ADLER'S CONCEPTS IN COMMUNITY PSYCHIATRY[1]

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Adler's theory was developed between 1912 and 1937. Today those of us within the Adlerian group, and others who are in sympathy with us, remain impressed with the validity and importance of his contributions. We are aware, too, that originators of recent theories, researchers, and practitioners rediscover and re-apply these revolutionary and fruitful ideas to their own work, without full cognizance of their origin.

I should like to elaborate on those Adlerian concepts which have been most useful in the macrocosm of the mental health movement which is presently tending toward community psychiatry, as well as in the microcosm of the psychotherapist's office.

Social Feeling and Community Psychiatry

The basic Adlerian propositions of man's social embeddedness and man's capacity for social feeling have infiltrated the entire theory and practice of the behavioral sciences. Social feeling is as natural to man, as characteristic of his maturation process, as are language, symbolic thought, foresight, and self-awareness.

In this connection I cannot resist citing Masserman's (10) recent experiments with rhesus monkeys: Ten out of 15 trained animals refused to operate a chain which secured a food pellet but, at the same time, administered an electric shock to another animal in an adjoining cage. Even if the first animal merely saw the "victim's" expressions of suffering without hearing his cries (as they were separated by a soundproof, one-way screen), some of the "altruistic" monkeys suffered hunger rather than hurt their neighbor. Sensitivity to the victim's distress was increased if the operator monkey had previous experience with shock or if operator and victim monkey had previously shared a cage and were familiar with each other.

Erikson who considers himself a neo-Freudian nevertheless agrees with anthropologists and animal psychologists that it is a prerogative of man alone to fight his own species, and then only in specific socio-

[1]Presidential Address read at American Society of Adlerian Psychology, Chicago, May 29, 1965.

cultural settings. He states that human aggression is not instinctive, but is based on the "fear of otherness" (6). We would say, it is based on insecurity and the desire to protect one's own psychosocial identity.

Perhaps the fear of total destruction, the awareness of the new and real danger to the human species as a whole, contributes to the rediscovery that man's instincts are natural only in socialized form, and that social feeling is the only hope for survival. Certainly concepts similar to Adler's social feeling which he emphasized as the most important factor in the development of an individual and of the race have influenced the present mental health movement and procedures of psychotherapy.

Awareness of man's social embeddedness, beyond enriching individual and group psychotherapy, has created a whole new field—community psychiatry.

The term community psychiatry which has become familiar during the last decade, is as meaningful to me as is the term Individual Psychology. Adler's distrust of fixed and separate categories, of artificial entities, of dichotomized thinking, is vividly illustrated by the apparent contradiction between the name he invented for his theory, "*Individual* Psychology," and the emphasis he laid on the importance of man's social context. Both components—the individual, a lower system, less open, an "indivisible, inseparable entity;" and society, a higher system, more open—are of equal importance in Adler's theory. Adler took a bold step forward; he replaced the Freudian viewpoint which sees society in conflict with the "drives" of the individual, by his philosophy of individual success—or fulfillment, to use Charlotte Buhler's term (3, pp. 753ff.)—through social striving within society.

THE COMMUNITY AND THE PSYCHIATRIC PATIENT

The term community psychiatry, like Adler's Individual Psychology, synthesizes two opposing trends which can be observed in the history of psychiatry during the last three centuries. In its historical development, psychiatry initially sided with society, intent on protecting the community's disregard for the mentally sick person. The age-old tradition of isolating and confining the psychiatric patient as the only means to safeguard the welfare of others was broken during the eighteenth century. The first psychiatric revolution in Europe and in this country was the humanization of treatment as symbolized by freeing patients of their chains. Around 1900 the

second psychiatric revolution took place. Emphasis shifted from protection of the community to protection of the individual patient from the "repressive" impact of society. The pendulum swung to the other extreme, especially in the orthodox Freudian technique of treating the patient in the sanctity of the isolated office. Any contaminating influence by the analyst's colleagues or the patient's relatives and friends was prohibited.

Adler never agreed with this approach and fervently tried to counteract it with his independent and committed thinking and teaching. His ideas started the third psychiatric revolution. Dreikurs described it this way: "The third Psychiatric Revolution may well go down in history as the period when psychiatry became aware of the social factor, both as a noxious and as a therapeutic agent. Its onset may perhaps be placed in the second decade of the century, when Alfred Adler developed his therapeutic theories and methods and Moreno began his group experiments" (4).

Ten years ago we did not know that the advent of group psychotherapy was only a beginning. It is a sociologist, Leo Simmons of Western Reserve University, who now tells psychiatrists, "Present trends suggest a third revolution under the banner of community psychiatry or community oriented treatment which keeps the patient within and in contact with his own community" (13). An Adlerian will especially appreciate Simmons' appeal, "For the psychiatrist abreast of the times, the old and cherished axiom to 'know thy patient' must make room for a companion admonition to 'know thy community,' and this can be almost like learning another discipline" (13).

There is no need for me to go into a detailed description of the work already done by those involved in community psychiatry, and of their exciting plans for the near future. Adler's theoretical formulations and the practical application of his concepts to psychotherapy, child guidance and education—both individual *and* community—were just the beginning. Adler charted the course for this third psychiatric revolution.

FREUDIAN THEORY AND THE NEW DEVELOPMENTS

The younger generation of Freudians is eager to participate and to elaborate on the application of psychoanalysis to the problems of community psychiatry. Linn says: "Just as analysts were once inclined toward a one-sided concern for the intrapsychic problems of the

developing infant without adequate concern for the role of the parents, by the same token there has been a one-sided preoccupation with the developmental phases of infancy and early childhood" (7). He then discusses the implications of the "data of ego psychology" to practical planning in group settings.

These efforts are praiseworthy. But some of the strictures of the traditional speculations remain: mental disorders are now not explained only by intrapsychic conflicts, but concern is shown for social issues by interest in "disorganized families" and "transference significance of paranoid feelings in the community" (7). From these quotes we can draw the conclusion that Freudian emphasis has not only shifted from the id to the ego, but also from intrapsychic to intrafamilial dynamics. In applying psychoanalytic theory to social settings, analogies and conclusions based on the model of family interaction and/or transference patterns, prove to be slightly more appropriate and usable than those evolved from the hypothetical three conflicting psychic apparatuses.

In this decade it has been pointed out in many papers in this *Journal* and throughout the world, that the Freudian scheme led to progress in clinical observations, but became an obstacle in the development of the behavioral sciences if adhered to in its rigid, complicated and artificial structure.

A *primary* social approach to socio-psychological problems, as characteristic of community psychiatry, is imperative. Otherwise, by introducing society as a *secondary* factor, unnecessary detours, misinterpretations, failures and waste of money and manpower occur. As an example, I doubt whether any delinquent youth was ever successfully treated by having his behavior interpreted as guilt-ridden and punishment-seeking. We have to prove to the disturbed youngster that his disorganized family is not indicative of or equivalent to society, and reawaken in him social feelings which the family setting failed to develop (11).

The social setting within which the individual develops contributes greatly to his mental health or disease. The family and the relationships within the family are part of this social setting, and a very important part at that. But the family is neither the only existing nor the only possible social milieu in our complicated modern society. Similarly, family interaction alone, whether observed or inferred, particularly if seen exclusively as a variation on the Oedipal theme, does not provide a workable model to explain behavior. Most im-

portant, however, is the fact that conclusions drawn from this model do relatively little to alter delinquent behavior, help cure addiction or alcoholism, alleviate consequences of discrimination, foster constructive use of leisure time, provide humanitarian values, etc. In other words, our need is for a comprehensive psychological and sociological theory applicable to the treatment and prevention of mental illnesses and disorder.

THE PROBLEM OF DEFINING MENTAL HEALTH

As president of the National Association for Mental Health, Mrs. Winthrop Rockefeller says:

> The greatest, and presently most vaguely defined, area of dual responsibility for the American Psychiatric Association and the National Association for Mental Health is the identification of future goals representing mental *health* programs, as contrasted with treatment for the emotionally ill. In the face of continuing scientific progress, increased leisure time, heightened world tensions and fluctuating moral standards, the need for new, sound concepts of good mental health which reflect modern realities becomes paramount. The old, nagging question of "What *is* good mental health?" must be answered, and in terms that will have meaning and significance to today's average citizen (12).

I am glad that the importance of this problem is recognized. I regret that the president of the National Association for Mental Health is unaware of Adler's answer to this "old nagging question," or of the work of others who contributed to the definition of positive mental health.

Adler developed a criterion for mental health in his concept of social feeling. The infant develops his innate potentiality for social feeling in the relationship between mother and child, who need each other. The educability of the child derives from growing social interest. Reason and intelligence develop with and through human interaction. If the child grows up under favorable circumstances, self-interest is transformed into a striving for a socially meaningful life, and this goal is reached in accordance with social reality. As man's greatest fears concern social isolation and vulnerability of the self through loss of self-esteem, a healthy life style is directed toward achieving competence and social success by working for a goal of social usefulness. Perhaps Masserman expressed a similar idea in speaking of man's Ur-defenses against anxiety and disintegration, when he mentioned feelings of mastery, of invulnerability of the self, and the conviction of man's kindness to man, "faiths necessary to mankind" (9).

Let us take pride in the recognition that Adler opened our minds

to socio-psychological thinking, which is the only logical approach in community psychiatry, and had great impact, not only on the process of psychotherapy (how to make people change), but also on its goal (principles of positive mental health toward which the patient should move). The so-called neutrality of the therapist has been recognized as an impossibility, a confusing pseudogoal and a rationalization for detached lack of concern for either the patient and/or people around him.

Present-day concern with social issues has brought attention to the shortcomings of psychotherapeutic methods. The statistical evidence that one-third of the patients treated fail to improve sufficiently indicates the need for improved techniques. The concern with these resistant or unsuccessful cases is accompanied by a problem of equal importance—possibilities for achieving lasting therapeutic change in brief psychotherapy. This ongoing evaluation of the results of psychotherapies has led many practitioners and researchers to apply or rediscover Adlerian principles.

USEFULNESS OF THE LIFE STYLE CONCEPT

The concept of life style had proven its usefulness because it connotes movement, purposefulness, and plasticity rather than static structure and rigid causality. Judd Marmor, professor of psychiatry, California School of Medicine, said at a recent symposium: "The tortuous maze of the libido theory has been replaced by a unified field theory" (8). To restate Adler's unified field theory in three sentences: People cannot cope with problems and enjoy social life because as children they put together their early experiences more to protect themselves than to acquire adequate building stones for orientation and identity. Once their cognitive organization, their "private map," their inner psychological world has developed, it is hard for them to give up even one little piece of their distorted subjective creation. All the pieces fit together and every change disrupts the only adaptive pattern the individual has been able to derive from what appeared to be the crucial cues in his early environment.

The unity of the life style is not only a heuristic concept for the professional who studies the patient, a concept which enables the therapist to understand the field of interweaving dynamic forces and gives meaning to his patient's behavior. This unity is also an experiential necessity for the individual which gives him a subjective sense of identity and continuity.

The therapist or counselor who applies the concept of life style has to be open-minded, flexible and creative so that he can reconstruct the unity and purposefulness of "what life means" subjectively to this other person. Through his training the therapist acquires the ability for empathetic understanding. He knows how difficult it is for the patient to give up his private map and all the safeguarding devices which make him feel secure in his insecurity. It is painful to change one's cognitive structure. It takes a lot of courage to expose one's vulnerable self-esteem. One needs a supportive relationship to be able to admit to oneself or to the therapist that one's life goal, selected on the basis of misapprehension, is inappropriate to a satisfying, meaningful life.

Daniel Blain, as president of the American Psychiatric Association, said:

> "Behavioral Man" adjusts his perception to fit not only the objective reality but also what suits his wishes and his needs. He tends to remember what fits his needs and expectations, or what he thinks others will want to hear. His need for psychological protection is so great that he has become expert in the "defense mechanisms." He will misinterpret rather than face up to an opposing set of facts or points of view; he avoids the conflicts of issues and ideals whenever he can by changing the people around him rather than his mind; and, when he cannot, private fantasies can lighten the load and carry him through (1).

This describes well the basic deficiency of the neurotic and psychotic, their biased apperception as part of their life style. According to Hilde Bruch, the patient "excludes essential information and validation, develops a poorly differentiated concept of the outer world and of his own mental and physical faculties, and inadequate tools for the widening demands of self-experience and interpersonal experiences" (2).

UNDERSTANDING THE PATIENT'S PURPOSES

What has all this to do with the practical and at present very "fashionable" problems of the difficult or untreatable patient or with brief psychotherapy?

This country's need for the five-dollar psychotherapist and for increased community clinics has been emphasized. Pertinent research and clinical observation have pointed to the importance of certain specialized techniques in psychotherapy with patients of a low socioeconomic class. Instead of the Procrustean attachment to psychoanalytically oriented techniques, and unrealistic expectations that the patient—who is neither verbally nor intellectually sophisticated—

has to adjust to the therapist by becoming an "interesting case," the therapist has to provide what the patient seeks—assurance, advice, comfort. Not a therapist's or counselor's passivity and distance, but only his active approach can contribute to shortening the course of therapy and bring desired results even in resistant cases. This active approach is based on his empathy and on the awareness of how much courage the neurotic needs in order to seek creatively an alternate choice for his life goal.

The essence of psychotherapy, as research and experience have shown again and again, is the therapist's rapport and empathy with the patient, his hopeful attitude toward the possibility of change, and his responsive and responsible actions.

Emphasis upon the past may perpetuate and strengthen neurotic attitudes. I have never found a better pseudo-explanation or rationalization for a persistent neurotic life style than the term "repetition compulsion." Both therapist and patient, by applying this meaningless label, console themselves for lack of therapeutic improvement.

Therapists who are not satisfied with the patient's mere attendance at regularly scheduled therapy hours, but whose concern is with helping him to grow into a happier and more useful person, have repeatedly rediscovered the Adlerian emphasis on the purpose of neurotic behavior. Dr. Marianne Eckhardt, the daughter of Karen Horney wrote in a recent paper: "The patient finds himself in trouble and our question has to be not only what gets him into trouble, but also what keeps him from finding his own answer in the situation. The problem arises when an 'I-want-my-cake-and-eat-it-too' situation arises and life does not oblige. The patient will thus have to learn, or develop, or reach out into new ways of behaving that promise better results" (5). Or, as Solomon imaginatively described the antitherapeutic effect of focussing on the past instead of the future: "As a device for ego mastery it is the role of the therapist to point out to the patient that he is constantly confusing the past and the future. It is as though he is driving through life by looking at the rear view mirror and mistaking it for the road that lies ahead" (14). This approach—the explanation of persistent neurotic symptomatology by an exploration of its purposefulness—gives useful therapeutic assistance in unlocking the static feedback mechanism of early experiences which have created a vicious circle of distorted apperceptions leading to behavior motivated by irrational anxiety and discouraging any attempt to correct faulty expectations and conceptualizations.

CONCLUDING REMARKS

As Adlerians it is certainly our responsibility and our task to remind professionals and all educated and interested people of Adler's original contributions which not only marked the beginning of the third psychiatric revolution, but also anticipated so many recent trends in community psychiatry. That we have had some success in this task seems to be indicated by the growing number of publications which give Adler due and overdue recognition.

Still there are frustrations and disappointments in our ranks when recognition is not adequately given, Adler's priority is not recognized, or his contributions are misunderstood. Compensation for these feelings is found, first, by noticing that the mainstream of psychiatry and psychology is moving in the right direction; second, by each of us finding our place within this mainstream, and, well aware of what we learned from Adler, being prepared to point this out to our colleagues and students.

There are, at present, many opportunities to enrich Adler's frame of reference, to research its propositions, or to be involved in its practical application either in the psychotherapist's and counselor's office or in some area of community psychiatry. This social usefulness, this cooperation with others in the whole professional field is what really counts. Constructive ideas survive even if they change names.

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