

EXISTENTIAL TRENDS TOWARD INDIVIDUAL PSYCHOLOGY *

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Several investigators have noted similarities between Adler's concepts and those from existentialism or existential analysis. Dreikurs (1960) isolates several tenets from Adlerian psychology and finds a model that includes all the characteristic assumptions of existential analysis which made its impact felt in America. Van Dusen reports fundamental similarities in Individual Psychology and existence analysis in their mutual emphasis on phenomenological, holistic, and idiographic concepts (1959). Stern (1958) views the existentialists as siding with Adlerian psychologists on the basic issues of values, man's freedom to choose, his responsibility and ability to discharge this freedom, and the need for a subjective understanding of behavior.

However, themes of subjectivity, identity, and self that have been so characteristic of the traditional existentialist philosophies are in opposition to the Adlerian position. The latter is well known for its relationship between men, for its unselfish qualities and its emphasis on compassion, generosity, and concern for others. Adler's emphasis on the interhuman aspects of man and his reference to society and the existential quest for the personal "I" seem to bring back an old issue in psychology that certainly has been restated a number of times in recent literature.

While it is true that Adlerian ideas are contrary to the original existential concepts, they are becoming congruent to the more recent existential trends, and appear to coincide almost perfectly with those trends which are making their way into psychiatry and psychology. The statement here shows how existentialist ideas have evolved toward the Adlerian thesis in their newer emphasis on social responsibility, commitment, involvement and social relations.

Existentialism was conceived in impoverished individuality, and seems to revolt against systems or groups which limit freedom of choice. It was a warning against compulsions toward conventionality and depersonalization in a modern world. The movement was often viewed as a last desperate attempt to establish man as a distinct being, separate from this environment, and differentiated from the other beings or "herds." Mass society was seen as the fertile ground for alienation and depersonalization in every form and mass production was viewed as making man like his machines. The "other-directed" man, who attempted to find guides for his conduct in sources outside himself was doomed to the inauthentic existence of the "crowd." Thus, the original concepts of existentialism were

* This paper was part of a block of studies on "Existentialism in American Psychology" supported by a research grant from Mississippi State College for Women.

in quest for identity and selfhood, the approach was subjective, and man's responsibility was to himself to actualize his potential.

While existence for sake of "myself" describes the point of departure of Kierkegaard, Nietzsche, and Heidegger and other founding figures of existentialism, more recent trends in the philosophy direct attention back to "man to man" relationships. Heidegger's own concept, being-in-the-world, may have initiated this trend. This subject-object unification had the ultimate result of cementing the subject with other persons. Being-with-others, which is a form of being-in-the-world, does not refer to a subject who perceives other people, but who is involved completely and totally within them. Thus, the phenomenological conceptions, which were derived largely from Husserl and Brentano, placed the individual in a close, personal and unified relationship with those people and things he encountered.

Heidegger's Sorge, or care, describes an existence which is not only characterized by consciousness about the world, but one in which there is concern for the world of things and people. The person deals with the world, he is involved in it. But even in Heidegger, the subject appears to be the most powerful element in his existence. The individual is dominant over his existence; he guides his concerns and chooses his particular mode of being-in-the-world. While Heidegger may place existence over subjectivity, the person remains at the center of his personal solar system. Being-in-the-world may absorb both subject and object in unity, but subject still reigns. Lyons (1961) states that Heidegger's type of being is subjective and individual, and his concept of being-with-others "does not at all mean being with others, but refers to a condition in which others may show their presence." (p. 161)

Another step toward the Adlerian theme was taken by Jaspers who extended existentialist concepts into psychopathology. Naturally, Jaspers became concerned with the relationship between doctor and patient in therapy. This sort of relationship implies an inter-subjectivity which is described by Jaspers' concept of existential communication. To Jaspers, personal others became indispensable factors in one's own authentic existence, and while existence, itself, remains in solitude, it is out of solitude that a communication with another solitude takes place. This communication out of mutual solitude is essential for transcendence.

Concepts of the "encounter," and the "I-Thou" relationship, under the influence of Buber and Marcel, have added a new facet to existentialism which makes the movement similar in many respects to interpersonal theories and social psychologies. Thus, the movement has made almost a complete turn from pure individuality and subjectivity to a type of authenticity which is expressed in joint relationships. However, these newer conceptions do not capture individuality and engulf the person in dialogical meetings, but provide the media for a better expression of individuality. Individuality is not viewed in terms of nomadistic existence, but is measured in terms of participation, interaction, and the specific way the person responds to the encounter. The individual reveals himself through the I-Thou relationships.

Adler speaks of the importance of identification with others to

make "us capable of friendship, humane love, pity, vocation and love." (1965, p. 102) He, in a manner similar to the dialogical and "relationship" existentialists, sees a mutual interaction between man and others in a man-cosmos relation which makes a person a creature and creator of society. Style of life represents a form of individuality which is derived from the social base, and which is fashioned as a prototype out of early strategies and successes in the social framework. Adler, then, places socialization and society first, and individuality (style of life) develops within the framework of social sense. In contrast, the dialogical existential approaches put subjectivity and individuality first, and view its expression in significant relationships between people.

Finally in existential analysis, under the leadership of Binswanger, the turn is complete. Binswanger's position appears to be a synthesis of Heidegger's existence analysis and Buber's dialogical approach, but has been developed independently within the discipline of psychiatry. Binswanger speaks of human existence in general which is the existence of mankind, rather than the individual's existence which marked the point of departure for the existential philosophies. Kahn (1962) translates the following from Binswanger's writings: "Body and soul are abstractions from the inseparable unity of Being-human, seen from the anthropological viewpoint." (p. 207) Kahn further states that Binswanger views plurality, duality, and singularity as fundamental modes of Being-human: "Only in these modes and their special modifications and interweavings ('complexions'), is human existence really by itself. Where one cannot speak of an I, a thou, a dual we, a he or she nor of a plural we or they, there human existence is no longer 'by itself' but 'beside itself.'" (p. 207)

While Binswanger's analysis may be on a deeper philosophical level than Adler's, the parallel between the two positions is obvious. Binswanger's is concerned with existence; Adler's apparently accepts existence and is more concerned with society which culminates from existence. Binswanger develops the concept of love to hold together human existence and Adler develops the principle of "social feeling" or "cooperation" to preserve the human community. Binswanger views the neuroses and psychoses as particular disturbances in human existence, and Adler sees all nervous symptoms as lack of proper degree of social feeling.

The inter-human dimension, unified in either relationships or human existence, embraces the Adlerian thesis and the more recent existential conceptions which are invading psychology and psychiatry. Individuality, often viewed as being reduced by such membership, is viewed as being enhanced in expressions of love, or Gemeinschaftsgefühl. In a similar vein, alienation as described in original existentialist philosophies as being rooted in conformity and "other-directedness" is re-defined in terms of isolation and estrangement from proper human relationships in newer existential positions.

The following is a brief section from Dr. Shulman's prospective book on schizophrenia. It was first presented as a talk to the Individual Psychology Association of Chicago on November 13, 1965. This section shows the different possible reasons for mutism, a symptom commonly found in the schizophrenic patient.

X. THE MUTE PATIENT

A. Reasons for being mute

Textbooks that discuss mutism in the schizophrenic usually focus on the symptom as found in the acute catatonic state. There are, however, other times when the patient does not speak, and other reasons:

1. The patient who sulks.

Like all of us, the schizophrenic may become insulted and sulk, refusing to give us the satisfaction of conversing with us. A sulk usually does not last for a long period of time and the patient is usually willing to talk to someone who is not the object of his anger, especially if it gives him the chance to complain about the people who have angered him.

2. The patient who will not submit to the procedure (the use of passive power to defeat the therapist).

Sometimes a patient will refuse to converse because the situation is not to his liking. For example, he may have been brought to the doctor or hospital against his will. The doctor may be trying to initiate psychotherapy while the patient wants to be left alone. The patient may refuse to talk about certain items or aspects of his life and may, in self-defense, try to destroy the possibility of a relationship by not talking at all. The patient may even deliberately distract his attention from the therapist and pay attention to all sorts of other things so that he seems to be hallucinating or even is hallucinating at the time.

3. "Silence is golden."

When one can't be sure what to say, it may seem better to say nothing. When the patient is faced with an unfamiliar or threatening situation, he may deliberately decide to keep silent (as if he were pleading the 5th Amendment) or may experience himself as "blocked" or "confused." In this case, the "confusion" and "blocking" are automatic defensive maneuvers, which may or may not be conscious, intended as a safety device.

4. The patient who feels surrounded by enemies.

One device used by captured criminals is the "I won't talk" position. When the therapist is seen as an enemy, his attempts to engage the patient in conversation may seem like a third degree interrogation. The patient then steels himself against the interrogation.

5. "Silent splendor."

In his delusional state a patient sometimes views himself as a special, superior and godlike creature. At these times he may sit, as if on a throne, staring into space or perhaps making mysterious passes. By being silent at these times he announces his superiority to those who would talk to him and his disdain for them. After all, God doesn't talk to just anybody!

6. "I mustn't talk."

A patient in a veterans hospital had not talked for a year. He was beginning to respond to the patient approach of his doctor* who offered him cigarettes, spoke to him briefly and only in a soft voice and did not otherwise pressure him. He would now answer questions in monosyllables, but otherwise did not speak. There had been considerable behavioral improvement. He was smiling and pleasant in his contacts, had accepted ward assignments and was generally cooperative and helpful. He was brought to staff to discuss the mutism. At the staff conference, that patient seemed affable and shook hands willingly. The consultant asked a few innocuous questions and the patient responded with one-word answers in a very soft voice. Where possible, he nodded or shook his head in answer and thus avoided speaking. The consultant deliberately asked some questions that required more than one-word answers. The patient did not answer these at all. The consultant then said, "Mr. --- is certainly a cooperative person, he is helpful to the nurses and other patients, he smiles and tries to be friendly, but he doesn't really talk to us. Talking must have a special meaning for him. Is there a special reason why you don't talk, Mr. ---?"

The patient nodded affirmatively.

"Would talking be dangerous? Does not talking make it possible for you to be friendly to people?"

Again, he nodded.

"This seems to be a very important point. If you don't want to talk, how about whispering. Could you do that?"

"I can try," whispered the patient.

"Then whisper to us why it is important not to talk." (This conversation was held in a serious though friendly tone. The consultant was not making fun of the patient.)

The patient whispered, "I get the feeling that things will go O.K. if I don't talk."

The consultant said, "Do you mean that not talking is the price you have to pay for keeping everything going smoothly?"

"Yes, it's like that."

The patient went on to explain (in whispered tones) that at one time he had been mute because he heard voices criticizing whatever he said and telling him not to talk. Then he had gone through a period where he had not wanted to talk to anyone and had been belligerent to the staff. After a necessary surgical procedure, he had begun to believe that the nurses were well-disposed toward him and he had decided to try to please them and to be friendly to aides and doctors. He felt he had become considerably better. However, in order to maintain this improvement, he must not talk. It was his conviction that he would become sick again if he began to talk freely. He optimistically indicated that he expected to talk more and more as his improvement continues.

This is common schizophrenic behavior. It is another example of the conditional relationship. In this case, not talking was the necessary condition for relating. Such a symptom has the advantage of preventing complete human relationships before the pa- is ready for them and still permitting a controlled form of relating;

i.e., "I am willing to relate to you in a limited way." The chief function of such a symptom is to act as a safeguard against the demand for full human functioning. A neurotic might use anxieties or neurasthenic symptoms for the same reason. During the acute catatonic state, the mutism may be explained in the ways just mentioned. In addition, however, the patient goes through periods of disorientation so that he sometimes cannot perform the logical operation required to speak. At other times, he is struggling with an inner problem and is "too busy" to talk to people.

7. Being too busy to speak.

One girl developed an acute psychotic break after two years of analysis. The onset was sudden and overwhelming. She was hospitalized and for three weeks did not speak. She was aware of her surroundings, knew she would come out of her state, but felt she had first to reconsider everything she had been through. She submitted passively to the hospital ward routine during this time. At the end of the third week she felt ready to leave the hospital and began abruptly to talk again.

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EXCHANGE IDEA COLUMN

by Nahum E. Shoobs

In our previous edition, we illustrated the use of devices in the interview procedure. We now plan to instance their use in the insight stage of therapy.

The interpretative statement must do more than offer intellectual insight. Therapy is not pumping views or insights into the patient.

I. Surprise Devices

What is needed is an emotional shock or explosion, revealing in dazzling form the patient's goal and behavior pattern. Sometimes an interpretation that is unexpected and unfamiliar may produce the desired affect and effect.¹

Case A: Mrs. B., a highly intelligent and cultured lady, complained that she is always imposed upon by everyone—her husband, her children, in-laws, friends and the like. She helped many who did not really need help. (She reminded me of the old question, "Have you ever seen a willing horse that wasn't saddled?")

I refrained from fully disclosing her life style until I had gained her confidence. The opportunity came after she had had a relapse which she tied into a frequently recurring situation.

Her husband usually arrived home from his office by 5:30 P.M. Whenever he was delayed he telephoned her. But at times he had been unable to do so, and she said, "When that happens, I have diarrhea."

To which I said, "Are you trying to control your husband with your bowels?"

1. Dreikurs, Rudolph, M.D., "Some Efficacious Factors in Psychotherapy," *International Zeitschrift für Individualpsychologie*, Vol. X, No. 3.

Startling interpretations should be followed up with supportive therapy, for such disclosures may at times temporarily deflate or even inflate the patient to an undesirable pitch. We must not leave him in such a state; hence the supportive theory.

But an unfamiliar interpretation need not be cruelly stated.

Case B: Jerry, ten years old, had been labeled incorrigible in school and simply impossible at home. After he had been treated for six months his mother complained, "I give up. It's useless. For the last two weeks, he really changed. Just as I was beginning to convince my husband that it paid off to have him see you, Jerry started in again. Yesterday his teacher sent for me. At home he was just plain mean."

I turned to the sulky angry child and said, "Congratulations, Jerry! For the last two weeks, everybody liked you. If for the next two weeks, you can again be helpful and grown up, then come to me and say, 'I want a day off to act like a baby again.'"¹

II. Visiodrama -- Use of Drawings

Visiodrama is role playing in the form of comics or cartoons. The patient² does the drawing. (If he objects, saying, "I can't even draw a straight line," suggest that he use stick figures or dialogue alone.)

It is a picture medium which, the originator R.L. Switzen³ claims, "accomplishes three important factors of identification, concretization and externalization to quickly warm up the group." It is an invaluable device in the individual interview.

For example: On one occasion when the family was planning to visit relatives, Jerry refused to dress appropriately. Since he is an avid reader of comics, I suggested that he present this incident in cartoon form. I drew the first figure and he did the others. In all five figures were drawn.

Daddy (with speech balloon):⁴ Jerry, we're going to visit Uncle Bill right after dinner.

Jerry (with speech balloon): I'll put on my jeans.

Daddy (with thought balloon): I bet he's going to put up an argument. (With speech balloon): Put on your black pants and a jacket.

Jerry (with speech balloon): I like my old jeans.

Daddy (with thought balloon): Boy, he has no respect for his relatives. (With speech balloon): O.K., then stay home or wear what I told you to.

1. Dr. Alfred Adler often used this device.

2. Dr. Kunkel illustrated his interview with his own drawings. Gondor did likewise, but he also allowed his patients to make drawings.

3. Switzen, R.L., How to Make Effective Visiodrama Episodes, Santa Monica, California, P.O. Box 322.

4. Shoobs, Nahum E., Role Playing in the Individual Psychotherapy Interview, Journal of Individual Psychology, Vol. 20, May, 1964, pp. 84-89.