Clinical psychotherapy and acting-out

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1. Introduction

In the following exposition I will try to demonstrate to you some of my ideas on clinical psychotherapy and acting-out. To facilitate the possibility of discussion I will end by witnessing from clinical experience.
I am a psychoanalytically trained psychiatrist, psychotherapist and group psychotherapist with about ten years experience in the residential psychoanalytic treatment of neurotic and borderline patients.

I hope it will become evident that the holding, the containment and interpretation of acting-out is the principle strength of residential psychoanalytic treatment.
That the setting of clinical psychotherapy is a quintessential instrument in the psychotherapeutic handling of this kind of problems.
That on the other hand the ubiquity of acting-out and action symptoms, the severity of psychiatric disturbance and/or the limited introspective and/or symbol formation capacities of these patients make ambulatory psychoanalytic therapy difficult if not impossible.
Whereas it is my conviction ànd experience that a true psychoanalytic process with these patients can be developed given the specific clinical psychotherapy setting.
Moreover I believe that clinical psychotherapy allows for the integration of psychiatric intervention within a psychoanalytical framework.

2. Clinical psychotherapy and acting-out

In order to avoid useless misunderstandings I will start by specifying what I mean by clinical psychotherapy, a concept that in its narrow sense is coined in the Netherlands and that may be considered to be a *specific type of applied psychoanalysis* within the psychiatric institution. While talking about it I will implicitly refer to Dutch authors like Jongerius, Rylant, Janzing and Lansen (1985, 1989).

First of all this clinical psychotherapy has to be distinguished from the not uncommon practice of psychotherapy *within* the clinic. Psychotherapy that is offered to in-patients alongside other kinds of therapies such as occupational therapy, psychomotor therapy etc. but in an *isolated, un-integrated* way.

In contrast to psychotherapy *in* the clinic clinical psychotherapy means psychotherapy *via, by means of* the clinic.

One might say that the whole of the therapeutic milieu is structured along psychotherapeutic lines and according to psychotherapeutic principles.
Every therapy, activity, patient-staff encounter and even the total atmosphere of the ward is *cohesively and coherently integrated within a psychotherapeutic project*.
As such it is only operational in a minority of psychiatric institutions.

Moreover clinical psychotherapy should also be *distinguished* from the so-called *institutional psychotherapy*, or in the French original 'la psychotherapie institutionelle', which is characterized by the installation of psychoanalytical *ethics* in a psychiatric institution employing itself mainly by treating the *psychotic* patient.

Whereas clinical psychotherapy is characterized not only *ethically* but also *methodically* by clear boundaries, strict therapeutic rules and the dis-covering and working-through of transference relations among patients and between patients and staff-members.

Classically patients in clinical psychotherapy situate themselves within the *neurotic* and *borderline* spectrum of psychopathology.

For therapists like me, who are working within clinical psychotherapy units acting-out is not something to be avoided, not something undesired, pejorative, a phenomenon to be wiped out. On the contrary we consider it to be *the stuff that our work is made of*. After all it often is the or one of the reasons why a person is hospitalised, treated on an in-patient basis.
Need I remind you of suicide attempts, fugue, automutilation, aggressive or sexual acting-out that so frequently prompt a psychiatric emergency, ergo hospitalisation.

Acting-out provides material that is alive, in vivo and can often be one of the ways by which the Unconscious expresses itself.
As such it may be said to be *equivalent* to the symptom, the parapraxes, the dream etc.

Sometimes it may be what the French call a *'passage à l'acte'* or what the Bionians might call an evacuation or expulsion of beta-elements, i.e. *un-mentalised impulse* or *traumatic content*.
In this case also it can be categorised as a product of the Unconscious.

In a clinical psychotherapy unit acting-out is granted a space and a *raison d'être*.
On the other hand there are sufficient boundaries and rules not so much intended to eliminate acting-out but to *minimize possible damage* to self, to others and to the therapeutic alliance.

Furthermore these boundaries and rules enable the staff to hold and contain and make it possible to interpret acting-out as a *signifier*.

All this doesn't mean that acting-out is stimulated ! After all a culture of talking is established, therapies and activities are offered to allow non- or preverbal expression and consequent upholding of the Law creates *as much civilisation as possible*.
All of the therapeutic activities are offered in the same treatment group and so is psychoanalytical psychotherapy.
Thus the diversity of transferences and repetition is experienced in vivo and can be contained, lived, worked and acted through within the group and within the ward.
It is this peculiarity that accounts for one of the major assets of clinical psychotherapy, especially in handling acting-out.
This handling of acting-out is a *joint staff effort*.

In the staff-meetings there is continuous reflection, striving for insight and integration of various, diverse and often splitted unconscious processes within the individual, the group and/or the whole of the ward.

The capacity to think of the staff is constantly threatened although this capacity is essential, a conditio sine qua non to keep on doing 'our work' which is to hold, to contain, to interpret and to intervene.

It may be argued that the function of the staff is similar to the function of the individual psychotherapist.
Important differences are the *severity of the psychiatric psychopathology*, sometimes necessitating farmacological treatment as an essential a priori for a psychoanalytic process to be made possible.
Severity of acting-out (suicidal impulse, automutilation etc.)
may also necessitate the integration within the psychotherapeutic process of *limit-setting* procedures, to be agreed upon by patient and the nursing staff.
Perhaps the most important difference is the fact that acting-out manifests itself *within* the clinical psychotherapy milieu, i.e. within view of the staff-members and as such it provides often very valuable information about the patients' Unconscious.
A staff functioning properly reminds me of the French statement : 'Du *choc des idées jaillit la lumière.' ;* the whole is more than the sum of
its parts.

3. Acting-out

Acting-out as a concept causes considerable *controversy* on a definition level.
First and foremost I think this is due to *language* and *translation* difficulties. In German : agieren, abreagieren. In French : acting-out, passage à l' acte, mise en acte, acte manqué. In English : acting-out, enactment, action symptoms etc.
Confusion around the the acting-out concept can also be explained by the evolving changes in opinion and in valuation or devaluation of the phenomenon.
These changing perspectives occurred during the lifetime of Freud but maybe especially after Freud in the so diverging views of (for example) the Lacanian and (post)Kleinian schools of psychoanalysis.

As we all know Freud introduced the term agieren in '*Remembering, repeating and working-through'* (1914*).*
It is described as a mechanism by which the patient expresses drive, fantasy, desire in an action and it is introduced in close connection with phenomena such as resistance, transference, repetition compulsion and remembering.
Often the patient *acts* instead of associating freely, instead of remembering. He gives in to repetition compulsion, repeats without realising thàt he repeats. Resistance manifests itself as transference *actions*.

In *'Inhibitions, symptoms and anxiety'* (1926) Freud describes different types of resistance. Whereas he considers the transference resistance as a resistance coming from the Ego, repetition compulsion is supposed to be coming from the Id. It is this repetition compulsion that makes working-through such a difficult and time-consuming process.

On the one hand agieren according to Freud is *part of every psychoanalytic process*, accompanying transference phenomena, on the other hand and later on in his writings agieren is considered to be the *trademark of certain patients* who tend to act out their impulses outside of the treatment situation.
Here Freud considers agieren as the *enemy* of the psychoanalytic work, instead of viewing it as a necessary and inevitable by-product.
In his Outline (1938) he puts forward the ideal that the patient behaves 'normally' outside of the treatment situation.

According to the Vocabulary of Laplanche and Pontalis (1967) acting-out is defined as actions having an impulsive character, experienced as discontinuous with habitual motivation and identifiable as more or less isolated phenomena within the global activities of the patient. They often have an auto- or allo-aggressive component and from the part of the analyst they are considered to be a return of the repressed.
When they occur during therapy, they have to be understood in connection with the transference, often as a radical attempt to deny it.

Mise en acte or enactment can than be reserved for the translation of agieren in the first sense : to put impulses, fantasies or desires into action. Acting as transference actions i.e. as a form of resistance and/or repetition compulsion.
This rather *neurotic repetition* should by the way be distinguished from *posttraumatic repetition* as an effort to belated mastery of the traumatic experience : agieren as abre-agieren, whereby the traumatic affect is abreacted in a cathartic moment.

Some acting-out can be considered to be familiar to *parapraxes*.
An act one wants to perform is substituted by another act as a result of intrapsychic conflict. It may also result in a disruptive phenomenon that is at once isolated and ephemeral and that may be akin to acting-out.

Laplanche and Pontalis call it a challenge for psychoanalysis to make a distinction between acting as transference and acting as acting-out.
One might wonder –the say- whether impulsive actions in everyday life cannot be interpreted as transference actions.
Working in a clinical psychotherapy setting I would be inclined to answer this question positively.

Psychoanalytic thinking did not stop with Freuds' death.
Classical *indication criteria broadened* to children, psychotics, forensic psychiatric patients and so on.
Treatment settings were adapted to the specific needs of different types of psychopathology.
Correspondingly the view on agieren and acting-out has evolved and acting-out gradually gained a *less ominous*, more constructive connotation.

Already in 1930 Alexander withheld some patients whose life consists of actions that are not adapted to external reality, but that rather serve to diminish intrapsychic tensions.

Not only there exists acting-out within or outside of the treatment as a manifestation of resistance and/or transference.
We also have acting-out as an *ingredient* of certain personality disorders that were not originally an indication for psychoanalytic treatment.

In her paper *'General problems of acting-out'* (1950) Phyllis Greenacre considers acting-out *a way of* remembering, especially
in patients with a limited verbal potential, low frustration tolerance, traumatic life-history etc.

Joyce Mc Dougall (1986) mentions so-called *action symptoms* : patients who compulsively and repetitively act out in order to solve internal tensions. Their symbol formation is limited, they cannot contain painful emotional experiences and are weak in the constructive use of fantasy.

In the 60's authors like Masud Khan and James have stressed the *positive aspects* of acting-out, considering it one of our chief clinical allies. Acting-out is viewed as a form of unconscious communication, rather than as a type of resistance.
This has to be understood as a result of Kleinian and post-Kleinian theory and more specifically of the Kleinian view on transference.
Kleinian analysts have an astute eye for the *unconscious manifestations of transference*.
Transference phenomena are understood as the enactment of unconscious fantasies that have their roots in the most archaic layers of our psychosexual development and they often relate to partial or splitted drives and/or objects.

Acting-out is always accompanied by *affect* ; it offers us a very real and lively psychic reality and it very often can lead to genuine insight, when analysed adequately, be it as 'memories in feeling' or as highly condensed microscripts.

In order to situate acting-out we perhaps ought to remember a statement that Freud made at the end of *'Totem and Tabu'* : Am Anfang war die Tat.
In our ontogenetic prehistory that is and not in our filogenetic prehistory. As a baby we all cried, hurled, peed, kicked and defaecated.
The baby acts.
Thought developed later on, as trial-action.
After all, the in-fant does not yet have words at his disposal to communicate.

According to Bionian theory thoughts can only be born given an adequate balance between frustration and containment, good- and bad-enough mothering.
If this delicate balance is not met intrapsychic content is *not mentalised, but evacuated*. Beta-elements are not transformed through alpha-function into elements for thought or to put it in a Lacanian way : the child is 'victimized' by the Real.

As I mentioned earlier I am inclined to consider acting-out to be a means of expression of the Unconscious alongside and *equivalent* to others.
Also I can agree fully with my colleague Dr. Vansina, who differentiates acting-out from *acting-through*.

In acting-through there is a component of creativity and of enjoyment. It can be a *means of working-through*, not on the Ego level, but on the level of the Unconscious.

She proclaims that the patient can contribute to his becoming-a-subject by means of actions that have symbolic meaning and that can be regarded as a language that the Unconscious speaks ànd understands.
It is in agreement with the Lacanian view : acting-out as a demand for translation directed towards the Other.

Indeed, Lacan differentiates *three modes of acting*.
First there is '*passage à l'acte'*. It is originally a concept springing from French psychiatry and reserved to a violent or criminal impulsive act. In Lacans' view it is an impulsive act without any reference to the transference, impossible to be brought into the symbolic.
In this passage à l'acte the subject throws itself into total rupture, identifies with the traumatic Real.
One might say that the Real, the trauma has become Flesh.
Maybe Bion would call this evacuation proper.

Secondly we have *acting-out*, to be understood as a demand for symbolisation, addressed to the analyst.
A moment of folly to avoid fear and according to Lacan often related to a kind of failure not only on the part of the patient, but also –as he specifically points out- on the part of the analyst.
Exemplary is the case of Dora.

Finally we have the *act*.
Act being a construction wherein the patient takes up his own responsibility for his own desire, somehow identifying with it. He knows what he wants and he knows what he does.
Acting-out was blind. Desire imposes itself without the conscious awareness of the subject.
Whereas the act is conscious. It is a way of generating sense and meaning allowing the subject to transform retroactively, nachträglich, après-coup.

It provides us with an interesting hierarchy and implies a different practice on the part of the analyst.
Passage à l'acte : holding and containment.
Acting-out : interpretation.
Act : a rigorously sustained neutrality, leaving the patient the possibility to make his own choices and decisions and taking up the responsibility for them.

Like I promised, to conclude and to facilitate further discussion I will end by witnessing from my clinical experience as coordinating psychiatrist and psychoanalyst within a clinical psychotherapy unit.

4. Clinical experience

Needless to say that various *acting-out* behaviour often *prompts in-patient treatment* : fugue, suicide attempt, automutilation, aggression dyscontrol, sexual acting-out, substance abuse and so on.

Consequently we have got to *accept* the fact that this kind of behaviour is *liable to repeat itself* during residential psychoanalytic treatment and that we will have to find constructive ways of coping with it.

Patients who have predominantly pre-oedipal features, often very limited symbol-formation or mentalisation capacities and who more broadly speaking are wrestling with problems dating in preverbal psychosexual development (i.e. *when they could not yet talk)* initially have little other means of communication than deeds or actions.
They have not yet learnt to speak and they have to be contained within *a mother tongue environment*.
Also they can profit significantly from *non-verbal expressive ther*apies so as to develop symbol-formation and the constructive use of fantasy.
Evacuation and expulsion of intrapsychic content can gradually be transformed or so to speak up-graded to higher levels of communication.

This phenomenon of evacuation or expulsion so common in clinical psychotherapeutic practice more seldomly reaches its peak in the *cataclysm* of le passage à l'acte, whereby the patient identifies with the Real in the Lacanian sense.
This Real may be pure death-drive, resulting for example in violent suicide or in a destructive rage, resulting for example in a dramatic living-room redecoration.
Or this Real may be pure trauma, for example in the mechanism of identification with the agressor or with the offender when the acting-out involves or produces a new and innocent victim.
In this last instance one could also consider this to be a manifestation of projective identification.
Elaborating a Kleinian perspective one might even wonder if passage à l' acte couldn't be the realm of partial drives and partial objects.

Transferences in the clinical psychotherapy unit manifest themselves as actions. Dependency towards certain staff-members, oral greediness, conflicts over power or authority, sibling rivalry, they are all repeatedly enacted, mises en acte.

Acting-out may have pretty sound symbolic meaning. I have in mind an extremely regressed patient, son of a depressive mother and an anal father. The behaviour of this patient could be interpreted as follows : 'Do this, do that ? Shit ! I do nothing. Take care of me !'
There was this young lady who felt abandoned by her cold demanding mother, suppressed her anger, but each night attacked
the refrigerator.
Or there was this girl entering the ward on admission with automutilation scars all over her face, like a fucked-up bloody Mary.
Her psychosexual development indeed was devastated by an ongoing incestuous relationship with her elder brother.

Action can be abre-action of trauma. After all anger and rage towards the rapist cannot be ventilated with a stiff upper lip and inevitably implies some motor discharge.

Acting-out can be closely akin to a parapraxis. A patient who had sex with several female co-patients during residential treatment and who had a dangerous liaison with his niece who happened at that time to be working in our hospital, fled away from psychotherapy.

A year later he had an accident at word. With some uncanniness he stuck a red hot bar into a test-tube, thereby injuring and burning his hand seriously. He interpreted this himself : I have got to continue my psychoanalytic treatment ; to play with fire is to ask for punishment.

Action can have the characteristics of acting-through. Docility and submissiveness transforming into revolt or an infantile personality resembling a latency child experiencing a first love during residential psychoanalytic treatment. Isn't this to be considered growth rather than acting-out ?

Action may sometimes be considered an act : the loyal and devoted husband, masochistically dependent on his castrating spouse starting up divorce during his psychoanalytic process.

Action finally can also be situated on the group level instead of on the individual level. I refer to one of the basic assumption groups that Bion defined in his *'Experiences in groups'* as the fight-flight group or the schizoid-paranoid group.
Individual group-members are sucked up in a gang intent on fighting or fleeing the imaginary enemy that can be located within or outside ot the group and there is a tremendous pressure for action.
Mutatis mutandis there may be extreme passivity and dependency from the group towards a formal or informal leader, which may be interpreted as an non-active acting-out. Bion called this the dependent basic assumption group. In both cases acting-out is an epiphenomenonon of group transference.
But I guess the following speakers will delve deeper into these group dynamic forces, so I will leave it at this.