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.