

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 ease 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 vengeance must be uncovered. He "knocks the weapon out of the patient's hand" as follows:

Patients have tested me with the question of how I would 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), Peizman (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 Adlerians 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 high 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 (Shien, 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 Maniaci'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 patterns 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.

therapy 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 an instructor to us, the therapists, in what are 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 psychoanalysis, 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 opioid 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 meaningless 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 10

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 rages 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 "orry as much as he can. He is surprised and dismisses it as "bad advice."

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March SQ

B was sick on March 26, so patient saw A. "It was useless." No longer worried about B was sick on March 26, so patient saw A. "It was useless." No longer drunk last week. His state hospital. Thinks he will now wind up as bum because he got drunk and abuse. No one treats a boss secretary gave him notice but he hopes to keep her "by taking abuse. Not out selling but "everyone like she treats me." Got out of bed and worked last week. Went out selling, insists he's deteriorating 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 4

Too Cak 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 W falls to knees and sobs, "Help me! Help me to be a human being."

April 11

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 14

Didn't do anything this week 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 15

Wants B to accompany him back to his office because he forgot something. Wants shorter hours 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 16

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."

Ab

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.

M ^ユ

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 electro-

tion back to him. He makes appointment.
want to go. Take me. I'm getting crazy and you don't help me. Help me, Lieber Doktor!

State hospital might be appropriate if he is becoming "crazier." "Then my me. It's terrible. They have bars there. I won't go. I'm hot that bad yet

T,

Seen by A and B, who did summary of his family constellation 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 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."

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 on your clay."

May 2,0

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 C 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. He wants to be big but doesn't think he can make it. He is a perverted 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 2,2.

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. 14

Since yesterday his symptoms have returned. Heart palpitations

Se

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, prejudices, 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, side shows, 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 Adier 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 "Homey" 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 Adler 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).

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- Ansbacher, H. L., & Ansbacher, R. (Eds.). (1964). *Individual psychology of Alfred Adler* (2nd ed.). New York: Harper & Row. This book covers more or less the same materials. Two features make it unique. It contains the most nearly complete Adler volume displays both the great variety of topics in Adlerian psychology and the evolution of his thinking. A section abstracting the more important research studies published in the field of Adlerian psychology. Because of the nature of the construction of this book, it is imperative that the reader read the preface.
- Mosak, H. H., & Maniacci, M. (1999). *A primer of Adlerian psychology*. Philadelphia: Brunner/Mazel. This is the newest book on Adlerian psychotherapy. The primer discusses the basic assumptions of Adlerian psychology, life-style, the life tasks as well as their applications such as the therapeutic relationship; individual and couple psychotherapy, child guidance, parent education, group, and family counseling and therapy; assessment and marriage counseling, and social advocacy. 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. 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 client is...?" Various differential diagnosis, encouragement, confrontation, and counter-tactics are among the methods described and illustrated.

CASE READINGS

Adler, A. (1929). The case of Miss R: The interpretation of a child. *The Adlerian*, 1, 1-10. The identified patient, a 9-year-old boy, is described by his parents as an angry child.

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. A young anorexic woman describes the course of her eating problem as well as the various treatments, Adlerian 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 style. In H. L. Ansbacher & R. R. Ansbacher (Eds.), *Adlerian psychology* (pp. 159-190). Evanston, IL: Northwestern University Press. (Also Chicago: Alfred Adler Institute, 1969.)

Chapter 17 offers verbatim excerpts of a course of therapy for a woman who in dualistic fashion perceives herself as "very" and "not very." (Original work published in 1931.) [Reprinted in D. W. Mosak & R. J. Corsini (Eds.) (1979). *Great cases in psychotherapy*. Itasca, IL: E. 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. A "very" family.

The psychodynamics of John F. Kennedy's assassination are presented from the Adlerian point of view. (Mosak, H. H., & Maniaci, M. (2011). The case of Roger. In D. W. Mosak & R. J. Corsini (Eds.), *Case studies in psychotherapy*. Itasca, IL: E. E. Peacock.)

Dreikurs, R. (1959). A record of family counseling. 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. Reading of the case should help the student more fully appreciate how an Adlerian actually proceeds in therapy.

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