

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

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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 therapy 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. Rosenzweig 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 "C" 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, 1963 a, 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's 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 on 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. 26)

Adler (1963 a) 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 in that game the patient is the professional, having played it successfully since childhood (although often in self-defeating fashion), while 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 & Maniaci, 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.

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 Adierian translates the descriptive statement "I feel 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 ..."). Adierians 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" (Adier, 1931), because people selectively recollect incidents consonant with their life-styles. The following recollection of Adier 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, Adier 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 of the patient's "basic mistakes" (Mosak & DiPietro, 2006). It is conceived as a personal mythology. The individual will behave *as if* things are true because for him or her they are true. Consequently, there are "truths." Basic mistakes may be classified as follows:

1. Over generalizations. "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. *Misperceptions* 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

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John is the younger of two children, the only boy. He grew up fast and became notorious for his aggressive behavior. He acted in a very

John is the younger of two children, the only boy. He grew up fast. His sister was so precocious that John became discouraged. He would never become famous, he decided perhaps he could at least be interested in and engaged in something. He decided to act in a very aggressive and brought himself to the attention of others through negative behavior and acquired the reputation of a "holy terror." He was going to do ever

SUMMARY OF EARLY RECOLLECTIONS

"I'm still 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. I'm still scared. Women give men a hard time. They betray 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.
2. Others call that bad and want to punish me for it, but I don't see it that way.

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

ASSETS

4 He is a driver. When he puts his mind to things, he makes them work
 He engages in creative problem solving.
 He knows how to get what he wants.

5 He knows how to ask a woman "nicely."

1 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 himself or herself 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-a-vis the life tasks.

4 Dreams

Adler sees 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" (Bottomo, 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."

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.

standing

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 Verbalization

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.

Adlerians use the
"business" but

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.

technique (Shulman)

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).

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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

A common patient refrain in treatment is "If only I could ..." (Adler, 1963 a). 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 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 sit 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 succeed at 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 Wexler (1929) or paradoxical intention by Frankl (1963). This method, used nonclinically by Knight Dunlap (1933), was labeled negative-practice. The symptomatic patient unwittingly

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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.

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 over-ambitious 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, "Bowwow." The following week, the patient informed the members of his group, "I bowwowed."

course. before

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

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.

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Who Can We Help?

Although Adler, like the other Nervenarzte ("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 the Westwyck 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, & Pflanzler, 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; Lombard, 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 can 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; PCW & 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, 1964) (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. He 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 (Birnbau, 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).

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Adlerians function in every imaginable setting: the private-practice office, hospitals, 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. necessary if therapy is to proceed.
4. 3. What does the patient come for? Is it treatment to alleviate 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. 6. What are the patient's expectations about treatment?

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 and caring person Ernst Papanek wrote,

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