

The therapeutic aim and hope of combined therapy is that the arrangement of group and individual therapy affords greater therapeutic effect because of its psychic interactions. For some patients, the two modalities together may lead to promising if often complex analysis, through an open flow of information between the two modalities: dyadic and group. However, the two cases I present illustrate problems that may arise in combined treatment. In these two cases, the interaction between the modalities may have prevented important working through, and caused an irreparable breach in the therapeutic alliance. The interdependence among complex enactments, my countertransference, and the respective groups' transferences was quite powerful. In this paper I will describe various forms of these enactments, explore some ideas about the reasons the enactments occurred, and discuss their impact on the treatment of these patients.

Some problems with treatment destructive enactments in combined therapy

The surface of a working group can be thought of as composed of the collection of words carrying meaning exchanged among the participants, yet there is much more that is psychically going on in the group beyond the literal meaning the words. Communication in all therapy, whether dyadic or group, occurs within a system of interactive non-discursive cues that are responsive to and aim to influence the **recipient** in the dialogue. Words and speaking them are a primary form of interaction and in most therapies a unique shared spoken language is required and developed. Within the animated dialogue, restrictions against "action" in analytic treatment places additional burdens on language to convey the endless variety of layered nuanced emotional and symbolic meanings, and collateral psycho-motor activity is very common. In dyadic treatment, spoken words with accompanying nonverbal activity influence both participants, while in group treatment the effects spread through various psychic levels of all the participants. The rapid psychic interactive process of communicating with words in a dyad is little understood and yet in psychotherapy we are dependent upon talking and the interactional effect of spoken language to create meaning, understandings and change.

Communication in any therapy, because of its highly charged and complex emotional nature, is a flawed or incomplete process even when the mutual wish of both participants is to be understood.

Psychoanalytic theory and practice has accommodated to contemporary changes in understanding the emotional interaction in dyadic relationships by more closely investigating the complex dynamics of verbal interaction of the two participants. It is much more problematic to hold the same magnifying glass to the verbal-emotional interaction in a therapy group of individuals, as the language-generated relationships and interactions are geometrically multiplied and often not visible. An analysis of a communication by a single person in the multi-person environment of analytic group therapy would certainly require a complex layered interactive model to understand the influence of these utterances and its layered psychic reception and response; but a model that offers conscious and unconscious meanings of communication including non-discursive signals is not currently available

In this paper I will make use of certain ideas that were clarified in McLaughlin's (1991) refinements of the term, "enactment." and apply enactment theory to group and individual events in the hope of demonstrating its appearance and impact. I hope to shed some light on the forms of enactment that occur in combined (group and individual) therapy to provide a tool of observation that will illuminate clinical events that have been present, and which perhaps have been noticed, yet have created clinical and technical problems. It is not possible to explain the entirety of the nuanced dynamics of the total group situation, but I intend to focus on some dynamic elements of what are treatment destructive enactments in combined treatment. I now believe that a large number of events in group therapy fall under the definition of enactments. For the purposes of this paper it will be necessary to take the clinical event out of its embedded context of the group dynamics that led to its emergence and to simplify some of the interactive dynamics in words which may not fully convey its liveliness or emotional context. Two purposes must be served in this extraction: to protect the privacy of the patients used in the clinical examples and to present the clinical material in a linear understandable and readable form. A review of the concept of enactment is followed by two clinical examples and discussion.

Enactment defined with difficulty.

With the increased interest in the interactive elements of psychoanalytic process as it occurs in the dyadic relationship, a number of authors have proposed a clinical distinction between two psychoanalytic concepts: acting out and enactment. They both refer to the turning into action events that are refused expression in verbal language or occur alongside or in spite of a patient's spoken words. From a more general interactive perspective, all verbal and nonverbal exchanges that occur in therapy have been assumed to be "enactments," however I think enactments require some delimitations. "Acting out," or "acting in," to a greater extent has been reserved for the behavior of the patient. "Enactment" is operationally used to refer to the product of nuanced processes occurring between the patient and the analyst on other than conscious levels, in which an action or emotion dominates or interferes with the patients' capacity to speak and the analyst capacity to understand what the patient is conveying. Usually the action of the patient is unconsciously determined by transference(s) and conflicts while the action of the receptive analyst is open to his or her self-examination. In summary, for current purposes then, enactment involves the analyst as participant, vulnerable to his own transferences, susceptible to "blind spots," and caught up in the relationship rather than observing it, whereas acting out implicates the analyst solely as an observer.

From a dynamic perspective enactment, in its broadest communicative sense, refers to a process of discursive and non-discursive communication occurring between the participants that has unknown meaning for a long period of time and then may suddenly become apparent to one or more participants. Enactments as performance dynamically bridge the interface between what is expressible and inexpressible, what is forgotten and what is pressing for revival, what is preconscious and is forced out of awareness, what is past and what is present, what is reality and what is imagined (Boesky 2000.)

Within the dyadic setup, the therapist-analyst continuously sorts out the clinically relevant material of the transferences –counter-transference interaction with the patient. As we know, this is a difficult, often impossible self-analytic task. The group setup requires a still more difficult process. The intense power of projections group members

make onto the group leader (Grinberg, 1976) and each other results in frequent transference role induction. The group analyst must be able to stand apart from the patients' verbal and nonverbal expressions, while still absorbing their projections, and hopefully, becoming an alternative source of knowing the minds of the patients as well as the collective group, rather than merely being a co-participating member.

To the extent to which these dynamics are contained and understood, the group analyst is capable of verbalizing to the patients and group, through the available reflective filter of transference-counter transference, what he or she perceives is happening in the group, among individuals in the group and in the psyche of one person. For instance, the analyst may describe how and why a patient pressures certain group members into particular roles, such as to enact a dynamically significant scene (or scenario) or for the purposes of his own conflictual needs

The extensive and growing literature on enactments (see Boesky, 2000, for a review) typically describes how an acute or dramatic episode is understood retrospectively: that is significance is discovered in the interactions that, prior to its "performance," had not been expressible and hence, comprehensible. I will present such a dramatic enactment. For clarity I will use the term enactment to denote not only the action scenario, but also the therapeutic work that follows its discovery. The enactments I describe involve group members, the therapist and the whole group, and the therapist and a particular group member. Of course, locating the psychic source or sources of an enactment is inexact and incomplete as unconscious elements may only become known at a later date. Further, since projective-introjective processes occur continually in the intense flow of analytic group work, new enactments may be developing while old ones are emerging and understood. Finally, as in the following two examples, as the material unfolds in real time, understanding the interaction(s) and the links to unconscious individual and group processes may not necessarily arrive in a timely enough fashion to enable the therapist to forge a constructive therapeutic advance, as that material is not yet expressible.

Clinical example 1

In my group room there are no tissue boxes available as I believe it is not necessarily a part of therapeutic furnishings. For my purposes the group set up is cut off from the outside world and focuses on the facts and phenomena that occur within the confines of the group experience. This takes the members to be carried along to experiences that they did not anticipate and are outside of normal social interaction. One result is if someone tears or cries within the group session, the individual or a sympathetic group member may take action and search for a tissue. In the latter situation, I often ask the member supplying the tissue to verbalize what he or she was feeling in this non-verbal but highly social and supportive exchange. In the instance before us, a group member was sobbing and talking without any effort on the part of her cohorts to offer a tissue. Aware that none was being offered, and feeling some uncharacteristic responsibility as her sobbing intensified. I got up, went into my adjoining office and retrieved a box of tissues, while speaking that I was doing so.

Reentering the group, tissue box in hand, I was greeted with “Don’t offer me tissues” by the sobbing member, Emma. “ If you do, I’ll throw the box in your face.”

I responded: “Now I know why no one offered you a tissue.”

“I have great aim,” she retorted.

“You are making your unspoken response much louder,” I clarified. I then commented that nobody moved to offer a tissue, leaving it up to me.

What had moved me to the unusual act of leaving the group boundary and returning with a box of tissues? What was occurring beneath the surface such that I carried out a social action with this patient unlike my behavior in similar past situations? And further, what about my innocence or lack of expectancy in regard to her sudden threats to throw it back in my face? Thus, under the surface of the action of my social response were special transference counter-transference dynamics.

First, there is a group member crying and contrary to this group’s customary behavior, no one offers a “personal” tissue. I take action, rather than commenting on the unusual circumstance. The patient then threatens to throw back my offering. Again the group is silent. I reflect that the group’s lack of response was determined by their earlier

recognition of her possible threatening behavior. And so, it appears, I acted for the group and drew her fury, while the members remained safe from her threatening emotional outburst.

Emma would come to express, by her actions and enactments how dangerous any form of dependency was. Defensively and aggressively independent, with a workaholic life style, she acted as though she could not accept help from any member of the group, including me. She described herself as living in a tower and pulling up the drawbridge. In individual sessions after and relating to the group event, tears streamed down her face, yet she averted her gaze and remained rigid, wiping her tears with her hand not looking directly at me.

She never cried again in group, while in individual treatment, she would not bring herself to use a tissue when she was in tears, despite my repeated efforts to offer her one. Indeed, for the remainder of her treatment, she refused to use, take, or accept a tissue and kept her gaze averted when she cried.

In the following two years, Emma progressed in her world of work to gain higher status and recognition at her job. She took her professional dedication into group, although she could not establish fully trusting relationships. She was able to accurately assess the plights of others in work or group, and use her considerable intelligence to offer insightful comments; but would not share intimate material

Her initial rage at and contempt for me continued after the group incident, and remained the constant theme of our therapeutic interactions. She alternated between rigid though watchful withdrawal in group sessions, silently observing others, while expressing contempt, rage and crying in the individual sessions. She remained unable or unwilling to bring her rage into the group for examination, as some more integrated patients are able to use the group members' perceptions for perspective of their negative transference. Thus she rarely, if ever, made a bridge between individual and group sessions. She left group a year later after many threats to do so, and left individual sessions after another eighteen months. When I made reference to the two leavings in terms of their angry adolescent quality, she replied "so what."

At the same time she was “secretly” developing a positive relationship with a man outside of the group, becoming both erotic and warm. I did not think it a coincidence that, prior to termination, she engaged in an intimate sexual relationship for the first time in 10 years. He was a somewhat older married man who treated her with kindness. She tolerated this new experience to the extent of allowing him to stay in her home, but would not talk to us about her feelings for the man or her experience other than to say “its temporary”. She appeared to be unable to tolerate two men in her life at the same time due to the opposing feelings they stimulated in her. There was no doubt, in retrospect, that her threatening outburst in the group was the first step in the emergence of her powerful negative transference that had never been expressed openly. Hence, the enactment had an expressive purpose and achieved a therapeutic goal.

Brief case formulation. Beyond her depressive withdrawal was Emma’s fear of a omnipotent parent who would consume her or whom she would murder. Her malignant rage, constant self criticism and lack of eye contact clinically indicated her very early trauma and primal fear of any but work relationships. I became continuously and alternately the object of need, rage and contempt, which actually served to allow the start of a capacity to be in an emotionally reactive relationship. As she had difficulty integrating the two therapy modalities, she had similar difficulties in assimilating ambivalent feelings about one individual. She “solved” this problem by having two men in her life, one caring, and the other as the object of her anger and rage. Still, she now had the capacity for two types of object relationships with men, whereas prior to therapy she displayed a capacity for none.

Clinical example 2

A young man, Paul, was describing in group a recent interaction he had with his wife. In prior individual sessions he had described his tendency to step into emotional traps with his wife, from which arguments would start. These were situations in which he could not express his feelings while his wife volubly criticized him. Their arguments quickly escalated to expressions of mutual grievances with no resolution, and he had raised the question whether they could live together and remain married.

Paul accurately described himself as practical, problem solving, and action oriented. He described his wife as emotional, seeking reciprocal feelings, and which when not offered, withholding of sex, unhappily for Paul. Her explanation for sexual withdrawal was that Paul was not on the same “emotional page” as she. Although satisfying before the marriage, sex gradually had become almost totally absent.

Paul retold an incident that he had related in an individual session: “I was leaving the house, going to get coffee. My wife was walking down the street coming toward me, and I went over to her and kissed her on the cheek. I told her I would be back in five minutes. When I returned home, she said: ‘I told you three times never to kiss me on the cheek in public. Kiss me on the lips or don’t kiss me at all. She was in a rage. Dr. R. [the therapist] said I stepped into a trap with her, and I did. I told her ‘I don’t feel like kissing you on the lips, why should I. It goes nowhere. When we have sex, I’ll kiss you on the lips.’”

I pointed out to the group how quickly the argument ignited and how quickly accusations began. Another member, Allan responded, “That sounds like my wife. Since we separated, when she does that to me on the phone I hang up. I put up with it for years.”

Paul: “Put up with what?”

Allan: “Her telling me all the things I do wrong. Now she calls my boss and tells him. She calls my secretary when I’m not in the office. All the time she calls me when I have the kids and tells me I have to do this or that and then in an hour she calls me to find out if I didn’t do it.”

Ann, a woman who has never been in any long term relationship, responded to Paul: “Don’t you wish that your wife would say to you: ‘I wish you would want to kiss me on the lips?’”

Paul: “Yes, I’d like that.”

I joined in: “You know, Ann is right.” An accusation is not the start of a dialogue. It’s the start of an argument that elicits other accusations and ends in bitterness on both sides.”

Another member, Bob, harshly questioned Paul: “Why do you think you just kissed her on the cheek?”

Paul: “I said that was all I felt like doing.”

Bob: “Why didn’t you explain that to her?”

“I did!” Paul replied.

Bob continued to fire rapid questions: “Why aren’t you having sex? Don’t you like sex? Are you having an affair?”

I was aware of feelings of concern as Bob continued to throw words as accusations at Paul. The psychic bombardment seemed to be a replication of the treatment Paul received from his wife, now enacted in the group treatment. I intervened by attempting to stop Bob who often acted as a bully with younger men noting the different objects each played for the other.

I asked Bob why he went back at Paul and he replied, “There is something fishy about the story. I can’t put my finger on it, but it’s fishy.” The group moved onto another topic.

In the following individual session I found the opportunity to reflect to Paul that the group seemed difficult for him and I wonder how he managed it. Surprising to me, he replied that he told his wife about what happened and how she had disappointed him, (an act that was against the suggestion that group discussions remain in the group). He liked very much what the woman said to him, Paul reported saying to his wife: “Why can’t you tell me what you want.”

I said to him: “That isn’t quite what Ann said, and it seems that now your tone is one of making accusations about your wife.”

Paul replied: “My mother always makes accusations against my father, he took money of hers and lost it in a business and she never lets him forget it.”

I reflected: “I see the pattern in your family but it seems that you take turns making accusation. I wonder what’s going on between you and your wife that accusation is the form of the relationship right now.”

Paul: “Her father is constantly buying us things. With the baby now he bought us an expensive stroller, and I didn’t want her to accept it and she did. She feels that her father has to make up for things that he did in the past when he abandoned her and now she wants him to make up for it. And when he gives her something, I feel enraged. She is saying that I can’t give it to her, that I am an inadequate father and husband, like my father.

I continued: “You seem to know that easily. You feel inadequate and then you kiss her on the cheek. I don’t get the connection you are making.”

Paul moved away emotionally from the question, and I could not pursue him successfully. I did not feel satisfied with his parental explanations for the marital argument, which seemed facile. I thought of Bob, who found something “fishy” in Paul’s presentation. However, Bob’s aggressive style called attention to itself and away from his intuition about Paul.

Paul told of similar incidents with his wife, and I formulated from the repeated data that the couple was involved in a sado-masochistic, critical relationship. Paul seemed to believe he was repeating the marriage of his parents, in which there was constant criticizing and carping. But the underlying story emerged serendipitously in an individual session and never appeared in the group.

Paul remarked on getting up in the middle of the night, secretly masturbating, and almost being caught by his wife. I asked for him to tell his masturbatory fantasy, expecting a sado-masochistic compensation for the battles with his wife. I was stunned to hear that he masturbated to the fantasy of touching a beautiful boy he had seen in the subway. He then told a story, not unlike *Death in Venice* (Mann, 1912), in which he felt compelled to follow this child of about 6, and could not tear his “eyes from him.” He quickly acknowledged that he had married in partial compensation for his fantasy interest in young boys. While embarrassed, he did not appear to be experiencing any guilt, perhaps because he blurted out his impulses.

Discussion. A complex set of enactments emerges in this clinical sequence: between Paul and the group; between therapist and two group members, Paul and Bob; and between the individual sessions and group sessions. On the surface of the group Paul

misleads the group into attending to the surface of material, his kissing his wife on the cheek. He is successful in keeping the material at the manifest level and not responding to Bob's questions regarding his possible lack of sexual interest in his wife. It appears that a splitting of the transference, having a relationship with a wife whom he is not sexually interested in, and hiding his erotic interests represents an early split in presentation of his self and his internal identity. This same psychic split is replicated in Paul's marriage. The group stands for his family of origin and his marriage, in which he battles his "immature" wife, obscuring his sexual interest. Segregated from the group were the discussions in the individual sessions in which he began tentatively to reveal his attraction to boys and his complex mutually provocative relationship with his wife.

He remained unable and frightened to bring the relevant material from individual sessions to the group setting and conversely could not deal with the overt lying to the group by which he controlled what the group knew about his sexual fantasies and inner life. By continuing to misrepresent himself to the group he created a stalemate in which growth was pre-empted. Eventually, he found a disguised way to end his therapeutic relationship to both modalities by lying to the group about his reasons to move his wife and family to a suburb. Hence, another enactment maintained the integrity of his split transferences while the group went along with his reasons and made no effort to understand his sudden actions.

Enactments in groups

The setup of group and individual therapy for the same patient creates unique and distinct transference worlds for clinical material to emerge. Each patient participating in this dual arrangement makes an adjustment to the transference worlds and regressive demands of distinctly different situations. Most therapeutically useful is an interactive relationship in which emotionally significant material raised in one situation is worked on in the other, resulting in a flow of material around salient interpersonal or psychical conflicts. While often the group situation has social meaning and the dyadic situation has a self focused intensity, different kinds of material may emerge in each setting. The two patients I described formed dissociated therapeutic relationships, such that the

combination of the two modalities did not work to full advantage and treatment for both was prematurely ended.

How then can we understand enactments in the distinct worlds of individual and group psychotherapy interact that belong to the same person? One clinical answer has to do with destructive enactments and the presentation of powerful splitting of the transference as a defense that is dynamically related to the propensity for action without words. Reformulating the clinical situation with Paul in terms of enactments reveals additional clinical information: Bob's response clearly indicates that he is skeptical and he strongly confronts Paul with questions doubting his explanations for not having sex. He is the only group person, because of his own sensitivities to facades, to see through the façade presented by Paul. He does it harshly and he remains staunchly certain that Paul is misrepresenting himself in the group. I selectively focused on Bob's emotional harshness and ignore his message's content, I later realized, because he often projects his own fears onto younger and feminized men in the group. I do not recognize the content of Bob's projective response to Paul as having any creditability contributing to an enactment where I privileged Paul's false truth over Bob's harshness. After Paul's revelation about his sexual interests in individual sessions, I had the chance to correct the enactment with Bob and he was then able to reveal with embarrassment that he often also avoids genital sex and that I viewed understanding his verbal aggression as essential in his treatment.

My own responses to the group and individual events are also complex and revealing. I have information from individual sessions about Paul's developmental struggle that the group doesn't know, as well as information about Bob's sexual preferences and fears. Particular information about Paul's physical immaturity during and after college, his feelings of sexual ambiguity as he psychologically developed, and the unexplainable neglect by his parents of his developmental immaturity by ignoring his delayed adolescent physical development. I am certain that this played some part in a transference of "protecting" him in the group from Bob's angry questions. Yet, his distinct double transference, one truth about his sexual interests in the group and a different truth in the individual sessions, while not uncommon, was rigidly maintained. I experienced this doubling as hampering both my thinking and interventions. Paul withheld his permission to bring content from the individual session to the group, while

he continued an active charade in the group. I too assumed the role of a parent in the group, who paid no attention to his inner dynamics, and who participated in being initially fooled by his brave and provocative façade of cheek kissing; a fooled and foolish parent.

In regard to Bob, whose remarks to Paul I didn't decode well enough, the group situation is also complex. His participation in the group is also fraught with problematic interactions and inconsistent behaviors. He is aggressive with other men and avoidant of emotional and full genital interactions with women. His intimate relationships with both sexes outside of group are problematic and disguised in his telling. He is frequently angry, manipulating in his attempts to make me like him despite his behavior, or attempting to be intimidating behind a clown-like demeanor. His anger at other men and his angry conflicts with his college age son had been the recent focus of the individual material. My attention is focused on his anger and aggressivized speaking and when I ignored the content of his response to Paul it contributed to the enactment affecting both men.

In regards to Emma, the situation is less complex, but the event more dramatic. The event takes places within a context that I have described, a persisting problem in this group regarding silence that I experience as empty and death-like: a particular emotional absence that carries with it the notion of a developmentally early damaged or absent parent. Much of this I felt at a group level in the silence to Emma's crying. Emma herself had reported being told that her mother hardly picked her up in the first two years of her life and here we have a confluence of emotional forces in the group between the absence of "Emma's maternal caretaker leaving her wet and crying," and the group's absence and fear of making emotional contact and of being able to feel and express empathy. I realized that I acted impatiently to once again show and correct their indifference within the group. I may have been better off allowing Emma to be ignored and to have the group transference of indifference heat the group's detachment, though I do not know how this will affect their links to each other. Instead, I found myself trying to correct an absence in the group that is developmentally apparent: a difficult task, since the corrective behavior is always through me and becoming a burden. Not

acting, not getting a tissue means I must be quiet, patient and able to accept more of their frustration of their projected omnipotent parental fantasies and tolerate the feeling of silent emptiness in the room. I come to understand that I am moved to act and met with group level rage expressed through Emma that will continue to be present in the group. Rage, I think, may be a better therapeutic solution than indifference.

Joseph (1981, 1989), among other individual analysts described how the analyst inevitably is drawn into playing a role in a patient's fantasy or inner life. In observing and reflecting upon this relationship and role, the analyst can come to understand the patient's defensive system, and habitual style of object relationships. When such transference manipulations or provocations occur in ordinary life, the person towards whom they are directed may either show that he does not accept the role, or may, if he is unconsciously disposed in that direction, in fact accept it, and act accordingly. It is likely that such acceptance or rejection of a transference role is not based on a conscious awareness of what is happening, but rather on unconscious cues. In group therapy there are a confluence of pressures for the therapist to play a particular role in the group at a particular time. Selecting any role, such as getting a tissue as I did, is antagonistic to one role while conforming to others, setting off psychic responses in the participating group members.

In analytic group therapy, such subtle transference interactions are the subject of magnification and examination as we select some behaviors to examine and understand from the seeming constant array and levels of complex group interactions. The selection process is fraught with its own dynamics and is likely the place where the therapist is prone to become a participant in an unavoidable enactment, much as I responded to Bob's tone and not the content of his message.

From another perspective these two patients, Emma and Paul, illustrate how quickly unconscious processes can ignite in combined group and individual treatment and contribute to the selection of material by the group therapist. One additional contributing factor in effecting selection of material is that both patients had a powerful capacity for projective identification and splitting as a defense, due in part to early developmental trauma: both were able to relate too separately to the group and to the individual session,

but not cohesively or interactively. This adaptive failure with its powerful projective elements deeply affects the therapist role and the choice of interpretations (Feldman, M. 1997) because the therapist is made aware that both patients remained vulnerable to further internal splitting of the transference and of internal representations in general, and further destructive actions. These destructive forms of splitting were reactivated and lived out in the combined group and individual settings and provided not only a frame for enactments impacting the therapeutic alliance, but as well resulted in the therapy becoming unsafe for the enactors.

Patients capable of both projective and introjective identification are able to use the combined setting differently, as a good and containing object, as a means of learning about themselves and others, about their internal states and (empathically) the internal states of others and come to understand how it is they have developed into the people they have become. They have the opportunity to learn, to introject (take in) the group experience and to then empathically recognize themselves in others and be able to without much prompting to recognize significant internal states or internal objects in other members of the group. These reflective circumstances in the group member eventually come to dilute the variable intensity of projections into the group situation so that interpretative communication is possible. Of the three patients mentioned above Bob, was furthest on the path to doing this more reflective work

Other types of patients are also prone to this kind of splitting in combined therapy and are a particular clinical risk. For those with an inadequately constructed sense of independent self, for whom adhesive identification (Bick, 1968) is the mode of their functioning, the group situation can serve as an alternative skin, as if a membrane holding them and the others in a temporary container. Usually that patient has developmental lacks, such as an inadequate sense of time and future (which is dependent on hope and anticipation) that result in severe acting out at the occasion of separations. In addition, problems will arise for some when the individual therapy takes on the function of being an intrusive object threatening the defensive structure of the person. That occurs when the patient feels deep psychic insecurity and vulnerability in the individual sessions and fears that the therapist can potentially attack, take over, or otherwise alter their internal mind. I

believe this may account for the continued silence in the group interaction I described with Emma's tissue.

Combined treatment offers many opportunities to see the personality development from a variety of analytic perspectives and depths. From the developmental issues of psychic maturity, to the uses of projection and identification in a variety of settings that lead to transference gatherings and the emergence of conflicts, group and individual session are a diamond field of psychic data. Combined therapy seems to present both opportunities and problems in the treatment of many patients. The combined set up seems to encourage both a lack of continuity between the dyadic and individual set up as well as creating or encouraging enactments. Members of therapy groups function in a receptive-responsive mode quite differently from the therapeutic-receptive stance of a therapist as they have no real therapeutic responsibility for each other. For example, silence, as in the group's response to Emma's sobbing, seemed to be a powerful nonverbal statement about the hostility between Emma and the rest of the group while protecting the members of the group from some form of intrusion. Silence by the group therapist has a different function. As an enactment, the unusual silence to the sobbing revealed the group's unresolved problem of converting unpleasant thoughts or emotions into language. By my action of getting the tissue, I took action rather than verbalize and put myself in the "line of fire," and Emma's emotional fire was not friendly. Interesting too, was the absence of support or perspective from other group members after Emma's outburst.

Paul's complex behavior set up a situation for many continuous and contiguous enactments. He misrepresented himself to the group for defensive and transference-laden reasons. Bob's sensitivity to this misrepresentation, my emotional reactions to both Bob and Paul, and the emergence of Paul's separate uses of the group and individual treatment were never resolved. Additionally, the emergence of Paul's sexual fantasies and conflicts remained significantly unavailable to therapeutic work.

Under these conditions that we found with Paul the group session can more easily resemble a façade of a defensive personality, a mask, a false self that is supported by certain complex dynamics in the group makeup. Upon later reflection I came to realize that with both Paul and Bob there was an undercurrent of false, fragile or defensive masculinity that had eluded my awareness and contributed to the enactments.

The separation of setting and the different nature of the transference alliance(s) in combined therapy may foster the emergence of valuable clinical information or it may reveal a form of splitting, a façade of honest involvement that may not be understood by the group members, the patient, or the therapist. Or, from another perspective the transference façade places the therapist in a bind so that he cannot deal with the character façade in either therapeutic setting or may be forced to make choices which contribute to enactments. These kinds of defense must be respected for the false mask may be the only integrative element in the individual's functioning.

The clinical study of the patients who could not manage combined therapy may also help us understand patients who are willing to negotiate the complexity of multiple attachments and regressive behaviors in groups with the dyadic intensity of the two person situation with certain therapists. These two patients stood out because of the dramatic nature of their enactment: with Emma, in my response to my attempt to give her a tissue box, and my group countertransference to silence and inaction; with Paul in the unmasking of his preoccupation with beautiful male children. While the pessimistic among us may say all patients may suffer from similar fates and the issues of truly combined treatment are too problematic to successfully negotiate, I believe it is a worthwhile endeavor and the majority of patients are willing to cooperate in moving between and inside the complex boundaries of multiple transference demands. Yet Bob, Paul and Emma made progress clinically, though, to a degree somewhat unsatisfactory to me. Paul broke off treatment suddenly as did Emma. There was a temporary resolution for her in finding a relationship, but I had no clinical sense that she had any further understanding of herself, although aware that her choice was better than earlier ones of other men. Paul remained a blur. His conflictual world could not maintain given its pressures, although I am fairly certain he would not act on his sexual fantasies.

I also agree with Joseph that enactments are part of the web of unconscious behaviors, some subtle, others obvious, which may lead to further understanding of the patient's complex inner life. It has been pointed out previously that when such transference manipulations or provocations occur in ordinary life, the person towards whom they are directed may either show that he does not accept the role, or may, if he is unconsciously disposed in that direction, in fact accept it, and act accordingly. It is likely

that such acceptance or rejection of a transference role is not based on a conscious awareness of what is happening, but rather on unconscious cues. Without such interaction deeper psychological treatment may not be possible, yet enactments may totally disrupt the treatment alliance.

Enactments, I have come to understand, are of many different varieties in group therapy. Bateman (1998) has described various psychic levels of enactments, and I believe there are normal, continuous, and possibly multiple simultaneous enactments that dynamically propel a therapy group forward into conflictual relationships. Among them are acute episodes, such as the dramatic one in response to the tissue box, and chronic ones for an individual or a group, like the silence in response to Emma's sobbing. This intense and prolonged silence may also have represented a reaction against the pull of positive relatedness within the group setup, due to early developmental trauma. Some enactments, like Emma's, take the form of aggressive threats. Others, as with Paul, recapitulate powerful transference histories. Still others are in response to the varying emerging themes in response to the internal pressures among the participants created as the therapist selects from the array of generated material an element or dynamic as his or her focus.

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