

Problems in Psychotherapy¹

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Modern psychotherapeutic methods have been applied now for some fifty years. Although this seems like a long period, there is a considerable lack of knowledge about the long-range course and outcome of the various types of neuroses which have been studied and treated. Each psychotherapist has a complete follow-up on only a few patients. A therapist who has been in practice for about twenty years usually will have at his disposal less than 150 patients whose history and later adjustment he can thoroughly describe. In many instances contact during or after therapy has been terminated because the patient or therapist has moved away. Two world wars, followed by much migration and relocation, have complicated or broken up many contacts. For these reasons it is imperative that all the knowledge acquired should be summarized at intervals and the conclusions generally applicable imparted to a larger group.

I should like to begin with a somewhat broad description of the outcome of treatment in the various groups and sub-groups of the neuroses, the character disorders, or what is called in children "behavior problems," and the psychoses, in particular the borderline psychoses. As is customary, I shall divide the neuroses into: hysteria, anxiety neurosis, compulsive-obsessive neurosis, phobia and psychogenic depression, all with or without psychosomatic complaints. It is well known that some elements of the various categories are present in almost any neurosis and that, consequently, we classify the neuroses according to their predominant symptoms, which incidentally, may vary from time to time.

I shall begin with a description of some aspects of hysteria. It is well known that the classical forms of hysteria, exhibiting wild convulsions, complete paralysis, anaesthesia, and other pronounced symptoms which imitate an organic disease, are rarely seen nowadays. This has been accomplished by informing the public that such symptoms are the expression of mental conflict rather than of organic disease. In hysteria the psychodynamics are more obvious than in most other

¹ Presented to the International Congress for Individual Psychology, Zurich, July 26-29, 1954.

neuroses. Such case histories are very instructive when applied to the theories of Individual Psychology. Almost twenty years ago, for instance, I had the opportunity of treating a ten-year-old boy who had been walking on his toes for almost a year, unable to touch the floor with his heels. This choice of symptom evidently was suggested to him when a football hit his heel a year before. He happened to be the shortest in his class and his classmates ridiculed him by calling him "half pint." He was, in addition, involved in a constant losing competition with his older brother, who was tall and got much better grades in school than he. We know that in such circumstances a child will create means of liberating himself from his oppressing situation. He may overcompensate or concede defeat, or, to some extent, do both, expressed through the formation of the neurotic symptom. This boy's aim was to be as tall as his brother, thus to escape from the humiliation of a physical inferiority, his shortness. The symptom also has to serve as a screen behind which the patient hides in order to be protected from the firing line of life, his obligations. All this was accomplished by the patient's walking on his toes. There may be many measures taken which may eliminate the hysteric symptom, such as hypnosis, suggestion, persuasion and the like. However, only if the psychodynamics are recognized, can the patient be helped to adjust to the future without the necessity of reverting to a neurotic escape. We always have to take into consideration the whole situation, which, in this instance, made it imperative to establish a reconciliation between the rival elder brother and the patient. It was possible to obtain the cooperation of the older brother. The patient soon was able to walk normally, became an active, interested boy and, as far as we know, has been well adjusted ever since. This stress on clarifying interpersonal relations is one of the cornerstones of Individual Psychology in psychotherapy.

Experience has taught us that, whereas the majority of mental patients in the First World War suffered from hysteria, there was a preponderance of anxiety reactions and anxiety neuroses during World War II. I am wondering what will be the next neurotic mass reaction after anxiety reactions have become so well known that they, too, may become obsolete. Anxiety reactions, however, with all their concomitants, such as heart palpitations, perspiration, forced breathing and the like, occur as a response to overwhelming situations in the normal, too. From such temporary physiologic reactions there is a steady transition to the fixed psychosomatic complaints in the chronic anxiety

neuroses. Evidently, whether or not the patient recovers quickly from an initial trauma depends on his attitude toward the various problems of life. For instance, investigations showed clearly that if an injury occurred to an individual harboring conflicts in relation to his work and without any suitable escape from his professional problems, the injury was likely to lead to an anxiety neurosis. This would prevent him from returning to a profession charged with conflict. On the other hand, one could not find any instance of post-traumatic anxiety neurosis after injury sustained during recreational activities. Evidently, recreation is a voluntary activity, and to avoid it is not desired. Similar considerations apply to the war neuroses. They will develop or be avoided as the result of the quality of group morale, leadership, identification with buddies, acceptance of ideals, and the like. It was interesting to see, for instance, that the anxiety reactions which developed in victims of the horrible Cocomanut Grove night club disaster in Boston in 1942 vanished within a short time. In view of the high percentage of panic reactions in the survivors, namely 75 per cent, this rapid recovery is remarkable. Most of the patrons were young, healthy individuals, enjoying themselves in a way they had no intention of giving up; dancing, singing, and drinking. In addition, no compensation could be expected from the night club owners, because they were bankrupt as the result of this disaster. Much can be done to avoid the development of an acute anxiety neurosis by facing the whole situation. The patient should be reconciled with his tasks and induced to take an active part by trying to solve his problems rather than to retreat into a neurosis.

We know the agonies of patients who suffer from fully developed compulsive-obsessive neuroses, who, in spite of the best care, improved only temporarily, with only partial alleviation of suffering. It is often difficult to answer the anxious questions of the patient and his family concerning the possible duration and outcome of treatment of such neuroses. In order to enable the patient to control his anxieties and, consequently, actively to develop mechanisms for counteracting obsessions and compulsions, it is advisable to tell him that, even in the most promising cases, there is a continuous up and down of symptoms, and that relapses should be expected.

It seems that parents as well as siblings of the compulsive-obsessive neurotics are more heavily weighted with neurotic and psychotic manifestations than they are when the patient suffers from other conditions. What this means can only be conjectured. Naturally, the geneticists trace this type of neurosis to inherited characteristics and

often stress the possible relation of obsessive-compulsive neurosis to schizophrenia. However, as long as we know nothing, or practically nothing, about the causation of schizophrenia, such speculations are of no advantage. Limited types of psychosurgery have been of use in some of the most severe cases. After psychosurgery the whole personality functions on a lower level of adjustment. In particular, the patient's ability to plan for the future is strikingly interfered with. Evidently an intact brain together with the ability to think logically and purposefully is needed if one is to create the structure of a neurosis. Psychosurgery, therefore, should be able to eliminate any type of neurosis. Of course, in most cases the price to be paid, namely the impairment of the highest human qualities and abilities, would be too high compared with the gain. According to our theory, the neurotic goal has to be *changed* to free the individual for greater activities, but we do not plan to sacrifice all goal-directed thinking, such as might result from psychosurgery.

The anxiety to avoid any open defeat is always clearly expressed in the symptomatology of an obsessive-compulsive neurosis. Often such patients are helped if they can be shown that they behave as if life were an insurance company from which they should receive insurance against all possible pitfalls of life. If they cannot get this insurance policy, they do not want to go ahead. They want insurance and assurance that whatever they may do will be successful. They want to be assured that they will be able to cross the street safely, never will have a spot on their clothes, always will have clean hands, that their relatives never will say a harsh word, and the like. This can never be accomplished and consequently the desperate struggle of the obsessive-compulsive ensues. Normally, we all act like pioneers who go out into the unknown, and we enjoy doing so. On the other hand, the obsessive-compulsive aims to turn the whole world into an insurance company. During therapy he has to be made aware of this, and he usually grasps the meaning of this comparison.

The phobias are often classified as a sub-group of either the obsessive-compulsive neuroses or of the anxiety neuroses. The chief complaints may be morbid fear of being injured by a knife, killing a relative, in particular a child, fear of jumping out of a window, and so forth. Such fears often come singly. Experience has shown that the prognosis usually is poor if the patient suffers from multiple phobias, and vice versa. When sound human relations are preserved, they will form a suitable ground upon which to build. This is an element which

has to be stressed whenever possible: patients can be taught to learn from their positive relations and can be induced to use such knowledge when confronted with their neurotic conflicts.

Patients often are profoundly confused when first seen, and unable to understand the deeper meaning of their neurotic symptoms, which they experience as strange elements. Consequently, they often feel thoroughly changed and are afraid of becoming insane. Such panicky patients are often able to grasp the meaning of their symptoms better if they are compared with a drowning person. Nobody will expect a drowning person to admire the scenery or to be interested in anything except how to be saved. He may be mistaken in his belief that he cannot touch ground, but as long as he thinks that he is drowning he will behave like a drowning man, desperately struggling for something to hold on to. Only when he realizes that he can touch ground, can he look around again and enjoy life. In this way patients are able to understand why their neurosis limits them to the point of excluding all that embellishes life, and restricts their activities.

Psychogenic depressions usually occur in individuals not prepared for disappointments, people who grew up with the expectation that a particular effort should always be made to protect and promote them. We may find this type of reaction in an only child who may grow up expecting special favors. Often such patients stem from families that are very proud of their social standing, thus creating in the children a permanent expectation of special consideration. Protracted grief reactions after the death of a loved one, breakdowns after the termination of a love affair, disabling depressions after financial losses, and the like, are all exaggerations of otherwise normal reactions. We have to study the whole personality in order to understand why such a reaction occurred. It is understandable that, of all the neuroses, suicide and suicidal attempts are most likely to occur in this group of hypersensitive, resentful patients. They are most likely to commit an act which, as we know, is a demonstration with the meaning: "You have let me down. You have not taken care of me. You have made it impossible for me to live and be a useful member of society." This aggressive attitude also explains why such patients are more likely to commit suicide at a time when they notice that the therapist expects a speedy recovery. As usual, it is helpful to make the patient a partner of one's plans. It often helps to tell the patient that one realizes that the only absolute safeguard against suicide would be to confine him in a hospital, which could be arranged easily. If this is what the patient wants, one is ready to do so. Hardly

ever will a patient agree to proceed to a confined place if he is determined to control his suicidal tendencies. He then is more likely to cooperate with the psychotherapist, knowing that the risk is a calculated one, and that he has resumed responsibility himself.

The question of shock treatment in severe psychogenic depressions has to be approached on an individual basis. While there is no question any more that endogenous depressions react most readily to electric shock treatment, this is not so with the psychogenic depressions. However, patients with psychogenic depressions, too, occasionally derive benefit from shock treatment. Of course, it can be advised only in cases which are not helped by psychotherapy. It seems that in such cases the amnesia, which results from the shock treatment, provides an opening for a new, more constructive pattern, which the patient then may be able to solidify with the help of the psychotherapist. I have convinced myself that some patients whose grief and depression center around a single event occasionally were helped by shock treatment, but I have seen no improvement in neurotic depressions of a more general nature.

Psychosomatic conditions may complicate any of the various types of neuroses. William James' saying: "The Lord forgives you all your sins, but your nervous system never does" provides a fitting characterization. It is often a difficult task to clear such cases medically, in particular since medical knowledge now widely disseminated, in my experience has biased self-observation to an even greater extent than formerly.

Step by step, patients have to be made aware of the goal-directed way of functioning of the nervous system and the organs such as the heart, intestines, the genito-urinary system. It is instructive to point out to the patient that if he is taken ill with an organic disease, his psychosomatic complaints vanish at least temporarily. An analysis of this change of symptomatology helps the patient to a greater understanding of his pattern. For instance, a patient who suffers from frequent and disturbing intestinal upsets related to anxiety, often is surprised by the normal functioning of his bowels while suffering from a severe cold. Such observations give additional support to the basic theories of Individual Psychology.

Under deplorable conditions we have made an observation on the course which neurotic symptoms may take when they have become useless to the patient. The inmates of concentration camps who for years might have suffered from severe neuroses lost all their symp-

toms while incarcerated. Many statements of survivors from concentration camps testify to this fact. It is possible however, that all those who did not lose their symptoms did not survive. The inmates realized that, if handicapped by their neurosis, for instance wash-compulsion, they would immediately be exterminated, because they were useless for work. When they were released, their neurotic symptoms usually returned and, because of the shock they had gone through, often in an even more severe form. Fortunately, such inhuman conditions cannot be reconstructed at random. All through the history of mankind, sickness has brought exemption, except where extreme conditions prevailed. The neurotic knows the laws of our human society and his symptoms are gauged accordingly and are in keeping with our social structure, which he neurotically abuses.

Occasionally, however, a change of symptoms can be traced to similar circumstances. This happened recently with a middle-aged woman in New York, who had been arrested for stealing from her employer. She had suffered from claustrophobia since the age of sixteen. This had made it impossible for her to be in a small room with the doors closed, to ride in a subway car or bus, or to enter an elevator. While waiting for her sentence in a small room adjoining the courtroom, she cut her wrist in a suicidal attempt, from panic, and certainly also as a demonstration against being confined in a small room in spite of her protests. She was taken to prison in a taxicab, since it was impossible to get her into the closed prison van. While waiting to be told how long her jail sentence would be, she did not leave the huge room, which she shared with a few other inmates. However, when her sentence of one year was finally given in writing and she realized that her claustrophobia was of no further avail, her neurotic symptoms disappeared. She soon asked for a single cell, always preferred by prison inmates, and she went up and down the elevator without hesitation in order to be able to attend recreational activities and to shop at the commissary. She was greatly pleased by this sudden improvement in her neurosis. Only once during her term, she almost experienced a relapse when she started to complain of symptoms of gastric neurosis in a more or less conscious attempt to be assigned a special diet. This was counteracted quickly and the inmate, now out of prison for half a year, has had no recurrence of her claustrophobia. She is still under supervision, works, and is greatly satisfied with her recovery. Such examples are of great theoretic as well as practical significance. They demonstrate the teleologic structure of the symptom in

the neuroses. The symptom represents the end result of a creation and also has to fit the neurotic needs. If environmental changes make the symptoms useless, such as they were under the inhuman conditions of concentration camps, or in the prisoner with claustrophobia, the neurotic symptoms vanish.

The question has often been raised as to how much the theory and practice of Individual Psychology contribute to the treatment of borderline psychoses. Here, more even than during treatment in the neuroses, each step will vary according to the condition of the patient. The course and outcome may often be even more unpredictable than in the neuroses. The common denominator for a constructive approach in these conditions is the necessity of making the patient realize that he has a friend in the therapist who stands on his side. Then, even if the patient is unable to accept reality, he will look to the therapist for help, will discuss his fears, suspicions and plans with him, and make a co-operation possible. Fundamentally, this approach is not different from the treatment of the neuroses. It varies, however, from that taken by other schools, in particular the psychoanalytic, which is opposed to the patient's being close to and on a familiar footing with the therapist. This may be one of the reasons why cases of schizophrenia are more often accepted as ambulatory patients by Individual Psychologists than by adherents of other schools.

Particular attention should be paid to patients suffering from borderline schizophrenia. They usually never enter a mental hospital, but still do not function normally and cannot adjust to society. Borderline schizophrenia—also called “pseudoneurotic schizophrenia”—is an eminently chronic condition and no striking success should be expected from treatment. The relatives should be forewarned because otherwise their impatience and lack of understanding of the slow progress and frequent failures contribute to the fears of the patients. Often the patient's condition is diagnosed differently by various therapists, such as anxiety neurosis, tension state, phobia, until finally ideas of reference and paranoid distortions come to the fore, clarifying the diagnosis. In my experience, it is advisable to lay more stress on dealing with everyday happenings than on extensive explanations of the psychodynamics of their difficulties and on delving into the past. The patients should, however, learn to anticipate their pathologic reactions. This often enables them to keep a more even balance and to make the most of their assets, although they usually can function in a protected environment only. For instance, a borderline schizophrenic may finally be

able to manage comparatively well as a clerk if a screen is placed between the customers and himself such as is possible in a post office. While it is true that the therapist should always aim for the best results, it is not helpful to express unconditional optimism, disregarding facts and sometimes experience.

Adults with severe character disturbances, in particular criminals and drug addicts, are rarely ambulatory patients. There is one fundamental difference between neurotics and patients with character disturbances: Whereas the neurotic *suffers* from his symptoms, tries to fight them off but cannot, the patient with character disorders, in particular the criminal, outwardly is chiefly concerned about the consequences of his unconventional activities, for instance, about being arrested and jailed. Therefore, the latter usually does not even apply for treatment. The neurotic may be unable to recover on his own even if apparently he desires to conquer his symptoms. If the criminal were equally desirous to get rid of his symptom, namely criminality, he could do so on his own and without the help of the therapist. On the other hand, if he does not whole-heartedly wish to adjust, a therapist cannot help him. Therefore, whereas the wish to recover forms the basis of psychotherapy in the neurotic, such a wish would have to be awakened in the criminal before any cooperation and improvement could be expected. No common denominator has so far been found to promote this desire. Not infrequently, long term prisoners get a great deal of help through certain books, others through group activities, such as religious gatherings or group therapy. Evidently, the whole area of interpersonal relations has to be recreated for the criminal and the individual with other character disturbances to make up for the lack of constructive human relations normally developed during childhood.

The concept of the "psychopathic personality" is still unsettled and not much progress has been made in this respect. The geneticists define "psychopathic personality" as one having an inherited disorder although admittedly there is no proof that any psychologic characteristics can be inherited. Their chief argument rests on the observation that in the psychopathic personality abnormal antisocial characteristics can be observed from early childhood. However, the character trends of the neurotic, too, can be traced back to early childhood. Alfred Adler clearly described the two different types of children who later may or may not develop into neurotics or criminals. The childhood of the pre-neurotic is characterized by the "yes-but" style, which indicates

outward acceptance of the responsibilities to the society, but involves excuses for not being able to cooperate. On the other hand, the early life period of the pre-criminal exhibits the "no" pattern, expressing open protest against social conventions, which are fought regardless of the hardship this may inflict on others. Recently extensive investigations on the childhood of criminals, that were conducted by S. and E. Glueck in the United States, have confirmed these observations.

The treatment of the sexual difficulties and sexual perversions requires exceptional skill and experience, because hardly any generalizations can be made to serve as guide during therapy. In any type of sexual aberration the underlying difficulty may be the expression of a neurosis, a character disturbance, psychosis, feeble-mindedness. In particular, impotence and frigidity may be also related to a glandular or local organic disturbance. Accordingly, the kinds of treatment will vary.

Homosexuality seems numerically still one of the most frequent sexual aberrations among the patients. There is wide agreement that the male homosexual often has an overbearing, intimidating mother who has been unable to foster confidence in the opposite sex. In the female homosexual, on the other hand, there is frequently a hard, abusive father, often an alcoholic, who has instilled fear and distrust in the opposite sex in the young girl. It is known that a certain percentage of the homosexuals finally adjust satisfactorily to heterosexual life. This should be the aim of the treatment. Whether it will be achieved or not can probably soon be seen: In favorable cases the homosexual patient will give up his homosexual contacts even before he feels sexually stimulated by the opposite sex. This indicates that he is serious in his efforts to adjust heterosexually. Without this serious intention no success can be achieved. Comparatively frequently a homosexual asks for help in order to be happier in his homosexual relations, without intention to attempt a heterosexual adjustment. I seriously doubt whether to help along this line is worth the effort of the therapist, or of the patient.

During psychotherapy dreams and first recollections are extensively evaluated for a better understanding of the patient. Dreams, in particular, give a good indication of the progress of therapy. For instance, the homosexual who finally adjusts heterosexually, regularly shows this development through his dreams. In the beginning, women will appear in his dreams which formerly were occupied by men exclusively. They will, at first, have no appeal to the patient. On the contrary, they will

seem to justify the patient in staying away from the opposite sex. The male homosexual will dream of women who smear lipstick all over the place, are untidy, comb their hair so that it flies all over the room, leave their cosmetics lying around, talk incessantly and are "fickle." Then children may appear in the dreams. This will indicate that the patient tempts himself into looking further ahead. However, such children, too, may indicate that the patient still abhors a heterosexual adjustment and the foundation of a family. Such children may look disfigured, with their eyes in the back of their heads, or be shaped like animals and scream incessantly. Only later, women take on a more appealing form, and males take roles which are in accordance with the general notion of virility.

It is revealing to trace the occurrence of dreams in the acute neuroses of traumatic origin. It is a fact that under particularly terrifying conditions nightmares will occur in the majority of patients even if no neurosis ensues. In such instances nightmares are experienced immediately after the trauma, indicating that the individual has passed through an experience too horrible to be dealt with on a conscious level. Nightmares which occur after an interval are of much graver significance. They indicate that the situation which is charged with conflict lies in the future rather than in the past. They are the precursors of a neurosis geared towards preventing the patient from returning to full activity. This may, for instance, be the course of events when a laborer who is resentful of his working conditions has an accident. As long as he is protected from returning to work by injury, his mental condition may be comparatively reassured and his sleep undisturbed. When he is close to recovery, however, sometimes even after months, he may experience nightmares which disturb his sleep. At the same time he may become conscious of various anxieties and psychosomatic symptoms, such as headaches and giddiness. In other words, the patient now suffers from a typical anxiety neurosis, with the unconscious aim of helping him to stay away from his former place of work, which to him has meant physical and moral defeat. Thus, dreams can often be explored for a better understanding, and their interpretation may enable the patient to grasp his problems. Hardly ever, however, are several sessions filled with interpretation and associations relating to the same dream. We are conscious that such elaborations often lead into fields, the exploration of which does not exert any constructive influence on the patient, but implies a waste of time and effort.

Finally, a few more comments may be added about methods and techniques of psychotherapy in Individual Psychology. Our minds should constantly be kept open to every possible improvement and enlargement of our approach. However, we can state, in retrospect, that the fundamental structure has remained unchanged through the years. The relation between therapist and patient has always been on a more or less equal basis, with the patient as collaborator. The splendid isolation of the psychotherapist, which is mandatory according to some schools of psychology, is discouraged by ours. The couch, which, according to a statement of Freud, was partly introduced because he could not bear to be gazed at for eight hours a day, is hardly ever used. Although the anxiety of the patient and his relatives about the length of treatment is understandable, hardly ever can a definite statement as to its duration be made, particularly not in the beginning. However, one can tell a patient that he should wait until after a few weeks of treatment, at which time he ought to realize himself whether any progress is being made, and whether he feels interested enough to continue. Towards the end of treatment the intervals between the sessions are usually stretched, which enables the patient to find out whether he is able to shift for himself. Therefore, there hardly ever should be any difference of opinion about whether and when treatment should be terminated. There is no doubt that certain categories of patients may need support for a great many years, but they finally may be seen only a few times a year. This may, for instance, be the best arrangement in the case of the borderline schizophrenics. We know, however, that neurotic patients too may need supportive treatment and guidance over a long period. This often is necessary with the compulsive-obsessive. But even patients with mild tension states may occasionally, after the formal treatment has terminated, experience a flare-up when the demands of life become pressing, and they often can be greatly helped in a few sessions.

Group therapy is used increasingly wherever psychotherapy is practised. It will be remembered that this type of group approach was demonstrated by Alfred Adler before 1920, in his Child Guidance Clinics in Vienna. In these sessions the whole group of teachers, parents, staff of the Guidance Clinic and, last but not least, the child participated in an effort to make the child aware that his problems were not of a private nature but pertained to the welfare of the whole community. At that time considerable protest was directed against the intrusion into the privacy of the patient-therapist relationship. This form of

group therapy, too, has stood the test of time. Several Individual Psychologists are well known for their activities in this field, which extend over a long period. The splendid record of Oskar Spiel in his experimental school in Vienna is internationally known. Joshua Bierer is known for his group activities in England, in day hospitals and other organizations. To name only a few others in the United States, we have group sessions at the Alfred Adler Consultation Center in New York, for many years under the leadership of Danica Deutsch, and group sessions in public and private organizations conducted by Rudolf Dreikurs in Chicago. It is a welcome sign of inner strength that new techniques are constantly tested, and if proven helpful, incorporated into the methods of therapy of the Individual Psychologists. It might well be that some form or another of group therapy will prove to be the preferred approach in the case of character disturbances, whereas in the neuroses the group approach seems particularly suitable as an adjunct to Individual Psychologic treatment and may be performed by the same therapist, or by a different person, who then cooperates with the therapist.

Summarizing, we may state that through the years we have gained much experience which has helped to consolidate and increase our knowledge. It should be possible to improve further the help we can give to our patients through a clearer formulation of our data and results, through the teaching of the methods of psychotherapy to the younger generation, and through steady improvement of our methods of research based on recent scientific progress. In all these ways we shall be able to contribute to the alleviation of the suffering of the mental patient.