Alfred Adler, 1870–1937

3 ADLERIAN PSYCHOTHERAPY

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OVERVIEW

Adlerian psychology, developed by Alfred Adler (who referred to it as Individual Psychology), views the person holistically as a creative, responsible, "becoming" individual moving toward fictional goals within his or her phenomenal field. It holds that one's life-style is sometimes self-defeating because of inferiority feelings. The individual with "psychopathology" is discouraged rather than sick, and the therapeutic task is to encourage the person to activate his or her social interest and to develop a new life-style through relationship, analysis, and action methods.

Basic Concepts

Adlerian psychology is predicated upon assumptions that differ in significant ways from the Freudian "womb" from which it emerged. Adler throughout his lifetime credited Freud with primacy in the development of a dynamic psychology. He consistently gave credit to Freud for explicating the purposefulness of symptoms and for discovering that dreams were meaningful.

The influence of early childhood experiences in personality development constitutes still another point of agreement. Freud emphasized the role of psychosexual development and the Oedipus complex, and Adler focused on the effects of children's perceptions of their family constellation and on their struggle to find a place of significance within it.

Adlerian basic assumptions can be expressed as follows:

1. All behavior occurs in a social context. Humans are born into an environment with which they must engage in reciprocal relations. The oft-quoted statement by the gestalt psychologist Kurt Lewin that "behavior is a function of person and environment" is a striking parallel to Adler's contention that people cannot be studied in isolation.

2. Individual Psychology is an interpersonal psychology. How individuals interact with the others sharing "this crust of earth" (Adler, 1931/1958, p. 6)[1] is paramount. Transcending interpersonal transactions is the development of the feeling of being a part of a larger social whole that Adler (1964b) incorporated under the heading of *Gemeinschaftsgefühl,* or social interest.

3. Adlerian psychology rejects reductionism in favor of holism. The Adlerian demotes part-functions from the central investigative focus in favor of studying the whole person and how he or she moves through life. This renders the polarities of *conscious* and *unconscious, mind* and *body, approach* and *avoidance,* and *ambivalence* and *conflict* meaningless except as subjective experiences of the whole person. That is, people behave *as if* the conscious mind moves in one direction while the unconscious mind moves in another. From the external observer's viewpoint, all part-functions are subordinate functions of the individual's goals and style of life.

4. *Conscious* and *unconscious* are both in the service of the individual, who uses them to further personal goals. Adler (1963a) treats *unconscious* as an adjective rather than as a noun. That which is unconscious is the nonunderstood. Like Otto Rank, Adler felt that humans know more than they understand. *Conflict,* defined as intrapersonal by others, is defined as a "one step forward and one step backward movement," the net effect being to maintain the individual at a point "dead center." Although people experience themselves in the throes of a conflict, unable to move, in reality they *create* these antagonistic feelings, ideas, and values because they are unwilling to move in the direction of solving their problems (Mosak & LaFevre, 1976).

5. Understanding the individual requires understanding his or her cognitive organization and life-style. The latter concept refers to the convictions individuals develop early in life to help them organize experience, to understand it, to predict it, and to control it. *Convictions* are conclusions derived from the individual's apperceptions, and they constitute a biased mode of apperception. Consequently, a *life-style* is neither right nor wrong, normal nor abnormal, but merely the "spectacles" through which people view themselves in relation to the way in which they perceive life. Subjectivity rather than so-called objective evaluation becomes the major tool for understanding the person. As Adler wrote, "We must be able to see with his eyes and listen with his ears" (1931/1958, p. 72).

6. Behavior may change throughout a person's life span in accordance with both the immediate demands of the situation and the long-range goals inherent in the life-style. The life-style remains relatively constant through life unless the convictions change through the mediation of psychotherapy. Although the definition of *psychotherapy* customarily refers to what transpires within a consulting room, a broader view of psychotherapy would include the fact that life in itself may often be psychotherapeutic.

7. According to the Adlerian conception, people are not pushed by causes; that is, they are not determined by heredity and environment. "Both are giving only the frame and the influences which are answered by the individual in regard to the styled creative power" (Ansbacher & Ansbacher, 1956). People move toward self-selected goals that they feel will give them a place in the world, will provide them with security, and will

[1] "1931/1958" indicates that the original date of publication was 1931 but that the page number refers to the reprint published in 1958.

preserve their self-esteem. Life is a dynamic striving. "The life of the human soul is not a 'being' but a 'becoming'" (Adler, 1963a, p. ix).

8. The central striving of human beings has been variously described as completion (Adler, 1931), perfection (Adler, 1964a), superiority (Adler, 1926), self-realization (Horney, 1951), self-actualization (Goldstein, 1939), competence (White, 1957), and mastery (Adler, 1926). Adler distinguishes among such strivings in terms of the direction a striving takes. If strivings are solely for the individual's greater glory, he considers them socially useless and, in extreme conditions, characteristic of mental problems. On the other hand, if the strivings are for the purpose of overcoming life's problems, the individual is engaged in striving for self-realization, in contributing to humanity, and in making the world a better place to live.

9. Moving through life, the individual is confronted with alternatives. Because Adlerians are either nondeterminists or soft determinists, the conceptualization of humans as creative, choosing, self-determined decision makers permits them to choose the goals they want to pursue. Individuals may select socially useful goals or they may devote themselves to the useless side of life. They may choose to be task oriented or they may, as does the neurotic, concern themselves with their own superiority.

10. The freedom to choose (McArthur, 1958) introduces the concepts of *value* and *meaning* into psychology. These were unpopular concepts at the time (1931) that Adler wrote *What Life Should Mean to You.* The greatest value for the Adlerian is *Gemeinschaftsgefühl,* or social interest (Ansbacher, 1968). Although Adler contends that it is an innate feature of human beings, at least as potential, acceptance of this criterion is not absolutely necessary. Mosak (1991) defines social interest as a construct rather than as an innate disposition. People possess the capacity for coexisting and interrelating with others. Indeed, the "iron logic of social living" (Adler, 1959) demands that we do so. Even in severe psychopathology, total extinction of social interest does not occur. Even people who are psychotic retain some commonality with "normal" people.

As Rabbi Akiva noted two millennia ago, "The greatest principle of living is to love one's neighbor as oneself." If we regard ourselves as fellow human beings with fellow feeling, we are socially contributive people interested in the common welfare and, by Adler's pragmatic definition of *normality,* mentally healthy (Dreikurs, 1969; Shoben, 1957).

If my feeling derives from my observation and conviction that life and people are hostile and I am inferior, I may divorce myself from the direct solution of life's problems and strive for personal superiority through overcompensation, wearing a mask, withdrawal, attempting only safe tasks where the outcome promises to be successful, and other devices for protecting my self-esteem. Adler said the neurotic in terms of movement displayed a "hesitating attitude" toward life (1964a). Also, the neurotic was described as a "yes-but" personality (Adler, 1934); at still other times, the neurotic was described as an "if only" personality (Adler, 1964a): "If only I didn't have these symptoms, I'd . . ." The latter provided the rationale for "The Question," a device Adler used for differential diagnosis as well as for understanding the individual's task avoidance.

11. Because Adlerians are concerned with process, little diagnosis is done in terms of nomenclature. Differential diagnosis between functional and organic disorder does often present a problem. Because all behavior is purposeful, a *psychogenic* symptom will have a psychological or social purpose, and an *organic* symptom will have a somatic purpose. An Adlerian would ask "The Question" (Adler, 1964a; Dreikurs, 1958, 1962), "If I had a magic wand or a magic pill that would eliminate your symptom immediately, what would be different in your life?" If the patient answers, "I'd go out more often socially" or "I'd write my book," the symptom would most likely be psychogenic. If the patient responds, "I wouldn't have this excruciating pain," the symptom would most likely be organic.

12. Life presents challenges in the form of life tasks. Adler named three of these explicitly but referred to two others without specifically naming them (Dreikurs & Mosak, 1966).

The original three tasks were those of *society, work,* and *sex.* The first has already been alluded to. Because no person can claim self-sufficiency, we are all interdependent. Not only do we need social recognition, but each of us also is dependent on the labor of other people, and they, in turn, are dependent on our contribution. Work thus becomes essential for human survival. The cooperative individual assumes this role willingly. In the sexual realm, because two different sexes exist, we must also learn how to relate to that fact. We must define our sex roles, partly on the basis of cultural definitions and stereotypes, and train ourselves to relate to the *other,* not the *opposite,* sex. Other people, of either sex, do not represent the enemy. They are our fellows, with whom we must learn to cooperate.

Fourth (Dreikurs & Mosak, 1967) and fifth tasks (Mosak & Dreikurs, 1967) have been described. Although Adler alluded to the *spiritual,* he never specifically named it (Jahn & Adler, 1964). But each of us must deal with the problem of defining the nature of the universe, the existence and nature of God, and how to relate to these concepts. Finally, we must address the task of *coping with ourselves.* William James (1890) made the distinction between the self as subject and the self as object, and it is as imperative, for the sake of mental health, that good relations exist between the "I" and the "me" as between the "I" and other people. In this task we must also deal, subjectively and reductionistically on the part of the person, with the "good me" and the "bad me."

13. Because life constantly poses challenges, living demands courage (Neuer, 1936). Courage is not an *ability* one either possesses or lacks. Nor is courage synonymous with bravery, such as falling on a grenade to save one's buddies from injury or death. *Courage* is the *willingness* to engage in risk-taking behavior either when one does not know the consequences or when the consequences might be adverse. We are all *capable* of courageous behavior, provided that we are *willing* to engage in it. Our willingness will depend on many variables, internal and external, such as our life-style convictions, our degree of social interest, the extent of risk as we appraise it, and whether we are task oriented or prestige oriented. Given that life offers few guarantees, all living requires risk taking. It would require very little courage to live if we were perfect, omniscient, or omnipotent. The question we must each answer is whether we have the courage to live despite the knowledge of our imperfections (Lazarsfeld, 1966).

14. Life has no intrinsic meaning. We give meaning to life, each of us in our own fashion. We declare it to be meaningful, meaningless, an absurdity, a prison sentence (cf., the adolescent's justification for doing as he pleases—"I didn't ask to be born"), a vale of tears, a preparation for the next world, and so on. Dreikurs (1957, 1971) maintained that the meaning of life resided in doing for others and in contributing to social life and social change. Viktor Frankl (1963) believed the meaning of life lay in love. The meaning we attribute to life will "determine" our behavior. We will behave *as if* life were really in accord with our perceptions, and therefore, certain meanings will have greater practical utility than others. Optimists will live an optimistic life, take chances, and not be discouraged by failure and adversity. They will be able to distinguish between failing and being a failure. Pessimists will refuse to be engaged with life, refuse to try, sabotage their efforts if they do make an attempt, and, through their methods of operation, endeavor to confirm their preexisting pessimistic anticipations (Krausz, 1935).

Other Systems

Students often have asked, "Do you Adlerians believe in sex, too?" The question is not always asked facetiously. Freud accorded sex the status of the master motive in behavior. Adler merely categorized sex as one of several tasks the individual is required to solve. Freud employed esoteric jargon, and Adler favored common-sense language. One story has it that a psychiatrist took Adler to task after a lecture, denigrating his approach with the criticism "You're only talking common sense," to which Adler replied, "I wish more psychiatrists did." Table 3.1 lists other differences between the theories of Freud and Adler.

TABLE 3.1 **Comparison of Freud's and Adler's Concepts**

Freud	Adler
1. Objective.	1. Subjective.
2. Physiological substratum for theory.	2. A social psychology.
3. Emphasized causality.	3. Emphasized teleology.
4. Reductionistic. The individual was divided into "parts" that were antagonistic toward each other: e.g., id-ego-superego, Eros vs. Thanatos, conscious vs. unconscious.	4. Holistic. The individual is indivisible. He or she is a unity, and all "parts" (memory, emotions, behavior) are in the service of the whole individual.
5. The study of the individual centers on the intrapersonal, the intrapsychic.	5. People can be understood only interpersonally and as social beings moving through and interacting with their environment.
6. The establishment of intrapsychic harmony constitutes the ideal goal of psychotherapy. "Where id was, there shall ego be."	6. The expansion of the individual, self-realization, and the enhancement of social interest represent the ideal goals for the individual.
7. People are basically "bad." Civilization attempts to domesticate them, for which they pay a heavy price. Through therapy, the instinctual demands may be sublimated but not eliminated.	7. People are neither "good" nor "bad," but as creative, choosing human beings, they may choose to be "good" or "bad" or both, depending on their life-styles and their appraisal of the immediate situation and its payoffs. Through the medium of therapy, people can choose to actualize themselves.
8. People are victims of both instinctual life and civilization.	8. People, as choosers, can shape both their internal and external environments. Although they cannot always choose what will happen to them, they can always choose the posture they will adopt toward life's stimuli.
9. Description of child development was postdictive and based not on direct observation of children but on the free associations of adults.	9. Children were studied directly in families, schools, and family education centers.
10. Emphasis on the Oedipus situation and its resolution.	10. Emphasis on the family constellation.
11. People are enemies. Others are our competitors, and we must protect ourselves from them. Theodore Reik quotes Nestroy: "If chance brings two wolves together, . . . neither feels the least uneasy because the other is a wolf; two human beings, however, can never meet in the forest, but one must think: That fellow may be a robber" (Reik, 1948, p. 477).	11. Other people are *Mitmenschen,* fellow human beings. They are our equals, our collaborators, our cooperators in life.
12. Women feel inferior because they envy men their penises. Women are inferior. Anatomy is destiny.	12. Women feel inferior because in our cultural milieu, women are undervalued. Men have privileges, rights, and preferred status, although in the current cultural ferment, their roles are being reevaluated.
13. Neurosis has a sexual etiology.	13. Neurosis is a failure of learning, a product of distorted perceptions.
14. Neurosis is the price we pay for civilization.	14. Neurosis is the price we pay for our lack of civilization.

A more extended comparison of Freud's and Adler's concepts of humankind may be found in articles by Carlson, Watts, & Maniacci (2006), H. W. von Sassen (1967), and Otto Hinrichsen (1913).

Adler and the Neo-Freudians

Adler once proclaimed that he was more concerned that his theories survive than that people remember to associate his theories with his name. His wish apparently was granted. In discussing Adler's influence on contemporary psychological theory and practice, Henri Ellenberger commented, "It would not be easy to find another author from which so much has been borrowed from all sides without acknowledgment than Adler" (1970, p. 645). However, many neo-Freudians have credited Adler with contributing to and influencing their work. In her last book, Karen Horney wrote of "neurotic ambition," "the need for perfection," and "the category of power." "All drives for glory," she wrote, "have in common the reaching out for greater knowledge, wisdom, virtue or powers than are given to human beings; they all aim at the absolute, the unlimited, the infinite" (1951, pp. 34–35). Those familiar with Adler's writings on the neurotic's perfectionistic, godlike striving will immediately be struck by the similarity in viewpoint.

Horney (1951) rejected Freud's pessimism, "his disbelief in human goodness and human growth," in favor of the Adlerian view that a person could grow and could "become a decent human being."

Others have also remarked on the resemblance between the theories of Horney and Adler; the reviewer of one Horney book wrote that Karen Horney had just written a new book by Alfred Adler (Farau, 1953).

Erich Fromm also expresses views similar to those of Adler. According to Fromm, people make choices. The attitude of the mother in child rearing is of paramount importance. Life fosters feelings of powerlessness and anxiety. Patrick Mullahy (1955) indicates that

> The only adequate solution, according to Fromm, is a relationship with man and nature, chiefly by love and productive work, which strengthens the total personality, sustains the person in his sense of uniqueness, and at the same time gives him a feeling of belonging, a sense of unity and common destiny with mankind. (pp. 251–252)

Although Harry Stack Sullivan places greater emphasis on developmental child psychology than does Adler, Sullivan's "person" moves through life in much the same manner as Adler's. Thus, Sullivan (1954) speaks of the "security operations" of the individual, a direct translation of Adler's and Lene Credner's (1930) *Sicherungen*. His "good me" and "bad me" dichotomy is, in expression if not in manner of development, essentially the same as that described by Adlerians.

So many similarities between Adler and the neo-Freudians have been noted that Gardner Murphy concluded, "If this way of reasoning is correct, neurosis should be the general characteristic of man under industrialism, a point suspected by many Freudians and, in particular, by that branch of the Freudian school (Horney and her associates) that has learned most from Adler" (1947, p. 569). A summary of such resemblances appears in Heinz and Rowena Ansbacher's *Individual Psychology of Alfred Adler* (1956), as well as in an article by Walter James (1947). Fritz Wittels (1939) has proposed that the neo-Freudians should more properly be called "neo-Adlerians," and a study by Heinz Ansbacher (1952) suggests that many traditional Freudians would concur.

Adler and Rogers

Although the therapies of Adler and Carl Rogers are diametrically opposed, their theories share many commonalities. Both are phenomenological, goal directed, and holistic.

Each views people as self-consistent, creative, and capable of change. To illustrate, Rogers (1951) postulates the following:

1. The organism reacts as an organized whole to the phenomenal field (p. 486).
2. The best vantage point for understanding behavior is from the internal frame of reference of the individual (p. 494).
3. The organism reacts to the field as it is experienced and perceived (pp. 484–485).
4. The organism has one basic tendency and striving—to actualize, maintain, and enhance the experiencing organism (p. 487).

Much of the early research on nondirective and client-centered therapy measured the discrepancy between *self-concept* and *self-ideal.* The Adlerian would describe the extent of discrepancy as a measure of inferiority feelings.

Adler and Ellis

The theories of Adler and Ellis exhibit many points of convergence. Albert Ellis (1970, 1971) finds his rational–emotive psychology to parallel that of Adler. What Adler calls basic mistakes, Albert Ellis refers to as irrational beliefs or attitudes. Both accept the notion that emotions are actually a form of thinking and that people create or control their emotions by controlling their thinking. They agree that we are not victims of our emotions but their creators. In psychotherapy, they (1) adopt similar stances with respect to unconscious motivation, (2) confront patients with their irrational ideas (basic mistakes or internalized sentences), (3) counterpropagandize the patient, (4) insist on action, and (5) constantly *encourage* patients to assume responsibility for the direction of their lives in more positive channels. The last phrase, however, reflects the major disagreement between Adler and Ellis—namely, what is "positive." Ellis puts it as follows:

> Where Adler writes, therefore, that "All my efforts are devoted towards increasing the social interest of the patient," the rational therapist would prefer to say, "Most of my efforts are devoted towards increasing the self-interest of the patient." He assumes that if the individual possesses rational self-interest he will, on both biological and logical grounds, almost invariably tend to have a high degree of social interest as well. (1957, p. 43)

Adlerian and Cognitive Therapy

Adlerian and cognitive therapy have much in common, as Beck and Weishaar (2005) acknowledge. Both are phenomenological psychologies, and both are concerned with the way individuals view the world and themselves. Both emphasize the role of cognition in emotion and behavior (Beck & Weishaar, 2005; Dreikurs, 1951; Mosak, 1985). Each posits a set of cognitive structures (for the Adlerian it is the life-style; for the cognitive therapist it is a schema). These cognitive structures *may be* (the cognitive therapist would say *are*) related to certain kinds of emotional behavior (Beck & Weishaar, 2005; Mosak, 1968). Beck and Weishaar speak of cognitive distortion and Adler of "basic mistakes." Beck and Weishaar's term is preferable, but both processes are essentially the same. The reader may wish to compare Beck's description of cognitive distortions (p. 272) and Mosak's description of basic mistakes (p. 82) in this volume.

Therapy in each system is a collaborative effort, employing what Beck and Weishaar call "collaborative empiricism, Socratic dialogue, and guided discovery" (Beck & Weishaar, 2005).

The two therapies also differ in significant ways. Cognitive therapy is not designed for personal growth, whereas Adlerians focus on personal growth even for the patient with psychopathology. Cognitive therapists narrow the types of psychopathology with which they will deal; Adlerians do not. For example, cognitive therapists do not obtain good results with people coping with psychosis (Beck & Weishaar, 2005), but Adlerians regularly treat these patients. As with Freudian analysis, a certain amount of intellectual and/or psychological sophistication on the part of the patient brings the best results from cognitive therapy. However, the Adlerian therapist has no such requirement and meets the patient's level of sophistication by speaking at the patient's level of intelligence and in the patient's idiom (Mosak & Shulman, 1963). In spite of these differences, cognitive therapy appears to be "variations on a theme by Adler," even though Beck reads better because of his use of the language of contemporary psychology rather than the archaic language of Adler and his contemporaries. Watts (2003) has provided an extensive review of Adler's influence on contemporary cognitive therapies, particularly the constructivist school. Experts from various divisions of cognitive therapy (e.g., cognitive–behavioral and constructivist) and Adlerian psychology offer their views on how the two schools of therapy have influenced and might grow from each other.

Adler and Other Systems

The many points of convergence and divergence between Adler and several of the existentialist thinkers have been noted by many writers (Birnbaum, 1961; Farau, 1964; Frankl, 1970). Phyllis Bottome had written in 1939 that "Adler was the first founder of an existence psychology" (p. 199). Given that existential psychology is not a school but a viewpoint, it is difficult to make comparisons, but interested readers may discover for themselves, in an editorial by Ansbacher (1959), the lines of continuity between Adler's ideas and existential thought.

The recognition of Adler as one of the earliest humanistic psychologists is clear. Ellis pays homage to Adler as "one of the first humanistic psychologists" (1970, p. 32). Abraham Maslow (1962, 1970) published five papers in Adlerian journals over a period of 35 years. As we have already observed, many of Adler's ideas have been incorporated by the humanistic psychologists with little awareness of Adler's contributions. "The model of man as a composite of part functions" that James Bugental (1963) questioned has been repudiated by Adlerians for more than half a century. Adlerian psychology is a value psychology (Adler wrote *What Life Should Mean to You* in 1931), as Viktor Frankl and Rollo May, among others, recognize in acknowledging their debt to Adler. Here is Frankl:

> What he [Adler] . . . achieved and accomplished was no less than a Copernican switch. . . . Beyond this, Alfred Adler may well be regarded as an existential thinker and as a forerunner of the existential-psychiatric movement. (1970, p. 38)

May expresses his debt as follows:

> I appreciate Adler more and more. . . . Adler's thoughts as I learned them in studying with him in Vienna in the summers of 1932 and 1933 led me indirectly into psychology, and were very influential in the later work in this country of Sullivan and William Alanson White, etc. (1970, p. 39)

And Abraham Maslow wrote,

> For me Alfred Adler becomes more and more correct year by year. As the facts come in, they give stronger and stronger support to his image of man. I should say that in one respect especially the times have not yet caught up with him. I refer to his holistic emphasis. (1970, p. 39)

HISTORY

Precursors

Adler's insistence that people cannot be studied in isolation but only in their social context was previously expressed by Aristotle, who referred to the human being as a *zoon politikon,* a political animal (Adler, 1959). Adler exhibits his affinity with the philosophy of stoicism, as both Ellenberger (1970) and H. N. Simpson (1966) point out. Other commentators have noted the resemblance of Adler's writings to Kant's philosophy, especially with respect to the categorical imperative, private logic, and overcoming. Adler and Nietzsche have often been compared, and much has been made of their common usage of the concept of the *will to power* (Ansbacher, 1972; Crookshank, 1933). Adler spoke of it in terms of the normal strivings for competence, however, whereas Nietzsche's references to this concept involved what Adler would call the "useless side of life." Nietzsche stressed the *Übermensch* (superman) and Adler spoke of equality. Adler further stressed *social feeling,* a concept totally alien to the Nietzschian philosophy.

Throughout history, philosophers have struggled with the mind–body problem. Psychology experienced a renaissance when psychologists and psychiatrists began to apply themselves to the study of psychosomatic syndromes. Psychosomatic and somatopsychic hypotheses were advanced to explain how emotions could influence the production of symptoms and how bodily states might create emotional or mental illness. Adler rejected such divisions. Like Kurt Lewin (1935), he rejected categorization and dichotomies. Like Jan Smuts (1961), he was a holist, and the term *Individual Psychology* was not meant to describe the psychology of the individual. It referred rather to Adler's holistic stance—that a person could be understood only as a whole, an indivisible unity. To study people atomistically was to fail to capture fully the nature of humanity. For Adler, the question was neither "How does mind affect body?" nor "How does body affect mind?" but rather "How does the individual use body and mind in the pursuit of goals?" Although Adler's *Study of Organ Inferiority and Its Psychical Compensation* (1917) might seem to contradict such statements by expressing a causalistic viewpoint, this highly original theory was formulated when Adler was a member of the Freudian circle. Later Adler added the subjective factor:

> It might be suggested, therefore, that in order to find out where a child's interest lies, we need only to ascertain which organ is defective. But things do not work out quite so simply. The child does not experience the fact of organ inferiority in the way that an external observer sees it, but as modified by his own scheme of apperception. (1969)

Perhaps the greatest influence on Adler was Hans Vaihinger's (1965) "philosophy of 'as if.'" According to Vaihinger, a fiction is "a mere piece of imagination" that deviates from reality but that is nevertheless utilitarian for the individual. Both the concept of the world and the concept of the self are subjective—fictional—and therefore in error. *Truth* is "only the most expedient error, that is, the system of ideas which enables us to act and to deal with things most rapidly, neatly, and safely, and with the minimum of irrational elements" (p. 108).

Finally, Adler's psychology has a religious tone (Adler, 1958; Jahn & Adler, 1964; Mosak, 1987c). His placement of social interest at the pinnacle of his value theory is in the tradition of those religions that stress people's responsibility for each other. Indeed, Adler maintained that "Individual Psychology makes good religion if you are unfortunate enough not to have another" (Rasey, 1956, p. 254).

Beginnings

Adler was born near Vienna on February 7, 1870, and he died while on a lecture tour in Aberdeen, Scotland, on May 27, 1937. After graduating from the University of Vienna in 1895, Adler entered private practice as an ophthalmologist in 1898. He later switched to general practice and then to neurology. During this period, Adler gave portents of his later social orientation by writing a book on the health of tailors (1898). In this respect, he may be regarded as the progenitor of industrial medicine and of community outreach.

In 1902, Adler, at Freud's invitation, joined in the latter's Wednesday evening discussion circle. Biographers agree that Adler wrote two defenses of Freud's theories, which may have gained him the invitation. Although textbooks frequently refer to Adler as a student of Freud, Adler was actually a colleague (Ansbacher, 1962; Ellenberger, 1970; Federn, 1963; Maslow, 1962). Through the next decade, Adler had one foot in and one foot out of the Freudian circle. Although his *Study of Organ Inferiority* won Freud's unqualified endorsement, Adler's introduction of the aggression instinct in 1908 met with Freud's disapproval. Not until 1923, long after Adler had discarded instinct theory, did Freud incorporate the aggressive instinct into psychoanalysis (Sicher & Mosak, 1967), at which time Adler declared, "I enriched psychoanalysis by the aggressive drive. I gladly make them a present of it!" (Bottome, 1939, p. 63).

Adler's increasing divergence from Freud's viewpoint led to discomfort and disillusion in the Vienna Psychoanalytic Society. Adler criticized Freud's sexual stance; Freud condemned Adler's ego psychology. They disagreed on (1) the unity of neuroses, (2) penis envy (sexual) versus the masculine protest (social), (3) the defensive role of the ego in neuroses, and (4) the role of the unconscious. Freud thought that Adler had not discovered anything new but had merely reinterpreted what psychoanalysis had already said. He believed that what Adler discovered was "trivial" and that it was "methodologically deplorable and condemns his whole work to sterility" (Colby, 1951). In 1911, after a series of meetings where these issues were discussed in an atmosphere of fencing, heckling, and vitriol (Brome, 1968), Adler resigned as president of the Vienna Society. Later that year, Freud forced the choice between Adler and himself. Several members of the circle expressed their sympathy for Adler by resigning and forming the Society for Free Psychoanalytic Research. The word *free* was meant to imply that this was still a psychoanalytic society, but one free of Freud.

During the next decade, with the exception of the war period, Adler and his coworkers developed the social view of the neuroses. Their focus was primarily clinical, although as early as 1908, Adler (1914) had demonstrated an interest in children, families, and education. In 1922 Adler initiated what was perhaps the first community outreach program, child-guidance centers within the community. These centers were located in public schools and were directed by psychologists who served without pay. The method, for which Adler drew much criticism, was that of public family education, a method still used in Adlerian family education centers. Twenty-eight such centers existed in Vienna until 1934, when an unfriendly government closed them. This form of center was transported to the United States by Rudolf Dreikurs and his students (Dreikurs, Corsini, Lowe, & Sonstegard, 1959). The success of these centers motivated the Vienna school authorities to invite several Adlerians to plan a school along Adlerian lines, and from this invitation emerged the school described in Oskar Spiel's *Discipline Without Punishment* (1962). The school emphasized encouragement, class discussions, democratic principles, and the responsibility of children for themselves and for each other—educational methods still in use today.

The social orientation of Adler's Individual Psychology inevitably led to interest in group methods and Adler's introduction of family therapy (1922). Dreikurs (1959) is credited with the first use of group psychotherapy in private practice.

Between World Wars I and II, Adlerian groups existed in 20 European countries and in the United States. In 1926 Adler was invited to the United States to lecture, and until 1934, when fascism took hold in Austria, he divided his time between the United States, where he was on the medical faculty of the Long Island College of Medicine, and abroad. Two of his children, Alexandra and Kurt, practiced psychiatry in New York City. With the march of Nazism, many Adlerians were forced to flee their European homelands and made the United States the center of their activities. Today, Individual Psychology societies exist in the United States, England, Canada, France, Denmark, Switzerland, Germany, Austria, the Netherlands, Greece, Italy, Israel, and Australia.

Current Status

The resurgence of the Adlerian school after the dispersion from Europe was an uphill effort. Personal hardships of refugee Adlerians were compounded by the existing psychological climate in this country. The economic depression still prevailed. The Freudian school held a near monopoly, both in the treatment area and with respect to appointments in medical schools. Some Adlerians defected; others became crypto-Adlerians. However, others persevered in retaining their identity and their optimism. Local societies were founded, and 1952 saw the formation of the American Society of Adlerian Psychology (now the North American Society of Adlerian Psychology). Several journals appeared; the major American one is the *Journal of Individual Psychology,* formerly called *Individual Psychology,* which itself was the successor of the *Individual Psychology Bulletin,* of which Dreikurs was the editor for many years. The International Association of Individual Psychology also publishes the *Individual Psychology Newsletter.*

Training institutes that offer certificates in psychotherapy, counseling, and child guidance are found in New York; Chicago; Minneapolis; Berkeley, California; San Francisco; St. Louis; Fort Wayne, Indiana; Vancouver; and Montreal. Individual courses and programs of study are offered at many universities, such as Oregon, Arizona, West Virginia, Vermont, Governors State, Southern Illinois, and Georgia State. Master's degrees based on an Adlerian curriculum are offered by Bowie State College and by the Adler School of Professional Psychology in Chicago. The latter has been accredited to offer a doctoral program in clinical psychology.

Although Adlerian psychology was once dismissed as moribund, superficial (i.e., an "ego psychology"), and suitable mainly for children, it is today considered a viable psychology.

Today's Adlerian may operate as a traditional clinician but remains innovative. For example, Joshua Bierer was a pioneer in social psychiatry (Bierer & Evans, 1969) and a leader in the day-hospital movement (1951). Therapeutic social clubs have been in operation at the Alfred Adler Mental Hygiene Clinic in New York and at Saint Joseph Hospital in Chicago. Dreikurs originated multiple psychotherapy (1950), and he, Harold Mosak, and Bernard Shulman contributed to its development (1952a, 1952b, 1982). Rudolf Dreikurs, Asya Kadis, Helene Papanek, and Bernard Shulman have made extensive contributions to group therapy. Because they prefer the goal of prevention to that of healing, Adlerians function extensively in the area of education. Manford Sonstegard, Raymond Lowe, Bronia Grunwald, Oscar Christensen, Raymond Corsini, and Loren Grey are among those responsible for applying Adlerian principles in the schools. All have been students of Dreikurs, who transported the tradition from Vienna, and who himself made a great contribution in this area. In the Adlerian social tradition, Adlerians may be involved in community outreach programs or may dedicate their efforts to the study of subjects such as drugs, aging, delinquency, religion, and poverty.

In 2008, the *Journal of Individual Psychology* (volume 64) devoted an entire issue to lesbian, gay, bisexual, and transgender individuals (Mansager, 2008). Hill, Brack, Qalinge, and Dean (2008) presented research detailing AIDS treatment in South Africa from

an Adlerian perspective. Also recently published, Foley, Matheny, and Curlette (2008) have presented research detailing an Adlerian assessment of personality traits in Mainland China. In 2007, Linden presented an updated perspective of aging from an Adlerian view. Sperry and Mansager (2007) have discussed spirituality and Adlerian psychology. In yet another special issue of the *Journal of Individual Psychology,* Rasmussen (2006) has collected a series of articles updating the Adlerian view of depression. In a similar vein, Schneider, Kern and Curlette (2007) have published a special issue of the journal updating the Adlerian view of narcissism. Rotgers and Maniacci (2006) have published a volume on comparative treatments of antisocial personality disorder, with two chapters covering Adlerian perspectives.

The contemporary Adlerian finds the growth model of personality infinitely more congenial than the sickness model. The Adlerian is interested not in curing sick individuals or a sick society but in reeducating individuals and in reshaping society. Adlerians are even branching out into the Internet. Two sites of interest are www.alfredadler.org and www.adleriancounselingandtherapy.com.

Henry Stein and colleagues at the Alfred Adler Institute of San Francisco have recently completed the Alfred Adler translation project. This 12-volume set comprises newly edited and retranslated volumes of the complete clinical collected works of Alfred Adler; these translations are sorely needed to bring Adler's original writings to English-speaking audiences. The volumes are readily available via commercial bookstores, online booksellers, or through the Alfred Adler Institute of San Francisco.

PERSONALITY

Theory of Personality

Adlerian psychology is a psychology of use rather than of possession. This assumption decreases the importance of the question "How do heredity and environment shape the individual?" The functionalist, holistic Adlerian asks instead, "How does the individual use heredity and environment?" Since theirs is a psychology of use, Adlerians find it improper to employ such phrases as "He *has* social interest." People *display* social interest rather than possess it (Mosak, 1991).

For Adler, the *family constellation* constitutes the primary social environment. Every child searches for significance in this environment and competes for position within the family constellation. One sibling becomes the "best" child, another the "worst." Being favored, being one of the favored sex within the family, adopting the family values, or identifying or allying oneself with a parent or sibling may provide the grounds for the feeling of having a place. Handicaps, organ inferiorities, or being an orphan are other "position makers" for some children.

Of supreme importance is the child's position in the family constellation. Thus, it would appear that the first child usually is a conservative and the second is often a rebel. The baby is ordinarily either everyone's darling or one who stands on tiptoes to see above the preceding siblings. If these general characteristics possess any validity, at best they exist as statistical probabilities and not as defining traits. Considering the family constellation in terms of birth order or ordinal position creates the problem of characterizing, let us say, the fifth child in the family. Although the fifth child is often encountered in the therapy situation, he or she never receives any attention in the literature. Birth order, per se, also fails to take into account the gender position of the child. The children in two-sibling families in which the possible configurations are boy-boy, girl-girl, boy-girl, and girl-boy do not possess similar characteristics based on ordinal position alone (Shulman & Mosak, 1977).

The Adlerian prefers to study the family constellation in terms of the *psychological* position. A simple example illustrates this point of view. Take two siblings separated in age by 10 years. In birth order research, these would be treated as a first child and a second child. From the Adlerian point of view, the psychological position of each would *most likely* be that of an only child, with the older child *perhaps* functioning as an additional parent figure for the younger. The italicized terms *most likely* and *perhaps* are used expressly to indicate that (1) Adlerians do not recognize a causalistic, one-to-one relationship between family position and sibling traits, and (2) whatever relationship exists can be understood only in context—that is, when one knows the family climate and the total configuration of factors in the family constellation. Adler, whenever he generalized or ventured a prediction, was fond of reminding his students, "Everything could also be quite different."

The search for significance and the consequent sibling competition reflect the values of the competitive society in which we live. We are encouraged to be first, to excel, to be popular, to be athletic, to be a "real" man, to "never say die," to recall that "practice makes perfect," and to "dream the impossible dream." Consequently, each child must stake out a "territory" that includes the attributes or abilities that the child hopes will give him or her a feeling of worth. If through their evaluations of their own potency (abilities, courage, and confidence) children are convinced that they can achieve this place through useful endeavor, they will pursue "the useful side of life." Should children feel that they cannot attain the goal of having a "place" in this fashion, they will become discouraged and engage in disturbed or disturbing behavior in their efforts to find a place. For the Adlerian, the "maladjusted" child is not a "sick" child. He or she is a "discouraged" child. Dreikurs (1948, 1949) classifies the goals of the discouraged child into four groups: attention getting, power seeking, revenge taking, and declaring deficiency or defeat. Dreikurs is speaking of immediate rather than long-range goals. These are the goals of children's "misbehavior," not of all children's behavior (Mosak & Mosak, 1975b).

In the process of becoming socialized human beings, children form conclusions on the basis of their subjective experiences. Because judgment and logical processes are not highly developed in young children, many of their growing convictions contain errors or only partial "truths." Nevertheless, they accept these conclusions about themselves and others *as if* they were true. Such conclusions are subjective evaluations, biased apperceptions of themselves and of the world, rather than objective "reality." Thus, one can be truly inferior without feeling inferior. Conversely, one can feel inferior without being inferior.

The child creates a cognitive map or life-style that will assist "little me" in coping with the "big" world. The life-style includes the aspirations, the long-range goals, and a "statement" of the conditions, personal or social, that are requisite for the individual's "security." The latter are also fictions and are stated in therapy as "If only . . . , then I . . . ."

Mosak (1954) divided life-style convictions into four groups:

1. The *self-concept*—the convictions I have about who I am.
2. The *self-ideal* (Adler coined this phrase in 1912)—the convictions of what I should be or am obliged to be to have a place.
3. The *Weltbild,* or "picture of the world"—convictions about the not-self (world, people, nature, and so on) and what the world demands of me.
4. The *ethical convictions*—the personal "right–wrong" code.

When there is a discrepancy between self and ideal-self convictions ("I am short; I should be tall"), *inferiority feelings* ensue. Although an infinite variety of inferiority feelings exist, one that Adler discussed while he was still in the Freudian Society should

be mentioned. This idea, the *masculine protest*, eventually led to the rift between Adler and Freud, and it assumes monumental importance in some circles today. In a culture that places a premium on masculinity, some women feel inferior because they have not been accorded the prerogatives or privileges of men ("I am woman; I should be equal to man"). But men also suffered from the masculine protest because being a man is not sufficient to provide a "place" for some men ("I am a man, but I should be a *real* man"). Because Adler believed in the equality of the sexes, he could not accept these fictions (Mosak & Schneider, 1977).

Lack of congruence between convictions in the self-concept and those in the *Weltbild* ("I am weak and helpless; life is dangerous") also results in inferiority feelings. Discrepancies between self-concept and ethical convictions ("One should always tell the truth; I lie") lead to inferiority feelings in the moral realm. Thus, the guilt feeling is merely a variant of the inferiority feeling (Mosak, 1987b).

These variations of inferiority feelings in and of themselves are not "abnormal." It would be difficult to quarrel with Adler's observations that to live is to *feel* inferior. It is only when individuals act *as if* they were inferior, develop symptoms, or behave as "sick" that we see evidence of what in the medical model would be called *pathology* and what Adlerians call *discouragement* or the *inferiority complex.* To oversimplify, the *inferiority feeling* is universal and "normal," although it may leave us uncomfortable; the *inferiority complex* reflects the discouragement of a limited segment of our society and is usually "abnormal." The former may be masked or hidden from the view of others; the latter is an open demonstration of inadequacy, or "sickness."

Using their "maps," people facilitate their movements through life. This permits them to evaluate, understand, experience, predict, and control experience. Lawrence Frank writes in this connection,

> The personality process might be regarded as a sort of rubber stamp which the individual imposes upon every situation by which he gives it the configuration that he, as an individual, requires; in so doing he necessarily ignores or subordinates many aspects of the situation that for him are irrelevant and meaningless and selectively reacts to those aspects that are personally significant. (1939, p. 392)

Although the life-style is the instrument for coping with experience, it is very largely nonconscious. The life-style comprises the cognitive organization of the individual rather than the behavioral organization. As an illustration, the conviction "I require excitement" may lead to the vocational choices of actor, racing car driver, or explorer, or to "acting out" behavior. Such a conviction may further lead to getting into jams or exciting situations, engaging in creative acts, or discovery.

Within the same life-style, one can behave usefully or uselessly. This distinction permits Adlerians (e.g., Dreikurs, 1961; Nikelly, 1971a) to distinguish between *psychotherapy* and *counseling.* The former, they maintain, has as its aim the change of life-style; the latter has as its goal the change of behavior within the existing life-style.

Because the Adlerian literature discusses the life tasks of occupation, society, and love so extensively, these tasks of life will not be elaborated on here, except for some brief comments. Lewis Way points out that "The problems they pose can never be solved once and for all, but demand from the individual a continuous and creative movement toward adaptation" (1962, pp. 179–180).

Love, as an emotion like other emotions, is cognitively based. People are not "victims" of their emotions. They create emotions to assist them in the attainment of their goals. Love is the conjunctive emotion we create when we want to move toward people.

Although the life tasks of love, occupation, and society demand solution, it is possible to avoid or postpone them if one can compensate in other areas. "Even successful persons fall into neurosis because they are not more successful" (Way, 1962, p. 206).

The *neurotic symptom* is an expression of "I *can't* because I'm sick"; the person's movement betrays the "I *won't* because my self-esteem might get hurt" (Krausz, 1959, p. 112). Although neurotics' movements are consonant with their "private logic" (Nikelly, 1971b), they still cling to "common sense." They know what they should do or feel, but they "can't." Adler referred to them as "yes-but" personalities. Eric Berne (1964) has graphically described their interpersonal maneuvers in the "Why don't you—Yes, but" game. The genesis of neurosis lies in discouragement. People avoid and postpone or take circuitous routes to solutions so they can "save face." Even when they expect or arrange to fail, they try to salvage some self-esteem. Students, fearful of failing examinations, will refrain from studying. In the event they do fail, they merely have to hold that they were lazy or neglectful but not stupid.

The psychotic's goal of superiority is often loftier than that which can be achieved by mere humans. "Individual Psychology has shown that the goal of superiority can only be fixed at such attitudes when the individual has, by losing interest in others, also lost interest in his own reason and understanding . . . common sense has become useless to him" (Adler, 1964a, pp. 128–129). Adler used "common sense" in much the same manner that Sullivan spoke of "consensual validation." In the pseudo work area, the psychotic becomes superintendent of the mental hospital. In the pseudo social area, the hypomanic patient resembles the cheerful extrovert, and the more acutely manic patient becomes a "name dropper" and "swallows up" people (Shulman, 1962). The paranoid patient pictures people as threatening and manifests a "search for glory," to use Karen Horney's (1951) phrase, by the persecutory delusion that *they* are conspiring to do something to *me*. The delusions of grandeur of psychotic depressive patients ("I'm the *worst* sinner of all time") and of the schizophrenic who claims to be Christ are some other "solutions" to the pseudo spiritual tasks. The reifying hallucinations of talking with the devil fall in this category (Adler, 1963a; Mosak & Fletcher, 1973).

The *psychologically healthy* or *normal* individual has developed social interest and is willing to commit to life and the life tasks without evasion, excuse, or "side shows" (Wolfe, 1932). This person proceeds with confidence and optimism about meeting life's challenges. There is a sense of belonging and contributing, the "courage to be imperfect," and the serene knowledge that one can be acceptable to others, although imperfect. Above all, this person rejects the faulty values that culture projects and attempts to substitute for them values more consonant with the "ironclad logic of social living." Such a person does not exist, nor will psychotherapy produce such a person. Yet this is the Adlerian ideal, and because Adler's intent was to substitute small errors for larger errors, many of these goals can be approximated in psychotherapy. Many fortunate people have the courage (Adler, 1928) and social interest to do this for themselves without therapeutic assistance.

Variety of Concepts

The simplicity of Adlerian vocabulary renders definition and interpretation generally unnecessary. Yet some differences of opinion and emphasis about Adlerian concepts remain unresolved. In terms of *life-style,* Adlerians disagree with respect to what it describes—behavioral or cognitive organization. *Social interest* (Bickhard & Ford, 1976; Crandall, 1981; Edgar, 1975; Kazan, 1978; Mosak, 1991) apparently is not a unitary concept but a cluster of feelings and behaviors (Ansbacher, 1968). Although social interest is often described as "innate," many Adlerians wonder what makes it so, given that it appears to be neither genetic nor constitutional. As one looks at the theories of Adler, Freud, and Jung, one is struck with the effort on the part of all three to "biologize" their theories. Perhaps it was the temper of the times. Perhaps it was because all three were physicians. Perhaps it resulted from the need to make their theories respectable during

a period when psychoanalysis was held in low esteem. None of these theories would incur any great damage if "instincts," "social interest," and "racial unconscious" were treated as psychological constructs rather than as biological processes. Adler, having introduced the concept of *organ inferiority* with its consequent compensation, actually had proposed a biopsychological theory, but this transpired during his Freudian period. Later he substituted the *social inferiority feeling* for actual organ inferiority, and with the exception of one important article (Shulman & Klapman, 1968), Adlerians have published little on organ inferiority. Although people undoubtedly do compensate for organ inferiority, the latter is no longer the cornerstone of the Adlerian edifice.

Gardner Murphy (1947) took issue with Adler's use of compensation as the only defense mechanism. Literally, Adler's writings do read that way. On the other hand, if one reads more closely, compensation becomes an umbrella to cover all coping mechanisms. Thus Adler speaks of safeguards, excuses, projection, the depreciation tendency, creating distance, and identification. Although a Freudian might view these as defense mechanisms, the Adlerian prefers to view them as problem-solving devices the person uses to protect self-esteem, reputation, and physical self. Because Adlerians do not accept the concept of *the* unconscious, such mechanisms as repression and sublimation become irrelevant. Adlerian theory has no room for instincts, drives, libido, and other alleged movers.

Because of their mutual emphasis on behavior (movement), Adlerian psychology and behavior modification theory have been equated. This is an error. Adlerians, although interested in changing behavior, have as their major goal not behavior modification but *motivation* modification. Dreikurs writes, "We do not attempt primarily to change behavior patterns or remove symptoms. If a patient improves his behavior because he finds it profitable at the time, without changing his basic premises, then we do not consider that as a therapeutic success. We are trying to change goals, concepts, and notions" (1963, p. 79).

PSYCHOTHERAPY

Theory of Psychotherapy

All scientific schools of psychotherapy have their shares of successes and failures. A considerable number of therapies based on nonscientific foundations probably result in equivalent levels of success. In any event, regardless of its validity or endurance, any theory must be implemented within the context of the therapist–patient relationship. As Fred Fiedler (1950) has shown, therapeutic success is a function of the expertness of the therapist rather than of the therapist's orientation.

Given that the underlying psychodynamic theory is not the crucial factor in therapy, perhaps it is the special techniques that contribute to therapeutic effectiveness. This would certainly seem to have been Rogers's early position before nondirective therapy became client-centered therapy. For the early nondirective school, the creation of a warm, permissive, nonjudgmental atmosphere; reflection of feeling; and avoidance of interpretation, advice, persuasion, and suggestion were paramount in the therapeutic situation.

The Freudian assigns central importance to transference, but behavior modification therapists ignore it. To many directive therapists, content and manner of interpretation are crucial. The Adlerian emphasizes interpretation of the patient's life-style and movement.

Criteria for "getting well" correspond to the particular therapeutic emphasis. Some therapists propose depth of therapy as the decisive factor. For most Adlerians, depth of therapy does not constitute a major concern. In this connection, therapy is neither deep nor superficial except as the patient experiences it as such.

If neither theory nor the use of prescribed techniques is decisive, is it the transference relationship that makes cure possible? Or is it the egalitarian relationship? Or the warm, permissive atmosphere with the nonjudgmental therapist accepting the patient as is? Because all of these relationships are involved in various forms of both effective and ineffective therapy, we must hypothesize either that therapeutic effectiveness is a matter of matching certain therapeutic relationships to certain patients or that all therapeutic relationships possess common factors. These factors—variations on the Christian virtues of faith, hope, and love—appear to be necessary, but not sufficient, conditions of effective therapy.

Faith

D. Rosenthal and Jerome D. Frank (1956) discuss the implications of faith in the therapeutic process. Franz Alexander and Thomas French state that

> As a general rule, the patient who comes for help voluntarily has this confidence, this expectation that the therapist is both able and willing to help him, before he comes to treatment; if not, if the patient is forced into treatment, the therapist must build up this feeling of rapport before any therapeutic change can be effected. (1946, p. 173)

Many therapeutic mechanisms may enhance the patient's faith. A simple explanation clarifies matters for some patients, a complex interpretation for others. The therapist's own faith in himself or herself; the therapist's appearance of wisdom, strength, and assurance; and the therapist's willingness to listen without criticism may all be used by patients to strengthen their faith.

Hope

Patients seek treatment with varying degrees of hope, running the gamut from complete hopelessness to hope for (and expectation of) everything, including a miracle. Because of the efficacy of the self-fulfilling prophecy, people *tend* to move in the direction of making their anticipations come true. Therefore, the therapist must keep the patient's hope elevated.

Because the Adlerian holds that the patient suffers from *discouragement,* a primary therapeutic technique lies in encouragement. Expression of faith in the patient, noncondemnation, and avoidance of being overly demanding may give the patient hope. The patient may also derive hope from feeling understood. Accordingly, the construction of therapy as a "we" experience where patients do not feel they stand alone, where they feel security in the strength and competency of their therapist, and where they feel some symptom alleviation may prove helpful. Patients may also gain hope from attempting some course of action they feared or did not know was available to them. Humor assists in the retention of hope (Mosak, 1987a). Lewis Way comments, "Humor such as Adler possessed in such abundance is an invaluable asset, since, if one can occasionally joke, things cannot be so bad" (1962, p. 267). Each therapist has faith in his methods for encouraging and sustaining hope. They are put to the most severe test in patients who are depressed or suicidal.

Love

In the broadest sense of love, the patient must feel that the therapist cares (Adler, 1963a, 1964a). The mere act of treating the patient may furnish such evidence by employing empathic listening, "working through" together, or having two therapists in multiple

psychotherapy offering interest in the patient. Transfer of a patient to another therapist or from individual to group therapy may have a contrary effect unless it is "worked through."

However, the therapist must avoid pitfalls such as infantilizing, oversupporting, or becoming a victim of the patient when the patient accuses the therapist of not caring enough. In Adlerian group therapy, the group is conceptualized as a "reexperiencing of the family constellation" (Kadis, 1956). Thus, the therapist may be accused of playing favorites, of caring too much for one patient or too little for another.

The Adlerian theory of psychotherapy rests on the notion that psychotherapy is a cooperative educational enterprise involving one or more therapists and one or more patients. The goal of therapy is to develop the patient's social interest. To accomplish this, therapy involves changing faulty social values (Dreikurs, 1957). The subject matter of this course in reeducation is the patient—the life-style and the relationship to the life tasks. Learning the "basic mistakes" in the cognitive map, the patient has the opportunity to decide whether to continue in the old ways or to move in other directions. "The consultee must under all circumstances get the conviction in relation to treatment that he is absolutely free. He can do, or not do, as he pleases" (Ansbacher & Ansbacher, 1956, p. 341). The patient can choose between self-interest and social interest. The educational process has the following goals:

1. The fostering of social interest.
2. The decrease of inferiority feelings, the overcoming of discouragement, and the recognition and utilization of one's resources.
3. Changes in the person's life-style—that is, in her or his perceptions and goals. The therapeutic goal, as we have noted, involves transforming big errors into little ones (as with automobiles, some need a tune-up and others require a major overhaul).
4. Changing faulty motivation that underlies even acceptable behavior, or changing values.
5. Encouraging the individual to recognize equality among people (Dreikurs, 1971).
6. Helping the person to become a contributing human being.

"Students" who reach these educational objectives will feel a sense of belonging and display acceptance of themselves and others. They will feel that they can arrange, within life's limits, their own destinies. Such patients eventually come to feel encouraged, optimistic, confident, courageous, secure—and asymptomatic.

Process of Psychotherapy

The process of psychotherapy, as practiced by Adlerians, has four aims: (1) establishing and maintaining a "good" relationship; (2) uncovering the dynamics of the patient, including life-style and goals, and assessing how they affect life movement; (3) interpretation culminating in insight; and (4) reorientation.

The Relationship

A "good" therapeutic relationship is a friendly one between equals. The Adlerian therapist and the patient sit facing each other, their chairs at the same level. Many Adlerians prefer to work without a desk because distancing and separation may engender undesirable psychological sets. Having abandoned the medical model, the Adlerian looks with disfavor upon casting the doctor in the role of the actor (omnipotent, omniscient, and mysterious) and the patient in the role of the acted-upon. Therapy is structured to inform the patient that creative human beings play a role in creating their problems, that

one is responsible (not in the sense of blame) for one's actions, and that one's problems are based on faulty perceptions and inadequate or faulty learning, especially of faulty values (Dreikurs, 1957). If this is so, one can assume responsibility for change. What has not been learned can be learned. What has been learned "poorly" can be replaced by better learning. Faulty perception and values can be altered and modified. From the initiation of treatment, the patient's efforts to remain passive are discouraged. The patient has an active role in the therapy. Although assuming the role of student, the patient is still an active learner responsible for contributing to his or her own education.

Therapy requires cooperation, which means alignment of goals. Noncoincidence of goals may prevent the therapy from getting off the ground, as, for example, when the patient denies the need for therapy. The initial interview(s) must not, therefore, omit the consideration of initial goals and expectations. The patient may wish to overpower the therapist or to make the therapist powerful and responsible. The therapist's goal must be to avoid these traps. The patient may want to relinquish symptoms but not underlying convictions and may be looking for a miracle. In each case, at least a temporary agreement on goals must be arrived at before the therapy can proceed. Way cautions that

> A refusal to be caught in this way [succumbing to the patient's appeals to the therapist's vanity or bids for sympathy] gives the patient little opportunity for developing serious resistances and transferences, and is indeed the doctor's only defense against a reversal of roles and against finding that he is being treated by the patient. The cure must always be a cooperation and never a fight. It is a hard test for the doctor's own balance and is likely to succeed only if he himself is free from neurosis. (1962, p. 265)

Adler (1963a) offers similar warnings against role reversal.

Because the problems of resistance and transference are defined in terms of patient–therapist goal discrepancies, throughout therapy the goals will diverge, and the common task will consist of realigning the goals so that patient and therapist move in the same direction.

The patient, in bringing a life-style to therapy, expects from the therapist the kind of response expected from all others. The patient may feel misunderstood, unfairly treated, or unloved and may anticipate that the therapist will behave accordingly. Often the patient unconsciously creates situations to invite the therapist to behave in this manner. For this reason, the therapist must be alert to what Adlerians call "scripts," and Eric Berne (1964) calls "games," and foil the patient's expectations. A patient, for example, will declare, "Have you ever seen a patient like me before?" to establish uniqueness and to challenge the therapist's competence. The therapist's response may be a straightforward, but not sarcastic, "Not since the last hour," followed by a discussion of uniqueness. Because assessment begins with the first moment of contact, the patient is generally given some interpretation, usually phrased as a guess, during the first interview. This gives the patient something to think about until the next interview. The therapist will soon find it possible to assess how the patient will respond to interpretation, to therapy, and to the therapist and will gain some glimpse of the life-style framework. The therapist does not play the patient's game, because at that game the patient is the professional, having played it successfully since childhood (although often in self-defeating fashion), whereas the therapist is a relative amateur. The therapist does not have to *win* the game but merely does not play it. Only one side wins in a tug-of-war. However, in this case, one side (the therapist) is uninterested in victories or defeats and simply doesn't pick up the end of the rope. This renders the "opponent's" game ineffective, and the two can proceed to play more productive, cooperative games (Mosak & Maniacci, 1998).

The whole relationship process increases the education of the patient. For some patients, it is their first experience of a good interpersonal relationship involving cooperation, mutual respect, and trust. Despite occasional bad feelings, the relationship can

endure and survive. The patient learns that good and bad relationships do not merely happen—they are products of people's efforts—and that poor interpersonal relationships are products of misperceptions, inaccurate conclusions, and unwarranted anticipations incorporated in the life-style.

Analysis

Investigation of a patient's dynamics is divided into two parts. The therapist, first, wants to understand the patient's life-style and, second, aims to understand how the life-style affects current function with respect to the life tasks. Not all suffering stems from the patient's life-style. Many patients with adequate life-styles develop problems or symptoms in the face of intolerable or extreme situations from which they cannot extricate themselves.

Analytic investigation begins with the first moment. The way a patient enters the room, posture, and choice of seating (especially important in family therapy) all provide important clues. What the patient says and how it is said expand the therapist's understanding, especially when the therapist interprets the patient's communications in interpersonal terms, or "scripts," rather than in descriptive terms. Thus, the Adlerian translates the descriptive statement "I am confused" into the admonition "Don't pin me down." "It's a habit" conveys the declaration "And that's another thing you're not going to get me to change" (Mosak & Gushurst, 1971). The therapist assesses, follows up, and juxtaposes clues in patterns, accepting some hypotheses and rejecting others in an effort to understand the patient. As therapy progresses, the patient offers information one way or another, and the therapist pieces it together bit by bit like a jigsaw puzzle.

The Life-Style Investigation

In formal assessment procedures, the patient's family constellation is explored. The therapist obtains glimpses of what position the child found in the family and how he or she went about finding a place within the family, in school, and among peers. The second portion of the assessment consists of interpreting the patient's early recollections. An *early recollection* occurs in the period before continuous memory and may be inaccurate or a complete fiction. It represents a single event ("One day I remember . . .") rather than a group of events ("We used to . . ."). Adlerians refer to the latter as *a report* rather than a recollection. Reports are important to the therapeutic assessment process. However, they are not interpreted the same way as early recollections (Shulman & Mosak, 1988). Recollections are treated as a projective technique (Mosak, 1958). If one understands the early recollections, one understands the patient's "Story of My Life" (Adler, 1931), because people selectively recollect incidents consonant with their life-styles. The following recollection of Adler himself (1947) may serve to illustrate the consonance between his earliest recollection and his later psychological views:

> One of my earliest recollections is of sitting on a bench, bandaged up on account of rickets, with my healthy elder brother sitting opposite me. He could run, jump, and move about quite effortlessly, while for me movement of any sort was a strain and an effort. Everyone went to great pains to help me, and my mother and father did all that was in their power to do. At the time of this recollection I must have been about two years old. (p. 9)

In a single recollection, Adler refers to organ inferiority, the inferiority feeling, the emphasis on "my desire to move freely—to see all psychic manifestations in terms of movements" (p. 10), and social feeling (Mosak & Kopp, 1973).

The summary of early recollections, the story of the patient's life, permits the derivation of the patient's "basic mistakes" (Mosak & DiPietro, 2006). The life-style can be conceived as a personal mythology. The individual will behave *as if* the myths were true because, for him or her, they are true. Consequently, there are "truths" or partial "truths" in myths, and there are myths we confuse with truth. The latter are *basic mistakes.*

Basic mistakes may be classified as follows:

1. *Overgeneralizations.* "People are hostile." "Life is dangerous."
2. *False or impossible goals of security.* "One false step and you're dead." "I have to please everybody."
3. *Misperceptions of life and life's demands.* Typical convictions might be "Life never gives me any breaks" and "Life is so hard."
4. *Minimization or denial of one's worth.* "I'm stupid" and "I'm undeserving" or "I'm just a housewife."
5. *Faulty values.* "Be first even if you have to climb over others."

Finally, the therapist is interested in how the patient perceives his or her assets.

Sample Life-Style Summary

The following sample life-style summary is not intended to be a complete personality description, but it does offer patient and therapist initial hypotheses.

Summary of Family Constellation

John is the younger of two children, the only boy. He grew up fatherless after age 9. His sister was so precocious that John became discouraged. Because he felt he would never become famous, he decided perhaps he could at least be notorious and brought himself to the attention of others through negative behavior. He acquired the reputation of a "holy terror." He was going to do everything his way, and nobody was going to stop him. He patterned his behavior after that of his strong, "masculine" father, from whom he learned that the toughest man wins. Because notoriety came with doing the disapproved, John early became interested in and engaged in sex. This also reinforced his feelings of masculinity. Because both parents were handicapped and yet still "made it," John apparently decided that without any physical handicaps, the sky would be the limit for him.

Summary of Early Recollections

"I run scared in life, and even when people tell me there's nothing to be scared of, I'm still scared. Women give men a hard time. They betray them, they punish them, and they interfere with what men want to do. A real man takes no crap from anybody. Somebody always interferes. I am not going to do what others want me to do. Others call that bad and want to punish me for it, but I don't see it that way. Doing what I want is merely part of being a man."

"Basic Mistakes"

1. John exaggerates the significance of masculinity and equates it with doing what he pleases.
2. He is not on the same wavelength as women. They see his behavior as "bad"; he sees it as only "natural" for a man.

3. He is too ready to fight, many times just to preserve his sense of masculinity.
4. He perceives women as the enemy, even though he looks to them for comfort.
5. Victory is snatched from him at the last moment.

ASSETS

1. He is a driver. When he puts his mind to things, he makes them work.
2. He engages in creative problem solving.
3. He knows how to get what he wants.
4. He knows how to ask a woman "nicely."

During the course of the treatment, other forms of analysis will occur. Because the therapist views the life-style as consistent, it will express itself in all of the patient's behavior—physical behavior, language and speech, fantasy productions, dreams, and interpersonal relationships, past and present. Because of this consistency, the patient may choose to express herself or himself in any or all of these media because they all express life-style. The therapist observes behavior, speech, and language closely during each interview. Sometimes the dialogue will center on the present, sometimes on the past, often on the future. Free association and chitchat, except when the latter serves a therapeutic purpose, are mostly discouraged. Although dream analysis is an integral part of psychotherapy, the patient who speaks only of dreams receives gentle dissuasion (Alexandra Adler, 1943). The analysis proceeds with an examination of the interplay between life-style and the life tasks: how the life-style affects the person's function and dysfunction vis-à-vis the life tasks.

Dreams

Adler saw the dream as a problem-solving activity with a future orientation, in contrast to Freud's view that it was an attempt to solve an old problem. The *dream* is seen by Adlerians as a rehearsal of possible future courses of action. If we want to postpone action, we forget the dream. If we want to dissuade ourselves from some action, we frighten ourselves with a nightmare.

The dream, Adler said, was the "factory of emotions." In it we create moods that move us toward or away from the next day's activities. Commonly, people say, "I don't know why but I woke up in a lousy mood today." The day before Adler died, he told friends, "I woke smiling . . . so I knew my dreams were good although I had forgotten them" (Bottome, 1939, p. 240). Just as early recollections reflect long-range goals, the dream experiments with possible answers to immediate problems. In accordance with their view of the individual's uniqueness, Adlerians reject the theory of fixed symbolism. One cannot understand a dream without knowing the dreamer, although Adler (1963b) and Erwin Wexberg (1929) do address themselves to some frequently encountered dream themes. Way admonishes,

> One is reminded again of two boys, instanced by Adler [1964a, p. 150], each of whom wished to be a horse, one because he would have to bear the responsibility for his family, the other to outstrip all the others. This should be a salutary warning against making dictionary interpretations. (1962, pp. 282–284)

The interpretation of the dream does not terminate with the analysis of the content but must include the purposive function. Dreams serve as weather vanes for treatment, bringing problems to the surface and pointing to the patient's movement. Dreikurs describes a patient who related recurrent dreams that were short and actionless, reflecting his life-style of figuring out "the best way of getting out of a problem, mostly without doing anything. . . . When his dreams started to move and become active he started to move in his life, too" (Dreikurs, 1944, p. 26).

Reorientation

Reorientation in all therapies proceeds from persuading the patient, gently or forcefully, that change is in his or her best interest. The patient's present manner of living affords "safety" but not happiness. Because neither therapy nor life offers guarantees, one must risk some "safety" for the possibility of greater happiness and self-fulfillment. This dilemma is not easily solved. Like Hamlet, the patient wonders whether it is better to "bear those ills we have than fly to others that we know not of."

Insight

Analytic psychotherapists frequently assign central importance to insight, assuming that "basic change" cannot occur in its absence. The conviction that insight must precede behavioral change often results in extended treatment, in encouraging some patients to become "sicker" to avoid or postpone change, and in increasing their self-absorption rather than their self-awareness. Meanwhile, patients relieve themselves from the responsibility of living life until they have achieved insight.

A second assumption, treasured by therapists and patients alike, distinguishes between *intellectual* and *emotional* insight (Ellis, 1963; Papanek, 1959), a dualism the holistic Adlerian experiences difficulty in accepting. This and other dualisms, such as conscious versus unconscious, undeniably exist in the patient's subjective experience. But these antagonistic forces are creations of the patient that delay action. Simultaneously, the patient can maintain a good conscience because he or she is the victim of conflicting forces or an emotional block. Solving problems is relegated to the future while the patient pursues insight. *Insight,* as the Adlerian defines it, is understanding translated into constructive action. It reflects the patient's understanding of the purposive nature of behavior and mistaken apperceptions, as well as an understanding of the role both play in life movement. So-called intellectual insight merely reflects the patient's desire to play the game of therapy rather than the game of life.

Interpretation

The Adlerian therapist facilitates insight mainly by interpreting ordinary communications, dreams, fantasies, behavior, symptoms, the patient–therapist transactions, and the patient's interpersonal transactions. The emphasis in interpretation is on purpose rather than cause, on movement rather than description, on use rather than possession. Through interpretation, the therapist holds up a mirror for the patient.

The therapist relates past to present only to indicate the continuity of the maladaptive life-style, not to demonstrate a causal connection. The therapist may also use humor (Mosak, 1987a) or illustrate with fables (Pancner, 1978), anecdotes, and biography. Irony may prove effective, but it must be handled with care. The therapist may "spit in the patient's soup," a crude expression for exposing the patient's intentions in such a way as to make them unpalatable. The therapist may offer the interpretation directly or in the form of "Could it be that . . .?" or may invite the patient to make interpretations. Although timing, exaggeration, understatement, and accuracy are technical concerns of any therapist, they are not emphasized by the Adlerian therapist, who does not view the patient as fragile.

Other Verbal Techniques

Advice is often frowned upon by therapists. Hans Strupp relates, "It has been said that Freud, following his own recommendations, never gave advice to an analysand on the couch but did not stint with the commodity from the couch to the door" (1972, p. 40).

Wexberg (1929/1970) frowned on giving advice to a patient, but the Adlerian therapist freely gives advice, as did Freud, taking care, however, not to encourage dependency. In practice, the therapist may merely outline the alternatives and let the patient make the decision. This invitation develops faith in self rather than faith in the therapist. On the other hand, the therapist may offer direct advice, taking care to encourage the patient's self-directiveness and willingness to stand alone.

Given that Adlerians consider the patient discouraged rather than sick, it is no surprise that they make extensive use of encouragement. Enhancing the patient's faith in self, "accentuating the positive and eliminating the negative," and keeping up the patient's hope all contribute to counteracting discouragement. The patient who "walks and falls" learns it is not fatal and can get up and walk again. Therapy also counteracts the patient's social values, thus altering his or her view of life and helping give meaning to it. Moralizing is avoided, although therapists must not deceive themselves into believing their system has no value orientation. The dialogue concerns "useful" and "useless" behavior rather than "good" and "bad" behavior.

The therapist avoids rational argument and trying to "out-logic" the patient. These tactics are easily defeated by the patient who operates according to the rules of *psychologic* (private logic) rather than formal logic. Catharsis, abreaction, and confession may afford the patient relief by freeing him or her from carrying the burden of "unfinished business," but as has been noted (Alexander & French, 1946), these may also be a test of whether the patient can place trust in the therapist.

Action Techniques

Adlerians regularly use role playing, talking to an empty chair (Shoobs, 1964), the Midas technique (Shulman, 1962), the behind-the-back technique (Corsini, 1953), and other action procedures to assist the patient in reorientation. The extent of use is a function of the therapist's preference, training, and readiness to experiment with the novel.

Mechanisms of Psychotherapy

The Therapist as Model

The therapist represents values the patient may attempt to imitate. Adlerian therapists represent themselves as being "for real," fallible, able to laugh at themselves, caring—models for social interest. If the therapist can possess these characteristics, perhaps the patient can, too, and many patients emulate their therapists, whom they use as referents for normality (Mosak, 1967).

Change

There comes a time in psychotherapy when analysis must be abandoned and the patient must be encouraged to move forward. Insight has to give way to decisive action.

Some of the techniques Adlerians use to elicit change are described below and by Mosak and Maniacci (1998). They are not panaceas, nor are they used indiscriminately. The creative therapist will improvise techniques to meet the needs of the therapeutic moment and will remember, above all, that people are more important than techniques and strategies. The therapist who loses sight of these cautions is a technician who does all the "right" things but is never engaged in a human encounter with another human being.

Acting "As If"

A common patient refrain in treatment is "If only I could . . ." (Adler, 1963a). Adlerian therapists often request that for the next week the patient act "as if." The patient may protest that it would only be an act and therefore phony. We explain that all acting is not phony pretense, that one can try on a role as one might try on a suit. It does not change the person wearing the suit, but sometimes with a handsome suit of clothes, one may feel differently and perhaps behave differently, thus becoming a different person.

Task Setting

Adler (1964a) gave us the prototype for task setting in his treatment of depressives:

> To return to the indirect method of treatment: I recommend it especially in melancholia. After establishing a sympathetic relation I give suggestions for a change of conduct in two stages. In the first stage my suggestion is "Only do what is agreeable to you." The patient usually answers, "Nothing is agreeable." "Then at least," I respond, "do not exert yourself to do what is disagreeable." The patient, who has usually been exhorted to do various uncongenial things to remedy this condition, finds a rather flattering novelty in my advice, and may improve in behavior. Later I insinuate the second rule of conduct, saying that "it is much more difficult and I do not know if you can follow it." After saying this I am silent, and look doubtfully at the patient. In this way I excite his curiosity and ensure his attention, and then proceed, "If you could follow this second rule you would be cured in fourteen days. It is helpful to consider from time to time how you can give another person pleasure. It would very soon enable you to sleep and would chase away all your sad thoughts. You would feel yourself to be useful and worthwhile."
>
> I receive various replies to my suggestion, but every patient thinks it is too difficult to act upon. If the answer is, "How can I give pleasure to others when I have none myself?" I relieve the prospect by saying, "Then you will need four weeks." The more transparent response, "Who gives *me* pleasure?" I counter with what is probably the strongest move in the game, by saying, "Perhaps you had better train yourself a little thus: Do not actually DO anything to please anyone else, but just think out how you COULD do it!" (pp. 25–26)

The tasks are relatively simple and are set at a level at which patients can sabotage the task, but they cannot fail and then scold the therapist.

> The patient must understand that not the physician but life itself is inexorable. He must understand that ultimately [he will have] to transfer to practical life that which has been theoretically recognized. . . . But from the physician he hears no word of reproach or of impatience, at most an occasional kindly, harmless, ironical remark. (p. 101)

A 50-year-old man who professed "genuine" intention to get married but simultaneously avoided women was instructed to seek one meaningful contact with a woman (how to do so was up to him) every day. After raising many objections, he complained, "But it's so hard! I'll get so tired out I won't be able to function." The therapist good-humoredly relented and informed him, "Since God rested on the seventh day, I can't ask you to do more than God. So you need carry out the task only six days a week."

One form of task setting that Adler introduced is called *antisuggestion* by Wexberg (1929) and *paradoxical intention* by Frankl (1963). This method, used nonclinically by Knight Dunlap (1933), was labeled *negative practice.* The symptomatic patient unwittingly

reinforces symptoms by fighting them, by saying, "Why did this have to happen to *me*?" The insomniac keeps one eye open to observe whether the other is falling asleep. To halt this fight, the patient is instructed to intend and even increase that which he or she is fighting against.

Creating Images

Adler was fond of describing patients with a simple phrase—for example, "the beggar as king." Other Adlerians give patients similar shorthand images that confirm the adage that "one picture is worth a thousand words." Remembering this image, the patient can remember goals and, in later stages, can learn to use the image to laugh at self. One overambitious patient, labeled "Superman," one day began to unbutton his shirt. When the therapist made inquiry, the patient laughingly replied, "So you can see my blue shirt with the big 'S' on it." Another patient, fearing sexual impotence, concurred with the therapist's observation that he had never seen an impotent dog. The patient advanced as explanation: "The dog just does what he's supposed to do without worrying about whether he'll be able to perform." The therapist suggested that at his next attempt at sexual intercourse, before he made any advances, he should smile and say inwardly, "Bow wow." The following week, the patient informed the members of his group, "I bow wowed."

Catching Oneself

When patients understand personal goals and want to change, they are instructed to catch themselves "with their hand in the cookie jar." Patients may catch themselves in the midst of their old behavior but still feel incapable of doing anything about it at the moment. With additional practice, they learn to anticipate situations in time to avoid them.

The Push-Button Technique

This method, effective with people who feel they are victims of their disjunctive emotions, involves requesting patients to close their eyes, to re-create a pleasant incident from past experience, and to note the feeling that accompanies this image. Then they are asked to re-create an unpleasant incident of hurt, humiliation, failure, or anger and to note the accompanying feeling. Following this, the patient re-creates the first scene again. The lesson Adlerians try to teach clients is that they can create whatever feeling they wish merely by deciding what they will think about. One is the creator, not the victim, of emotions. To be depressed, for example, requires *choosing* to be depressed. We try to impress patients with their power for self-determination. This method, devised for clinical use by Mosak (1985), has been the subject of experimental investigation by Brewer (1976), who found it an effective technique in treating state depression.

The "Aha" Experience

The patient who gains awareness in treatment and increases participation in life recurrently has "aha" or "eureka" experiences. With this greater understanding, the patient generates self-confidence and optimism, resulting in increased encouragement and willingness to confront life's problems with commitment, compassion, and empathy.

Post-therapy

After therapy is over, the patient can implement newly acquired learning. Operationally, the goal of therapy may be defined as making the therapist superfluous. If therapist and patient have both done their jobs well, the goal will have been achieved.

APPLICATIONS

Who Can We Help?

Although Adler, like the other *Nervenärzte* ("nerve doctors") of his era, conducted one-to-one psychotherapy, his own social orientation moved him out of the consulting room and into the community. Although he never relinquished his clinical interests, he concurrently was an educator and a social reformer. Joost Meerloo, a Freudian, eulogizes Adler with his confession:

> As a matter of fact, the whole body of psychoanalysis and psychiatry is imbued with Adler's ideas, although few want to acknowledge this fact. We are all plagiarists, though we hate to confess it. . . . The whole body of social psychiatry would have been impossible without Adler's pioneering zest. (1970, p. 40)

Clinical

All the early pioneers in psychotherapy treated neurotics. Psychotics were considered not amenable to psychotherapy because they could not enter into a transference relationship. Adlerians, unencumbered by the concept of transference, treated psychotics regularly.

Henri Ellenberger (1970, p. 618) suggests that "among the great pioneers of dynamic psychiatry, Janet and Adler are the only ones who had personal clinical experience with criminals, and Adler was the only one who wrote something on the subject from his direct experience." An Adlerian, Ernst Papanek (1971), of whom Claude Brown (1965) wrote so glowingly in *Manchild in the Promised Land,* was director of Wiltwyck School (a reform school). Mosak set up a group therapy program at Cook County Jail in Chicago employing paraprofessionals as therapists (O'Reilly, Cizon, Flanagan, & Pflanczer, 1965). The growth model implicit in Adlerian theory has prompted Adlerians to see human problems in terms of people's realizing themselves and becoming fellow human beings. Much "treatment" then is of "normal" people with "normal" problems. A therapy that does not provide the client with a philosophy of life, whatever else it may accomplish in the way of symptom eradication or alleviation, behavior modification, or insight, is an incomplete therapy. Hence the Adlerian is concerned with the client's problems of living and existence. Deficiency, suffering, and illness do not constitute the price of admission to Adlerian therapy. One may enter therapy to learn about oneself, to grow, and to actualize oneself.

Social

Adler's interests were rather catholic. In the area of education, he believed in prevention rather than cure and founded family education centers. Dreikurs and his students (Dreikurs et al., 1959) have founded family education centers throughout the world. Offshoots of these centers include hundreds of parent study groups (Soltz, 1967). In addition, professional therapists have used a variety of methods for teaching child-rearing practices (Allred, 1976; Beecher & Beecher, 1966; Corsini & Painter, 1975; Dreikurs, 1948; Dreikurs & Soltz, 1964; Painter & Corsini, 1989).

Adler himself wrote on social issues and problems such as crime, war, religion, group psychology, Bolshevism, leadership, and nationalism. Among contemporary Adlerians (Angers, 1960; Clark, 1965, 1967a, 1967b; Elam, 1969a, 1969b; Gottesfeld, 1966; Hemming, 1956; La Porte, 1966; Lombardi, 1969; Nikelly, 1971c), the "newer" social problems of protest, race, drugs, and social conditions, as well as the "newer" views of religion (Mosak, 1987b), have been added to the Adlerians' previous interests.

Treatment

One can hardly identify a mode of treatment in which some Adlerian is not engaged. From a historical standpoint, the initial Adlerian modality was one-to-one psychotherapy. Many Adlerians still regard individual psychotherapy as the treatment of choice. Adlerians have demonstrated willingness to undertake treatment with any who sought their services (Watts & Carlson, 1999).

Dreikurs, Mosak, and Shulman (1952a, 1952b, 1982) introduced *multiple psychotherapy,* a format in which several therapists treat a single patient. It offers constant consultation between therapists, prevents the emotional attachment of a patient to a single therapist, and obviates or dissolves impasses. Countertransference reactions are minimized. Flexibility in the number of therapist roles and models is increased. Patients are more impressed or reassured when two therapists independently agree. The patient also may benefit from the experience of observing disagreement between therapists and may learn that people can disagree without loss of face.

Multiple therapy creates an atmosphere that facilitates learning. Therapeutic impasses and problems of dependency are resolved more easily. These include the responsibility for self, therapist–transference reactions, and termination. In the event that therapist and patient do not hit it off, the patient does not become a therapeutic casualty and is merely transferred to the second therapist.

In the mid-1920s, Dreikurs (1959) initiated group therapy in private practice. This application was a natural evolution from the Adlerian axiom that people's problems are always social problems. Group therapy finds considerable adherents among Adlerians. Some Adlerian therapists regard group therapy as the method of choice either on practical grounds (e.g., fees, large numbers of patients to be treated, etc.) or because they believe that human problems are most effectively handled in the group social situation. Others use group therapy as a preface to individual therapy or to wean patients from intensive individual psychotherapy. A number of therapists combine individual and group psychotherapy in the conviction that this combination maximizes therapeutic effect (Papanek, 1954, 1956). Still other therapists visualize the group as assisting in the solution of certain selected problems or with certain types of populations. Co-therapist groups are very common among Adlerians.

An offshoot of group treatment is the therapeutic social club in a mental hospital, as initiated by the British Adlerian, Joshua Bierer. Although these clubs possess superficial similarities to Abraham Low's recovery groups (Low, 1952) and to halfway houses in that all attempt to facilitate the patient's reentrance into society, the therapeutic social club emphasizes the "social" rather than the "therapeutic" aspects of life, taking the "healthy" rather than the "sick" model.

Psychodrama has been used by Adlerians, sometimes as separate therapy, sometimes in conjunction with another therapeutic modality (Starr, 1977).

Marriage counseling has figured prominently in Adlerian activities. Adlerians defied the trend of the times and preferred to treat the couple as a unit rather than as separate individuals. To "treat" merely one mate may be compared to having only half the dialogue of a play. Seeing the couple together suggests that they have a joint relationship problem rather than individual problems and invites joint effort in the solution of these problems. The counselor can observe and describe their interaction (Mozdzierz & Lottman, 1973; Pew & Pew, 1972). Married couples group therapy (Deutsch, 1967) and married couples study groups are two more settings for conducting marriage counseling. Phillips and Corsini (1982) and Dinkmeyer and Carlson (1989) have written self-help books designed to be used by married people who are experiencing trouble in their marriage.

In the early 1920s, Adler persuaded the Viennese school administration to establish child-guidance centers. The social group was the primary vehicle for treatment (Adler,

1963a; Alexandra Adler, 1951; Seidler & Zilahi, 1949). Dreikurs wrote several popular books and many articles (Dreikurs, 1948; Dreikurs & Grey, 1968; Dreikurs & Soltz, 1964) to disseminate this information to parents and teachers, and today thousands of parents are enrolled in study groups where they obtain supplementary information on child rearing.

Adler's preventive methods in schools were adopted by educators and school counselors who used them in individual classes and schools and, in one case, in an entire school system (Mosak, 1971). The methods were originally applied in the Individual Psychological Experimental School in Vienna (Birnbaum, 1935; Spiel, 1962) and have been elaborated on in this country (Corsini, 1977, 1979; Dinkmeyer & Dreikurs, 1963; Dreikurs, 1968, 1972; Dreikurs, Grunwald, & Pepper, 1982; Grunwald, 1954).

With respect to broader social problems, Dreikurs devoted the last part of his life to the problem of interindividual and intergroup conflict resolution. Much of this work was performed in Israel and has not been reported. Kenneth Clark, a former president of the American Psychological Association, has devoted much of his career to studying and providing recommendations for solutions for problems of African-Americans, as have Harry Elam (1969a, 1969b) and Jacqueline Brown (1976).

The Setting

Adlerians function in every imaginable setting: the private-practice office, hospitals, day hospitals, jails, schools, and community programs. Offices do not need any special furnishings but reflect either the therapist's aesthetic preferences or the condition of the institution's budget. No special equipment is used, except perhaps for special projects. Although voice recordings are a matter of individual choice, they are sometimes maintained as the patient's file.

In the initial interviews, the therapist generally obtains the following kinds of information (in addition to demographic information):

1. Was the patient self-referred?
2. Is the patient negative about treatment? If the patient is reluctant, "conversion" is necessary if therapy is to proceed.
3. What does the patient come for? Is it treatment to alleviate suffering? If so, suffering from what? Some new patients are "supermarket shoppers" who announce the number of therapists who have helped them already. Their secret goal is to be perfect. Unless such a patient's fictional goal is disclosed, today's therapist may be the latest of many therapists about whom the patient will be telling the next one.
4. What are the patient's expectations about treatment?
5. What are the patient's expectations about outcome? Perfection? Failure? A solution for a specific problem without any major personality alterations? Immediate cure?
6. What are the patient's goals in psychotherapy? We must distinguish between stated goals—to get well, to learn about self, to be a better spouse and parent, to gain a new philosophy of life—and nonverbalized goals—to remain sick, to punish others, to defeat the therapist and sabotage therapy, to maintain good intentions without changing.

The patient may also resist in order to depreciate or defeat the therapist because the patient lacks the courage to live on the useful side of life and fears that the therapist might nudge him or her in that direction. The intensification of such escape methods may become most pronounced during the termination phase of treatment, when the patient realizes he or she must soon face the realistic tasks of life without the therapist's support.

Tests

Routine physical examinations are not required by Adlerians, in view of the therapy's educational orientation. Nevertheless, many patients do have physiological problems, and Adlerians are trained to be sensitive to the presence of these problems. The therapist who suspects such problems will make referrals for physical examination.

Adlerians are divided on the issue of psychological testing. Most Adlerians avoid nosological diagnosis, except for nontherapeutic purposes such as filling out insurance forms. Labels are static descriptions that ignore the *movement* of the individual. They describe what the individual *has,* but not how he or she moves through life.

Regine Seidler placed more faith in projective testing than in so-called objective tests, maintaining that the latter are actually subjective tests because "the *subjective attitude* of each and every individual toward any given test necessarily renders the test nonobjective" (1967, p. 4). Objective tests were more useful to her as measures of test-taking attitude than as measures of what the test was purportedly measuring.

Early recollections serve as a test for Adlerians, assisting them in the life-style assessment, and Mosak & DiPietro (2006) have published a manual for interpreting them. Younger Adlerians employ many conventional tests and some unconventional ones for diagnostic purposes as well as in the treatment of the patient.

The BASIS-A Inventory (Wheeler, Kern, & Curlette, 1993), more formally known as the Basic Adlerian Scales for Interpersonal Success, is a 65-item test grounded in Adlerian principles. It measures individuals along five dimensions: Belonging-Social Interest, Going Along, Taking Charge, Wanting Recognition, and Being Cautious. In addition, there are five supporting scales that help round out the personality picture: Harshness, Entitlement, Liked by All, Striving for Perfection, and Softness. This instrument has been used in dozens of research studies (Kern, Gormley, & Curlette, 2008), and has become widely used to supplement the life-style assessment procedure commonly used by more traditionally trained clinicians.

The Therapist

The Adlerian therapist ideally is an authentically sharing, caring person. Helene and Ernst Papanek write,

> The therapist participates actively. Without playing any sharply defined "role," he shows warmth toward and a genuine interest in the patient and encourages especially his desire for change and betterment. The relationship itself has a purpose: to help the patient help himself. (1961, p. 117)

Adlerian therapists remain free to have feelings and opinions and to express them. Such expression in a spontaneous way permits patients to view therapists as human beings. If therapists err, they err—but then the patient may learn the courage to be imperfect from this experience (Lazarsfeld, 1966). The experience may also facilitate therapy.

Therapists must not inject evaluation of their own worth into the therapy; rather, they must do their therapeutic job without concern for prestige, not reveling in successes or becoming discouraged by failures. Otherwise, they may bounce like a rubber ball from therapy hour to therapy hour or perhaps even within the same hour. The therapist's worth depends not on external factors but on what lies within the self. The therapist is task oriented rather than self oriented.

Therapists reveal themselves as persons. The concept of the *anonymous therapist* is foreign to Adlerian psychology. Such a role would increase social distance between therapist and patient, interfering with the establishment of an egalitarian, human relationship. The "anonymous therapist" role was created to facilitate the establishment of

a transference relationship, and because the Adlerian rejects the transference concept as Freud formulated it, maintaining such a posture would be irrelevant, if not harmful, to the relationship. Dreikurs (1961) deplored the prevalent attitude among therapists of not coming too close to patients because it might affect the therapeutic relationship adversely. Shulman (Wexberg, 1929/1970, p. 88) defines the role of the therapist as that of "a helping friend." Self-revelation can occur only when therapists feel secure, at home with others, unafraid to be human and fallible, and thus unafraid of their patients' evaluations, criticism, or hostility (compare Rogers's "congruence").

Is the Adlerian therapist judgmental? In a sense, all therapists are judgmental in that therapy rests upon some value orientation: a belief that certain behavior is better than other behavior, that certain goals are better than other goals, that one organization of personality is superior to another form of organization. However, given that two cardinal principles of the Adlerian intervention are caring and encouragement, a critical or judgmental stance is best avoided.

Patient Problems

If the therapist does not like the patient, it raises problems for a therapist of any persuasion (Fromm-Reichman, 1949). Some therapists merely do not accept such patients. Still others feel they ought not to have (or ought to overcome) such negative feelings and therefore accept the patient for treatment, which often leads to both participants "suffering." It appears difficult to have "unconditional positive regard" for a patient you dislike. Adlerians meet this situation in the same manner other therapists do.

Seduction problems are treated as any other patient problem. The secure therapist will not become frightened, panic, or succumb. If the patient's activities nevertheless prevent the therapy from continuing, the patient may be referred to another therapist. Flattery problems are in some ways similar and have been discussed elsewhere (Berne, 1964; Mosak & Gushurst, 1971).

Suicide threats are always taken seriously (Ansbacher, 1961, 1969). Alfred Adler warned, however, that our goal is "to knock the weapon out of his hand" so the patient cannot make us vulnerable and intimidate us at will with his threats. As an example, he recounts that "A patient once asked me, smiling, 'Has anyone ever taken his life while being treated by you?' I answered him, 'Not yet, but I am prepared for this to happen at any time'" (Ansbacher & Ansbacher, 1956, pp. 338–339). Kurt Adler postulates "an underlying rage against people" in suicide threats and believes that this goal of vengefulness must be uncovered. He "knocks the weapon out of the patient's hand" as follows:

> Patients have tested me with the question of how would I feel if I were to read of their suicide in the newspaper. I answer that it is possible that some reporter hungry for news would pick up such an item from a police blotter. But, the next day, the paper will already be old, and only a dog perhaps may honor their suicide notice by lifting a leg over it in some corner. (1961, p. 66)

Alexandra Adler (1943), Lazarsfeld (1952), Pelzman (1952), Boldt (1994), and Zborowski (1997) discuss problems beyond the scope of this chapter.

Evidence

Until very recently, little research had emerged from the Adlerian group. Like most European clinicians, European Adlerians were suspicious of research based on statistical methods. A complicating factor was the *idiographic* (case method) approach on which Adlerians relied. Even now, statisticians have not developed appropriate sophisticated methods for idiographic studies. The research methods lent themselves well to studies

of causal factors, but the Adlerian rejected causalism, feeling that causes can only be imputed (and therefore disputed) in retrospective fashion but that they contributed little to the understanding of humans.

The most often-cited studies involving Adlerian psychology were conducted by non-Adlerians. Fred Fiedler (1950) compared therapeutic relationships in psychoanalytic, nondirective, and Adlerian therapy. He found that there was greater similarity between therapeutic relationships developed by experts of the three schools than between expert and less expert therapists within the same school. Crandall (1981) presented the first large-scale investigation of an Adlerian construct. Using his Social Interest Scale, Crandall found positive correlations between social interest and optimism about human nature, altruism, trustworthiness, being liked, and several measures of adjustment and well-being. Because of the number of ways in which social interest has been defined (Bickhard & Ford, 1976; Crandall, 1981; Edgar, 1975; Kazan, 1978; Mosak, 1991), his study represents a valuable contribution to the understanding of this concept.

A joint research study conducted by the (Rogerian) Counseling Center of the University of Chicago and the Alfred Adler Institute of Chicago examined the effects of time limits in psychotherapy (Shlien, Mosak, & Dreikurs, 1962). Patients of both groups of therapists were given 20 interviews, and the groups were compared with each other and with two control groups. The investigators reported changes in self-ideal correlations. These correlations improved significantly and, according to this measure, suggest that time-limited therapy "may be said to be not only *effective* but also twice as *efficient* as time-unlimited therapy" (p. 33).

Follow-up of these patients in both experimental groups indicated that the gains were retained one year later.

Much of the research in family constellation has been done by non-Adlerians. Charles Miley (1969) and Lucille Forer (1977) have compiled bibliographies of this literature. The results reported are contradictory, probably because non-Adlerians treat birth order as a matter of ordinal position and Adlerians consider birth order in terms of psychological position (Mosak, 1972). Walter Toman (1970) recognized this distinction in his many studies of the family constellation.

Ansbacher (1946) and Mosak (1958) have also distinguished between Freudian and Adlerian approaches to the interpretation of early recollections. Robin Gushurst (1971) provides a manual for interpreting and scoring one class of recollections. His reliability studies demonstrate that judges can interpret early-recollection data with high interjudge reliability. He also conducted three validity studies to investigate the hypothesis that life goals may be identified from early-recollection data and found that he could do this with two of his three experimental groups. Whereas Fiedler compared therapists of different orientations, Heine (1953) compared patients' reports of their experiences in Adlerian, Freudian, and Rogerian therapy. Taylor (1975) has written an excellent review of some early-recollection validity studies.

Adlerian psychology would undoubtedly benefit from more research. With the shift in locus from Europe to the United States, with the accelerated growth of the Adlerian school in recent years, with the introduction of more American-trained Adlerians into academic settings, and with the development of new research strategies suitable for idiographic data, there is increasing integration of Adlerians into research activities. A summary of these activities appears in articles by Watkins (1982, 1983) and Watkins and Guarnaccia (1999).

Westen, Novotny, and Thompson-Brenner (2004) have recently argued that the emphasis on empirically supported treatments is misplaced, for many reasons. Among other things, proponents of ESTs advocate something they call empirically informed treatments. The change is more than terminological. Rather than advocating empirically supported treatments per se, they advocate investigating techniques that could be used

by clinicians across treatments, regardless of orientation. If this were to be done, books such as Mosak and Maniacci's (1998) would be useful in supplying a range of techniques (i.e., tactics) that could be investigated across a range of situations. As Westen, Novotny, and Thompson-Brenner discuss, if techniques were empirically supported, treatments then would be empirically informed, even if the theories themselves were not. Additionally, they advocate tailoring treatment much more specifically to the personality pattern of clients, and not simply to symptoms and behaviors, a point long emphasized by the Adlerian concept of life-style.

Kern, Gormley, and Curlette (2008) have presented an invaluable summary of findings that used an Adlerian-based instrument, the BASIS-A, in more than 40 research studies across a wide range of issues (from the years 2000 through 2006). As the personality inventory continues to gain wider use, more research is expected, reversing a once unfortunate but common trend in Adlerian psychology that overlooked the importance of research. Similarly, Eckstein and Kern (2002) have summarized research in Adlerian psychology, with a special emphasis upon birth order research, citing more than 250 different studies.

Psychotherapy in a Multicultural World

Psychotherapy is an interpersonal transaction. For Adlerians especially, it entails the meeting of two worlds, the therapist's and the client's. This meeting requires both respect and tact.

In a multicultural world, psychotherapy can be perceived as intrusive. One of the reasons for such a perception is the therapist's insensitivity to the world view of the client. However, Adlerians have an answer to this dilemma: the life style assessment. Through the process of asking about the early family situation, including the family dynamics, values, interactions, and the social, academic, and religious factors of development, Adlerians quickly become sensitized to the particulars of an individual's development. In fact, the life style assessment process is typically a quick course in multiculturalism during which the client teaches the therapist about his or her culture. In the course of numerous life style assessments the authors have conducted with clients from several countries (including, but not limited to, China, Ghana, Ireland, Iraq, Iran, Israel, South Africa, Thailand, Japan, Italy, Columbia, England, France, Turkey and Germany), the client has served as instructor to us, the therapists, in what were key factors in his or her development. The life style assessment served as a bridge between cultures.

CASE EXAMPLE

Background

The patient was a 53-year-old, Vienna-born man who had been in treatment almost continuously with Freudian psychoanalysts, both in the United States and abroad, since he was 17. With the advent of tranquilizers, he had transferred his allegiances to psychiatrists who treated him with a combination of drugs and psychotherapy and finally with drugs alone. When he entered Adlerian treatment, he was being maintained by his previous therapist on an opium derivative and Thorazine. He failed to tell his previous therapist of his decision to see us and also failed to inform us that he was still obtaining medication from his previous therapist.

The treatment process was atypical in the sense that the patient's "illness" prevented our following our customary procedure. Having over the years become therapy-wise, he invested his creativity in efforts to run the therapy. Cooperative effort was virtually impossible. In conventional terms, the co-therapists, Drs. A and B, had their hands full dealing with the patient's resistances and "transference."

Problem

When the patient entered treatment, he had taken to bed and spent almost all his time there because he felt too weak to get up. His wife had to be constantly at his side or he would panic. Once she was encouraged by a friend to attend the opera alone. The patient wished her a good time and then told her, "When you return, I shall be dead." His secretary was forced into conducting his successful business. Everyone was forced into "the emperor's service." The price he paid for this service was intense suffering in the form of depression, obsessive-compulsive behavior, phobic behavior (especially agoraphobia), divorce from the social world, somatic symptoms, and invalidism.

Treatment

The patient was seen in multiple psychotherapy by Drs. A and B, but both therapists were not present at each interview. We dispensed with the life-style assessment because the patient had other immediate goals. It seemed to us from the patient's behavior that he probably had been raised as a pampered child and that he was using "illness" to tyrannize the world and to gain exemption from the life tasks. If these guesses were correct, we anticipated he would attempt to remain "sick," would resist giving up drugs, and would demand special attention from his therapists. As part of the treatment strategy, the therapists decided to wean him from medication, to give him no special attention, and not to be manipulated by him. Given that he had undergone analysis over a period of more than three decades, the therapists thought he could probably produce a better analysis of his problems than they could. For this reason, interpretation was kept at a minimum. The treatment plan envisaged a tactical and strategic, rather than interpretive, approach.

Some excerpts from the therapists' notes on the early part of treatment follow.

March 8

Dr. B wanted to collect life-style information but the patient immediately complained that he wanted to terminate. He said his previous therapist, Dr. C, had treated him differently. Therapist B was too impersonal. "You won't even give me your home phone number. You aren't impressed by my illness. Your treatment is well meaning but it won't help. Nothing helps. I'm going to go back to Dr. C and ask him to put me in the hospital. He gave me advice and you are so cruel by not telling me what to do."

March 19

Relatively calm. Compares B with Dr. C. Later compares B with A. Favors B over Dr. C because he respects former's strength. Favors B over A because he can succeed in ruffling latter but not former. Talk centers about his use of weakness to overpower others.

March 22

Telephones to say he must be hospitalized. Wife left him [untrue] and secretary left him [it turns out she went to lunch]. Would B come to his office to see him? B asks him to keep appointment in B's office. Patient races about office upset. "I'm sweating water and blood." When B remains calm, patient takes out bottle of Thorazine and threatens to take all. Next he climbs up on radiator, opens window (17th floor), jumps back, and says, "No, it's too high." "You don't help me. Why can't I have an injection?" Then he informs B that B is a soothing influence. "I wish I could spend the whole day with you." B speaks softly to patient and patient speaks quietly. Patient asks for advice about what to do this weekend. B gives antisuggestion and tells him to try to worry as much as he can. He is surprised and dismisses it as "bad advice."

March 29

B was sick on March 26, so patient saw A. "It was useless." No longer worried about state hospital. Thinks he will now wind up as bum because he got drunk last week. His secretary gave him notice but he hopes to keep her "by taking abuse. No one treats a boss like she treats me." Got out of bed and worked last week. Went out selling but "everyone rejected me." When B indicates that he seems to be better, he insists he's deteriorating. When B inquires how, he replies paradoxically, "I beat out my competitors this week."

April 2

Has habit of sticking finger down throat to induce vomiting. Threatens to do so when enters office today. B tells patient about the logical consequences of his act—he will have to mop up. Patient withdraws finger. "If you would leave me alone, I'd fall asleep so fast." B leaves him alone. Patient angrily declaims, "Why do you let me sleep?"

April 9

Too weak even to telephone therapist. If wife goes on vacation, he will kill himself. How can he survive with no one to tell him to eat, to go to bed, to get up? "All I do is vomit and sleep." B suggests that he tyrannizes his wife as he did his mother and sister. He opens window and inquires, "Shall I jump?" B recognizes this as an attempt to intimidate rather than a serious threat and responds, "Suit yourself." Patient closes window and accuses, "You don't care either." Asks whether he can see A next time and before receiving answer, says, "I don't want him anyway." Follows this with "I want to go to the state hospital. Can you get me a private room?" At end of interview falls to knees and sobs, "Help me! Help me to be a human being."

April 12

Enters, falls to knees, encircles therapist's knees, whimpers, "Help me!" So depressed. If only he could end it all. B gives him Adler's suggestion to do one thing each day that would give someone pleasure. Patient admits behaving better. Stopped annoying secretary and let her go home early because of bad weather. Agitation stops.

April 15

Didn't do anything this weekend to give pleasure. However, he did play cards with wife. Took her for drive. Sex with wife for "first time in a long time." B gives encouragement and then repeats "pleasure" suggestion. He can't do it. Calm whole hour. Says his wife has told him to discontinue treatment. Upon inquiry, he says she didn't say exactly that but had said, "I leave it up to you."

April 19

Wants B to accompany him back to his office because he forgot something. Wants shorter hour this week and longer one next week. "Dr. C let me do that." When B declines, he complains, "Doctor, I don't know what to do with you anymore."

April 23

Wouldn't consider suicide. "Perhaps I have a masochistic desire to live." B suggests he must be angry with life. He responds that he wants to be an infant and have all his needs gratified. The world should be a big breast and he should be able to drink

without having to suck [probably an interpretation he had received in psychoanalysis]. Yesterday he had fantasy of destroying the whole city.

This weekend he helped his wife work in the garden. He asks for suggestions for weekend. B and patient play "yes-but." B does so deliberately to point out game (cf. Berne's "Why don't you . . .? Yes but" [1964]) to patient. Patient then volunteers possibility of clay modeling. B indicates this may be good choice in that patient can mold, manipulate, and "be violent."

April 29

Had birthday last week and resolved to turn over new leaf for new year but didn't. Cries, "Help me, help me." Depreciates B. "How much would you charge me to come to my summer home? I'm so sick, I vomited blood." When B tells him if he's that sick, hospitalization might be advisable, he smiles and says, "For money, you'd come out." B and patient speak of attitude toward B and attitude toward his father. Patient depreciates both, possibly because he could not dominate either.

May 1

Didn't think he could make it today because he was afraid to walk on street. Didn't sleep all night. So excited, so upset [he seems calm]. Perhaps he should be put in hospital, but then what will happen to his business?

"We could sit here forever and all you would tell me is to get clay. Why don't you give me medicine or advice?" B points out that the patient is much stronger than any medication, as evidenced by number of therapists and treatments he has defeated.

He says he is out of step with world. B repeats an earlier interpretation by A that the patient wants the world to conform to him and follows with statement about his desire to be omnipotent, a desire that makes him feel weak and simultaneously compensates for his feelings of weakness. He confirms with "All Chicago should stand still so I could have a holiday. The police should stop at gunpoint anyone who wants to go to work. But I don't want to. I don't want to do anything anymore. I want a paycheck but I don't want to work." B remarks on shift from "I can't" to "I don't want to." Patient admits and says, "I don't want to get well. Should I make another appointment?" B refers decision back to him. He makes appointment.

May 6

"I'm at the end, dying with fear [enumerates symptoms]. Since five this morning I'm murdering ——— and ———. Such nice people and I'm murdering them and I'm electrocuted. And my secretary and wife can't stand it anymore. Take me to a state hospital. I don't want to go. Take me. I'm getting crazy and you don't help me. Help me, *Lieber Doktor!* I went to the ladies' room twice today to get my secretary and the girls complained to the building office. I'm not above the rules. I knew I violated them. My zipper was down again [he frequently "forgets"] and I just pulled it up before you came in today." B agrees that state hospital might be appropriate if he is becoming "crazier." "Then my wife will divorce me. It's terrible. They have bars there. I won't go. I'm not that bad yet. Why, last week I went out and made a big sale!" B suggests he "practice" his fears and obsessions.

May 8

Seen by A and B, who did summary of his family constellation. It was done very tentatively because of the meager information elicited.

May 13

Complains about symptoms. He had taken his wife to the movies but "was too upset to watch it." He had helped with the raking. Returns to symptoms and begging for Thorazine. "How will I live without Thorazine?" B suggests they ought to talk about how to live. He yells, "With your quiet voice, you'll drive me crazy." B asks, "Would you like me to yell at you like your father did?" "I won't talk to you anymore." "*Lieber Gott,* liberate me from the evil within me." Prays to everyone for help. B counters with "Have you ever solicited your own help?" Patient replies, "I have no strength, I could *cry.* I could shout. I don't have strength. Let me vomit."

May 15

Demands Thorazine or he will have heart attack. B requests a future autobiography. Responds "I don't anticipate anything" and returns to Thorazine question. B points out his real achievement in staying off Thorazine. Patient mentions price in suffering. B points out that this makes it an even greater achievement. Patient accepts idea reluctantly. B points out that they are at cross-purposes because patient wants to continue suffering but have pills; B's goal is to have him stop his suffering. "I want pills." B offers clay. "Shit on your clay."

May 20

Must have Thorazine. Has murderous and self-castrating fantasies. Tells A that A does not know anything about medicine. Dr. C did. Why don't we let him go back to Dr. C? A leaves room with patient following. After three to four minutes patient returns and complains, "You call this treatment?" Dr. A points out demand of patient to have own way. He is a little boy who wants to be big but doesn't think he can make it. He is a pampered tyrant. A also refers to patient's favorite childhood game of lying in bed with sister and playing "Emperor and Empress."

Patient points out innate badness in himself. A points out he creates it. Patient talks of hostility and murder. A interprets look on his face as taking pride in his bad behavior. Patient picks up letter opener, trembles, then grasps hand with other hand but continues to tremble. A tells him that this is a spurious fight between good and evil, that he can decide how he will behave.

He kneaded clay a little while this weekend.

May 22

Last weekend he mowed lawn, tried to read but "I'm nervous. I'm talking to you like a human being but I'm not really a human being." Raw throat. Fears might have throat cancer. Stopped sticking finger down throat to vomit as consequence. Discussion of previously expressed ideas of "like a human being." Fantasy of riding a boat through a storm. Fantasy of A being acclaimed by crowd and patient in fantasy asking B, "Are you used to A getting all the attention?" Complains about wife and secretary, neither of whom will any longer permit tyrannization.

June 3

Relates fantasy of being magician and performing unbelievable feats at the White House. He asked the President whether he was happily married and then produced the President's ring. Nice weekend. Made love to wife at his initiative. Grudgingly admits enjoying it.

June 10

"Ignored my wife this week." Yet he took initiative and they had sex again. Both enjoyed it but he was afraid because he read in a magazine that sex is a drain on the heart. At work secretary is angry. After she checks things, he rechecks. Pledged to God today he wouldn't do it anymore. He'll only check one time more. Outlines several plans for improving business "but I don't have the strength." Wants to cut down to one interview per week because he doesn't get well and can't afford to pay. B suggests that perhaps he is improving if he wants to reduce the number of sessions. Patient rejects and agrees to two sessions weekly.

June 24

Talks about fears. B tells him he will go on vacation next week. He accepts it calmly although he had previously claimed to be unendurably upset. Patient tells B that he has given up vomiting and masturbation, saying, "You have enormous influence on me." B encourages by saying patient made the decision by himself.

Sept. 4

[Patient was not seen during August because he went on a "wonderful" vacation.] Stopped all medication except for occasional use of a mild tranquilizer his family physician prescribed. Able to read and concentrate again. Has surrendered his obsessive ruminations. He and his secretary get along without fighting although she doesn't like him. He is punctual at the office. He and wife get along well. He is more considerate of her. Both are sexually satisfied.

B and patient plan for treatment. Patient expresses reluctance, feeling that he has gone as far as he can. After all, one psychoanalyst said that he was hopeless and had recommended a lobotomy, so this was marked improvement. B agreed, telling patient that if he had considered the patient hopeless, he would not have undertaken treatment, nor would he now be recommending continuation. "What kind of treatment?" B tells him that no external agent (e.g., medicine, lobotomy) will do it, that his salvation will come from within, that he can choose to live life destructively (and self-destructively) or constructively. He proposes to come weekly for four weeks and then biweekly. B does not accept the offer.

Sept. 17

Since yesterday his symptoms have returned. Heart palpitations.

Sept. 25

Took wife to dinner last night. Very pleasant. Business is slow and his obligations are heavy but he is working. He has to exert effort not to backslide. B schedules double interview. Patient doesn't want to see A. It will upset him. He doesn't see any sense in seeing B either but since B insists. . . . Heart palpitations disappeared after last interview. Expresses realistic concerns today and has dropped usual frantic manner. Wants biweekly interviews. B wants weekly. Patient accepts without protest.

As therapy continued, the patient's discussion of symptoms was superseded by discussion of realistic concerns. Resistance waned. When he entered treatment, he perceived himself as a good person who behaved badly because he was "sick." During therapy, he saw through his pretenses and settled for being "a bad guy." However, once he understood his tyranny and was able to accept it, he had the opportunity to ask himself how he preferred to live his life—usefully or uselessly. Because the therapists

used the monolithic approach (Alexander & French, 1946; Mosak & Shulman, 1963), after resolving the issue of his tyranny, therapy moved on to his other "basic mistakes," one at a time. The frequency of interviews was decreased, and termination was by mutual agreement.

Follow-Up

The patient improved, remaining off medication. When he devoted himself to his business, it prospered to the point where he could retire early. He moved to a university town, where he studied archaeology, the activity he liked best in life. His relationship with his wife improved, and they traveled abroad. Because of the geographical distance between them, the therapists and the patient had no further contact.

SUMMARY

Adlerian theory may be described as follows:

1. Its approach is social, teleological, phenomenological, holistic, idiographic, and humanistic.
2. Its underlying assumptions are that (a) the individual is unique, (b) the individual is self-consistent, (c) the individual is responsible, (d) the person is creative, an actor, a chooser, and (e) people in a soft-deterministic way can direct their own behavior and control their destinies.
3. Its personality theory takes as its central construct the life-style, a system of subjective convictions held by the individual that contains his or her self-view and world view. From these convictions, other convictions, methods of operation, and goals are derived. The person behaves as if these convictions were true and uses his life-style as a cognitive map with which he explores, comprehends, prejudges, predicts, and controls the environment (the life tasks). Because the person cannot be understood in a vacuum but only in his or her social context, the interaction between the individual and the individual's life tasks is indispensable for the purpose of fully comprehending that individual.
4. "Psychopathology," "mental illness," and similar nomenclature are reifications and perpetuate the *nominal fallacy,* "the tendency to confuse naming with explaining" (Beach, 1955). The "psychopathological" individual is a discouraged person. Such people either have never developed or have lost their courage with respect to meeting the life tasks. With their pessimistic anticipations, they create "arrangements"—evasions, excuses, sideshows, symptoms—to protect their self-esteem, or they may "cop out" completely.
5. Because people's difficulties emanate from faulty perceptions, learnings, values, and goals that have resulted in discouragement, therapy consists of an educative or re-educative endeavor in which two equals cooperatively tackle the educational task. Many of the traditional analytic methods have been retained, although they are understood, and sometimes used, differently by the Adlerian. The focus of therapy is encouragement of the individual. The individual learns to have faith in self, to trust, and to love. The ultimate, *ideal* goal of psychotherapy is to release people's social interest so they may become fellow human beings, cooperators, and contributors to the creation of a better society. Such patients can be said to have actualized themselves. Because therapy is learning, everyone can change. On the entrance door of the Guidance Clinic for Juvenile Delinquency in Vienna was the inscription "It is never too late" (Kramer, 1947).

Adlerian psychology has become a viable, flourishing system. Neglected for several decades, it has in recent years acquired respectability. Training institutes, professional

societies, family education centers, and study groups continue to proliferate. With Adlerians being trained in universities rather than solely in institutes, they are writing more and doing research. Non-Adlerians are also engaged in Adlerian research. The previously rare Adlerian dissertation has become more commonplace. Currently, Adlerians are moving into society to renew their attention to the social issues Adler raised 70 years ago—poverty, war, conflict resolution, aggression, religion, substance abuse, and social cooperation. As Way puts it, "We shall need not only, as Adler says, more cooperative individuals, but a society better fitted to fulfill the needs of human beings" (1962, p. 360).

Complementing the Adlerians' endeavors are individuals and groups who have borrowed heavily from Adler, often without acknowledgment or awareness. Keith Sward, reviewing Alexander and French's *Psychoanalytic Therapy* (1946), writes,

> The Chicago group would seem to be Adlerian through and through. . . . The Chicago Institute for Psychoanalysis is not alone in this seeming rediscovery of Rank and Adler. Psychiatry and psychology as a whole seem to be drifting in the same direction. . . . Adler has come to life in other vigorous circles, notably in the publications of the "Horney" school. (1947, p. 601)

We get glimpses of Adler in the Freudian ego-psychologists, neo-Freudians, existential systems, humanistic psychologies, cognitive and constructivist psychologies, person-centered theory, rational emotive therapy, integrity therapy, transactional analysis, and reality therapy. This does not mean that Adlerian psychology will eventually disappear through absorption into other schools of psychology, for, as the motto of the Rockford, Illinois, Teacher Development Center claims, "Education is like a flame. . . . You can give it away without diminishing the one from whom it came." As Joseph Wilder writes in his introduction to *Essays in Individual Psychology* (Adler & Deutsch, 1959), "Most observations and ideas of Alfred Adler have subtly and quietly permeated modern psychological thinking to such a degree that the proper question is not whether one is Adlerian but how much of an Adlerian one is" (p. xv).

ANNOTATED BIBLIOGRAPHY

Ansbacher, H. L., & Ansbacher, R. (Eds.). (1964). *Individual psychology of Alfred Adler* (2nd ed.). New York: Harper Torchbooks.
An almost encyclopedic collection of Adler's writings, this volume displays both the great variety of topics that commanded his attention and the evolution of his thinking. Because of the nature of the construction of this book, it is imperative that the reader read the preface.

Carlson, J., Watts, R. E., & Maniacci, M. (2006). *Adlerian therapy: Theory and practice.* Washington, DC: American Psychological Association.
This is the newest book on Adlerian psychotherapy. Topics such as the therapeutic relationship; individual, couple, group, and family counseling and therapy; assessment and psychological testing; and personality development are covered in detail. Many updated references are included, as well as lists of Adlerian intervention videos that are available.

Manaster, G. J., & Corsini, R. J. (1982). *Individual psychology.* Itasca, IL: F. E. Peacock.
This is the first textbook of Adlerian psychology written in English by two students of Rudolf Dreikurs. Corsini was the former editor of the *Journal of Individual Psychology,* and Manaster succeeded him. Written in a much simpler style than the Ansbacher and Ansbacher text (1956), this book covers more or less the same materials. Two features make it unique: It contains the most nearly complete Adlerian psychotherapy case summary published to date, and there is a section abstracting the more important research studies published in the field of Adlerian psychology.

Mosak, H. H., & Maniacci, M. (1999). *A primer of Adlerian psychology.* Philadelphia: Brunner/Mazel.
A more recent textbook than Manaster and Corsini (1982), the *Primer* discusses the basic assumptions of Adlerian psychology, life-style, the life tasks as well as their applications in psychotherapy, child guidance, parent education, schools, marriage counseling, and social advocacy.

Mosak, H. H., & Maniacci, M. (1998). *Tactics in counseling and psychotherapy.* Itasca, IL: F. E. Peacock.
The authors present a variety of tactics that may serve as interventions for both Adlerians and non-Adlerians. These tactics aim to answer such questions as "What do I do when my patient . . .?" Various differential diagnosis, encouragement, confrontation, and countertactics are among the methods described and illustrated.

CASE READINGS

Adler, A. (1929). The case of Miss R: The interpretation of a life study. New York: Greenberg.

Adler does an interlinear interpretation of the case study of a patient who in his time would have been labeled "psychasthenic." The patient is also agoraphobic. Since Adler did not treat this patient, the course of therapy is unknown. However, we can observe how Adler constructs a life-style, as well as his understanding of the patient's approach to the life tasks.

Adler, A. (1964). *The case of Mrs. A.: The diagnosis of a life style.* In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Superiority and social interest* (pp. 159–190). Evanston, IL: Northwestern University Press (1969). [Also Chicago: Alfred Adler Institute.] (Original work published in 1931.) [Reprinted in D. Wedding & R. J. Corsini (Eds.) (1979). *Great cases in psychotherapy.* Itasca, IL: F. E. Peacock.]

This publication is similar to the one discussed above and interprets the case study of an obsessive–compulsive woman who fears that she will kill her children.

Ansbacher, H. L. (1966). Lee Harvey Oswald: An Adlerian interpretation. *Psychoanalytic Review, 53,* 379–390.

The psychodynamics of John F. Kennedy's assassin are presented from the Adlerian point of view.

Dreikurs, R. (1959). A record of family counseling sessions. In R. Dreikurs, R. Lowe, M. Sonstegard, & R. J. Corsini (Eds.), *Adlerian family counseling* (pp. 109–152). Eugene, OR: University of Oregon Press.

Two sessions of family counseling conducted by Rudolf Dreikurs and Stefanie Necheles are presented. The identified patient, a 9-year-old boy, is described by his parents as an angry child.

Frank, I. (1981). My flight toward a new life. *Journal of Individual Psychology, 37*(1), 15–30.

A young anorexic woman describes the course of her eating problem as well as the various treatments, Adlerian and non-Adlerian, that she underwent until the problem was resolved.

Manaster, G. J., & Corsini, R. J. (1982). *Individual psychology.* Itasca, IL: F. E. Peacock.

Chapter 17 offers verbatim excerpts of a course of therapy for a man who in dualistic fashion perceives himself as conflicted, ambivalent, and self-contradictory.

Mosak, H. H. (1972). Life-style assessment: A demonstration based on family constellation. *Individual Psychology, 28,* 232–247.

A verbatim description of a life-style assessment done in public demonstration is presented. The subject is a teenage girl who feels that she is the sole "non-very" person in a "very" family.

Mosak, H. H., & Maniacci, M. (2011). The case of Roger. In D. Wedding & R. J. Corsini (Eds.), *Case studies in psychotherapy.* Belmont, CA: Brooks/Cole.

This case history, which was specifically written to complement this chapter, illustrates many of the methods, techniques, and principles of Adlerian psychotherapy. Careful reading of the case should help the student more fully appreciate how an Adlerian actually proceeds in therapy.