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Rational behavior therapy for acting-out adolescents

Persistent, neurotic emotional conflict
is a cause of the behavior whose specific episodes are
described as following a six-step sequence

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Before acting-out adolescents can be treated rationally, they must be accurately diagnosed. Otto Fenichel was one of the first psychoanalysts to see that acting-out is not unique to patients undergoing psychoanalysis.[1] He, and later Phyllis Greenacre, correctly saw acting-out as a common neurotic habit.[2] The people most likely to exhibit it have three outstanding behavioral tendencies: (1) Although they deny that they believe in magic, they act as if they do believe in it; (2) without realizing it, they often mix inappropriate past memories with present reality; and (3) they prefer rigid patterns of repetitive behavior to new adaptive learning.

Those clinical insights made it clear that acting-out of repressed memories and acting-out of current neurotic emotional conflicts are merely different forms of the same psychic events. That knowledge led to precise criteria for a positive diagnosis of acting-out[3] that therapists of different theoretical backgrounds could use. Furthermore, it enabled therapists to produce a differential diagnosis of adolescents, based primarily on their behavioral patterns as opposed to their unconscious dynamics. A clinically useful differential diagnostic system distinguishes five types of adolescents:

adolescents who act out (neurotic adolescents)
adolescents who act up (normal adolescents)
adolescents who act bad (antisocial adolescents)
adolescents who act for real (psychotic adolescents)
adolescents who act *their* best (mentally defective adolescents)

To use this system well, mental health professionals must view adolescents as developing, whole people. Although adolescents respond to numerous psychological forces that they do not understand, their somewhat fluid personality has a definite framework and structure. That fact makes the most significant, observable adolescent behavior almost always fit into one definite type of basic personality structure. That basic personality structure causes definite behavioral clusters or patterns that enable perceptive therapists to make positive, differential behavioral diagnoses.

Diagnosing acting-out adolescents

A complete, accurate history is the best clinical aid in diagnosing all five groups of adoles-

[1]Otto Fenichel, Neurotic Acting Out, *Psychoanalytical Review*, 32:197–206 (April 1945).

[2]Phyllis Greenacre, General Problems of Acting Out, *Psychoanalytical Quarterly*, 19:455–67 (Winter 1950).

[3]Merrill Eaton and Margaret Peterson, *Psychiatry*, Medical Outline Series, 2d ed. (Flushing, N.Y.: Medical Examination Publishing Co., 1969), p. 174.

cents. Acting-out adolescents are neurotic, and their history usually shows it. There will be clear-cut evidence of persistent emotional conflict—usually anxiety or some of its derivatives (tension, feelings of inferiority, guilt, depression, and so forth). Their emotional conflict will usually have a fairly definite date of onset.

Rather than a single precipitating event, there is more likely to be a precipitating stressful life period lasting from several weeks to several months. Ego boundaries and reality-testing will be normal. Disability varies from mild to severe, but it is usually confined to only one or two life areas.

Persistent, neurotic emotional conflict causes acting-out behavior, and specific episodes of it typically follow this six-step sequence:

an increase in the core neurotic emotional conflict
a stereotyped behavioral attempt to relieve that neurotic emotional conflict
a temporary decrease or complete relief from the core neurotic emotional conflict
secondary guilt feelings, if the acted-out behavior is socially unacceptable
resumption of core neurotic emotional conflict
cyclic repetition of the previous five steps

Acting-out behavior is repetitive for two main reasons. First, it produces temporary relief from the core neurotic emotional conflict. That temporary relief reinforces the acting-out behavior in the same way that the temporary relief from emotional conflicts produced by alcohol or psychoactive drugs reinforces their own habitual use and, often, ultimate abuse. Second, the core emotional conflict invariably resumes, initiating a new cycle of acting-out behavior.

Distinguishing acting-up (normal) adolescents

Carefully taken case histories of acting-up (normal) adolescents reveal neither significant disability in any life areas nor evidence of persistent emotional conflict. The questionable behavior of normal adolescents is usually rebellious, reflecting a definite but transient interpersonal conflict, usually with a parent or some other authority figure. The rebellious behavior is not likely to be repetitive or stereotyped. It is usually a logical but immature reaction to the external precipitating event. If the acting-out behavior is socially unacceptable, normal adolescents will have appropriate feelings of guilt.

Guilt, triggered by socially disapproved behavior, usually has a different effect on normal adolescents than on neurotic (acting-out) adolescents. In normal adolescents, such guilt is a stimulus to seek forgiveness and try to achieve mutually acceptable, compromise solutions to the interpersonal conflict. In neurotic adolescents, such guilt usually acts as a stimulus to reinitiate the acting-out behavioral cycle.

Whether normal adolescents succeed or fail in their attempts to achieve an acceptable compromise solution to their interpersonal conflicts, they soon stop rebelling. They return to their preconflict patterns of satisfactory interactions with their significant others.

Distinguishing acting-bad (antisocial) adolescents

Carefully taken case histories of acting-bad (antisocial) adolescents usually reveal little or no evidence of persistent emotional conflict. These adolescents almost always come for psychological evaluation under court order because of a history of several of the following:

maladaptive behavioral patterns in all life areas (home, school, social life, work, and so forth)
abuse of alcohol or other drugs
multiple deviant sexual behaviors
refusal to postpone immediate pleasure for possible greater pleasure later
extremely low frustration tolerance
little or no apparent learning from past failures
few or no lasting personal relationships
minimal or no apparent guilt feelings regarding their behavior
consistently poor judgment
poor school and work record
multiple legal difficulties

Distinguishing acting-for-real (psychotic) adolescents

Psychotic adolescents are usually brought involuntarily by their families to psychological evaluation because of a history of grossly abnormal behavior. With such adolescents, differential diagnosis is usually not difficult. The peers of such psychotic adolescents will have diagnosed them as "crazy" long before mental health professionals are consulted.

Psychosis involves the total personality. Therefore, psychotic adolescents usually have moderate to severe disability in all life areas, largely because they inaccurately perceive, and incorrectly interpret, reality. Without realizing it, they confuse reality with their fantasies, fears, and hopes about it. Still, their confused perception of reality is all they have to direct their reactions to it. That is why the phrase *acting-for-real* accurately describes psychotic adolescents. They believe and act as if their inaccurate perceptions and incorrect interpretations of reality are actually valid, a fact that explains their four other outstanding characteristics: disorganized thoughts that have weird content; judgment that is not only poor, but bizarre; delusions; and hallucinations.

Mental health professionals are usually able to understand psychotic adolescents, but rarely able to empathize with them, probably because psychotic adolescents often trigger an involuntary emotional withdrawal in others. For experienced mental health professionals, that involuntary emotional withdrawal is markedly different from the involuntary emotional reaching-out usually experienced with normal and neurotic adolescents. In borderline cases, where other signs and symptoms are unclear, this "soft" sign can be useful; at least it should keep the mental health professional more alert to the real possibility of a frank psychotic break in some future stressful situation.

The most common causes of psychosis in adolescents are schizophrenia and organic brain syndrome resulting from the use of alcohol and other drugs. Because of the seriousness of these diagnoses and the possible need for drug or other somatic therapy, every suspected psychotic adolescent merits a thorough psychiatric evaluation. Such an evaluation will usually reveal the less common causes of adolescent psychosis.

Distinguishing acting-their-best (mentally defective) adolescents

Except in borderline cases, mentally defective adolescents are fairly easy to recognize. They are usually brought to psychological evaluation by their families with a history of inappriate behavior and retarded or subnormal social or academic progress. Often, past history reveals grossly subnormal physical, social, and academic growth and development. All cases merit thorough medical evaluation and intelligence and psychological testing.

Clinical insights into acting-out adolescents

Acting-out adolescents are as likely to be brought involuntarily for psychological evaluation because of family or school pressure as because of legal pressure. On their own, acting-out adolescents rarely ask for professional help. When they do, their request is more likely to be a subtle form of acting-out than a sincere desire for therapeutic change. That fact is easy to understand if one remembers the outstanding behavior habits of acting-out adolescents: behavioral commitment to magic, an inappropriate mixture of past memories with present reality, and the preference for rigid patterns of reactions rather than adaptive new learning.

For therapeutic change, acting-out adolescents must replace those habits with more adaptive ones. Because they usually do not want to alter their habits, they rarely come voluntarily to psychotherapy and often will not voluntarily cooperate sufficiently in psychotherapy to make therapeutic progress.

The core problem of acting-out adolescents is persistent, neurotic emotional conflict. Unlike acting-up (normal) adolescents, who try to think their way out of emotional conflict, acting-out adolescents try to act their way out of emotional conflict. That fact makes acting-out adolescents a greater potential danger to themselves and to others than normal adolescents. Consequently, acting-out adolescents

need more external direction and structure and greater limits placed on their areas of personal choices than normal adolescents need.

To effect therapeutic change in acting-out adolescents, therapists must have clearly established therapeutic authority over them. Ideally, therapists will be able to give acting-out adolescents the choice of immediate reinforcement for appropriate therapeutic cooperation or immediate penalty for lack of it. The difference between the possible reinforcements and possible penalties needs to be definite and significant—for example, loss of allowance or a weekend in jail, for missing appointments, versus receiving their allowance or having personal freedom, for keeping appointments. Given those choices, acting-out adolescents will usually choose to cooperate quickly with minimal conflict.

Persistent neurotic emotional conflict keeps the acting-out cycle going. Identifying and eliminating that conflict should be the first therapeutic task. The careful taking of a case history is the quickest way to identify the core conflict, and giving acting-out adolescents psychotropic drugs is the quickest way to suppress it. Although drugs give only temporary relief and can turn acting-out adolescents into drug-dependent, acting-out adolescents, the use of drugs is sometimes necessary. Rational therapists, however, do not substitute drugs for consistent, diligent efforts to get therapeutic change without them.

Such clinical insights indicate that the best type of psychotherapy for acting-out adolescents has the following five features:

1. It enables therapists to work as effectively with involuntary patients as with voluntary patients.

2. It eliminates emotional conflict without the use of drugs.

3. It teaches involuntary patients mature decision-making skills.

4. It allows therapists to exercise sufficient therapeutic authority over adolescents to insure consistent, appropriate therapeutic cooperation.

5. It enhances healthy adolescent strivings for progressive self-actualization.

Rational behavior therapy (RBT) has those five features.[4] RBT is based on the learning theories of Orval H. Mowrer, James G. Holland, B.F. Skinner, Julian B. Rotter, and Donald O. Hebb.[5] The basic hypothesis in RBT was enunciated by Epictetus two thousand years ago: It is not facts or events that upset man, but the view he takes of them.

RBT has three clinical concepts that enable acting-out adolescents to make therapeutic use of the insight of Epictetus: the rational behavior theory of human emotions, the five rules used in RBT to recognize rational attitudes and beliefs, and the idea that therapeutic self-help is one of the most important aids to efficient therapeutic progress.

In most situations, people are usually more likely to react logically to their emotional feelings than contrarily to them. Acting-out behavior is the logical result of the painful emotional feelings that trigger it. The RBT theory of human emotions is that people change their emotional feelings without drugs only by changing their attitudes and beliefs—that is, their habits of thinking. For that reason, RBT for acting-out adolescents focuses on getting them to change the habits of thinking that cause their painful emotions. Then, their secondary acting-out behavior disappears.

Getting acting-out adolescents to understand those facts is the first step in their RBT. Then, the RB therapists teach the adolescents the five rules for recognizing rational thinking.

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[4] Rational behavior therapy (RBT) is also called rational emotive therapy (RET). See Albert Ellis, *Reason and Emotions in Psychotherapy* (New York: Lyle Stuart, 1963).

[5] Orval H. Mowrer, *Learning Theory and Behavior* (New York: John Wiley and Sons, 1960); idem, *Learning Theory and the Symbolic Process* (New York: John Wiley and Sons, 1963); James G. Holland and B. F. Skinner, *The Analysis of Behavior* (New York: McGraw Hill, 1961); B.F. Skinner, *Verbal Behavior* (New York: Appleton-Century-Crofts, 1957); Julian B. Rotter, *Social Learning and Clinical Psychology* (New York: Prentice-Hall, 1954); and Donald O. Hebb, *The Organization of Behavior* (New York: John Wiley and Sons, 1959).

The five rules for rational thinking

Thinking is rational if (1) it is based on objective reality, (2) it causes people to protect their lives, (3) it enables people to achieve their goals most efficiently, (4) it keeps people out of significant trouble with other people, and (5) it prevents significant personal emotional conflict. To use the five rules well, people must know how much conflict or trouble is *significant*: Significant conflict is the amount that they do not want to have and that they act to avoid. Learning the five rules for rational thinking usually leads most acting-out adolescents quickly to five useful insights:

1. What is rational thinking for some people may not be rational thinking for other people.

2. What is rational thinking for people at one time may not be rational thinking for them at another time.

3. In each situation, people have the responsibility of deciding for themselves what seems to be rational thinking for them. RBT teaches acting-out adolescents to make that decision with ease and confidence.

4. No one can have perfectly rational thinking all of the time. Thinking needs to meet only three of the five rules above to be called rational.

5. Rational thinking creates optimum emotional health. It is almost impossible to think of a useful meaning of *optimum emotional health* that does not include or imply the five rules for rational thinking.

Therapeutic self-help

Rational behavior therapy teaches people to help themselves as much as possible—mentally, emotionally, and behaviorally. Most acting-out adolescents like that idea. They especially like the ever-increasing feeling of self-mastery they get by using the rational self-help techniques.[6] The most important of those self-help techniques are the *ABC*'s of rational self-analysis (RSA):

A Facts and events	*Da* Camera check of *A*
B Self-talk	*Db* Rational debate of *B*
1.	1.
2.	2.
3. (etc.)	3.
C Emotional consequences of *B*	*E* Emotional effects of *Db*

Instructions for doing RSA

On the left half of a sheet of paper, patients write *A*, the facts and events involved in a negative emotional experience. When patients do not have a current, negative emotional experience to analyze, they are told to analyze a recent past one. Next, they write *B*, the self-talk section. Here they describe their thoughts about *A*. For easy reference, patients number each sentence in the *B* section. Next, they write *C*, the emotional feeling section. Here, patients describe how they felt emotionally about *A* and *B*. Under the *C* section, they write the five rules for rational thinking.

Only then do patients write the *Da* and *Db* sections of the rational self-analysis. This is where they train themselves to recognize and replace irrational with rational thinking.

Before writing the *Da* section, patients first reread the *A* section. They then decide if the *A* section statements accurately describe what objectively happened. To make that decision, patients use the camera rule of thumb. They ask themselves: "If I had taken a moving picture of my *A* section, would I now see and hear all that I called facts?" If their answer is no, they correct the *A* section under *Da* until it describes only what a movie camera would have shown.[7]

[6] Maxie C. Maultsby, The Pamphlet as a Psychotherapeutic Aid, *Rational Living*, 3:31–35 (Summer 1969); idem, Routine Tape Recorder Use in RET, *Rational Living*, 5:8–23 (1970); idem, Rational Emotive Imagery, *Rational Living*, 6:24–26 (Summer 1971); and idem, Systematic Written Homework in Psychotherapy, *Psychotherapy: Theory, Research and Practice*, 8:195–98 (Fall 1971).

[7] The camera rule of thumb applies only to external events, but internal events like emotional feelings are factual events and can best be described in the *A* section. Statements like "I got angry" can be put in the *A* section. Even so, all emotional feelings are still to be described in the *C* section.

In the *Db* section, patients make a sentence-by-sentence rational debate of each *B* section sentence. If a *B* statement obeys three of the five rules for rational thinking, it is rational. So patients write, "That seems rational to me." If a statement does not obey three rational rules, patients change that statement to one that is both personally acceptable and also obeys three of the five rules for rational thinking. Next, patients write the *E*, the emotional goal section. Here they describe the new emotional feelings they want to learn to have in similar *A* situations. Finally, to get rational self-change after doing appropriate RSA's, patient must take the last therapeutic self-help step: They must consistently think and act according to the *Da* and *Db* sections of RSA. Their consistent rational behavior is the real cause of permanent therapeutic changes in their neurotic emotional conflicts. That therapeutic change eliminates any associated acting-out habits.

Case illustration

Richard B, a fifteen-year-old, ninth-grade student, was a typical quiet, good boy. He caused no significant problems at home or at school. After he had been in the ninth grade about three months, Richard appeared depressed. Both his parents and his teachers noticed that he had begun to be critical of himself more often and more strongly than usual. Usually, his self-criticism appeared justified, but sometimes it seemed somewhat exaggerated. However, as Richard had always been such a "nice, stable boy," people now thought that he was just developing a healthy sense of responsibility. Everyone was surprised, therefore, when Richard was arrested with three other teen-agers for stripping cars. The other three had several previous arrests, but Richard had none.

The psychologist assigned to juvenile court gave this evaluation:

> Richard B is basically a neurotic boy with severe feelings of inferiority. He was under constant emotional stress during the months he was in the delinquent gang. But he stayed in the gang because he thought being accepted by those "tough guys" would prove that he was no longer inferior, but actually superior.
>
> On the other hand, Richard believes that stealing is wrong. He therefore felt, and still feels, genuine guilt about the car strippings. The one time he tried to quit the gang, the members ridiculed him severely. Richard felt so bad about that, he begged to be taken back into the gang.
>
> In view of these facts and Richard's past history, I consider him to be a neurotic acting-out adolescent. Because his delinquent behavior seems to be a symptom of his neurosis, treating him as a simple delinquent would be inappropriate and possibly damaging to him. I therefore recommend strict probation for outpatient psychotherapy.

Richard was put on probation to a rational behavior therapist. In the first two sessions, the therapist taught Richard the rational concept of human emotions and the five rules for rational behavior. Then the therapist asked him to do a rational self-analysis of the time he had tried to quit the gang. The therapist wanted Richard to see the irrationality of his thinking when he decided to rejoin the gang and how more rational thinking would have kept him out of it.

In discussing a written RSA, patients read their *A* and *Da* sections. Then, they and the therapist discuss them. Next, patients read a sentence from the *B* section and the *Db* rational debate of it. Then, they and the therapist discuss the debate. That process is repeated through the *C* and *E* sections. Like most first attempts at RSA, Richard's was not perfect. But it was a good start at therapeutic self-help.

A Facts and events	*Da* Camera check of *A*
I tried to quit my gang because they wouldn't stop stripping cars. They called me bad names and laughed at me. That hurt my feelings so much that I couldn't stand it, so I begged them to take me back.	*That's what happened, so it must be fact.*

THERAPIST: I'd say that your camera was a bit out of focus. It's a fact that the gang called you names, but that fact did not hurt your

feelings. You hurt your own feelings by believing that those names really applied to you. If you had made the rational insight that those names really did not apply to you, you would have ignored them, just as you ignore the words *John* or *Alan*. You don't come running when you hear those names, do you?

RICHARD: No.

THERAPIST: Why not?

RICHARD: Because I know that's not me.

THERAPIST: Right. You ignore the names *John* and *Alan* because you know they don't apply to you. And the bad names you now upset yourself about don't apply to you either. That's why rational *thinking* will *cause* you to ignore them, too. In addition, you told an emotional white lie when you said you couldn't stand to be called names.[8] You did stand it. I mean, you didn't die from it, did you?

RICHARD: (*Laughing*) No, I didn't die from it, that's obvious. But I didn't like it either.

THERAPIST: That's irrelevant. It's never fun to be called names you don't like. But the point is, *the names* didn't kill you. Therefore, you did stand them, just as you had stood them many times before. That is, you stood them miserably; but you still stood them. Right? That wasn't the first time you'd been called bad names. Right?

RICHARD: Yes, I've been called names before.

THERAPIST: Okay, if you had pointed that out to yourself, instead of begging your way back into the gang, you might have started to stand silly names less miserably. What do you think about that?

RICHARD: I see what you mean. I never thought of it that way before.

B Self-talk	*Db* Rational debate of *B*
1. *I can't stand to steal.*	1. *That's rational.*

THERAPIST: Did you write the five rules for rational thinking after your *C* section?

RICHARD: No, I forgot.

THERAPIST: Well, can you tell me what they are?

RICHARD: Let's see, there's one about being real and staying out of trouble. (*Pause*) I can't understand it. I knew them as well as anything last week. I guess I need to review them.

THERAPIST: I agree. You can't think and react rationally if you don't know what rational means. I guessed that you had forgotten because your *Db*-1 statement disobeys the first rule for rational thinking: objective reality. The objective reality is that you can stand to steal. You stood *it right* up until you were arrested.

RICHARD: But I hated every minute of it.

THERAPIST: But you stood it. That's the only point I'm trying to make. You see, Richard, rational thinking is, first and foremost, accurate, factual thinking. You either can or can not stand something. If you can, then you are lying if you say you can't. Since you really meant that you hate stealing, it would have been more accurate to have said that. Then, had you added, "Because I hate stealing, I wanted to stop it," your statement would have been both truthful and rational. Do you understand?

RICHARD: I hear you, but it sounds to me like you're just playing a word game.

THERAPIST: Many people think that at first. That's probably why most first attempts at RSA's are not very rational. But let's go on to your *B*-2; I think after you've had time to think about it, you'll see that this is not a game.

B Self-talk	*Db* Rational debate of *B*
2. *I have to quit this gang.*	2. *That's rational.*

THERAPIST: I disagree; it's neither a rational nor factual statement. You did not have to quit the gang. You proved that fact by not doing it. You just tried to quit, then gave up. Again, I want to emphasize that rational thinking is factual thinking. You wanted to quit the gang, and you proved that by trying to quit. But you made yourself feel so miserable about trying to quit the gang, you went back. If you had thought, "It's in my best interest to quit this gang," your thought would have been rational.

RICHARD: But that's what I meant. That's why I say this rational stuff is just a word game. I mean, you know you have to do what's in your best interest.

THERAPIST: Oh no, you don't! And you proved that you don't by not doing it. Was rejoining the gang in your best interest?

RICHARD: (*Pause*) No, I guess it wasn't.

THERAPIST: But you did it. So you see, you don't have to behave in your best interest, but it's certainly the rational thing to do. That's why you need to begin thinking more rationally;

[8] In RBT, an emotional white lie is an obvious lie that feels true.

THERAPIST: Your *Db* debate is irrelevant to the rational solution to your problems. It sounds more like positive thinking than rational thinking. That is, it sounds like you're just trying to trick yourself into feeling better by thinking something that sounds good. Even if your *Db* thought is true, it won't help you see that your *B*-4 thought is not worth thinking. That's another reason you need to start thinking rationally: to see clearly which thoughts are worth thinking and which are not. In terms of helping you to stop feeling miserable about silly names, neither your *B*-4 nor your *Db*-4 statement seems to be worth thinking.

A more rational debate of your *B*-4 would be, "I can stand to be laughed at. I just don't like it. Nobody put me down, and I don't know how a filthy louse feels. That makes my *B*-4 thoughts not worth having. I'd feel much better about myself if I stopped thinking that way."

B Self-talk	*Db* Rational debate of *B*
5. *If I weren't such a yellow-bellied rat, I wouldn't feel so bad.*	5. *Maybe I can stop being a rat.*

THERAPIST: Again, both your *B* throught and your rational debate are irrational; they both say that you are a rat. That's not only an incorrect statement, it's a ridiculous idea.

B Self-talk	*Db* Rational debate of *B*
6. *I can't stand being a rat with no friends.*	6. *Maybe I can make new friends.*

THERAPIST: Here your rational debate is rational as far as it goes. But, you still didn't challenge your irrational belief that you are a rat. The objective reality is that you're not a rat. You're only a fallible human being; you always have been and always will be. So your *B*-6 thought is not worth thinking. If you had pointed that fact out to yourself, you would have been more likely to try to make new friends. That way, you probably wouldn't be in trouble now.

RICHARD: I see what you mean. It seems so clear now. Why didn't I think of it before?

THERAPIST: Because you didn't have the habit of thinking about your thoughts. Your habit was to get an idea and blindly act on it, with no thought about how rational the idea was.

RICHARD: Well, I didn't know what was rational.

THERAPIST: That's right! And you still haven't learned the five rules for rational thinking. That's why I advise you to follow the RSA format to the letter. That means writing the five rules for rational thinking immediately under each *C* section. That way you'll force yourself to learn them.

C Emotional consequences of *B*	*E* Emotional effects of *Db*
I felt like a dirty rat, and I couldn't stand it.	*Not to care what a bunch of thieves think about me. To like myself better.*

RICHARD: If I were to write my *C* section now, I'd put, "I felt angry and depressed, but I knew I could stand it." I'd leave out the bit about a dirty rat. That was really stupid when you stop and think about it. And I'd leave the *E* section as it is.

THERAPIST: Good! It looks as if you are beginning to get the hang of doing RSA's. Now do you see that RSA is not just a word game?

RICHARD: Yes, when you stop and think, you see it's really for real.

Richard was ideally motivated to help himself. He kept his therapy appointments, and he did at least two RSA's per week. Within three months he was beginning to overcome his feelings of inferiority. He made several new friends and began to enjoy himself.

After three months of individual rational behavior therapy, Richard's therapist suggested rational behavior group therapy without individual sessions. After three months of RB group therapy, Richard was discharged from therapy, and six months later he got off probation. He completed high school and is now in college doing well.

It is somewhat rare to find such a clear-cut grouping of only neurotic symptoms. Usually there will be one or two symptoms from one or more of the other diagnostic categories. When the differential diagnosis is in doubt, close observation is recommended while treating the adolescent as an acting-out adolescent. That diagnosis has a good prognosis, and treatment based on it is least likely to cause harm to the adolescent. If the diagnosis is wrong, that fact will usually become apparent within six to eight weeks in RBT. A thorough reevaluation and differential behavior diagnosis at that time will usually reveal the correct diagnosis.