

Some Techniques Used in Psychotherapy with Mental Patients¹

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The effectiveness of Adlerian psychotherapy in dealing with maladjustment and neurosis, including juvenile delinquency and crime, is well established. My experiences with psychotherapy of psychotic patients in state hospitals for the mentally ill in the United States indicate that our approach is equally useful in the understanding and treatment of psychoses. I used various therapeutic procedures in treating psychoses, but I found the Adlerian techniques most helpful in reaching patients, lifting them out of their mental derangement, and particularly in *resocializing* them, as far as it was possible within the limitations of the reality in a hospital setting.

I. *Individual Psychotherapy*

I conducted dynamically oriented brief psychotherapy mostly with young adults, in close teamwork with the psychiatrists. Patients were assigned for treatment concurrently with, or after they had received convulsive and other medical therapies. I used clinical tests in cases only where I needed some aid for my psychotherapy; for instance, in order to detect some disturbance in the sex area and the extent of its psychopathology. Otherwise I did not pay much attention to the differential diagnosis of the mental diseases, since there are no differential treatment procedures for the various clinical syndromes of psychosis as there have been, e.g., for organic diseases for many decades.

From the Adlerian "socio-teleological" (9) holistic point of view, a functional psychosis, i.e., a mental disorder with no organic lesions and no toxins, appears as a severe mental disturbance of an individual who objectively or subjectively feels hurt and defeated by the world around him. In a mood of utter helplessness and despondency he has retreated from a dreary reality into a protective shelter, the insane asylum. Living in a world of phantasy, the psychotic patients are social shirkers, but not aware of their hidden aim, which is to dodge social

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responsibility. This definition may appear to be a broad oversimplification, but it stands the test as an inspirational working hypothesis to any practitioner in his therapeutic work with the mentally ill.

From this point of departure I did not treat the mental illness, let alone pathological symptoms, as such. I rather made a massive concentration on the whole individual with his mental illness. I then treated the unique personality (2) in its total intra-mural and extra-mural environment, as far as I could get hold of it. My main objective was to re-educate (20) the patient by showing him that the reality of community living was not such a great threat to him, as he with his real or imagined inferiorities mistakenly felt. For this very purpose I started to improve, along with the treatment of the sick personality, the attitudes of the family, the social and psychological constellation of his surroundings (3). I enlarged the actual therapeutic area by cheerfully and tirelessly manipulating all those institutional workers in the ward and in the assigned activity program who were in more or less close contact with the patient. Attendants, supervisors, occupational and recreational workers followed suit. I may say from my experience that genuine therapeutic enthusiasm spreads in a hospital setting, or at least counteracts the understandable tendency among institutional workers to become "case-hardened." As the workers thus gained a better understanding of the abnormal behavior of the patient, they became, with all their responsibility for the morale of the group, more permissive towards so-called misbehavior. They limited their disciplinary action to letting the patient bear the natural consequences (4) only of his non-cooperation, as far as the disturbed patient could grasp the situation at all. For instance:

"You bothered the other patients at the lunch table; you will understand that you will have to eat your supper in your room."

Besides this practical in-service-training for institutional workers, I tried to reach all the relatives and friends who came to see the patient, in order to obtain clues for the understanding of the pre-psychotic condition of the patient and particularly of the aggravating factors which precipitated his mental breakdown. At the same time I conducted *active counseling* with them, such as parental guidance, marital counseling (10), with the following result: I found the sensitive areas in the family constellation, and disentangled conflict situations which were sometimes of long standing. Thus I improved the social and

emotional climate for the patient in his relations with those who were nearest to him (11). Under the pressure of work, often "rapid fire" counselling only could be offered. But psychological guidance of relatives, beyond psychotherapy with the patient, invariably accelerated the therapeutic process in the hospital. What is more, we did secure some emotional and material support for the patient for later, since further professional help was, as a rule, not available owing to the lack of mental health clinics in the various communities. To avoid any possible misunderstandings or overstatements, we should like to point out the deplorable fact that in the hospitals for psychotic patients in the United States as well as in other civilized countries there is a desperate shortage of trained and experienced psychotherapists. Therefore, neither intensive nor extensive dynamically oriented treatment can be offered such as to "immunize" the patient against mental disease for his life. The less so as the patients, once they have more or less recovered from their psychoses—often as a result of electroshock and insulin treatment or drug therapy—usually insist on leaving the hospital. For this they advance rational reasons, such as taking care of young children, finding employment, etc. It is here that the Adlerian sound and quick type of psychotherapy is useful to a practitioner who is keen on lending a hand to many and not only to a few selected patients in the vast sea of human distress.

Any therapist using Adler's straightforward approach without formalities will, first of all, get down to the level of the patient and maintain this parity by leveling off the social and educational distance between himself and the patient (5) throughout the therapeutic process. From the very start this writer reassured the patient that he or she was not "brainsick"—of course, in cases only where the tests did not reveal any organic damage. We made a point of stressing:

"You are just confused in your mind because you did not get help with your emotional problems in time; you know, 'A stitch in time saves nine'" (and the like).

The response was, as a rule, a flare-up in the eyes of the patient or a sigh of relief from a feeling of worthlessness, a reflection of his "shameful illness." It was often accompanied by an appreciative remark from the depth of his heart: "It is good to know this." At the same time this therapist would make light of the stigma of confinement in a hospital for psychotic patients. For example:

"You are not ashamed of taking care of your teeth. Why should you be ashamed of getting rid of your emotional and mental problems? All of us have problems. There is an inscription on the main gate of a state hospital which says 'Not all who are inside are insane, and not all who are outside are sane.' Nowadays mental sickness needs the same care as a bodily disease."

When the patient happens to have relatives who are also mentally ill, it is advisable to reassure the patient by discarding constitution and heredity as a cause of mental illness, though in full awareness of the scientific inaccuracy of such an authoritative reassurance.

Those who were fortunate enough to sit in the sun of our great teacher Adler and to have their fellow-feeling psychologically strengthened, know that the analyst's unlimited, though realistic *optimism* has to permeate the whole therapeutic relationship from the very beginning up to the termination of the treatment. Sometimes the relationship may be allowed to be a symbiotic one for a limited time, but not a parasitic one at any time. The personality of the analyst is, to my mind, the most important tool in psychotherapy. His deep empathy with, and genuine respect and warmth (19) for the suffering fellow-being, with all the subtle nuances in voice, tone, gesture and movements, make the patient feel that he is accepted not only by a person in authority, but also by a good parent. The reward for the analyst is a positive emotional charge ("transference") (16) on the part of the patient—with all its valuable therapeutic implications. After all, a mutually strong positive relationship is an indispensable prerequisite to any success in psychotherapy, no matter which theoretical frame of reference or which therapeutic tools are used by the analyst (22). Once a satisfactory rapport has been established, the patient's weak ego (17) feels effectively supported by the strong ego of the therapist. It is the first step towards the socialization of the patient, since the therapist appears to him as an omnipotent representative of society.

The next technique used by an Adlerian psychotherapist is to comprehend the "style of life" (2, 1) of the patient, as it has been established in his formative years from the interaction between the members of the family, as well as from his early childhood recollections (12) and dreams (6). Usually an experienced therapist after having read the social history and the intake record of the mental patient, even before having seen him, will get some grasp of the profile of the basic personality structure and make a mental note of the pathological factors which have to be explored in the therapeutic process. The patient is

encouraged to express not only positive, but also negative feelings about his parents and siblings, spouse and children, as follows:

“You see, nobody is perfect; we parents are not perfect either; we may speak about the faults of our parents and still have to accept them the way they are; if they are no longer living, we still have respect for them. Maybe they needed help, too.”

With some introductory explanation the patient is also stimulated to dig out his earliest childhood memories of home, school, church, neighborhood, etc., and to relate his present and past dreams (18). As a matter of principle, the patient is spoken to as if he were perfectly normal, even if he has no critical faculties; actually he does not use them in his role as a non-participant, his apathy being a defense mechanism.

In giving interpretation we drive home the paramount importance of an adequate self-esteem and of sound human relations. The mistaken or distorted concept of the self is indefatigably dealt with. Its devastating effect on his emotional life is pointed out again and again, as for instance:

“Such an inferiority feeling is a poison in your soul” (Adler). If the patient hesitated to reveal the causes of his inferiority complex, this therapist would say:

“You see, life inflicts wounds on all of us; we have to drain off the pus as much as possible; it is up to you to tell me where it hurts,” — or, “You can’t live in isolation from the world outside; human beings have been living in herds since time immemorial,”

with an elaboration on the “gregarious animal” and the “inexorable logic of living in groups” (5). Thus the patient is led to re-live his traumatic and frustrating experiences in a permissive atmosphere. He is shown his faulty mechanisms of adjustment and his wrong compensatory efforts (7) in the areas of work, sex and love, and social contacts.

The patient’s verbalizations are often irrelevant and incoherent or in symbolic language like dream material (18). Whatever a mental patient spontaneously projects, or whatever is elicited from his troubled mind by the psychotherapist, reveals his “private logic” (4). Although his morbid mental processes are qualitatively different from normal thinking, they can be more or less understood by an empathetic, patient-centered therapist who keenly observes facial expressions and motor

activities accompanying the patient's utterances, and who listens to his asides in autistic thinking. While evaluating commissions and omissions of the patient, the therapist will always keep in mind what Adler taught: "*Don't look at their mouths only, look also at their fists,*" since the patients' goal-directed actions may sometimes belie their utterances. Mental patients, following their established emotional patterns, cannot but use their former mechanisms of defense (17, 15), too, such as projections, rationalizations, etc. This therapist feels that frequently some artistic quality of *intuition* has to supplement the *gift of empathy* in the analyst in order that he may arrive at an accurate understanding of the incoherent and bizarre material of a mental patient.

After having discovered the main areas of sensitivity and tension in the patient, this therapist would in the presence of the institutional workers gloss over the shortcomings in the patient's personality and his failure in his interpersonal relations. As the workers had been counseled beforehand, they would see eye to eye with the therapist in whatever he might say as a professional about the patient and "his mistakes." Generally we tried to bring the patient into some social relationship with people, though within limited reach, and stressed the strong points of the patient, adding, for instance:

"You know, Mr. X or Mrs. Y, Alma is, all in all, a good girl, she looks fine, has a nice family, is well liked . . . The great American mental hygienist, J. E. Wallace Wallin, used to say 'There is so much good in the worst of us and there are so many blemishes in the best of us, that it behooves none of us to cast the blame on the rest of us' (21). Is he not perfectly right?"

Of course, when involving an outsider in the therapeutic process, the analyst has to use his discretion and tactfully stay within certain limits. Such socializing endeavors invariably lessened the patient's social anxiety, for he experienced the soothing feeling of being accepted as he is, not only by the therapist, his good friend, but also by other workers and even strange visitors. This is again a useful step towards the intra-mural resocialization of the patient, forging some links with the outside world.

After some adequate preparation and as soon as the patient's condition permitted it, this therapist would also dictate to the patient, informal personal letters to all those outside the hospital who were, or still were close or at least significant to him or her. This was done

for several reasons: First of all, when the patient resented the preliminary electroshock therapy, the necessity of this and other psychiatric therapies was explained to the addressee, but actually the explanation was directed to the patient; for instance:

"You know, Mom, all of us are more or less rigid; electro-shock definitely reduces our rigidity; it certainly helps in the final result."

At the same time a brief was held for psychotherapy, and its salutary effect "on everyone" was pointed out in the letters. This therapist in an aside to the patient, liked to say, in a matter-of-fact way:

"You see, I, too, had to undergo such a procedure and speak out about my deepest sentiments. I had to get rid of my own problems before I was allowed to help my fellow-beings with their emotional problems. It is good to bring out of the system all the disappointments and humiliations in life; when you speak out, you will look at the people who hurt you, in a different way and you will not hate them any more, because they just could not help acting the way they did; believe me, they had their own problems, else they would not feel the need to belittle the others."

Then indirect interpretation was given in black and white. This was meant as a kind of suggestive therapy for the patient and at the same time as some interpretation tailored for the addressee; for instance:

"My therapist has found that I have a rankling feeling of inferiority" (17) [worded in all variations] "because you, Mom, always preferred the boys at home. Maybe you did not, but I being the only girl among boys felt that way; I also kept comparing myself with other girls. He is right, to me the grass over the fence was always greener. He says, nobody is perfect, human beings are like zebras, they have white and black stripes, good and bad qualities. My trouble was that I always looked at my weak points and got discouraged; now I see it was the worst thing to do and I want to change. My therapist is right, it is never too late to change."

Such reassurances in writing effectively confirmed the oral interpretations and were often accepted by the patient while he was writing, with a nod of his head or an understanding look at the therapist. Some letters would specifically deal with acute conflict situations in the relationship between sender and addressee, and thus build bridges between them in order to improve strained relations and to correct affect-laden attitudes on either side. For instance (a patient writing to his well-adjusted sister):

"You see, I do not hate people any more; my therapist is right, as long as I hate my father, I'll hate a policeman, and as long as I hate my brother, I might not get along with young men of my age; therefore, I got into trouble with the police."

Those letters were also used to lay down some interpretation on the thoughtless stigma of hospitalization for mental illness, with a view to lessening the impact of it on the family of the patient, too. Thus troubled parents were relieved of ideas of sin or feelings of guilt about hereditary impairment of their offspring; siblings and children of the patient got rid of a feeling of shame because of the mental illness of a member of the family.

Then the patient was told to read "his letter" *aloud*. As a rule, he felt greatly relieved and often said, "You are good to me," or "You are a good doctor." This writer feels that the dictation of such letters can be unreservedly recommended as a constructive step towards reconciling the patient with himself and the outside world.

In general, interpretations are given gradually, often—as Adler used to do—in colloquialisms, proverbs, quotations from the Bible or poetry, and always on the intellectual and cultural level of the patient. For instance, this therapist would say to hospitalized farmers:

"You see, your core is like a sound plant, but your feelings of inferiority are like weeds around the sound plant; the more you speak out and do away with the rampant weeds, the better the plant will grow and thrive "; or— "The more I examine you, the more I find you are like a sound grain; you just have to winnow the chaff from the good grain."

Or the mental breakdown would be explained to the farmers who came to visit the patient in the therapist's office:

"You see, Mr. X and Mrs. Y, take me; I am a strong man; I can carry on my back about 250 pounds; but when you load on me a weight of say 400 pounds, I'll break down; however, I'll get on my feet again. The same is true with your Irene. Her pregnancy-divorce-childbirth were too heavy a load for this young mother of three children, so she broke down, as she had always been spoiled as the 'baby' in your home. Now she understands herself better and will be able to stand more in life, if she is helped by all of you after her release. It is quite a job to care for four children with no husband, but she is not sorry for herself any more, are you, Irene?"

Sometimes, when the patient acts and reacts like a helpless child (in order to get more attention), interpretation is—by way of exception—

best given on a childish level, with a change in voice and tone of the therapist. To such patients we have to sell ourselves as good parents, in order to win their childlike trust. We may say that the psychotherapy of Alfred Adler who has been recognized as the "father of child psychiatry" cannot fail in the understanding and treatment of psychotics who, having regressed to a childish level, behave like children although they are physically and intellectually grown-up.

It is needless to stress that untimely interpretations should be avoided, particularly in the sensitive area of sex and love, marriage. Even timely interpretation must not release more anxiety than the patient can handle in a given therapeutic session. A guiding principle in giving interpretation should be that the predominant mood of the patient has to structure the therapeutic procedure. Therefore, in the ups and downs of the therapeutic process we ought to adapt the methods of treatment to the mood of the patient, often varying from session to session.

In cases where we receive clues for sore spots in the patient from collateral informants, it is advisable to "spoon-feed" him with general interpretation in a very guarded way, such as to overcome his resistance to revealing painful experiences in his life later on; for instance:

"You see, I had another patient here, also an attractive girl; she had a love affair and was jilted by her boy friend. Why? Not because she was not a good girl, but because he himself had problems, he was marriage-shy. That girl mistakenly felt it was her fault, she kept reproaching herself for having made blunders in handling him. This was, of course, sheer nonsense; besides, if it were not this, it would be something else, and so on."

This therapist made a point of "catching his darlings" on their daily walks through the yards, in the corridors, or in the patients' store. After some conventional talk as a member of the group, he would touch on the specific problems by whispering into the ear of one or the other, some pertinent interpretation in a few simple words, such as:

". . . and your value as a woman is certainly not dependent on the opinion of that man; you had better say every day 'good riddance,' for he is not worthy of you."

At the same time we would give some jocose explanation to the others in the social setting (humor considerably facilitates the work with disturbed individuals). For instance:

"Lilly and I confide our secrets to each other; we just trust each other."

Such a whispered thumbnail interpretation would invariably bring on a visible relief, especially in the withdrawn patients, and some relaxation in the other members of the group who rightly felt that they were not the only ones who had secrets.

It goes without saying that constructive spiritual values to which the patient adheres must be fully respected (13). They have to be preserved, since spiritual forces are often a potent source of encouragement for the disheartened patient (8). This therapist, following the example of Adler, would harmonize constructive religious precepts with sound principles of mental health. For instance, when dealing with the necessity of social interest for our emotional well-being by stressing the *we* rather than the *I*, he would say:

"You see, what the psychiatrists and psychologists say is nothing new under the sun, so to speak; for this interest in our fellow-beings is nothing else but the good old precept of our Bible, 'Thou shalt love thy neighbor as thy self,' " — or "You will find all I explained to you in the Sermon on the Mount."

The most valuable technique Adler equipped us with seems to be his "Question" (1). We know that Adler stressed the "striving for superiority" whereas Freud considered the "libido" as the primary dynamic force in any human being. Therefore, an Adlerian psychotherapist, never losing sight of the *goal* in the structure of psychopathology, brings home to the patient the idea that human behavior is *purposive*, goal-directed. Our paramount task, then, is to let the patient win insight into the specific aim which he pursues, when he persists in his retreat from society. When the patient fails to verbalize his goal, because it is either unconscious to him or not yet accessible to his self (not yet "expression-ripe"), Dreikurs' question is asked:

"Suppose you were perfectly well tomorrow; what would you do differently from what you are doing now?" (9).

When further prodding is necessary to elicit the motive for his persisting in his illness, this therapist would repeat the question in Dreikurs' words:

"Let us imagine I gave you a pill and you were completely well as soon as you leave my office, what would be different from before?" (9).

Sometimes a leading question in a very general way may help the patient find out by himself, or admit, the hidden purpose of his withdrawal from a life with responsibilities into his mental sickness, i.e., a life without any responsibility.

It is futile to speculate upon whether this flight into sickness is a primary gain (Adler) or a secondary gain (Freud), as long as the patient, encouraged to be imperfect, returns to a society that is not perfect either. If it is a "flight into health" only, it does not matter either, as long as the patient musters sufficient strength to stay and to cooperate in the community to the best of his power. At any rate, Adler's question in Dreikurs' wording often proves to be a forceful lever in lifting the patient out of his entrenchment into the open battlefield of life.

And now we should like to elucidate the practical advantage of the above mentioned techniques by a very sketchy presentation of three cases discharged from individual psychotherapy, as an empirical evidence of the theoretical principles stated above. In view of the limitation of space we shall try to bring into relief one point only in each case. The unavoidably incomplete presentation should not lead to gross misunderstandings. We worked on the cases at a state hospital in the Northeast United States, where there was one hospital for psychotic patients only. Let us call the patients concerned *Arnold*, *Berta*, and *Lilly*.

ARNOLD, age nineteen, working on his parents' farm, a well developed, good-looking youngster, high school graduate, was diagnosed on his first commitment to the hospital as "Schizophrenic reaction, hebephrenic type." At home he giggled and displayed silly, crazy behavior, particularly when "telling off" his mother. He did the same with persons in authority at the hospital. His affect was inappropriate. In psychotherapy he also giggled in the first session, but listened attentively to explanations about the value of speaking out to a therapist. When asked about his attitude towards his parents, he was protective of his family, saying, "All are O.K." Asked what was on his heart, he expressed concern over his hernia. When his parents came to see this therapist in his office, he learned that some boy had teased Arnold by warning him he would be castrated along with the operation on his rupture. The father when asked what else might bother his son pointed an accusing finger at his wife, who gave the impression of having a severe obsessive-compulsive neurosis. At home she kept nag-

ging Arnold and younger sister upon any occasion, without apparent reason. In short, in five regular sessions only, and several daily individual and group contacts, we succeeded in helping the patient to accept himself with his rupture and some other inferiorities without the fear of losing his manhood. After having overcome his castration complex in a very real sense, he also won insight into the purpose of his psychotic behavior. In simple explanations he was led to understand that he harbored a great deal of hostility against his mother for several reasons, but that he did not dare to "tell her off" for her fault-finding. Therefore, he played the role of a silly, even *crazy* boy at home in order to "bring out of his system" all the resentment he felt towards his mother without being punished by his father or older brothers. He was also shown that he used the same mask of a crazy boy in the state hospital, when he laughed at and teased his attendants, nurses and doctors. As he felt wronged by being kept in confinement, he wanted to get even with them and yet be irresponsible for his abnormal behavior. Once the boy had won insight into his tricky goal, he changed his hebephrenic behavior into the mature behavior of a grown-up young man. Thus, when he was seen again in a longer session by the psychiatrist in charge of the ward, he gave the impression of a normal youngster. When I asked the supervising psychiatrist about his findings, he looked at me with surprise, and shrugging his shoulders, exclaimed: "Quite a changed boy!" The patient gave the same impression when his ward doctor presented him to the medical staff for parole from the hospital. We should like to emphasize the fact that this patient after his recovery from his psychosis was still in need of further psychotherapy. He was told to come for a therapeutic session whenever he felt "nervous." But as he did not return from his parole, we may say that he was strengthened enough to carry on in the community without further professional help, although he was definitely not neurosis-free, when he begged to be sent home.

In passing we might mention one early childhood recollection of his eighteen-year old sister, who was also a mental patient, and released together with her brother Arnold, after some brief psychotherapy. (Between the ages of fourteen and eighteen, she had been twice committed to the state hospital without having the opportunity of speaking out about the severe traumatic experiences she was subjected to from the age of nine on.) It was the following ECR² which mainly consti-

² ECR = Early childhood recollections.

tuted her style of life and led to maladjustment-neurosis-psychosis. She was diagnosed as "Schizophrenic reaction, catatonic type." When she was two years old, her parents visited the grandparents, taking their children along with them. When they arrived at the railroad station in the small community, our patient was carried in a wheelbarrow to the home of her grandparents, while her parents and siblings had to walk. Aunts and uncles took turns in pushing the wheelbarrow to the home of her grandparents, and in giving her cookies, a situation which she enjoyed very much. In the course of psychotherapy she was shown that she could not expect the whole world to spoil her as her uncles and aunts did, when they vied in treating her as a "privileged character." Once the girl had won insight into her goal, when she made up her mind to be on her own and to take frustrations in her stride, she literally flew into health. After she had re-lived all her shocking experiences in a permissive atmosphere, she felt she had been a victim rather than a monster, and responded well when the therapist told her:

"You see, Alma, all of us have to paddle our own boat, or let us say, to drive our car by ourselves without help from uncles and aunts. You just lost the wheel of your car and want us to drive you; you were very quick to throw up your sponge when you had to face difficulties as a result of all that happened to you from nine to fourteen years and afterwards."

BERTA, twenty-four years old, single, a nurse in training, was diagnosed as "Schizophrenic reaction, paranoid type." She received treatment first at a private sanitarium, where the same diagnosis was made: "Prognosis in this case poor." At the state hospital she had delusions of all kinds of physical ailments for twelve months (liver disease, etc.). She was very critical of the hospital saying: "I, Berta, have a flexible snappy judgment." Actually she was, as a result of psychiatric treatment (EST³ and ICT⁴) and psychotherapy, more or less in contact with reality, but still firmly entrenched in her fortress and continued enumerating all her ailments as a response to our attempt at psychotherapy. However, when this therapist after a "heated argument" exclaimed: "and yet, Berta, I am not going to give up on

³ EST = Electro Shock Therapy.

⁴ ICT = Insulin Coma Therapy.

you, —I can't stand by when such a good girl is going to waste," she began to respond to interpretations. In eight regular sessions and several daily contacts in the course of her intramural resocialization, she accepted the following interpretation: As the youngest of three children she was badly spoiled by her parents, especially by her father and her older brothers. At the age of two, she was dethroned from her privileged position by a younger brother; this she resented very much. When she was eight years old, her beloved father died. This bereavement involved a loss of emotional security ("I had a lost and empty sensation.") When six months later her younger brother died, she felt relieved of a rival, but she also had feelings of guilt because of her hidden hostility against him. She felt, therefore, a need for punishment on the one hand, and on the other, her need for protection attained dangerous proportions. Hence she wanted to force more attention from her mother and older siblings. She developed psychosomatic symptoms of all kinds ("I started doctoring right after my brother's death, for fifteen years"), as if she wanted to prove that she, too, was sick and suffering. At the same time she became the center of attention of mother, siblings, nurses, doctors, and clinics. But when Berta insisted on still not being her normal self, the "key-question"⁵ was asked: "What would you do, if you were perfectly healthy, say tomorrow?" Her answer was most revealing: "Maybe I'll stay home with my mother and take liver extract for a while, then go to an aunt and uncle in California, register in the Medical Association, *unless there are definite reasons that I should not work.*" Here it was not hard to explain to her her hidden aim, since it was self-evident. She did win insight into her escape from constructive work and competition in the community into a pressure-free asylum; she also understood the irrational reasons for her destructive criticism to some extent, although she still had the tendency to depreciate the hospital in order to gain some fictitious superiority. Again and again we pointed out how pitiable such a refuge was for a good-looking, intelligent girl like herself, and that there was no sense in delaying the return to a normal life with responsibilities. Finally she surrendered, so to speak. In a low voice she said: "*I see, I will have to give up the whole monkey business.*" From this moment she gathered more and more strength and became ready for release from the hospital in a short time. She was earnestly advised to take up further professional help with her neurotic prob-

⁵ From personal communication with Dr. Lydia Sicher.

lems. But it seems that she might get along in the community without it, since her personality assets far outweigh her shortcomings.

LILLY, twenty-three years old, single, daughter of a painter, was in a private sanitarium for three months before she was committed to the hospital. She was twenty-one years old when she was admitted the first time (twice paroled and returned to the hospital, as psychotherapy could not be afforded at that time). She was diagnosed as "Schizophrenic reaction, mixed type." After her mental breakdown she showed a marked lack of affective contact with her environment and had the delusion that she was married, waiting for her boy friend, a doctor, to return from the Army. In the course of short-term psychotherapy she became somewhat communicative. Eventually she admitted feelings of inferiority. She was especially self-conscious about her outward appearance, although she was, on an average, a good-looking girl. She felt utterly frustrated in her longing for love and wish to get married, although she did not admit it directly out of a false pride. We called her attention to her attractive feminine qualities, saying:

"You got a square deal in life; what do you want to be? Miss U.S.A. or Miss Universe?" [patient could not but laugh]. "Marriage is O.K., but take your time; nowadays girls get married at thirty and even later. I am going to show you the way to solve your problems more courageously, then you will find the right man, doctor or employee or business man, all the same. Lilly, there is not such a thing as unalloyed human happiness; it is work that is the main yardstick for the worth of any human being."

As the patient started to re-evaluate her attitude towards sex and love, she gradually improved, but not without relapses into her apathy. Finally she was led to understand that she unconsciously retreated from the outside world because she did not want to be a looker-on while other girls went to the altar and enjoyed marital life. When her younger sister with her husband came to see the therapist, active counseling was conducted with the couple in order to win their respect for the frustrated girl. Then Lilly and her siblings were seen in a joint session. We pointed out the fatal mistake of staying for years "cooped up with really brainsick people." We called the hospital—incidentally, an institution that is in continuous psychiatric progress—all sorts of disparaging names, repeating the rhetorical question: "How long do

you want to stay in this crazy house? . . . in this nut house? . . . in this bug house?" When all burst into laughter, we became more serious about the progressive hospital, but added: "And yet, even a gilt cage is still a cage." The result was that the patient literally flew into health. The attendant in charge of the ward, a typical mother figure, said in surprise: "Quite a different girl." When Lilly accompanied by her sister and brother-in-law came to the therapist to say good-bye, she looked like a young lady who had come for an employment interview. She and her relatives were happy to hear this compliment from the therapist. Of course, no drastic personality changes can be expected after only nine regular sessions and several daily individual and group contacts. However, Lilly's low level of frustration tolerance, particularly in the area of sex and love, was raised to such an extent that she could adopt a more hopeful outlook on life and was optimistic enough to start a new life with renewed vigor. Hitherto this young woman had shown a dangerous tendency towards becoming a lifelong ward of the State. But as she was taught to substitute fight reaction for flight reaction, she found courage enough to leave the hospital before she was "institutionalized," i.e., conditioned to hospital life and its deteriorating implications.

II. *Group Psychotherapy*

Frequently we supplement our individual psychotherapy with group therapy, open end type. As the retreat of a mental patient from society is actually the result of his total failure in his interpersonal relations, it is indicated to place him in a therapy *group*, i.e., a society in microcosm, just as the family is the matrix of socialization of any human being.

It is not our intention here to analyze group dynamics or to give a detailed description of the techniques of group therapy. We know that Alfred Adler introduced a specific type of group therapy in his famous child guidance clinics in Vienna as early as 1920. His therapy groups were democratic, indeed. "Problem children" and "problem parents" were helped there in the shortest possible time.

We should like to mention only the vantage ground of an Adlerian group therapist, whose theoretical frame of reference makes it easy for him to lead the group like a loving father on well trodden paths and to let his patients experience the status of full social equality with all members of the group, including the group leader. As, according

to Adler, virtue is teachable, we left no stone unturned in order to inculcate in our patients an active social interest in their fellow-beings; for instance:

"You can't be happy as long as you are not interested in others and feel bothered, for instance, when Dorothy brings out her troubles." — or "You can't answer back, 'Am I my brother's keeper?' as Cain did when he was asked about his brother Abel." — or "You should have compassion for a fellow-sufferer even if he gets on your nerves. Look, nobody is responsible for his or her problems, for if it is inherited, you can't blame him or her for it, and if it is rather a result of his or her environment, as we strongly feel, you can't blame that on him or her either, can you? We all have problems . . . and now let us get away from problems, let us sing together."

Group discussions were concluded by group singing only when the majority of the group was in favor of it. Songs had a socializing effect on the members of the group and cheered up the patients. Some welcomed group singing as an opportunity for success. We tried to overcome resistance to participation in group singing by saying:

"Nowadays nobody is expected to sing well or to sing at all—we do have good singers in radio and television; but it helps us to forget our troubles."

The therapy group was also used as a testing ground for the development of social interest; for instance:

"And now, Margaret, you are so far along that you can look at other people again, don't look at me only, look at others, too." — or "We all have troubles, we all are in the same boat; so you can speak out freely on what is in your own heart."

An Adlerian group therapist (14) will lead the group to find the following common denominators in the problems of the group:

1. *All in the group:*

- (a) have a rankling feeling of inferiority, since all of them feel too weak to compete with others in the main areas of life in the community;
- (b) are too sensitive (cannot take blows of life and are too easily hurt);

- (c) therefore have retreated from a harsh world of reality into a world of day dreams, i.e., mental illness, and
- (d) want the hospital to take care of them, as if they still were children:

("But you, see, life is a give and take; you can't always be on the taking side only; let us see how many people work for you to keep a roof over your head, get your food, your clothes . . .");

- (e) are too profoundly discouraged to work, to meet other people outside; and
- (f) therefore have to gain more self-confidence and gather strength enough to change their destructive goal of retreat into a constructive goal of a normal, useful life in the community.

2. *Problems which sub-groups have in common:*

- (a) rejection by one parent or both, or by parent-substitutes (incidentally, "organ inferiorities" should be glossed over, unless they are common to all members of a specific group);
- (b) overprotection by one parent or both, or by parent-substitutes;
- (c) style of life of the first born, of the middle, of the youngest child; in mixed groups: style of life of boys and girls in our culture;
- (d) same frustrations in the area of work, socio-economic status, and the like;
- (e) same frustrations in the area of sex, love, marriage (pros and cons of single women versus married women, or of married women versus divorced women; in mixed groups men's uncertainty of fatherhood and limited potency as compared to the lesser "handicaps" of menstruation and childbirth);
- (f) same attention-getting devices, same compensatory efforts, same "masculine protest";
- (g) same early childhood memories, same dreams, same family constellation, same current happenings (lack of visits, no correspondence, etc.).

III. *Cumulative Effect of Therapies*

It does seem that mental patients, vague as their feelings may be, expect of us more than a merely professional interest in their well-being. The more the patient senses that the psychotherapist respects his inalienable right to some measure of happiness, the more the patient sees that the therapist like a good parent is not at ease as long as "the child" is uneasy, the more he will trust the therapist and the more he can be prevailed upon to leave his retreat for a new start in the community.

A mental patient can be considered as helped, to the extent to which he appears *resocialized* in individual and group contacts. In view of our collaborative approach, it is only just and fair to give credit for a recovery from a psychosis, not only to the professional staff (psychiatrists, psychotherapists, psychologists, social workers, occupational and recreational therapists, nurses, ministers of religion, teachers, vocational counselors), but also to all the non-professional workers who contributed to the better adjustment of the patient to his environment. I, for one, considered myself as an extension of the hand of the psychiatrist, both in my efforts to bring about a mental and emotional reintegration of the sick personality, and in my attempts at marshalling and coordinating all the services available for a successful rehabilitation of the more or less disorganized patient.

IV. *Are the Adlerian Techniques Really Effective?*

An elaborate study of the Adlerian therapeutic procedures may be reserved for a larger discussion, based on rich case material and statistical data. My supervising psychiatrists, devoted to their curative work, were not interested in brilliant formulations, nor did they ask of me experimental findings to support the Adlerian principles. They saw the patients before, during and after the psychotherapeutic process. I may say that they were satisfied with the empirical findings demonstrated in my therapeutic output, as far as it was obtainable in a woefully short period of treatment. Being expert witnesses, they rather believed in the wisdom of the scriptural formulation: "*By their fruits ye shall know them.*"

V. *Summary*

Alfred Adler's socio-teleological, holistic approach to the personality is most helpful in reaching mental patients, lifting them out of their psychoses and *resocializing* them. This quick and sound type of psychotherapy is particularly indicated in hospitals for psychotic patients, as at the present stage of curative psychiatry no mass remedy for mental illness can be offered.

An individual suffering from a functional psychosis is, to our feeling, a person who because of his utter despair of solving the main problems of life and because of his total failure in his inter-personal relations, has retreated into a protective shelter, the insane asylum. It is the task of the psychotherapist, not only to build up the sick personality and to let him win insight into his destructive goal, but also to resocialize him—as far as possible—in his intra-mural and extra-mural environment.

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