Chapter 12

Object Loss and Mourning In the Enacted Dimension

The vignettes presented in Chapters 5 and 6 illustrated how early preverbal traumatic events may be re-created and relived in the enacted dimension of the treatment. In this chapter I will describe how a consciously acknowledged, but simultaneously denied, adult trauma—specifically a devastating object loss during adolescence—required an extensive period of time for the trauma to achieve symbolic actualization within the transference–countertransference matrix before the patient could emotionally acknowledge and mourn the loss.

For unpredictable periods of time—weeks, and on one occasion, three months—this patient did not attend his sessions. He never formally stopped his treatment nor did he ever indicate that he would not be coming. Rather, he would simply not show up. Attempts to analyze with him the meaning of his absent behavior had little effect, and at times produced an intensification of the enactment. The absent behavior had its roots in the death of his father, who died while away for six months on business when the patient was fifteen years old. In the enacted dimension of the treatment, the patient re-created the absence and loss, over time, through an identification with his father as abandoner. An interpenetrating countertransference receptivity allowed the patient's actions to engender within the analyst the patient's disavowed experience of the trauma—the uncertainty and anxiety of waiting, the deprivation and despair of loss, and finally the immutability and finality of death. The analyst's eventual giving up on the patient's return—the culmination of this treatment-long, unconsciously negotiated transference–countertransference process—created an analytic version of the original traumatic death. As the enacted dimension of the treatment was gradually brought within the verbally symbolized realm, the patient began the initial stages of mourning for his father, now more in consciousness instead of action.

* * *

Jimmy[1]

Jimmy walked into my office two weeks before the anniversary of his father's death eight years earlier. I was to remain unaware of this connection for some time. Jimmy was 15 when his father died, and while he appeared in my office at the age of 23, in many ways he had not aged—he had a chubby, boyish face; his clothes were unkempt; and his manner was halting, shy, and insecure. He carried with him a large cup of soda from which he sipped regularly. While he did mention his father's death during that first consultation session, it was not his primary preoccupation. He came to therapy because he was unemployed and still living with his mother and sister, his girlfriend was breaking up with him, and he suffered from vaguely described symptoms of alienation, depersonalization, and dysphoria. His affect was flat, and he seemed lost and unfocused, a character unformed. He stated that he could come to treatment only once a week because he had little money. I recommended twice a week and offered to see him for a modest fee. He agreed to my recommendation, but overslept and missed our next session, a prelude of what was to come.

Jimmy was a middle child, with an older and younger sister. His father was an architect and contractor who designed and built large housing developments. He was on-site on a long-term project in California when he died of a massive coronary. Jimmy revered his father but was also terrified of his volatile and sadistic temper. He was a stern disciplinarian and ran the household with what Jimmy described as "the strict rule of law." Jimmy longed for his father's pride and love but felt he received derision and criticism from him instead, making him feel inadequate and unworthy. Jimmy's mother was a needy and narcissistic woman who was overprotective and seductive in her attentiveness to her only son, an attitude that intensified after the father's death.

Over the course of the first nine months of treatment, a picture emerged of Jimmy as a young

[1] This treatment case was first presented at the 1993 Division of Psychoanalysis (39) Spring Meeting, under the title, "A Death in the Countertransference: A Patient's Unconscious Enactment of Object Loss in the Analytic Relationship" (Katz, 1993). An earlier version of this chapter was published previously as "Missing in action: The enacted dimension of analytic process in a patient with traumatic object loss. In *Symbolization and Desymbolization: Essays in Honor of Norbert Freedman*, (2002), R. Lasky (Ed.), New York: Other Press, Chapter 18: pp. 407–430.

The treatment segment reported is the initial two-year period of a psychoanalytic psychotherapy that enabled the patient to later enter a traditional psychoanalysis. It is not intended as a full case history.

adolescent boy struggling to achieve a secure masculine identification with a father perceived as powerful and dangerous on the one hand, and loved, idealized, and desperately needed on the other. He described his father's temper and the many occasions when he felt criticized and ridiculed by him; and he also described his idolization of his father along with fears of being homosexual. These fears had begun when he developed a dependent relationship with a male mentor at college, although he had never had any conscious homosexual desires or actual experiences. He felt anxious and overwhelmed living with his mother and sister, describing both the seductive pull of his mother's nurturance and sexuality—they watched television together in the evenings on her bed—and his own conflicted and confused feelings. His girlfriend broke up with him shortly after he began treatment because of his dependency on her, and he was unable to decide on a career or get interested in any job. He wanted to become a stand-up comic but could not take any steps to implement the desire. (I must add that he was in no way funny.) He began living an itinerant existence, alternately living at his mother's house and at the homes of friends and relatives until they asked him to move. He was passive and dysphoric, staying up late into the night, over-eating, smoking cigarettes, drinking beer, and watching old movies on TV, and then sleeping late into the afternoon, allowing whole days at a time to pass him by.

The transference during this early phase was silent but intense. I gradually became aware that he felt quite afraid of me, attributing to me sadistic and sexual motivations. His own anger and homosexual wishes were rarely brought directly into the treatment. They were instead projected in this fashion, causing him to feel painfully constricted and blocked, often unable to articulate his thoughts. Most important, from the beginning of the treatment Jimmy often came late, missed sessions without calling, paid erratically, and bounced checks. His attitude toward this behavior was one of chagrin, self-blame, and helplessness. He could not understand why he kept doing it or how to change it. His responses to my attempts to interpret the motivation in his behavior were contradictory. At times, he seemed to understand that his actions were provocative, recreating the relationship with his critical and angry father. At other moments, even within the same hour, he seemed genuinely confused and disoriented, unable to comprehend what I was saying, unable to organize or articulate his thoughts. What did not vary, though, was the behavior. It persisted and intensified despite my attempts to keep it in the forefront of our work.

Toward the end of the first year Jimmy's debt to me had reached an unmanageable level. He was

impulsively spending any money he earned on indulgences and acquisitions—junk food, alcohol, cigarettes, a second-hand car—and he was unable to attend sessions on any consistent basis. I felt that the treatment could no longer be sustained productively as long as his indebtedness continued. I discussed this with him and he appeared to understand and agree with my assessment. We agreed to suspend the treatment until he could repay what he owed.

He did not, however, respond to my bills for several months, and I felt I had to inform him that I might have to pursue legal recourse. This counter-action on my part quickly produced a phone call from him and a desperate plea for my patience. I received a check shortly thereafter. Unbeknownst to me it arrived on the anniversary of his father's death, which was also the anniversary of the start of our work together a year earlier. I received a check from him approximately every other week for three months until his bill was fully paid. I did not hear from him again until the summer, a month later, when he called to ask if he could resume his treatment. We had five appointments scheduled prior to the August break. He missed the last two.

When we resumed in the fall, Jimmy decided on his own to use the couch, and to regulate his finances by paying me after each session. I commented on his effort to be responsible and to safeguard our relationship and agreed to his suggestion, keeping my questions about this procedure on the back burner.

This second phase of the treatment lasted from that September until the following July. It was characterized by a general, but far from complete, diminution in the frequency of his missing sessions and a greater involvement in the treatment. Over the first several months he attended consistently and paid me regularly. Gradually, he began missing about a session every other week. Over the four months preceding the August break, he missed sessions more frequently, up to half of his appointments, but he paid me his entire debt when he did come.

The content of the sessions during this phase centered more consistently on his relationship with his father and with father-substitutes at work. During his seven-month absence from treatment, he had worked full-time in an established restaurant as a waiter and bartender. He expressed ambivalence about being a waiter, but he was liked by both the owner and the maître d' and was being groomed for a more responsible position. He spoke often of his desires and his confused feelings toward these two men—his need for their approval, his feelings of intimidation, his confusion and inability to assert himself—which

led us to various facets of his relationship with his father while growing up.

However, he still found it almost impossible to talk about his feelings or reactions to me. He seemed to understand and benefit from my interventions, yet alternately and even simultaneously seemed to be completely perplexed and disoriented. In addition to his steady employment and the displaced transference arena it provided for our work, there were other improvements in his life. He stopped his drinking and he moved into his own apartment, ceasing his itinerant living arrangements.

Jimmy's depressive symptoms, however, continued unabated—feelings of despair, meaninglessness, suicidal thoughts and fears—along with fears of losing control of what he called "a powerful rage," which he did not understand and could not further articulate. I gradually began to pay more attention to the fact of his father's death and to his apparent incomplete mourning, and to the ways in which this intersected with the adolescent conflicts with his father prior to his death. But attempts to connect his feelings and symptoms to his father's death, while never rejected, did not go anywhere either. Moreover, as these issues began to emerge more in the treatment during the early spring of that year, he began to miss sessions again.

The increasing irregularity of our meetings made it difficult for me to maintain the continuity of the process, but Jimmy, in contrast, seemed to be able to easily pick up where he had left off two or three sessions earlier. I struggled with frustration, with doubts about the viability of the treatment relationship, and with continual technical quandaries about whether and when to call him when he disappeared for two or three sessions at a time, and how to bring this up without engendering an intensification of his absences. I became aware that he was making me wait for him as he had been forced to wait for his father when he was away in California, and was making me feel the frustration of not being able to do anything about it, as he too had no doubt felt. My interpretations along these lines had the same effect as before: he seemed to understand, but his behavior did not change. Indeed, his absences were about to increase exponentially. He did not show up for any of his appointments during the month prior to the August break.

A Dramatic Event

I called him toward the end of the month to let him know I would be away. He apologized for not attending his sessions, said that he wanted to come, asked for an extra appointment, then did not

show up. After he missed his first session following my return in September I called him again, at which point he once more apologized and assured me he would come next time. He did not come then and I continued to wait, session after session, as three more weeks passed.

It was now late September, almost three months since I had last seen him. I had gradually become less preoccupied with the treatment and with what I should do, although I continued to hold his time. Then one evening as I was closing the office, I was startled to realize that I still had one more patient scheduled—Jimmy. As I reflected on my lapse, I realized that I had given up hope in the treatment. "It's about time," I admonished myself. "This has clearly never been any kind of viable treatment." I decided that I would wait out this last session and then write it off as a failed case. After 35 minutes I was about to leave when the doorbell rang. When I went out to the waiting room Jimmy greeted me with a slightly self-conscious but nonetheless warm and familiar "hello." It was as if he had returned from the grave, come back to life. He entered the office, took his place on the couch, and picked up where he had left off.

He was contrite and apologetic about not coming for so long, said he had some of the money he owed me and asked if it would be okay if he paid me the remainder in installments over the next few weeks. He then went on to consider, without being asked, why he had not come for three months. He stated, in his halting way, that it was perplexing to him because he had thought of coming all the time, planned on it every evening prior to a session, but never seemed to be able to make it. I was stunned to hear this as I had so irrevocably lost all sense that there was any connection at all remaining between us. He asked how long it had been. He reflected on the time period of three months and said, "Now that I'm thinking about it, three months was how long it was between the last time I saw my father and when he died." As I continued to listen in amazed silence, he went on to inform me, for the first time, that his father had been away for a total of six months. He had left for California in September, Jimmy visited him three months later over Christmas, and he died three months after that in March. There had been two three-month absences. Jimmy then reflected on the fact that it was now the end of September, the time of year his father had first left him. Aware now of the induced source of my countertransference experience of having given him up for dead, I commented to him that he returned on this day to undo his father's departure, and that perhaps he had not come for three months to re-create his father's absence and that he returned to undo his father's death. I also commented on how he "thought of coming

all the time." I told him that it was quite striking—and quite meaningful—that despite our not seeing each other for so long, his experience of our relationship did not change, that despite the fact that he did not come or call, he never doubted that I would be here waiting for him. He nodded his agreement, and so ended our 10 minute reunion.

Jimmy did not come for his next session. In the following session, he stated, with much difficulty, that he was angry at me. He was angry, first, because I did not seem to sufficiently appreciate his efforts at setting up a payment schedule—he had wanted more approval and support from me; second, because I seemed not to have known that his father had been away for six months—it didn't seem possible that he had never told me; and third, because of my comment about his never doubting I would hold the time for him—he experienced this comment to mean that I might not have held the time and that I had doubted his commitment. I commented that he seemed to fear that, in one way or another, I would not be available to him, that I would fail him in some way or abandon his treatment. He agreed, comparing it to the time the treatment had been suspended: in his words, "the time you kicked me out for six months." He described how hard that period of time had been for him, how painful it felt to be "cut off" that way. I asked him about the "six months," since the time period had been closer to eight months, and he again associated to the six-month period when his father was away. I commented on how powerful and important his relationship with his father had been during that six month period, how intact and vivid it was in his mind then and now, and how present it had always been with us in the treatment.

Aftermath

In the phase of the treatment following the time the enacted process became conscious, about a year, Jimmy still did not come regularly to his sessions, sometimes not showing up for weeks at a time, sometimes showing up twenty or thirty minutes late for the session. During the periods of waiting, I continued to struggle with the countertransference fantasies of abandonment and loss, although my greater understanding of Jimmy's need for this enactment, and my own reactions to it, made it easier to sustain faith in the presence of an ongoing and meaningful treatment relationship. In the sessions Jimmy did attend, memories of his father's death and its psychological sequelae emerged, and his life outside the sessions steadily improved.

On sporadic and discontinuous occasions, Jimmy described his sense of abandonment when he

missed sessions. He imagined that, like his father, I, too, must feel critical of him for owing me money and that I should kick him out of treatment, "cut him off," as his father had done by taking leave of him. At the same time, he felt his father still owed him and that he should not have to pay for a father now. Other poignant enactments became verbally accessible: he mentioned that on his way to work now he often drove out of his way to pass through the housing developments that his father had built. He would park his car and sit looking for people he had known through his father. I commented on his efforts to keep his father alive and with him. In a later session, he told me of a time he had come late for our appointment and sat in his parked car across the street from my office for the duration of the session, looking at the light shining in my window. I likened this to his vigils in the housing developments, and asked him if he ever visited his father's grave. He said he had not been there since the funeral.

Midway through this year, after an absence of nearly a month, he called to say he wanted to "get back into the swing of things," pay me what he owed me, and that he would attend his next session. Two days later my own father died. I called him and told him that there had been a death in my family and that I would not be in the office for the week. With emotion in his voice he said, "I'm very sorry to hear the news. I hope you're all right—as well as anybody could be under the circumstances." I was struck by the immediate connection he made with me, in such contrast to his usual halting, frightened, and blocked manner. I called after the week to confirm our next appointment, but Jimmy did not come for another two weeks.

When he did return, he stated that he felt like a liar for being in therapy but not coming. I suggested that perhaps he felt that I was the liar. I was his therapist, but I was unavailable to him for a week. He repeated his concern about the death in my family. He imagined it had been my father, and feared I would not be able to deal with my patients and would cut him off as a result. He worried whether his expression of consolation had been appropriate; he wanted to convey how much he felt for my loss. I told him that what he had conveyed had been heartfelt, and that he seemed to understand something about loss very deeply. After a pause, he went on to say that he had been doing better—he had given up smoking, lost weight, and was becoming more confident at work—and that he had been able to think about his father with more love and with less anger. At the session's conclusion, he paid me and said, again with more feeling than usual, "Thanks for being patient and for letting me be a patient."

Over the next several months, Jimmy was able to carve out a position as wine steward at the restaurant, and to free up time for a social life. He also felt more assertive in his interactions with his mother. His grandfather died, his father's father, arousing his ambivalent feelings toward both paternal figures. He received a financial inheritance which he felt was a direct line from his grandfather through his father to him, but receiving money rather than love and support also made him angry. He related this to his unexpressed anger about wanting more from me, and yet was also able to express gratitude that I had not given up on him.

DISCUSSION

I will now describe the elaborately developed enacted dimension of this treatment process. I will describe how Jimmy's traumatic object loss was enactively recreated and symbolized in the treatment and the process by which this dissociated trauma gradually came to be integrated within the verbally symbolized dimension of the treatment. I will show how an unconscious, enacted countertransference process inadvertently intertwined with the patient's enacted transference to form this therapeutically necessary analytic version of the trauma, an experience that made possible the emotionally based, experiential insight (see also Bromberg 2003; Chused 1991, 1996; Jacobs 1991, 1993, 1997) necessary for a resumption of psychological growth. I will conclude with some comments about enacted processes and analytic technique.

The Inability to Mourn and the Enacted Dimension

The process of mourning is a most difficult one, a process that even under the most favorable conditions is perhaps never fully completed (Freud, 1917). When the task of mourning must be accomplished by an immature ego, one that is still dependent on the object, the task may be nearly insurmountable and may take a long, circuitous route (see A. Freud, 1958; Jacobson, 1961, 1964; Lampl-De Groot, 1960; Wolfenstein 1966, 1969).

Jimmy's father died at a crucial time in his adolescent development, at a time in his life when positive and negative oedipal issues were active, a time when his developmental need to have a father was vital (Blos, 1979). As an adolescent who had not yet consolidated his identification with his father,

he lacked sufficient superego structuralization to do without the external presence of his father (Deutsch, 1937; Laufer, 1966). As a result, he was unable to accept the death and mourn his father's loss, remaining in many respects a 15-year-old boy, arrested in his psychological development in the midst of an unresolved negative oedipal struggle (see Altschul, 1968; Fleming & Altschul, 1963). Many of Jimmy's presenting symptoms reflected this arrest: his frozen affect, his stunted level of object relations, and his infantile ego ideal that resulted in pervasive vocational indecision, lack of initiative, and aimless dysphoria.

Jimmy's pathological solution to his dilemma was to disavow the experience of his father's death and to maintain its dissociation as he proceeded to live his life. Freud (1927, 1940a, 1940b), in his discussions of the dissociative processes found in fetishism, described the process wherein the individual maintained two contradictory beliefs simultaneously. Jimmy believed both that his father was alive and that his father was dead at the same time (see Altschul, 1968; Blum, 1983; Fleming & Altschul, 1963). From a cognitive neuroscience perspective (see the discussion of multiple code theory in Chapter 11), this kind of dissociation can be understood as a disruption in the referential process between neurobiological systems, a disruption in Jimmy's capacity to integrate the intellectual knowledge of his father's death, encoded in the symbolic cortical areas of the brain, with the affective experience of this trauma that had been registered in, but had overwhelmed, the affective core of the subsymbolic neurobiological system. In the treatment, these dissociated self/brain states were evident in the erratic nature of his functioning within any given session: the way he could talk poignantly and thoughtfully about his father at one moment, and then seem detached and perplexed an instant later; and also the way he reacted to his behavioral enactments as if they were being done by someone else. Attempts on my part to connect his distress and his behavior with his unmourned loss were accepted in that self-state (or sector of his brain) that contained intellectual knowledge of his father's death, but did not register in the other, emotionally traumatized, self-state (or sector of his brain).

Whichever model one uses to conceptualize the dissociative process, when there is an inability to mourn a death—an inability to integrate emotional knowledge into the intellectual knowledge of the event—aspects of the traumatic experience will find expression in more primitive forms of enacted behavior and enactive language (Busch, 1989, 1995; Loewald, 1975), and will continue to organize psychic life side by side with higher forms of symbolic functioning. Bereaved individuals will tend to

support the dissociated, emotionally inaccessible, reality by living out circumscribed segments of their lives as if the love object were not dead. When they come for treatment, they re-create aspects of their unmourned trauma in the enacted dimension of the treatment, regardless of whether or not they talk directly about the death.

In addition to its primary purpose of maintaining the dissociation and denial of his father's death, the enacted dimension of the treatment also served the additional function of reestablishing for Jimmy his six-month relationship-in-fantasy that preceded his father's death. His behavioral "enactments"—missing sessions and then showing up again, disappearing and reappearing—sustained and actualized an ongoing unconscious fantasy that his father was absent but still alive, transforming the treatment process and its participants into a living memorial of his unmourned trauma. Specifically, I will elucidate the underlying meaning of Jimmy's behavior in terms of the following: (1) denying time, (2) alterations in identity, (3) reversing the trauma, and (4) undoing the trauma.

Denying time

When Jimmy's father died, the movement of time became dangerous. To be aware of time meant to acknowledge the end of waiting for his father, to acknowledge his death. Holding time still, on the other hand, meant he could remain waiting for a father who might return. So Jimmy stopped the clock and put his psychological growth, and indeed his whole life, on hold. He tried to reverse time—sleeping during the day and staying up through the night—in an effort to reverse the trauma. He was unable to adapt to the conventional demands of time such as maintaining a schedule or keeping appointments. No appointments kept, no date with death. He stayed up all night watching old movies on TV, involved in "reruns" of earlier times in his life.

Thus, in the treatment, each absence represented a retreat in time to the relationship he had had with his father in fantasy during the six-month absence—a "waiting-relationship" with an absent but, most important, a still living object. As it had been with this relationship-in-fantasy with his father, his relationship with me was most intense and most safe when he was not in sessions, when it remained a fantasy in his mind. Thus, after having been away for a long period, he was able to easily pick up where he left off because in his psychic reality, time had stood still and we had never really been apart. In his mind, we were alive and well and together. It was only I, keeping one eye on the external structure of

the treatment, who experienced absence and the reality of time passing when we did not meet.

Put another way, Jimmy stayed away from his sessions because he could not yet tolerate his transference to me as the father of his adolescence who would die. The danger of abandonment and death was too real and imminent. Every vacation, every holiday, every weekend was a death waiting to happen. By absenting himself from treatment he could avoid a relationship with me which would, by definition, move forward in time, and therefore ultimately, in his mind, eventuate in death.

Alterations in identity

Many facets of Jimmy's identity became concrete embodiments of preserving the pre-death "waiting relationship" with his father. Having been forced to "wait" for his father, in anger and unrequited longing, Jimmy became a "waiter" by profession. He "waited" in the restaurant, in boredom, impatience, and anger on the chance that his father would reappear, establishing relationships with the "regulars," the ones who did come back. Unable to experience the loss of his father, Jimmy not only became one of those individuals who continually misplace or lose their belongings (A. Freud, 1967), unconsciously repeating the loss, he became, from that moment on, the personification of loss: he became a "loser," a young man unable to accomplish anything with his life, stuck in a "loser" job, waiting on tables. And he became a "lost soul," lonely, alone, and unable to feel emotionally whole.

Reversing the trauma

Jimmy sustained his fantasy of a relationship with an absent but living father by reversing the passively experienced trauma and identifying in action with his father, becoming reunited with him in the act of abandoning and depriving. As his father had abandoned him, so he abandoned me; as his father had deprived him of a needed relationship and an object for identification, so he deprived me by not allowing me to work and by not paying his bills. This "identification with the doer" (Segel, 1969), enabled him to re-create the trauma but avoid the suffering of being abandoned and deprived himself. His actions engendered in me his own disavowed experience of the waiting that eventuated in death. He turned me into the "waiter" and the "loser," and I experienced the same questions, doubts, and feelings about Jimmy and our work together as he had no doubt experienced toward his father and their relationship: Did I have a patient? Was this a treatment? Was he coming back? Was the treatment over?

Had it died? On an unconscious level, in the treatment's enacted dimension, he was testing the safety of the process and my capacity to endure his trauma: "Can you tolerate absence? Can you tolerate interminable waiting? Can you tolerate death?" he was challenging. "If you can, perhaps I will be able to risk the pain of it also."

Undoing the trauma

Jimmy's enactment also actualized his fantasy of a reunion with his lost father. Throughout the treatment, in addition to missing sessions, Jimmy was repeatedly returning to sessions, his attempt to cheat death of its victory. Identifying with the aggressor and absenting himself from his sessions was an act of revenge and hostility; returning and reappearing was an act of reparation, restoration, and renewal. It was as if we were playing hide-and-seek, or an elaborate game of peek-a-boo (Frankiel, 1993). "Look," his absences were saying to me, "I am away and gone like my father, you can't get anything from me now"; but then, unexpectedly reappearing, he would add, "Peek-a-boo! Here I am."

From Enacted Symbolization to Verbal Symbolization

I will now focus on that day I so irrevocably gave up on Jimmy's return and he in turn reappeared. Although the trauma and accompanying transference fantasies (as well as countertransference fantasies, as I will presently describe) were being actualized from the treatment's inception, it was on that day that they finally became conscious in a way that allowed them to be symbolized on the verbal level. That day's dramatic events signified that an important shift had already taken place in Jimmy's intrapsychic balance—from the denial of his father's death toward its acceptance, from enacted symbolization toward verbal symbolization. As I pointed out in Chapter 3, dramatic behavioral "enactments," as distinct from the underlying unconscious fantasies being actualized, are often "lagging indicators" of psychic change that has forged ahead of both the patient's and the analyst's awareness. They are a wake-up call that summons the analyst to recognize that the enacted and verbally symbolized dimensions of the treatment are ready for integration.

All through the early phase of this treatment, although it was not recognizable at the time, Jimmy's abandoning and depriving behavior had actually been proceeding beyond the actualization of his fantasy that his father was absent but alive, toward the actualization of the very trauma he was trying to

deny—his father's death. Through increasingly longer periods of absence, he was coming ever closer to letting the treatment die.

Over the same period of time, I was involved in an anticipatory mourning process for my own ambivalently held father who was in the advanced stages of Alzheimer's disease. In a sense, my father too was both dead and alive: present in body but absent in mind. This idiosyncratic parallel led to a countertransference disposition to the patient's unconscious fantasy, and an availability to be enlisted in his playing out of this fantasy. That is, I may well have been, in my unconscious identification with him, inclined to wait for Jimmy when he was absent in order to deny the impending loss of my own father. Or, from another viewpoint, I may have been reluctant to let go of Jimmy and become the depriving and abandoning father. Without being fully aware of it, the interpenetration of this countertransference disposition (connected as well to issues at deeper levels) with Jimmy's transference press—what Sandler (1976) termed the analyst's role-responsive countertransference, what Tower (1956) called a countertransference structure, and what Boesky (1990) called an unconsciously negotiated resistance—had made me increasingly able to tolerate the idea, far longer than I typically would have, that absence and waiting could be part of a viable relationship.

Within the enacted dimension of the treatment created by this shared unconscious fantasy of denying death,[2] Jimmy extended his absence toward the symbolic three-month time period, just beyond the period of time he must have unconsciously gauged would be the limit of my patience, thus moving the treatment toward the re-creation of a death, his father's death, represented in the countertransference by the day I so conclusively gave up on his return.

Jimmy then returned on that day, to fulfill his unconscious fantasy of reversing death—both the death of his father and its enacted re-creation in the treatment. But his return also signified a readiness to allow the disavowed trauma a measure of conscious, verbal representation. In Loewald's (1971) terms, the enactment had moved toward a "re-creative repetition" of the trauma in the sphere of the ego's organizing activity, as opposed to a compulsive reproduction of it. The analytic version of the trauma

[2] To again distinguish the unconscious interpsychic aspects of this process from its overt, behavioral manifestation, and from what is commonly referred to as "co-creation" (see Chapter 7): Jimmy and I each had our own version of the fantasy, each with its own genetic roots, unconscious dynamics, and subjective experience; what was uniquely "co-created" by our particular analytic dyad, was the overt form taken by their interpenetration— the atypical and extreme forms of absence and waiting.

played out in the enacted dimension of the treatment constituted, in Freedman's (1994) terms, a "nonverbal transformation" of Jimmy's experience that served as a precursor to the alteration of his internal representational space. Further, the "shared fantasy space" created between us (see also Bach, 1994; Winnicott, 1971) now made transformational dialogue possible, leading to higher levels of symbolization.

These developments were evident at the outset of that session, when Jimmy spontaneously brought up the symbolic meaning of his three-month absence, as well as new information about the six-month absence that preceded his father's death. I had temporarily experienced the loss he was trying to disavow in my reaction of giving up on the treatment. But when Jimmy unexpectedly returned, my recognition of the event's meaning, in interaction with Jimmy's readiness to understand and accept it, allowed my verbal representation of the enactment—the interpretation of his unconscious fantasy of undoing his father's death—to finally have mutative effect.

My comment to Jimmy during this sequence—that there was something to be understood about his never doubting that I would still be there—implied that important relationships can end, and that it may not make sense to assume that an abandoned relationship can always or so easily be resurrected. I implied in it that I had doubted—that I had not shared his denial of reality and unreciprocated commitment to a relationship—I had doubted, and by implication had despaired and suffered when he had not returned for so long. Not surprisingly, confronting his denial of death had made him angry, but he tolerated this affect without having to disavow it. Specifically, for the first time Jimmy was able to talk about his anger with me over the earlier "six-month" hiatus in the treatment, and he was able to relate this experience to his father's six-month absence and death.

This shift from enactive symbolization to verbal symbolization marked the beginning of a process of integrating and working through experience that had previously been disavowed. This process was, initially, a formative psychic activity, one in which new internal representations and object relationships were constructed as dissociated states were gradually integrated, rather than one characterized by an undoing of a repression followed by the recall of a once-conscious representational memory. It had been made possible by the unwitting creation of an analytic version of the patient's trauma in the enacted dimension of the treatment, a treatment experience that was crucial to making it accessible to verbal symbolization and meaningful insight. Jimmy's ensuing process of fully accepting

the trauma, which involved the working through of the many layers of conflict, defense, and psychic meaning that had subsequently been attached to the death of his father, was predictably slow and uneven. Despite a growing capacity to experience and contemplate his father's death, there were times when the dissociated state in which his father was still alive continued to find expression in action and behavior. During this phase of treatment I continued, now consciously, to contain the awareness of the disavowed trauma on his behalf and bear his absences without rushing to comment or interpret.

As this phase proceeded, time began to move again in Jimmy's life. He brought in a large appointment book one day—his attempt to acknowledge the reality of time and to invest in the reality of living in the present. He began to look physically older and more mature, as if the aging process had resumed. Relationships with people began to deepen and he started a serious relationship with a new girlfriend. When he thanked me for "letting him be a patient," he was acknowledging that he was a patient, as opposed to an abandoned boy or an abandoning father. He began allowing himself more memories of his father and, in his dreams, the psychic representation of his father's age was no longer fixed at the age he had been when he died. During sessions, he began to feel pressure and itching in his eyes—the physical sensations of grief. And he visited his father's grave for the first time since his death, the symbolic action of acknowledging death.

CONCLUDING COMMENTS

I have illustrated the enacted dimension of analytic process as it occurred in this dramatic case of a patient traumatized by the loss of his father in early adolescence. The patient's necessary task of completing the mourning process required a preliminary period during which he literally re-created absence and waiting within the transference–countertransference relationship. In short, he replaced one external reality—death—with a less traumatic external reality—absence—and then created concrete experiences of absence and waiting to support his fantasy that his father was alive. His effort was to enlist me as a witness to this new reality (see Boesky, 1982; Reis, 2009) and for it to remain an unalterable "fact," unamenable to interpretation, for a symbolically meaningful period of time. An ongoing countertransference receptivity to the enactment ultimately allowed the death itself to find symbolic actualization in the treatment, following which it could begin to be symbolized verbally and

integrated into conscious experience.

With patients who are less traumatized and more able to symbolize verbally, such dramatic behavioral enactments do not typically form the ongoing foreground of the treatment. Nevertheless, unwitting actualizations of transference (and countertransference) wishes and defenses are continuously woven into the fabric of the analytic process, emerging into awareness in the form of seemingly discrete "enactments" as developing psychic transformations in the treatment allow or demand. Such processes within the enacted dimension of the treatment fashion an attenuated, symbolic version—a living analytic version—of the patient's central conflicts. As lived-in experience, these "original creations" (Poland, 1992) between patient and analyst infuse the patient's core conflicts with the immediacy and affective vitality necessary for effective interpretation and ultimate integration within the verbal sphere.

As I discussed in detail in Chapter 8, our increased awareness of the ubiquity and importance of the enacted dimension of analytic process does not, in and of itself, necessitate or justify recent calls for the abandonment of the basic treatment model or the principles of relative neutrality and abstinence. To reiterate, enactments are not a component of technique; they are the observable aspect of an unconscious process—an unconscious transference-countertransference process—that is continuously evolving. Enactments are unintended, but dynamically meaningful, departures from the optimal analytic attitude that technical discipline, however defined, is intended to promote. They will occur regularly in every treatment, regardless of the analyst's conscious technical stance, whether it be strict adherence to standard technical principles, or abandonment of these principles in favor of a more spontaneous and deliberately interactive style. Any technical approach can be psychically appropriated and organized by enacted transference–countertransference processes.

To illustrate, both technical approaches I took with Jimmy—setting a limit on his disruptive behavior by suspending the treatment (as in the early part of the process), and then allowing these behaviors to continue (as in the process leading up to the dramatic session)—had an additional level of meaning, for each of us, in the enacted dimension of the treatment. Jimmy experienced my suspending the treatment as an actualization of his father's leaving him for "six months" and then, later on, he utilized my tolerating the absences to enact a reversal of this trauma (leaving me for the symbolically significant period of time) until he could re-create the death itself and then undo it (by returning that fateful day). On my end, neither technical approach was a simple matter of conscious or rational

technique. Each was shaped, in significant degree, by enacted processes. Each was an unconscious compromise formation, fashioned out of Jimmy's pressure toward transference actualization and the press toward actualization of my own interpenetrating countertransference. Each technical decision, as well its timing, was part of an unconscious transference–countertransference drama that was unique to our particular unconscious, interpsychic fit. They were part of the enacted dimension of the treatment.