THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH PATIENTS WITH ACTING-OUT DISORDERS

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Psychotherapy with Patients with Acting-out Disorders

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Acting-out is the behavioral manifestation of those impulses, desires and needs that an individual cannot accept or reconcile with his conscience. When the characteristic style of acting-out is socially or personally maladaptive such behavior is termed an "acting-out disorder." Acting-out disorders are common amongst character neurotics, impulse disorders, psychopaths, homosexuals, perverts, drug addicts and many neurotic and psychotic patients.

Not all acting-out behavior is maladaptive. Everyone acts out. All of us have life styles and characteristic ways of living. Imbedded in these stylized expressions are impulses that normally are abhorrent to the individual. The smoker, for example, would become infuriated if you told him that his smoking is a manifestation of his deep-seated wish to suck his mother's breast. The good natured, affable executive would find it repugnant to hear that he is controlling and manipulating his staff through the use of his personality. A therapist would be termed vulgar and insulting if he pointed out the seductive and sexual wishes inherent in the mini-skirted, perfumed young lady's attire and toilet. National characteristics such as the German efficiency, the Irish happy-go-lucky attitude and the Latin sensuality are examples of culturally stylized ways of living which harbor sadistic, dependent and sexual urges. Indeed, in order for anyone to adapt to his

environment he must incorporate those cultural traits which allow him to act out those very impulses which his society strongly condemns.

When psychotherapists speak of acting-out disorders, they generally refer to those patients whose particular behavior manifestations get them into trouble. The typical referral of such an individual for treatment comes from a law enforcement agency or some other authority. Seldom are such individuals motivated to become self-referrals.

There are patients with acting-out difficulties whose behavior is personally maladaptive rather than antisocial. These patients come into therapy as self-referrals for reasons other than their character problems. For example, homosexuals often enter treatment because of the anxiety engendered by the acquisition or loss of an intimate relationship. Their motivation is not to curb their acting-out behavior but rather to alleviate anxiety and become free to pursue their previous style of living. Sometimes middle-aged women who are sexually promiscuous initiate therapy because of a vague sense of unfulfillment and an inability to form close emotional ties. They display neither guilt nor anxiety about their sexual acting-out; instead they focus on their unfulfilled dependency needs.

Traditional psychotherapy has long seen acting-out as the main deterrent to successful treatment. The repetition compulsion to give vent to

those unacceptable forces behind acting-out behavior denies the patient a conscious awareness of his motives and thus responsibility for his actions. Besides depriving the individual of gratification and satisfaction in the expression of his urges, acting-out can work against personal growth, preventing the individual from participating in a viable struggle between his impulses and his conscience. A chief factor behind this is the role the unconscious plays in acting-out behavior. Few individuals have any awareness of the motives affecting their characteristic behavior or acting-out patterns. They function in accordance with the rules and procedures they were raised with without questioning the nature of their needs or whether their conduct succeeds in bringing them the rewards their actions appear to aim at. This almost total repression serves to placate those moral and ethical standards which would normally not tolerate the manifest expression of certain needs. Yet, the unconscious manages to expedite such behavior in a fashion consistent with the ego's self-image. The key factor here is the persistence of the individual's life style, even in the face of overwhelming reality evidence of its destructive nature. In this fashion, such a person can remain emotionally fixated on an early developmental level without feeling shame or anxiety.

The chronic alcoholic typically is reared in an environment that stresses self-sufficiency but rewards passivity and dependence. Both messages are received and incorporated as a special kind of ambivalence. When the

alcoholic drinks he is achieving his superego standard of individualism, independent self-fulfillment and manliness. At the same time he is living up to the ego ideal of lying passively on his back and letting the world take care of him. The force of satisfying both sides of this standard along with the habituation of his drinking becomes too great for his ego to challenge. No amount of rational or judgmental persuasion can effectively intervene against this combination of forces. The acting-out is unconscious, ego fulfilling and in consonance with the early standards of idealized behavior. The drinking is incorporated into the alcoholic's life style, hiding the destructive nature of his emotional fixation on an infantile dependency level. Effecting a behavioral change under these circumstances becomes a herculean task.

To add to the difficulty of both patients and therapists is the subjective and personal nature of standards for appropriate behavior. What is considered aggressive, controlling and manipulating conduct to one individual may be seen as assertive, ambitious and responsible behavior to another. Employing the yardstick of reality testing as a measure of adaptiveness only confuses the picture further. The industrial tycoon or general who employs psychopathic tactics to run a business or win a battle is praised and honored while the con artist who is caught is sent to jail. The overeater, compulsive gambler and accident-prone person are pitied and given sympathy while the drug addict, embezzler and pervert face legal prosecution.

The psychotherapist must ultimately rely on arousing the patient's conscience as well as his ego before he can successfully treat an individual with an acting-out disorder. In order to do this he must help the patient become aware of the motives behind his behavior. Since such patients have ego-syntonic life styles and character traits that are deeply embedded in the fabric of their personalities, helping them to become aware of the motivations inherent in their conduct is no easy task.

TRADITIONAL TREATMENT METHODS

Until twenty years ago acting-out patients were generally considered untreatable. The earliest references to this form of behavior were heavily laden with moralistic and judgmental criticism of such individuals. Prichard, who coined the term "psychopath," viewed such patients as "indecent and lacking in propriety," referring to them as morally insane. Henderson placed such behavior on the level of primitive savages. Cleckley felt that such actions reflect constitutional inferiority. These authors held little hope for a therapeutic cure, recommending incarceration and custodial care.

Sigmund Freud introduced the term "acting-out" in his paper, "Remembering, Repeating and Working Through," published in 1914. He used the term to describe compulsive repetitive behavior as a defense against remembering past traumas. The psychoanalytic method, based on recalling

early history, could not be effective while the patient's behavior expressed the very conflicts from which he was seeking relief.

The concept of acting-out became widespread and was used more loosely and vaguely. Generally, however, the literature deals with this type of pathology as a form of character defect.

The character of a healthy child, with an adequate environment, evolves gradually with the successful fulfillment of his basic needs. The style of ego expression coincides with his stages of development. As each stage of development is successfully completed the young child's experience in attempting novel ways and means of gaining satisfaction increases. The well-adjusted youngster increases his self-confidence and eventually develops a characteristic style of fulfillment that is reality oriented, flexible, anxiety free and expressive of the integrity of his needs in consonance with the demands of his environment. When there are fundamental conflicts between his urges and the standards of society, he learns to successfully sublimate.

Potentially acting-out youngsters, on the other hand, do not find adequate sublimation for their basic needs and become fixated at one or more stages of their development. The character of such children similarly becomes stunted and does not acquire the flexibility associated with mature behavior. If his oral needs are not gratified, for example, his character formation

develops a fixation at this point in his history. All further growth is hampered and colored by this limitation. Whether or not neurotic symptoms and their respective defenses evolve from this fixation, the character of the child is already defective and will be observed clearly regardless of the future course of his development. He does not have the integrity to find a satisfactory outlet for his needs while remaining in harmony with his environment. It is therefore well to consider and deal with the character defects of all neurotic patients even if the form of their pathology is not that of an acting-out disorder proper.

Hartmann sees the acting-out patient as having a defective ego structure. Such individuals cannot adequately regulate their reactions to environmental demands. Minor slights or rebuffs, easily tolerated by others, exceed this patient's threshold for adaptation. Spitz and Erikson emphasize the loss of trust in the mother-child relationship as leading to unstable ego development and maladaptive behavior. Henderson cites studies indicating the high incidence of illegitimacy and the absence of a father figure as leading to psychopathic states. The inability to resolve the Oedipus complex is described by Reich as operating to insulate the individual from external stimuli and render him less susceptible to adapting his behavior.

The denial of fulfillment along with punishing the child for making demands is cited by Eissler as leading to delinquent behavior. Such children

learn to act as though they are self-sufficient and appear submissive when confronted by authority. However, they develop covert ways of attempting gratification which neither fulfills nor brings them acceptance by the environment. Deep-seated hostility and rejection of parental standards is described by Redl and Wineman as leading to acting-out behavior. Adult insincerity and exploitation of the child is pointed out by Greenwald as a factor in antisocial conduct.

With a shift in outlook to the environment's effect on the acting-out patient, rather than *his* social destructiveness, the etiology of such symptoms was studied. The most common factors cited are the rejection of the child's spontaneity coupled with parental failure to establish alternative standards of conduct. Some investigators report an early history of indulgence, encouraging overt dependence. When in later life the indulgence stops, the individual tends to continue seeking gratification through acting-out. It has been shown that many parents of such patients usually fail to integrate their own forbidden impulses and seek these satisfactions vicariously through their children. Parental narcissistic investment in the child is most frequent when there is serious marital discord. Marital dissatisfactions centering around emotional and behavioral constrictions can readily influence a child to act out a parent's hostility towards those social standards that bind him to his unhappy marriage. Paradoxically, it is often the child's acting-out behavior and the family's rallying to help that keeps such a marriage from

disintegrating.

Attempts to influence the acting-out patient primarily through traditional psychotherapy are met with a host of problems. Poor motivation, particularly a lack of guilt and anxiety, lack of affective identifications or transferences, poor ego controls, difficulty in postponing gratifications, infantile dependency needs and the associated hostility when denied are but a few of the obstacles cited. It is impossible for the acting-out patient to adopt the value system and controls of the therapist if he is not involved in the therapeutic relationship. The passivity of the therapist as well as his emphasis on the interpretation of unconscious material are cited as deterring a therapeutic tie.

Of equal importance in the limitations of traditional psychotherapy for the acting-out patient is his lack of confidence in the ability to alter his behavior. Even with an ample understanding of the causes of his actions, he feels impotent to stop his self-defeating patterns. His poor self-image all but eliminates his active attempts to control himself. Without the support and positive participation of the patient's ego, traditional treatment methods are ineffective. The recognition of these circumstances led psychotherapists to devise novel and creative ways of intervening in the pathology of such patients.

NEW METHODS

Some clinicians, recognizing the difficulties in establishing transferences, worked instead towards the development of a narcissistic relationship. The therapist demonstrated that he was more clever and cunning and had better methods of outwitting law enforcement agencies than the patient. He would discuss a patient's plan to commit robbery, point out the flaws in the scheme and suggest a far superior alternative. One therapist attempted to get his psychopathic patients to view him as omnipotent. Often the therapist would be entertaining in order to hold the patient's interest. Some intervened in the individual's family in order to help the patient out of difficulty. Utilizing such methods, therapists were able to treat more socially maladaptive acting-out disorders successfully.

These techniques demonstrate that when an empathic bond is formed between the therapist and patient, based on the latter's needs, a close therapeutic relationship can be formed with such individuals. However, these authors stress only the patient's eventual incorporation of the therapist's social standards. It is the writers' contention that along with the evolvement of a narcissistic relationship, the patient requires a systematic approach to strengthen his self-discipline on matters related to his own value system. If he can be helped to postpone immediate gratification for purposes of achieving his goals, then he is in a position to utilize increased ego strength to

understand his self-defeating style of living.

Besides the innovation of new techniques to engage the acting-out patient in treatment, psychotherapists also created and modified therapeutic structures to deal with this problem. Topic House and Synanon evolved to cope with the drug addict. Here the pressure of peer group acceptance served to establish the necessary commitment for the patient's active participation in treatment. The encounter group further helped reluctant patients to respond and relate to the immediacy of a here-and-now interaction. Lowering the defensive armor was helped through the introduction of the marathon. Therapists became more actively involved with such patients and tended to stress the experiential and existential aspects of the doctor-patient relationship. Some practitioners made house calls and occasionally invited the patient to live in his home. Combinations of traditional and newer therapies were used with the advent of the behavior modification techniques. Therapists of the latter persuasion are symptom focused rather than disease oriented and tend to concern themselves with whatever seems appropriate to aid the patient in overcoming his symptoms.

Since acting-out problems stem from character defects, successful therapeutic intervention begins with enabling the patient to view his behavior as an unsuccessful attempt to solve an internal struggle. Once the patient is aware of the self-defeating nature of his behavior, he is both

motivated and prepared to take steps to undergo changes. Enlisting the patient's motivation to change is an important part of the process of Ellis' rational-emotive therapy. Not only must the patient accept the construct that he has been living with an irrational philosophy of life, but he must also be prepared to substitute a rational view of himself. To use Ellis' example, a client was initially made aware of his belief that he had to succeed in order to be a worthwhile human being. The irrationality of this concept was pointed out to him and he was encouraged to ask himself, Why must I be great in order to accept myself as a person? Homework assignments are an integral part of Ellis' therapy. They are designed to help patients de-propagandize themselves from their self-defeating attitudes and values. Homework is also used by Bergin as an adjunct to his self-regulation technique for impulse control. In this treatment procedure clients are trained in a method of conscious self-control which they rehearse during the therapy hour and exercise between sessions. The Bergin method is an outgrowth of behavior modification techniques and is used in conjunction with them.

The concurrent use of behavior modification techniques and psychotherapy is reported by D'Alessio. Both therapies are used either in alternate sessions or in specific time allotments in each session. Behavior modification techniques are used to extinguish undesirable behavior as well as to teach alternate ways of functioning while psychotherapy is employed to deal with the anxiety and resistance attendant upon subsequent progress or

failure.

Farley's initial treatment approach with hospitalized psychopaths involves the use of an assaultive technique. He verbally criticizes, scolds and berates the psychopath for his irresponsibility and dependency on others. He attacks their pride and self-image, invariably arousing a strong defensive response as well as a counterattack. The typically unemotional and "cool" psychopath is instantly thrust into a struggle with an authority figure upon whom he is dependent. Farley employs this ignited affect to help patients experience a new and often more rewarding relationship. Manipulations, game playing and the "put on" are minimized while authentic interaction is pronounced. Usually trust is established and a working therapeutic union is formed.

Peris wastes little time in getting his character neurotic patients to relate their immediate feelings and experiences to him. Attempts at intellectualizing are termed "mind-fucking" and dismissed forthright. Expressions of helplessness are challenged directly, with the internal area of blockage and discomfort identified and dealt with as a polar aspect of the patient's gestalt. The individual is guided into a dialogue between these seemingly opposite facets of his makeup. As the patient responds in his own fashion to the complaints and inadequacies of his internalized resistance to change, he begins to display a mastery over his previously impotent state.

The paradigmatic approach also employs the technique of getting the patient to find a solution to his own resistances to change. The therapist, using the patient's own expressions of helplessness as a model, expresses an extreme version of this incompetence as a statement describing him. The patient typically defends against this image and frequently paves the way for therapeutic intervention by showing the therapist how to deal with the resistance.

Drug addicts are often given a no-nonsense set of rules to follow before they are permitted to enter a residential treatment center. Fellow addicts immediately engage the newcomer in his set of rationalizations, denials and projections, pointing out that they too employed such defenses against facing their true motives for acting-out. This group encounter technique, employing the experience of patients with similar conditions, affords the addict a sense of belonging and security with people who understand his problem. A somewhat similar procedure, in a nonresidential setting, is used by some alcoholic anonymous and weight watcher groups.

All of these therapies have in common the threefold goal of enlisting the patient's active involvement in therapy, bringing into awareness the motives behind his behavior and strengthening self-discipline in order to master and overcome the acting-out disorder.

TREATMENT

An initial procedure in treating socially maladaptive individuals revolves around the therapist's acceptance of the patient's needs and the formation of an alliance to fulfill them. The fact that the acting-out patient feels isolated and alien to the social mainstream and usually lacks close interpersonal ties is employed to strengthen the working relationship. Recognizing that the self-image of such individuals is concomitant with their ability to gratify basic urges the therapist strives to optimize the secondary pleasures that the patient typically seeks through this acting-out behavior. The therapist's effectiveness in helping him find ways to achieve such gratifications helps gain the patient's confidence and respect. The therapist must participate actively in the patient's immediate needs in living as opposed to the passive posture in rendering abstract interpretations typical of conventional psychotherapy. A low threshold of anxiety, coupled with a history of failure in interpersonal intimacy, leaves the patient with little tolerance for attempts to induce self-questions, self-doubts and self-awareness. The only relationship he is amenable to is one whereby he can experience himself with some success on his own terms. The therapist initially accepts the patient's view of him as an object to be used and manipulated before attempting a more intimate and trusting relationship. In order to establish this initial union authentically the therapist must unearth and appreciate those acting-out traits and tendencies in himself. Since all

socially adaptive individuals, including therapists, have learned to sublimate the immediate fulfillment of their needs in favor of social acceptance, remnants of acting-out behavior remain in each of us.

The following is an example of an initial treatment procedure employed by one of the authors in his work with a psychopath.

Bette is an 18-year-old high school senior, referred for private psychotherapy by school authorities because of her sexual promiscuity, truancy, forging of her parents' names, stealing a car and attempted suicide. Despite her high IQ she is barely getting by in her schoolwork. She is seldom overtly insolent or rebellious to authority. Instead, she appears to be the epitome of innocence when confronted with her recalcitrant behavior. When caught red-handed she is quick and brilliant in providing reasons for her actions which absolve her of responsibility.

Despite her slight obesity, Bette is pretty and well groomed. She appears passively cooperative during the initial interview, indicating neither concern nor curiosity about the psychotherapeutic procedure. She readily reveals that she is the youngest of two children, her brother two years her senior. Her father is a successful self-made businessman, while her mother comes from a highly respected family in the community. Her formative years were marked by a host of family quarrels, emotional turmoils and separations. Her mother

was hospitalized for two years and received private psychotherapy over a six-year period for severe depressions and many physical complaints. An alternately restricting and overprotecting maternal grandmother played an important part in her upbringing. Her father was seldom at home, appearing preoccupied and distant while in the household.

Bette thinks of her parents and most of her teachers as "dumb" and easily manipulated. She considers schoolwork, home chores and any disciplined activity as a "waste" and prefers to "route." The latter consists of riding around town, stopping at various bars, meeting different boys and staying out half the night. While she has no friends, she considers herself part of an "in-group" that is full of "action." She readily admits to a series of sexual experiences with different boys. She displays no concern, remorse or fear over her actions but does consider the restrictions placed on her at home as "criminal." She believes it is funny that she is seeing a "shrink" since it is clear to her that it is her parents who really require help. She agrees to treatment to quiet her parents and school officials.

After obtaining a detailed account of Bette's pleasure-seeking activities, I wondered why she allowed herself to be restricted at home so often. She expressed surprise at this question, exclaiming that this was obviously due to her "square" parents. I pointed out that if, according to her account, her parents watched television every night and went to bed early, it might be

smarter if she waited until they were asleep and then walked to the comer where she could meet her friends. I noted further that if caught, she could truthfully say she could not sleep and went out for a walk. Bette thought this was “neat” and planned to try it. The next session she laughed uproariously as she described her “breakout” and her parent’s remark the following morning on how well she looked after a good night’s sleep. She quickly challenged me to help her get the use of the family car more often. I questioned her minutely regarding her parents’ attitudes and habits concerning this vehicle and finally advised that she arrange to have a series of dental appointments just before dinnertime. When this too worked out well, Bette began to show a real interest in psychotherapy.

For the next several weeks I helped Bette to play truant by suggesting that she report to her homeroom at the beginning and end of the school day, turn in book reports and term papers prepared two years earlier by her brother, obtain more spending money by returning to local stores purchases that were charged to her parents’ account and deceive her parents about her drinking by advising that she switch to vodka. Once, when she “just had to” get out at night to see a friend, I suggested that she tell her parents that she had a late appointment with me.

Throughout this early phase of treatment, the therapeutic relationship is focused on the patient’s external reality. The therapist and patient enter

into a variety of discussions, calculations, predictions and assumptions regarding this reality in order to more fully help the psychopath achieve satisfaction.

As the patient's needs become more complex and require an increased time interval before gratification can be obtained, greater emphasis is placed on postponing immediate fulfillment in order to obtain information, test reality and deliberate the execution of one or more premeditated plans.

In the course of inquiring about the environment, the therapist increasingly displays his ignorance of the facts necessary in making a decision to satisfy a need. He therefore turns to the patient and urges him to obtain this information, supporting his efforts to function independently. When the delinquent succeeds in this function, he is praised and rewarded.

In the case of Bette, the successful fulfillment of her immediate needs led to an increase in the complexity of her wants and a more demanding challenge to the therapeutic relationship. My questions concerning the nature of her needs and the reality of her environment grew more numerous and complex. We once spent a whole week trying to figure out how she could obtain her own telephone. After a series of inquiries regarding the comparative cost of an extension phone, an intercom system and a portable two-way radio, we outlined a plan that required three stages before a solution

could be effected. First, Bette was to have someone call her up early in the morning and she was to allow the telephone to ring a few times before answering it. The next day the phone was to ring early again and she was not to answer it nor "awake" when her parents called her from downstairs. They would have to walk upstairs or shout loudly enough to awaken her brother. Thirdly, she was to keep the telephone occupied when her father usually expected business calls to be coming in. By the end of the week, Bette's parents suggested to her that she get her own private telephone which they would gladly pay for.

When Bette returned to a session with information necessary to solve one of her problems, I praised her and immediately placed a great deal of importance on these facts. In one instance, she was especially clever in learning that one of her midterm examinations was marked by a school clerk. I was genuinely impressed with her detective work and she knew it. With Bette expending most of the effort, we figured out how she could achieve a perfect score on this test even before she took it. It then seemed that she tried to find ways to obtain information cleverly so as to please me. I never failed to express my approval of these efforts and results.

While the socially maladaptive patient often requires an unorthodox initial therapeutic procedure to engage him in therapy, he too must sometime deal with and become aware of the motives behind his acting-out behavior.

Unlike those patients with ego-alien symptoms of phobia, anxiety or depression, his motivation to scrutinize his inner dynamics is quite poor. He, therefore, usually needs a particularly strong dependency transference on the therapist before he will examine the causes of his socially unacceptable conduct.

Such patients are typically reared in an environment that denies fulfillment and criticizes the expression of his needs. His real nature is rejected and a premium placed on his acting as though he were self-sufficient. If he decides to inhibit or suppress a wish because he has been promised some later fulfillment, invariably he is disappointed. Furthermore, his hostility towards the rejecting environment is too intense for him to contain. Nor can he be gratified by identifying with the values of the socially acceptable adults around him. He is too aware of the insincerity and exploitative nature of these values as they apply to him. The resultant stress on getting his own way, through the most expedient and rapid means, is a logical consequence of this type of upbringing. The therapist, however, knows that the emphasis on immediate gratification is a display of deep-seated dependency needs. He can employ this knowledge to help establish a dependency transference and subsequently expose the motives behind the socially maladaptive functioning in order to help the patient arrive at better ego controls.

In the case of Bette, as she identified with the therapist more and more her interests shifted to helping other people. She encouraged several friends to remain in school, helped to arrange an abortion for one of them, directed several people into psychotherapy and turned her room into a veritable way station for youngsters leaving home. She was affectionately referred to as "Dr. Bette Brothers." As her "practice" increased she sought my advice in handling her "clients." After a few successful interchanges, I told her, "You are a lousy analyst." When she recovered from this first direct criticism, she wanted to know why. I told her that she was sending out two opposing messages to her friends. In addition to the overt encouragement to act responsible she was pointing out that her own behavior was immature. She was breaking appointments with her friends, her job and me. Her lack of adequate sleep caused her to "poop out" when she could benefit by being alert. She was not eating properly. She smoked too much.

With a wry smile, Bette began to defend her own behavior. She tried rationalizing that because of her "heavy caseload," she could not realistically take proper care of her own needs. I countered with, "Do you think your patients' will buy that?" She shifted with, "I'm really in much better condition than most of them so that the same standards do not apply." I said, "Bullshit." She accused me of being unfair, of demanding too much from her, indicating that while I was paid for my services, she acted gratuitously. I told her that was precisely my point. How could she expect others to respect and follow

her advice if she could not act in her own self-interest? She finally agreed that this was true but added that because of old habits she really did not think that she could discipline herself. She tried to diet and stop smoking, for example, but always failed. I taunted her with, "That's right, Bette, be a good girl and act just like your parents say you are. Support their view of you by being lazy, irresponsible, weak-willed and a failure. If you prove that they were right about you all along, maybe then they will love you." This got to her and she became determined to show those "bastards" that she really is adequate and independent. She soon began to stop smoking in the office, to cut down on her eating and to sleep eight hours the night before a session.

For those patients whose acting-out behavior is personally maladaptive rather than specifically antisocial, other techniques are employed. When an acting-out patient seeks help because of some vague dissatisfaction, anxiety or somatic complaint, the initial therapeutic intervention is designed to promote the patient's awareness of his behavior and enlist his cooperation to modify or change it. One possible first step in this direction involves getting the patient to act out his "acting-out" expressions in an exaggerated form, thereby forcing him to defend against the unacceptability of his typical behavior.

An extremely hostile patient who constantly ingratiates himself with others through his cooperative, friendly, helpful manner was given the task of

putting down each member of a group by being overly sweet and complimentary. He started the task by saying to another group participant, “you sound intelligent.” When he was asked to exaggerate this it became, “you act like you know everything.” As he spoke to each member of the group his task of exaggerating the positive was performed more and more spontaneously. This exercise enabled him to experience the hidden meaning behind his characteristic behavior. When he no longer defended himself through his typical sweetness and friendliness he was able to accept and express his hostility more directly.

The potency of this approach was demonstrated by this patient in a subsequent group session. At this meeting he reported awakening early one morning feeling very angry with his wife who was lying next to him. He had two impulses almost simultaneously; one to hug her and the other to kick her out of bed. He recognized both impulses as expressions of his hostility and knew that his wife would reject him regardless of which course he took. He finally decided that hugging her would be the more hostile act because she would feel guilty when she rejected him and he, accordingly, pursued that tactic. When he recounted the story it was with both a sense of pride in his increased awareness of himself and a sense of horror at his sadism. He saw clearly for the first time that it is kinder to directly express a given feeling of anger toward a loved one than to mask it behind a pseudo-loving act.

Helping the patient become aware of, and take responsibility for, the unconscious impulses inherent in his acting-out behavior is basic to the psychotherapeutic procedure. One way to deal with this resistance is to urge the personally maladaptive patient to interact, employing his typical life style. He is given the task of relating to others with his usual self-defeating behavior. Exaggerated and pronounced forms of his actions are constructed so that he can readily become aware of the true meaning of his relationships. This method of making manifest a previously unconscious motive through a reenactment of the patient's typical acting-out behavior, the authors have termed "therapeutic acting-out."

THERAPEUTIC ACTING-OUT

The authors employ a combination of traditional and more recent psychotherapeutic structures to implement the therapeutic acting-out method. Because the aim of the unacceptable impulses of such patients is commonly directed towards the most significant people in their lives, we frequently use the vehicle of couples group therapy to utilize this technique. In couples therapy, we often discover that either one or both partners manifestly express the unconscious wishes of the other. This expression of forbidden impulses through the marital partner sometimes becomes so pronounced as to make the marriage itself appear to be the means of acting-out by both husband and wife. By keeping our focus on the process and

structure of the interaction between the couple, we uncover the behavioral outlet for those urges that neither partner is aware. We devise exercises and homework assignments geared to help the couple act out that which their deeds secretly express.

We also utilize the therapeutic acting-out method along with encounter techniques. Encounter techniques in group therapy were devised to clarify and make explicit the nature of interpersonal ties. Patients are encouraged to deal directly with areas of their relationship that remain unresolved. The methods employed by Schutz and Malamud and Machover are designed to create an interaction that concretely depicts a problem in interpersonal living. Thus, a "one down-man-ship" outcome is realized by having the individuals place their hands on each other's shoulders and literally try to put one another down on the floor. Or a couple that argues repetitiously (going around in circles) are placed in the middle of the room and asked to circle one another without verbalizing. Competitive behavior designed to avoid closeness is manifestly depicted by arm or leg wrestling. The physical experience offers the participants a new perspective in which to view their conflict. The novelty of the exchange induces authentic responses rather than stereotyped behavior. The game-like nature of the exercises creates an atmosphere of levity and friendship vital to the supportive function of the group. Encouragement and social rewards usually are spontaneously offered by other members of the group.

Another recent psychotherapeutic structure employed as a vehicle for the therapeutic acting-out method is the marathon. Marathon therapy is a time extended group session usually running for twenty-seven consecutive hours. The unique therapeutic dimension offered by a marathon evolves from the extended period of group interaction. Four factors are operative which seldom obtain in any other therapeutic structure. First, the intensity of participation mounts as one individual after another begins to unfold his story, breaks through a previously cherished defense and has a fresh insight into his condition. Each succeeding experience tends to carry over and add to the collective emotionality. Tolerance for anxiety increases as the group is exposed, without let up, to these life dramas. This additional capacity to cope with anxiety permits the release of deep feelings such as profound grief, utter despair and overwhelming love. Secondly, the continuity of the group does not allow for the typical reestablishment of defenses observed in shorter forms of therapy. Participants are deprived of their usual environments wherein they maintain life styles and roles. Those character traits and patterns of behavior dependent on such external support and reinforcement thus become more accessible to change. Thirdly, the fatigue factor is important in helping to break down defenses and resistances, leading to a more authentic, spontaneous expression of interpersonal relations. After so many hours of heightened experiences it is rare to find an individual who is unaffected. Fourthly, as the hour for termination approaches, the pressure to

expose conflicts and problems increases. Knowing that the group will cease to exist shortly, each participant is struck with his personal responsibility to get from the marathon what he came for. This urgency may become desperate; in fact, during the final hours of a marathon there is a release of emotion seldom seen in any other setting.

The following case history of a couple in treatment illustrates how the above techniques and structures are employed.

Ruth and Herb sought treatment jointly and were accepted into one of the couples therapy groups led by the authors. The symptoms, as presented by Ruth, were her severe headaches, Herb's sexual impotence and his compulsive gambling. Both of them accepted her description of Herb as the irresponsible acting-out partner and Ruth as the responsible one. Before they left the first session Herb managed to inform each of the therapists privately that he had had an affair which Ruth did not know about. He said he could not tell her about this because it would "hurt her too much." He was pessimistic about being helped by the group as long as his wife was in it, because he probably "would not be able to open up." He was urged to attend for a few months to learn if his fears were justified.

Ruth was the principal complainer of the couple and initially the primary target of the group. She sat smugly judging and giving advice to every

participant. Under the guise of being the practical, responsible partner in the marriage she was able to act out her deep-seated belief that unless she controlled every situation in her family something dreadful would happen. The authors used this attitude, asking her to role play "therapist" and tell each group member how he could improve his life. She started to go around the room saying,

"Sylvia—you should go on a diet and get thinner."

"Harold—you shouldn't be so quiet. You should speak up more." She began to falter and claimed the task was more difficult than she thought it would be. She was encouraged to continue and finally completed the exercise with a great deal of prodding. When asked how she felt about the experience Ruth replied, "I really don't want to tell anyone what to do and how to live. I want to be taken care of myself." Using this overt statement we worked to change the nature of her contract with Herb. She was urged to become more irresponsible and was given specific tasks to promote this kind of behavior. She had to report the results to the group each week.

Several weeks after they joined the group Herb was still a fairly silent participant and seemed to be keeping his promise to "not open up." At this time he was asked to attend a marathon without Ruth. Despite the fact that his participation in the marathon group was minimal, the experience was

very meaningful to him. One lasting effect of this involvement was that he was subsequently less intimidated by his wife and the group. Under these circumstances, and motivated by a discussion of the sexual problems of another couple in the group, Herb initiated a discussion of the sexual inactivity in his marriage. When he was pushed to verbalize what he saw as the problem he reported, "When Ruth makes sexual advances to me I get turned off and if I feel warmly towards her I'm afraid to put my arms around her because I think she'll expect me to fuck her."

Both Ruth and Herb were asked to play out their bedroom scene in the group (on the floor and fully clothed). In the midst of the first tentative, amorous gestures from both of them Herb froze. When asked to sort out his feelings he expressed anxiety with respect to Ruth's expectations and anger toward her for making demands on him. He was then given his first assignment since initiating treatment. During the coming week he was to physically express his warmth for Ruth whenever he felt it, particularly when they were in bed, but under no circumstances was he to have intercourse with her. How they handled this exercise was typical of their interaction. The first time Herb expressed his warmth to Ruth he obviously became aroused. Ruth said, "You know we don't have to listen to them just because they said not to." Herb immediately was turned off and did not attempt the assignment again for the rest of the week. Ruth was furious with the therapists for giving the task and with Herb for not disobeying. Apparently, Herb's act of self-

assertion was threatening enough for Ruth to regress to the point where she again had to reassure herself that she was still in control.

To help Ruth disengage from Herb, to promote some loosening and, hopefully, to enable her to experience some gratification, we had her attend a marathon without Herb. At the marathon she was urged to be as irresponsible as she could and encouraged to act out a sexual fantasy that she verbalized of having two men at once. The men entered the game enthusiastically with Ruth resisting initially. Ultimately, she abandoned herself to the simulated fantasy experience.

After the marathon Ruth was more spontaneous than she had ever been, her headaches were gone and some sexual activity ensued between her and Herb. When Ruth became more demanding, Herb's passive-resistive mode of responding again set in and she became quite bitter. When she brought this complaint to the group, some members responded by encouraging her to have an affair. She indicated that she was going to consider it, that her fifteen years of marriage had apparently been a waste. At that, Herb exploded. He claimed that was the end, he was leaving the group and the marriage—he was finished. He was persuaded to stay for a while and give Ruth more of his anger. He let out fifteen years of hostility, recounting incidents that occurred in the first year of their marriage. He claimed she had him brainwashed into believing she was always right and he was always wrong. He was particularly

angry at always having to feel guilty. This reminded him of what he felt guilty about and he ended with, “so I fucked a broad; so what—I don’t have to feel guilty about that forever—and I don’t.”

Both of them were a bit shocked by this revelation and his rage abated enough for them to begin to talk about what had happened. Ruth was completely intimidated by him and Herb was beginning to appreciate the notion, “she doesn’t have to be right, she could be wrong.”

For three days after that session Ruth walked around hurt and shattered. Herb stood his ground and did not act guilty. On the fourth day they began to talk and both of them were able to be open and share their feelings. When they returned for the next group session they were obviously together in a new way.

Over the next several months it became apparent that two of the presenting symptoms, the headaches and the impotency, had disappeared. The gambling had lessened considerably but still had Ruth concerned. However, Herb was able to handle her attacks on his gambling. He did not become guilty or unduly defensive and managed to suggest that she might have a problem in making an issue of it.

The key factors to be noted in this case are the use of the technique of therapeutic acting-out, consideration of the marital contract between Ruth

and Herb, as another manifestation of their mutual acting-out and the use of structural innovations to enhance the ongoing therapy.

Ruth was initially encouraged to act out her typical role of being the responsible, nurturing marital partner when she was directed to give advice to the whole group. This exercise enabled her to become aware of her controlling behavior and the hidden impulse behind it; which was to demand that she be cared for. When Herb was directed to act out his usual role of withholding by being told to fondle his wife but not to have sex with her, Ruth sabotaged this assignment and clarified her part in Herb's acting-out behavior. The encounter techniques, homework assignments, marathons and role playing exercises were used to uncover the impulses behind the acting-out and enabled the patients to find a more satisfying way of expressing these urges. They also helped to make explicit the implicit contract inherent in their interpersonal behavior.

SUMMARY AND CONCLUSIONS

Acting-out has long been seen by traditional psychotherapists as a deterrent to successful treatment. Few individuals are aware of the forces affecting their acting-out patterns. The motives are imbedded in ego syntonic life styles and character traits. Because of this, patients with acting-out disorders have little or no guilt about their behavior and are not motivated to

change. At best, they come into treatment either because they were coerced or to alleviate the anxiety due to circumstances other than their character problems.

Attempts to influence the acting-out patient through traditional psychotherapy have been relatively unsuccessful. In addition to poor motivation and a lack of guilt, obstacles to treatment are a lack of affective identification, poor ego controls, difficulty in postponing gratification and infantile dependency needs, and the associated hostility when these are denied.

The successful treatment of acting-out disorders centers on the establishment of an initial working relationship, bringing into awareness those unconscious needs reflected in the patient's behavior and providing positive experiences to achieve genuine gratification. Because these individuals suffer from a character defect, the therapist must reeducate them to acknowledge and respect the integrity of their insights and their related attempts at fulfillment while remaining in harmony with the demands of society. The therapist must be more involved, active and concretely focused on the patient's immediate problems in living. Traditional techniques and structures must not interfere with the practitioner's ability to demonstrate his commitment to the patient rather than to theory or a particular format of working. Acting-out patients challenge the therapist's ability to employ,

innovate and create therapeutic interventions of a highly flexible and imaginative nature leveled at the specific needs of such individuals. If the therapist is not prepared for the type of intensive involvement where his own schedule, style of living and value system will likely be shaken, he should refer such patients elsewhere.

The initial therapeutic relationship with socially maladaptive persons of this type often calls for the complete acceptance of the individual's wants and needs, value system and style of attempting self-fulfillment. A low tolerance for anxiety and failure requires that such patients quickly experience the therapist as an ally in helping them achieve satisfaction. A strong dependency transference, based on trust and authentic involvement, must be built up quickly. Aiding the patient to become more effective, on his own terms, is usually necessary before such a transference can be established.

Personally maladaptive acting-out patients, on the other hand, enter therapy motivated to overcome their discomfort. The early therapeutic problems with these individuals is similar to the traditional psychotherapeutic methods with typical neurotics. While a dependency transference is established with these patients also, it is rarely as deep nor on as infantile a level as with antisocial acting-out patients.

Once the dependency transference is clearly observed through the

patient's greater emphasis on pleasing the therapist than on direct self-fulfillment, it becomes possible to reveal the hidden motives behind his acting-out behavior. The precarious nature of the ego controls and positive self-image of the patient requires a heightened sensitivity to the content and timing of such interpretations. The general rule to follow is to find those areas of behavior where the unconscious meaning is closest to the patient's awareness before making an interpretation. The use of the therapeutic acting-out method is employed to this end. Given the task to exaggerate typical acting-out conduct, the patient experiences his motives in a concrete interpersonal fashion. He is often able to discern, accept, take responsibility for and articulate his real needs through this technique. Encounter, role playing and gestalt methods, as well as other techniques, are similarly employed to help uncover those unconscious factors inherent in the patient's stylized conduct. Group, encounter and marathon psychotherapeutic structures are designed to serve as a vehicle for the application of these methodologies.

After the patient displays insight into his behavior, he requires a systematic procedure to gain confidence and the skills to learn more rewarding patterns of living. The effectiveness of personal integrity is demonstrated through an emphasis on the integration of the patient's needs, his attempts at fulfillment and the reality demands of his environment. Pronouncements of helplessness, impotence and habituation as factors

precluding effective change are interpreted as resistance to mature growth embedded in the unconscious dynamics of the acting-out behavior. Behavioral modification, rational-emotive, impulse control and parts of other therapeutic techniques, alone and in combination, are used to provide the patient with an increased confidence in his ability to act fruitfully. The gradual increase in the patient's repertoire of responses adds to his flexibility and appropriateness in living.

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