



Techniques that Shorten Psychotherapy: Illustrated with Five Cases¹

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Adlerian therapists have at their disposal quite a number of special techniques which can shorten psychotherapy in many cases without sacrificing either depth of treatment or degree of change that occurs in the patient.

In order for change to occur at all, according to Adler, the patient must learn to understand something—about his life, his relations to others, his behavior—that he did not understand before. One would say, perhaps, this is a new insight. But insight alone is not enough; there must be, in addition, a sort of artistic penetration and permeation of the patient's life attitudes with this newly understood and more social behavior. Not all cases, therefore, will be capable of profiting immediately from short-term therapy.

Purposiveness of the Symptoms. The first basic principle of Adler's theory is that all behavior, all thinking, all feeling is directed toward the individual goal of a patient. This is already of enormous help in shortening the time needed to understand what is usually called the dynamics of the patient's symptoms. Adlerians will ask themselves and, at an appropriate time, also the patient: "Where is the patient aiming with his symptoms? What are the symptoms designed to achieve for the patient?" The purpose of a neurosis is usually not too difficult to detect; the patient, of course cannot tell you; but, he will often reveal his purpose unknowingly when you ask him: "What would you do if you were completely free of your symptoms?" The patient will then as a rule

mention precisely that which he claimed he had been prevented from doing by his symptoms.

Unity of the Personality. The fact that the individual strives unerringly with his thinking, his feeling, and his actions toward his goal has been termed "the unity of the personality"; and the mode of movement toward this goal, his unique mode of movement, has been termed by Adler the individual's "style of life."

Differential Diagnosis. From these few concepts alone, some very important criteria for differential diagnosis can be arrived at, in addition to the self-checking mechanism they present for confirming the dynamics of the case. They are: (a) The symptom must be usable and necessary in the pursuit of the patient's goal. (The goal of the neurotic is, as a rule, the cover-up, the excuse for avoiding the problem he is faced with and feels not ready for.) (b) The use of this particular symptom must be traceable throughout his history from childhood on. (c) The symptom, which is thus part of his life style, must be found to pervade all his attitudes, all his movements, his dreams, his memory, and all his feeling life and relations. If these criteria are not fulfilled, the chances are that his condition has some organic basis.

Early Recollections. The technique of using early recollections as a quick index for the underlying dynamics of a case is another of Adler's innovations. When a person tells you what he thinks is an incident from his early childhood, he is in reality telling you what his central interest is and what he constantly keeps before his mind's eye. Why would he otherwise remember just this, out of millions of possibilities? Without the patient becoming self-conscious, because a childhood memory is considered a trivial episode, he reveals as much or more about his unconscious strivings than the so-called "free" associations do.

Birth Order. Another of Adler's techniques for quickly arriving at a thumbnail sketch of the total personality is the use of the birth order position. The invention of this technique shows most clearly the social and inter-personal nature of Adler's personality theory. Ford and Urban (1963) in their book, *Systems of Psychotherapy*, write, "Adler seems to have been the first theorist to call attention to the other children in the family and their effects upon the child's development" (pp. 322-323). This technique is based upon the fact that each child is in a unique position during his growing years, due to the existence or non-existence of sisters and brothers, their distance from him, and their relation to him. The total development of his life will be decisively influenced by this and will give him a definitive stamp for life. Understanding this, the therapist can more

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easily and more definitely reconstruct for himself the dynamics of this patient's personality and his behavior.

Dreams. As interpreted in an Adlerian way, dreams can also be used to great advantage by pinpointing the problem the patient is faced with and showing him how he intends to escape from it.

So far, I have been talking only about techniques, which make for a quicker understanding of the patient by the therapist, and, although this is a preliminary necessity, it is still all-important that the patient arrive at an understanding of his own personality, of the errors he makes and has been making, why he makes them, and how he can avoid them.

Life-Style. Understanding of the patient, and therefore also interpretations to the patient, can only be sketchy, patchy and vague, unless the therapist gets a thorough history of the patient's development and present condition. The first interview, therefore, and often some subsequent ones are devoted to airing the patient's relations with his parents, his siblings, his mates, his attitudes to sex, to occupation, to friendships, in addition to the development of his symptomatology. With the help of key indices, of which I have mentioned early recollections, birth-order position, and dreams, a composite picture of the patient's personality, his life-style, including his secret goals and the areas where he is unprepared for the handling of the confronting problems, is very quickly constructed, and can then, at the appropriate time, be presented to the patient for his consideration.

Face-to-face Position. Since all psychic disorders stem from some insecurity, and all symptoms are frantic efforts to undo it, the first task for the therapist is to see that the patient can feel more secure in his presence. This calls for a friendly, accepting attitude of a fellowman toward the patient, one that presents no threats of criticism or superiority. The face-to-face position is therefore the setting of choice, this being a more habitual position of two friends discussing a problem in the solution of which they have to cooperate, since neither can solve it alone.

Lying on the couch is always felt by the patient as a position of inferiority and *not* facing the therapist always enhances unreality. Both of these introduce new problems for the patient that have to be resolved first before insights can begin. Being actively interested in the patient, on the other hand, and clearly showing interest in the problem at hand, represents a much more real relationship, and thus counteracts the patient's distorted interpersonal relationships and greatly reduces the development of false transferences.

Tactfulness and Cooperation. On account of the patient's insecurity, the therapist must proceed with great tact and care in order not to offend the patient or put him on the defensive. Thus, there must be a constant gauging as to what the patient is ready for at any time. In addition, interpretation should nearly always be made in a tentative way, again, to impress the patient with the fact that you want him as your collaborator. When a patient then says: "I have never thought of it in this way," you know that you have won the patient over for cooperation, and he is on his way to an understanding of his problem.

It has to be made very clear to the patient right from the beginning that without his help, you, the therapist, are entirely impotent. This immediately undercuts competition of the patient with the therapist and practically tones down resistance to a minimum. A ready acceptance of this arrangement by the patient is probably the strongest indication that this is a case where short-term therapy is possible.

Slowly, carefully, and gently, yet often already in the first session, the unconscious purpose of the symptom, the patient's creation of the symptom, and his attempts at escape from the problem can be made quite explicit with a constant weaving back and forth from childhood habits to present-day attitudes.

How, after such preparation, a parallel drawn between an early childhood memory and a present-day operation makes its telling impact on the patient, I will now demonstrate by a few concrete examples.

Expecting to Overwhelm Everybody

This was a 30-year-old man, married, without children. He was a network correspondent. He was depressed, discouraged, had difficulties in his work and in his marriage.

He had been an only child, and the parents divorced early in his life. He was raised almost entirely by his mother. He had been a very good student, got a B.A. in political science and an M.S. in journalism. At first he held a few radio jobs and finally became a TV network correspondent which had always been his aim and desire. He was sure he would become famous and make a quick career. But the network gave him only minor jobs, never the glamor spots.

He came from a distant town and could consult me only twice. This made it necessary for me to work fast. After a few basic background facts, I asked him for his earliest recollection. It was: "On my first day in school, the teacher found that I could already read. She took me to the principal, and I read for the principal. The principal was amazed and put me in a class one and a half years ahead."

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A simple and innocuous memory of a bright little boy? But Adlerians would ask: "What thoughts, what feelings does this patient keep constantly in his mind, by the selective choice of this particular memory?" To Adlerians it would seem quite obvious. He says constantly to himself: "When I open my mouth, everybody should be amazed, and I should be put ahead of all others." If this doesn't happen, he is offended, furious at the people who do not recognize his genius, and discouraged. Crying and pouting had been his childhood method of dominating his mother and holding her attention when she did not make him her central interest.

I asked him, did he think he was very good at his job. Yes, he said, he thought he was very good. Did the network people think he was good? No, they thought he wasn't so good. Why did they think so? He didn't know. Didn't you ask them? No he didn't. Why? He said he never asked; he was just discouraged and thought he may just not be gifted for this job, and should look for something else.

It had become quite obvious to me that this man never wanted to hear criticism and had simply not learned to profit from criticism. He had, since childhood, depended on his inborn genius, which he expected should overwhelm everybody.

With his wife, his difficulties came from the same source. If she expressed an opinion different from his, this meant to him that what he was saying was not being appreciated; he would withdraw offended, angry, and therefore depressed, and felt she did not love him.

When I showed him the connection between his attitudes now, and his early recollection, he really listened and was amazed. He was eager to make our second (and last) appointment.

At this second visit he said he had thought a lot about his wrong way of thinking and feeling about himself and his life, and had decided to stick with his job and really try to find out what he did wrong and how he could improve it. We then talked about his relation with his wife, and he was quite clear about how he could improve that in a similar way. He had dropped his anger and his depression with it and felt encouraged.

I have been hearing from him for the past four years; he has advanced in his position, and they have a child now. No more symptoms of deep depression.

When in this case we ask for the purpose of the neurotic symptom, we find the patient wanted to keep himself free from responsibility for failure, and achieved this in his neurotic spurious way by blaming others and painting himself, to himself and to others, as the suffering victim of a world that does not understand him.

Victory Through Illness

A 26-year-old strapping, good-looking man showed a certain fear in his eyes and manifested an over-careful manner the way he sat down in his chair, as if he were made of glass. He reported his difficulties as follows: Five months ago, while going with his younger sister, age 19, and just married, to buy wallpaper for her new apartment, he felt hot flushes throughout his body, felt dizzy, and his heart pounded at a terrific rate. He was taken to a hospital where an intern said that he might have had a heart attack and stayed for a week for observation. But nothing was found, he felt very well, and was discharged with the diagnosis of acute indigestion. But the next day while watching TV, he had the same kind of attack and became panicky. A doctor said it was just gas and gave him some tranquilizers. The patient did not dare any more to drive his car, walk more than a few blocks away from home, or stay at home alone, fearing another attack. He could not sleep at night fearing he would never wake up, although he slept very well in the morning into the late noon hours.

He was a house painter in the employ of his father who had a house painting contracting firm. The patient is the third of four children with two older brothers and a sister seven years younger. Both brothers also work for the father. About his mother he said that she always had been sick and nervous, believing she has an obstruction in her throat and cannot breathe. She is not talkative but very sarcastic when she talks.

The patient has always been the pride and joy and favorite of his father, who considered him the brightest and most capable of his children. Nevertheless, it was always difficult to get praise from his father, and when the patient wanted to go to college his father decided on a business school instead, and the patient never protested. He felt his father knew better and he said, "I never could believe that my father could ever be wrong, and whenever there was an argument with him, I got a stirring in my chest and a fear.

Now this patient is married and has one child, but his father always told him he should not have married, and since his attack the patient had been afraid to have sexual relations because the strain might cause an attack. In the past two years, since the birth of his child, the patient had started to resent his father's domination and felt his father had exploited him because he considered him his best worker. The fact that he now had a family, while his brothers were unmarried set him back financially, and he started also to resent his wife for being a financial burden. He was somewhat afraid of his older brothers when he was alone with them, but when his father was there he felt safe.

The patient's earliest recollection was of an appendectomy. He told in glowing terms about his hospital experience where he was the center of at-

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tention, didn't have to go to school, had no responsibility, a lot of toys—without any unpleasant memories. Now we see here, a youngest son, who had overtaken his brothers and depended entirely on his father for maintaining his superiority, fearing to lose his superiority, and working hard to maintain it. But now a father himself, he feels increasingly that he should prove himself independent from his father and be no longer “poppa's baby.” But when he tries to stand up to his father, that burning in his chest and the fear warn him not to forfeit his father's support.

Five months before he came, the exogenous factor mentioned in Dr. Ansbacher's paper made its appearance. The patient had agreed to help his sister, to whom he had always been the benevolent older brother, to select wallpaper for her apartment. Now this may seem an innocuous reason for the outbreak of a neurosis—and I did not catch it for four sessions. But then it dawned on me that for the daughter of a house painter to wallpaper her apartment is the utmost in defiance. According to my patient, when she told her father, he said, “That's silly, me and your brothers will come up to your apartment and have it painted in no time.” My patient had been encouraged by his sister's defiance of his father, but in front of the wallpaper store his courage failed him. He could not enter the shop, but he could also not renege on the promise to his sister and perhaps be called “poppa's baby.”

The situation was desperate, but here, like a trusted old friend, his long-trained fear whenever he tried to defy his father, this burning and stirring in his chest, heightened at this point by the additional threat of losing self-esteem, came to his aid. He got sick. This was surely not a conscious act. On the contrary, any awareness of the use of such a devious act for the purpose of escaping responsibility would have nullified his attempt to bolster his self-esteem, but now sick in the hospital, there was no loss of self-esteem, nor did he have to defy his father. A perfect solution! He was also the center of attention, pampered, relieved of all responsibilities, and we are reminded of his earliest recollections in the hospital.

Now, although it appeared to be an ingenious solution for the momentary problem, five months later the patient was still suffering from the same condition. But had he relinquished the old long-trained method, now intensified, the problem with his father would have reappeared immediately. So he now adapted his sickness to fit all situations, and it worked. He used to have to go to the garage, pick up the truck, pick up his father, and go to work. Now, his father must pick up the truck, pick him up, and go to work because he can't drive. He now can refuse difficult or extra work. He has the business books that he had to do in the office brought to his home. He didn't get paid for that before, but now he demands pay for it and his father pays him extra. He now makes more money than his brothers. He gets his way in everything while he actually defies his father without having

the responsibility for it. He doesn't call it defiance; it's his sickness. He is still the best of sons under the given circumstances.

Right from the beginning, at the end of the first session, I told the patient to think about how his sickness that troubles him so much might also help him. After four weeks the patient had the following dream: "Two men stuck me up in my car. I was with my wife and child. The men asked me for money. I told them to leave me alone, that I was sick, and had no money. I subdued them both knocking their heads together. I was the hero, yet I was sick." There is a lot one could interpret from this dream, but I shall only claim it shows that the patient wants to be a hero—even though he is sick, and the sickness even enhances his heroism.

The relationship with the therapist is always the best lever in therapy. And we worked together, comparing his feelings in his more cooperative relationships—with his coworkers, with his friends, with his wife, and with me—to his feelings in his more competitive, exploitative relationships—with his father, his brothers, and his mother. The patient very soon came to realize the advantages to him in his more cooperative relationships. We shed light on his spurious goals of superiority which always arise where there is no cooperation in a relationship, and explored the ways in which his symptoms might also be of help to him, while acknowledging at the same time how distressing they are. When eventually I was able to suggest to him that he just might play act to his father that he is still sick, when actually otherwise feeling very well and being without complaints, he smiled sheepishly and I did not hear any more complaints.

I saw him for five months, once a week, and then every second week. When a year was over, he formed his own company with his two brothers but without his father. The exclusion of his father still caused him some burning and stirring in his chest. His fictitious goal, to be sure, remains the same, to be the first, to be the hero. But he had concretized it in different ways now, with greater ability to cooperate, with increased social interest and self-confidence, and his phobic symptom as well as its precursors had become unnecessary and unusable in the pursuit of his present goal.

Significance Through Paranoid Ideas

Now to show you an entirely different case. The next one is that of a 73-year-old spinster who had come to the medical clinic for a routine check-up. The attending physician noted, however, that she was making references about men on the street staring at her, and he sent her to the psychiatric clinic.

The patient was an answering-service operator now only on parttime schedule. She lived alone and was in the process of making arrangements for her retirement at a church home for the aged.

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Right from the beginning she said that she neither wanted, nor felt she needed, treatment from a psychiatrist. She made light of her paranoid ideas that she had expressed, and said that they did not bother her any more. I dismissed her with a friendly invitation to call on the clinic if these thoughts began bothering her again.

Three weeks later she came and complained that men were looking at her again, making suggestive gestures, grinning at her, and making lewd remarks. She said she did not understand what was going on. In the course of discussing her forthcoming retirement, she expressed the feeling that entering the church home was running away from life.

I asked her if it wasn't a bit conceited on her part to think that men in stores and on the street had nothing else to do than look at her and talk about her? This, I said, was in reality quite a bit of vanity on her part. Maybe, at a time when she was preparing to retire to a home for the aged, she felt that she was now useless, like thrown on a rubbish heap. If she felt that was the meaning of her retirement, it was quite natural that she should need to make herself feel of great importance and significance, the center of attraction. The patient laughed at that. I continued, jokingly, that vanity was one of the famous temptations of the devil, and that she should not fall for them now, at her age.

Then, I tried to convey to her the considerable importance a senior citizen can have in the home for the aged as well as outside of it, that her life and its usefulness were by no means over, and how much good she could still do in this world.

When, shortly before the end of our session I suggested she might take some drugs that will reduce these thoughts and feelings, she said she thought she understood quite well how she had come to feel the way she did, and she would try it without drugs. That was the last time I saw her. But for the past eight years now, the patient has sent Christmas cards to the clinic, telling us how well she was doing.

In this case again, the purpose of her symptoms, paranoid ideas, to increase greatly, in an illusory way, her significance to herself, had to be quickly grasped and conveyed in a most friendly and acceptable way to the patient. Of course the exogenous factor here was her intended retirement.

The Young TV Critic

An 18-year-old girl was sent to me by her parents because she wanted to quit college at the end of her first year. She was the youngest of three, with two very successful older brothers. I had only one month in which to work with her, since I was leaving for my vacation, and then her sophomore year would begin.

She had suffered from enuresis till the age of ten and had always wanted to stay with her mother, making a big fuss when the mother would leave the house without her. She had never ventured much outside their suburban home and had not made any real friends at school. To go to college, therefore, had been quite anxiety provoking. On the other hand, she had an extremely high IQ, was well-read, and articulate.

Her earliest recollection was: A car had run over her toe, but it actually had run only over her shoe, and she was not hurt. Nevertheless, a big fuss was made over it by her parents. The patient said, "It was a pride of mine." When I discussed with her the implications of this memory, she acknowledged that she had used complaints about minor ailments all her life in order to get attention and sympathy from her mother, and often also, to get her own way.

Her second recollection was of a repetitive dream she had had in childhood. She dreamt that she was inside her garden and was swinging on the garden door in and out. People were passing by outside. But, outside there was also poison ivy, and she got it on her leg. I was able to explain to her how she had mobilized fears about venturing outside her home in her dreams, which she could see easily.

Her third memory was more intricate in its meaning, and the full implication of it dawned on me only many years later. She recalled: My older brother and I were walking, and he was singing a song; I found that he had mangled the words, and I criticized and corrected him. I felt proud. In general, that would indicate to me that she wants to feel superior to her older brother. Being the youngest, weakest, and smallest, it was only natural to me that she should strive to be the biggest, best, smartest; and I showed her in the course of her treatment her competitive striving in relation to her brother in that she found something wrong with what he did thus displaying her own superiority.

It was fortunate that she resumed and finished her college education. Years later I saw her on TV, and found out that she had taken up a very active career, the direction of which had been indicated by her last recollection, without my recognizing it in its full implication at that time. Now its implication became quite clear. She had become a critic.

Her goal, to aggrandize herself through criticism of others, to be sure, had remained the same; but she had channeled it into more social forms, that were useful and acceptable. Having an active career and appearing on TV showed that she had certainly, in part at least, overcome her avoidance of the outside world.

Anxiety to Postpone a Decision

A 22-year-old woman was sent to me by her physician who had found

her to have tachycardia, hyperventilation, and increased perspiration, with complaints of fear—although she does not know of what—which, in turn, made her fear that she was going insane. The condition had started about three weeks previously. All sorts of organic conditions had been ruled out. The referring physician had given her some tranquilizers which had somewhat diminished her anxiety and the other symptoms but had made her dizzy, sleepy, and interfered with her work.

She is the older of two sisters by two years. The patient had finished college and was working for an insurance company, while her sister was still at college. The patient had always been very efficient in everything she undertook and had been quite a bit perfectionistic. She had dated a bit, but not as much as her sister. She was now engaged and had been discussing marriage. There had been some necking and petting, but no intercourse. Her own and the young man's parents had recently been pressing them a bit about setting a date for the wedding.

The immediate suspicion that the onset of the symptoms had something to do with the anticipated marriage had to be confirmed. So, I asked her, "What would you do, if you were completely cured of your symptoms?" She answered, "Oh, I would immediately start arrangements for the wedding." This, we must conclude, must therefore be what her symptoms had been designed to avoid. Or, as we would say, her symptoms have been shown to be usable and necessary for the pursuit of her goals.

How could we tranquilize her best? By moving the threatening problem, for whose sake she had created her symptoms, far into the distance. That works much better than any medication. So, I told her that I could see no need to rush into this marriage precipitously. Then, I tried to confirm if anxiety was her particular life-long safe-guarding device. It was. She had been afraid of the dark, suffered from nightmares, had been afraid to be left alone, would not let her mother leave her, had to have the door open to her parent's bedroom. There were fears about the beginning of her menstrual function, about her first date, about necking, and fears whenever she encountered a new situation, a new school or college, etc. Both her parents always assuaged her fears by coddling her, overprotecting her, and taking responsibility onto their own shoulders. Thus we see that her symptoms pervaded her entire character structure.

For this girl, for whom her parents represented her only security, to take a definitive step towards independence, away from them, and join her life to a stranger, was more than she dared. However, social pressures, competition with her sister, and her self-image of a mature, efficient person, which she felt she had to uphold at any cost, put her on the horns of a dilemma. At that moment, her long-trained and often proven mechanism of mobilizing anxiety came to her aid, like an old, trusted friend. Because now, it was not herself, but her sickness that prevented her from doing

what she was in reality not prepared to do. Since she is not conscious of this, she can easily delude herself, and hopefully also others.

That was the time to tell her, "You know, that reminds me of your early recollection when you were little and your mother wanted to leave you alone. You would cry and show such fears until your mother decided to stay home with you. And now, you are thinking of leaving your mother and a very similar anxiety appears to come over you. You have, evidently, still not really prepared yourself for sufficient independence. Nobody can do what he has not prepared himself for. And you had always been such a good girl, different from many others; you never rebelled against your parents, who overprotected you; where should you have prepared for independence?"

Now she has official permission, doctor's advice, to postpone what she is so afraid of doing. At the same time this prepares the way to show her her own part in creating her symptoms, by showing her her old pattern of mobilizing anxiety for her purposes.

After a few visits, when she had calmed down appreciably, she was told that her symptoms had really been a lucky thing for her, because without them she might have rushed into marriage without being really prepared for it. Her symptoms had gained her time, so she can now slowly prepare for greater independence.

To show a patient his symptom as part of his pattern and personality reconciles him with his symptoms so that he will not any more consider them foreign devils that have to be exorcised, which is the reason so many think they may go insane. It is equally important to make it very clear to the patient that his so-called sickness is only the result of an error he has made as a baby and small child by developing this pattern, and he should not expect to abolish the tendency for this pattern to reappear. But, when she feels her anxiety coming on, she should ask herself: Do I really need my anxiety on this occasion, or can I not, perhaps, do without it? But, if she feels she needs her anxiety for this occasion, she should mobilize it for all its worth. Again, we give her permission to have anxiety so that she is not disappointed in herself when she feels it coming on again. But, if she really tries consciously to mobilize anxiety, she will not be able to do it because consciously she will not be able to conjure up all the pictures, thoughts, anticipations, and stories she uses to mobilize her anxiety. Consciously she could not do it because her common sense would militate against it.

Concluding Words

The Adlerian process does not necessarily encompass brief psychotherapy. However, we have various ways of coming quickly to the issues,

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and depending on the readiness of the patient, we do use the confrontation of brief therapy. I have presented a few such cases. Two of them were treated twice only, one was treated a month, one was treated a year, and the fifth was treated about two months. The cases were seen once a week which is the rule, except the college girl who was seen twice or three times a week.

Reference Note

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Reference

Ford, D. H., & Urban, H. B. (1963). *Systems of psychotherapy: A comparative study*. New York: John Wiley & Sons.

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