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.