic process began when the first interview was completed so that data collection and analysis could proceed concurrently. This allowed the researcher the option of revising interview topics as deemed appropriate by the material.

## Reliability and Validity

Reliability and validity are the criteria commonly used to evaluate both quantitative and qualitative types of research, though each research approach uses

different standards by which validity and reliability are judged and applied. In quantitative research, reliability refers to the accuracy of the measuring instrument or procedure. That is, does the measuring procedure yield the same result on repeated trials? Can other researchers reproduce the experiment? Reliability in qualitative research is also concerned with reproducibility of the findings. Strauss and Corbin (1998) state:

> Given the same theoretical perspective of the original researcher, following the same general rules for data gathering and analysis, and assuming a similar set of conditions, other researchers should be able to come up with either the same or a very similar theoretical explanation about the phenomenon under investigation. (pp. 266-267)

Validity in quantitative research is concerned with whether or not the study measures what the researcher intended and whether the study's findings are generalizeable. Validity relates to the rigor of the research design and the extent to which researchers take into account alternative explanations for any causal relationships they explore (Howell, et al., 2005).

Validity in qualitative research is not based on the assumption that there is only "one true interpretation of an array of data" (Mishler, 1986, p. 110), but on the "assessment of the relative plausibility of an interpretation when compared with other specific and potentially plausible alternative interpretations" (p. 112). In other words, multiple meanings and interpretations may fit the data. Because each interview is necessarily unique and contextually grounded in the life experiences of each participant, a relationship between discourse and meaning of

the subject being discussed develops, allowing for various plausible interpretations.

Since the analysis of the data is interpretative, the researcher is the primary instrument of validity and reliability. Therefore, validity and reliability depend on the skill, sensitivity and integrity of the researcher (Patton, 1990). Mishler (1986) adds that the validity of a qualitative study is in direct relationship to the care and quality of the research process. The validity of a study resides in the care with which the research process is carried out, including observation, interviewing, documentation, the specification of the rules that guide the analysis, the explanation of a theoretical framework, and the ways inferences and interpretations of analyses are grounded in and related to it.

Polkinghorne's (1986) adds that for the research to be valid, its conclusions must be persuasive and inspire confidence. "The degree of validity of the findings of a phenomenological [or other qualitative] research project then depends on the power of its presentation to convince the reader that its findings are accurate" (p. 38).

## Participants

### *Nature of the Sample*

This study used a small, non-random, varied sample. In qualitative research, the sampling is purposeful and focused on a small number of information-rich cases which allows an in-depth focus. Michael Quinn Patton (1990) describes information-rich cases as "those from which one can learn a great deal about

issues of central importance to the purpose of the research . . . whose study will illuminate the questions under study" (p. 169). Participants who have the greatest capacity of adding knowledge to the subject under investigation are selected. Patton suggests maximizing the sample variation in order to achieve "the central themes or principal outcomes that cut across a great deal of participant or program variation, by selecting a sample of great diversity" (p. 172).

The size of the sample is planned to be between 7-11 participants. Patton (1990) states that "qualitative inquiry typically focuses in depth on relatively small samples" (p. 169). The number of participants is determined by whether sufficient information has been gathered to do justice to the subject in question, or to the point of redundancy. When the purpose of the research is to maximize information, "the sampling is terminated when no new information is forthcoming from new sampled units" (Patton, 1990, pp. 185-186). Grounded theory advocates that, as a general rule when building theory, data is to be gathered "until each category is saturated" (Strauss & Corbin, 1998, p. 212). Saturation is achieved when no new or relevant data seem to emerge regarding a category, and the category is well-developed and demonstrates variation.

There is a dynamic relationship between data collection and analysis – analysis of the data from early interviews may influence the form of subsequent interviews and/or point to the need for additional, unanticipated interviews. As Strauss and Corbin (1998) say, "Sampling often continues right into the writing because it often is at these times when persons discover that certain categories are not fully developed. Then, data gathering functions in the service of filling in and

refining" (p. 214).

In my sample, I attempted to maximize variation in the sample by selecting participants from different professional fields. The aim of maximum variation sampling is to discover central themes that cut across a great deal of participant variation. A small sample of great diversity yields "high-quality, detailed descriptions of each case, which are useful for documenting uniqueness, and important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity" (Strauss & Corbin, 1998, p. 172). To maximize variation in a small sample, the researcher must identify diverse characteristics or criteria for constructing the sample.

### *Criteria for Selection*

To be included in the present study, participants had to be experienced, psychodynamically-oriented couples therapists. "Experienced" means a therapist who has worked with couples for at least 10 years, a length of time which should allow them to have developed their own style of practice and be able to reflect on their clinical work as couples therapists. In addition, therapists must either identify themselves as a couples therapists or consider couples therapy to be one of their primary specialties; this will ensure that, for most of the time, the therapist sees a larger number of couples in his/her caseload and has a wealth of experience working with a variety of couples.

In order to have the widest variation possible, I did not control for gender, age, or other demographic variables. Further, I did include representatives of the

various mental health professions who are licensed in California: psychiatrists, social workers, clinical psychologists, and marriage and family therapists. I selected participants from different theoretical schools within the framework of psychoanalytic psychotherapy; this included classical, Kleinian, self-psychological, interpersonal, and relational orientations. I attempted to maximize variation in these areas of licensure and theoretical schools in order to have the broadest view of how psychodynamically-oriented therapists address the central questions.

### *Recruitment*

I recruited participants through recommendations from colleagues, and from the memberships of professional organizations in the San Francisco Bay Area. I sent a letter describing the research project (see Appendix A) to colleagues asking them to recommend potential participants. In addition, I advertised (see Appendix B) in the newsletters of the California Society for Clinical Social Work and the Sonoma and Marin Counties California Association of Marriage and Family Therapists, briefly describing the research and asking interested therapists to contact me by phone or email. I also placed a similar advertisement in the newsletters of The Psychotherapy Institute in Berkeley and the San Francisco Psychoanalytic Institute.

To those potential participants whose names I received, I sent a letter (see Appendix C) describing the research and its methods. I included a brief screening questionnaire (see Appendix D) and a consent form (see Appendix E) for potential

participants to review. I then telephoned those participants that I selected for inclusion and set up a time and place for the interview. I reviewed with them the purpose of my research and asked them to think of several case examples of enactments for the interview.

## Data Collection: The Interview

Data for the study was collected through semi-structured interviews. Mishler (1986) describes this type of research interviewing as a form of discourse that involves two people and that relies on context and mutually constructed meaning:

> Rather than serving as a stimulus having a predetermined and presumably shared meaning and intended to elicit a response, a question may more usefully be thought of as part of a circular process through which its meaning and that of its answer are created in the discourse between interviewer and respondent as they try to make continuing sense of what they are saying to each other. (pp. 53-54)

An open-ended interview is the most appropriate tool to gather the type of information sought in this study, (i.e., the thoughts and other subjective experiences of therapists about an aspect of their clinical work). According to Patton (1990):

> The purpose of open-ended interviewing is not to put things in someone's mind (for example, the interviewer's preconceived categories for organizing the world), but to access the perspective of the person being interviewed. We interview people to find out from them those things we cannot directly

observe. . . . Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, able to be made explicit. (p. 278)

*Procedure*

I conducted 60- to 90-minute interviews of each participant in the setting of their preference, usually their office. I tape recorded the interviews and had the tapes transcribed. Before beginning the tape-recorded interview, I briefly reviewed the purpose of the study and issues of confidentiality with the participants and had them sign the informed consent form (Appendix E), a copy of which they received prior to the interview.

I used an interview guide (see Appendix F) consisting of a set of topics and probe questions which helped me insure that certain questions were covered during the interview. However, the interview guide was for my own use and was not intended to direct or shape the interview. I began the interview with an introductory statement about the research question, reviewing the purpose of the research and an explanation of confidentiality issues (see first paragraph, Interview Guide, Appendix F), and by asking participants to share their thoughts about the research topic. After the participant signed the copy of the Informed Consent Form (see Appendix E), I discussed with him/her whatever questions he/she may have had about the project.

Each participant was asked to talk about his/her initial reactions and thoughts about my research question. Following their lead, I raised questions as they

emerged in the interview rather than asking them in a preconceived order. In this way I allowed room for the participant's narrative and flow of ideas about the central research questions to emerge spontaneously. Using the "constant comparative" approach of Glaser and Strauss (1967), and with the Interview Guide as a framework, I developed new interview topics for further elaboration as data began to emerge from the interviews. I also deleted topics which did not seem helpful. To bring closure, at the end of the interview I asked the participants whether they felt there was anything we missed in talking about this topic. I also asked how they felt about the interview and whether they had any closing reflections.

### *The Topics of the Interview Guide*

The preliminary interview guide (see Appendix F) consisted of a list of topics and probe questions designed to help me attend to areas of inquiry that shed light on the research questions. Although the topics are presented here in a certain logical order, during the interview, it was not necessary for me to follow any pre-conceived order of questioning as this was entirely dependent on how the interview proceeded. As I proceeded through each interview, additional topics and probe questions were added to (or subtracted from) the interview guide for subsequent interviews. The following are categories of topics that I considered:

#### *Awareness of Transference/Countertransference Dynamics*

The purpose of this topic was to initiate a discussion about whether the

participant was aware of the transference/countertransference dimension of working with couples. Since many psychodynamically-oriented psychotherapists work differently in couples therapy than they do with individuals, it was not a certainty that they pay attention to this aspect of the work. This topic allowed participants to discuss their theoretical orientation, ways of working with couples, and whether they think in terms of the transference/countertransference dynamics.

*Experiencing Countertransference Reactions*

This topic began to flesh out how each participant experienced countertransference in their couples work. I explored the participant's typical reactions when they encounter a particular type of couple or problematic situation that activates their countertransference. This includes personality disordered, polarized, oppositional, hostile/blaming, or abusive types of couples. It can also include the couple's emotional conflicts that trigger the therapist's vulnerabilities, such as parenting struggles, extra-marital affairs, sexual concerns, separation and divorce, domestic violence, intense aggression, and the revival of oedipal themes (e.g. competition, rivalry, jealousy, attraction, seduction). The therapist's countertransference can also be activated when he is triangulated by the couple, as in when he feels pressured to take sides or is induced to keep secrets. My intent in exploring these reactions was to get a sense of what kinds of negative countertransference most therapists are experiencing.

*Getting Caught Up or Acting Out Countertransference*

Since countertransference may not always result in an enactment, the purpose of this topic was to explore those situations in which the therapist did get caught up in and/or act out on his countertransference. Though the line between a countertransference reaction and an enactment can be unclear, I attempted to tease out big E enactments as described in my introduction. These are times in which the therapist clearly and persistently felt caught up in his countertransference reactions manifesting in some type of acting out behavior. For example, the therapist might have felt so completely overwhelmed, confused, anxious, angry, or helpless that it resulted in his withdrawing, criticizing, lecturing, yelling, bullying, or becoming excessive in giving advice. I also examined situations in which the therapist got stuck in a misalliance with one partner, colluded to avoid important issues or attempted to impose his view of reality on the partner/couple. I allowed time for the therapist to talk about how he felt about his enactment

*Thinking About the Enactment*

In this part of the interview, I wanted to explore how the participant thought about and conceptualized the enactment. Was the enactment experienced as a mutual event in which all participants were implicated? Did the therapist feel provoked or induced by the partner/couple to act this way? What did he think was being activated in himself — a vulnerability, an unresolved conflict? Did the therapist recognize he was acting out during the enactment or did he gain awareness only after the fact? I also explored the participant's ideas about

whether he/she felt the enactment was helpful or detrimental to the therapeutic process.

*Dealing with Countertransference Enactments*

This topic area explored how the participant dealt with the enactment. Once the enactment was recognized, was he/she able to contain the acting out or did they feel out of control? How do the therapists typically deal with their countertransference in couple therapy? Did they work with the feelings within themselves, get consultation, or both? Did they disclose their countertransference to the couple? In what way did they disclose their countertransference – did they share only their reactions to the partner/couple or do they also disclose their personal conflicts and vulnerabilities? I also examined how participants worked their way out of entrenched misalliances which may have been caused by the enactment. Did they attempt to repair the misalliance with the partner, and how do they do this?

## Data Analysis

The "constant comparative method" as described by Strauss and Corbin (1998) was used to analyze material from the interviews. This method is particularly useful in that it is a systematic method for generating hypotheses from the themes and patterns that emerge organically as participants talk about their experience with the topic. The "constant comparative method" is best suited for research that examines the subjective experience of participants (Polkinghorne,

1986). Mishler (1986) adds that the construction of narratives is the natural way that people order and make meaning of their experiences.

In the Grounded Theory approach, analysis of the data begins as soon as the initial data has been collected, in contrast to other approaches where all of the data is collected prior to analysis. A Grounded Theory researcher asks what something in the data is or what it means, and considers qualities belonging to emergent categories or data in order to begin to make sense out of the phenomenon under study. Asking questions and making comparisons permeates the Grounded Theory approach because it is the medium for data collection and a tool for understanding the data that has been collected. As the researcher begins making comparisons, he may find that further questions based on the evolving theoretical analysis are suggested; these questions influence the process of collecting data, deepen and broaden the understanding of the phenomena under study, and move it from the particular to the more general and abstract.

### *Procedure for Data Analysis*

I began my data analysis by taking notes about my initial thoughts and reactions following the interview. I listened to the audiotapes of each interview to get a sense of the participant's unique "voice" and to summarize the themes that stood out. Each interview was transcribed for additional review. Mishler (1986) asserts that systematic transcription of interviews is essential for capturing as accurately and completely as possible the discourse between the two people and is essential for data analysis. He recommends that the transcriber return repeatedly

to the tape-recording to insure that the transcription has been heard correctly, insuring that the analysis is accurate. As more interviews are conducted and their audiotapes reviewed, new themes may arise, requiring the collection of more data until saturation is reached.

Analysis of the data occurs through a series of coding procedures, open, axial, and selective; these different types of coding do not take place in a linear, sequential manner, but operate concurrently. Coding procedures facilitate theory building from the particular phenomenon to more abstract and interrelated conceptualizations and categorizations. Initial analysis of the transcribed material will proceed with "open coding" procedures as defined by Strauss and Corbin (1998). This consists of breaking down the text into units of meanings, comparing these units to one another first within, and then between, each interview. The data is examined closely for similarities and differences. Transcripts of the interviews are examined line by line, looking for collections of phrases and words or clusters of related phrases that seem important while also paying attention to general themes. "To uncover, name, and develop concepts, we must open up the text and expose the thoughts, ideas, and meanings contained therein" (Strauss & Corbin, 1998, p. 102). Thus, the work of open coding is to name concepts, define categories, and develop those categories in terms of their properties and dimensions.

The second coding process is called "axial coding"; this refers to the process of reassembling data that was broken down in open coding, relating categories to sub-categories to arrive at more precise and complete explanations about

phenomena and adding depth and structure to categories (Strauss & Corbin, 1998, p. 124). The final coding procedure is called "selective coding"; this process helps integrate and refine categories and their relationships to one another, moving the data towards a theory. From many cases, the data is reduced into concepts and sets of relational statements that can explain the phenomenon in question. By this point in the analysis, a central or core category has emerged and becomes a focus for further theoretical construction (p. 145). A core category is the primary phenomenon which best describes the data.

### *Presentation of the Findings*

I will present the results of this research in two chapters. First, I will present a narrative summary and overview of the data analysis and findings. Being careful to protect anonymity, I will describe the participants, noting their common features and variations. I will describe the categories and sub-categories that emerge through coding and organization of the data with illustrations from the data. The final chapter is devoted to an interpretive discussion of the findings in terms of the research question. In it, I will discuss how the patterns and themes that emerged in the data analysis relate to the research questions and to the literature, as well as the study's implications and significance. Limitations of the study will also be addressed.

# CHAPTER 4: FINDINGS

This research explores how psychodynamically oriented psychotherapists experience, think about, and deal with situations in which they get caught up in and/or act out their countertransference in couples therapy; I refer to these types of reactions as countertransference enactments. I expected couples therapists in my sample who identified themselves as psychodynamically oriented to have familiarity with countertransference issues, which they did. I also expected them to have some familiarity with the concept of enactment, which they did. Since my review of the literature had yielded some discussion, but little depth, regarding therapist's actual experiences of enactment encounters in couples therapy, I wondered how participants would discuss those times when they got caught up in their reactions. The study was designed to explore these reactions with some depth through actual case material.

Because I thought it might be difficult for participants to remember examples of enactments spontaneously, before the meeting I asked them to be thinking of a few clinical examples of times when they got caught up in and became reactive in their work with couples. While this may have taken some of the spontaneity away from the interview, I thought it was more important for participants to remember the details of cases since this was the heart of the data for my study. All participants but one came to the interview with a short list of cases which they had thought about. The one who did not prepare had a much harder time coming up with an example of a countertransference enactment and needed a lot of coaching.

In the beginning of the interview, I asked participants for their thoughts about

my research question. Next, I asked general questions about how they view countertransference issues in couples therapy, including their familiarity with the concept of enactment. I soon realized that these types of questions, while helpful in making participants feel comfortable, would not provide the kind of data I was looking for – how therapists are experiencing and working with enactments. Thus, I began getting to case material sooner in the interviews, and this allowed me to get two case vignettes from most participants. Interviews were unstructured and open-ended, and I brought up questions from my preliminary interview guide to help focus participants when needed. Some participants had some question about how much case detail to provide, but this worked itself out as the interviews progressed.

I will begin this chapter with a brief description of the participants, followed by an introductory overview of the findings. Finally, I will present the findings grouped within thematic categories to be described below.

## Participants

The participants are described according to their group characteristics for the purpose of protecting their anonymity. The ten participants were experienced psychodynamically oriented psychotherapists from each of the licensed mental health professions in California except psychiatry: three psychologists, three marriage and family therapists, and four clinical social workers. Seven had doctoral degrees in psychology. There were seven women and three men ranging in ages from 40 to 65; nine participants were in their fifties and above. All the

therapists came from the San Francisco Bay area and were in private practice, seeing individuals and couples.

One of the requirements of the study was that participants either identify themselves as a couples therapist or claim couples therapy to be one of their primary specialties. This was true of all the participants. In addition, participants were to be experienced, meaning that they were to have at least ten years experience as practicing therapists. All the participants fit this criterion; the number of years participants had worked as licensed therapists ranged from 12 to 43. Five participants had worked in the field for over 30 years, three others for over 20. Most were very seasoned therapists who had a great deal of experience working with couples. Several were teaching courses on some facet of couples therapy; others were consultants in the field.

In my recruiting materials (see Appendix A and B) I specified that research participants be "psychodynamically oriented psychotherapists." All of the participants met this criterion, listing a variety of theoretical orientations on the screening forms. These included psychodynamic approaches as well a few non-psychodynamic approaches, such as family systems and eclectic. The theoretical approaches mentioned included psychoanalytic, object relations, character analytic, control mastery, relational, and self psychological. Once the interviews began, the theoretical orientation was not a point of emphasis.

All the participants were thoughtful and articulate and all, except perhaps for one, seemed genuinely interested in my research question. The participant in question had not come to the interview prepared with any examples of

enactments; he said he did not usually think in terms of enactments and that the reason he decided to do the interview was that he had been involved in teaching and wanted to help out with my study. Ironically, after a fairly frustrating 45-minute interview with this participant, I managed to extract from him one of the most unusual examples of an enactment in my study. All the other participants were very forthright about their countertransference participation in the enactments. These clinicians were not only very willing to share the mistakes they made as therapists, they were also quite revealing about their countertransference triggers. This contributed to bringing a depth and richness to the interviews.

## Overview

Due to the highly conflictual nature of the couple relationship, the therapist may begin to have intense countertransference reactions in the very first session with a couple. Transference/countertranference dynamics can become quite complex. Participants acknowledged this complexity as one facet that makes couples work so demanding. As one participant said, one is entering a minefield and is probably going to get blown up. Participants concurred; it is easy to get triggered when working with couples. Its fast pace, the emotional volatility, partners pressuring the therapists to take sides, the shifting alliances, and other such factors all contribute to making couples therapy a fertile ground where enactments can occur. This is the subject of this research. It explores how therapists experience, think about, and work with countertransference enactments

in couples therapy.

The enactments presented in this study are stories within a larger story of the couples therapy. Enactments are about a dramatic time in the case when feelings are heightened, tensions are building, and the pressure on the therapist is intensifying. In telling the enactment story, participants first talked about what happened in the case. They provided a brief history of the couple, the couple's dynamics, the course of therapy, their countertransference and the events leading to the enactment. They then discussed what was said and done in the enactment and went on to talk about what occurred afterwards – how they thought about and understood it, analyzed themselves and the case, how they worked with the couple, and how they dealt with their own reactions. Of course, not all of this was laid out in so orderly a manner, and in some accounts, it was much more chaotic. But, for the most part, therapists told me the story of the events of the case and how they understood their experiences and those of their clients. Because of this, the findings of my study are organized sequentially as a process of events and, except for the first two sections, the categories reflect this.

There were several challenges in the study. While participants seemed to be familiar with the concept of enactment, most had difficulty describing in theoretical terms exactly what constitutes an enactment; only three were able to present a conceptual understanding of the term. Instead, these therapists seemed to have a more experiential understanding of an enactment; they provided several rich clinical examples of enactments. Or, they described its properties – it is a feeling of pressure, it is an impulsive action, it is losing the ability to think, a

stirring up of anxiety, etc. When taken as a whole, within the twenty-three clinical vignettes that were presented, participants described many of the properties of enactments described in the literature.

The participants also found it challenging to differentiate their enactments from the ongoing flow of their countertransference reactions. When did an enactment begin? When did it end? This was difficult to ascertain. Sometimes this was more clear, like when a therapist snapped in frustration at a client. But at other times, the enactment was more subtle and pervasive, for example, when the therapist felt a strong dislike of a client and this permeated the way she treated him.

In addition, there was also the challenge of recollection. In many of the accounts, therapists could not always remember what they or the clients said and did and the exact sequence of interaction. This made it more difficult to track the details of an enactment in a way that may have provided more clarity and comprehension about what really happened. Nevertheless, while something may have been lost in the details of the stories, participants still presented a rich array of enactment examples.

Most of the enactments described were accounts involving just one partner, not both. Although both partners clearly played a part in the dynamics, therapists still tended to experience one partner as more difficult in some way (angry, narcissistic, controlling, passive-aggressive, etc.). This resulted in the therapist often becoming frustrated or angry with that partner, a type of enactment that occurred frequently in the findings. Several participants got into a power struggle

with a partner; one female therapist got into a power struggle with the wife but actually felt ganged up on by the couple, whom she experienced as unconsciously colluding against her.

There were other kinds of enactments as well. For example, participants discussed how they felt they acted out their countertransference by taking on different roles. One felt compelled to take on the role of judge; she felt pressured to decide on the issue of fairness regarding a conflict over an affair. Another participant took on the role of parent-educator; he said he enacted this role as a way to feel relief from dealing with the couple's bitter fighting. Some enactments were more subtle. One participant discussed how her strong disgust for a partner's controlling behavior affected her ability to be understanding of that person's experience; she defined this as her enactment. Another kind of enactment occurred when a therapist allowed a husband to vent his rage towards his wife for a whole session. The wife, who was emotionally fragile, felt beat up. She did not feel protected by the therapist and was so upset she quit treatment.

The findings show that therapists recognized that an enactment occurred by one of two ways: (a) from reflecting upon their countertransference or (b) from their awareness of the client's reaction. Once recognized, participants made efforts to understand why the enactment occurred and work it through with the couple. While these processes are very much interlinked, I have separated them as two distinct processes for the purposes of evaluating the findings.

Understanding why the enactment occurred is an important step for the therapist. Because the countertransference feelings that motivate enactments are

usually unconscious, therapists want to understand what happened. Why did they say or do what they did? What was behind their feelings? What were their triggers? What was happening in the dynamics between the couple and among all three of them to cause the enactment? Therapists made conscientious efforts to unravel these questions in order to understand why the enactment occurred. Prior to and throughout the interview process, participants demonstrated a keen capacity to think about their cases and evaluate countertransference triggers; they showed their ability to conceptualize the dynamics of the couple while also being able to reflect on their own participation in the enactment.

Several countertransference themes emerged from the findings. Enactments tended to coalesce around countertransference affect themes such as frustration and anger, dread and anxiety, and hopelessness and ineffectiveness. Of course, most, if not all of these affects might be present during a particular enactment, but the findings show that certain affects seem to predominate during certain enactments. Frustration and anger seemed to be the countertransference feelings that were described the most by participants as present before and during an enactment; this was followed by hopelessness and ineffectiveness, and then by anxiety and dread.

There were also other countertransference themes. One had to do with the therapist's vulnerability, or what I call the therapist's Achilles heel. A few participants talked about how the therapist can sometimes have a vulnerability to a certain type of individual, couple, or emotional conflict that was particularly challenging. Another theme is perhaps more obvious – three person dynamics.

Triangular dynamics played some role in most of these countertransference reactions; for example, several therapists discussed how they felt pulled to protect a spouse who was getting verbally beaten up by his/her abusive partner. Other therapists talked about how they felt drawn to verbalize partners' unexpressed anger for them when they were not able to express it themselves. How therapists felt about the enactment was also a countertransference theme examined. Therapists, for the most part, felt badly about their enactments, especially if they felt they hurt their clients in some way.

An overarching countertransference theme was the therapist's experience of pressure. Therapists often experienced a sense of pressure coming from couples, and it was often this pressure that contributed to the acting out of the therapist. Participants talked about feeling pressure in a number of ways. For example, therapists felt pressured to take sides. Partners also often demanded that their mates change in some fundamental way and usually solicited the therapist's help. Pressure was also implicit in the various countertransference feelings that were activated, such as frustration and anger; for example, the therapist felt a build-up of frustration or anger with a partner, and acted out his feelings in some way. Or, for example, pressure may have come from the therapist's feelings of ineffectiveness, especially when clients complained that therapy was going nowhere and put pressure on the therapist to do more.

How therapists worked through the enactment with the couple while managing their own countertransference reactions was a primary area of the findings. As one participant mentioned, there are no models in the

psychodynamic couples therapy literature for how to work with enactments; thus, most therapists are "flying by the seat of their pants." Yet, therapists in the study seemed to work through enactments with the couples in very similar ways. Most likely, this is because an enactment can be seen as a rupture in the therapeutic relationship, and most therapists have experience in working through such ruptures.

Therapists used a variety of methods in attempting to work through an enactment with a couple and repair the rupture in the therapeutic relationship. The first part of the reparation process usually included the therapist acknowledging the enactment, after which, most, though not all, therapists expressed an apology or regret for their actions. Therapists then began an exploration of the partners' experience. As the therapist developed a clearer idea of why the enactment occurred through understanding his countertransference triggers and the case dynamics, he or she usually interpreted this understanding to the couple. Such an explanation usually included an interpretation of the transference/countertransference dynamics as well. Some therapists also disclosed their personal feelings to the couple in order to explain why they reacted the way they did, although this was a controversial issue among a few participants who debated its therapeutic effects. Some said that self disclosure unnecessarily burdened the client with the therapist's personal conflicts.

Therapists also used a variety of coping strategies to manage the intensity of their countertransference reactions. Several participants said that, ideally, they attempt to contain strong feelings until such time they can get a better

understanding of what is driving them. They also said that while containment was important, it was also crucial to think through what was going on in order to bring understanding to that which is being contained.

After an enactment occurred, participants tried to get a handle on their reactions. Several participants discussed how they try to talk themselves through difficult situations with couples, doing a form of self-supervision. They have a repertoire of ways to self-soothe, which helps them contain their reactions when tensions build with clients.

Therapists also worked on developing greater compassion and empathy for their clients. When participants are caught up in negative countertransference reactions with a partner, the data shows that many work on finding a way to develop increased empathic understanding towards that individual. This was particularly challenging for couple therapists who can sometimes see the worst in people – partners hurting and treating each other badly. Participants are often triggered by partners treating them this way as well. For example, a participant was continually provoked by a withholding husband who rarely talked in sessions and always seemed cold and angry; she worked at developing empathy by trying to see his vulnerability underneath his cold exterior. He was scared of getting close.

Overall, therapists in the study were very conscientious in wanting to understand themselves and the couple's experience; they seemed intent on working though the enactment with the couple. As a result, many enactments were either successfully worked through or were still being worked through;

participants felt a deepening in the therapy or a better working relationship with the client. However, not all enactments worked out so well; some damaged the trust in the therapeutic relationship and derailed the therapy.

Note: The confidentiality of the participants and their clients has been protected. Identifying information has been eliminated or disguised in the data. Transcripts of participants remain intact. In some instances, when cases have been alluded to in the narrative, details may have been changed to disguise identifying case material.

## Findings

I will discuss my findings in six sections. The first two sections review participants' views on countertransference issues in couples therapy and their conceptualization of the term enactment. Then, the findings are organized as a process analysis: participants describe their enactments and then discuss how they thought about and worked with the enactment with the couple. The categories are: Complexity of Transference and Countertransference in Couples Therapy; How Therapists Conceptualize Enactments: What is an Enactment?; What Happened: Therapists Describe Their Enactments; How Therapists Recognize That an Enactment Occurred; How Therapists Analyzed the Enactment: Attempts to Understand Why the Enactment Occurred; How Therapists Work Through the Enactment.

*The Complexity of Transference and Countertransference in Couples Therapy*

The aim of my research was to delve more deeply into how couple therapists were dealing with countertransference enactments; thus, most of my interview questions were directed towards soliciting actual case material. However, in the beginning of the interviews I asked participants to talk about some general considerations of transference/countertransference issues in couples therapy.

Participants regard couples therapy as a difficult and challenging endeavor, one which engenders intense countertransference reactions in the therapist. This is not surprising since several participants noted that most couples come to treatment already embroiled in painful relationship dynamics, and that the intensity of couple relationship results in powerful pulls and shifting alliances among all three participants. It is the very nature of these highly conflictual relationship dynamics that potentially leads to strong countertransference reactions, which may then result in countertransference enactments. This section is illustrated by three sub-categories: "The emotional intensity of the couple relationship," "multiple transference and countertransferences," and "triangulation."

*The Emotional Intensity of the Couple Relationship*

The transference between intimate partners tends to be intense and enduring, and the therapist often has to contend with very entrenched painful, emotional dynamics which, of course, can activate the therapist's countertransference. As one participant said, "one must deal with a system which has already existed for

some time." Partners have their own private language and cues that the therapist is trying to understand. This participant conveyed a sense of this by talking about how much goes on between partners on a non-verbal and invisible level.

> I think there are things that couples are doing to each other that, you know, we can't even see. You know, that [there] is so much under the surface or even are non-verbal; different things that go on where they are quite acting upon each other.

Partners come to therapy in emotional pain; they are usually stuck in repetitive cycles of negative interactions in which they are hurting each other. According to one participant, partners tend to trigger each other's vulnerabilities. Here is her description of how that happens.

> Couple dynamics are powerful. There are these really lovely people in the room who can be doing really hurtful things to one another or saying hurtful things. . . . And so, over the years I've watched these incredibly powerful dynamics pull people like an undertow back into the same problematic way of relating. . . . But I could see how tenacious they [problematic ways of relating] were . . . what I call our primary vulnerability . . . places where we're the least protected, you know, uh get triggered in our couple relationship. . . . The primary vulnerability or primary anxiety to exposure or to abandonment. Or, the, you know, the fear of attack . . . or the fear of one's own destructiveness. It seemed like there was just a handful – it seemed to come up over and over again. And it was like – the way I talked about it was that there was the fight and if the fight continued or got, people got gripped in

> it – I mean, people can always fight about driving or childcare or whatever, but if you get gripped, usually it means that the underlying conflict has gotten triggered. And that underlying conflict, to me, was about these primary vulnerabilities.

This participant continues, saying how vulnerabilities get triggered in an interlocking way; one's reactions to getting hurt causes one to protect oneself in a way that triggers the other's vulnerability. These develop into patterns of self-reinforcing, unproductive vicious cycles.

> . . . in an interlocking vulnerability, the way I would see it is that if one person's deep vulnerability is to abandonment and the way he or she responds to that is in this self-protective behavior pursuing and commenting and reminding and, you know, complaining, but pursuing, and the other person's primary vulnerability is to exposure and being found out as wanting or being criticized, and their response is to go away – to retreat; to withdraw, uh, you can see how there would be this total interlocking. You know, the abandoned person will pursue and expose, and the feared person who's afraid of exposure will retreat and abandon. . . . You can see how each person's solution actually triggers the other person's [self-protective response].

The couple therapist is attempting to understand and work with these interlocking vulnerabilities, which can be quite difficult. The following participant talked about the frequent tendency for couples to become locked into attack and blame cycles. Speaking from a Kleinian perspective, she said that when couples became entrenched in blaming each other, they were in the

paranoid-schizoid position. While in this mode of relating, the partner attempts to evacuate affect onto the other and often loses the capacity to think, increasing the tendency to act out. I asked this participant if therapists can also be swept into the paranoid schizoid state by the couple and she said:

> Definitely. A paranoid schizoid position is evacuative. That is, people can't stand what it is they're feeling. They can't tolerate what it is they're feeling and so they behave in such a way – I want to get rid of the feeling, you know, so they need to find a person, a partner, who will catch those feelings and introject them and take them in, and then they re-project them. . . . There's a constant, on-going evacuation of affect. And so there's an attack of what Bion calls an attack on linking, so people can't really think very much – it's just a knee jerk reaction. You may as well forget about doing any couples therapy when they're in that state.

These kinds of couple dynamics can activate the therapist's triggers. As another participant cautioned, "The dynamics that you're working with are guaranteed to stimulate reactivity in you. If you can't identify your own triggers, you're in real trouble."

This same therapist goes on to point out that the therapist's counter-transference can include projections onto the client. These projections, if negative, can result in the therapist reacting defensively toward one or both partners in the couple.

> At its worst, I think I could project something negative, say, regarding my own mother or father, into the circumstance and identify this man [the

husband] or this woman [the wife] with something negative in them, you know. And it could pose them feeling defensive about the way that I'm being with them.

*Multiple Transferences and Countertransferences*

Triangular relationships are more complex than dyads. Because three people are now involved in the therapeutic relationship, multiple transference-countertransference dynamics between the partners, therapist, and each partner and the therapist and couple occur. Several participants commented on the fact that the complexity of the transference/countertransference dynamics is what contributes to making couples therapy so challenging. The therapist not only has to attend to his relationship to each partner, but also pay attention to the couple's relationship as a whole and the fast and furious flow of dynamics between them. This is expressed by one participant who claims there are potentially nine different relationship configurations of transference/countertranference dynamics alive in the room at any one point.

Anytime you go from two people to three, whether it's children playing or in a couple having a baby or people in a therapy situation, the complexities add up unconsciously and consciously. . . . When you do couples therapy, the number of transferences explodes exponentially. You could add them up. I think there are nine if I got it right, 'cause you also have a shared transference from the part of the couple to the therapist. . . . You also have multiple countertransferences. You have countertransferences to each person

> individually and you could have a countertransference to the couple. You can have countertransferences to their transferences to each other, actually.

According to this same participant, the three-person dynamics seen in couples therapy can lead to different kinds of transference/countertransference configurations than one might find in dyadic relationships. She noted that certain themes might appear in couples therapy, such as triangulations, favoritism, sibling transferences, oedipal rivalries, jealousy, and the feeling of being left out. She also said that these themes might emerge in a different way than in individual treatment. As such, the couple therapist may face different kinds of pressures.

> And I think that promotes different countertransferences. . . . The pressures and I think the content can be quite different. That is, you can have by virtue that there are three people in the room, the kind of triadic countertransferences that get going are, um, sometimes different. For example, themes of triangulations and jealously and people being left out and favoritism and uh, sexual kinds of things. Um, sibling kinds of transferences and uh, transferences that pull for the therapist to act like a judge and mediator. These countertransference enactments as well as – and I don't think this is countertransference per say, but perhaps transference from the therapist having to do with primal scene anxieties and all kinds of oedipal problems.

Another participant also talked about a type of parental countertransference that can occur in couples therapy specifically related to the child's wish to heal the parent's relationship.

> Or they [the couple] can remind me of my parents' relationship that I forever wanted to fix and never could (laughs a little). . . .Yeah, just something about wanting to cure the parents, you know, make them happy. Um, and so, I think there's probably that.

Therapists not only have to attend to the multiple transference-countertransferences with the couple, but may have to pay attention to different levels of regressed transference dynamics, which can occur with one or both partners. When these occur simultaneously, it is a lot for the therapist to keep track of. The following participant made note of this, and said it is this aspect of psychodynamic couples therapy (as compared to cognitive couples psychotherapy) which makes it so difficult. Having to attune to the deeper layers of each person's more primitive states while also attending to the relationship dynamics is like entering a "mine field." Sometimes things will just blow up.

> I think that psychodynamic couples therapy is hard. I think – I've been to cognitive-behavioral couples therapists, and it's like, that was then, this is now. So those primitive states are not held in the same way. So, yeah, I think that that is what makes it so difficult, because you are holding those individual core issues and you're trying to also, um, not just work them one on one, but you're trying to have a flow through the whole thing so that the other person gains some, what I think of, they gain more wiggle room. They gain more space around their partner. And it's just so imperative when um, when there are these long-term, chronic patterns, you know, that have almost no hope of getting out of 'em, unless there's that they can really witness the

other and also be in their own. Nobody gets how hard it is. Not if you're gonna go, not if you're gonna go to that lower strata. That lower strata and hold those little guys, those children who just wanna be seen, who wanna be listened to. Or, they wanna be left alone or something, you know. But basically . . . getting there is like a mine field. And then you get there and you're still gonna get blown up some, you know.

*Triangulation*

One of the most common transference/countertransference dynamics occurring in couples therapy is triangulation. Triangulation is the process by which the therapist is triangulated into the couple relationship system; it is the way the therapist feels pulled or pressured into aligning with one or the other partner. It is believed that couples in conflict triangulate a third person, be it a child or a therapist, as a way to reduce the tension in the system. Because the couple comes to therapy already enacting their full-blown conflicts with each other, the tendency is for the therapist to quickly and powerfully get pulled into the couple system. Participants had different ways of describing this experience, using words such as hooked, pulled, pressured, or sucked into the system. This can occur quite powerfully. As one said, " I think that [because of] the transference and the intensity . . . between the couple, it is easy for the therapist to feel pulled in; it can be very quick and very powerful with couples in the room."

Some talked about it in terms of pulls for attention, others in terms of shifting alliances. One participant said the pulls and shifting alliances occurring in

couples therapy are a fluctuating process, a constantly changing dynamic flow among all three participants. She thinks when this triangulation gets stuck on one person it sets up the possibility for an enactment.

> I think that's always the pull in couples therapy, when you have three people in the room and there's various tensions going on. . . . There is a pull towards allying with one or allying, uh, with the other or sometimes the couple allying vis a vis the therapist so there's this fluctuating process of triangulation that goes on. . . . But sometimes the triangulation can get stuck on one particular axis, and that's probably what I think would be the grounds for enactments.

Similarly, the following therapist thinks about the experience of triangulation in terms of each partner's vying for her attention. She feels like it is having two kids pulling at her, splicing her in half.

> I think of Bowen a lot because it really does feel like that triangulation. And with couples, what I feel almost all the time are the variations of attention. You know, this person's pulling for attention and then this person's pulling for attention. And there's always, you know, who's getting more; who's getting less? . . . I mean I'm always like aware of trying to bring this person in, but giving this person their time, then trying to get them to interact based on that. And so it feels internally there's a lot of busy-ness in me in that, in that watching the attention and time. And especially I'm thinking of . . . working with people who both came from large families, 'cause it really is like having two kids in the room most of the time. And that's why their history, my

> history, all kinda collides; because I remember having a couple, they were both middle children in very large families, and I felt like I was sliced in half all the time because it was like always, you know, I'd be processing with one and then the other one would just be fidgeting over here, you know, and then I'd be pulled.

The couple can also join together to align against the therapist for a number of reasons. One of the enactments that I will later describe involved a couple unconsciously colluding against the therapist. The following therapist talks about this process in a general way. As a control mastery therapist, he discusses the transference tests clients put their therapists through; it is as a way to determine whether the therapist will hang through discouraging times with the couple or instead collude with their hopelessness.

> They [the couple] may do it [test] to me and they both may they both attack me. . . . I know it has happened and then they've been unified in their attacking me, um and, and I may allow that to happen for a while just so they can feel together on something. And I'll just tolerate it. For example, they'll tell me I'm not helping them; we're not getting anywhere. Now, this I understand, and I tolerate for a couple of reasons. One is, you know, they're feeling together and at least they're unified in something. But more importantly it represents, uh, a very important discouragement test on their part. They've been in this a long time, they don't know their way out, they think it's hopeless, and they're attacking me to see if I'm going to be hopeless or just discouraged.

*How Therapists Conceptualize Enactments: What Is an Enactment?*

In order to gain a common ground, I asked the participants to conceptualize their understanding of the definition of an enactment. Participants gave a variety of responses to this question. It is interesting to note that most therapists in the study did not (or perhaps were not able to) give a clear conceptual definition of the term. Only three were able to do so, and it seemed to me that these descriptions were not entirely clear in their meaning. Nevertheless, my sense is that all the therapists in the study had heard of the concept because they were able to talk about the various properties of enactments and/or give excellent experiential descriptions. Perhaps more important, participants were able to give me one or two rich clinical examples of a countertransference enactment, demonstrating that it might be easier to describe an actual enactment than it is to define it conceptually. I will begin this section with a discussion about the sense of confusion some participants felt about enactments. I will then describe three definitions of enactments provided by participants and follow with a discussion of how participants viewed the common properties of enactments.

*Defining Enactments*

Among a few of the participants, there seemed to be some uncertainty about what an enactment is. As one participant said: "I think it's a very ephemeral concept that you're trying to grasp and identify . . . and there's so many different ways of looking at it and so many different lenses." Only three participants were able to give a fairly comprehensible definition of an enactment; the rest either

talked about some of its properties or described it in experiential terms. Two participants asked first for my definition and then did not provide their own explanation. A couple of others were confused about the concept altogether, and when they began talking about it were either unclear or seemed to be scrambling to come up with something. I should note here that I am not pointing out the difficulty in defining enactment to disparage any of the participants, but rather to demonstrate the challenge some had in conceptualizing an elusive, somewhat unfamiliar psychoanalytic concept. To give an example of this, when I asked the following participant to define an enactment, she seemed to be thinking as she spoke and her response was convoluted.

> Um, well, um, one, one simple part of it is just my – if, if my counter-transference reflects something that I've observed in the couple. So sometimes my countertransference will be like one of the partner's reactions to the other partner, um, so that I consider that an enactment because it's not just my personal reaction but it represents something that's happening in the system. Um, another kind of enactment is, uh, well, uh, where there's a projective identification and I'm taking something on that doesn't belong to me. But I actually don't believe very much in the concept of projective identification. I, I think passive into active is a more active, accurate term. I don't believe someone can put a feeling in you that you don't already have the ability to resonate with. I do think that we influence each other in non-verbal ways, but I do not think that I can be influenced unless something in me rises to meet it. So, um, so in that sense, I don't believe that I would

> purely be reacting to something that the other person is unconsciously projecting. And I don't believe that they can unconsciously project into me like projective identification talks about.

I am not really clear about what the therapist was trying to state, but I think she is saying that her countertransference is a reaction to part of the larger system of the threesome. This therapist goes on to explain how another enactment can occur when the therapist takes on a projective identification from the client, but then the therapist backpedals, stating that she does not believe in the concept of projective identification; rather, she believes in the concept of mutual influence. She seems to make a distinction between the two processes, but leaves it unclear what they have to do with an enactment. It seemed she never quite explains what an enactment is, and it is easy to get lost in her definition.

Another participant refused to even define the concept, saying that he never uses labels in his work and that terms are not important to him because they are not descriptive. My sense is that he did not have an understanding of the concept because he had difficulty coming up with an example of a countertransference enactment and needed a lot of coaching in the interview to provide one.

> Well I don't, I don't. It's like you're asking me how would I describe enactment, well, I don't. You know (laughs a little) uuhhh. It's, it's, you know, the terms are, are not as important to me as, as, because they're not descriptive. I'm trying, I, I never use labels. I never use it with my patients. I mean, I try to be just descriptive and let them come to it with whatever. . . . I don't want to define it.

Yet, as mentioned, three participants did attempt to conceptualize their understanding. One in particular, with a strong background in studying and using enactments in her work, had perhaps the best grasp of the concept. Here is her specific definition of a countertranference enactment.

> It's an intersection of transference with something in the therapist that, to some degree, might be inevitable if you're going to be working. . . . But it also, to some degree, constitutes um, probably a vulnerability in the therapist. In other words, it involves the inevitability of a projection. But um, to the extent to which we all have an unconscious, it intersects in some way, and then it, it creates an enactment I think when the therapist um, feels compelled consciously or unconsciously to sort of act that out in the same way and deviate from some conception of what would be, how they would normally or routinely think about working.

While this was the most conceptually detailed description of a countertransference enactment encountered in the study, it too is not entirely clear in its theoretical meaning, again demonstrating how elusive and difficult it is to define, even by someone in the know. I believe this therapist is saying that when the therapist and patient's vulnerabilities are mutually triggered in treatment and these intersect in some way through the process of projection (or projective identification), the therapist may feel compelled to act out his/her countertransference and thereby deviate from how he or she would normally work. A couple of key properties of enactments brought up in this description are (a) the therapist's vulnerability gets activated, usually through an unconscious

process, like projection, and (b) the therapist feels compelled to act on these feelings. These properties are suggested by others in the study and will be discussed below.

In one of the other clearly defined explanations, the therapist also discussed the therapist's tendency unconsciously to get pulled to react to the client. Since the therapist often has little awareness of her countertransference triggers during an enactment, she usually has not developed sufficient consciousness to make clear decisions about the interactions between therapist and couple.

> Uh, my understanding would be that . . . there's often a pull from the client that I'm seeing, unconsciously, to see things and react to things in a certain way and I unwittingly comply. That would be one way, um, I would see it. And, another way I would see it is that there could be something going on in my life that the person triggered and out of my own uh, unconscious or, you know, semi-conscious reactivity, I could respond in a way that would be um, not constructive. Or, sometimes constructive, actually; I mean, it could go either way. But that to me, what it implies is um, not-yet sufficient consciousness about the interaction to be making clear decisions about it. Sometimes enactments probably work out real well, um, but sometimes they don't. But it's like, it's not sufficient consciousness awareness about the implications of the interaction.

A third participant uses more experiential language to describe her sense of what an enactment is, feeling something emotional evoked in her body. She describes a few properties that others have suggested – the sense that an affect

belongs to both the client and therapist simultaneously. It makes this therapist feel she is induced to act out somebody's piece, meaning that she is taking on the client's projection and then living it out in the therapy together with that client in some way. This is suggestive of what occurs in projective identification, according to the enactment literature.

> An enactment for me – and this is really where something is evoked from me – I can really feel that front part of my body being pulled. . . . But something goes right into the middle of me and suddenly I am feeling a lot of emotion in my body and it's not mine, but it is mine at the same time. And I am, I'm literally being pulled and colluding with – a lot of this is in retrospect – something that has now come into the room. And I'm saying things or I'm doing things where it feels like – I don't know if this is too vague – I feel like I'm acting out somebody's piece. But it's close enough to my own where there's – and, it's close enough to a therapeutic process where it all gets very confused for a while. And it's usually not until they're gone that I know that I've even been in it.

This same participant goes on to explain how an enactment is like a dovetailing of client and therapist's unconscious parts.

> I think it is a meeting. It's like when I talk to couples, I say, you know, there are unconscious parts that are like a dove tail joint. I say, you know, you come together, and there is all the good stuff. Well, there's also, there is an edge down here that wants healing and . . . I think it is my dove tail joint with them, whether either with the system, or there's something that is both.

*Properties of Enactments*

The other participants were less descriptive in explaining the concept and instead, illustrated what comprises an enactment by its properties: it's an action, a feeling of pressure, the loss of one's ability to think, the stirring up of anxiety and confusion, it's unconscious, a surprise as in "something came over me," or regret as in "I can't believe I just said that." Each participant tended to talk about just one or two qualities, as if they were describing parts of the whole of an enactment. Yet, when taken as a whole, it is easy to see how these qualities fit together and formed a more complete picture: an enactment is experienced in the session as a pressure coming from the couple causing the therapist to lose his ability to think and reflect. This may induce the therapist to act out unconsciously, resulting in countertransference behaviors that cause him to break the frame, lose neutrality, develop misalliances or say and do things he normally would not. The therapist may experience confusion or anxiety as well. The enactment may be a one-time event or ongoing, and would symbolically contain the seeds of the couple's larger problem.

To describe the properties in more detail, I will begin by talking about pressure. Several participants addressed the experience of pressure as something commonly felt preceding and during an enactment. In fact, therapists often experience some sort of pressure throughout couples therapy because there are two individuals continually vying for the therapist's attention and favor. When a therapist feels pressured, it often affects his ability to think clearly during a session. Several participants said they believe this was one of the experiential

conditions that was a precursor to an enactment – therapists may lose their capacity to think and act out instead. Enactments are actions that tend to lack reflection. One therapist was struck by how the pressure she sometimes experiences during her work with couples affects her ability to think and makes her say things she normally would not. As she thought about what constitutes an enactment for her, she asked herself:

> Why am I sort of pressured to be thinking in this particular way? You know, this isn't how I think I would think if I was on my own. . . .You know, the feeling, the pressure of what the feeling is in the room is more than I can process and think about intelligently. And so I have to say what I'm going to say and then go – now why did I say that?! What was I thinking?! How did I get lost there?!

Another participant suggested that sometimes a therapist loses the capacity to think and gets swept along in the therapeutic process.

> Sometimes there are times when the therapist really can't think and they get caught up in something in the process. And they might fight with this person, and you might do something, which upon reflection, you realize that you weren't really thinking, you were just flowing along with the crowd, you could say.

Another participant expresses a similar notion, but includes the idea that something is not being talked about, or reflected upon.

> And then I guess the more sort of concrete way I'd think about an enactment is it is kind of a bit of an action that occurs as opposed to something that's

talked about. You know, some sort of action like extending the hour. An action like – I had this in one of my cases – a couple giving me something to read that they think is going to be helpful, you know. To do that without examining it . . . I think of as an enactment.

The following therapist talks about the pressure that comes from partners pushing and pulling at her. Here, partners are pressuring her to take sides Potentially, this can lead to a loss of therapeutic neutrality and may cause the therapist to say or do certain things that he later regrets.

Uh, there is a pull towards allying with one or allying with the other . . . so there's this fluctuating process of triangulation that goes on. . . . But sometimes the triangulation can get stuck on one particular axis and that's probably what I think would be the grounds for enactments. When there's something going on that is, uh, not allowing the movement to stay fairly fluid, and if it's the therapist doing it, and they do something that at least on the face of it looks like a break in that the sort of neutrality that we think of the couples therapist holding, and then does something that, um, at least on the face of it, looks like not the best therapeutic move, uh, although of course the processing of it afterwards can lead to something useful. But it's the kind of moments when you think, "Oh, I wish I hadn't said that (laughs) or I wish I hadn't done that, or, you know, oh something just came over me." That kind of moment is what you're talking about.

Similarly, the pressure to break the therapeutic frame can result in a countertransference enactment. A few participants mentioned when they find

themselves breaking the frame, a red flag goes up helping them recognize a potential enactment taking place. Again, the operative term here is pressure, the pressure to deviate from the frame.

> So, for example, frame – I like to think about the frame a lot because it provides uh, a consistent way of approaching the work. So when there are pressures to deviate from the frame, break the frame, change the frame in some way, it's an opportunity – it's like a red flag to me about potential countertransference enactments. That's not to say one doesn't do it but, you know, it's a way to monitor that, for example. That's a, that's a kind of a symptom of a countertransference enactment if you will.

Besides the feeling of pressure, the only other affect mentioned as a property of enactments was confusion and anxiety. This participant pointed out that when she feels confusion and anxiety during a session, these signal an enactment may be occurring.

> Where now I have, you know, red alerts going off in me [when an enactment is occurring]. But I don't know, is this, is this my terror? Am I picking up on somebody [else's]? It gets very confused. It's the confusion and the anxiety. Those are the two things that are consistent when there's an enactment that takes place.

Another prominent feature of an enactment mentioned by several of the participants is that enactments tend to be unconscious. The recognition that the therapist has been caught up in an enactment comes in hindsight, after enacting. One therapist called this "not-yet reflection," meaning, that the awareness of the

countertransference comes after the therapist breaks out of the spell. The word "spell" connotes a sense of unconsciousness.

> Yeah, or not-yet reflection. I mean, to me, I think of it as I said before, we are probably doing that [enacting] all the time. We have to be. And then we have more awareness of what we've done and we reflect after it comes to us or we break out of the spell we've been in, or whatever; so, it's all the time in my head.

The unconscious aspect of an enactment makes it the most difficult to handle, according to this same participant; in situations when the therapist is most unconscious of her countertransference the potential for an enactment is high. In the case example, the therapist was aware of her aggression, but unconscious of how impotent she was feeling towards the couple. This caused her to act out.

> I think it's the things [referring to countertransference] you can't be aware of that lead to these [enactments]. See I think if you're aware of it [countertransference], then it's something that consciously can be thought about; then I think it's not – even if it were something [that] got enacted – it's not that big a deal. It's more the unconscious, unknowable things like – I would have to watch my aggression, for example. That's not hard. But what I couldn't know was how do I tolerate feeling impotent? You see, that I think was the harder problem.

Another dimension of enactments concerns it length. Are enactments one time events or are they ongoing? While no participants expressed their views on whether enactments are only one time events, a few participants in the study took

the position that perhaps all countertransference should be considered one ongoing enactment. As one therapist expressed, "But if you believe in transference and countertransference, then all therapy is an enactment. I mean, the whole thing." Another participant echoed her sentiments:

> You know, in order to even know what my countertransference is, there's some way which I'm pulled upon to speak a certain way or think a certain way or not think . . . you know, so that there's an enactment that I think is always happening. And then, so as I started thinking about that, I thought, well, I think there's always kind of enactment that I'm in with a couple if I'm working with them and if I'm really in there.

In conclusion, one participant seemed to suggest the enactments occurring between therapist and couple are symbolic of the larger problem with which the couple is struggling. He thinks this gets linked to the therapist through the process of projective identification as the clients and therapist's vulnerabilities intermesh. Though he does not give much detail as to how this occurs, he alludes to an idea that is current in the literature on enactments.

> I remember the first time I read about enactments. The psychoanalytic literature has changed; they used to view acting out as resistance. And now I think it's very wise and it's more along the object-relations line of viewing an enactment as actually containing the dilemma that you're actually working with. You understand what I'm saying? But, you know, most of the literature I was reading was looking at it from the standpoint of the patient's enactments. But of course, the therapist does the same thing. . . . I think if I

act out with a couple, you know, or an individual, that I'm working with, usually the very seeds of the problem are going be right there in my acting out. . . . This is not coming out of nowhere. . . . And, again, you know I'm probably reacting to the projective identification. It just happens to be one I'm very vulnerable to. And so, in other words, they do A and it's to get a B response and I'm vulnerable to giving a B response under those circumstances.

### *What Happened? Therapists Describe Their Enactments*

A total of twenty three clinical vignettes of enactments were described by the participants in the study, two by each participant, and in some cases three. Some descriptions were richer in clinical detail than others; others were quite brief. While there were many similarities in the kinds of enactments described, there was also quite a variety. In this section I will present five detailed examples of countertransference enactments as well as provide an overview of the kinds of enactments described by participants.

I asked participants to give me a few clinical examples of countertransference enactments, letting them choose the amount of case detail. Some gave me more case background, some less. After providing me with a little background on the case, usually including some case history, the dynamics of the couple relationship and the countertransference issues encountered, participants told their story of the enactment.

In many situations it was actually quite challenging for participants to tease

out their enactment from the ongoing flow of countertransference. Thus, responses to the following types of questions about the various aspects of an enactment were not easy to come by: What exactly was the enactment? Was it expressed in a behavior, a remark, or in an attitude, or all of the above? When did the enactment begin? When did it end? How was it recognized? What exactly was said and done? What was the response from the client? Partly what made answering these types of questions difficult for some was their not knowing exactly what an enactment is. But the other aspect that made it hard was that participants often had difficulty recollecting the specifics of what was actually said and done during the enactment. However, even with this in mind, participants did provide rich clinical examples of times when they got caught up in the countertransference with a couple.

*Patterns of Enactments*

I will first examine a few of the patterns I observed in the twenty-three enactments. One thing that jumps out in the findings is that even though therapists are working with couples, most participants reported that many enactments occurred with just one of the partners rather than with the couple. This is not to say that couple dynamics were not involved because participants talked about three-person dynamics in follow-up questions. Many of the enactments with one partner happened when the therapist became critical or frustrated. There were eight such situations. Often the therapist felt triggered by their difficulty with a partner whom they claimed persistently had one or more of

the following personality qualities: belligerent, narcissistic, passive aggressive, abusive, defensive, blaming, controlling, crazy-making, sadistic, and borderline. The therapist's response in these situations was to become critical or frustrated with that partner.

Closely related to the frustration type of enactment was when the therapist became angry at a client. To make an arbitrary distinction between anger and frustration types of enactments is difficult because these two are usually part of the same affect constellation in every countertransference enactment of this type. I make a distinction because it seemed clear in certain situations a participant mentioned anger as the more dominant response and in another, frustration. Enactments where anger predominated occurred in four different situations. One took place when the therapist angrily challenged a client who had devalued her. Another occurred when a female therapist felt so thwarted by a hostile passive-aggressive husband that she gave him an ultimatum to basically get to work in therapy or leave treatment.

Another type of enactment occurred when a participant felt compelled to take on a role. This happened in three situations. One therapist, in helping a couple resolve a conflict over an affair, felt induced to take on the role of a judge. She felt she had to arbitrate fairness, but ended up taking sides, resulting in a misalliance and an enactment. Another therapist felt he colluded with a couple to take on the role of parent-educator. The couple fought bitterly, finding relief only when they talked to the therapist about their children. The therapist gladly took on this role because he wanted relief from the fighting and tension as well, but

later realized his collusion was a countertransference enactment of avoidance.

One interesting ongoing enactment occurred when a therapist worked with a very chaotic, accusatory couple; each blamed the other, neither listened or confirmed the other partner's reality leading the therapist to continually feel that she never knew the truth of the couple's situation. She felt compelled to become the judge who attempts to seek the truth – get the facts, discover whose version of the story is accurate, decide who is at fault. She felt caught in a countertransference enactment from which she had a hard time extricating herself.

There were several situations in which therapists worked with abusive, sadomasochistic couples. Several participants said it was quite painful to observe partners treating each other abusively, and this led to a few examples of countertransference enactments. It is interesting to note that in most of these situations participants expressed having reactions to the abusive partner rather than to the passive or masochistic partner. When I inquired about this, participants stated that they did think about it in terms of the passive partner, and, in fact, felt drawn to protecting him/her. I will discuss this countertertransference phenomenon in more detail later.

Is an enactment a discrete one-time event or is it ongoing? Participants seem to describe both. There were several situations in which the therapist acted out by saying something in an inappropriate manner, like snapping at a client out of frustration; this seems to fit the enactment as a one-time event, even though the frustration may have been building over several sessions. On the other hand, there are other examples of a therapist getting caught up over a period of time; several

described experiences where they felt the enactment continued over many sessions. In one situation, a therapist felt compelled continually to pursue a wife whom he experienced as impenetrable. He knew he was caught up in an ongoing enactment, but could not stop himself.

Several other interesting things emerged in the findings. Many participants tended to give examples of enactments that were, more or less, successfully worked through with their clients. It was not until I began asking for vignettes of enactments which derailed the therapy that I got a few examples of that. Also interesting, and somewhat puzzling, is that one participant gave me an example from the 1970s which did not seem complex nor intense to be that memorable. He had been dismissive of a woman's initial complaint, downplaying that her husband was alcoholic. As a result the woman/couple quit therapy after three sessions.

*Clinical Vignettes*

I will now present five detailed accounts of enactment stories. I have chosen a wide range of enactments to illustrate the variety in the nature and type of enactments told by participants. In this first description of an enactment, the therapist worked with a couple in which the partners blamed each other for causing the problems in the relationship. Each spouse put constant pressure on the other to change and then attempted to manipulate the therapist into doing the same. Because the therapist was so intent on wanting to please this couple, he got caught up in complying with their pressure, resulting in an enactment.

I guess the enactment in this was . . . there was a lot of pressure, uh, on me to sort of do what they wanted me to do. So, um, the guy at one point said, – sometimes he was subtle about it, sometimes he was not so subtle – he wanted me to get his wife to say, to talk about her feelings and to own her part of the problems. This is what he wanted me to get her to do. And he would do all kinds of [things] – I mean, it was almost like he'd wink at me. . . . He would shake his head in appreciation . . . when I would ask her a question that would be in line with this, um. . . . And really the message was get her to be more vocal about her feelings. So a tremendous amount of pressure from him. . . . They both were trying to show that the other one had problems. . . . And they try to do it sometimes quite subtly and sophisticatedly. So, she thought that he really had problems so she actually read this chapter in this book . . . and she thought this really is him, and she gave me the chapter. . . . And then not only that, but then she also said that she thought it was really important that I speak with his therapist. And first he didn't like that but then, um, you know, she pursued it and she said, you know, we want things to go faster here and it could only help; it can't hurt. So, now, with all this, there was kind of a, I call it, I guess I call it an enactment. I mean, there are a lot of enactments in this things with this couple, because in a way, I was like just getting kind of carried along, you know.

The following enactment occurred during a very destructive session; the therapist felt he did not sufficiently protect an emotionally fragile wife from the

wrath of her husband. The wife was depressed and abusing alcohol. For various reasons, she was furious at her husband, and for months on end, while abusing alcohol, the wife vented her rage at him during the sessions; the husband tried his best to absorb it. Finally, after taking anti-depressants, the wife stabilized and said she was able to listen to her husband's view of things. The husband expressed his pent up anger at his wife. The therapist, thinking that it was important for the wife to hear her husband's hurt and anger, allowed the husband to vent and left the wife unprotected for the entire session. However, he had not taken into account her fragility, and this is where he felt his enactment occurred.

> She was just spewing poison and she was out of control. . . . During the time that she was spewing and so forth, I was doing a lot of intervening, re-framing, restating things to try to take the poison out of them, you know. Trying to talk about her pain so he could understand her pain more. Trying to help her to understand his pain, which she really couldn't have cared less about for a long time. When she got on the anti-depressant, she was able to be more empathic, um. . . . He, you know, felt more of a need to surface what he had viewed as very pathological about her and needed to confront her on this, you know, which, generally I thought was, needed to happen. Um, and this is where the enactment comes in, during a session when he was – and she encouraged him – she wanted to hear about his hurt and what she had done and so forth. . . . I didn't think that he was over the top in what he was expressing to her, um, and I think here's where I see the enactment actually. I felt that she had been unbelievably abusive of this guy for months, and he had

sort of taken the battering, you know, and been pretty understanding and so forth with not much room for his affect. He sort of had taken care of her when she was passing out and non-functional . . . so I felt like, you know, there needed to be a little more of a balance in this. So uh, what happened was, in a particular session, when he was confronting her about this, and he was clearly angry, you know, rage was really coming out of him and there were several times during that that she looked over at me like, you know, almost to say isn't he crazy, or isn't he being inappropriate or something like that? And I did not stop him. And looking back on it, I should have stopped it; I should have uh, toned it down more. But I, I didn't and, where I made a therapeutic error was I was not really remembering or honoring her fragility like I should have. But she left, and she wouldn't come back.

One participant talked about how enactments can occur on more subtle levels and do not always necessarily involve some kind of actual acting out by the therapist; rather, negative countertransference can influence one's attitude towards the client and impact treatment. In this case, the therapist worked with a couple in which the wife treated a passive husband abusively. The therapist found the wife's hurtful and destructive behavior so repugnant that she was unable to be empathic; she felt her empathic failure was her enactment.

It was a heterosexual couple and that I felt that the woman's, um, way that she spoke in an unreflected way was so hurtful and destructive that out of a sense of protectiveness toward the man in the case, um, I really was struggling to

> fully enter her subjective experience. Because . . . I felt that I just couldn't. And, you know, working with people, I'm used to people saying really hard things. I'm fine with people screaming at each other if they have to. But this was abusive. And so that was a situation where I just, . . . where I felt like I just did not succeed at entering her experience enough for her to feel like I was aligned with her. Because I just felt like every time I tried to do that, I left him exposed to abuse.

The therapist goes on to talk about how she could not experience her usual sense of expansiveness, and the wife picked up on it.

> Um, but I couldn't find my way to it [a feeling of expansiveness] because it felt so, you know, undermining and abusive with this person; I wasn't expansive in that way. I, I think my aversion leaked out. You know, again, it was subtle but I'm sure energetically she picked up on something.

The wife became increasingly angry towards the husband, feeling duped by the husband's lies and angry that therapist had not caught it.

> I wasn't able to convince her that she had not been duped, um. And I think, partly 'cause . . . I wasn't able to align with her experience of being duped enough for her to get settled and probably because on some level I was feeling accused too completely unfairly. And it was hard to align with her when I was feeling . . . some of what would come to him toward me, and she, kind of in an uproar, stopped [therapy].

In one of the more unusual enactments described, the therapist acted out his countertransference through an interpretation. The therapist had just begun

working with a couple and had an immediate negative countertransference to them because they bore striking similarities to another couple who had just bolted from therapy.

> I had a couple that was referred to me. It was almost identical to another couple I saw in which they were both actively acting out. I found [them] to be unpleasant and unproductive . . . and I couldn't make any headway with them . . . and they quit. Uh, and so when I got this new couple and the guy was acting the same way, uh, it evoked this feeling that I didn't like him. . . . And I was actually doubtful that I could help them . . . 'cause drugs and alcohol were involved, uh, and I was having a hard time connecting with him. And I unconsciously acted something out; that is, I made an interpretation, although was accurate, uh, he experienced as disloyalty to his father. His father was very sadistic, and when the kid was in high school, he – I can't remember what he did, something the father didn't like – the father punched him. . . . I just said – I was trying to be empathic, but I might have had another agenda here – I said to him that – and he was presenting a belief that he deserved it – and I said, no one deserves that. You know, children come to think that they deserve everything they get. There is no justification for this. And he never came back.

In the cancellation message, it was revealed that the man viewed the therapist's intervention as an attack on his father. In retrospect, the therapist realized his unconscious countertransference enactment was expressed through the interpretation forcing the husband to choose between his loyalty to his father

and the therapist. The therapist also realized that he did not really want to see this couple and that in making this man choose, the therapist somehow knew the man would choose to be loyal to his father and terminate the treatment. As the therapist put it,

> And I was making him choose this stance to be loyal to me or to his father 'cause I couldn't stand his not connecting [to me]. And I knew . . . this is going to be just like this other couple . . . and I don't feel bad about not continuing with them.

Perhaps the strongest emotional reaction from an enactment of those I encountered was reported by a therapist who worked with a couple who appeared extremely sweet to each other. The partners spoke in kind, muted tones and hardly had anything negative to say to each other even when discussing a problem. After awhile, the therapist remarked that there seemed to be little room for anger in their relationship, an idea the wife, at first, completely agreed with. However, after briefly exploring this, the therapist again felt that the couple tried to bypass all the angry, messy feelings involved in such a discussion, and this is where the countertransference enactment occurred. In the next session, the therapist locked horns with the wife in a power struggle over whether the couple was in denial about their anger. As the enactment unfolded, the therapist became quite upset and agitated, as did the wife. Later, the therapist remarked that she felt she became the receptacle for all the anger in the relationship and felt "dumped on" by the couple.

> And then the next week . . . the woman went, oh, I've just been thinking about

this and I think you're absolutely right on [about the anger]. . . . And they were sort of kind of exploring the idea literally and then at the very end, there was something about – and I'm making this very vague – there was a leap to jumping over all the intensity of those feelings to, you know, kind of like the rainbow kind of thing – happy ending, flight to health, yada, yada. And so I just noted it and I said, you know, I think that's kind of a leap to go all the way here without ever having to get messy, to get upset, to really express some of these deeper upsetting feelings. Well, the next week they came in and um, she took issue with me about this particular thing that I had said and she was very upset about it. And I was like – the feeling that I got was I was sitting here and suddenly my stomach had just blown up. . . . And we got into this unbelievable power struggle about what I had meant by what I said. It started off very intellectual, but there was this, this split between discussing it intellectually and what was her obvious charged nature and what was going on in my body (laughs). I was like going, whoa! Whoa! And my anxiety came in. I was, I was angry! I was terrified! I was, I was, I was really, really charged! And the back of my mind is going, Get a grip! Get a grip! And I just remember – and then I kept checking in with her partner saying, well what is it like for you to see us engaged like this? And he'd go, oh I think she's doing a wonderful job. Ok. I think she's just great. And . . . I went twenty minutes over and didn't know it. I had never done that, but it was so intense. And they left and I went almost into a hysteria, and I was like (gasps) – it was really on that energetic level of really, primitive rage –

> borderline characteristics or whatever you want to say. But I just got loaded. And I didn't know what to do with myself. This was my last client of the night. I didn't sleep that night. Poison, you know, like I was having to like digest and eliminate.

Even in the retelling of this enactment, this participant was full of feeling, demonstrating how emotionally charged this experience was for her.

### *How Therapists Recognized That an Enactment Occurred*

In this section, I will examine how therapists recognized that an enactment has occurred and will organize it into three sub-categories: Distinguishing Enactments From Other Countertransference Phenomena, Learning About the Occurrence From the Client, and Clues From Self-Reflection.

#### *Distinguishing Enactments From Other Countertransference Phenomena*

It can be difficult to recognize that an enactment is happening or has occurred. Some participants noted they felt confused about how to determine when countertransference becomes an enactment, because that line is often blurred. Others speak of clues coming directly from the client or from self-reflection. One participant had not realized he was caught in an enactment until he reviewed his case with his consultant by telephone. "It was actually a consultation I had with one of the people in London. I was talking about the case and she helped me see that [I was caught in an enactment]." The following participant speaks to this issue; she conveys the sense that each session contains

countless moments where she struggles with some bias or concern, and distinguishing an enactment from countertransference is a challenge.

> Trying to figure out what enactments are is not such a straightforward thing, from my point of view. Um, it seems like it's a label that we have to try to identify something, that from my point of view, is way more complex. And that really, uh, we're never reacting to anyone we see except through the lens of our own experience and our own biases and our own expectations. And so, it actually isn't so simple for me to come up with, you know, straightforward – something I could think of as a straightforward enactment. I mean, I could think of – there are moments in every session with a couple where I am struggling with some bias, concern, that I'm aware of. And then of course there are millions of moments where I'm not even aware of them, you know. So it's not actually such a simple [thing] for me.

Another participant expressed similar sentiments; while discussing a case, she became confused about when her countertransference should be considered an enactment or not.

> So, um, how can I say, . . . is this an enactment and I'm caught up in something that she's experiencing with him? You know, I think this is where the concept – either I don't understand it fully enough or it's where its edges are blurry in terms of I was having my own reactions to him but it also paralleled her reactions to him and that he had had, out of the five years of marriage, two and a half years worth of affairs with two different people, um. And so, you know, it, it's just all in the field and, and it's hard to say where it

all comes from.

Or, as mentioned in a previous section, some participants think that all counter-transference is an enactment; so, in fact, there is nothing to distinguish.

*Learning About the Occurrence From the Client*

One of the ways therapists gain the awareness that an enactment has occurred is directly through the client. Participants reported that many of the enactments that had occurred came to their attention when one or both members of the couple had a strong emotional reaction (for example hurt or anger) to something the therapist said. Often, there was a disruption to the therapeutic alliance. In some instances, the therapist may not have even been aware that he or she was upsetting the client, and the therapist was surprised to find out that the client felt wounded.

In one case, the therapist became aware of her enactment when the client became upset with the therapist for making an accusatory, shaming remark to her. The therapist had been unaware her remark had been taken in such a manner until the client reacted. The therapist was working with a couple where the wife previously had an affair and was now developing a close friendship with a man at work. Although her husband felt threatened, the wife claimed she had a right to her friendship. The therapist felt protective towards the husband and challenged the wife, saying she believed there could be potential pitfalls in this new work relationship.

And I did say something along that line [confronting wife about the affair] and the, the woman became really angry with me and said she felt like that

was a shaming kind of remark. That I was shaming her for having had an affair.

The therapist was somewhat surprised at the wife's strong reaction because she did not think she had been overly challenging or shaming. She realized after the fact that there had been probably more of a charge in her countertransference toward the wife than she originally thought.

Another participant had not recognized her enactment until the following week when the wife came in quite upset with her. In the previous session, without realizing it, the therapist had given the husband an ultimatum; she told him something to the effect: either get to work in therapy, or don't come anymore. Of course, the therapist thought she said that more tactfully, but she was clearly irritated with him. However, it was the wife who got upset, not the husband.

> And the next time we met, the wife came in and said that she was pretty upset with me, that she felt like I had – was firing them as clients, basically, you know. And I felt irritated. But I realized I had kind of given him an ultimatum. It was sort of saying like, look it, you're not really doing work; I don't see how this is going to help. Like, how is this really going to change? You can sit here and do this but I don't see how this is going to get us anywhere. But she was upset and I was a little bit surprised.

*Clues From Self-Reflection*

Therapists also became aware of countertransference enactments by becoming self-reflective, recognizing any feelings or behaviors that seem to be out

of the ordinary. Several participants mentioned they pay attention to a number of various clues such as when they break in the frame, become defensive, lose neutrality, etc., and that these alert them that something is going on in their countertransference. Here, the therapist discusses how he looks for clues in his atypical behaviors and thoughts.

> One of the ways I notice it, I think, one of the big tip-offs is when I feel I'm more focused or more aligned on one person as compared to the other; why am I so caught up in this with this one person? . . . If I'm doing something or thinking a particular way that is a little unusual for me . . . and then I act on that, I think of that as an enactment. So, if I extend [the session] – I'm usually pretty punctual. If I spend an inordinate amount of attention on one person, you know; if I tell something sort of chatty and personal, I would be thinking about that. If I do something different, uh, from my ordinary way of working.

A few participants begin noticing their own defensiveness as a signal that an enactment may be occurring. One says, "And usually I only get it by recognizing how defensive I'm being – that there's something under that." Another recognizes that she is slipping into what she calls pressured explaining.

> Well, the strength of the reaction and my own feeling like you're trying to state your case; you're trying to, you know, clinically explain this to her and it's not hitting anywhere. Oh, yeah. I'm the clinician and this is why I did that and I'm not gonna let you be, you know, da da da da. This is why. You know, it's the thing of whenever I hear myself explaining the way that I was; I

> mean, that I was on the top layer of a deeper process. Does that make sense? Yeah, I've got physical cues. . . . Um, I get body sensation. It's like, uh oh. And when I go to certain ways of explaining – pressured explaining – that's what it feels like, you know.

Sometimes, it is not until a session is over and therapists have time to assess how badly they feel that indicates an enactment just occurred in the session. This happened to the following therapist, and she was able to put a humorous spin on it.

> So it all was clinically very sound, but it felt so bad. Again, it was that thing and it feels so bad. And they [the couple] left and I just went (laughs) this is what I always know; I always know when something's up 'cause I go, I don't want to be a therapist anymore (laughs). I'm going to go to Boise, Idaho and buy a little farm and be a waitress in a truck stop and, you know, and grow bananas.

Of course, most therapists pay attention to both the clients' reactions and their countertransference, using clues from each to help them determine whether an enactment is occurring.

### *How Therapists Analyzed the Enactment: Attempts to Understand Why the Enactment Occurred*

Once becoming aware of the enactment, therapists begin a process of exploring why it occurred. This entails the therapists' efforts to understand their own triggers, conflicts, and vulnerabilities as well as their conceptualizations

about the case. As therapists go back and forth between attempting to understand what is going on with the couple and then using that information as a way to highlight something in their own countertransference, they develop a deeper comprehension about why the enactment occurred. Of course, such an understanding is never-ending, and this was evident in the interviews; participants seemed to come up with fresh insights about their situation as they explored it with me in the interviews, showing that the understanding of a case and oneself is a continuous unfolding process. In this section I will discuss how the participants analyzed the enactments; this includes an examination of their countertransference triggers as well as a conceptualization of the case dynamics. It will be divided into two subcategories: Therapists' Analysis of Their Countertransference Triggers, and Therapists' Conceptualizing Case Dynamics.

*Therapists' Analysis of Their Countertransference Triggers*

A therapist's analysis of what was activated in their countertransference during their therapy with a couple is not only a crucial step in understanding why the enactment occurred, it is the crux of the matter. There are perhaps many ways to organize the data in this section, but I chose to organize it by countertransference themes, first looking at the various affect constellations that seemed to be common before and during enactment sequences. These include frustration and anger, ineffectiveness and helplessness, dread and anxiety. Of course, the categorization into affect themes is arbitrary and is done for the sake of making comparisons. In reality, most, if not all, of these different feeling states

may be present during an enactment. I am presenting the idea that when participants talked about their countertransference, a certain constellation of affects seemed to predominate during an enactment. Thus, for example, anger may be the most predominant affect identified by a therapist during an enactment, but certainly anxiety or helplessness or a range of other feelings may be present as well. I will also examine countertransference themes of the therapists' Achilles heel, three-person dynamics, and lastly, I will look at the therapists' feelings about the enactment itself. This, too, is part of the countertransference constellation.

In addition to these themes, participants also identified the feeling of pressure as a countertransference experience preceding an enactment. This was mentioned by a few therapists directly and certainly implied by others. Since there was not quite enough data in the findings, I will not discuss this as a separate subcategory, but will talk about it in the last chapter. However, the feeling of pressure is perhaps evident by implication in most of the accounts. For example, when a therapist is frustrated and angry, or filled with dread towards a client, there may be a feeling of tension or pressure in the session. Or, when the therapist is feeling ineffective, he may feel pressure to do a better job.

*Frustrated and angry.* One common countertransference theme occurred when the therapist became frustrated or angry with one or both members of the couple. Participants reported that frustration and anger, in most situations, occurred with only one of the partners with whom the therapist had difficulty, rather than the couple as a whole. Several spoke of instances where they could

feel tensions or frustrations building, finally culminating in an enactment. Frustration and anger can be provoked in a variety of situations, such as power struggles, sadomasochistic couples, or dealing with a difficult partner (passive-aggressive, hostile, thwarting, critical, narcissistic, etc.). Of course, these are but a few of the situations evoking frustration and anger. In the following example, the therapist had been working with a couple in which the husband tended to be critical and belligerent; his wife had long grown weary of it and wanted him to change. The therapist had been making slow but steady progress with the husband on this issue. Towards the end of one session, the husband suddenly reverted back to his angry self, and the therapist lost patience and snapped at him.

> I think I just got frustrated beyond the point of tolerance, like – and I think it's partly because I had seen him do that over and over and over again and, um, and I think – I don't know, I just felt like I had worked so hard and so carefully in that session to get to this point and then he just bluuuuuah, you know, sort of annihilated it by his reaction that I was mad at him for doing that. And I think it just came out spontaneously that way.

In another situation, the therapist worked with a couple in which the wife felt the therapist criticized her. The therapist was frustrated with the wife because she experienced the wife as repeatedly thwarting and not listening to her. The therapist's criticism of the wife almost led the wife to quit therapy.

> Yeah, I was feeling kind of critical. I mean, I was feeling critical of her and also feeling this is what the problem is. I think I was feeling frustrated with her, probably. . . . I know I thought I don't know what I could say to you here

> or how can I do this work if you're not listening to me. Um, is that critical, I'm not sure. But, yeah, I was feeling I wasn't being listened to. That's true. She couldn't hear that I was trying.

There seemed to be a difference between those situations when participants experienced frustration toward a client and those when they experienced anger. Though the line at times blurs, participants seemed to have much more intensity when they talked about their anger. For example, one therapist was working with a couple in which she experienced the husband as extremely provocative; she described him as shut down and hostile in a passive-aggressive way to both the wife and her. A typical interaction between the partners involved the wife talking for awhile about her experience in the relationship. Then, the therapist turned to the husband and asked him what he thought about what the wife said, and the husband would give a sparse reply. And this would occur repeatedly. Increasingly, the therapist started having strong negative reactions to the husband until she finally acted out by giving him an ultimatum to either to work on himself or quit therapy. Here, the therapist talks about her countertransference.

> Because he's extremely provocative, I mean, there's no way I can't not fall for the provocation, like I would have to be Mother Theresa or something (laughs) I think to not bite. . . . Oh, I just was pissed. I think at that point I was so feeling provoked by him that he could just shut me down. It was kind of like, well, if you're not going to talk to me then get out of my office, you know. . . . I mean really, it's so rejecting the way he responds, and it's so dismissive. Maybe that's it. It's just so incredibly dismissive. . . . I just want

to kill this guy! You know, he was just driving me wild.

The following example illustrates how the therapist's anger can be played out by the couple. In this enactment (previously described) the therapist said he had allowed the husband to vent his anger towards his wife who was emotionally fragile. In trying to understand why he allowed this to happen, the therapist said, at first, it was a therapeutic decision. But as he more fully explored his countertransference and reflected on his own history, he began recognizing parallels between the couple and his parents.

> And I think, you know, if we want to take it into the countertransference thing, my own thought was, um, if we take it way down deep, there could have been some of me feeling like she [the wife] deserved to get blasted some because she had been so abusive of this guy, you know. Uh, I think when she was beating him up . . . her attacks on him had more sort of venomous irrationality. And uh, if we take it way further down, I think, you know, that my mother would be abusive, you know, verbally to my dad and so forth, and he wouldn't fight back; he wouldn't stand up, so, I think some of that was there. . . . I think the part of it that I do think was an enactment was it did fit my own history to some degree with my mom and my dad. And I think I, I was more empathic with him than I was with her around this, you know.

One therapist talks about how difficult it is to work with anger in sadomasochistic relationships. She states that the therapist is usually forced to manage the rage between the partners, and in so doing, is provoked to anger as

well; either the therapist feels pulled to attack the sadistic partner for cruelty or gets upset with the masochistic partner for not fighting back. Here is her description of how painful and aggravating it is to witness such dynamics.

> What I'm aware of has to do with kind of sadomasochistic kind of relating. And I don't mean the sexual act of it but I mean in terms of [the anger]. It's very hard, I think, in the countertransference not to get – relate on those terms. To either relate masochistically or sadistically. Very, very challenging. And um, so one of the cases I'm thinking of I've seen for quite a long time and um, it's difficult to not take up an attack on the person who's doing the attacking, for one, right. To attack her for attacking him or to not attack him for him masochistically allowing this and offering himself up. In other words, there's a kind of aggression and rage that I think um, I'm being forced to manage either because something's being split off into me or frankly, it's not easy to witness this. It's very, very, very uncomfortable. And I'd, you know, personally, rather listen to people talk about very intimate sexual material than this. This is far more uncomfortable. It's very painful.

The therapist goes on to describe a case in which she ended up acting out by attacking the husband. In this enactment, the wife and husband had a sadomasochistic pattern of relating. The wife was sadistic, devaluing, and castrating towards the husband while the husband masochistically allowed the abuse. The therapist claimed she worked for a long period of time trying to interpret the dynamics of the relationship to the couple, but increasingly became frustrated with the couple when she did not feel she was making any headway.

So, in one session, out of frustration, the therapist blurted out to the husband:

> And then one day, out of just complete and utter frustration, I said, why do you take this!? Why do you put up with this!? . . . I think that I felt that she was uh, being disrespectful to the treatment and to me, really. And so I went on the attack of him. That's how I now understand it. Yeah, because she was – we had talked about, you know, appropriate boundaries and what this means when she treats him so disrespectfully with her lover and she came in and flaunted this yet again I thought in a really hostile, aggressive way . . . . But I think in retrospect, I felt she was not just being disrespectful to him and trying to humiliate him but she was trying to do that to me and to the work. So I think that's why I reacted. But instead of reacting toward her aggressively, I then – and, and this is why I think it's a countertransference enactment – I enacted the very thing that they do in their dynamics – I went and attacked him. And I went and attacked him in the name of protecting him, which is really incredibly sadistic, you know. . . . It was me, it was me acting, um, out of desperation.

*Ineffectiveness and helplessness.* Another common countertransference theme presented by participants were feelings of helplessness and ineffectiveness. Several participants talked about the importance of feeling effective as a therapist, yet mentioned that couples therapy provides ample opportunity to feel ineffective and helpless. When this feeling is provoked, some therapists become paralyzed, others respond by taking action. In this case, the therapist may feel a pressure to

perform more effectively, which can be even more strongly activated if clients complain that therapy is going nowhere or that sessions are a waste of time. This may lead the therapist to want to overdo it by becoming too active; they may tend to problem-solve, give advice, or over control the session. For example, the following participant felt pulled to take control of the sessions in order to counteract feelings of helplessness. The couple with whom he was working often fought intensely in sessions and then complained that the sessions were a waste of time. The therapist felt a pressure to do more for the couple and, as a result, he tightly controlled how things went in the session. Here, he discusses how the couple's fighting triggered him.

> You know, it triggers in me a few things, um. One will be a feeling of helplessness, a feeling also of I'm not providing enough for them. . . . And feeling pressure from them in various points in time over saying how those kinds of sessions they find, uh, unhelpful. So I can feel the anxiety, am I going to be helpful enough? But also, I get placed in the position of um, of regulating them, you know, their own difficulty in regulating themselves. But I think I do feel like I take that on a bit. You know, am I going to be able to say the right things, to do the right things, so that they will be regulated better and therefore not feel so destroyed by something out of the session, I guess. So I feel sometimes a pressure to do that for them. . . . I can feel very pulled to be very much more – really controlling of the session and guiding and trying to make sure that I stop any uh, particular explosions from occurring. For another therapist, it was a feeling of being rendered impotent to stop a

sadomasochistic way of relating that provoked a countertransference enactment. As mentioned in the previous section, she worked with a sadistic wife and masochistic husband and acted out by getting frustrated with the husband, exclaiming, "why do you put up with this?!" Although she also felt frustrated and devalued, the therapist said what pushed her over the edge to act out was being made to feel impotent; the therapist's attempt to counteract feeling impotent led to the enactment.

> I think the main aspect that was hard for me was witnessing it [the abusive behavior]. I felt like I was rendered impotent to not be able to stop it, you see. And that I think, that was what was the main part of it that was hard. I think as therapists we really like to be effective and I think that's – he was rendered impotent and I think I felt that [as well] – and I think that's a hard thing to sit with. . . . And I think when you feel impotent, you tend to, you know, it's an uncomfortable feeling to have and, particularly if you're unconscious of it, then it can lead to an enactment. [It leads to] trying to take control or take charge.

While most therapists tend to swing in the direction of trying too hard to be effective to compensate for feeling ineffectual, sometimes this feeling can lead a therapist to wanting to give up and stop trying. The following therapist worked with partners who discounted and devalued almost everything they said to each other. As a result, the therapist found it extremely difficult to get clarity on what was truly happening between them; facts about their reality became easily twisted and distorted. The therapist felt it was crazy-making to work with them. Here,

she describes a sense of feeling completely ineffectual with this couple which led to a "breakdown feeling."

> The feeling of like that breakdown feeling – the last session I had with them, or maybe it was the one before, I remember reaching a point . . . like I can't, I don't fucking care anymore! They just can do this forever! [referring to their crazy-making ways of discounting each other]. And I'm so ineffective here. Like it doesn't matter what I say or what I do. And I literally just had this feeling of kind of just wanting to just kind of melt in the chair. I just give up; I can't care anymore; I can't try anymore. I'm done thinking about you.

A variant on the theme of wanting to be an effective therapist is the wish to please and impress a couple. The therapist here did not get pulled into an enactment out of feeling helpless, but out of a desire to be to impress the couple. He worried if he did not do a good job, he would be fired. In addition, he liked them and wanted to be liked by them. As a result, he was induced into an enactment, doing what they each asked of him.

> This was a couple that I kind of, um, related to and liked. This guy . . . he's very interested in psychology and, you know, he's sort of, I mean in a way, he seduced me. He seduced me and then let me have it. It was an unusual situation for me. So I think that with this couple I just felt a kind of a . . . not an identification but a connection to them and a liking of them. I wanted to do right by them. I wanted to be really helpful . . . and I wanted to be smart . . . and I had something to offer. . . . But I think that early, uh, my early contact with them really, you know, sort of set the stage for my being more

caught up in trying to be smart and be helpful. . . . I think the countertransference there is also very useful. I think that my feeling was if I don't produce, they'll dump me.

*Dread and anxiety.* Working with very difficult couples brought up intense anxiety and the feeling of dread in a few participants; there were several examples of enactments where this affect was prominent. While other feeling states such as frustration, irritation, ineffectiveness, and a sense of overwhelm were active as well, an overriding sense of dread and anxiety predominated. The kind of couple that elicited this kind of reaction tended to be intense and chaotic in their interactions, often overwhelming the therapist's ability to track them. In one example, the therapist found both partners obnoxious and disliked them. She said their fighting was so out of control she could not find any way to manage it, and this was unusual for her. As a result, she claimed this induced her to enact the role of a strict overbearing parent chastising her misbehaving children. She dreaded the sessions.

I did as much as I could with them, but I just found them obnoxious. I didn't like either one of them. I, um, I tried hard to really –he was very – talk about demeaning. He's very demeaning and belittling. What was just hard was the fighting, fighting, fighting. The chaos – the not really caring about anybody enough to get into a plan. And maybe it was – my father was a drinker, um; he was very macho in the way this guy was. My mother was not borderline; uh, she was schizoid. But, you know, the fighting and – that's hard for me to

be around a lot of. I usually can get the system under some control, but this, I could not get it under control. We'd made progress and they'd undo it hugely. And their system was chaotic. They were a difficult couple for me. I didn't really want to be around them. I dreaded each session.

Couples stuck in blaming each other also seemed to stir up a lot of counter-transference, especially when there seems little the therapist can do to change the pattern. The following participant talks about how abusive and accusatory this couple was, leaving him with a sense of dread and trepidation every time he saw them. It is not mentioned here, but he ended up in an enactment with the husband with whom he had a power struggle.

Both of them had super egos that would scare the shit out of you. Just horrible. Moralistic, um, accusatory, blaming, the whole thing. And I think the way that they connected was they both saw the abusiveness that both of them had endured. Most of the work that I did with them was to try, uh, to get at that poisonous critic inside both of them. . . . And um, let's see, the countertransference stuff – I kind of dreaded working with these people. You know, when they were out in the waiting room, I knew it was gonna be hell to pay, you know (laughs). And it's the kind of case that actually I felt really badly, but I was glad when they canceled sometimes 'cause I knew it was just gonna be a knock-down, drag-out, autonomic upheaval, you know. Oh, this is important, she would be threatening physically, particularly toward him, but uh, it was coming my way a couple of times. . . . Well actually I think the enactment – I don't think I acted it out. It was more an internal kind of thing,

you know, in terms of just my trepidation and my uh, sense of threat working with them. . . . The anxiety was that he was going to get more uh, aggressive toward me or sue me for some irrational thing or something like that.

In the following situation, the therapist worked with a couple who stirred up a sense of profoundly deep anxiety. The partners constantly discounted each other's experience which made for a very crazy-making experience for the therapist; she could never get a handle on what was really going on. They never reached any consensus, and this created a deep anxiety in her. The therapist goes on to talk about how she tried to defend against this anxiety; she tried to sort things out, get the facts, find the truth. She felt this fact-finding mission was her enactment.

I think really at the most honest level there's a deep anxiety about no consensus, you know, that nobody can acknowledge that what the other person is saying is true at all. And I think if I really were to drop into what that creates in me, it creates a feeling of psychosis. You know, what's real, and what's up, what's down, who do I trust, what can I believe, you know? And I think in defense against allowing that to live inside me a little more and sit with that countertransference, I'm defending against it by, I'm going to sort this out; I'm going to get to something solid and provable and we can all rally around. . . . My mind doesn't know it's true and doesn't know what to trust and what to believe in so you hang on really tightly to your story, you know, 'cause I've organized it; it gives you some sense that you've got solid ground under your feet.

*The therapist's Achilles heel.* Another way to analyze countertransference triggers that evoke enactments is to examine the therapists' Achilles heel. I use this phrase because several participants mentioned that there were types of individuals or couples who were most challenging. It was as if the therapists had an Achilles heel that made them more vulnerable to being triggered by a certain type of personality or by a particular emotional conflict. The conflict could be conscious or unconscious. As this therapist suggests, when the therapist's vulnerability coincides with the clients' vulnerability in some way, it may mobilize both individual's defenses and eventually lead to an enactment. Here, she is refers to a case in which she felt devalued by the wife.

> So I think that I was also reacting narcissistically [vulnerable] in the countertransference that she's devaluing me, that she's treating me disrespectfully; she's doing this to the treatment. . . . You know, you want to say it's true, and it is true, I think. But, also I think what I'm trying to get at is that it's in sync with the vulnerability – that there has to be a way in, in the therapist, if you understand what I mean. So, part of the countertransference enactment is that it mobilizes, I think, defenses that are coinciding with the defenses of the treatment – narcissistic vulnerabilities, right? Like she should be treating me more respectfully.

One participant expressed she had a particular difficulty when a partner exhibits either degrading or crazy-making behaviors and attitudes; this tended to trigger her more than other kinds of negative behaviors. She worked with a

couple in which the husband was controlling, critical, and crazy-making. He was crazy-making in the sense he would always turn things around so that every problem in the relationship was caused by his wife; he would not take ownership for his contribution. Everything was her fault. The therapist had such a strong dislike of this man it affected how she treated him.

> He would be controlling about things about how she was in the world and she would complain about it, and rather than in any way owning that sometimes he could be critical or particular, he would turn it around and make it about her lack of self-confidence. Oh, so you can't hear feedback? I mean, you don't have enough confidence to hear feedback? . . . I felt like the man was particularly destructive in the way and hurtful in the way that he responded to his wife, um. And, at first I had a really hard time liking the guy, you know. He was very, uh, self involved and had a very hard time owning his own contribution to the problem and was a little crazy-making. Like I said before, crazy-making bothers me. And there was no direct way to say [to him] this is crazy-making what you're saying 'cause he was totally attuned to anything critical I might say to him. . . . Um, so, I was really struggling with how to align with him and see something about his experience in all of this because I was so averse to the crazy-making and very kind of controlling dynamic that was going on. . . . And the way I talk to myself about it was that one thing that really was hard for me was just from a purely feminist point of view. Like all the feminist bones in my body were just like rattling because he was so unconscious of the um, his use of a kind of bullying, um, you know, that

> crazy-making and controlling of what his wife could do in the world. But, um, I think it's the thing I said before, where one person's passive and the other person is either degrading or crazy-making, those two things seem to hook me more.

One participant claimed she especially got triggered when thwarted by a client. In fact, she brought up two case vignettes of enactments in which this countertransference was activated. In one case, the therapist worked with a wife whom she experienced as narcissistic. In one session, the wife said something to the therapist which the therapist experienced as extremely personally devaluing; the therapist felt thwarted and put down. The therapist responded by acting in a challenging manner towards the wife. The therapist realized she was triggered and could not seem to stop herself from treating the wife in this way. Eventually, the wife terminated therapy.

> I think I felt chastened and red-faced about it in a certain way and it was maybe a part of me that didn't want to be, um, dominated by her. . . . I just think there was something about her narcissism that was a trigger for me. I, I don't remember what I came to. I know I thought about it a lot afterwards. . . . She triggered something in me, um, maybe again, maybe I have a personal, um, issue around being thwarted or blocked by another person 'cause that would be comparable to the case I was just telling you about. I would, but more than that, I was being discredited; I was being told I had no right to say something and all I can imagine is that I was then proving that I had the right to say it. Or something like that. I mean, something very

> childish, . . . but at some level like, you're not going to shut me up, or some really childish kind of thing. That's all I can imagine. Is that she went somewhere in me. It wasn't therapeutic; I didn't handle it therapeutically.

The following therapist refers to the notion of the therapist's Achilles heel as her "greased path;" she views it as that behavior in her which, when activated, is like the line of least resistance. When her vulnerability is triggered, her greased path is to take action and problem solve for the client, especially in couples work.

> My greased path when I get scared or . . . get pulled a lot is to do something about this. Now, in individual [therapy], I get it a lot, you know, and I can sit back with it more, and it's like, whoa, you [the client] really want me to fix this, don't you? . . . But, with the couples, because there is that aspect of we're supposed to be working on this relationship, one of the big questions is, what is working? And, and how do I come into it, you know, as a facilitator, therapist, whatever; we're going to do something about this, we're going to fix this now, you know; this is what's gotta change. I kind of think of it as like a greased path. . . . So, going, taking charge and, you know, kind of calling the shots . . . I can do and I picked it right up and did it.

The same therapist then discusses a case in which her greased path got activated with the wife, resulting in an enactment. In the case, the wife had for some time yearned for closeness from the husband, but when a tender moment arose, the wife pulled away instead of reaching out for the husband. The therapist's "greased path" got activated, and she ended up overriding the wife's need to withdraw and instead pushed her to be intimate. The wife felt impinged

upon and shut down.

> Instead of going, wow, . . . you're really feeling this right now, [and] being with the feeling, being with her and being with the vulnerability and listening to her, [and] her saying no, don't, I overrode her. . . . What I felt I did was I really picked up her ball and said, no, we're gonna, we're gonna, we're gonna change this right now! . . . And I'm sitting here goin' no, we're comin' in, we're comin in! You know, so that's where, you know, I can look at it and go, oh boy, yeah, that's what I did, that's what I did. . . . But there's always, you know, my greased places, they come in, 'cause there I am, wherever I go.

*Three-person dynamics.* Another way to examine countertransference themes underlying enactments in couples therapy is perhaps the most obvious – three-person dynamics. Three-person dynamics plays an important role in activating the therapist's countertransference. However, it was interesting that many participants often did not begin discussing their countertransference by talking about the triangular dynamics in the case. Rather, most therapists first talked about their struggles with the most difficult partner. It was often not until I asked if there was something about the way the couple dynamics played out among the threesome that participants then responded affirmatively. At that point, participants willingly shared their astute observations.

A few participants discussed triangular dynamics in terms of collusion. In couples therapy, collusion is a concept that essentially means the secret alliance of two individuals against the third; it is similar to the idea of triangulation. For

example, one therapist described an experience in which she felt the couple was in an unconscious collusion against her. Over a couple of sessions, the therapist got into a major power struggle with the wife, arguing about whether they, as a couple, were in denial about their anger; the therapist believed they were; the wife felt they were not. When the therapist checked in with the husband about his feelings, he, of course, completely backed his wife. As the power struggle ensued, the therapist reacted with intense emotional upset and anger. She concluded that the couple had "dumped" their anger onto her, colluding to have her express it. Another therapist talked about collusion in terms of aligning with one partner against the other; he ended up in an enactment by colluding with the husband's view of his wife as "crazy." Both the husband and therapist treated the wife as the identified patient until the therapist recognized his collusion.

One way that three-person dynamics were activated in the countertransference was when the therapist seemed to enact one of the partner's unexpressed affects. There were several examples in which the therapist seemed to act on behalf of the passive partner by being assertive for him or her. Sometimes the therapist even felt driven to do it. For example, in this case, the therapist worked with a couple where the husband had an affair. The husband, who was passive, rarely confronted his wife about anything; she brought him into therapy to make him face his problems. However, it was not the husband who triggered the therapist, but the wife, whom the therapist experienced as narcissistic and headstrong. As a result, the therapist took the wife on, and felt driven to do it. She realized she was taking on what she believed was the husband's job, that of confronting the wife.

> He didn't take her on, yeah, not call her on it, um, not stick with it. If he had something [he was upset about], he'd go around her – have an affair, um, get away from her and take trips and, and things like that. And, and so I'm doing what he would not do [confront his wife]. And, and I'm driven – I'm being driven to do it. It's very odd. So, and maybe in that sense, that's maybe a truer meaning for projective identification, if that's possible.

Another therapist also felt somewhat driven; in this case, it was in pursuit of an "impenetrable" wife. The therapist said that he usually feels "hooked" by such women and pursues them in order to understand them further. But he also felt he was playing out a dynamic in the relationship, believing the wife wanted the husband to pursue her in the same way he was.

> It's a couple I've seen for a long time, but it's one of those that I was talking about before where I get very caught up in this case focusing on the woman in the couple and letting the guy sort of, you know, off the hook. And even when I try to even things out so to speak, or try to, well, you know he's got a part in this, it feels forced in me. Whereas with her, you know, it's like I just have these feelings about her being, um, impenetrable. And by the way, I think that's the countertransference hook for me, meaning that, and maybe it's with women particularly, . . . when it feels like someone's impenetrable, my reaction is to, you know, sort of work harder or to try harder to penetrate or to push harder. *I'm playing out . . . an energy that she wants from him* [italics mine]. So I think it may very well be that, um, her being a little frustrating is a way to get someone to sort of come after her with a little more

vigor that he doesn't really do.

One participant described a difficult countertransference dilemma she encountered with a couple; when she empathized or supported one partner, it caused the other to get worse, and vice versa. The therapist had tried and failed to make a therapeutic alliance with the wife because she could not tolerate how abusively the wife treated her partner. On the one hand, the therapist helped give voice to the wife's anger, and the husband felt abused and became depressed. On the other hand, if the therapist stopped the wife's expression of rage in order to protect the husband, the wife felt unheard and became more upset.

> It was abusive, and so that was a situation where I just . . . did not succeed at entering her experience enough for her to feel like I was aligned with her. Because I just felt like every time I tried to do that, I left him exposed to abuse. . . . So the enactment part, if we're going to call it that –I mean it's hard to even know – was that to really try to help her give voice to some of what was troubling her, the only way she was able to talk about it, was with rage and contempt. And so even though I tried very hard to find ways of having her express what all of this was soliciting in her, it would almost constantly, inevitably come out in this deeply accusatory, rageful, contemptuous way. And so, um, he would get more and more deflated by it. And so, when I would try to stop that kind of expression of her distress, she would feel like I was not really getting her experience. Um, but when I would make room for it, I would watch him get more and more deflated and, you know, despairing and hopeless. And he already had so much shame about this particular thing

that it was very hard for me to help him, uh, set limits around how she could talk about it 'cause he had so much shame. So, it, it really was just so hard.

In a similar situation, the therapist said she worked with a couple who had a sadomasochistic style of relating. The therapist acted out her aggression towards the husband when, in fact, she felt mostly angry at the wife. Her elaboration of triangular dynamics is a good example of how the multilayered countertransference can play out in indirect ways in couples therapy. The therapist, who was feeling devalued and upset with the wife, got frustrated with the husband and said, "Why do you put up with this?" In the interview, the therapist revealed that she was actually angry at the wife for devaluing the treatment and making the therapist feel impotent. The therapist acted out her anger towards the husband, all the while saying she was trying to protect him, while also indirectly expressing her anger at the wife.

I think that I felt that she was uh, being disrespectful to the treatment and to me, really, and so I went on the attack of him. That's how I now understand it. We had talked about, you know, appropriate boundaries and what this means when she treats him so disrespectfully with her lover and she came in and flaunted this yet again I thought in a really hostile, aggressive way. . . . Now if I think I had been conscious of it at the time, I would have been better off. But I think in retrospect, I felt she was not just being disrespectful to him and trying to humiliate him, but she was trying to do that to me and to the work. So I think that's why I reacted. But instead of reacting toward her aggressively, I then – and, and this is why I think it's a countertransference

> enactment – I enacted the very thing that they do in their dynamics; I went and attacked him. And I went and attacked him in the name of protecting him, which is really incredibly sadistic, you know. . . . It was me, it was me acting, um, out of desperation.

*Therapists' feelings about the enactment.* This section would not be complete without a discussion about how therapists felt about the enactment itself. While not all the participants talked about their reactions to their enactments, many did, and, as would be obvious, most felt bad about it. Often in the telling of the enactment there seemed to be some embarrassment by several participants, who sheepishly laughed as they told me what they did. For example, I noted that one participant in particular must have laughed hard for about twenty seconds after she revealed her enactment. Clearly, she seemed self-conscious. This, of course, is only my observation and should come as no surprise, since enactments are what some therapists might consider to be a major therapeutic blunder. I noted that many other participants laughed nervously as well in the telling.

Responses varied from therapists feeling angry at themselves, to feeling bad about hurting the client, to accepting enactments as part of the work. A number of participants expressed milder misgivings about their enactment: "Well, I don't like it when I, uh, say something impulsive like that 'cause it can go either way. And obviously if I am inflamed and say something like that, I'm sort of in the soup with this guy." Or, this therapist feeling bad about lecturing the husband with whom she just enacted: "I think I just knew by the end I wasn't doing my best

work. . . . I feel like I've kind of lectured him, you know, gave him ok, this is your crap and you need to lie in this."

Typically, therapists felt bad about hurting the client in some way, especially those with whom they had worked for quite awhile, and with whom they had developed a trusting relationship. As the above therapist said, after allowing the husband to vent his rage towards his wife, resulting in the wife terminating therapy, "That was very painful for me because this was uh, an individual, and then a couple that I've worked with for years, you know. I felt horrible." Another participant felt bad about herself. In this enactment, the therapist felt thwarted and devalued by the wife, and a power struggle ensued until the wife quit therapy. The therapist said she felt that her acting out ruined the therapy and was a "childish thing to do."

> She told me I had no right to say something and all I can imagine is that I was then proving that I had the right to say it (laughs), or something like that, I mean, something very childish, or, even I, you know, but at some level like, you're not going to shut me up, or some really childish kind of thing. That's all I can imagine is that she went somewhere in me. It wasn't therapeutic; I didn't handle it therapeutically. . . . And then when they left [quit therapy], it was like, you know, I'd really ruined it (laughs a little). I, I, so I felt very – it was kind of a humiliating thing, like I had acted out. I knew that. But I didn't want to call her. I just, I just, I felt that I had really ruined it. I mean, that was part of it. I didn't think there was going to be, yeah, if I had called her, I probably didn't want to face her contempt.

One participant had a particular powerful multilayered reaction to her enactment. The therapist got caught up in a power struggle with the wife over the issue of whether the couple was denying their anger. She and the wife argued about this for most of the session and, in the end, the therapist felt "dumped on," and had an intense emotional response after the couple left.

> Oh I was, I was just, I just crashed. I just crashed . . . was mad at myself. Because I had it; I felt like I had allowed it to happen . . . when I finally could really cop to how strong it was. Like I said, I get sensation and I get a lot of images and, you know, there's a lot going on in here all the time. But this was something totally different. . . . And I messed up so bad and ahhh! You know, because I think the people who are attracted to the field is we all have these, you know, we all have these insecurities and we're trying to do it right, and that always is right there. . . . And so that's where I think that this issue of enactment gets so sticky because we're – from what I can tell, myself included – we're always ready to take the blame, you know. . . . And they terminated with me over the phone. And it was just like, you know, there was a part of me that was just like, bye-bye (laughs), and then there was this part of me that felt like a failure. . . . But this particular case was so – I mean, like I say, it took me like two days to really calm down.

Another participant, while feeling bad about the enactment, was also somewhat philosophical about it. In his enactment, he made an interpretation to the husband which resulted in the husband not coming back to therapy.

> Well, I always feel bad about when I do something . . . that has that kind of

result. Wish I had handled it in another way. And I didn't tolerate, you know, his [lack of connection to me]. But, you know, you can't help everybody, and that's just something you have to accept as a therapist. And that there's some people you're not going to be able to help because, you know, either their pathology uh, is just too vulnerable or um, or touches on something in you. . . . You just can't be a universal therapist.

*Therapists Conceptualizing Case Dynamics*

In addition to analyzing their countertransference reactions, participants also reflected on the psychodynamics of the case as a way to understand why the enactment occurred. Insight about the case seemed to help the therapists think reflectively about what was activated in themselves, and vice versa. In fact, the process of sorting through their countertransference and case dynamics seemed so entwined at times that there were more than a few instances when I asked a participant a direct question about their countertransference, and they responded with a discussion about the case. For the most part, participants had quite a bit to say about their conceptualizations of the case and often thought about the dynamics on many levels. What I will present in this section are a few examples of how therapists thought about the dynamics of a case in reference to the enactment.

Therapists usually have a reason for their interventions. The enactment that occurred in the following case was a result of a therapeutic misjudgment, according to the therapist. Yet, the therapist has a justification for her

intervention. In this case, the therapist challenged a wife who was developing a friendship with a man. Her husband felt threatened because his wife previously had an affair, and the couple had just worked through it. The therapist felt it necessary to confront the wife, suggesting that perhaps this relationship was becoming dangerous, but the woman took the confrontation as shaming and accusatory. Here, the therapist justifies why she believed she was in the right to challenge the partner and why it backfired.

> I think I was wanting to bring that possibility [that she was in danger of having an affair] in there, because I felt like she was quite unconscious of what she was doing and that she was really flirting quite a bit . . . and having sort of secret meetings . . . and that she would then sort of confess later; and it just sort of had all the earmarks of something more than friendship. And I think she was unaware of how vulnerable she was to just doing it [i.e. having an affair] again, so I wanted to bring that reality into the room, that, you know, she had that vulnerability and that that was going to be really harmful to the relationship. . . . She couldn't recognize that there was risk there. I mean, she wasn't saying, ok, I feel a little at risk here and I, that's what I'm trying to talk about. Um, and I think by my naming it too precipitously, it foreclosed the possibility of that happening.

Some therapists choose to explain their understanding of the dynamics of an enactment to the couple; others do not. Here is an example of a therapist who did. In the enactment, the therapist worked with a husband whom she experienced as withholding, a style of relating the therapist experienced as provocative and

triggering. The husband's frequent sparse responses to the wife and therapist made the therapist feel the husband was not committed to being in therapy. In frustration, the therapist gave him an ultimatum that unless he got down to work in therapy, she did not see how she could help him. The wife got upset at the ultimatum. As it turned out, the wife was also frustrated with the husband about some bothersome habits and demanded that he stop these behaviors. The therapist talked with the couple about the function that ultimatums serve in the relationship – that the only way effective change is going to be made is through the absolute force of an ultimatum. Here, the therapist discusses the power dynamics in the relationships and elucidates how she and each partner vie for control. She quotes herself speaking to the couple, primarily addressing the wife.

> I'm aware it was an ultimatum and I was aware that you were mad at me when I made an ultimatum. And I'm wondering that it seems like there's a belief that if anything's going to change, it's going to come from an ultimatum and why is it that change has to come; like why is it, you know, that the only way something's going to be effective is through this absolute force, you know. And that it seems like there's something really problematic in change coming through being forced. . . . That there's a hopelessness about anything else changing, and so . . . the only way to feel like one survives in a relationship is to grab the power.

Of course, not all therapists have a clear understanding about what is going on in the dynamics of the case. Some cases are more puzzling, and the therapist may have to live with a feeling of confusion, sometimes for extended periods of

time. For example, in the enactment in which the therapist found himself caught up in pursuing a wife whom he experienced as impenetrable, the therapist claimed he still did not have a good handle on the case, even though he had given it a lot of thought. Here, he seems to still to be thinking through the case as we talked about it together.

> I don't know, I don't think I know, well, I don't think I have a good handle on really what's going on. . . .You know, her personality style. . . . And so she can . . . sort of contradict herself. [It's] hard to pin her down, uh, you know, hard to really know what she really wants and thinks. And I think this is her difficulty, but it draws me to, you know, try to get her to be more specific. . . . You know, once you try to get somebody to do something, you're caught up in something. . . . which is that in their relationship, it's all about taking care of her. He has a hard time, uh, knowing what he wants; so much of his life is in reaction to her, [he] not having much of a self, um. And so in a way, you know, he focuses on her . . . in lieu of him, of knowing himself. And um, and then I focus on her. . . . Maybe that's the whole story and I just can't, you know, can't get myself out of that or maybe there's more. Or maybe it's just a very powerful, tremendously powerful dynamic that all of us are caught up in, which is, everybody's going to focus on her and she's not really going to let us in. . . . And that's what we're all playing out. You know, two men trying to get through to her and, um, and she's always, you know, she's kind of tricky.

The following therapist was one of the few participants who talked about the

dynamics of the couple in terms of the system. She had gotten into a power struggle with the wife because they disagreed about whether the couple was in denial of their anger. In this passage, the therapist brings up the idea that the partners could not tolerate anger between them and as a system unconsciously colluded to project it onto the therapist who then became the carrier for the anger.

> You know, in retrospect, I can see now – and this is where the system comes in – there's no room in the system for anger. It was too terrifying to this couple to even get impatient with each other, ok. It just flipped them into like – I don't know where 'cause we never got there. So what happened was it came back in and it got me. So they came together in the system, and I was loaded with the anger – the conduit for all of the rage and the terror and all of this. They gave it to me and they left. And they literally left. . . . The system needed an outside, something outside itself to maintain the system of "we are good and sweet and kind people with each other." They needed someplace to, to drop off the anger and the rage, etc. . . . And I think that it was almost like, the energy from him into her at me. So that's what I mean about the system. The system will not tolerate anger. So the system's anger was given to me along with the terror and the confusion and the need to do something about it – to be right. . . . And that was a system piece. The system needed the outside person, the outside object to just go, yours! You take it. We don't want it. We can't tolerate it.

*How Therapists Worked Through the Enactment*

In this section, I will examine how therapists worked through the enactment with the couple while attempting to manage their intense countertransference reactions. First, I will take a brief look at what a few therapists said about the value of paying attention to enactments. Included in this is the notion that there seems to be a lack of models to help guide the couples therapist through an enactment. Next, I will examine how therapists worked directly with the couple after the enactment occurred. Lastly, I will look at the coping strategies therapists used during and after enactments that helped them manage their countertransference. Of course, therapists usually worked on both levels simultaneously, but for the purposes of evaluation, I will examine these separately.

Since an enactment is often experienced as a rupture in the therapeutic relationship, most psychodynamic therapists have been trained to explore and repair ruptures in order to reestablish a good therapeutic working relationship and get therapy back on track. The findings support this; participants tended to work towards reparation with their clients once they recognized that an enactment had occurred.

Overall, there were many similarities in the ways therapists worked towards reparation. Most participants expressed apologies or regrets for what they said or did. Participants explored and tried to understand the clients' experience, after which they articulated this understanding to the couple. In articulating this understanding, they may have disclosed personal feelings to explain to the couple

why they reacted the way they did. Participants reported that when clients felt their experience was understood, they often were able to move through the disruption in the therapeutic relationship and reestablish trust. In addition, important insights were often gained into the couple relationship dynamics.

Differences in how therapists applied these therapeutic methods were mostly idiosyncratic; for example, some participants may have tended to use interpretations, explanations, apologies, or self disclosures more than others; some tended to explore the dynamics more, while others leaned towards using interpretations. While working through the enactment with the couple, participants also worked at gaining a deeper insight into their countertransference reactions and developing more empathic understanding towards the partner(s).

*The Value of Paying Attention to Enactments*

A few participants talked about the value of paying attention to enactments. Of these, two spoke about it theoretically. One said that she thought that there was a similarity in working with enactments and how one works with empathic failure in the self psychological model. The other said that she believed couple therapists have no psychodynamic couples therapy models about how to work with enactments. The consequence of having no model, she believes, is that more therapists are probably "flying by the seat of their pants" when an enactment occurs and are probably reacting instinctively to the situation rather than following a technique proscribed by a model. Therapists who are trained to think in terms of enactments may actually tend to be less prone to act out.

> And I think there's not enough talked about in terms of technique for couples from an analytic point of view, so that's important. . . . It's hard to think about it absent the model . . . because I think when people have a model, they're probably less likely to be prone to enactments and . . . and they're more likely to have way to manage to think about them. Um, so I think a lot of it is people just flying by the seat of their pants, you know. If I think about the people I know who I think have, you know, are well trained, I think it's less likely [they'll be prone to enact].

The therapist basing her work on self-psychology brings up the point that enactments are a form of empathic failure and therapists must work through their empathic failures with their clients in order to form a more real relationship. This process is a major reparative part of the work. She also believes that an enactment is a way to a deeper understanding of the couple; the therapist learns more about the partners through her empathic failure and the understanding that comes from working that through.

> I just think it's an interesting topic because enactments are for many people the only way to really know what's happening with a couple . . . or to be able to incorporate one's reactions into forming more of a real relationship with the clients, or dealing with real things that are happening from within the system. . . . It is my countertransference or the enactment that gets started among us that I think is diagnostic; it gives a sense of experience, and it allows something to be learned from an empathic kind of stance, especially dealing with an empathic failure that's involved in a real enactment. . . .Yeah,

> um, self-psychology talks a lot about, um, what's reparative about empathic failures and that's, uh, part of my theoretical foundation, so in order – and I also have a strong intersubjective orientation – and so both of those require really attending to what's happening between the people in the field. So, yeah, it's very much a part of what I do.

Others talked about the value of paying attention to enactments. One participant discusses the notion that enactments provide important information about what is going on in therapy, especially on a deeper level.

> I do think that what we're calling enactments are essential data and very powerful ways to inform me about what's going on, and even, you know, on a deeper level what's happening with the couple. So I'm a believer in the tremendous usefulness of, uh, trying to kind of look at, analyze, and figure out what's happening with the enactments.

Another discusses the idea that therapists are similar to parents; parents inevitably make mistakes raising their children, but these mistakes are developmentally formative. The same holds true for enactments; they are a therapist's mistakes, but can be growth enhancing to the therapeutic process, especially if they can be successfully worked through.

> But here's what I think, actually, . . . [about] enactments. It's like that thing I was talking about earlier, which is that you all – I'm a parent, ok. So I've got a kid and I know that from early on that I'm set up to fail. I have to make mistakes otherwise he's not going to leap. You know, he's not going to make those developmental leaps. There are going to be times when I will not be

> able to soothe him so he has to soothe himself and so on, so forth. And what I see in these enactments is that we really hit – just like with individuals, only it's much more complicated [with couples] – we hit those places of wounding, and you either get to work them through or . . . you don't get to work it through. But it has served some purpose for the system. Now, in the best of worlds, you get to work them through and you get to look at it. That's why I always say that I did it [i.e. enacted] again because I look at my piece in it – these are my, you know, my top pieces of my own edge.

*Repairing the Rupture in the Therapeutic Relationship*

In virtually every case, participants reported a rupture occurred in the therapeutic relationship as a result of an enactment. Sometimes the enactment was so disruptive that the couple terminated treatment. In cases where they did not terminate, therapists usually attempted to repair the relationship with the couple, especially if the therapist felt that the therapeutic alliance had been adversely affected. Yet, as one participant noted, " Usually, I thank God, with most psychotherapy, you get many, many chances to repair things. Sometimes you don't. But most of the time you do."

Participants primarily attempted to repair and work through the enactment with the couple by first acknowledging the enactment. If they hurt the client(s) or were excessively critical towards them, most participants chose to apologize or express regrets for what they said or did. As would be expected, participants explored and attempted to more deeply understand their clients' experience

through questioning and clarification. This could be a fairly lengthy process depending on factors such as how hurt, angry, or misunderstood the partners felt or the level of conflict stirred up between the therapist and partners.

After gaining an understanding, some therapists chose to make an interpretation of the transference/countertransference dynamics to the couple, or the meaning of the enactment. This often helped clarify some important dynamic in the couple relationship, helping the couple gain a deeper insight. Sometimes the therapist may have felt the need to confront a partner about some dynamic he or she was not recognizing that the therapist felt was important. Therapists also made comments about both content and process of the couple's dynamics. That is, they talked about why partners may have acted in the way they did, but also talked about how their actions affected each other. As part of their explanation to the couple, some participants disclosed their personal feelings to explain why they reacted as they did.

There were only a few references made by participants discussing how they specifically explored clinical material with a couple; this was more implicit in the interviews rather than explicit. Here are a few examples of that exploration. In this first example, the therapist had upset the wife by becoming overly intrusive; she pushed the wife to express her vulnerability to her husband before she felt ready. The therapist's intrusive pushiness was her enactment. Here, she talks about how she attempted to explore the wife's feelings about the enactment.

> It was just like, hey, you know, can you tell me what's happening? Well, she got very upset with me so it was pretty clear . . . she has a very strong anger.

> . . . And then my mind is kinda going, ok, I know why I did what I did, but there's something else here. And so I just, well, tell me what happened for you? You know, have her tell me her feelings. . . . And I said this and you did this anyway and so on. And, well, inviting her – what else do you need to say to me about this? And, trying to also try to engage, what was this like for you?

Then, in the next session, the therapist continues the process of exploring what had occurred in the enactment and deepens the process.

> So the next week . . . she was very quiet and she really didn't want to talk much and she said she was processing a lot of things and so we were kind of working. But then these issues came up again. I said, well, you know, this is really – the issues that are coming up are a variation of what started last week around feeling like you're not seen and you're not heard and that he's really not stepping forward to be here with you. I said, so let's go back to what happened when that thing with us happened. And we got to the point of where I really had picked up her defensive mode, and she was able to see that she was . . . shamed deeply for having strong emotion. . . . And then we got into being able to, you know, explore the history and so on and then it opened up into the compassion of, wow, I didn't realize how layered this vulnerability is for you, you know, and it just opened it all up.

In the next example, the therapist does not actually go into detail how she specifically explored an issue with the wife, but does talk about how she shifted into developing a more empathic understanding. The therapist realized she was

increasingly losing her connection with the wife, believing she might be ready to terminate therapy. The therapist had been interpreting the dynamics of the relationship to the couple, thinking she was empathic in her approach. But no matter how she presented it, the wife either felt misunderstood or criticized. The therapist, too, felt frustrated with the wife. Just as the wife seemed ready to quit therapy, the therapist decided she had to let go of her agenda and shift to a different, more intuitive, way of working; she had to restore the connection to the wife by trying to understand what the wife was trying to tell her.

> I thought, oh my god, I'm going lose this case if I don't somehow get on top of this and get what she's trying to tell me. She was saying, I'm trying to say something here and I hadn't been getting it. And I think the emotional level and my concern about losing the case or not being helpful . . . um, jumped me into a more intuitive level where I realized what she was trying to talk about was a big picture with him [her husband]. . . .Yeah, I knew I had to drop what I was doing and just attend to what was happening . . . which is to deal with the empathic failure and to talk what was happening between us, to really get what she was trying to say. It's like, uh, ok, I had this agenda, but, you know, the relationship is the most important thing here. And, so what is it that I need to do to get back into a relationship with her? . . . I think that was probably a big piece of work in terms of maybe trust between her and me.

Expressing regrets or apologies was usually part of the repair process, especially when participants felt they had said or done something which might have hurt one or both partners. Some admitted they used apologies to show the

clients they recognized their role in the enactment and as a way of showing accountability. It seemed that some therapists were more prone to apologize while others were more judicious in their use of an apology, depending on whether they thought it would serve a therapeutic purpose.

For example, one participant described two enactments involving two different couples who had a similar sadomasochistic style of relating. In the first case, she became frustrated with the husband but chose not to apologize, feeling that it would not be therapeutically beneficial; instead she explored the meaning of the enactment with the couple. However, in the second case, the therapist became quite critical of the masochistic partner and felt it was therapeutically important to apologize to the wife, not only because she realized she had been overly critical, but also because it would serve as a model for the husband who was never accountable for his actions.

> I had another case with a very kind of similar dynamic, sadomasochistic dynamic, and I did apologize to somebody for I thought, you know, kind of being overly critical. . . . I thought it was an example of the same kind of thing where the sadomasochistic relating got into the countertransference and I apologized. But, I think in that kind of [situation], uh, the apology was useful because it's something that the spouse really never does – you know, notice that you've injured somebody and take responsibility and be remorseful.

Apologies are not always helpful; there were several situations in which participants apologized, but the apology did not seem to help in repairing the

relationship. For example, in one situation, the therapist and client seemed to clash over whose reality would prevail; the client had one view, and the therapist another. Even though the therapist apologized for upsetting the client, deep down, the therapist still believed what she said to the client was correct, and perhaps because of this, the apology may have felt hollow to the client. This is only my speculation.

In this case, the therapist had confronted the wife about the potential pitfalls of developing a male friendship. The client became quite upset at the therapist for challenging her about this. The therapist said she was merely trying to bring this to the wife's attention because her husband seemed threatened by this friendship. The therapist was surprised at this client's strong reaction, but then came to realize that perhaps she had confronted the client a little too harshly and prematurely. Nevertheless, the therapist still believed she was correct in bringing awareness to the issue but wrong in her therapeutic approach. The therapist and client clashed over how they saw reality, which ultimately resulted in the therapeutic alliance not being restored, apology notwithstanding.

> Well, I apologized to her; I said I was really sorry, that that had certainly not been my intention. But I think I couldn't say the thing that she wanted me to say, which was the content of what I was saying was wrong. I felt like I had handled it wrongly. . . . I have thought about it more and thought about how to bring that reality [i.e. that she may be in danger of having an affair] into the couple. Uh, and she just wanted me to say that, that it wasn't true, that there wasn't any reason for the partner to be suspicious of her and the partner

was just naturally a suspicious person. And I couldn't say that, you know. So I think it was very hard to repair between us. That there was, there was something, I think, very powerful going on of her really wanting to, um, have the right to name what the reality was. That I felt like could really derail the work of what we were trying to do. And I think we didn't really resolve it and they did leave at some point I think in an unresolved state. They didn't leave immediately, but I think it was never fully repaired.

Sometimes apologies fall on deaf ears; the damage has been done and it is just too late to repair the relationship. This occurred to a couple of participants who either called or wrote a letter of apology after the enactment caused the couple to terminate therapy. One participant, involved in the enactment in which he had allowed the husband to vent his rage at the wife in session, called the wife to apologize, but to no avail.

And uh, I called her and left her a couple of messages 'cause she wouldn't talk to me on the phone, you know. She was very injured, you know. And I wrote her a note, you know, and told her that I was sorry that I had not realized that she was hurting as bad as she was in the session and blah, blah, blah. But she wouldn't come back.

Another participant, while not writing a letter of apology, wrote a final letter of summary which had a conciliatory tone to it. She used the letter as a way to let go of the intense interaction and as a way summarize the issues they had been working on. She was involved in the power struggle with the wife over whether the couple was in denial about their anger.

> And then I wrote a very short letter just saying I feel that this is what, you know, I feel is integral to the issues that we were talking about and hopefully in the future, if you feel you want to continue to work on these issues, please feel free to give me a call. . . . Less is more. I just said I realize that the last session was intense, but that I do feel that that is part of this particular therapeutic process and didn't go into it. Ok, I couldn't do it in the room; let me do it in the letter. And so this was just like, ok, I disagree with you; that, this isn't in your best interest, and if you come to that over time, I'm here, you know. And that was my letting go.

I include the following response from a participant because this is how she would have liked to have responded to her enactment if she had been able to maintain her composure and had the clients remained in therapy. This was the situation in which the therapist felt continually thwarted and devalued by the wife who had demeaned her. The therapist felt humiliated, and, in response, the therapist challenged her. Here, the therapist summarizes how she would have approached dealing with the enactment had the wife stayed in treatment. She would have apologized, attempted to understand why the enactment kept happening, taken ownership, and looked for parallels between the transference and the relationship between the partners.

> I would have really had to have thought about how, why am I saying . . . things that I know I shouldn't say? And how would I have approached that? It might have been to say I'm sorry, I think I really hurt you with some of the things that I've said um, and I'd like to see if I can understand that more. I

> don't want to keep doing that and yet it seems like it keeps happening. I'd probably do that . . . and to really own something of my part in it. But to see if we could understand it; see if we could, um, work it through so it didn't keep [happening] . . . and then, finding out if it fit in any way between them – you know, the broadening into the work to see if there's anything of what happened between her and me that was similar to things that might happen between them. . . . I mean, those to me are always ways further into the dynamics.

When a therapist is able to repair a rupture following an enactment, it eventually establishes a more trusting connection between therapist and client. According to the following participant, this connection can provide a resource that can be drawn upon should the relationship be challenged again at a later time. The participant discusses this idea, stating that she thinks enactments are good mistakes to have because it can help develop this resource. In the enactment, the therapist snapped in frustration at the husband when he became belligerent, but worked it through with him. Later, she was able to use the repair as a point of reference when they again came up against a similar challenge in their relationship. She summarizes what many of the therapists in the study implied; if there is a strong relationship between therapist and client and a fundamental sense of empathy, when an enactment occurs, the therapeutic relationship can handle the rupture, and the therapist and client can take their relationship to a more trusting level. Clients are usually forgiving of the therapist's mistakes.

> Although, like many enactments, it was a mistake that was good to have. . . .

> But when I can find that reconnection, I think that has actually opened a new door in the therapy that then is very helpful and that I know I have that as a resource now, too. That we are able to look at what happens between us and process and some. And that's really, really useful. I actually feel heartened about the potential of the therapy when we've done that. . . . I did think it was an error of mine, a flaw. But I think we learned from those and I do have some fundamental empathy with him and I think without that, if you don't have that, you haven't really established that kind of empathy or that kind of alliance with somebody. It's very hard to repair those things. 'Cause I think that's what you have to fall back on that you're essentially saying to the person, ok, maybe I made a mistake here or maybe I did something that didn't feel good to you and I regret that, um, but, we do have a relationship that's been ongoing for a while that we can sort of trust will absorb some mistakes. That's the nature of relationships; people do things and then they don't feel good, but the overall tenor of the relationship is what matters and, um. That's what we're drawing on to repair those things.

*Interpretation/Explanation*

Therapists also worked through the enactment by making interpretations and explanations to the couple. Usually this included an interpretation of the dynamics of the transference/countertransference among the threesome; the therapist told the couple about the psychodynamics of their relationship and how the therapist was drawn into the field. For example, the following therapist felt

pressure from each partner to change their mate's behavior. When the therapist realized he was caught up in an enactment, he chose to interpret the dynamics of transference.

> So I made this interpretation to them about this fear that they had about putting themselves into the hands of the other and that how what they did instead was to, in some way, not accept the other and try to, in some ways, control the other. And I said, you know how I know this? I know this because that's what you both do with me. . . . And then I laid all these things out that they had done in terms of not trusting me. . . . And it was, you know, it was really quite powerful to them. I know it was really . . . because actually, I just interpreted this to them just very recently and I think they really took it in. . . . I think it was good that it went on for a while and that I had so much in the office data. You know how Kleinians say, show the patient what they've done, and I had so many, so many different examples of what they were doing with me. So in a way, I think the overtness of these enactments helped me to be able to really describe it to them and there was no doubt about it.

In another example, the therapist explained how she viewed the dynamics of power playing out among the three of them. In the enactment (previously described), the therapist had given the husband an ultimatum about either getting down to work in therapy or quitting. Later in therapy, the wife gives the husband an ultimatum. Here is how the therapist talks about the dynamics of power and change in the couple's relationship. Here, she addresses the wife.

> I'm aware it was an ultimatum. And I was aware that you [the wife] were mad at me when I made an ultimatum. And I'm wondering that it seems like there's a belief that if anything's going to change, it's going to come from an ultimatum; and why is it that change has to come, like why is it, you know, that the only way something's going to be effective is through this absolute force, you know? And that it seems like there's something really problematic in change coming through being forced. . . .That there's a hopelessness about anything else changing. And so, it kind of opened up a little bit more of an awareness that the only way to feel like one survives in a relationship is to grab the power, and that he constantly is grabbing the power. He totally shuts down, and he controls a lot in that way, and your attempt then to get control is to pose an ultimatum and my attempt, ultimately, to gain some control is to kind of push the issue, too.

As part of the process of working through an enactment, some therapists disclosed their personal feelings. It was difficult to get a clear read on how much participants self-disclosed from the interviews, but it is evident that the issue of self-disclosure is a controversial subject. Some therapists seem to feel more at ease in self-disclosing, and even regard it as therapeutic, while others try to keep self-disclosure to a minimum, feeling it overburdens the client(s). Sometimes self-disclosure is dependent on the therapeutic context; a therapist who does not normally self disclose in one situation may self disclose in another, if it seems therapeutically important to do so.

The main reason participants revealed personal reactions was to explain why

they reacted the way did. This could have a strong impact on the client. For example, the therapist here explains why she got frustrated with the husband. The husband had been making solid progress working on his anger when suddenly, towards the end of a session, he reverted and became belligerent; the therapist snapped at him in frustration. The therapist not only apologized but then disclosed why she got frustrated.

> And I said, yeah, I was sorry. I think I, um, was very frustrated. And I sort of explained to him what I thought had happened, that I thought we had really been doing well and then I felt like he just went back into that mode [of being angry] and I really became very frustrated and, um, reacted to him and that I was sorry. I think that what I really wanted him to see was that he could have that affect on someone, even his wife. I wanted him to understand that, and I think he did, and he was sort of stunned by that. Um, and we were able to work with that a bit, and . . . But, um, but I think it was so powerful to him that I did, that it really sort of got through to him in a way that, uh, his wife hadn't been able to. So ultimately it was useful.

The following participant used self disclosure in an entirely different way; she used it as a way to stay involved with a very difficult couple whom she experienced as chaotic and out of control. They were constantly fighting, and she found them both obnoxious. The therapist claimed that one of the ways she dealt with feeling out of control was to self disclose how the couple made her feel.

> I think I told them sometimes, you guys are driving me crazy. . . . I said, you're fighting so much; I can't do it. . . . I did verbalize it sometimes because

that was the only way to stay involved . . . because I was, um, it was being real; it was allowing myself to have my feeling and to share that feeling and to stay involved in some way. I used to have a problem with, . . . if people were really angry . . . I would sometimes freeze. And I'd look like I was there, but I wouldn't have anything to say. I had no way of staying, um, involved. And that actually constituted a huge failure with her [the wife], um, because she had been so abandoned, um. So I guess over the time, you know, I've, I've gotten more comfortable with anger. . . . I don't know, but I didn't feel badly saying it [i.e., "you're driving me crazy!"] because it is kind of like I am here; I'm the only one that's saying and trying to achieve some order here; and you are obnoxious! It kept – yeah, I think it did keep me in it in a certain way. I think that really was what it did. It kept – helped me stay in it because if stuff is just coming, coming, coming, coming and there's no control over it, you know.

A few participants cautioned against self-disclosure. One said that, in her opinion, some of the pitfalls to self-disclosure are that the client may feel intruded upon by the therapist's personal reactions, which could potentially lead to misunderstanding and hurt. She feels she discloses in more discrete ways, for example, by occasionally telling stories about her life without revealing they are hers.

But, overall I don't do a lot of self-disclosing. I don't think it's right or wrong. I think what works, works for a particular person. But overall my own experience is that people know an enormous amount about me and how I am

> in the world, and I feel disclosed all over the place. So it's like I'm not a blank screen. I'm very forthcoming; I say what I think; I use lots of stories. But, if I use a story from my own life, I don't say it's from my own life, um. You know, I might just tell a story, because I do think that people are influenced and can feel uh, impinged upon by that. . . . I think I treat the relationship as something a little sacred. That I am working on, working with my own personal stuff, to get a lot of my stuff out of the way and I'm not wanting to be bringing it in on an interpersonal level that much, unless it really seems like there's a good purpose for that, um. And I also think that a lot of misunderstanding can happen that way, if you look at it. It's too tumultuous I think to be doing too interpersonally; there's so much room for hurt.

Another participant thinks about the issue of self-disclosure more theoretically; is self-disclosure reparative to the client? In the case she presented, she did not believe it would be. In general, she says that when a therapist is processing her countertransference reactions, she has to be able to think about, contain, and metabolize her feelings in order to offer it up in some way that would be useful to the client. The therapist brings up projective identification in this regard, saying that it is up to the therapist to process the therapist's part of the projective identification experience without burdening the client with personal reactions.

> I've tried a variety of ways of working with it [self disclosure] actually and I think I tend not to believe in the value of self-disclosure so much. . . .

Because, if I can just speak theoretically about it for a minute, I think that um, what I believe is useful is that it would be reparative, right. In this example, it's not one where it's reparative. But what I would hope for would be that it would – I'd be able to think, contain it, metabolize it, think about it and offer it up in some way. That would be useful. Now, sometimes that means you have to call direct attention to what happened and say we have to talk about this and sometimes it means that you wouldn't. It would mean that you kind of sit with it, knowing that somehow something's going to be useful and you're going to use it to inform the work, because not everybody can have that discussion. Not everybody can sit in the room and do that, A. And B, I think I do believe that projective identification is a concept. I believe in it and I think it's true; it rings true to me, not just intellectually, but it rings true to me as a, in terms of a way of describing the experience. So I don't want to burden the patient with that, you know, with my, um, – it's not their job to then have to work out what I insert into it, if you see what I mean. So I think what I would hope for in the ideal case would be that there's a kind of thought process about something that was previously unthinkable that then helps me reorient myself. That's how I think about it. Not so much like talking or confessing about it, but sometimes, it depends on what it is.

Finally, this therapist partly solves the dilemma of deciding when it is alright to disclose personal reactions: she asks the client. Here, she checks in with the client to see if the client wants to hear what is going on for the therapist soon after the enactment occurred: "I said, do you want to hear what happened for me in the

moment? Can you hear me right now or are you too upset?"

### *How Therapists Manage Intense Countertransference: Therapists' Coping Strategies*

In this section, I will present the findings regarding how therapists worked with their countertransference reactions after an enactment occurred. It goes without saying that working with countertransference material is an ongoing process, one that requires the therapist continually self-monitor and attempt to understand and contain his reactions. It is not surprising that the findings show that participants used a variety of tried and true ways therapists have always used to accomplish this: self-restraint, self-supervision, developing empathy, and consultation.

This is highlighted wonderfully in one participant's apt description about how she works on herself during a session when countertransference reactions are overwhelming her. It is a good account of how one therapist attempts to hold onto to herself and get through a difficult session. She employs a variety of coping strategies such as self-talk, self-restraint, employing an observing ego, and keeping a sense of faith that she'll find meaning in the chaos; it is her attempt to bear what seems unbearable.

> I mean, I think there is sort of like a division within myself. I mean, there is always some part of myself I suppose speaking to myself, you know, while I'm listening or while I'm sitting in the chair. You know, I mean I can sort of think some part of me sometimes goes like, okay, what the fuck is going on

(laughs) you know; this question at least holds me a little bit outside of it. But I think the part of myself that I don't probably ever fully lose is always saying, ok, there's something going on here, you know, like I don't know what it is but I know there's something meaningful in this. Um, and even I suppose last week at that point where I just sat back and they were just going at each other and I just thought, I give up. Like, this is too painful; I don't want to do this anymore. Um, I think there was still part of me that felt, one day I'll understand what I'm feeling, you know, why I'm feeling this way but I didn't have a sense that I did in that moment. I just knew I was feeling overwhelmed. . . . And this has been after doing work for the amount of time I've been doing it. And I do think I have a lot of faith that eventually I'll get it; eventually it will help, like it can be something I can actually use. Um, so some of it is just a matter of like living through it and just sort of bearing it and sort of saying okay, this feels unbearable but I'm just going to get through this hour, and then I'm going to try and figure out what is going on. So I think there's a fair amount of restraint that it's happening and really holding on to not act on it. It feels like it takes a lot of self-control.

*Self-restraint.* The notion of self-restraint as an important theme came up quite a few times in the interviews. Therapists felt that when the intensity of countertransference feelings was building and the pressure increased, their ability to hold onto their reactions was crucial. The following therapist says when he is in a reactive state, he is unable to make a good intervention; thus, he tries to

contain his reactivity. This has the added benefit of showing the couple that therapy can be a safe container for them.

> 'Cause I don't want to intervene from a stance of uh, being pissed off or feeling hurt or feeling scared. I know that something's going on if I start having that strong reactivity. And I know it's not generally, it's not going to be good for me to, you know, try to sort of pull myself up by my bootstraps and make an intervention when, you know, I'm not feeling on very solid ground at all. So usually I'll just sit with it. And maybe I generally think it's better to not do anything in that moment. Yeah, contain it. And actually um, this is something I'm trying to teach the couple is, you know, that this can be a uh, container. All of it can be, you know. And that nobody has to get harmed in this container.

Another participant voices the same idea, but points out that the therapist can also bring understanding and meaning to that which is contained.

> I mean, my rule, which I try to do, is to not act and to sit on things, you know . . . to try and contain intense feelings and desires to act. One doesn't always have that luxury, you know. The problem is that we're often pressed to actually not have that. Um, but that's my number one rule. . . . And I think that when there is space to do that, it's a very fruitful kind of thing because you can then think about something that has [been] split off and the therapist [is] being called upon to kind of contain something and to bring meaning to it, understand it. And that's really what containing is. It's not simply not acting. It's, it's pairing that and organizing it with some kind of thinking and

then being able to use it in terms of informing uh, the work.

*Self-supervision.* Several participants seemed to do a kind of self-supervision during the clinical hour when they were having strong reactions. One participant viewed self-supervision as activating her therapeutic observing ego; when she is in the middle of powerful countertransference feelings, part of her is fully involved in the work while the therapeutic ego can split off and observe the part of her that is having the intense reactions. This helps her gain some distance from her feelings which, in turn, may prevent her from acting out. Another therapist thought of self-supervision as a form of ongoing self talk. She states, "I said to myself, I'm just going to sit with this; I'm going to. She [the wife] can keep going, but at some point, we'll shift, you know, we can shift this."

In the following example, the therapist also used self talk as a way to self soothe; she felt very irritated with the husband and had to talk herself down.

He was so unconscious of it and it was like so irritating to me (laughs a little). Um, so, you know, that was part of how I was talking to myself, okay. Look, you know, it's their relationship; it's not yours. She's living with this. These are her choices. You wouldn't, but she is. So I really had to work with myself just on that level of getting my own, um, reactions out of the way.

In this next example, the therapist is working on her countertransference reactions of being critical and trying to temper it by developing some insight into what she is doing – trying to fix herself by fixing him.

And so that's another way I talk to myself about it. You know, just like, okay,

> I think you're giving him a harder time because you have some identification with him even though it looks far worse in him. Um, so, that was another way I talked to myself about, you know, trying to loosen that. You're not going to fix yourself by fixing him, you know.

In the following example, a therapist who had just finished a session in which she had been flooded with feelings from an enactment talked herself through it by reassuring herself that she would soon see her consultant. Then, because she was still filled with emotion before her next client arrived, she tried to compartmentalize her reactions as a way to move on to the next session; this allowed her to let go of it in the moment.

> This is just too hard because I knew what had happened . . . and I knew that I was feeling awful. And so I thought, well, okay, you know – and that's where the consultation comes in – I can bring this to consultation. But that's a week away so what am I gonna do. Well, okay, I've got other clients coming in, and when another client comes in, often I can really just, just say, okay, they're over here; now I'm gonna go focus here. And it might take about five minutes into the next session, you know, but then I'm engaged with that one. So that's one of the things that I do is it's like I can somewhat compartmentalize and just say I will, but I have to be able to say to myself, I will take care of this. I will look at what else this is [referring to the enactment]. And I do have to.

*Developing empathy.* All therapists work at developing an empathic

understanding of their clients. But it is particularly difficult to do so when therapists are experiencing negative countertransference. A number of participants talked about their efforts to develop an empathic attitude in the face of negative reactions towards one or both partners. This, of course, was not easy, and in some cases necessitated extra vigilance. More than vigilance, it required that the clinician find a way to understand what motivated that client to act in hurtful and negative ways. Several participants said they struggled to find a way to empathize with a client's experience when that client was particularly troublesome to them. They had to work on themselves to find a way in. One way was to try to see the client's vulnerability underneath anger. In the example where the therapist had given the husband an ultimatum to either get to work in therapy or quit, the therapist experienced an ongoing struggle with the way the husband provoked her. But gradually she grew to see his underlying vulnerability and learned to not become reactive to him.

> Oh. I think it's ongoing [i.e. the struggle not to react] Like, I have to constantly try to not punch back. Like, I feel like he's constantly kind of jabbing at me and I feel like I constantly have to not jab back. And what I'm trying to hold on to now is to remember, he's scared; he's hurt. This is what this is under this provocation. And don't kind of go down the road of provocation. I have to try to hold onto what's under there. Yeah, but it's hard, um. But he doesn't deny it at least when I talk about his fear or that I think he's really scared, you know. And that helps me.

Another therapist talked about the way she tries to develop more empathy for

a client with whom she is having difficulty, and that is by developing a compassionate stance. When she feels she is unable to make an alliance or connection with a partner, or finds herself excessively critical, she tries to expand her compassion towards that person. She believes compassion is a stance, not a feeling, although it is a feeling too, and that it can be cultivated to change negative countertransference. Here, the therapist discusses an enactment in which she had a strong negative reaction to the husband; she experienced him as crazy making and controlling, such that "all her feminist bones were rattling." This is how she attempted to work through those feelings.

> I made a deep effort to be sympathetic to him. One of the things I believe is that compassion is not a feeling – doesn't have to be a feeling – sometimes it's a feeling. But it's a stance. So sometimes when I find myself having a very uncompassionate feeling towards somebody, I don't try to change my feeling. I change my stance. So that I really make the effort to have a compassionate stance. Even though my feelings can be wildly all over the place, like oh, I can't stand this, you know, as a feeling. . . . I mean, for me, it, it also has a spiritual component. But, you know, it's working with um, the judgment about that person as a human being and really having a stance that this person's doing the best that he or she can. And that, you know, um, it isn't up to me to judge it and to assess it. I mean, I work with it; they're coming to me to do that. But, it's really holding [that they] really truly are doing the best they can. And when I can take that stance, even though my feelings may be upset, usually, it's very interesting, usually my feelings will

follow um, and I will become more compassionate toward [that person]. The therapist reports that by working on herself in this way, it had a positive effect on the treatment.

> I think he picked up the energetic that I was less critical of him and more sympathetic toward him. And then I think he felt and it just all felt friendlier. Um, I think before I was working hard, but it wasn't as relaxed as it became when I kind of got a hold of myself around, you know, disparity of how I was treating them. . . . I think all this can happen on a very subtle level. . . . You know how vicious circles go one way? Virtuous circles go the other. You know, then once I started to be uh, more sympathetic, he relaxed. He became more likable from my point of view. Now, that's not to say I didn't have to work at it, you know, on an ongoing basis. But, it became much less difficult.

*Consultation.* It is not surprising that the participants said they seek consultation to help them get through difficult situations with couples. The consultant may be the one person who can truly help the therapist navigate the unconscious minefield emerging when powerful countertransference reactions are stirred up. Participants noted that it helps them sort through their reactions and develop self awareness and insight into the case. Peer or group consultation can serve the same purpose. One participant said that he did not even know that he was caught up in an enactment until his consultant brought it to his attention. Another said that she talked to several consultants about how to manage her feelings about a very difficult couple.

> I think consultation [is important]. I mean, I know I talked with uh, several different consultants about the case. I talked to a peer consultation group where I complained about them a lot. Uh, the fact that I'm bringing this case to you as an example out of all of the cases is another example of the management, I think – manage what's been put into me.

One participant said that immediately after the session in which the enactment occurred, she spoke with her consultant. Here, she talks about how she could not do without consultation, feeling the need for it when she experiences negative countertransference.

> I couldn't do this work without consultation. You know, I mean, it's just too hard. Because I think that we all – well, I can't speak for the world of therapists – but we have such a tendency to be hard on ourselves, you know, when something um, well, when negative countertransference comes up and you have to hold that negative transference, you know. And you have to just sit here and be the bad guy (laughs). And just say, well, whoa.

Another participant talked about having ongoing consultation with a consultant and a peer group as well. She talks about getting help when an enactment occurs and brings up the point that consultation provides her with a container.

> I've been in ongoing consultation, you know, since I was licensed and I'm in a consultation group now. So there's always some sort of sense of like, I'll get help with this, like I'm not just totally alone in this. I think if I didn't have that container, an outside container, it would be much harder to stay

contained myself within that. So I think there is often a sense of, hey, I'll present this couple and we'll see, you know, I'll get some help, we'll come to figure this out. That, that absolutely helps.

# CHAPTER 5: DISCUSSION

My study explores how psychodynamically oriented couples therapists experience, think about, and deal with situations in which they get caught up and/or act out their countertransference in couples therapy. I refer to these types of reactions as countertransference enactments. The following research questions were posed: Are countertranference enactments occurring in couples therapy, and what are therapists' experience of them? Once therapists recognize an enactment has occurred, how are they thinking about and conceptualizing these interactions? Finally, how are they working through the enactment with the couple?

This research grew out of my interest in enactments and from my own ongoing struggle to understand the intense countertransference experiences I was having as a couples therapist. I realized that there were times I felt I was getting caught up in my countertransference, and from my understanding of enactments, clearly felt that I was acting out. I wanted to know whether other couple therapists were having similar experiences. From discussions with colleagues, I gathered most were having the same kinds of encounters.

In exploring the psychoanalytic literature on couples therapy, I found some, but, overall, very little, in-depth discussion of the therapist's experience during enactments. While there is an increasing body of psychodynamic literature about the therapist's countertransference experience, most of the couples therapy literature deals mainly with case dynamics and the treatment of the couple. Relatively little is written on the therapist's counter transference, especially in reference to its ongoing influence on treatment. My study clearly shows that

therapists are not only experiencing intense countertransference reactions with couples, they are getting caught up in and acting out these reactions. In this chapter, I present my interpretation of the data and examine my findings and conclusions in terms of the literature. The chapter will end with suggestions for further research and limitations of this study.

In the interpretative discussion, I will first show how couples therapists are under pressure. It is this experience of being under pressure which best captures their countertransference experience before and during enactments. Then I will look at therapists' familiarity with the concept of enactments and discuss how some participants were more familiar with the concept of enactments than others. I will show how there are clinical advantages to this familiarity, including the recognition of enactments. In the next section, I will examine how therapists worked with the enactments. Here I will explore clinical experiences in two groups of enactments, those causing a rupture in the therapeutic alliance and those which were ongoing. Next, in further clinical considerations, I will highlight clinical factors that affected how therapists approached the working through process. I will illustrate this with three examples. In the last two sections, I will discuss enactments that derailed the therapy and the value of working through enactments.

## Therapists Under Pressure: The Therapist's Countertransference Experience in Couples Therapy

Enactments occurred to every participant in the study, showing that

therapists are experiencing intense countertransference reactions in their work with couples and, at times, are getting caught up and acting out these reactions. In order to understand why these enactments occurred, it is important to understand their overall countertransference experience. What best captures the essence of couples therapist's experience preceding and during an enactment is the experience of pressure. When the pressure is especially intense, the therapist's thinking capacity can be diminished, and he may be more susceptible to act out on his own uncontained feelings. The result can be an enactment. In the following sub-sections, I will explore the types of pressures the therapist experiences during couples therapy: the couple's high expectations, triangulation pressures, the sheer amount of clinical material, feeling ineffective, and destructive dynamics.

### *Couples' High Expectations*

Some general observations of my experience as a couples therapist are relevant for understanding how the therapist experiences pressure. While these observations are not be true of every couple or couples therapy, since much depends on the couple's level of pathology, they are generalizations that seem to describe some of the particular aspects of the pressures a couples therapist encounters. The stories told by participants in this study reveal that the therapist experiences pressure aroused by such circumstances.

Sometimes couples therapy can feel like a pressure cooker because the demands on the couples therapist are many. Couples often bring an array of intense conflicts to therapy. Arguments have become repetitive and circular with

no solution in sight, leaving many couples feeling frustrated, hopeless and angry. Many lack the skills for resolution. By the time the therapist sees them, partners are often resentful and distant towards each other while also feeling shame that they have not been able to resolve their own problems.

Whatever issues bring couples to therapy, whether it is an affair, endless fighting, some recent crisis, or the feeling that this may be the last chance to save their relationship, many couples hope that the therapist will help them bring back their love. They may have magical (usually unconscious) expectations of the therapist, wanting or expecting quick answers to fix their relationship; they believe all the therapist needs to do is give them "tools," and all their problems can be resolved. Partners usually pressure therapists to meet these expectations, and in turn, the therapist often feels compelled to become the marriage savior (Sharpe, 1997). As Sharpe noted, the couples therapist is often loaded to a greater degree with impossible expectations (like saving the marriage and fixing the partner), while bestowed with less authority than the individual therapist.

Partners not only pressure the therapist to save their marriage, many tend to resist self-examination; they blame their partner for the problems. Projections are rampant, especially in personality disordered couples (Barbera, 2001). Additionally, one partner is often reluctant to be there and is dragged in by the other (Crosby, 1989). These factors can make it harder for the therapist who must find ways to motivate spouses to take ownership for their contribution to the issues.

*Triangulation Pressures*

From an object relations perspective, marriage is seen as an unconscious contract where partners contain split off and disowned aspects of the other, a system of mutual projective identifications (Dicks 1967; D. Scharff & J. Savege Scharff, 1991). According to Ruszczynski (1998), a marriage can get into trouble when one spouse refuses to take on the projections attributed to them by their partner. As that partner begins to individuate from the other, a crisis is precipitated, destabilizing the relationship and often landing the couple in therapy. Sometimes others get enlisted into this destabilized situation (e.g. family members, lovers, ministers, divorce attorneys). The therapist might be another such player in this complex drama. This can lead to triangulation and lead to another set of pressures on the therapist.

In general, the motivation underlying a triangle is that each of the three persons involved will either be seeking closeness with one of the other two or trying to avoid tension by seeking distance in periods of stress (Guerin et al., 1996). In couples therapy, triangulation is the process by which the therapist feels pulled into aligning with one or the other partner. The therapist can feel the pull to get triangulated almost as soon as the partners walk into the consulting room; each spouse tells his/her side of the story, complains about his/her partner, and builds a case for how he/she have been hurt and wronged. Partners tell their stories in part to get the therapist on their side. They are vying for his validation, hoping that they will feel vindicated that their partner was the cause of the problems all along. The therapist feels pressured to respond empathically to both

without taking sides.

Participants talked about how partners often pulled for attention, and how difficult it was to maintain a balanced connection with each one. One participant discussed her dilemma; when she empathized with one partner, it severely disrupted the other, and vice versa. The therapist's experiences in his family of origin, unconscious conflicts, relationship preferences and experiences, communication style, gender, age, ethnicity, values, and organizing principles make it easier for him to empathize and identify with one partner more than the other (Shaddock, 2000, Ringstrom, 1998). In addition, some of the pressure for triangulation occurs on an unconscious level in the form of unconscious collusions (Willi, 1982). Participants discussed collusions and how they led to misalliances (Broderick, 1983; Freedman, 1998).

However, nothing remains static. The therapist's alliances and identifications with partners tend to shift as therapy proceeds. Triadic transferences are fluid and fast moving, requiring spontaneity and improvisation in order to stay in touch with the ever-changing dynamics (Ehrlich, 2000). Most enactments described in this study occurred because the therapist could not easily form an alliance, did not like, or was frustrated with one of the partners. Participants continually found themselves, during enactments, in the middle of some sort of triangulation where there was a push/pull of a shifting alliance, each partner competing for or demanding something from the therapist.

*Sheer Amount of Clinical Material: Pressure from the Intensity of the Work*

Participants also spoke of the complexity of the couples therapist's countertransference experience. The complexity and the sheer amount of clinical material the therapist must attend contributes to the therapist feeling overwhelmed which, in turn, can lead to feeling pressured. Participants described their countertransference experience in couples therapy as complex and multilayered. Many noted that working with the transference-countertansference dynamics can often be more daunting than in individual therapy because, as one participant said, the number of transferential relationships to which the therapist must attend to in couples therapy as compared to individual therapy multiplies exponentially; there are numerous configurations of the transference and countertransference dynamics alive in the room at any one point: the transference and countertransference between the partners, between the therapist and each partner, and between the therapist and the couple as a relational system. One interesting point this participant made is that the therapist may have a pleasant experience of a partner and then an equally negative experience of that same person when observing his behavior towards his mate. Thus, there are many permutations, and the amount of clinical material the therapist encounters is immense.

Partners bring their complex relational histories to therapy and enact these patterns in their struggles with each other. With two individuals and two sets of internalized object relations in the room, the therapist must sort through all the projections and distortions and attempt to understand the complex array of self and object representations (Siegel, 2004). It is as if the therapist is dealing with

multiple mothers and fathers in the room (including his own). Participants discussed the difficulties of trying to keep track of two psyches simultaneously, a challenge by any measure. But what made this more daunting was when partners became reactive or regressed to more vulnerable or fragmented states.

One participant noted how difficult it was to do psychodynamic couples therapy when this occurred. Exploring one partner's deeply regressed state while keeping an awareness of the other partner's reactions is a continuous, intuitive process; the therapist must flow seamlessly between the partners to check how each is responding to the mate or therapist (Solomon 1989). If one partner is involved in important therapeutic work on some issue, and it triggers an angry reaction in her partner, the therapist has to manage two psyches, one vulnerable, one defensive.

This split attention described by participants is normal for the couples therapist. While it can feel almost automatic, it can be taxing, and it requires a large output of energy to manage and track two individuals with constantly changing emotional states. This is compounded by the fast-paced nature of the work; as one participant said, so much happens so quickly between partners and occurs on an invisible nonverbal level, that it is easy to miss what goes on. There are many layers of unconscious meaning in partners' communication. Intimate partners live in a world of private cues, communicating in so many conscious and unconscious ways to each other (Gerson, 1996). Family systems therapists attempted to make explicit some of these hidden rules of behavior and faulty patterns of communication existing between partners (Watzlawick, Weakland, &

Jackson, 1967) For the therapist to immerse himself in that world and disentangle what is going on becomes an enormous task, especially when couples are arguing or locked in a malignant repetition. This type of overload pressures the therapist, who, in his attempt to stay on top of things, must work harder. An overwhelmed therapist is more susceptible to feeling ineffective. This feeling is itself another pressure on the therapist who may tend to overcompensate by overdoing.

### *Feeling Ineffective: The Pressure to Help*

The countertansference theme of feeling ineffective, helpless and incompetent was quite common in the data. All therapists want to feel effective and are invested in doing good work. They want to feel helpful and competent. When things felt stuck in therapy, or couples complained things were getting worse or that therapy was not helping, participants often felt pressured to help more, tending towards enactments of overdoing. In order to counteract feelings of incompetence, shame and failure, the therapist may feel pressured to please or avoid further displeasing the client. One participant, feeling pressured to save the marriage, worked harder when things looked like they were failing.

Hill (1999) discussed how therapists get "wiped out" working with couples, and this can be seen as a "shared defense" against helping the couple think about feelings and issues that are intolerable, such as disappointed expectations, acceptance of differences and the limitations in the relationship, or the decision to separate. This could lead to therapists feeling ineffective. Whatever the

underlying reason, feeling ineffective seemed to result in several types of therapist over-activity: giving excessive advice, over controlling the session, becoming overly intrusive, and over-accommodating. In one or two cases, it also led to a certain paralysis and under-activity by the therapist.

### *Hurtful and Destructive Dynamics*

Many couples are entrenched in very stuck negative patterns of interaction; these dynamics become more intense depending on the level of the individual's pathology. For example, in borderline/narcissistic couples, it is typical to see acting out behaviors such as excessive blame, splitting and projection, anger, emotional and physical abuse, lack of containment, and the inability to take responsibility for issues. But even partners who are not characterlogically disturbed tend to get stuck in unproductive patterns where they say and do hurtful things to each other. Witnessing the raw intensity of such interactions often triggers the therapist; it can sometimes be so intense that it provokes a secondary traumatic stress reaction, particularly with raging or borderline couples (Herman, 1992). Participants spoke of being adversely affected by not only having to observe such painful and sometimes destructive dynamics, but also by the fact that they felt responsible to do something about it.

Therapists get pulled into the conflict with the couple when such dynamics are occurring because it is their job, but other factors are at work as well. One factor may have to do with the pain of the emotions being expressed, which I believe pulls the therapist in. A participant speaking from a Kleinian perspective

had one idea why this occurs. She said when partners are attacking and blaming each other, they tend to be in the paranoid-schizoid position. In this mode of relating, the partner attempts to evacuate affect onto the other and loses the capacity to think, increasing the tendency to act out. According to this participant, the therapist can also be swept into the paranoid-schizoid position with the couple; partners who are attacking each other can pull the therapist into the attack/blame mode as well. The participant said, "Forget about doing couples therapy when partners are stuck in this mode."

Perhaps another way to explain this phenomenon is through what has been called affect or emotional contagion. Affect contagion is the simple idea that affects are contagious; when one person strongly feels a powerful affect, another person, who is in strong empathic connection with that person, will tend to resonate with the affect, and "catch it," much like a tuning fork will cause another tuning fork to vibrate to its same frequency. This is experienced often in intimate relationships; for example, when one partner is in a bad mood, this mate may come into contact with her and get into a bad mood as well. Similarly, when couples fight, the pain of the couple's hurt and anger activates strong emotion in the therapist.

This idea overlaps with projective identification, in which the therapist is induced through verbal and nonverbal communication (interactional pressure) into thinking, feeling, and behaving in accordance with the partners' projections (Klein 1946; Ogden, 1979). Because the therapist may have a valence for the projection, his vulnerabilities and conflicts are activated and, thus, his experience is more

profoundly felt (Bion, 1961). Projective identification is a highly evocative communication that touches on deep unconscious states in another (Likierman, 2006). Whether the pull comes from the intensity of the affect, the resonance with the paranoid/schizoid position, or the interactional pressures of projective identification, the experience of the therapist is as if he is being "sucked into the system" (Slipp, 1988).

Another reason the therapist experiences pressure in this situation is because, as one participant said, the couple therapist is often forced to manage an enormous amount of aggression. This participant was referring to sadomasochistic relationships, but this can apply to almost all couples in therapy because most couples argue. When partners fight and blame each other, the therapist must often find a way to curtail the couple's unproductive anger to prevent further escalation. It may be difficult for the therapist to contain the conflict because managing the crisis usually requires an ongoing effort. Especially when partners are angrily hurting each other, the therapist may experience an ethical pressure because he bears clinical responsibilities towards two individuals and feels compelled to protect them from further harm (Pizer, B., & Pizer, S., 2006). The therapist can be pressed into action without having time to think. The Pizers state, "At such moments, the couples therapist may feel impelled to act unreflectively as a conscripted player in the drama" (p. 82). Several participants discussed being triggered by these kinds of destructive dynamics.

Therapists can be forced to manage anger and frustration within themselves as well. This was one of the most common countertransference themes emerging

in the findings. Heimann (1950) observed that strong emotion of any kind (love, hate, helplessness, or anger) impels one towards action rather than contemplation. This was certainly true for participants in this study. Several enactments occurred because participants became frustrated or angry with one partner's troublesome traits (e.g. passive-aggressive, angry, critical, sadistic, passive, critical, narcissistic, etc.). Some situations leading to these negative countertransference feelings included power struggles, feeling demeaned and criticized by a partner, or strongly disliking a partner or couple. While participants did not necessarily explicitly discuss the experience of pressure, the underlying feeling expressed was one of internal tension and building anxiety. When tensions build, more pressure is experienced.

In addition, an aspect of the therapist's experience, not reported directly in the findings but implied, was the length of time therapists had to tolerate negative countertransference. Participants had to endure long periods not only of frustration, but confusion, hopelessness, incompetence, and other difficult countertransference affects as well. Containing one's frustration and anger for long stretches of time can tax patience and ability to sustain containment. Despite one's best efforts, all therapists have a breaking point when pressures become overwhelming. This is the point where an enactment can occur.

In one situation, a participant said she worked with a sadomasochistic couple for quite a long while before the enactment occurred. She endured long periods of frustration with the couple, witnessing their abuse. Her primary approach was to make interpretations about their sadomasochistic dynamics, but she felt like she

was making very little progress. Finally, in one session, she blurted out to the husband (the masochist of the pair) "Why do you put up with this?!" Why, after so much time, did this therapist finally reach her breaking point? While there may be many underlying reasons, the therapist did try to explain why she finally snapped. She suddenly became acutely aware that the wife made her feel impotent and devalued, and though the frustration had been building, it was this emerging experience that sent her over the edge. These feelings had been unconscious until they suddenly erupted in the enactment.

## Familiarity With the Concept of Enactment

In this section, I will look at participants in terms of their familiarity with the concept of enactment. I detected two groups of participants, those who were more familiar with the concept of enactment and seemed to employ the concept as a way to think about the transference-countertransference dynamics, and those who were not as familiar with the concept. I will explore the evidence suggesting how those more familiar with the concept have a clinical advantage in working with enactments.

Those with familiarity appeared to understand some of the unconscious processes underlying enactments and have a grasp on how they played out in the transference-countertransference dynamics. Based on their responses in the interviews, they were able to define an enactment conceptually and describe its properties. They sought to interpret the interpersonal dynamics of the enactment and also seemed to use the concept to help them identify and think about aspects

of their countertransference experience.

One advantage these participants had was in the recognition of an enactment. They talked about how they tried to look for clues in their behaviors that might signal the emergence of an enactment. Clues mentioned included breaks in the frame, losing neutrality, excessive chattiness, focusing too much on one partner, extending a session, body tension, rising anxiety, and becoming defensive. These participants appeared to be able to detect the more subtle gradations of the enactments they described and consequently were closer to uncovering some important aspect of their countertransference experience.

These participants also seemed to have ways of working through that made understanding the enactment more useful and meaningful to the couple. They explored and interpreted the meaning of the enactment and how the transference-countertransference played out among the threesome. They showed more belief that enactments are a valuable and necessary part of the work; this seemed to help them accept and tolerate their own enactments with less shame. It helped them open an analytic space to explore the meaning of the interaction rather than simply mending the rupture. I also think it overall helped these therapists contain their feelings, making them a little less inclined to enact. One participant agreed, stating that therapists who have a model of enactments are probably less prone to enact because they have a way to think about and manage their feelings.

While all the participants were seasoned therapists and seemed to have effective ways of working and dealing with enactments, participants who were not as familiar with the concept seemed to have more confusion about enactments.

Most had difficulty in defining the concept, and for some, it did not appear to be part of their theoretical approach. Others had heard of the concept, but they did not seem to employ it in their practice. Since they did not think in terms of enactments, they found it more difficult to label a behavior an enactment and would probably not have labeled their countertransference reaction as an enactment had it not been for my study; I believe they labeled their reactions retrospectively.

However, these participants, in general, were aware of acting out. All the therapists in the study were experienced psychodynamically oriented clinicians who are accustomed to examining and working with their own countertransference. All participants had a subjective sense about when they were beginning to get caught up in their reactions and were able to provide excellent examples of this. Before the interviews, I asked participants to think of times when they got caught up in their countertransference or acted out with a couple. Therapists can relate to the terms "caught up" and "acted out;" these words convey a more visceral quality to one's countertransference, (even though "acting out" has a pejorative connotation).

## How Therapists Worked Through the Enactment

There are many variables associated with how a therapist attempted to work through an enactment with a couple; in this section I will explore some of these. But first, a caveat. Enactments involve complicated relationship entanglements, taking time to develop and time to work through. Because of the complexity of

the clinical material and the brevity of the interviews, it was difficult to get an in-depth understanding of how therapists actually worked through these difficult passages. I felt I was able to get only a general understanding of how therapists approached the working through process, and I had to make several inferences about the clinical data.

In this section, I will analyze how therapists approached the working-through process and explore some of the clinical experiences they encountered during enactments. I will examine two groups of enactments. The first group contains those which caused a rupture or break in the therapeutic alliance, and the second group contains ongoing enactments. I will then discuss further clinical considerations: factors that played a role in affecting how the therapist approached the working-through process. I will highlight these factors through three brief case vignettes. In the third part, I will discuss enactments that derailed the therapy. Finally, I will conclude with a discussion of the value of working through enactments.

### *Two Groups of Enactments*

Participants described many different kinds of countertransference enactments, each having various properties. For example, what was the type of enactment? Was it playing out a role? Was it a frustration-anger type enactment, etc.? What was the enactment's emotional intensity? Did it have a strong impact on one or both partners? Did they react differently? What was its duration? Was it a one-time event or ongoing? The answers to these questions, the kind of

couple, the therapeutic context, and other such clinical factors affect how the therapist worked through the enactment with the couple. While there are many ways to classify enactments, in this section I will examine two basic groups of enactments and some of the clinical experiences of the therapist within each group. There is some obvious overlap because enactments resist categorization, but for the purposes of analysis, I will examine the two groups separately.

The first group of enactments were those which caused some level of rupture or break in the therapeutic alliance. Although not all enactments in this group caused the same degree of disruption to the therapeutic relationship, they were similar in that they did cause some. Often there was a build up of tension in the relationship between the therapist and couple, or with one partner, which ended with the therapist saying or doing something that hurt, angered, or criticized the partners. Other times the disruptions came from a therapeutic misjudgment, a mistimed intervention or an inadvertent remark. In one case, it came from the therapist's inactivity. Depending on several factors, such as the strength of therapeutic alliance and the severity of the rupture, the therapeutic alliance was adversely effected; the stronger the alliance, the more successfully the therapist and couple were able to work through the rupture.

The second group of enactments were those in which the therapist unconsciously enacted a role or was in compliance with some other pressures for a longer period of time; these enactments tended to be ongoing. Or, the therapist was pulled into some kind of repetitive action. While strong countertransference still occurred, these enactments usually did not cause a major disruption in the

therapeutic relationship. In both enactments, but especially in the latter type, the interactions can evoke confusion, feeling overwhelmed, anger, feeling ineffective, and sometimes dissociative and fragmented states in the therapist. These feelings can sometimes persist for quite some time.

*Enactments Causing Rupture*

In this category of enactments, participants usually had to deal with several clinical issues. Most participants seemed to feel a pressure to repair the rupture with the client(s) while attempting to contain their reactions. While experiencing this pressure, participants also had to manage their shame and guilt and think about how to handle apologies and explanations therapeutically. Therapists also had to deal with the transference-countertransference dynamics that emerged as a result of the enactment. In the following discussion, I will consider these issues.

In most of the enactments in which there was a rupture or break in the therapeutic relationship, conflicts and vulnerabilities were often triggered in both client(s) and therapist. Both were provoked and upset. Therapist and client(s) felt: misunderstood, criticized, hurt, angered, confused, impotent, hopeless. Because they were reactive, many therapists found it challenging to contain their countertransference sufficiently to explore the client's experience. The majority of participants continued to be reactive even after the initial enactment, and some were reactive for weeks. Acting out did not necessarily dissipate the tension. In one case, the therapist said he found himself to be in a kind of competitive battle with the husband which extended for many sessions; he was never really able to

explore the husband's experience.

In addition to the strong countertransference reactions, most participants felt shame and guilt about hurting and upsetting their clients. Although they did not expressly refer to shame and guilt, it was certainly implied. Participants said of their enactments "it was a "mistake," a "therapeutic misjudgment," "I blew it," "I wasn't doing my best work," "I felt horrible," "it was a childish thing to do," I had really ruined it," "I messed up so bad and ahhh!" A few felt they lost control of themselves. Clearly, several participants seemed embarrassed by their behaviors; they laughed self-consciously when they told me about their acting out. It is embarrassing for all of us to reveal stories of how we blew it with clients.

A therapist feeling bad about his enactment can often experience a pressure to repair the relationship, and this pressure may extend the enactment (Haldane & Vincent, 1998). There may be times when the therapist, out of a sense of shame or guilt, attempts to repair things too quickly; he may apologize as a way to alleviate guilt for the harm committed. This could be a way of undoing the act through an immediate reparation. This may have the effect of foreclosing exploration of the deeper meaning of the enactment and other strong feelings. Apologies, according to A. Goldberg (1987), can sometimes shut down the process. He said apologies are complicated and need to be approached according to the particular transference situation. What A. Goldberg means is that if apologies are just given without forethought, the deeper meaning of the therapist's and the clients' reactions might be missed. The therapist's shame can also interfere with his ability to empathize with the clients' experience (Howell, 2005).

Several participants apologized for upsetting their clients, and in some enactments, it seemed to be an important part of the repair process. In other cases, some participants seemed to apologize almost without thinking about it, and the apology may have foreclosed further exploration of the meaning of the enactment. Overall, it was difficult to determine which apologies may have constituted a continuation of the enactment because I do not have enough clinical data to make that assessment, and I did not explore this question sufficiently. The important point is that the therapist encounters new pressures even after the original enactment occurs, and if the therapist remains unconscious or is unable to contain his countertransference guilt and/or shame, he can act out again, collapsing the space for exploration.

Similarly, the therapist can also feel a pressure to explain himself and reveal why he acted out. Should he give a rationale for his behavior? Should he freely admit his fault and take ownership for his contribution to the enactment? Should he disclose his countertransference feelings? And if so, to what degree? Should he disclose only his feelings about the clients or should he discuss his vulnerabilities and conflicts as well? Because participants did not reveal in detail what was said in sessions, it is hard to ascertain the level of personal sharing. As discussed in the findings, two participants weighed in on the issue of self disclosure, generally cautioning against it, but recognizing situations in which it may be appropriate.

Certainly, an enactment is the kind of clinical event that pressures the therapist to explain himself. Would not a therapist want to defend and explain

what happened for him? I think many feel compelled. Whether it would be therapeutic is another question. Some clients may want to know why the therapist acted in such an unprofessional manner. "What got into him?" "It is so unlike him." The therapist's personal sharing may help some clients feel a sense of trust (Little, 1951).

Several participants did share their personal reactions; they explained themselves by disclosing why they reacted the way they did. In a few cases, participants said they became defensive in explaining themselves. One said she tried to justify why she acted out. In the several other cases, the sharing of personal reactions was seen as therapeutic for the couple. For example, in the case where the therapist snapped at the husband when she lost patience as he reverted to his angry and defensive ways, the therapist gave him feedback about her behavior. The feedback had a powerful and positive impact on him and corroborated his wife's experience of him. In a few cases, the therapist's transference interpretations included personal reactions as well. When these therapists revealed how they were affected and how the enactment played out among the threesome, they decided it would be therapeutic to share some of their personal feelings. These seemed to make the interpretations more effective.

Maroda (1999) believes it is important for the therapist to take responsibility and to admit what he is feeling, as long as the therapist deems the self-disclosure therapeutic. The therapist need not go into extensive explanations about why he enacted, but some explanation is helpful to the client, according to Maroda. It shows the client the therapist acknowledged that an enactment has occurred, is

potentially useful, and needs to be talked about in an open and honest way. It also shows that each had played a role in the enactment, and the therapist can take responsibility for his participation. Lander and Nahon (1995) take this position as well. However, the therapist must also be careful to not make it all about his experience. As Chused (2003) states, it is the patient's experience of the interaction, not the therapist's, that is ultimately therapeutic.

Along with dealing with the rupture to the therapeutic alliance, enactments usually constellate several transference-countertransference themes in the therapy. In several of the cases, enactments brought up transference themes that had been percolating in the treatment for some time. For example, in one enactment, issues about how the partners manipulated and controlled each other (and the therapist) as a way to avoid intimacy emerged. Another brought up themes of impotence and feelings of devaluation among the threesome.

The manner in which these dynamics were explored and discussed depended on the therapist's approach. Some participants actively engaged in working with the transference-countertransference dynamics and in exploring the meaning of the enactment. Those familiar with the concept of enactment worked in this way; these participants attempted to repair the rupture, but also attempted to make sense of the enactment to make it useful for the couple.

For example, in the enactment in which the participant acted out by giving an ultimatum to the husband, the therapist explored transference themes of power dynamics and how this played out among the threesome. She offered insights about how she believed the enactment occurred. The therapist was able to process

what occurred, gain a deeper understanding of her countertranference, help the couple make sense of the interactions, and give meaning to the acting-out behaviors. Therapists who only repair the rupture without exploring the meaning of the enactment may skip a valuable part of the process.

*Ongoing Enactments*

Not all the enactments resulted in a rupture or a break in the therapeutic alliance. Another group of enactments described by participants were of a different nature; they did not end in a dramatic act disrupting the therapeutic alliance. Rather, they tended to be more ongoing, lasting for weeks, even months. Examples of these kinds of enactments were ones in which the therapist enacted a role such as parent or judge. Sometimes the therapist complied with other pressures from the couple, such as the partners wanting the therapist to change their mate. This also occurred in situations in which the therapist entered into a unconscious collusion with a partner. An example of the latter occurred when the therapist felt she enacted by colluding with a wife not to confront a hostile husband.

These ongoing enactments seemed to be more elusive; they were difficult for the therapist to get a hold of because, while the therapist was still succumbing to pressures, it was often harder for him to get a sense of what was going on in the therapy. The therapist may not have experienced the build up of charged emotion that results in a dramatic and rupture-causing act, although intense countertransference still occurred. This type of enactment seemed to continue

throughout a period of time, meaning that the therapist remained unconscious about some aspect of his countertransference. The therapist may have had an inkling that he was in an enactment; he knew the signs and may have been able to observe himself and yet still be unaware of why he was acting the way he was.

I will provide two brief examples illustrating the diverse clinical experiences of the therapist involved in an ongoing enactment. In the following examples, the participants were familiar with the concept of enactment, but each had a different kind of clinical experience.

In the first example, the participant was caught up in pursuing an "impenetrable" wife. The therapist described this as an enactment that was not "working out so well." He felt that he was continuously focusing on the wife, and said this energy "feels forced in him." He felt "hooked." Something about her was chaotic; she was hard to pin down and understand, and he felt compelled to pursue her to get clarity. This was how he knew he was caught in an enactment. The therapist also knew the wife wanted the husband to pursue her, so the therapist realized he played out a dynamic in the threesome. Despite his understanding of these dynamics, the therapist felt he continued to get caught up in the enactment and could not stop himself from focusing on her. He states, "With this couple, it's very hard for me to get out from under this. . . . I don't think I have a good handle on really what's going on."

Even though the therapist knew they were all caught up in a powerful dynamic, something felt comfortable and familiar. He said there was a "lightheartedness" about the whole thing –"well, can't get out of this." The

therapist felt stuck, though he did not seem all that upset about his enactment; he was comfortable in his not knowing. He had an ongoing awareness of his participation in the enactment, while also being unable to stop it. Black (2003), a relational psychoanalyst, referred to this type of experience as a "watchful dissociation":

> Although at these moments I am certainly not feeling in control, often I am aware of a kind of watchful dissociation – which does not register as a feeling of simply being out of control. I feel I am using myself, letting myself be used, to "test something out." (p. 639)

There are certain elements of Black's statement which seem to mirror aspects of this therapist's experience: watching himself enact without complete loss of control. Since this was one of the participants who had a familiarity with enactments, perhaps this familiarity helped him to stay open and tolerate the experience of not knowing until more clarity arrived. Though frustrated about feeling stuck, he also seemed to feel a certain confidence that the enactment would eventually work itself out.

Apparently, in these types of enactments, therapists can remain in a confused or muddled state for long periods of time. Not that this is such an unusual experience for a couple therapist, nor does it always indicate an underlying enactment. But it does speak to the enactment's powerful hold on the psyche. Some participants talked about experiences in which they suffered through long bouts of chaos and confusion and reacted to these states by enacting. This particularly occurred with couples with personality disorders, those with a chaotic

and destructive style of relating; they can provoke overwhelmingly intense countertransference experiences.

An example that stands out was the therapist who worked with the couple who never agreed about anything; they discounted and devalued everything they said to each other, making the therapist feel crazy, confused, and overwhelmed. The therapist said she had to contend with feeling almost psychotic; she felt unreal with the couple, like there was no truth, no ground to stand on. As a response, she felt her ongoing enactment was to take on a role of a judge: looking for the facts in what each said, seeking the truth, determining who was right/wrong, and who was at fault. Though she realized this did not really move the therapy forward, it was an enactment borne out of an anxiety that she would be unable to determine what was real.

This therapist said that sometimes when this craziness occurred, she would go totally blank and be unable to think or hold on to her reality. This was when she tended to enact. The more she worked with the couple, the more crazy, chaotic, and lost she felt. At other times, she was seized by very powerful and intense countertransference reactions such as hate and anger. She even came to the point of experiencing a "breakdown" where she felt she could not care anymore; she was done trying and done thinking about them! She just wanted to melt into the chair and give up. Yet, another part of her wanted to get a grip and try to grasp what was really happening, to find the "emotional center." She knew she was caught up, but could not respond differently to the pressures in the room.

In thinking about this therapist's experience, I am struck by her profound

states of confusion, chaos, and fear of disintegration. These can be seen as fragmented and dissociative states, places where the therapist goes blank, gets lost, cannot hold onto herself, feels unreal. These kind of primitive states find their origins in fragments of infantile experience, which includes psychotic anxieties of disintegration and annihilation of the self (McCormack 2000). According to McCormack, couples with severely traumatic backgrounds, such as these partners, are able to activate the incompletely resolved chaotic aspects of the therapist's unconscious. This occurs through a "couple transference-countertransference" (D. Scharff & J. Savege Scharff, 1991). The partner's transference to each other – their relational style, the conscious and unconscious ways they communicate with each other (including mutual projective identifications), the manner in which they enact their conflicts – can eventually get under the therapist's skin (Sharpe 1997; Slipp, 1988). It can induce the therapist to experience what it feels like to be in their relationship, which in the above case, consisted of a crazy-making, chaotic, and relentlessly negating way of being with each other.

McCormack (2000) thinks a therapist is usually driven to respond to such a couple by relating to their tumultuous feelings in a content-bound, solution-focused way. Such an approach helps the therapist maintain psychic equilibrium by distancing from the pull of the chaotic mess. This is the manner in which this therapist approached the couple. Her enactment, as she put it, was to look for the facts, seek what is real, search for the truth, find some ground. Though McCormack states this approach is not ultimately therapeutic, (and this therapist

agreed), the pull to enact when encountering these dynamics is overpowering despite one's best efforts. No matter how aware of the dynamics and the triggers, sometimes the therapist is vulnerable to the powerful undertow of volatile, churning affects.

### *Further Clinical Considerations*

Therapists must take several clinical factors into account when working through an enactment with the couple. Enactments, like couples, cannot all be approached in the same manner. Also, each therapist has his own unique clinical style. While it is beyond the purview of this study to discuss these clinical factors in depth, I will highlight how a few factors affected how the therapist dealt with the enactment.

My first example illustrates how the therapist's clinical model influenced his working through the enactment. The second example shows how the therapist had to adjust her approach to fit the client's needs. The third example illustrates how the enactment itself determined the way the therapist worked; certain enactments may require different ways of working.

The first example is from a participant who is familiar with the concept of enactment and used this knowledge to inform his understanding of the transference-countertransference dynamics. It appears this therapist's approach was to facilitate the development of insight (emotional and cognitive) and demonstrate that the enactment symbolically encapsulates the couple's conflict. This was accomplished by exploring the deeper meaning of the enactment in

terms of how it played out among all three parties in the transference-countertransference dynamics. This therapist's goal appears to be to increase a client's capacity to reflect and think about their feelings and impulses so they will have a clearer understanding of why they act the way they do and be less inclined to act impulsively in the future. Also, as the therapist comes to understand his countertransference, he understands its ongoing influence on the couple and their treatment.

In the case presented, this therapist found himself trying to comply with each partner's request that he change the other. The therapist, seduced by his affection for the couple, continuously attempted to please each partner by complying with their requests until he realized he was entangled in an enactment. He told the couple that their desire to control one another derived from their fear of intimacy and that he, too, had been caught up in these dynamics. The therapist's interpretation was explored in depth, and the couple made positive use of this experience.

Because this participant has a background in working with enactments, I believe this helped him therapeutically; he has guidelines about how to work through the enactment because he is familiar with the territory, though, like all of us, he is not immune to enactments. In fact, the therapist had not even recognized his enactment until his consultant pointed it out. But his acceptance of enactments as a normal and necessary part of the work seems to have made him less prone to shame and guilt and helped him maintain an analytic space to think in an open and exploratory way.

The second example illustrates how the therapist had to make an adjustment in her clinical approach to fit the client's needs. The therapist had repeatedly attempted to interpret the dynamics of the relationship to the couple, but saw that the wife felt criticized and misunderstood. Because the client resisted, the therapist felt thwarted, frustrated, and not heard. The therapist realized she was caught up in her countertransference, but kept trying to explain, in a nonjudgmental way, the negative cycle occurring between them. However, the wife heard this as insult. Realizing that she was going to lose the case unless she changed from an interpretive style to a fully empathic one, she completely let go of her agenda and shifted to a different level of working, one fully committed to listening and understanding the wife's experience. This slowly helped restore the connection to the wife.

Steiner (1992), a Kleinian analyst, in his article on patient centered and analyst centered interpretations, believes that certain patients who may be functioning at the paranoid schizoid level cannot take in the analyst's understanding (i.e. interpretation) because they are not ready; their main concern is to obtain relief and security. The wife seemed to be operating at this level, hearing everything as a criticism no matter how the therapist expressed it. It was not until the therapist switched to a completely empathic mode of attunement and understanding that the woman could find relief and feel secure. While both kinds of approaches lead to deeper understanding, each follows a different path (one through understanding and one through explanations), and the right approach may determine the successful working-through of the enactment.

The third example is illustrative of how some enactments do not lend themselves to either interpretive or reparative/exploratory approaches. Sometimes it is the type of enactment that determines how the therapist will approach the working-through process. One participant said she had a strong disliking of the husband; she felt triggered because he acted in a crazy-making and controlling manner towards his partner. The therapist believed her enactment was that she was unable to empathize with his experience because she felt so irritated and critical of him; she believed he picked up on this. When she was with him, she felt "like all my feminist bones were just rattling."

In analyzing the case, the participant said she attempted to get her negative reactions out of the way. She also worked at developing a compassionate stance in order to develop empathy towards him. One could presume that the therapist was feeling guilt for disliking her client and was attempting to rid herself of her bad feelings towards the husband by denying or pushing them aside (Winnicott 1949). If this were true, I think her negative countertransference would find its way back into the treatment and would constitute the continuation of the enactment.

However, my sense is that this participant attempted to work through her negative countertransference with more conscious awareness. She spoke of becoming aware of her projections onto the husband and made efforts to analyze them. Her attempts to contain and tolerate her countertransference seemed to be a way of working through her negative feelings rather than ridding herself of them. Perhaps her ongoing efforts at developing a compassionate stance was her way to

strengthen her capacity to bear her negative countertransference. Tolerating her countertransference was this participant's way of dealing with the enactment (Hill, 1999).

Carpy (1989), a Kleinian psychoanalyst, addresses how the therapist tolerating powerful countertransference can lead to therapeutic change. Referring to individual psychotherapy, Carpy discusses cases where the therapist experienced intense countertransference as a result of the patient's projective identification. Because not all patients are able to make use of the therapist's interpretation, Carpy believes the therapist must tolerate his feelings without any interpretation or explanation to the patient, but must do so in a way which shows the patient he is affected by the projections. By this, Carpy means:

> It is an inevitable partial acting out of the countertransference which allows the patient to see that the analyst is being affected by what is projected, is struggling to tolerate it, and, if the analysis is to be effective, is managing sufficiently to maintain his analytic stance without grossly acting out. (p . 289)

The result of the process is the patient is gradually able to re-introject the previously intolerable aspects of himself as well as the capacity to tolerate them, a process he has observed in the therapist.

This process seems to mirror several elements in the above case; the therapist experienced a gradual shift in her negative feelings as she tolerated her countertransference. Gradually, she discovered what was sympathetic and likeable about the husband. As a result of being seen in a more positive light, the

husband became relaxed and less guarded in the sessions, and this led to a more productive treatment.

### *Enactments That Derailed the Therapy*

Therapists were not always able to repair the ruptures that occurred as a result of the enactment. Some enactments derailed the therapy. In the twenty three enactments reported in the study, eight ended in premature terminations, and of those eight, three clients quit within a session or two after the enactment. Participants said the enactment probably caused the early termination. In this section I will analyze some reasons why enactments derailed the therapy, basing my observations on the data. As Maroda (1999) points out, enactments can advance the therapeutic process or derail it, and this was certainly borne out in the study as participants were not always able to work through the enactment with the couple. In fact, sometimes the therapists were not given the chance.

Many therapists assume they should be able to handle whatever difficult negative countertransference arises, but in reality, therapists can be deeply affected by their clients. They are not always able to recover quickly from ways that clients can hurt, devalue, or anger them, nor are they always able to contain their negative countertransference reactions. When a therapist has acted out, if he is not able to sufficiently contain his feelings and/or become aware of the conflicts being activated, the enactment can continue. In such circumstances, there is a potential for the enactment to cause an impasse in the therapy or derail it. There were no examples in the study of the former, but several of the latter. A brief

example will illustrate this point.

In one case, the therapist felt so extremely humiliated and hurt by the wife's devaluing comment, the therapist began to criticize and challenge the wife until she finally quit therapy. The therapist realized she was acting inappropriately, and felt badly about it, but could not get a handle on her feelings nor stop herself from criticizing. During our interview (at least two years after seeing this couple) the therapist said she still did not fully understand why she had gotten so provoked. She knew it was difficult to be devalued, but she was still somewhat vague about the deeper reasons why this woman had triggered her. We have all had similar experiences where we are not able to contain or get clarity about our negative countertransference. Sometimes the understanding simply evades us.

The therapist's intense emotional reaction points to the activation of a vulnerability or conflict, and when this occurs, Maroda (1999) urges us to remember that the therapist in the throes of strong countertransference is under the influence of the same type of repetition compulsion as the client. Even though the preceding example was of shorter duration, and the therapist did not have much opportunity to work it through before the couple quit, I consider Maroda's comments to be applicable. The fact that the therapist could not get a handle on her behavior suggests it. Maroda goes on to explain how the experience of unconsciously stimulated strong, or even overwhelming affect, may be completely out of the therapist's control, and is inevitable; but the therapist still needs to try to be in reasonable control of how he or she behaves. Enactments will happen, but once they happen, it is important that therapists attempt to contain acting-out

behaviors as soon as they are able. Maroda expresses this with a full understanding of just how difficult it is for all of us to manage intense countertransference feelings.

Sometimes more subtle enactments derail therapy. In two cases, the therapist's misjudgment appeared to cause a breach of trust in the therapeutic relationship. The therapists had not realized it at the time, and only after they saw the client's reactions and the eventual derailing of the therapy did they realize that their interventions were mistakes influenced by their unconscious countertransference.

For example, in the enactment in which the therapist pointed out to the wife that she was in danger of having an affair, the wife got upset and shamed, and eventually quit treatment. Although the therapist apologized, she felt she was correct in her perceptions, but had been too quick to interpret them. The trust was never repaired, and the therapist said ultimately her client wanted the right to have her reality prevail in the relationship. The therapist also felt she had a right to her perceptions about the situation, and this power struggle appeared to be one of the factors that breached the trust.

There might be several ways to think about the case, but since I do not know all the clinical details, I can only make a few generalizations. Certainly any therapist who is caught up in an enactment potentially has the power to insure that her reality prevails. It might be very difficult for any therapist to see how she over-identifies with the role of expert or final arbiter of the truth (Shaddock 2000). I do not know if that occurred in this case. From an intersubjective perspective

this situation might also be viewed as a transference disjunction (Stolorow, Brandchaft, & Atwood, 1987). The therapist and client, because of their differently organized subjective worlds, are not able to understand each other; if the therapist repetitively assimilates the client's material in a way that significantly alters its meaning, it leads to misunderstanding, impasse, and even premature termination. In this case, the therapist may have formed a therapeutic conjunction (alliance) with one spouse and a disjunction (misalliance) with the other (Ringstrom, 1994, 1998, Trop, 1997). While this is a common occurrence in couples therapy, if a misalliance is ongoing, it can lead to a premature termination.

In several of the premature terminations, I can only imagine that the clients had an experience of the therapist's reaction that was severe enough to break the trust with the therapist. Did these clients feel that the trust was irreparable? It is hard to know. In one case, the therapist had such an intense reaction from a power struggle with the wife that it took the therapist two days to recover. How must the couple have felt? I imagine they were hurt by the encounter as well because they did not return to treatment. In another case, the therapist allowed the husband to vent his anger on his wife for an entire session. It made clinical sense from the therapist's point of view; the wife had vented her rage for months and the therapist felt it was now the husband's turn. However, the therapist later realized he misjudged because the wife was emotionally very fragile. I can only speculate that the wife felt hurt or betrayed by the therapist for allowing the husband to rage at her. She would not even talk to the therapist afterwards.

Enactments are ubiquitous and inevitable, and while they certainly can be a valuable part of the work, especially if approached with awareness and sensitivity, they can also can derail therapy and potentially hurt patient and therapist alike. Despite the fact that all the participants are caring, conscientious and self-reflective, these kinds of enactments occurr to all of us.

*Value of Working Through Enactments: "It was a good mistake to make"*

Participants talked about the importance of working through enactments and how it contributed to therapeutic progress. As one participant said in describing her enactment, "It was a good mistake to make." This therapist referred to an enactment in which she snapped at a husband but was able to process it successfully with him. Later in therapy, she again became frustrated with the husband, but because they had successfully negotiated the disruption and developed a trust, they were able to draw on the previous rift as a resource. This deepened their connection, and also helped the client be more resilient when the frustrations arose again later in therapy.

Another participant compared the process of therapists making mistakes to parents. When parents inevitably make mistakes, it can be developmentally formative for the child. She said the same holds true for the psychotherapist who helps the clients negotiate an enactment; it can spur therapeutic progress because therapist and clients must work through a painful, difficult passage together. Hill (1999) states that an enactment, while difficult and painful, creates a shared experience that cannot be ignored. When the process is negotiated with awareness

and honesty, an empathic bond can be created between the therapist and couple. The therapist's mistake becomes an essential component of therapeutic change (Tower, 1956).

A therapist working through the enactment also models for the couple how to work through conflict (Dasteel, 1994). While the therapist can coach conflict resolution skill-building, working through an enactment affords a first-hand experience for the client to process conflict directly with the therapist (Pizer B. & Pizer, S., 2006). The therapist, in struggling to contain his strong reactions, models how one holds onto one's reactivity while also attempting to exercise reflective listening. This is usually a couple's most challenged capacity – to contain defensiveness while keeping a space open to listen to the partner's upset and anger. The couple also observes how the therapist actually works through the conflict – how he asks questions, explores the other's experience, gives feedback, and even how he apologizes (Willi, 1982, 1984).

Enactments also provide opportunity for partners to observe how therapists take responsibility for their part (Goldberg, 1985b). Blame and the lack of taking ownership is one of the things plaguing many relationships and holding back couples from making progress. That is why it is important for the couple to observe how the therapist handles his reactivity. Does he try to examine himself? Is he accountable? He models how to take responsibility and be open, even when he is feeling defensive.

Enactments create an opportunity for each partner to gain insight. There are various ways the facilitation of insight occurs during couples therapy, but one of

the most important occurs during an enactment. The intensity and immediacy of the enactment experience heightens an individual's senses and feelings. The transference-countertransference dynamics are alive in the room. The moment is pregnant with tension and possibilities as everyone is alert to the present. It is during such times that the therapist can make here-and-now interpretations that are potentially transforming (Gill, 1979; Strachey, 1934). Insight can occur on both cognitive and affective levels. One participant referred to these types of interpretations as "office data," he said it is very powerful to show clients what they have done by providing them with many different examples of their actions with each other and the therapist. He suggested these types of interpretations can be quite effective because everything happened in the room and was experienced by all.

## Relevance of the Findings to the Literature

Here I review the salient points of the literature and contrast and compare them to my findings. While referring to the literature reviewed in Chapter 2, I will also include references to literature discovered during the process of analysis that was relevant to helping me understand aspects of the data. To provide a context, I will first present a brief overview.

In order to understand the concept of enactment, I began my literature review by looking at the psychoanalytic literature relating to countertransference, acting out and enactments in the treatment of individuals. The conceptual foundation for this study can be traced back to Freud's (1914) seminal paper "Remembering,

Repeating, and Working Through," in which he defined the concept of acting out: "The patient does not remember anything about what he has forgotten and repressed, but acts it out" (p. 150). While Freud was referring to the patient's actions, increasingly, psychoanalysts explored the role of the therapist's behavior. Ferenczi and Sullivan were instrumental in this regard. Heiman, Winnicott, Little, and Tower recognized the importance of countertransference in understanding the emotional states of the patient.

Klein (1946) developed the concept of projective identification, and this provided an important underpinning to the clinician's understanding of aspects of therapist-patient unconscious communication. I discussed the role of Klein's followers (Bion 1959, 1961; Racker, 1968) in elaborating this concept, especially in viewing projective identification as not only an intrapsychic defensive process, but as an interpersonal communicative (unconscious) one as well. To this day, this concept has stimulated valuable clinical discussions about the role of the patient's unconscious communication in influencing the therapist's actions. I examined the nature of analytic interaction in Bird, Levenson, Sandler and Boesky; they looked at how therapists get unwittingly pulled into interactions by the patient. These ideas eventually converged in the concept of enactment.

These writers formed the context for my understanding of how enactments occur in psychotherapy and the jumping off point to understand countertransference enactments in couples therapy. In the second part of my literature review, I looked at the literature of object relations couple therapists, examining, among other things, mutual projective identification in marriage,

countertransference experiences of therapists working with difficult couples, therapist's moral dilemmas, oedipal enactments, and intersubjective approaches to transference-countertransference in couples therapy.

### *Projective Identification's Role in Enactment*

One participant made reference to projective identification as a valuable clinical idea that she found useful in her practice. A few others talked about the concept in a general way. Participants did not conceptualize their cases using projective identification. However, there were several instances in which there was a clear implication that projective identification was occurring by the way participants described their involvement in the three-person dynamics. For example, participants talked about times when they felt "compelled" to defend or protect a partner against the abuses of a mate, "driven" to challenge a spouse on behalf of an unassertive partner, or felt "forced to pursue" an impenetrable wife on behalf of a passive husband. One participant even surmised that projective identification was occurring. In each of these situations, the therapist seemed to feel compelled to act, and such feeling states induced in the therapist suggest projective identification processes. In addition, projective identification was strongly indicated in many of the enactments, especially those in which the therapist felt an intense pressure to react to the couple.

I reviewed the literature on projective identification discussing Klein, who originated the concept in 1946. Klein first viewed projective identification as an intrapsychic process used for evacuative defensive purposes. I examined the role

of Klein's followers (Bion 1959, 1961; Racker, 1968) in viewing projective identification as an interpersonal process. Bion's ideas are relevant to object relations oriented couples therapists. He believed the mother was able to contain and metabolize the infant's raw, primitive anxiety, making it tolerable and bearable for him. In a similar way, the couples therapist may have to act as a container for the clients' intolerable affects communicated via projective identification. The therapist learns about the internal state of the client in this way.

Dicks (1967) looked at the couple relationship in terms of mutual projective identification processes. His model was later elaborated by the Scharffs (D. Scharff & J. Savege Scharff, 1991) and has been discussed by various marriage and family therapists (Caruso, 2003; Fisher, 1993; Middleberg, 2001; Ruszczynski, 1998; Solomon, 1997). Others have explored how these projective processes can become be used more defensively, leading to pathological styles of relating, particularly in borderline and narcissistic marriages (Barbera, 2001; McCormack, 2000; Morgan, 1995; Ruszczynski, 1998; Slipp, 1988; Solomon, 1997; Willi, 1982, 1984; Zinner, 1989). Participants discussed several couples whose pathological styles of relating probably involved these kinds of projective processes. One discussed a case of a sadomasochistic pattern of relating that may have involved a hostile-dependent projective identification system or a masochist triangulation (Glickauf-Hughes & Wells, 1995; Sharpe, 1997).

Therapists can get pulled into a couple's projective system if they resonate with one or the other partner's projections (Solomon 1997). Through interactional

pressures, and behavioral and communication patterns that tend to elicit certain responses, the projector induces the recipient into playing out (enacting) his disowned aspects (Siegel, 1995). Siegel discusses how the therapist may be induced to experience aspects of one partner's inner world through introjection, and strongly identify with that aspect. This may explain why participants identified and expressed one partner's unexpressed affects (e.g. anger) and acted out these dynamics between the partners. Slipp (1988) states the therapist can be sucked into the couple's dynamics in a similar way that he is in individual treatment through projective identification, except that in couple therapy, the induction comes from two individuals. Further, it is essential for the defensive equilibrium of the couple (Slipp, 1984). One participant felt induced to act out the couple's split-off anger. This participant felt the couple was in denial of their anger and believed they projected the anger onto her for defensive purposes. The therapist acted out the anger by getting into a power struggle with the wife. Depending on the central conflict the couple is enacting, the therapist's own unconscious conflicts will make him susceptible to certain projections being induced in him (Sharpe, 1997).

Several participants discussed enactments in which they felt induced to take on a role, such as judge or parent. Sandler (1976) discussed a concept called the actualization of the transference in which the therapist is pulled by the patient into taking on roles. The patient makes active, but unconscious efforts to provoke, manipulate, and impose an interaction between himself and his analyst by prodding the analyst into behaving in a particular way. Whether the process

described by Sandler, which occurs in psychoanalysis, is similar to the triangular dynamics of couples therapy, is a question for further research.

### *Kinds of Enactments*

In general, the literature revealed a wide variety of countertransference experiences that could emerge for the couples therapist. When I interviewed therapists, there seemed to be a more limited variety of countertransference experiences than described in the literature. However, there were several similarities in the types of the couples therapist's countertransference experiences illustrated in the literature that paralleled the enactments described in my study.

For example, in the enactment in which the therapist allowed the husband to vent his rage on his wife for the entire session, the enactment seemed to parallel a kind described by Basham and Miehls (2004) regarding therapists who enact bystander roles. The authors state that a therapist can be induced to enact the bystander role in a victim-victimizer-bystander triangle. The therapist can ignore the abusive behaviors occurring between the partners due to his own family of origin experiences. In the study, the participant seemed to enact the bystander role when he allowed the wife to be abused by the husband. The wife looked to the therapist for help frequently during the session, but the therapist allowed the abuse to continue, thinking the husband needed to express his anger. Later, the therapist realized he had gotten caught up in his countertransference because he had acted out a scenario from his own family of origin.

In the study, there were several misalliances that resulted in enactments that

paralleled several scenarios described in the literature (Broderick, 1983; Ringstrom, 1994; Solomon, 1989). One enactment seemed to have a moral/ethical component because it involved the therapist making a judgment about a wife having an affair (Finkelstein, 1991). The wife felt shamed and quit therapy. This also occurred in another enactment in which the therapist took a stand about the wife's affairs. One enactment paralleled what Lansky (1986) referred to as often occurring when therapists work with devaluing, narcissistic clients. Lansky said if the therapist is highly averse to being devalued, he may try to control or shame the client. This occurred in the enactment when the therapist felt demeaned by the wife and, as a result, began criticizing her until the wife finally quit therapy.

Participants made several references to the occurrences of unconscious collusions during enactment sequences. One participant discussed an example of unconsciously colluding with one partner against the other. Another participant talked about how she believed a couple formed an unconscious collusion to align against her. She thought the couple could not tolerate her interpretation that they, as a couple, were in denial of their anger. The therapist believed the couple felt threatened, and, as a result, colluded to "dump" their anger on her. Unconscious collusions were discussed by Willi (1982, 1984). This enactment may also be seen as a type of oedipal exclusion in an oedipal reenactment as discussed by Fisher (1993), Frank, (1997), Ruszczynski, (1998) and D. Scharff & J. Savege Scharff (1991).

### *How Therapists Dealt With Enactments*

Several of the enactments led to ruptures in the treatment, and in my findings, I discussed the various ways therapists attempted to work through these ruptures with the couple. Due to limited data, I did not elaborate how these ruptures were more fully worked through. I did not examine the literature that described the working through of ruptures in couples therapy. Nor was I able to find literature pertaining to the working through of enactments in couples therapy. However, I did review some of the literature pertaining to how therapists worked with their countertransference in couples therapy. Participants talked about how they worked with their countertransference, including using their countertransference to better understand themselves and the couple. I reviewed Dasteel, (1994), Goldberg, (1985b), Livingston, (2001), Ringstrom (1994, 1998), D. Scharff & J. Savege Scharff (1991), Shaddock (2000), Trop, (1997) and Willi (1982, 1984). These writers discussed issues such as the therapist's self disclosure and accountability. Willi said it is almost impossible for the therapist to not become enmeshed in the couple's conflicts. He concluded that rather than trying to be neutral, the therapist should make conscious use of his personal idiosyncrasies, reactive tendencies, and conflicts. He trusts the conflicts can be worked out with the couple, deepening the therapeutic relationship and helping the couple grow. Willi's ideas seemed to mirror several of the participants' experiences.

## Limitations of the Study

There were several limitations to this research. This was not a random

sample and thus was not representative of all couple therapists in the field. Participants in this study were selected because they were experienced, psychodynamically oriented couple therapists (10 years or more of clinical experience) from the San Francisco Bay Area. As such, these therapists might be better able to understand, be aware of, and articulate their experiences of countertransference enactments than those who are non-psychodynamically oriented and/or are less experienced.

There was also a lot of confusion over the concept of enactments. Some countertransference enactments were difficult to recognize and define, even for those participants who had more familiarity with the concept. As a result, participants sometimes experienced confusion, and this made it more difficult to study the phenomenon of enactments.

There also seemed to be gaps in the data. Countertransference enactments involve aspects of the therapist's countertransference experience of which he/she had been unconscious. Any study which attempts to explore such areas of the therapist's experience is bound to encounter gaps in the data. Also, several therapists had difficulty remembering what had transpired prior, during, and after the enactment. While this is normal in any research, in this study it may in part be due to the fact that many of the participants were not familiar with the concept of enactment and did not think in terms of enactments; they had to think retrospectively and perhaps could not recall details. These gaps influence the interpretation of the data.

A study in countertransference enactments would not be complete without

mentioning the researcher's own participation in a countertransference enactment. I became aware that I was caught up in an enactment during the early interviewing of participants. With the help of one of my committee members, I realized that I had lost my neutrality as a researcher and had taken on the role of clinical consultant; I was over zealous in trying to understand the participant's countertransference triggers. I felt anxious that some participants were not getting to the root of their underlying countertransference, so I pressed harder, trying to help them understand. This was not my role; I should have just stayed in my capacity as interviewer, it was more appropriate that I stay with their experience.

## Directions for Further Research

My research explored how therapists experienced, thought about, and dealt with their countertransference enactments while working with couples. Because each participant provided me with two case examples, I found that I was not able to explore in sufficient depth each part of my research question, for example, how therapists worked through the enactment with the couple. By examining a wider array of enactments, my study compared and contrasted the therapist's subjective experiences within a larger sampling of enactments. However, it might be interesting to study one case from each therapist. This would allow the researcher to examine certain clinical issues in more depth, particularly how therapists work through enactments. Included in this would be how therapists attempt to work through ruptures and deal with the issues of reparation, apology, and explanation. A researcher might also do a more elaborate study on one of his own cases of a

countertransference enactment.

The role of projective identification in enactments in couples therapy needs further research. Many psychotherapists in the literature have discussed projective identification, viewing it as a psychological process to explain how enactments occur. Several object relations couple therapists in the literature proposed a similar idea. However, since I did not explore how participants thought about and used the concept of projective identification in their clinical work, it might be helpful to get a more in-depth understanding of this. Do therapists see projective identification as playing a role in explaining their enactments? How do they conceptualize the transference-countertransference dynamics among the threesome using the concept of projective identification as a lens?

It would also be interesting to explore the differences between projective identification occurring in a dyad versus a triad. What is the nature of triadic projective identification? How does the therapist experience this? Slipp (1988) talks about how projective identification can occur among triadic relationships in a family. For example, through projective identification processes, the child can become the identified patient (the scapegoat) and play a role in a system. The child can also become the go-between, the savior, and the avenger, according to Slipp. Might the therapist be pulled to play out these roles as well through projective identification. It seems likely, but more research is needed to understand the therapist's experience.

Closely related to the idea of triadic projective identification is the notion of triadic enactment. Are there differences between the triadic enactments that occur

in couples therapy and the dyadic enactments that occur in individual psychotherapy? Are the properties of enactments the same whether dyadic or triadic? Most of the conceptual groundwork for understanding enactments was laid from detailing how therapist and patient interact in individual psychotherapy. This understanding was applied to enactments in couples therapy. However, since the triadic transferences that occur in couples therapy (e.g. oedipal triangles, sibling rivalries) are different in many respects than the dyadic transferences that occur in individual treatment, one would think that triadic enactments would have different properties as well. When I asked participants for their thoughts about triadic enactments, they did not shed any light on the matter. The subject needs more consideration.

# APPENDIX A

## RECRUITMENT LETTER

Sid Aaronson, MFT
# 7 Fourth Street, Suite 13
Petaluma, CA 94952
Telephone (707) 769-8050

Date:

Dear_____,

I am currently involved in the dissertation phase of the doctoral program at the Sanville Institute in Berkeley, CA. and am writing to ask your help in recruiting participants to interview for my research.

My qualitative study is on countertransference enactments in couple therapy. I will explore how psychodynamically-oriented couple therapists experience, think about and deal with situations in which they get caught-up in and/or act-out their countertransference while working with couples. I refer to these types of reactions as countertransference enactments. While there has recently been much written in the psychoanalytic literature about countertransference enactments in individual psychotherapy, much less attention has been paid to how such enactments occur in couple therapy. Given the enormous difficulties couple therapists sometimes face in sorting out, containing and dealing with intense countertransference reactions, this study hopes to bring more awareness to this important topic.

I am looking for a small number of experienced psychodynamically-oriented couple therapists from any of the mental health professions. Experienced means therapists who have worked with couples for at least 10 years and either identify themselves as a couple therapist or consider couple therapy one of their primary specialties.

I will spend about an hour with each participant in an unstructured interview that I will tape record. The place and time will be arranged for the convenience of the participant.

Can you think of someone who might be interested and appropriate for this study? If so, you could either tell them about it and suggest they contact me, or give me their names and contact information and I will get in touch with them directly.

My address and phone number are at the top of this letter. I can also be reached by email at sidaaron@comcast.net. Please let me know if you have any questions.

Sincerely,

Sid Aaaronson, MFT

# APPENDIX B

## RECRUITMENT AD FOR NEWSLETTERS

Sid Aaronson, MFT
7 Fourth Street, Suite 13
Petaluma, CA. 94952
(707) 769-8050

Ad to be submitted to professional newsletters:

1. SEEKING PARTICIPANTS FOR RESEARCH STUDY. I will interview experienced psychodynamically-oriented couple therapists concerning how they deal with situations in which they get caught-up in or act-out their countertransference (countertransference enactments). If you are interested, or would like to hear more, please contact me: Sid Aaronson, MFT, doctoral candidate at the Sanville Institute. (707) 769-8050, or Sidaaron@comcast.net

# APPENDIX C

## LETTER TO PROSPECTIVE PARTICIPANTS

Sid Aaronson, MFT
#7 Fourth Street, Suite 13
Petaluma, CA 94952
(707)-769-8050

Date_____

Dear_____

Thank you for your interest in participating in my doctoral research. This exploratory research will examine how psychodynamically-oriented couple therapists experience, think about and deal with situations in which they get caught-up in and/or act-out their countertransference while working with couples. I refer to these types of reactions as countertransference enactments. Given the enormous difficulties couple therapists sometimes face in sorting out, containing and dealing with intense countertransference reactions, couple therapy provides the perfect medium for countertransference enactments to occur. I am interested in understanding how you work with these types of reactions and hope you will share some clinical examples.

While there has recently been much written in the psychoanalytic literature about countertransference enactments in individual psychotherapy, much less attention has been paid to how such enactments occur in couple therapy. This study hopes to bring more awareness to this important topic.

Participation in this study means I will interview you for 60-90 minutes, at a time and place convenient for you. I will tape record the interview. I might also follow-up with a brief phone call if I need clarification about something we discussed. If you choose to participate, I hope you will find the process helpful in understanding how countertransference enactments may occur in couple therapy and will be happy to send you a summary of the study results if you wish.

All interviews will be confidential. Your anonymity and that of any clients you would discuss during the interview will be protected.

Please take a few minutes to review the enclosed Informed Consent Form, a copy of which you would be asked to sign at the time of the interview. If you wish to proceed, please fill out the brief screening questionnaire and return it to me in the enclosed pre-addressed stamped envelope as soon as possible. If you meet the criteria for this research project, I will call you to set up an appointment.

Thank you for your participation. Please feel free to contact me at the above phone number or my email Sidaaron@comcast.net if you have any questions. Thank you.

Sincerely,

Sid Aaronson, MFT
Doctoral Candidate, The Sanville Institute

# APPENDIX D

## SCREENING FORM

Sid Aaronson, MFT
7 Fourth Street, Suite 13
Petaluma, CA. 94952
(707) 769-8050

## SCREENING FORM

If you are interested and would be willing to participate in this research project, please complete this questionnaire and return it to me in the enclosed pre-addressed, stamped envelope.

NAME:_____AGE_____

ADDRESS_____

_____

TELEPHONE:
(Days)_____(Evening)_____

EMAIL:_____

DEGREE:_____LICENSURE:_____

THEORETICAL
ORIENTATION:_____

NUMBER OF YEARS IN PSYCHOTHERAPY
PRACTICE:_____

DO YOU IDENTIFY YOURSELF
AS A COUPLE THERAPIST?

_____

IS COUPLE THERAPY ONE OF
YOUR PRIMARY
SPECIALTIES?_____

# APPENDIX E

## INFORMED CONSENT FORM

Sid Aaronson, MFT
7 Fourth Street, Suite 13
Petaluma, CA. 94952
(707) 769-8050

## THE SANVILE INSTITUTE

## INFORMED CONSENT

I_____hereby willingly Consent to paricipate in An Exploratory Study of How Couple Therapists Experience, Think About, and Deal with Countertertransference Enactments When Working with Couples. This doctoral research project is to be conducted by Sid Aaronson, MFT, under the direction of Sylvia Sussman, PhD., principal investigator and research faculty member, and Cynthia O'Connell, faculty member at the Sanville Institute.

I understand the procedure to be as follows:

1) One 60-90 minute audiotaped interview will occur in a private confidential setting to be arranged between myself and the researcher. I will be talking about my thoughts and feelings as an experienced psychodynamically-oriented couple therapist discussing countertransference enactments in my work with couples. This will include a discussion of case vignettes. I am aware that some of these audiotapes will be sent to an outside transcribing service. The researcher will make every effort to avoid saying my name or other identifying information about myself or my clients on the audiotape. If such information gets into the interview, it will be omitted from the transcription. I am aware that the audiotape will have an identifying number rather than my name.

2) I am aware that talking about my countertransference and countertransference enactments may cause some emotional discomfort. Should this happen during the interview, I understand that I may terminate the interview at my discretion. Should I so request, the researcher will provide crisis counseling at this time. Should I experience discomfort after the interview, I understand that I may contact the researcher who will make provisions for me to receive professional help for a reasonable and limited time.

3) I understand that I may withdraw from this study at any time. I also understand that this study may be published and that my anonymity and the confidentiality of my material will be protected unless I give written consent to such disclosure. Otherwise, no names or individual identifying information will be used in any oral or written materials. The audiotape will be erased at the completion of data analysis.

4) I understand that I have the option to receive feedback from the results of the study. Please send me a summary of the results at the address below.

Yes_____No_____

Signature:_____

Date:_____

Address:_____

If you wish to receive a copy of the results of this study, please provide your name and address:

Name:_____

Address:_____

# APPENDIX F

# INTERVIEW GUIDE

## INTERVIEW GUIDE

### Introduction

First, I want to thank you for agreeing to this interview and helping me with my research. The interview, which I will audiotape, will last approximately 60-90 minutes. I am interested in hearing your thoughts and feelings about your countertransference reactions when working with couples. I am particularly interested in situations when you got caught-up in or acted-out your countertransference reactions, whether it be with one or both partners. For the purposes of my study, I am referring to these kinds of reactions as countertransference enactments. In individual treatment, most psychodynamically-oriented therapists use countertransference as a way to understand themselves and their clients better. In couple therapy, countertransference has often been neglected, but, as you know, intense countertransference reactions are quite common. I'm hoping you can help me better understand how you are experiencing, thinking about and dealing with your countertransference, especially when you feel it leads to an enactment. As we talk, I encourage you to bring up examples and case vignettes from your practice that will help me see the specific ways these enactments may be occurring. Let's begin by you sharing your initial thoughts about this question.

I. Awareness of Transference/Countertransference Dynamics
   a. Theoretical orientation? How do normally work with couples? Different from work with individuals? Combine approaches?
   b. Are you more active? Teach more? Interpret?
   c. How do use, attend to, work with transference/countertransference?

II. Experiencing Countertransference Reactions
   a. Typical countertransference reactions? Kinds of couples or situations that activate your countertransference
      1) Difficult types of partners or couples
      2) Particular emotional conflicts presented by the couple
      3) Triangulation
      4) Oedipal situations
   b. Therapist's relationship values and biases affecting countertransference. Therapist's marital conflicts
   c. Therapist's vulnerabilities. Areas of inadequacy

III. Getting Caught-Up In or Acting-Out on Countertransference

a. Discuss such times. How did you experience this? (taken over by a complex?

Act uncharacteristically?

b. Collusions. Did not confront couple.

c. Ways of acting-out. (withdraw, silence, criticize, yell, lecture, bully, overly advise,

pathologize, refer out, terminate)

d. Misalliances.

IV. Thinking About the Enactment

a. When did you become aware of the enactment?

b. How did you feel about your behavior?

c. What was activated in you? A vulnerability, an unresolved conflict

d. How did you conceptualize what was happening? (projective identification, mutual

Influence)

e. How did the enactment affect the treatment? Beneficial or detrimental

Are some enactments more damaging to treatment than others?

V. Dealing with Countertransference Enactments

a. How did you work with the enactment? Talk with the couple. Get consultation.

b. Typical ways of dealing with countertransference.

c. Self-disclosure of your countertransference? Personal vulnerabilities and conflicts

as well?

Do you ever feel your self-disclosure constitutes another enactment?

d. How do you work out misalliances caused by the enactment? Repair.

e. Reach an impasse?

VI. Anything you feel we missed in talking about this topic?

a. Feelings about the interview

b. Final thoughts

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