ADLERIAN PSYCHOLOGY: THE TRADITION OF BRIEF PSYCHOTHERAPY[1]

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The very fact that we are assembled here for a Fourth Brief Psychotherapy Conference is evidence for the extent to which brief psychotherapy has become an important development on the mental health scene.

The term, "brief psychotherapy," was probably coined by Franz Alexander of Chicago in the 1940's. Brief psychotherapy itself received its impetus about 10 years ago with the inception of the Community Mental Health Movement and the idea of Community Psychiatry, which approached mental health as a public health problem. As part of a vast conception, psychotherapy was to be made much more accessible, especially for low-income groups; and walk-in clinics were established. This alone made it imperative that psychotherapy should be made much shorter than was the customary procedure heretofore.

Various new brief therapies were developed empirically, and older ones received new interest. Some of these therapies were the topics of the previous three conferences, on two of which the Adlerian viewpoint was already represented, through Dr. Rudolf Dreikurs. This year, the entire program is given to Adlerian therapy which is not only the oldest, but also one with a broad theoretical and philosophical background, and we honor Rudolf Dreikurs for his great contribution to it.

Brief psychotherapy is generally contrasted with "traditional" psychotherapy, by which Freudian psychoanalysis is meant essentially. We wish to propose that brief psychotherapy has a tradition of its own. It is the tradition which Alfred Adler (1870-1937) established through his Individual Psychology.

The purpose of the present paper is to support this claim. We shall show, in the first part, that the various formal or structural attributes of brief therapy found in the current literature—far beyond the mere

time factor—have from the beginning been part of the Adlerian approach. In the second part we shall show that Adler laid a philosophical and theoretical foundation which included only such constructs as are conducive to therapy in general and brief therapy in particular.

ATTRIBUTES OF BRIEF PSYCHOTHERAPY

Some common attributes of brief therapy which we shall discuss are: (a) time factor, (b) importance of exogenous factor, (c) focused interview, (d) importance of first interview, (e) relationship with the patient, and (f) public health aspect.

Time Factor

The usual duration of brief therapy is about 6 to 20 sessions, with the time limit set at the start, according to Barten (7, p. 10), and while at first brief therapy was regarded almost as an emergency measure, it soon became evident that the time limit in itself is beneficial. According to Garner, "Evidence accumulates that 'brief therapy' may be the treatment choice in most patients" (12, p. 119). Wolberg concurs in this (33, p. 69).

This was exactly Adler's position. He suggested: "You may say right at the beginning, 'It will take 8 to 10 weeks.' In doubtful cases say, 'I don't know. Let us begin. In a month I shall ask you whether you are convinced that we are on the right track. If not, we shall break off' " (4, p. 201). When Adler spoke of 8 to 10 weeks this was probably at the rate of two sessions per week, so that his total general treatment duration was within the limit of 20 sessions just mentioned. On another occasion Adler spoke of "at least a perceptible partial success in three months, often even sooner," and again that he would say to the patient at the beginning, "If you are not convinced in one or two weeks that we are on the right path, I will stop the treatment" (3, p. 344). The practice of some present-day Adlerian therapists seems to call for two sessions per week over a period of ten weeks (28).

Importance of Exogenous Factor, or Crisis

The second common attribute of brief therapy is recognition of the importance of an exogenous factor, or a crisis situation, for upsetting the balance of an individual who is mentally in a precarious position, although he was able to manage up to the crisis situation.

Brief therapy developed in part as one aspect of "preventive psychiatry." Gerald Caplan (8) noted that it is during certain crisis periods in his life when the individual wants professional help, and that during these periods he is also most responsive to treatment. These are periods when the individual is confronted with a novel situation with which he is not able to cope adequately. In one walk-in clinic actually three-fourths of the patients were in some acute personal crisis when they came for help (16, p. 147).

New life situations which may become critical in this way are, according to Caplan: puberty, climacteric, illness, accident, death of a loved one, loss or change of a job, relocation, getting married, childbirth, entering kindergarten, grade school, high school, college or leaving these schools. These situations do, however, not directly cause the disturbence. Rather, "what actually occurs depends on the interplay of endogenous and exogenous forces in the course of the crisis" (8, p. 53).

Adler had recognized virtually the same situations as "typical occasions for the onset of a neurosis": puberty, marriage, pregnancy, climacteric, aging, examinations, choice of occuaption, mortal danger, loss of someone close (3, pp. 296-297); also, change of environment, beginning of school, change of school, change of teacher, birth of sibling, failure in school, divorce, remarriage, or death of the parents (3, p. 405). These represented the exogenous factor.

Like Caplan today, Adler also stressed: "Both endogenic and exogenic factors play a part in every neurotic symptom. The true bearing of the exogenic factor . . . can, however, only be understood when we understand the individual's . . . life style" (4, p. 92). And as Caplan characterizes the exogenic factor as a life situation so Adler considered it to be a life task. It becomes critical when it requires for its solution more social interest than the patient has been able to develop (3, pp. 297-298).

Focused Interview

A third common attribute of brief therapy and of Adlerian therapy is that the interview is focused. When time is limited, it becomes imperative that the interview be focused on a specific problem, and also be goal-oriented and action-oriented—quite in contrast to a patient-steered, open-ended, and feeling-oriented, free-association-type interview (7, p. 11).

Here is, of course, where the exogenous factor becomes thera-
peutically important. According to Jacob Swartz, at an outpatient
clinic in Boston the most common focus is "the reason the patient
gives, or that we may surmise the patient has, for having come for
treatment at a particular time" (29, pp. 108-109). C. Peter Rosen-
baum, director of the adult psychiatric clinic at Stanford, also states
that the focus is on the answer to the question, "Why now? Why
does this person come for help at this time?" (25, p. 72). However,
the interview may also be focused on any other "problem which is
crucial but only vaguely recognized." Thus H. H. Garner uses such
focusing in his "confrontation problem-solving technique" where the
problem in question becomes the "integrative task" (12, p. 233; 13).
From the principle of purposiveness Rosenbaum asks the patient also
for his own expectations and goals (25, p. 72).

Adler would ask: "Since when have you had your complaints?"
And he continued: "In psychotherapy this question is even more
justified than in organic pathology. We want to find out what the
situation was which appeared difficult to the patient. You must
focus on this point: How did it come about that he failed in a certain
situation?" (4, p. 194). In the often reprinted Individual Psychology
Interview Guide with children the first question is: "Since when has
there been cause for complaint? In what sort of situation . . . was the
disorder first noticed?" (3, p. 405).

As Rosenbaum does in brief therapy, so Adler found out the
patient's expectations and goals. This actually assumes very great
importance in the Adlerian approach. Adler generally asked, "What
would you do if you were completely well?" The answer was used
in focusing still better, in that Adler considered it to indicate "pre-
cisely that demand of society which we would expect the patient to
avoid" (3, p. 332). The patient may say, if he were well, "I would
marry" or "I would resume my work." "The neurotic has always
collected some more or less plausible reasons to justify his escape from
the challenge of life, but he does not realize what he is doing" (3, p.
332).

Importance of First Interview

Great importance of the first interview is the fourth attribute.
Lewis Wolberg of the New York Postgraduate Center for Psycho-
therapy, in writing about short-term psychotherapy summarizes,
"(*a*) Even at the first session an attempt is made to establish a work-

ing relationship while getting as complete information from the patient as possible. (*b*) At the end of the first session, the patient is given some explanation for his symptoms in language he understands" (32, p. 351).

Jacobson and co-workers report from a walk-in clinic in Los Angeles where treatment is limited to six visits: "A goal-oriented sense of commitment develops that stands in sharp contrast to the more modest pace of more traditional treatment modes. . . . Diagnostic assessment is not firmly separated from treatment. Whenever he can, the therapist accomplishes . . . during the first hour . . . a working diagnosis, tentatively formulates his treatment plan, and begins the therapeutic intervention" (16, p. 145).

Turning to Adler, we find him stating as far back as 1913: "It is essential to grasp as quickly as possible the neurotic system. With some experience this may usually be discovered on the first day" (3, p. 336). This was still Adler's position in one of his late papers. In stipulating that the uniqueness of the individual must be explored and considered, he added that this is not too difficult and can usually be accomplished "during the first interview" (4, p. 225). He also wrote then: "The physician, if he is well-grounded in Individual Psychology, can find his bearing after half an hour; but he must wait until the patient, too, has recognized his style of life and its mistakes" (3, p. 344).

Also, there is in Adlerian therapy no sharp separation between diagnosis and treatment. When a patient would say he was disorderly as a child, Adler would immediately confront him with the explanation: "You were disorderly, you passed on your obligation to others. It is still the same today. You are afraid to go ahead alone, by yourself" (4, p. 196).

Relationship with the Patient

A friendly relationship with the patient in an atmosphere of optimism is a fifth attribute. C. Knight Aldrich, University of Chicago School of Medicine, emphasizes the importance of "informed optimism" of the therapist, meaning a well-founded expectancy of improvement. In the traditional pessimistic expectation, early improvement is likely to be interpreted as a "flight into health." Thus we have, according to Aldrich, a "self-fulfilling prophecy," through which "a therapist may convert a short-term case into a long-term case" (5, pp. 490-591).

Other authors concur that brief therapy is "warmly supportive" and stresses "the capacity of individuals . . . to regain a reasonable level of health" (7, p. 8). "Favorable expectations should be aroused" (30, p. 582). This is contrasted with the cool detachment of the psychoanalyst who "adopts the model of the 'neutral mirror' and carefully protects his 'analytic incognito' " (23, p. 7).

Regarding transference, Wolberg recommends that whenever it begins to crystallize, it is handled as rapidly as possible to prevent the development of a transference neurosis" (32, pp. 349-350). Accordingly also "interviewing is face-to-face, the recumbent position being avoided" (22, p. 249).

All this is in complete agreement with the tradition established by Adler. He held that his Individual Psychology was an "optimistic science" (4, p. 26), while "psychoanalysis is pessimistic" (4, p. 209). He always drew attention "to errors only and never to innate defects, to the possibilities of cure and to equality with others" (3, p. 342). He stipulated, "in every step of the treatment, we must not deviate from the path of encouragement" (3, p. 342). Psychotherapy was for Adler "an exercise in cooperation and a test of cooperation. We can succeed only if we are genuinely interested in the other . . . The task is . . . to give the patient the experience of contact with a fellow man, and then to enable him to transfer this awakened social interest to others" (3, pp. 340-341).

As to Freud's "positive transference," Adler held that one must strictly avoid arousing it. "It only adds the new task of having to make this artificially created condition disappear again . . . Apart from sexual implications, it is merely social interest" (3, p. 343).

Public Health Aspect

As a sixth attribute we may point out the public health aspect of brief psychotherapy. As mentioned initially, brief therapy received its strong recent impetus from the Community Mental Health Movement, a public health concern. This aspect especially is also in line with the Adlerian tradition. Adler in fact was a pioneer in the area of community mental health. His contributions in this field have recently been aptly reviewed by Guerney (14).

Adler was from the beginning concerned about the devastating effect of poverty, as well as of other wrongs of society, on the psychological development of children, and he pleaded for institutions

which would, "rather than shut the young delinquent off from society, make him more inclined toward it" (1, pp. 349-350*). In this spirit Adler was also oriented toward prevention, just as the influential contemporary book in the community mental health field, by Caplan (8), to which we referred before, is entitled *Principles of Preventive Psychiatry*. Adler wrote: "It is an exceedingly difficult matter to pursue every individual who has gone wrong or who is afflicted with a neurotic illness or psychosis, to improve him, to heal him. This represents a tremendous waste of energy, and it would be time that we turn more toward prophylaxis" (1, p. 326*). Therefore, Adler proposed that the entire population be educated in workable mental health practices. He said: "The problem of human nature . . . cannot be pursued with the sole purpose of developing occasional experts. Only the understanding of human nature by every human being can be its proper goal" (2, p. 3).

Interestingly, when in 1969 the president of the American Psychological Association, George A. Miller spoke on "Psychology as a Means of Promoting Human Welfare," he used a very similar admonition. He said: "Our responsibility is less to assume the role of experts . . . than to give psychology away to the people who really need it—and that includes everybody" (24, p. 1071).

From this conviction, that psychology is for everybody, we find then also that Adler and Adlerians have always felt very comfortable using simple language, which was often held against them. By contrast Jacobson et al. (1971) found that the "traditional" therapist experiences "discomfort with persons seeking help who are unfamiliar with psychiatric language and concepts" (16, p. 140).

What is more, from the same spirit Adler pioneered in training nonprofessionals as psychotherapeutic or perhaps better prophylactic agents—parents, teachers, and peers; and he opened over 30 child guidance centers in Vienna where the counseling sessions were open to professional audiences for training purposes. This part of Adler's tradition has been continued primarily through the efforts of Rudolf Dreikurs and co-workers (9).

And so we have seen how six distinguishing attributes of present-day brief therapy are already to be found among the important innovative practices of Adler.

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*Translation modified from the original.

A CONCEPT OF MAN FOR PSYCHOTHERAPY

From the preceding it becomes apparent that brief therapy differs from the so-called traditional in much more than the time factor alone. The difference is more far-reaching and more fundamental. Various authors have noted that the two kinds of therapy actually require different theoretical and philosophical outlooks, and we have already mentioned the issue of optimism versus pessimism. A few statements regarding existing differences are the following:

Wolberg mentions right at the start of his chapter on this subject that short-term therapy "may run counter to the philosophies . . . of the psychoanalyst" (32, p. 343). Barten states that brief therapy is predicated on "an increasing shift . . . from psychoanalytic techniques to ego-oriented psychotherapy" (7, p. 3). Zwerling and Rosenbaum find, "We do not adequately understand the relationship between social and intrapsychic determinants . . . , and there are therefore discontinuities between individual and community psychiatry" (34, p. 84), the first identified with psychoanalytic theory, the second with social-system theory. Finally, Loeb notes in the context of a discussion of community psychiatry that the psychoanalytic era was more process-oriented, by which he means that there was great concern for what goes on in the treatment activity, and that "in a sense, we are returning to . . . the pre-Freudian period: psychiatry is once again goal-oriented [meaning greater concern for the outcome] rather than . . . process-oriented" (21, p. 237).

In some cases animosities among staff have developed from these differences. Sabshin notes that "extremists in social psychiatry and psychoanalysis view each other with marked suspicion" (27, p. 19). Zwerling and Rosenbaum report on a situation among a training staff, where initially quite modest and restrained debates between psychoanalytic and community-psychiatric members "flared into angry arguments with all the *ad hominem* accusations one might expect" (34, p. 84).

The present dispute has, in our view, its forerunner in the great historical dispute between Freud and Adler. If we now proceed to examine the issues between them, we hope thereby to contribute to a clarification of today's issues for the benefit of those engaged in brief therapy and therapy in general.

The issues as we see them are pragmatism vs. positivism, becoming vs. being, humanism vs. mechanism, and community feeling vs. superego.

Pragmatism vs. Positivism

Freud wanted to be a natural scientist in the positivistic sense. He hoped to find what really is, in what Rychlak calls the "demonstrative approach" (26, p. 456). Thus he also considered his inferences as discoveries. In line with his intention Freud also was a physiological-physicalistic reductionist who adhered to a strictly physicalistic model of man (15, 22).

Adler, on the other hand, had no ambition to be a great scientist. His ambition was rather to be a helper of mankind. He was a physician and in this sense a pragmatist and artist. A student of the work of Hans Vaihinger, the German pragmatist, and an admirer of William James, Adler included in his theory only those alternatives, wherever there was an issue, which would more readily serve the purpose of teaching people, including patients, how to lead more satisfactory lives, and he rejected all those alternatives which might stand in the way of change for the better. Adler, one might say, agreed with a statement by James Conant some time ago that "a scientific theory is not . . . a map . . . It is a policy—an economical and fruitful guide to action" (as quoted in 26, p. 19). Adler expressed his stand in the following: "There may be more venerable theories of an older academic science. There may be newer, more sophisticated theories. But there is certainly none which could bring greater gain to all people" (4, p. 364n).

From the viewpoint of the positivist, Freud investigated the past and made assumptions regarding the "sexual constitution" to "discover" the "cause" for the patient's condition. From the viewpoint of the pragmatist, Adler said: Of course there is the past, there is the heredity which may include organ inferiorities, and there is the patient's history which may include "traumatic" experiences. The patient knows a great deal of this himself and in this sense "every neurotic is partly right" (3, p. 334).

The problem is: Granted all this, what help is it as a "guide to action" from here on? And thus Adler shifted from the customary emphasis on the *causa efficiens* to stressing the *causa finalis*. Not the Whence, but the Whither is important (3, p. 91). Very simply: Just because your parents were wretched people, you may of course say, "Therefore I am wretched." But your parents are blameworthy only so long as you act in a blameworthy way (3, p. 92).

At the point of action, at the "here" and "now," a choice is always made, and the basis for this is best conceptualized as a goal, a pur-

pose, a guiding line. Thus Adler broke with the "hard" psychological determinism of which Freud was so proud, because it is in fact an impediment to change, and replaced it with what William James called "soft" determinism (3, p. 89). Now symptoms are explained in terms of goals of which the patient may not be aware, and the work of the therapist becomes that of changing goals. The past of the patient cannot be changed anyhow, but the future can. The therapist must have the optimistic expectation that this is possible.

Becoming vs. Being

To facilitate change, which is the therapeutic problem, Adler abandoned drives or instincts as absolutes. They are actually conservative agents which make for continuity. As long as an action is seen as instinctive it can really not be changed. Thus Adler abandoned the aggression drive which he had conceptualized originally. He replaced the drive or instinct dynamics with a dialectical dynamics which he had adopted from Nietzsche and which has wide human applicability.

Turning to the better is not only the concern in psychotherapy, but of all of us, all the time. Throughout our course of life we are confronted with choice situations; and the criterion for choice is always, which is the better alternative, which will have the more desirable consequences? All of human progress has been based on man continuously wanting and choosing the better—and there is no denying that there has been progress over the centuries, even if we admit only the technological progress. Thus the problem of psychotherapy is a part of the general problem of human progress and improvement.

Wanting the better, presupposes that the person is capable of conceptualizing what could or should be, and by contrast realizing at the same time that the present situation is inferior by comparison. Man's choices are then actually made from a future orientation with respect to his present situation, and the bridge from the one to the other represents the continuous state of becoming. This then is the basic human dynamics: realizing a plus and the corresponding minus situation and a continuous state of striving from the minus to the plus.

This is a striving toward a goal, toward some value. The therapeutic problem becomes how to show the patient in a manner that rings true to him that he is striving for mistaken values or goals, and that alternatives for better choices are open to him.

By contrast, Freud stayed with instinct, defining it as "a compulsion . . . to restore an earlier state" (11, p. 46-47). He declared his low expectation for improvement with the words: "I have no faith in the existence of an internal instinct toward perfection, and I cannot see how this benevolent illusion is to be preserved" (11, pp. 55-56). Thereby Freud not only rendered the problem of psychotherapy extremely difficult, but also withdrew the basis for even explaining desirable human development. Freud confirmed this in a letter to Dr. Putnam when he wrote: "Why I—and incidentally my six adult children also—have to be thoroughly decent human beings is quite incomprehensible to me" (17, p. 418). We feel that a psychologist who thus has no theory of mental health is at a serious handicap in trying to lead toward it.

Humanism vs. Mechanism

In line with his positivism, and conservativism, Freud fashioned a model of man which was in fact mechanistic, elementaristic, causalistic, and reductionistic (6). Freud actually took considerable pride in having provided through his views the greatest of the three "humiliations" (*Kränkungen*) which man had to suffer at the hands of modern science. In his frequently repeated statement, he named as the first humiliation the finding of Copernicus that the earth was not the center of the universe; as the second, Darwin's theory of man's descent from animals; and as the third, his own "discovery" that man "is not even master in his own house" (10, p. 252).

But Freud's view is not an objective fact: it is a construction, another of his anti-therapeutic constructions that Nathaniel Lehrman (20) has described. The antitherapeutic and even pathogenic nature of this construction has been demonstrated through the research on external vs. internal locus of control initiated by Julius Rotter and reviewed by Herbert Lefcourt (18, 19). It showed that lower-class and minority groups, as well as mental patients are indeed more likely to believe that the events in their lives are beyond their personal control (external control); while normal groups believe more that such events are under their personal control (internal control), e.g., that they *are* masters in their own house.

Adler's model of man was thoroughly humanistic and thus also holistic and teleological. One will find no metaphors from physics, chemistry, or animals in Adler's psychology—only from the human scene. When he introduced the name "Individual Psychology" for

his school, the modifier did not mean "individualistic" but "indivisible." And he quoted from a paper by the great 19th century pathologist, public health physician, and champion of the poor, Rudolf Virchow (31). In this paper, entitled "Atoms and Individuals," Virchow fully developed the position that for organic events in general and certainly for man, the mechanistic, reductionistic and causalistic approach is inadequate.

According to Adler man is indeed a unified organization, endowed with creative ability without any equal in all of nature, developing a unique way of living or style of life, pointing toward a goal and proceding as if according to a plan—only that the individual is not necessarily aware of this. The psychotherapist first tries to show to the patient that such a view of himself is possible and plausible. After the patient is then shown how he developed his erroneous style of life, he may also see how he can correct the error and discover the ability to do so. All this is encouraging, takes a burden from the patient, and raises his self-esteem, which is so essential to better mental health.

It is easier to have a therapeutic effect on an individual if you see him as such and not as a combination of components, because you have only the individual to deal with. To illustrate: When a patient coming from a "traditional" psychotherapist told Adler about his Oedipus complex (a component), Adler answered (addressing the individual): "Look here, what do you want of the old lady?"

Community Feeling vs. Superego

Adler's crowning theoretical achievement was the concept of community feeling (*Gemeinschaftsgefühl*), often also translated as social interest. It is a conception which greatly facilitates therapy and prophylaxis. It supports the conviction that harmonious social living is theoretically possible and can thus become a reasonable therapeutic goal, all existing contrary behavior notwithstanding. It creates in the therapist a basic trust in human nature, replacing the basic mistrust the therapist must have when he assumes destructive primary processes which have to be managed by the person through a precarious balance between repression and acting out, under the strictures of a more or less severe superego. Incidentally Adler's concept antedated that of Freud.

Adler started from the simple fact that man, after all, is outstandingly a social being. Our outstanding trait is the ability to express our thoughts in language and to communicate in this way

with other human beings. Language is a communal invention, and we acquire it through human interaction. Through language we become a member of the human kind and its cultural development. Through the division of labor and through the fact that even sexual gratification is most satisfactory in partnership with a member of the other sex, all the important problems in our lives become social problems.

Without disturbing his basic assumption of the unity of the individual and the master dynamics of striving toward improvement, Adler simply postulated that man is endowed with an aptitude for living the way he normally does live anyhow. This is an aptitude for community feeling or social interest, which, however, like any aptitude, must be consciously developed.

This conception gave Adler a definition for mental health and illness: If the aptitude for communal feeling or social interest has remained underdeveloped, the striving for success and superiority will be narrowly self-centered, on the socially useless side, leading to conflicts with the social system of which the person is a part. This is the basic condition of all mental disturbance. Such people are not prepared to solve the problems of human living successfully. They become the failures in life.

By contrast, with a well-developed social interest, the person will have a feeling of solidarity with his fellowmen, will feel at home on "this poor earth-crust," and most importantly, will strive for success on the useful side of life. This means his striving will automatically merge with the striving of others. The result is a synergy and cooperation, as we have, for example, in any successful partnership, including a marriage. This is not conformity, but a spontaneous effort, leaving room for innovation and even rebellion as healthy— provided it is on the side of greater social usefulness, striving for a better future society.

SUMMARY

We have attempted to develop the theme that Adlerian psychology represents the tradition of brief psychotherapy. Thus we have attempted in the first part to show the extent to which present-day brief therapy has the same structural attributes as Adlerian therapy: the short time span itself; recognition of the importance of the exogenous factor; focusing the interview; the importance of some therapeutic impact during the first session; a good relationship with the patient; and the wider implications of community mental health.

In the second part we have tried to show that Adler developed a conception of man which uses only such constructs as are therapeutically valuable: a pragmatic emphasis on goals and choices rather than on determinism; an optimistic and dynamic view of life as becoming rather than a more pessimistic and static view; a humanistic view of man as a unique and creative being rather than a mechanistic view; and the assumption that man has an aptitude for social living which, however, must be consciously developed. It is in this respect, we may add, that we feel the work of Adler still has a great deal to offer to brief therapy and psychotherapy in general.

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