Enactments: An Evolving Dyadic Concept of Acting Out*

DOUGLAS H. FRAYN, M.D., F.R.C.P.(C)**

Acting out seeks to communicate unconscious urges and important childhood experiences, yet can present as a resistance to insight. Mutual and interacting regressive transferences stimulate acting-out behaviors that have led to the concepts of actualization and enactment. An enactment is an unconscious but interpersonal communication, in which gestures and body language play a unique role. Initially an enactment may include a component of the therapist's reciprocal behavior as a precursor to fuller dynamic understanding and eventual definitive interpretation.

INTRODUCTION

If "actions speak louder than words"—what does acting-out behavior specifically say about the immediate psychotherapeutic situation, or about the patient's personality and past? During psychotherapy, spontaneous nonverbal interactions can occur between the patient and the therapist that are deeply puzzling to both the parties, yet are extremely meaningful and require understanding and eventual interpretation. In some psychotherapies, the activity is much more meaningful than the words.¹

The term "acting out" has had a variety of meanings over the years, with the common denominator being that the action, in the enactment, has unconscious determinants and replaces remembering or reflecting on the impulse. An enactment is the antithesis of free association and sometimes depicts a revival of behaviors from infantile life. Acting out is not idiosyncratic of a specific entity nor confined just to patients exhibiting impulsivity or hyperactivity. Diagnostically, habitual "action patients" most frequently fall into the borderline, psychopathic, substance-abusing, or erratic narcissistic Cluster B categories, yet acting out can be a transient feature of any therapeutic undertaking, regardless of the patients diagnoses.

*Based on Distinguished Scholar Lecture, Department of Psychiatry, University of Toronto, Clarke Institute of Psychiatry. October 25, 1995.
**Psychotherapy Consultant, Clarke Institute of Psychiatry; Associate Professor of Psychiatry, University of Toronto; Training & Supervising Analyst, Toronto Institute of Psychoanalysis. Mailing address: Clarke Institute of Psychiatry, 250 College St., Toronto, Ont. M5T 1RS.

AMERICAN JOURNAL OF PSYCHOTHERAPY, Vol. 50, No. 2, Spring 1996

194
One of the striking features, when working with patients who routinely are more prone to act than contemplate, is that many rapidly develop intense but distorted relationships with unpredictable alliances. The force of these transferences can also be observed in their social relations, as demonstrated by difficulties in sustaining meaningful attachments. Such transferences bring about repeated interpersonal crises because of the unpredictable intensity and lability of the accompanying emotions, as well as the tendency to split feelings into unambiguous love or hate.

The use of the word "enactment" is a relatively recent one, although aspects of this concept have been previously subsumed under the expressions, "acting out," "acting in," "actualization," "projective and introjective identification," and "treatment misalliance." All of these terms denote some form of repeating and putting into behavior, rather than remembering and verbalizing the core conflict, and in that sense also act as resistances.

The interplay between the more regressive manifestations of transference and countertransference has led to the concepts of actualization and enactment. Contemporary thought emphasizes that there is a dyadic or interpersonal component to enactments. It should be noted that either person in the therapeutic dyad can initiate such situations, with both parties tending to attribute the genesis of the action to the other. Therapeutic interventions, regardless of the therapist's avowed theoretical orientation, require that consideration be given to those subjective realities of both the therapist and the patient. This is not to deny the usefulness of metapsychological theorizing or inquiry concerning the individual (the so-called "one-person depth psychology"); but in psychoanalytically oriented psychotherapy it is the exploration of the transitional area, the relational field that joins the unconscious of the patient and the therapist, that presently is being emphasized.

Development and Relationship between Action and Symbolic Thought

The development of an infant's primal relationship involves a dual attachment with the mother, which includes both reverie and nurturing behavior. Our earliest internal objects are associated with experience, fantasy, and affects involving original caretakers—prior to any retrievable ideational memory. Our first autonomous reactions are to eat and sleep or to be more precise, the refusal to do either. Such symptoms are well known to the front-line psychiatrist albeit usually seen some 20 years after the original mother/infant struggle. Preverbal representations of people are fantastically connected with infantile reaction patterns and symbiotic forms of interaction, instead of mature whole autonomous relations. Busch1 (from an
ego-psychology point of view), sees action patients as functioning cognitively at the preoperational stage, particularly at times of regression. By that he means their thought processes are under the domination of action.

Piaget noted that in children under seven, it is age appropriate to act instead of talk. This is before the stage of concrete operations, when further integration and balancing of the cognitive system takes place. The primacy of verbal communication is part of ego development and when traumatic experiences have occurred prior to an organized memory being available, they are relived through transference actions rather than being merely verbalized. This is what Bion referred to as the discharge of sensory-motor or beta elements, prior to, or instead of, their transformation into personally meaningful thought and experience. A therapist’s understanding of this immature process is crucial in effecting empathic interventions in order to facilitate a therapeutic change.

**Dyadic Factor in Therapeutic Relationships: Background Considerations**

For centuries philosophers have acknowledged the presence of intersubjective influences on phenomenology. This was elucidated by Hegel and later by Binswanger in the discussion of existential concepts concerning the dyadic realities involving therapeutic encounters and is most relevant to our present-day theorizing. One of the major differences between contemporary or neoclassical techniques and that of the early Freud era, has been the additional emphasis on therapists’ actual relation with their patients, which now is seen as an essential focus for most therapeutic models. More recently and particularly stressed in relational theories, the dynamic dyadic treatment situation is seen as extending beyond Ego Psychology and Stolorow’s narrower concept of Intersubjectivity.

By the 1940s British theorists like Balint and Fairbairn, had championed the importance of a dyadic concept while still advocating the primary significance of intrapsychic fantasy over external interactions. They put the therapist’s personality and behavior, as well as the patient’s awareness and reactions to these, in the center of the therapeutic relationship. Rene Spitz emphasized the necessary role of the therapist’s maternal or diatrophic identification in helping to bring about therapeutic change in the patient. Winnicott stressed the dynamic significance of the dual contributions noted during infant development, that is the role of the mother in caring for the infant but also the effects of the infant’s responsiveness on the mother and on her subsequent nurturing. The central concept in Harry Stack Sullivan’s interpersonal school of dynamic thought, was the development of an interpersonal self and self-system, which came about through a
Enactments: An Evolving Dyadic Concept of Acting Out

dynamic understanding of the interactions with the therapist. The patient learned to identify and contain specific social anxieties that previously had been intolerable. The relevance of this dyadic situation was further documented by Elizabeth Zetzel's\(^17\) description of the "therapeutic alliance" as well as Greenson's\(^18\) highlighting "the real relationship." Although Kohut\(^19\) forcefully proposed that the only relevant reality that is accessible to inquiry is the patient's subjective reality, he graphically noted that narcissistic patients, not only made use of the therapist to enhance the development of the self but also could engender feelings of boredom, inattentiveness, and a wish to argue within the therapist.

When there is no obvious transference available, all there is to go on, at such times, is the therapist's countertransference experiences. Sandler\(^20\) has pointed out that a patient will seek to re-establish a role not only for him/herself but for the therapist as well. A responsive therapist may inadvertently comply and temporarily accept this role, before either of the parties involved becomes aware of it. This is often a compromise between the therapist's own tendencies and the role that the patient seeks to re-establish.

Transference and countertransference together form a system of mutual influence. This is illustrated by noting that in transference development not only is there a distortion of the object (the therapist) but there is a change within the patient as well. The patient can compel the therapist to experience the patient's inner world by inspiring in that therapist a feeling, thought or self state that previously had remained only within the patient. This makes use of the therapist (as a transference object) to relive parts of the patient's earlier life and to mutually exist within each other's internal world.\(^21\)

Therapists come to know more about their patients and themselves through self-inquiry and the process of temporary internal identifications with the patients. Gardner\(^22\) says: "I find my patient always struggles with universal and never fully solved problems (and that) there is a lively counterpart in me; it is better that this counterpart be accessible to my attention" (p.110). When therapy goes well, mutual inquiry and understanding go hand in hand, but the usual case is that productive mutuality between patient and therapist waxes and wanes. Both parties are engaged in a dyadic dialogue of listening and speaking.

Frequently the patient will gain insight only after the therapist has found out something subjectively relevant from self-analysis in that session. This is an important prelude to interpretation and working through, and one frequently overlooked by therapists. Regardless of the form and timing of therapists' interventions, its purpose should be to help patients express their
troubled subjective world through words, rather than through symptomatic behaviors and enactments.

**Acting Out and Other Regressive Phenomena**

There are several current and sometimes differing usages of the term and concept of acting out. Specifically, it was never meant to indicate just bad behavior or “acting up” and in the more restrictive analytic sense, it refers to the compelling urge to repeat the past through actions that replace remembering and self-reflection. These, usually syntonic, actions are linked to unconscious issues from the past, but now are displaced or transferred from the therapeutic situation to intense relationships elsewhere. Traumatic and passive experiences of childhood may lead to repeated attempts to master them through activity. Acting out is a commonly observed feature of transference resistance.

Freud says in “Remembering, Repeating and Working Through,” “[The patient] repeats [it] without, of course, knowing that he is repeating it . . . and in the end, we understand that this is his way of remembering” (p. 150). In the case of Dora, Freud had been treating a young woman who suffered from somatizations. After three months she suddenly and unexpectedly bolted from therapy. Dora previously had a similar revulsion reaction to the family friend, Herr K., and more specifically it was also part of the earlier relationship with her father. A subdued Freud retrospectively recounts: “At the beginning it was clear that I was replacing her father . . . she gave herself the warning that she had better leave my treatment, just as she had formerly left Herr K.’s house; I ought to have listened to the warning myself” (p. 118). “She acted out an essential part of her recollections and fantasies instead of reproducing it in the treatment” (p. 119). Freud saw in Dora’s behaviors a reliving of earlier fantasies and resentments, rather than talking about her original hurt and rage. Freud was reluctant to accept Dora’s anger and refused to see or to respond to her wish for a dependable all-giving maternal figure, rather he focused on the obvious oedipal struggle. These dyadic issues were to be continuing problems throughout Freud’s career, and probably played a significant part in Dora’s acting out through premature termination, prior to either of them having insight into these issues.

In every therapy situation there are constant oscillations between the patient’s introspective reporting mode and the behavioral discharging communication. The acting out that occurs within the treatment situation has also been given the term “acting in.” Acting in would therefore include all such symptoms and behaviors that take place during the session that replace remembering, regardless of the instigator. Although acting in identifies the
location of the acting out, probably there is little else to recommend special status for this older term.

**Actualization**

*Actualization* signifies a patient's (unilateral) motor or physiological activity, which represents a regressive reliving of the transference fantasies within that therapeutic situation. It is a behavioral component or the interpersonal externalization of that transference. Therefore in actualization, the emphasis is primarily on the patient rather than the dyadic interaction.² It should be noted that some writers²⁷ prefer the terms “a transference enactment” or “a countertransference enactment” instead of actualization, when describing a solitary component being actualized. Frayn and Leonoff¹¹ in their discussion say, “actualization is a symbolic living out of an early regressive experience but there are two basic differences between this phenomenon and enactment: [in actualization] (1) the therapist does not co-regress with the patient, and (2) the therapist is not destined to act in a spontaneous way, that only has meaning after the fact” (p.69).

**Clinical Illustration 1**

Mr. W.S., a thirty-year-old musician, sought therapy because of recurrent depressive episodes and a marital crisis, involving his wife's impending departure from their house and marriage. He was the youngest of three children and only son of a demanding, wealthy, hypochondriacal mother, who had been widowed since he was five. W.S.'s mother had been hospitalized several times for depression. The first episode being a prolonged postpartum depression that brought about a two-month hospitalization when W.S. was approximately six months old. He was an energetic man given more to action than to introspection. When his wife left him for another man he threw himself into his work and devoted his evenings to excessive drinking and frantic, indiscriminate searching for female company. He would ask some 10 to 15 different women for dates in an average day, to insure that he would not have to face sleeping alone. I interpreted this pseudosexual behavior as an acting out of a desperate attempt to make contact, originally, with his missing mother. He responded verbally in agreement with this intervention, but feared the emptiness of limiting his extra-therapeutic frenzy. Toward the end of the first year of therapy, when it became obvious that his wife would not be returning, he became quietly resigned and spent many silent sessions squirming on the couch.

During one of these sessions I noticed that he was beginning to develop what appeared to be involuntary jerking and thrashing movements of his arms and legs. These recurrent movements occurred primarily when he was...
not speaking. Although bewildering, his actions did not evoke a significant behavioral counterreaction within me and I felt comfortable just being quietly with him. He confessed to feeling panic, being fearful of me and wanting to run away, strike out, or go to sleep if forced to stay on the couch. Later he mentioned that during the two months of his mother’s hospitalization, his father had hired a Scottish nanny. She, reportedly, had “bundled” him hand and foot because of his frantic behavior in the crib. After a few weeks of this physical restraint, he eventually had “settled,” no longer protesting his mother’s absence.

Undoubtedly, his regressive transference reaction to me—the caretaker—and to the analytic couch—the crib—brought about a repetition of that wordless situation, when he was helpless and only able to fruitlessly struggle and jerk his bundled limbs. Of course at six months he could not recall his mother’s leaving, nor his helpless thrashing but he repetitively and somatically responded to this dynamically similar present situation. I made the interpretation that with the concurrent loss of his wife and the restrictions imposed by the therapist, these previously unconscious fantasies and body memories were activated—resulting in this automatism, a regressive transference actualization. The initial interpretations equated the loss of the mother and wife with his frenzied search for women. The thrashing movements had not been previously evident in the therapy. Following the subsequent interpretation of his swathing and its actualization (thrashing) in the therapeutic situation, this primitive physical manifestation gradually ceased, never to return.

In the more regressive actualizations, archaic fantasies predominate. The so-called “selfobject” merger fantasies and infantile narcissistic affective experiences that originated during preverbal life, now find resurgence in the present treatment situation. The appearance and expression of immature fantasies and bizarre physiological reactions may be bewildering to both parties. Such elements are not conducive to verbal elaboration or understanding through the usual format of therapeutic dialogue. Some actualizations are expressed through somatic, vocal, or other motor discharges, e.g., weeping, sighing, sneezing, sitting up or leaving. They also may be accompanied by senseless extra-analytic acting out, which is not primarily gratifying nor can be shown to be part of an organized memory base. These automatisms are mostly under the domain of the repetition compulsion. Evidence of regressive transference and its archaic actualizations are not readily accessible through conscious subjective images but are reflected in the repetitious affective “body memory” with its subsequent predictable, and unmodified behavioral outcome.
Enactments: An Evolving Dyadic Concept of Acting Out

Enactment is a nonverbal dyadic communication that manifests itself, symbolically, through motor movements or via autonomic discharge, during therapy. So, an enactment is designated as taking place whenever, during the session, the patient acts and stimulates a behavioral response from the therapist as well. Although not consistently used nor precisely defined, the concept of enactment always involves symbolic behavioral interactions between patient and therapist, that have unconscious meanings for both parties. Enactment really describes an interpersonal event whether the therapist enters into the enactment as the frustrator or as the gratifier of an infantile demand.

In the past the term “enactment” had been used to refer to thoroughly different phenomena such as the intentional replay of faulty family transactions, as well as an individual’s cathartic acting performance or forced fantasy (“reenactment”) of a traumatic event. Modell prefers to use the phrase “symbolic actualization” rather than “enactment” when considering similar dynamic and clinical circumstances. Currently enactment is often loosely used as a nonpejorative substitute for the overextended term “acting out.” An overview of this concept would seem to suggest that most consider enactment to be a regressive dyadic form of acting in, although not necessarily just a defensive manoeuvre. Rather than being a hindrance to the therapy, an enactment can be an unwitting attempt to communicate very early experiences. Hopefully this can also inspire the therapist to bring about understanding as well as a holding situation. Initially this may be a nonverbal but necessary feature of the therapeutic process, prior to definitive interpretation of the displayed developmental fault.

The psychodynamic understanding and management of enactment primarily focuses on the patient's discharge phenomena and is, of course, influenced by the therapist countertransference activity as well. An enactment sometimes relives a feared transference in an attempt to mimic or to master symbolically, the original trauma within the safety of the therapeutic situation. It is important for the therapist to maintain equanimity rather than strict neutrality in the face of projected attacks and enactment pressures. The patient may experience the therapist's co-response as an revival of earlier parental interactions and is frequently oblivious to his/her own activity. If continuing enactments are ignored or initiated by the therapist, they can foster boundary violations under the guise of helping or advising. McLaughlin points out that since gestures are older than speech, therapists need to closely observe their patients' movements and activities, as well as listen to
their words. Such actions are homologous to play in child analysis, that is a nonverbal equivalent to free association. The most common enactment themes have to do with the wish to be acknowledged, touched, and soothed. At times therapists should be able to act intuitively and extend listening to include the way that their patients wish to be responded to.

If an enactment simply meant that therapists react to their patients' fantasies or behaviors, it would be impossible to imagine an enactment-free therapy. It is not the presence or the awareness of the issues but the activity that is the potential liability; although, frequently, it may take an actual behavioral response before therapists can get in touch with the countertransference issues. The therapist's appreciation of the countertransference, like the patients' awareness of transference, is always retrospective, and in that sense is often preceded by an enactment. 24

Enactments can also include lack of action where routinely one might be expected to respond; for instance forgetting, being silent or not reacting to the patient's affects or provocative issues. The major issue is, can the enactment be recognized, minimized, and, most importantly, therapeutically used for interpretation and understanding. 33 The dynamic understanding of these behavioral reactions and their dyadic meaning, can be furthered through the therapist's use of empathy, containment, and self-analysis. 11

Clinical illustration 2

Dr. L., a distinguished but depressed and resentful middle-aged professor, entered therapy ostensibly because he was beginning to drink to excess, and felt that his relationships were essentially unfulfilling. As an example, he said that by phoning his elderly mother recently, he had been the one to give in and now felt humiliated. This phone call had followed several frustrating months of absolutely no communication between the two of them. Each had felt smugly entitled and expected that the other should call first. Within a few months, a similar conflict began to manifest itself within the therapy with me, as well. L. started to arrive later and later without any reflection on his recent tardiness. A frustrated silence began to overlay our sessions and the therapy was now experienced by me to be "in irons."

One evening, following a sullen session, L. nonchalantly strolled into the consulting room, fifteen minutes late. He settled down on the couch, did not speak, and became increasingly restless. After an extended silence, he made an offhand remark regarding the inclement weather. Following his comment, I had to suppress an unexpected urge to make a thunderous retort; fortunately I was able to respond with a half-hearted but affirmative grunt. As it turned out, I also had been preparing to end the session—just before
Enactments: An Evolving Dyadic Concept of Acting Out

the pithy “weather report” interaction—after which I realized (to my consternation) that it was I, who was now confused about the time. My action would have terminated his session 15 minutes too early!

This second near-slip of mine (within the same session) also paralleled his mother’s typical reactions that had occurred numerous times between them, when at home. Under similar hurtful circumstances both of them (like me) then would feel entitled, neglected and eventually vengeful. Rather surprisingly, L., on hearing my grunt, seemed to relax and then spoke more easily. “I really needed to hear from you—without my mother’s support I feel so lonely—it’s like I’m all alone in the universe. I wanted you to say something that would help—it makes a big difference hearing your voice, knowing that you are here with me.” I had now recovered and with some self-reflection was able to respond in a more thoughtful, interpretive mode rather than merely reacting grumpily, so I said: “What regularly happens between you and your mother also gets repeated here, with us. You feel abandoned when I’m quiet, then smothered when we get closer. When you feel insecure, you withdraw completely yet demand that I (like your mother) reassure you of my presence. It’s a familiar but potentially destructive way for you to express your need for others.” This led to the patient’s tearful recall of a reassuring childhood experience: his mother had hummed a song to him because he had been frightened by a thunderstorm. Following these interventions, the shared resultant feeling between us, was that “the therapy was back on track.”

A comfortable atmosphere along with the feeling of a new beginning had evolved, where the patient now felt that nothing harmful was being directed toward him or back at me. A significant shift had occurred in therapy, but not primarily because of my empathic lapse or the potential countertransference enactment. Those initial events had helped facilitate my own reflection and consequently I was able later to effectively interpret the transference enactment. Rather than these actions becoming a repetitive resistance to further associations, L.’s fantasy exploration and working alliance unexpectedly thrived. He became more involved not only with me, the fantasized transference therapist, but eventually he was able to make use of me as an integrating object, in his attempts to bring about more satisfying social relationships.

For my part at the time of the enactment, I had been aware of an increasing frustration at his thwarting of the frame and controlling avoidant conduct within the therapy. The patient’s anaclitic wishes were displaced and actualized within that session. My urge to reject him was not only in response to his behavior but it also included conflicted maternal issues of my own,
which eventually required some acknowledgment and further self-understand-
ing rather than personal disclosure. The patient’s behavior then was able to
be verbally analyzed by me, rather than remain repressed and a locus for
acting out.

Introspection and self-reflection are essential activities for therapists
regardless of the theoretical orientation or type of therapy offered. I have
found that my own recurring and affectively charged dreams (particularly
those in color or about patients) to be most useful and relevant in understand-
ing my work. Once when involved in a lengthy analytic stalemate, I dreamt
that the patient and I were crawling toward each other through a tight
underground tunnel. As each of us moved forward, it became obvious that
one of us would have to back up if anyone was to go forward. We talked it
over and magically both were able to proceed! On awaking I had the
recognition that the dream had reflected a movement that already had begun
in L.’s therapy, but now I was feeling more willing and able to alter my
approach. I believe that much of the basic work for the new-found alliance
had preceded this episode but was graphically illustrated by the manifest
interaction between us.

Harold Searles in his paper “The Patient as a Therapist to His Analyst”
drolly describes how his own self-reflection, albeit forced on him by his
patients, has led him to consider more useful and tactful stances in dealing
with countertransference enactments. A patient during a regressive shift in
therapy may seek to become subjectively at one with the therapist (“thera-
peutic symbiosis” or “selfobject” formation) and to bring about a temporary
integration with the auxiliary ego of the therapist. If the therapist can allow or
facilitate this empathic intervention, an external integration develops initially
within the intrapsychic experience of the therapist, prior to the patient’s
successful internalization. The hope of dynamic psychotherapy is that
traumatic experiences can now be transformed into words and newly
conceptualized rather than repetitively acted out through behavior.

Some antisocial, masochistic, and schizoid acting-out patients will prove
to be untreatable, especially if the therapist adopts a silent, expectant, and
abstinent “playing the spook” role. Isolated patients, when left primarily to
their own resources, “live out” within the confines of the consulting room, a
bleak and frequently hostile-dependent, disillusioning existence with their
therapist. Rather than being able to use the therapist and therapy to make
changes in their outside lives, frequently they will continue in a defensive and
apparently meaningless relationship to their therapists, with their goal now
being to ward off all feelings through senseless action or sullen inaction.

In therapy it is not sufficient only to interpret the archaic transferences.
The deficits need to be identified and at times a collaborative effort will be required to bring about the requisite interpersonal and decision-making skills, before a mutually beneficial relatedness can take place.\textsuperscript{30} As therapy unfolds the patients’ inadequate or archaic superego and the defensive function of their superficial attachments and cynical attitudes will become clearer. When manifested as a stalemate or ongoing transference enactments, this distrust is usually found to be associated with repeated disappointments and disillusionment with past intimate relationships and unrealistic but specific expectant fantasies. Episodes of actualization and enactment, not only represent impulses seeking gratification but can be restitutive attempts for earlier deficits, losses, and lack of self-cohesion.

A useful tactic when dealing with acting out in psychotherapy is to request that the patient delay action rather absolutely desist, so that the indistinct urge will develop into a conscious affect and theme—precursors to a fuller understanding. Resentment and rebellion often will be found to underlie the frustrating and repetitious acting-out behaviors, which seek satisfaction. Modification of these significant existential issues into a degree of patience, acceptance, and even gratitude is a demanding but rewarding goal for both parties. Progress rather than cure is a more realistic aspiration.

Like it or not, all psychotherapies heavily rely on the personality of the therapist to bring about a working alliance and other noninterpretative but significant events that in the past were subsumed under Alexander and French’s phrase “corrective emotional experiences.” Such beneficial incidents are frequently associated with nondestructive enactments, and can provide essential information for later mutative interpretations.

Contemporary therapeutic techniques have developed out of necessity, particularly from working with more regressed patients who tend to exhibit unstable transferences and are prone to action. This has influenced therapists toward the present position of being aware, active, and let’s hope more effective participants in the mutually modifying psychotherapeutic situation.\textsuperscript{30,32} Not all therapeutic change is due to interpretation and insight, and as therapists we should be open minded about how positive change can come about within our patients and even in ourselves, as a consequence of the vital dyadic forces at play.

**SUMMARY**

Unspoken actions between the therapist and the patient have major and often unconscious influences on the psychotherapeutic situation. Mutual transferences can bring about acting-out behaviors that portray transference wishes and defenses within both parties. Such actions tend to replace or...
overshadow verbalizing intrapsychic strife and in that sense can function as formidable resistance to therapeutic introspection. They also may represent behavioral attempts to communicate significant earlier experiences. Reflection on this dyadic interplay has led to contemporary treatment concepts.

Enactment, actualization, and treatment misalliances are behavioral manifestations of urges, conflicts, and identifications and they appear most frequently during regressive periods in psychotherapy. Initially an enactment may include a component of the therapist’s reciprocal behavior as a necessary feature of the process, prior to a fuller dynamic understanding and eventual definitive interpretation. Collusion by the therapist, through mutual and continuing acting out or through attempts to re-parent, will encourage antitherapeutic misalliances that can lead to continuing symptomatic behaviors and boundary violations.

Continuing self-inquiry is essential to facilitate therapeutic change and we need to be aware that the principal analyzing device available to bring about positive change in our patients, is to be found within ourselves.

REFERENCES

Enactments: An Evolving Dyadic Concept of Acting Out