Action Therapy

Walter E. O'Connell

The goal of action therapy is to help people increase their self-esteem and social interest by discovering the reasons (or mistakes) which keep them from cooperating as equals in society. The primary assumption is that patients are not hopelessly infected with a disease and therefore helpless victims. Rather, they are people who are actively making decisions, albeit unwittingly, about their behavior and are therefore ultimately responsible for their environment, actions, and feelings. Individuals are viewed as active agents in both their inner life (cognitions) and outer life (behavior). In other words, their behavior is purposive, extending even to the environment they select or allow to operate on them.

Action therapy is a democratically oriented method of group psychotherapy, using psychodramatic techniques for diagnosis, treatment, and training. Its goals are openness, self-disclosure, and the giving and receiving of feedback with mutual cooperation. The methodology is Adlerian, since it focuses on the consistent and creative lifestyle, degree of social interest, strength of inferiority feelings, and goals of superiority. Beginning with these few, fundamental beliefs, I have developed an existential-humanistic theory to help discover or guess the purpose of each individual's behavior and, more important, to teach the individual to view himself as capable of alternative actions. According to this theory, the most mature, rewarding style of life is that of cooperating as equals. If an individual has extensive social interest (feelings of similarity, closeness, belonging), then he can maximize his self-esteem as a *unique person* (feelings of worth) by encouraging others.

If an individual has a low self-esteem, he will not feel secure enough to work with another mutually toward a goal, but rather will often place demands on others or on life situations. For example, in the statement, "It's an unjust world," the demand is, "World, you should be just, no matter how I behave." When demands are not met, the attempts to understand this failure often lead to blame, *blaming self* ("I'm not good enough"), *blaming others* ("People are no good"), or *blaming the life situation* ("If only I had money"). Blaming others, oneself, or one's life situation is referred to as "negative nonsense:" the hopelessness, blame, and isolation experienced when demands

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Walter E. O'Connell, PhD, is a psychologist and director of the Glass Ark Drug Dependency Treatment Center at the Veteran's Administration Hospital, Houston, Texas.

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are not met. The individuals who create this demand cycle develop feelings of negative uniqueness by which they set themselves apart from the rest of humanity and narrow their social interest.

In working toward the goals of action therapy, the group atmosphere encourages feelings of commonality with others—the patients, director, and auxiliaries. Each person is respected as an individual, but he is seldom allowed to feel isolated, unless he makes an open decision to do so. An all-pervading thrust of this particular therapy is to demonstrate that each person holds many ideas, feelings, and conflicts in common with others. Further, each person has his own susceptibility to negative nonsense (or constriction) and can help others recognize its presence and reduce the felt necessity for it. In stressing commonalities between individuals, a therapeutic community is created where patients learn to disclose themselves—their demands, feelings, and mistaken certainties. The goal of action therapy is to extend this ability to search for commonalities with others, not only by experiencing this happy effect through encouragement in the group, but also by instilling a new way of conceptualizing oneself in the world that extends beyond the current situation.

History

Action therapy began at the Waco (Texas) Veterans Administration (V. A.) Hospital in 1959 when two other psychologists, one psychiatrist, and myself translated our impatience over perceived treatment deficiencies into action. Our dissatisfactions concerned the mechanical, discouragenic model of chronic disease in which intrapsychic, socioeconomic, and religious variables were totally neglected. Frequently, the typical psychiatric team follows bureaucratic strictures without ever examining the personalized meanings of "disease" and "cure." Action therapy was born out of an attempt to create staff involvement in its behavioral orientation. The typical session incorporated shared ideas of what staff could do and how patients might block staff efforts. Patients and their keepers were viewed as a system, each element with its own implicit demands. These demands should, for optimal functioning, be made overt (e.g., "I demand patients stay awake or I will not direct action therapy"). Implicit demands were examined openly (and therefore became explicit expectations) to detect hidden needs for attention, power, revenge, and special service. In the traditional mental hospital setting, both staff and patient population have trouble maintaining an active social interest (courage, in Adler's terms). Both groups model and reward mutual withdrawal. Action therapy was designed with the indifference of both groups in mind, realizing that a change in element of the system can reciprocally alter the action of the other. Action therapy was often called Adlerian because:

1. Man is not viewed as a mechanistic system powered by a closed source of energy. Feedback and resultant fluctuations in self-esteem better fit our world view and seem capable of explaining our behavior.

2. We worked ourselves free of intrapsychic overemphasis with its accentuation of infantile and pathological determinism in favor of behavioral responses amenable to change in the here-and-now.

3. It emphasizes a diagnosis that concerns self-induced states of self-esteem and social interest abstracted from behavior over time and changing external conditions.

4. Treatment is a process for correction of mistakes and stupidities instead of eliminating impersonal disease processes. It is conducted in a group setting that highlights the creative lifestyle of the individual (e.g., experiences lead to cognitions which are self-reinforced and induce strong expectations and demands toward others).

Initially labeled "psychodrama," the name became "action therapy" when the Morenos mentioned that psychodrama was a copyrighted term, reserved for those who had received formal training at their center. During 1963-1965, annual workshops on psychodrama and action therapy were conducted at the V. A. Hospital in Waco, Texas. In 1970 and 1971 the American Psychological Association, Division of Psychotherapy, sponsored workshops on psychodrama and action therapy. To choose leaders, 40 prominent psychodramatists were asked to select the top 10 directors. Three were selected from the Waco V. A. Action Therapy training center; seven from the Moreno group. When two of my colleagues and myself transferred to Houston, the Waco group ceased to function as an informal action therapy training site. I continued to direct action therapy on the Patients' Interactional Training Lab, Houston V.A. Hospital, as a research psychologist. The influence ot my research results, the development group lab approach, and more intensive work with Adlerian theory and techniques, led to the creation of the Natural High approach. I continue to use action therapy variations in my training, teaching, and therapy with Natural High goals.

The Technique

The final goal in action therapy is to increase the person's self-esteem, hopefully in harmony with a widening social interest. Operationally, this goal is defined by well-developed skills in giving and receiving feedback. Widening social interest and increasing self-esteem are difficult movements to teach, since the adult patient's lifestyle is no *tabula rasa* but, among other things, a creative system of "negative certainties." Therefore, immediate types of "replacement therapy" are doomed in advance. With adults, symptomatic behaviors have usually been highly practiced over time. Even more stable are their attitudes toward self, others, and life situations, which motivate feelings and actions. There are no flexible, mature persons whose sources of esteem and social interest are purely external and who live as recipients of passively received esteem by transplantation or replacement. In fact, the appearance of

such demands and their certain frustrations is the hallmark of the disturbed and disturbing person. From an Adlerian view, the protagonist is not a passive victim. He is capable of learning to change his lifestyle but purposively, yet unwittingly, exaggerates his symptoms and feelings of victimization and powerlessness to achieve power or influence according to his life plan.

The consistency and creativity of the lifestyle provides clues as to what the director selects for the problem the group will attempt to solve. He is attuned to negative nonsense or statements that express a hopeless disdain for self and others; that is, the subtle retreats from social responsibility which gain the patient interpersonal power but little self-esteem are major clues the director pursues. Consistency is used to help the director from becoming mired in factual debates about people, places, and things. The director can infer attitudes toward the self and others from patient behavior and can use this information to proceed beyond past situations. Action therapy might be compared at times to the Brechtian theater. Its aim is to stimulate an active puzzlement in people who believe humans are depersonalized, mechanized objects with whom they can never have favorable influence without brute force. To transform oneself from general passive acceptance, one needs to develop that detached eye with which Galileo observed a swinging chandelier, and many techniques can be used for that end. Consistency of the person allows generalization from one modality to another (attitudes to behavior and vice versa). Thinking about the inventive tenacity of the lifestyle gives the director impetus into the future. He can imagine probable stress situations and implicit goals of the protagonist who, like the rest of us, seeks rewards and reinforcements congruent with his lifestyle. So, from the use of the psychodramatic techniques of the soliloquy and the empty chair, for example, the Adlerian-minded director can exponentially increase working knowledge about protagonists. In summary, the successful growing director works his way free from unproductive verbal stalemates. He experiences the nonfatal effect of admitting imperfection, and he looks for evidence of negative nonsense in verbal and nonverbal communications. These are then generalized into a consistent holistic picture of the person's lifestyle. The creative power of the self and other attitudes is taught by experience and empathy through the use of asides, mirroring, and doubling.

Action therapy employs techniques that show the patient that changes in his errors in living, "negative nonsense," are his responsibility. If he desires to pursue minimal self-esteem via defective social interest, the natural consequences are misery for the patient and for those dependent on him. Self-esteem is chronically deflated by self-blame in the pursuit of the only influence or power the patient thinks is available to him. Patients in action therapy experience "how" and "why" they narrow their lives and are given a chance to practice alternative behaviors if they wish.

Staff as well as patients share needs for power and esteem, fear of

making mistakes, and hidden demands on each other. In the ensuing movement of action therapy, patients, by demonstrating past mistakes and practicing future actions, develop more hope and optimism. Auxiliaries (those who assume roles) reward socially creative movements and serve as doubles, mirrors, and significant others, making feelings of inferiority, asocial demands, and narcissistic goals of misbehavior public. Empathy is practiced by taking the role of others. No interpretation is inviolate. This would only increase dependencies. The point to be made is that there are alternatives to fearful and isolated attitudes and behaviors.

With all forms of mental illness, blaming self and/or others is paramount in maintaining misery. Patients go through the endless cycles of demands, frustrations, blame, and negative proof seeking. All persons are creative enough to find reasons for maintaining the premises of their lifestyles, no matter how self-punishing the consequences. The premises are maintained; at least until significant others give adequate feedback and do not reward behavior which serves useless goals. For a happy change, the protagonist must experience the pervasive demands he creates, which are so commonplace that he ignores them as a cause of his failures.

Our philosophy of therapy is so other-oriented, although undoubtedly self-centered, that we habitually and gently try to manipulate each patient into role reversal (RR). There are many types of RR. The action therapist does not view the patient as a passive victim. The auxiliary will act out the patient's lifestyle demands (the purpose of his symptoms, his muffled cry for magic, and its eventual frustration). In the beginning of the scene, he or she will probably interact with the patient as a significant other, in the way the patient reports seeing this person. As the patient's demands increase, a reversal is made. The auxiliary now caricatures the patient. The latter is then faced with the difficult task of relating to his own demands. The director keeps him in this role and reflecting on the trapped feelings of the person forced to interact with his own double binds. A marvelous experience is in the making, provided that the auxiliary and director are skillful at emotional tutoring.

Role Reversal, the most valuable technique in the psychodramatic armamentarium, is no exception to the rule that techniques are used for definite purposes. RR can be used to diagnose and/or teach the client a certain amount of flexibility in his movements and relationships. At times, RR may be selected for a cathartic effect, with the director selecting a type of role which could achieve maximum emotional release for the protagonist. But catharsis as an end result has many critics, both theoretical and experimental. In essence, the critics report that the benefits of abreaction are slight when compared to the negative effects of reinforcement of destructive, interpersonal acts. In action therapy, catharsis is used not for emotional release only but as a first step toward outsight and authenticity.

To understand how the individual conceptualizes himself, others, and the world, it is obvious that he must disclose himself. Everyone discloses a great deal about himself nonverbally, but few know how to understand and use this skill productively. The challenge is to encourage people to overcome the fear of disclosing themselves verbally. Consequently, the director must be sensitive to the patient's ability to defend against disclosing himself openly and must be able to judge quickly and accurately aspects of the individual (such as self-esteem and social interest) from his nonverbal behavior. For many patients it is a totally foreign idea that they should talk about the way they feel about themselves, others, and the world. There are others who are only too happy to express all their views but not their responsibilities. In choosing appropriate action therapy techniques, the therapist must be able to adjust to both extremes.

Techniques such as modeling self-disclosure are helpful in working with the patient to whom revealing his thoughts is an alien idea. The therapist can proceed from a nonthreatening technique, modeling self-disclosure while the patient observes, to the next step, modeling self-disclosure while the patient doubles, until the patient takes over and presents others and, finally, himself. The ultimate in techniques for developing social interest is when the patient experiences playing others, faced with his own demands, which are being mirrored by another. Once the patient begins revealing himself or begins the process of self-disclosure, it is possible for the director and others to begin identifying some of the negative nonsense they create and the consequent mistakes they make. The patient then becomes more capable of seeing how others are making the same or different mistakes. In either case, a common ground is established which helps each individual feel less isolated.

The next natural step in therapy is practice in giving others in the group feedback about what they observe in their behavior and guessing at their negative nonsense. If the patient can learn to think in terms of "demands on others," he can not only see this in himself but will be able to identify this characteristic in others who are significant to him. Practice at recognizing the mistakes that others in group are making and giving them feedback sensitizes the patient to such an extent that he will possibly be capable of observing his family interactions more objectively and intervening in his situation by appropriate feedback and encouragement. In other words, help each person contribute to another's self-esteem in a positive way and help them feel more a part of humanity and thereby increase their social interest. The same essential elements are stressed for the patient whether the topic is discovering mistakes people are making or reinforcing helping actions toward others. He must observe what he thinks the other is communicating verbally and nonverbally. The conceptual system used in action therapy teaches patients to become aware of the purpose of interpersonal behavior. Truly effective therapy is only the beginning of a process which the patients take with them.

Successful action therapy teaches the patient a sense of humor. Its use implies that the patient himself is not derogated, even if his actions are. He can, with help, learn to find esteem in more socially cooperative ways. Faith in the Adlerian lifestyle gets the therapist out of the rut of cloying pity for the patient, who is not a lower-order nitwit. Educating the patient in humor increases that of the therapist and is a sparkling and rare example of social synergy. A sense of humor is the polar opposite of the pathological demand. The humorist feels the shock of thwarted expectations but has outsight into the needs of others. He can disinvolve himself sufficiently from his space and time malaise to develop a "god's-eye view." A habitual sense of humor hinges on adequate self-esteem, social interest, and a playful aloofness from the seductive security of polarities, dualities, and abstractions (e.g., "Kill the commies, devils, blacks, yellows, whites, etc."). The humorous attitude, the epitome of love, respect, and independence can be taught. Action therapy takes a significant step toward teaching humor through the models of the director and the auxiliaries and through the role reversal technique.

An especially useful humorous technique combines role reversal and mirroring. When a patient *demands* esteem from others without outsight and cooperation, he is told to reverse roles and play the other person. The director warms the patient up to play this significant other, then selects an auxiliary to mirror the patient. The latter is then faced with interacting with "himself," a situation never experienced in daily living. The mirror should caricature the patient's demands and movements in condensed form (condensation is another mechanism of wit). The mirror, by exaggerating, understating, and condensing, gets the point across with a shocking performance. The protagonist, now playing the "rejecting" significant other, hears a rapid condensation of paradoxes; for example, "I love you and want you to be happy but raise the kids anyway. But do as I say and don't let me know you're making decisions. Tell me everything you do and how great I am but don't bother me or I'll shut up and think about things that will make me depressed." Condensing all the protagonist's contradictory, defeating attitudes and demands is without equal in getting a point across with laughter. Wit and humor are purposively used in action therapy, and good sessions are characterized by heightened attention and laughter. The veteran director often uses laughter for reducing group tension by pointing to ludicrous actions (but never implying that the patient is inferior.)

Applications

Action therapy has been used with all types of people, from actualizers to chronic schizophrenics, in all types of settings, from universities and churches to jails and mental hospitals. Its premise is that there is no unit of one and all human problems are social problems. The emphasis on movement and what the person cannot or will not do (e.g., cooperate as an equal or practice a sense of humor) focuses the professional on present action or inaction as a

route toward lifestyle diagnosis. The lifestyle is constructed chiefly from here-and-now action in real or simulated situations rather than inferred from one's present attitude toward the past. Since there is no group excluded from orthodox psychodrama, so there are no persons barred from action therapy, a close cousin in social psychotherapy.

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