

ADLERIAN ACTION THERAPY TECHNIQUE¹

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Action therapy is a form of group therapy which is focused on what the patient can do for others, rather than on the patient as such (9, 10-18). It is an attempt to put Adler's concept of social interest into action, along lines which over the years have led to some encouraging results with Veterans Administration patients.

DEVELOPMENT GROUPS

At the VA Hospital in Houston we have a problem-centered patient group program, called Human Relations Training Laboratory, HRTL (6, 7). Most participants selected for the program suffer from anxiety and depressive reactions, character disorders, or alcoholism. The problem of therapy is to move the participant from the conviction that he is largely controlled by external forces (external control) to the realization of the initiative that is actually his (internal control). Since people are often remote from where important decisions concerning their lives are made, they are prone to lapse into passivity, and lose enthusiasm, involvement, and a sense of responsibility in handling their own affairs, in planning and executing personal goals, and in managing their lives (21).

The major vehicle through which internal control is taught is the development group (D-group). That is, in the D-group many patients learn that they can indeed initiate movements which eventuate in positive or negative reinforcements from significant others (20).

A D-group consists of eight to twelve men who build from "scratch" a miniature society of four weeks duration which sets its own goals and procedures for living together. The men meet five times a week for one and one-half hours without a staff member and without a planned agenda. In the remaining program hours, lectures are given, mainly by psychology trainees, in skills related to giving and asking for feedback about behavior. Throughout the

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four-week period destructive acting out of a member is dealt with by the group, not the staff. A Rules Committee of peers works with the rule breakers to maintain ward justice and harmony. Outside resources, such as a consultant, are available but can be called into the group only through a consensus of all members.

Group members are told that in addition to getting help from other members they are expected to give help in the form of feedback about their feelings regarding here-and-now behavior of other members. This comes as a surprise to many who never thought that they could help anyone. Since the D-group (historically rooted in Kurt Lewin's work) must rely mostly on its own resources, there is at the start a sense of helplessness; members are frustrated and anxious when they realize that the help they want must come primarily from within their own group.

In such a program it becomes essential to demonstrate their own resources to the members. This may be done during the second week of the D-group sessions through a technique which I developed and have called "action therapy." It is a form of psychodrama, adapted to Adlerian theory, which by demonstrating resourcefulness increases the members' self-esteem and social interest.

In our socio-historical times, everyone, I presume, actively but unwittingly lowers self-esteem and social interest in pursuit of truncated, narrow identification. In such maneuvers we are all only looking for self-esteem through the social actions we consider to have the highest probability of success. The first sparkle of humor comes from a detached realization that we ourselves have crippled our self-esteem through negative nonsense, oughts, shoulds, while demanding unconditional approval from others. In the end, self-esteem is lowered by one's own internalized sentences and the reactive behavior of significant others who have suffered from our demands.

ACTION THERAPY LECTURETTE

Most patients do not really know why they are in the hospital, that is, in the sense of what in their attitudes has led to behavior which resulted in their being hospitalized. They mainly perceive "nerves" and fear of "loss of control" as causal factors. Therefore, on the first day of the second week I may give them a one-hour lecturette on Adlerian theory of mental disorder, using familiar terms, explaining the mistakes in living which all of us make in

varying degrees, and the ways in which we can overcome these errors. An outline of the lecturette is given to each member to implement my attempt to make students out of the patients, and concrete examples of misbehavior in the following days are discussed within the Adlerian frame of reference.

In the action therapy lecturette the need for self-esteem (significance or worth) is constantly reiterated, as is social interest (other-understanding or oversight)—the two “depth” factors to which all other perceptions and actions are ancillary.

The dangers of low self-esteem are illustrated through anecdotes around patient misbehavior as it happens: the failure to risk imperfection, the overcompensatory fantasy life; the strong tendency to be “sensitive” to any mentioning of one’s mistakes. One with low self-esteem translates any implied criticism of his behavior as an incontrovertible message of his worthlessness. He rejects even praise, for accepting it could mean added responsibilities, with increased opportunity for failure. Yet the honest, well-intentioned expressions by others of how they see you and feel about you (verbal feedback), are the way to understanding oneself.

The dis-ease of low self-esteem is described as a reactive “willing that which cannot be willed,” and a lack of courage to be imperfect, resulting in further humiliation, embarrassment, anxiety, and tension. It is manifested by demanding, blaming, punishing, and by avoiding situations through excuses such as “too nervous,” “need time to think,” “don’t want to be made a fool of.” Low self-esteem is usually accompanied by narrow social interest: creating distance from others, being hyperdependent on them, or actively or passively competitive.

A part of the lecturette is concerned with topics which help the director to get the group going, avoiding abstractions and past histories. One such topic is the specific error of lowering self-esteem and narrowing social interest in this present encounter. “We all do this. Why? and how? Why are you doing it right now?” Another topic is anxiety, feeling “certain” that something catastrophic is going to happen to one, beyond one’s control. “What do you fear will happen? Tell the group in a fit of openness and honesty. Is it a fear of loneliness, of humiliation, of others detecting imperfections?” Still another topic is knowing another, *i.e.*, understanding how he lowers his self-esteem and social interest in terms of outer

and inner (cognitive) movements; knowing his hidden anxieties; understanding the nature of his habitual relationships (hyperdependent, cooperative, or competitive); lastly, knowing how he wants to be confirmed, as "what," and by what types of reinforcements e.g., as the best speaker, by constant nodding and smiling of others. Ideally, all members know this information about all other members and are willing to share themselves, and confirm others. This builds authentic "community," and each member is able to mirror or double for every other.

ACTION THERAPY SESSIONS

For the next four days the members have their daily one and one-half hour action therapy session in the morning with the author as director. In the afternoon they view videotape playbacks, with their consultant (not the director) present. Playbacks are uninterrupted presentations of the morning action therapy sessions.

One member at a time volunteers to be the protagonist, one who has the courage to contribute his problems to the group. With the help of the group, which the director actively solicits, the protagonist's low self-esteem is explored along with the "negative nonsense" (arbitrary demanding, blaming, and stigmatizing) which he tells himself (19), such as, "If I show anxiety, I'm not a real man"; "I must never be laughed at or I'm a failure" (4).

While working with the protagonist the director inquires from other members for similarities and understanding. "Why don't you understand Joe?" "What information do you need? What movements does he have to make before you understand him?" "What do you tell yourself about Joe to keep distance from him?" "What have you said or done to Joe to help him tell himself that he is (or you are) inferior as a person?"

The director might ask if others have had similar problems. "Let's see the hands of those who have had sex problems" (*two hands up, ten arms motionless*). "I see we have two guys with guts and ten liars (*laughter*). I've had sex problems too. What do you think of that?"

The director can play upon competition itself to precipitate insight into the goals of competition on the useless side and develop group cohesion. One statement might be, "The group's task is to find the most depressed guys. Who is the sickest?"

The director can also capitalize upon competitive power struggles to stimulate sharing and practice of openness. When Harry, a sullen, violently-passive alcoholic, steadfastly refused to play the son who infuriated Harry and led him to drinking behavior, a bet was made with Joe. Joe, also on the stage because the director called for the group to select people with the "best tempers," was told by the director, "I'll bet you two bits you can't get Harry to play his son." Almost immediately the director lost his quarter and the group had a hearty laugh over their power to "defeat" authority. But authority in this case was not defeated since it also laughed and was pleased at the creativity of the group in demonstrating power struggles and provoking movement.

Guessing at another's constricting cognitions highlights the other's "creativity" (albeit of an unexpected negative kind) and focuses on the possibility of his making alternative choices. Guessing in itself is stressed because it is encouraging to realize that no one of us has absolute certainty and guessing is what we are all doing. Guessing at another's creativity also helps to show him a developmental route to the sense of humor through experiencing the tragicomic paradox, e.g., knocking one-self down while crying for help. The humor of unloving the self while demanding pampering from others, the humor of being the best or most perfect self-devaluator, can also be brought out through mirroring and doubling in action therapy.

Through playing the role of doctor or director, the patients may see that the role of the encouraging director can in time be only that of suggesting that the patient strive harder to be more accomplished in his "symptoms." Such a paradox again approaches humor: encouraging symptoms is a benign trick which places the patient in the untenable position of "I won't do what he says . . . I'll do the opposite" (5). The ploy illustrates experientially how actively competitive, low self-esteem people create misery. After that it opens the question of "Now what? Shall we practice to be happy and authentic?" At all times the lesson to be highlighted for the patient is: Either stop your negative nonsense, or immediately increase it and learn to enjoy your misery more fully.

Part of the training is desensitization toward psychiatric labeling. Most patients harbor some term (obsessive-compulsive, phobic, psychopathic, etc.) which they apply to themselves as a fearsome prejudicial abstraction, "I am nothing but a hopeless, helpless,

lonely . . ." To take the sting out of the word-magic, and to stimulate and develop hope, substitutions are presented, based upon different patient demands and reactions (instead of diseases), such as fighting for super-control over people and events, actively trying to achieve superiority in some ways to all others, avoiding people and events as a method of control. The director may play the patient, while the patient in the role of the doctor experiences the frustrations of a defeated autocrat.

When the director believes the locus for change to be the internal sentences of a patient, he might move to have the peer-group members flood the protagonist with encouragement, relevant to behavior. For example:

DIRECTOR: Joe is good because . . .

PEER: Joe always greets me and has the courage to share his mistakes with us right now.

If Joe should say, "I have no self-esteem, because no one likes me," and if there is validity to it in that others are actually repulsed by him, the question can then be, what movements in what dyad lead to like-dislike? Esteem comes from positive reinforcement of self and others. If one wishes for esteem from others, he must, for better or worse, at least in the beginning, confirm others in the way they expect to be seen. Arbitrary demanding to "be liked" is only the royal road to mental illness.

PATIENTS ON THEIR OWN

The final two weeks of the HRTL program are given over again to D-group functioning. Seeing themselves helpful to others and utilizing help from people like themselves, the participants begin to develop confidence, and experience an increase in self-esteem (19). Still seeking help from staff, they are less inclined to depend primarily on the "experts." They learn to distribute their dependencies upon themselves, the group, and the staff. Their relationships become interdependent rather than demanding, dependent, or counterdependent.

In the process the participant must assess what parts of his own behavior are effective or ineffective in dealing with others. He must learn to look at his own behavior and try to determine how he perpetuates his problems by believing the negative nonsense he tells himself, clinging to destructive attitudes, and playing habitual, self-defeating games (1). Psychotherapeutic changes are brought about

through mutual helpfulness and tolerance, not by blaming and punishing, but by trying to understand the other person. How does he want to be confirmed? Will he learn to accept a different role in life and a different confirming movement from others?

CONCLUDING COMMENT

This, then, is a report of an attempt to put into action the Adlerian faith that psychotherapeutic methodology belongs in part to all people, rather than being solely the property of restricted professional guilds (2, 3). Even beyond that slightly heretical stance is a faith in the person who has been solving his problems poorly yet "creatively": patients can learn to be therapeutic for each other. After our patients complete their D-group training of four weeks, they are either transferred to other wards or leave the hospital. And it is encouraging to report that of over 200 patients who have in recent years served as protagonists very few have returned to our hospital for further treatment.

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(continued from page 120)

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