Transformance: The AEDP® Journal
Volume 16 September 2026 Issue One

Just Imagination: The Suspension of Disbelief and Other Portrayal Principles

Processes and Techniques

Matt Fried

Abstract: Portrayals are a dynamic tool for the AEDP therapist. With historical links to Gestalt other expressive therapies, portrayals give clients a way to co-create new and memorable imaginative experiences within the safety of the therapeutic relationship. These experiences can help undo problematic expectations about the possibilities of living and relating to others. This article explains the underlying principles and practical techniques of portrayal work. Applicable skills and strategies will be offered to enhance the therapist's effectiveness in setting conditions for, accompanying and closing a portrayal. Annotated transcripts for and anger portrayal and a reversal portrayal will be offered to illustrate the principles and techniques in practice.

I. Introduction

In AEDP, portrayals are powerful psychotherapeutic tools for the evolution of the self (Fosha, 2000; Medley, 2020). They contain and integrate elements of each of the 9+1 AEDP affective change processes. My intention in this article is to make portrayal processes in AEDP psychotherapy, and particularly in AEDP, more understandable for both therapists and clients. I will lay out some of the principles, the nuts-and-bolts underlying portrayals, and discuss their therapeutic application and potential.

Portrayal work has its roots and principles in the theories and practices of Davanloo (1990), Moreno (1946), Perls (1968), Pesso (1997, 2000, 2003). Each of these pioneers understood the

Matt Fried, PhD, MA, MFA, is a New York State licensed psychologist with a private practice in New York City and upstate New York. He works with individuals, groups, and couples and supervises therapists. He is a certified AEDP therapist and supervisor, a certified international trainer in Pesso Boyden System Psychomotor (PBSP), and a certified Feldenkrais practitioner. In addition to his professional articles, he's published short stories, poetry, and a CD (Days of Hope) of his original music. Address correspondence to Matt Fried: mattf@aol.com

power of imagination to heal and each has contributed significantly to the variety of how portrayals are done.

For AEDP, a main goal of portrayal work is helping clients access, heighten and deepen the visceral experience of core affect and process it to a satisfying completion (Fosha, 2000; Medley, 2020). "Portrayals are real or imagined scenes from the past present or even future in which the client is invited to have a reparative, feared, or wished-for experience through the boundless world of imagination (Prenn, 2010)."

Another related goal and outcome of portrayal work, as described by Ecker (2012, 2018), is the creation of new imaginative experiences which can undo the power of trauma memories and the emotionally and relationally constricting conclusions drawn from them. He writes, "The emotional realness of …imaginal experiences…is what gives them disconfirming potency; research has shown that the emotional learning and memory system responds to imaginal experiences almost indistinguishably from *in vivo* experiences (Ecker, 2018, p.1–9)."

Most of the time when we do this imagining or remembering, wondering, wishing, replaying, hoping, regretting, we do it alone. Sometimes we risk telling others of our imaginings—friends, partners, therapists—but most of the time it's a solitary experience. In contrast, an essential principle in AEDP is the undoing of aloneness, with the therapist actively accompanying the client in the work of evolving the self.

Portrayals can be seen as *imagined interactions* (Honeycutt, 2019; Prenn, 2010) that happen in collaboration with the therapist in the ongoing here-and-now of the therapy session. In a portrayal the client might engage with parts, with people in the past, present or future, with fictional people, with animals, objects, places or even spirits or deities. Fantasizing and/or remembering are naturally occurring aspects in any therapy session. Portrayals happen when these experiences are extended, supported, encouraged, guided and/or re-shaped *in supportive collaboration with the therapist* to produce outcomes which benefit the client's growth and the healing of emotional wounds (Fosha, 2000; Medley 2021).

II. Imagining: a basic and continually exercised human capacity.

Underlying all portrayal processes is the human ability to imagine. Imagining is what we do a good deal of the time, a basic and consistently exercised activity of the human nervous system, although other species do it as well (Bompey, 2023). We remember and review our pasts, especially the hurts and absences. We recall easily, even involuntarily, what has been harmful, scary and/or dangerous. We wish certain things had been different. We remember, at times with difficulty, what has been good. We carry with us conscious and unconscious conclusions, assumptions and expectations about living, relationships, emotions, the possibility of hope (Ecker, 2012; Pesso, 2003). We long for good futures and for the absence of bad futures, while knowing there are some futures we cannot avoid. We pray for positive change, for justice, for rightness, for completions. We dream of ourselves and others being the people we want ourselves and others to be.

Kinds of memories which can be generated in an AEDP session

The AEDP therapist, in undoing aloneness (doing togetherness), provides a *consistent set of contrary memories* (Ecker, 2018) generated in the real time of the therapy session which are, in essence, reversals of the aloneness experiences in the client's history. The portrayal provides similar contrary (reversal) experiences *in imagination*, leaving the client with (1) the memory of what was imagined; (2) the memory and knowing of having repaired a significant troubling inner stuckness via imagination; that is, the nervous system has learned a new capacity; (3) the memory of having managed this process *in collaboration* with the therapist, i.e. a memory of safety and support from a true other.

Actual present-time memories and imagined memories can continuously activate each other. For example, the therapist affirms the client, who then tears up while recalling past non-affirmation. Together, therapist and client metaprocess the experience. Next, the client is guided in creating a reversal/reparative portrayal in which parent figures are affirming and both participants metaprocess this portrayal in real time. In any session, then, we are always traversing from the affirming/undoing aloneness in the present to the imagined affirming/undoing aloneness in the past and back again. Present experience and memory are mutually reactivating and mutually

enfolded. The opportunity for *contrary knowing* and deep affective work sits waiting at every moment.

III. Basic principles and elements of portrayals

Whatever the composition, content, and time frame of any portrayal, there are basic elements and principles common to all.

Reversals and Justice

The power of most portrayals comes from imaginatively reversing that which has been harmful in one's history or in the present due to factors of powerlessness or inhibition or other restraining forces. The client could not express anger but can in the portrayal. The client did not receive care, attention, support, affirmation but can in the portrayal. The client's suppressive parts did need to protect them but no longer need to. Perhaps a part has been alone and not trusted by the self but now an intra-relational portrayal can undo the part's isolation.

The notion of reversals aligns with the concept of justice—what should have happened to a person, what would have been the right way to be treated, parented, how should humans relate to other humans or the injured parts of the self? The notion of reversals coincides with Ecker's (2012) idea of "needed contrary knowing" or "contradictory knowledge." "The emotional realness of …imaginal experiences…is what gives them disconfirming potency; research has shown that the emotional learning and memory system responds to imaginal experiences almost indistinguishably from *in vivo* experiences (Ecker, 2018)."

When we work with the notion of reversals, we and/or can ask ourselves: what should have happened, what should not have happened and what should happen in the client's present or past? As we teach the client to generate and imagine positive scenarios, they gradually accumulate understandings about attachment needs— which ones were met, which ones were not, and how to construct imagined fulfillment scenarios (portrayals). In this way, clients

generate contrary knowing experiences (Ecker, 2018), feel relief from protective defenses, and generate greater optimism and hope.[1]

The suspension of disbelief

When we watch a compelling movie or play, when we are drawn into a novel, we know we are experiencing that which is not real, and yet we allow ourselves to be captured by the fiction (narrative) in a particular format (e.g., film). This duality has been called the *suspension of disbelief,* a term referring to one of Aristotle's principles of theater in which the audience accepts fiction as reality so as to experience a catharsis (Coleridge, 1817; see also, Kahneman, 2011; Ryan, 2001; Herman, 2013; Gallese & Guerra, 2019).

The suspension of disbelief is both a literary and theatrical concept that points to the fact that people can enter into an altered brain state in which there is a knowing/understanding/awareness that (a) the particular work of art - a play, novel, film - is just a work of art; (b) that one is a spectator, a viewer, a reader; and (c) a simultaneous experience of immediacy and emotional engagement with the work of art itself. We know we're sitting in a seat in the theater, yet our mind - on conscious and unconscious levels - is absorbed with the work of art itself, its story, the roles of the actors, etc. This capacity of the brain is inborn, hard-wired, a manifestation of neuroplasticity.

IV. Theatrical elements of portrayal work

It's important to keep in mind that portrayal work has much in common with the theater and other art forms. The client is tapping into their suspension of disbelief (neuroplasticity) capacity.

[1] "Indeed, when we are supporting the client for the first time in expressing love or anger or sadness towards images or symbols in the therapy room, we are supporting the expression of affect as a human right and undoing previous suppressions via shame and/or fear. When we support the client in receiving, in imagination, that which should have been received (love, tenderness, comfort, support, etc.), we are supporting the human right to be treated/related to with kindness and respect. Since imagination is malleable, the client, with our help, is free to envision figures, who are kind, strong, compassionate - figures who can rescue, protect figures, understand, emphasize, love, and be loved. We all have archetypes of these figures in our DNA and in our unconscious expectations about what life can be (Pesso, personal recorded communication, Sept. 25, 2004)."

The therapist can help deepen engagement, deepen the fiction of it, and thus enhance the impact of the work. Here are some ways to do that.

Externalizing elements of the client's consciousness

If the client is remembering and engaging with a past figure, the therapist can invite them to imagine (project) that figure into the room or into a specific location, and only then interact with it. Similarly, if the client is experiencing voices or parts or younger selves, externalize them, if possible. In a sense, the client is absorbed with their inner theater. Externalizing gives them an outer theater in which to process affect and reversals (Pesso, 2003).

Of course, whatever the client can or cannot do in this regard needs to be explicitly (and internally) acceptable by the therapist. Shame experiences are easily elicited and triggering them should be avoided at all costs. However, externalization does heighten the intensity of emotional processing and over time the client's capacity to tolerate this will usually improve. One final note in this regard, when the client has ended the portrayed engagement with that externalized figure or part and is returning to the here-and-now, the therapist should explicitly state that the figure is being re-located back into the client's self/mind and is no longer imagined to be in the room.

A related move which can be employed when externalizing good figures who speak *positively* to the client, is for the therapist to extend their arm in the direction of the figure and say, "I'm lending my voice to be that of (name of the figure)." At that point the therapist repeats the client's depiction of the figure's words as accurately as possible. If the focus shifts back and forth between figure and client, the therapist then is always ready to speak more of the figure's words.

There are two caveats to keep in mind when doing this kind of portrayal. First, the therapist should endeavor to not repeat the figure's words ~~in~~ **if** they are negative, critical or demeaning.

Repeating negative messages runs the risk of underlining them, (which many clients have already internalized). However, should the therapist choose to repeat the figure's negative words, it's important to clearly explain that the therapist *does not in any way agree with them*. To not do

this runs the risk of the client possibly associating them with the therapist. Remember, the client doing a portrayal is in a highly vulnerable and receptive state, so care must be taken in how the therapist vocalizes messages from portrayal figures.

Visible and/or audible impacts.

If the client is expressing anger or tender feelings towards a figure, there should be a visible or audible reaction by the figure and, if asked, the client will let the therapist know what that is. Expressive portrayals are *not* simply about expression. Our nervous system anticipates a reaction and seeks completions (Fosha, 2000; Pesso, 2003). An action seeks reaction. If the client expresses anger (or rage), how does she/he/they want it land? Should the target figure double over in pain, shriek in agony, say, "Ow!", beg forgiveness? Check with the client and then encourage them to imagine this outcome. If the client expresses tenderness what reaction would be anticipated? How would it be shown?

It's important to keep in mind that the drivers of anger are usually hurt and pain. Anger portrayals can be incomplete unless the underlying the pain and grief is accessed. Further, when the client accesses pain and grief there should be figures in her/his/their present (the therapist) or imagined past who both empathic and comforting.

Moreover, when anger or rage at a hurtful figure has been expressed in a portrayal and when the figure has registered the kind of impact which satisfies the client, tenderness may arise, or the wish or longing to receive an apology. Portrayals can be utilized to supply the needed apology (Fried, 2024; see *Apology Work*, page 22 of this paper).

V. Benefits of portrayal work

Below are some of the benefits of portrayal work. Subsequently, I will briefly discuss agency, creative freedom, and the organizing self.

- Portrayals are a highly effective means to access and process core affect; engage many right brain processes, engage somatic and motoric, affective experience, release adaptive action tendencies.

- Portrayals are simultaneously interpersonal and intrapsychic events, requiring and producing trust and safety.
- Portrayals teach the brain about its own capacity to repair through imagination; the client can learn to use these capacities in the therapy session and outside it.
- Portrayals help complete unfinished events which have not been processed to completion.
- Portrayals give more information to the self about the self. They help clients know more about their basic needs and wants.
- Portrayals lead to a clearer, more coherent narrative of the client's history.
- Portrayals help clients to feel agency and mastery.
- Portrayals help undo defensive exclusion.
- Portrayals help build and expand emotional tolerance, relational, receptive and expressive capacities.

A note on agency

It's vital that the transition into a portrayal, the unfolding of the portrayal itself, its ending, and the transition back to the present time is not abrupt and be client centered, not triggered or produced by the therapist's communications. A basic rule of thumb is that the client is always in charge of the narrative and the transitions in and out of the portrayal.

It seems obvious that clients learn over time to more effectively use the resources of the AEDP therapist and the therapy session. When portrayal processes become familiar and clients take ownership of them, the creative self is poised to leap ahead.

Creative Freedom is Inherent in Portrayals

Portrayals and all imagined interactions support and represent the freedom to create, to bend the rules of reality, of propriety, of time and space. The person can visit or revisit the past, change its scripting and its actions; the future can be imagined with outcomes quite different from what is anticipated. The person can their younger selves and interact with them. The range of the "possible" is vastly expanded and this is its gift.

The Client's organizing self

Keep in mind, that the suspension of disbelief underpinning a portrayal does *not* mean the client has entered an altered state devoid of normal consciousness. Far from it, in a portrayal the client's organizing self is very much at play, selectively remembering, directing, constructing and modifying images, providing a verbal narrative, assessing and responding to any coaching suggestions from the therapist, pausing, shifting the action of the portrayal, accessing associated memories, assessing when to stop the portrayal or slow it down if there is emotional overload or flooding, etc.

During a portrayal, the client will pause, perhaps look at the therapist, perhaps take several breaths. These are moments when the client's organizing self is receptive or seeking some response from you, the therapist. At this juncture, it might be most effective to ask something like in your own words, "What's happening? Do you need any input from me?"

VI. Nuts and Bolts of Portrayal Work

Types of Portrayals

AEDP classifies portrayals into four distinct types (Medley, 2021): Emotion to completion portrayals (ex. anger portrayals); reparative portrayals (completing longed for experiences such as acceptance, support, etc.); reunion portrayals (focusing on integrating and connecting with parts of the self—intra-relational); rescue portrayals, which have share commonalities with reparative portrayals. Any of these types of portrayals can lead to another type, as will be illustrated in the transcript below. For example, an anger portrayal can lead to underlying feelings of grief and from there to a reparative portrayal. Portrayals which embody anger expression and transition into reparative experiences are preferred when working with trauma (Fried, 2023).

Any of the above types of portrayals can also vary along the following dimensions: (a) *duration* - as little as thirty seconds as long as an hour; (b) *phase of life or chronological foci* -pre-birth, childhood, adolescence, adulthood, after-life; (c) *interactive dimensions* -inter-relational, intra-relational (i.e., focus on parts of the self in the present, past, or future); (d) *interactive direction* -

portrayals emphasizing *expression* of emotions and/or thoughts—verbally and/or motorically; portrayals emphasizing the *receiving* of positive emotions and actions from significant imagined figures; or portrayals combining both expressive and receptive aspects.

For this author, there is no one best type of portrayal. Portrayals should (1) reflect where the client is in her/his/their growth process, (2) lean on the strengths of the therapeutic relationship, including safety and trust, (3) express the imaginative fluidity of both therapist and client, (4) the issues being addressed by the client, etc.

In supporting and collaborating with clients doing portrayals, the therapist needs to be in her/his/their most flexible, creative-relational self, using what the client offers and letting the portrayal take the shape which fits the person, the content, the moment, and has the best chance of having a positive impact.

Possible target figures for portrayals

What follows is a sampling of types of figures the client might interact with in portrayal (imagined interaction) work:

- Self-Figures (Intra-relational Portrayals)
- younger self—at various ages or stages.
- parts, e.g. protection figures, warning voices.
- future self—at various future ages.
- new parts of the self which come online (into consciousness) in the here-and-now of the portrayal.

External Figures (Inter-relational portrayals)

These portrayals may include the following:

- Imagined figures—including animal and inanimate figures or religious/spiritual figures—who can be inserted into real historical experiences and imaginatively alter the outcome of those experiences.

- Real figures in the present, such as the therapist or partner, friends, authority figures.
- Combining real and imagined figures. The client may imagine real figures from her/his/their personal history be *helped* or *aided* by imaginary figures (e.g. an ideal therapist for a troubled parent during the client's childhood). These have been called holes-in-roles portrayals (Pesso, 2003).

Completions

Completions are inherent to living. We are conceived, born, grow, decline and die. We awaken from sleep only to sleep again. When we're hungry, we eat, digest, eliminate and at some point, eat again. We start thoughts and sentences and finish them. In our stories, beginnings go to endings. Life is a process of cycles, of beginnings and endings, and the portrayal as a healing form is an elegant vehicle to assist clients in achieving important completions.

With each therapy session, each processing of core affect, each portrayal—there is a beginning and a *good* ending, a completion which needs to feel right to the client. There may be a continuation of the work at a later session but there's a knowing on the client's part that this ending is a good stopping place.[2]

When to do a portrayal

The *opportunity* for a portrayal will come from the client and the ease of transition into it will depend on (1) whether the client is a novice to this kind of work or has done it before and achieved some satisfaction and completion in doing it, and (2) how much portrayal recognition ability the therapist has to massage the spontaneously arising seeds of a portrayal. If the client is unfamiliar with portrayals, the therapist should first explain the principles clearly and get the client's buy-in. While this kind of teaching has the potential to temporarily interrupt the client's flow, the driving (transformance based) forces can easily come back online, unfolding and moving the narrative towards completion.

[2] Apology portrayals are an excellent example of both completion and reparative work and will be discussed subsequently.

Should the client be familiar with the process sand feel positive about it, the therapist can simply suggest externalizing the figure(s) or part(s) in the room and encourage the interaction to continue.

Three windows when a portrayal is nascent, and ways help it fully develop

The first opportunity occurs when the client has spontaneously dropped into a pre-portrayal consciousness - meaning they are actively imagining/remembering an event or interaction with a figure or a part of the self, *and* are already speaking with affect to that figure or part. In this instance, all the therapist needs to do is suggest that the client imagine the person or part to be in the room and speak directly to them/it in the first person, present tense.

Another opportunity occurs when the client is working on material involving past or present neglect or harm (either in the past or present), and when there is obvious strong affect present. Perhaps the client is feeling hurt, pain or anger as interactions or relationships are remembered and spoken about to the therapist. At this juncture, the therapist can (a) encourage the client to express negative affect in a portrayal; (b) work with underlying grief and loss which come up after the expression of negative affect; (c) do apology work, as described above; (d) suggest the addition of ideal historical figures (Pesso, 1997), who would have behaved and related with kindness, care and love.

A third opportunity arises when the client clearly initiates the process. These are clients who not only have had good experiences with portrayals work but understand how to utilize them as well.

Transitions out of portrayal states

These shifts need to be gentle and client centered. If there is a time issue, the client should be informed about it prior to entering the portrayal process. Clients who tend to be compliant can leave the portrayal prematurely if the therapist communicates, even subtly, that such a direction is preferred. Also, time should be left after the portrayal after the client has fully re-oriented to the here-and-now, for meta-processing. Sometimes, this may have to wait until the following session when the client has fully metabolized the work.

In the theatre, the lights dim, the audience quiets, the curtain opens, there is a set, perhaps a character appears. This is the transition into imaginative time, not chronological time, but more akin to *kairos* time, when important events not confined to left brain logic and reality can occur. While not as specific and ritualized as the theatre, the transition into and out of portrayal time is similar in its aim and in its message to the client: we're entering (or leaving) a time in which something imaginatively meaningful can happen. When the portrayal is over, there needs to be a transition (echoing the curtain lowering, lights coming on in the theatre, applause) back to the equally special time of the here-and-now therapy relationship.

Clients will signal that the portrayal has reached its energetic and emotional ending via changes in breathing, looking around the room, making eye contact with the therapist, shifting of posture, a relaxation of musculature, telling us they're "back," or "that's enough for now."

If you're not sure the client has reached a stopping, gently ask them, "Is there more? Should *we* keep going?"

Lastly, the client may clearly initiate the process. These are clients who not only have had good experiences with portrayals work but understand how to utilize them as well.

VII. Frequently Encountered Portrayals

Keeping in mind that most portrayals, no matter their type, time frame or target, function to reverse what has been harmful, suppressive, unjust and/or unfair to the client, let us turn to some frequent kinds of portrayals occurring in AEDP.

Anger Portrayals:

Cues, Do's and Don'ts

When the client is complaining or recounting how they've been mistreated or treated unfairly, by a person, by more than one person, by an institution, even by God, it's likely that anger is close at hand. Complaints are a form of anger. Clenched fists, tightened jaw muscles, an edgy tone, are also body cues that anger is accessible. The therapist can check the client's access to anger with a simple validating probe, such as, "You sound (seem, look) angry at x for treating you that way."

If the client acknowledges their anger, the therapist can suggest doing some imaginative work—getting a fix on the figure in their mind and then externalizing it, imagining the figure in the here-and-now. Once this has been done, the therapist can ask, "What happens or what comes up when you imagine that person this way?" and "What would you like to say, or do to them?"

These questions give permission to the client to express long suppressed affect, either verbally or motorically or both (i.e., loud utterings, kicking out towards the figure, shouting epithets, or any variety or shade of anger expression). The therapist's role is to encourage expression until completion has been reached.

However, there are potential difficulties with doing anger portrayals. I discuss them below with possible work arounds.

First, the client has both positive and negative feelings towards the target and even in imagination is fearful or worried about harming the person. This leads to the client resisting doing the portrayal. One workaround I've used effectively is to imagine the target figure as two figures, one good and the other harmful. The "good" version of the target is the placed in an imagined very safe and protected space. This leaves the imagined field to the harmful target and the client can expressive all kinds of negative affect without fear of hurting the "good" version.

A second difficulty arises when the target of the anger is a perpetrator who has done harm when the client was powerless. In this case, externalizing the perpetrator with no imagined protector in place first risks recreating the harmful history, which can be re-traumatizing. To forestall this, the therapist needs to get an imagined protector figure in place prior to imagining the perpetrator. Then the client can express the anger behind the shield of the protector.

For example, the therapist might say, "Before we bring in your image of X, would you like a protector to be with you in the scene or right here in the room with you? I'm available to take that role, too, the scene or here with you? Where would you like to place me here in the room or in the scene?"

The third difficulty happens when the client expresses anger but completion doesn't happen because the client had not imagined the impact on the target. Does the target fall, scream in pain,

look humbled, or humiliated, etc.? These imagined reactions, generated by the client, and consciously or sub-consciously desired, will fully achieve the portrayal's completion.

Another issue related to anger portrayals concerns the possible pain, hurt, grief, and expanded awareness which may arise after the anger has been discharged to completion. The therapist needs to be alert to these new feelings surfacing and be ready to help the client process them in the here-and-now and/or possibly guide the client into a reparative portrayal focused an apology *from* the target figure.

Anger portrayal and resolution into grief

Client is in her late 40's. Raised in a strict religiously orthodox family, she was told what reality was, what to think and how to see things and what to say. She survived through her stunningly accurate memory for what people said and what they did, by developing a hilarious sense of humor and by hiding her true feelings and thoughts. She struggles with an inner critic who judges her impulses as "inappropriate," "dumb," and "harmful."

We've been working together for several years. I've done small pieces of imaginal work with her which have been occasional and short-lived and only slightly dipping into State II.

In this session, about 10 minutes have elapsed. The focus is an upcoming therapy session with she and her husband, and the husband's sister - devout, actively proselytizing born again Christian.

C: I have to admit...I don't want to reconcile with her. I'll meet because my husband wants it. Is that wrong? *(nervous laugh).* **[critical part/voice surfaces and seeks my validation. I might have explored that pathway—likely leading to history with dominating mother—but opted for expression of anger.]**

T: It's how you feel. Unforgiving. Not interested in making peace. **[I restate and validate her truth].**

C: Yes. Completely. Absolutely…(*looks down*). I know it's wrong (*looks at me, waiting*). **[C took it in, but only so far. Her critical voice reasserts itself—historically, a protective defense aimed at preserving her attachment to her mother].**

T: I'm not judging you at all. Is that what your look is asking? (*C: nods)* No…ah…this is your truth. You stand by it and I stand by you. *(Pause)* Can you take that in? **[I am explicitly claiming my role as her non-judgmental ally, undoing aloneness, doing acceptance and checking to see if that is accepted].**

C: (*laughs).* That's good, 'cause there's a lot more where that came from. Not just unforgiving. You know what I mean.

T: Well, let's go for the "a lot more." **(I'm nudging/inviting the reservoir of anger the client has indicated is waiting in the wings, using her phrasing, reiterating my a non-judgmental acceptance.)**

C: Really? *(laughs-again checking my readiness and acceptance)*

T: Sure. Where do we start? **[my "we" are emphasizing our collaboration, togetherness]**

C: well…I hate that bitch. There. *(she gazes directly at me, a bit challenging).*

T: How about first picturing her in your mind. That ok? **[Externalizing the figure will intensify her affect and motoric impulses, embodying more of her rage and making expression less likely to lessen when defenses arise; it also keeps C's words in the first person, present tense.]**

C: I'm doing it. Ugh.

T: Now imagine her somewhere in the room…where you are.

C: Yuk and ugh. Is this one of those imaginary things we sometimes try?

T: Yeah. One of those. Okay?

C*: (Nods)*

T: Can you get to what you'd like to say or do to her? Just go for. It. It's just you and me doing this. Not a rehearsal to do anything. Just a way to**— [As mentioned earlier these questions give permission to the client to express long suppressed affect, either verbally or motorically or both (i.e., loud utterings, kicking out towards the figure, shouting epithets, or any variety**

or shade of anger expression). The therapist's role is to encourage expression until completion has been reached].

C: Did you see "Kill Bill?" **[C. is an avid film watcher and her film choice of the main character, who has been severely traumatized and is a highly skilled swordswoman bent on revenge, has both humor and the exaggeration of violence. C's brilliant comedic sense, an adaptive defense, and her ability to articulate rage have already been manifested on other occasions. I am confident that she can do this safely, not be flooded or frightened, and that we can dyadically regulate so it unfolds with passion and humor].**

T: Actually, I did. **[I'm glad I can share this with her. It boosts her feeling of safety and undoes aloneness and negative self judgements.]**

C: *(laughs)* That's really good. Well, the way Uma Thurman slices up the bad people *(makes tentative cutting gestures)?* Fantastic!

T: Yeah**. [I'm reflecting C's pleasure in those images and impulses. There is no shame. In retrospect, I might have more explicitly, and succinctly, witnessed her pleasure and satisfaction].**

C: Well, that's what I want to do to that bitch, slice her up, into very thin slices. **[C's arms and torso are very engaged in sword-cutting gestures, her face displays anger, intensity and hints of humor and satisfaction.]**

T: Go for it**. [lending support, alliance; my voice is strong but not loud]**

C: *(continues cutting gestures towards the figure).*

T: You've got a sword? **[explicitly naming prop, underlining imaginative process and joining it].**

C: *(Nods, laughs)* Really sharp. *(keeps making cutting motions)*. Like dicing a sausage.

T: Any words go with… **[Activating, inviting, supporting verbal channel].**

C: You f— bitch. Crazy f— bitch. And stupid…big stupid mouth *(continuing cutting motions).*

C: *(pauses, catching her breath.)*

T: What's happening to her? **[checking on impact, progress towards completion].**

C: *(still cutting. Then kicking).* She's begging. She's bloody. All in pieces…this is good. **[Expressing satisfaction, pleasure].**

T: Let it come. **[Inviting residual angry energy].**

C: *(continues for another 30 seconds, then stops. She's smiling.)* That was…I don't know…didn't know I had that…. **[State 3]**

T: Fury.

C: Fury. Right. *(Shuts her eyes)*

T: What's happening?

C: *(Opens eyes)* I'm feeling...*(tearful)* upset…awful for what I had to go through with my mother…all those lies she told…the fear I had…to be a good girl… [The portrayal focus hás shifted here as **C accesses underlying grief and loss around mother. In previous sessions, her anger at mother—also religiously orthodox and relentlessly shaming—has been clothed in biting humor, recounting the mother's confusing communications. But she's never accessed her pain and grief. Here, C makes the link and drops down. I decide to try to deepen these feelings, C makes the link so quickly I decide to try and deepen the affect as opposed to interpreting the link between her sister-in-law and the mother.]**

T: Let's make room for this**… [I'm moved and hoping she can stay with her pain].**

C: *(looks at me)* I don't feel angry at her, just sad. **[C is touching her losses for the first time. Client's frequently will access their grief when anger has been completely discharged. In fact, in my experience, the more intense the anger, the greater the loss and grief.**

T: mmmm

C: Well, there's anger but…more…like what I didn't get…the closeness…you know. I was too busy being "good" and avoiding her accusations**. [At this point, C is no longer weeping. Her beathing is more even].**

T: Would you be interested in imagining a completely different mother, one who was loving and loved you for who you were? [As C has accessed her losses, and her unmet needs are also accessible, I'm reluctant to shift into metaprocessing and instead opt for a reparative (reversal) extension of the portrayal. I'm also saying to C: this is what you deserved.]

C: My mother would never be like that. [At first, C tries to plug those attributes into her real mother.]

T: Of course, of course. I'm suggesting a wholly different mother. Not your real mother. Wholly different. You can imagine her in a different part of the room. **[An ideal figure carries none of the negative history and only represents the reversals.]**

C: I don't know.

T: That's okay, not being sure.

C: Can I think about it?

T: Sure.

Anger portrayals express reactions to hurts, but retaliation scenarios also can mask underlying pain and loss. When anger portrayals reach completion, it's not uncommon for grief to rise into consciousness, setting up the opportunity for a reparative (reversal) portrayal, discussed in the next section.

Reversal figure(s) portrayals: true other, ideal figures, spiritual others and therapist-involved portrayals

In these portrayals, clients interact with imagined figures who provide secure attachment, safety, place, support, guidance, wisdom, consistent attention, love, protection, comfort in the past, present or future. They are reversal figures whose actions and characters embody all that should have happened and all that ought not have happened vis-à-vis the client.

If the client was neglected and alone, the figure provides, or would have provided, attachment and attention. If the client was not wanted by their parents, the portrayal provides ideal parents who would have wanted the client to be born. If the client is despairing of God's attention, the portrayal can provide an ideal God who would never lose track of them or who would've found just the right family to be born into.

If the client never had certain experiences with important figures, such as going to the movies, or playing in a sandbox, the therapist can invite the client to imagine the two of them going to the movies, etc. If the portrayal is an imagined *rescue*, the rescuing figure can be a warrior-like protector figure or even the therapist who is placed back in time and extracts the client from danger. Both of these kinds of portrayals require the client to be able to relate to the therapist in the present *and* to project her/him/they into a past situation. The therapist, also, must be willing to lend themselves in this fashion, to take a role in the client's imagination. It goes without saying, the meta-processing is essential after the portrayal completes.

One *caveat* concerning the use of reversal figures is that the client may initially choose to imagine real figures (e.g., a parent) behaving with kindness, empathy and compassion, etc., and yet still be themselves. This can result with the client saying, in essence, "That would never happen. They (i.e., the parent) would never do that or show that." In that case, the portrayal can flounder. The wished-for behaviors simply don't compute with the reality of the client's lived experiences with the real figure.

This dead end can be avoided by emphasizing to the client the wholly imaginary essence of the figure, one never before experienced (*true other*, *ideal* figure)— back in time - the ideal parent, grandparent, friend, ideal God, etc. (Pesso & Crandell, 2000). This imaginal figure, derived from and embodying the natural expectations of childhood, has no history to invalidate what is being given to the client.

Reversal possibilities in portrayals are limited only by what imaginal experiences are needed by the client in that particular session, as well as the therapist's and client's ability, and willingness, to enter into that imaginal space.

What follows is an illustration of a therapist-involved portrayal in which the therapist enters the portrayal.

Therapist-involved portrayal transcript

Client is a successful Scandinavian artist in her early fifties. She has a vivid and productive imaginative capacity. We've been working together for several years on zoom. She has a history of early neglect and aloneness. Lately she's been experiencing panic attacks when she's out walking in the forest or in the city. We've been exploring the somatic aspects of these "attacks" and various tools to help her self-regulate, some of which she's already tried unsuccessfully. While I'm *with* her (attuned) in the session, and while we've both acknowledged that this is a repetition of her history, it occurs to me that a portrayal might be useful.

C: I get so scared on those walks but they're so important.

T: Maybe we could imagine walking together.

C: Really? *(Her face lights up).*

T: Sure. Let yourself be on that forest path and imagine I'm there with you.

C: *(Closes eyes).* Trees, sunlight. So… you as you are now? **[She's clarifying the image].**

T: Sure…

C: At my pace, right… **[Checking to see if she has agency in creating this portrayal and that I'm still attuned to her]**.

T: Right.

C: We're laughing, joking. It's fall. Leaves crunching… I can touch you? **[She's incorporating more sensory channels].**

T: Yes. How are you doing that**? [Inviting even more specificity].**

C: I can hold your hand.

T: Of course.

C *(silence, C is imagining, eyes closed*). I never got to do this with my dad*. (some tears).*

T: Let's make room for your tears.

C: *(cries then blows her nose. Looks at me*)**. [In retrospect, I might have inquired as to the meaning of that look].**

T: Maybe you can give this experience to the younger you, who never got to do it with your dad.

C: *(nods*) We still walking…so peaceful. I feel the warmth and welcoming of your hand.

T: And I feel the same with yours. **[Emphasizing and heightening the experience of mutuality].**

C*: (remains with eyes closed for about a minute).*

C: (sighs). I think I'm coming back.

T: Maybe you can make a memory of this imagining…our walking together…

C: I was imagining different places we'd walk and playgrounds, too… **[C has expanded the portrayal to include other memories of togetherness].**

T: Maybe you can make a few memories…of your imagining…so right before you go to sleep at night, you'll remember them. [**installing/anchoring portrayal memory by placing**

remembering it at a future time. Note: our nervous systems remember negative events easily. Remembering positive events, both real and imaginal, requires conscious intention and inviting the nervous system to utilize this unused capacity.]

C: I can try.

T: Imagine going to sleep tonight and remembering our imagined walk in the forest.

Apology Portrayals

Just as the ADEP therapist in the immediacy of the session is encouraged to acknowledge and apologize to the client when ruptures occur, apology work can also occur via portrayals. Even

though the hurtful other may not be in the client's current life, due to death, distance, estrangement or other factors, there is still a longing to receive an acknowledgement of the of the wrongs and injuries experienced by them.

However, clients frequently say that the person whom they want the apology from would never apologize, because that is not who they are or were, leaving the client back where she/he/they started: frustrated, disappointed and often hopeless about moving on. Portrayal work can be particularly helpful in these situations because it allows the therapist to suggest that the client imagine a *different version* of the apologizer. I've called this newly imagined figure the *enhanced* version of the real person, enhanced meaning the figure has developed wisdom, empathy, perspective, regret, etc. and can take responsibility for past actions or inactions. Once this has been set up and the client can distinguish between the real figure and the enhanced figure, the portrayal can proceed to completion with the client receiving the longed-for words.

A portrayal can also be utilized when the client wants to express positive feelings -love, gratitude, tenderness, or feelings of regret and remorse towards a figure no longer available in real life or who, in the clients thinking, could never receive such feelings (Fried, 2024). In this instance, we encourage the client to imagine an *enhanced version* of the real figure who would be able to receive positive feelings without denying or discounting or using other defensive measures. Here, the enhanced figure will need to show behaviorally or verbally that the client's expressions have been received. The criteria for imagined believability will come from the client.

VII. Tips to Keep in Mind

Flexibility

The therapist should be be prepared to abandon the portrayal altogether or take an alternative direction if the client manifests a dearth of affective intensity, is too defended to disclose imagined experience, seems to be complying with the therapist's perceived wishes or direction, or verbalizes wanting different figures or a wish to stop.

Portrayal Psycho-Ed

Not infrequently, clients need to be educated about the power of portrayals as generators of healing narratives. The frequent objection, "But it's not real," needs a reply which says, "Of course, it's not real. It doesn't need to be real to contribute to your growth." "The emotional realness of imaginal experiences…is what gives them disconfirming potency; research has shown that the emotional learning and memory system responds to imaginal experiences almost indistinguishably from *in vivo* experiences (Ecker, 2018; cf. also Agren, et al., 2017; Kreiman, et al., 2000)."

Getting the Client Comfortable with Imagining-Priming the Pump

If we are going to work with portrayal processes, we must first assess the client's familiarity, comfort and skill in imagining. Some clients unable to imagine freely—having learned to mistrust their inner life. They may be fearful of not being in control of their minds, of their inner world being judged, affects such as rage, tenderness or thoughts implying disloyalty. Some have histories in which no one has evinced any interest whatsoever in their inner life and so it becomes uncharted and potentially dangerous territory.

Similarly, imagining and fantasy has much in common with childhood play, such as cops and robbers (Bateson, 1972). Using the capacity for the suspension of disbelief, young children can engage in a wide range of play with objects such as dolls and with other children. Still, as mentioned above many have had their playfulness and fantasizing suppressed as children and are not versed or comfortable with freely imagining.

For these clients, spending some time (with their permission) in *playful* fantasizing exercises can ease fears and "juice up" the brain circuitry utilized when imagining. It also provides an introduction to working collaboratively with imagination. I tend to use playful exercises, such as: "Imagine a pink elephant sitting on your couch eating a strawberry ice cream cone. What would you want to say to that elephant? What would you want the elephant to say to you?" Mini, brief

exercises like this can be pleasurable, can echo, resonate with, re-stimulate inner child-like fantasizing and help to build the client's comfort/ease in using their imagination.

This capacity comprises one of the core elements and healing power of the portrayal experience. We know we're sitting with our therapist, who may be coaching and supporting us, and yet at the same time we're deeply absorbed into a remembered or wished for imagined scenario with important figures in our lives, or deeply engaged with an imagined version of ourselves, perhaps at a younger age; or, with a "part" of ourselves.

A Note on the place of intrapersonal portrayals

Intrapersonal (self-self) portrayals are widely used and effective tools in AEDP. Attachment theory (Bowlby, 1988) posits that we receive nurturance, support, protection from external figures and subsequently internalize these interactions and their meanings so we can learn to nurture, support and protect ourselves. If the natural sequence of getting attachment needs met means reception from external figures, followed by internalization, then self-self types of portrayals might more naturally fit and have maximum impact *after* the client has internalized the AEDP therapist's supportive self and stance, and/or after portrayals emphasizing the receiving of consistent caring and kindness from imagined external figures have been done. To place self-self caring portrayals first poses the risk of reinforcing aloneness (i.e., the client has always had to rely upon themselves and now they are being asked to do it again)**.**

VII. Conclusion

Portrayals are a powerful tool of the AEDP therapist as well as for therapists using other approaches yet remain relatively untapped largely due to a lack of understanding of their workings and potential. Portrayals utilize naturally occurring, spontaneous, imaginative experiences supporting deep State II work. The intricacies and strategies of the portrayal are teachable and, once mastered by client and therapist, can substantially increase the effectiveness of the therapy. The imaginative underpinnings of the portrayal of are supported and encouraged by the ongoing, consistently connected, safe presence of the therapist, who is comfortable with their own imaginative processes.

References

Ågren, T., Björkstrand, J., & Fredrikson, M. (2017). Disruption of human fear reconsolidation using imaginal and in vivo extinction. Behavioural Brain Research, 319, 9–15.

Bateson, G. (1972). A theory of play and fantasy. In Steps to an ecology of mind (pp. 177–193). Ballantine Books

Bompey, N. (2023, November 2). Animals imagine too. Neuroscience News.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.

Coleridge, S. T. (2023). Biographia literaria (Project Gutenberg ed.). https://www.gutenberg.org/files/6081/6081-h/6081-h.htm (Original work published 1817)

Davanloo, H. (1990). Unlocking the unconscious: Selected papers of Habib Davanloo. Wiley.

Ecker, B., Ticic, R., & Hulley, L. (2012). *Unlocking the emotional brain: Eliminating symptoms at their roots using memory reconsolidation*. Routledge.

Ecker, B. (2018). Clinical translation of memory reconsolidation research: Therapeutic methodology for transformational change by erasing implicit emotional learnings driving symptom production. *International Journal of Neuropsychotherapy*, *6*(1), 1–9.

Fosha, D. (2000). *The transforming power of affect: A model for accelerated change*. Basic Books.

Fried, M. (2023, October 1). *Utilizing imaginal and relational interventions in working with trauma: Engaging the client's inner theater* [Video presentation]. New York State Psychological Association, Trauma Division.

Fried, M. (2024). *PBSP structures (portrayals) & apology work: How to work with the need to experience apologies from hurtful figures and the need to make apologies to those we have hurt* [Conference workshop]. USBPSPA National Conference, San Diego, CA, United States.

Gallese, V., & Guerra, M. (2019). *The empathic screen: Cinema and neuroscience* (F. Anderson, Trans.). Oxford University Press.

Green, M. C., & Brock, T. C. (2000). The role of transportation in the persuasiveness of public narratives. *Journal of Personality and Social Psychology*, *79*(5), 701–721.

Herman, D. (2013). *Storytelling and the sciences of mind*. MIT Press.

Honeycutt, J. M. (2019). *Promoting mental health through imagery and imagined interactions*. Peter Lang.

Kahneman, D. (2011). *Thinking, fast and slow*. Farrar, Straus and Giroux.

Kreiman, G., Koch, C., & Fried, I. (2000). Imagery neurons in the human brain. *Nature*, *408*(6810), 357–361.

Medley, B. (2021). Portrayals in work with emotion in AEDP. In D. Fosha (Ed.), *Undoing aloneness and the transformation of suffering into flourishing: AEDP 2.0* (pp. XX–XX). American Psychological Association.

Moreno, J. L. (2020). *Psychodrama*. Psychodrama Press. (Original work published 1946)

Perls, F. (1969). *Gestalt therapy verbatim*. Real People Press.

Pesso, A. (2003). Cultivating the seeds of hope. In R. Jacoby & G. Keinan (Eds.), *Between stress and hope: From a disease-centered to a health-centered perspective*. Praeger.

Pesso, A., & Crandell, J. S. (Eds.). (2000). *Moving psychotherapy: Theory and application of Pesso system/psychomotor therapy*. Brookline Books.

Pesso, A. (1997). Pesso Boyden System Psychomotor (PBSP). In C. Caldwell (Ed.), *Getting in touch: A guide to body-centered therapies* (pp. 118–130). Theosophical Publishing House.

Prenn, N. (2011). Mind the gap: AEDP interventions translating attachment theory into clinical practice. *Journal of Psychotherapy Integration*, *21*(3), 308–329.

Ryan, M.-L. (2001). *Narrative as virtual reality: Immersion and interactivity in literature and electronic media*. Johns Hopkins University Press.