The Adlerian Approach: A Practical Psychology for Family Practice

C. Dwight Townes, MD
Harold R. Ireton, PhD
Minneapolis, Minnesota

A systematic approach to understanding the patient's personality and helping him cope with common life problems is found in Adlerian Psychology. It is uniquely appropriate to family practice because it stresses the interpersonal purposes of behavior and symptoms and the influence of family constellation on the development of the individual life-style. By obtaining a small amount of data about the patient's present life situation and his family of origin, the physician can gain a basis for understanding how the patient developed his unique way of acting and reacting to the physical and social stresses of life. Interpretation of two or three early recollections reveals what the patient expects of himself, others, and life. The insight thus gained is used as the basis for a holistic assessment of the problem; a directive, supportive, action-oriented plan for treatment; and an ongoing doctor-patient relationship of mutual respect.

The family physician is confronted with many difficult situations involving patients in emotional distress. Symptomatic diagnosis of depression or anxiety, and treatment with mood altering drugs, often seem inadequate. In each case the physician is dealing with a unique individual who is trying to cope with his particular situation in his own way. What the physician needs is a systematic means of understanding his patient's personality and of helping him cope with his difficulties.

From the Departments of Family Practice of the Hennepin County Medical Center and the University of Minnesota School of Medicine, Minneapolis, Minnesota. Requests for reprints should be addressed to Dr. C. Dwight Townes, Department of Family Practice, Hennepin County Medical Center, Fifth and Portland South, Minneapolis, Minn 55415.

Most family physicians have been taught the importance of listening, sympathetic understanding, and reassurance. Unfortunately, a limited medical school experience with psychiatric patients may have left them pessimistic about people's ability to change for the better, and about their own ability to influence this change. They have learned to recognize and refer patients with major psychiatric problems, but they need to learn to diagnose in human relationship terms and to counsel the many patients with milder problems in living. A straightforward approach to establishing real psychologic contact with patients and for helping patients with common life problems is the "Individual Psychology" of Alfred Adler.

Adler was a family physician first and later a psychiatrist, a Viennese contemporary of Freud. Focusing on the social nature of people, he saw man as possessing a basic desire to belong and to be important in his group. Therefore, most human problems are seen as relationship problems. The individual's behavior is directed toward goals which he selects for himself. The basic striving is for significance. People make choices with the aim of achieving a place for themselves, and such choices are based on their private view of their world. Adler stressed the importance of subjective perceptions and expectations. Understanding the individual's outlook on life, other people, and himself is the key to understanding his behavior. Adler saw each individual as a unified, consistent person whose thoughts, emotions, actions, and symptoms are expressions of his life-style.

When a person is encouraged and experiences success from his efforts, he continues to move on the constructive, positive side of life. If he becomes discouraged he may feel inferior, become preoccupied with his own survival, withdraw from intimate contacts, and seek to manipulate others to prove his own worth. Some discouraged individuals move on the destructive, negative side of life to gain attention, power, revenge, sympathy, or service. Others strive for superiority by becoming highly competitive and dominating. Any of them may come to the physician's office with pain, tension, or other psychosomatic symptoms. Optimal help for such patients is based on a psychological understanding of each one as a unique individual.

Evaluation

Understanding the psychological condition of the patient involves consideration of the person and his situation as well as clarification of his presenting symptoms. Presenting complaints are often the symptoms of discouragement rather than of disease in the usual sense. This discouragement is usually related to the person's inability to meet life's demands, to gain acceptance from others, or to maintain a positive opinion of himself. In such cases, the following questions need to be considered:

How is this person feeling? What is he experiencing?

What is disturbing him? What stress is he facing?

What is his interpretation of his problems? His symptoms? His situation?

How is he coping with his problem?

Why is he coming to the physician now? What is he seeking? What does he expect?

What does his life consist of? How does he view his life? How satisfied is he?

How is he functioning in the area of work? Intimacy/sex? Family? Friendship?

What does he think of himself? What are his personal assets?

What sources of emotional support does he have? Spouse? Relatives? Friends? Church? Family physician?

Inquiry may suggest that the patient is (unconsciously) using his symptoms to avoid life demands, excuse failure, get attention, or control others. One key question for exploring the possible purpose of a symptom is, *"What would be different in your life if you were well, if you did not have symptom X, Y, Z?"* The patient's answer may reveal the key relationship or issue which is giving him difficulty, and which he feels he cannot face. This question may be particularly helpful with those patients who have somatic complaints without tangible physical findings, and with those whose dysfunction is apparently greater than that expected from physical findings.

In general, the physician needs to understand the patient's presenting symptoms in relation to his life situation and to his personality. This understanding provides a meaningful basis for deciding what is needed therapeutically.

Life-Style Evaluation

Life stresses alone do not provide a complete explanation of the patient's distress and dysfunction. The effect of his personality must always be considered, both in his subjective interpretation of his difficulties and in the goals he pursues in confronting or avoiding such difficulties.

Life-style evaluation provides information about the individual's beliefs and goals regarding himself, other people, life in general, and, especially, his beliefs about "what it takes" to be accepted and valued by others. One individual may believe that he is incapable and that he must get others to care for him if he is to survive; another may believe that he must constantly please others to gain acceptance; yet another is convinced that he is functioning well only if he is constantly striving, gaining recognition, and winning out.

The life-style interview consists of two main parts: (1) childhood family information, and (2) early recollections.

1. Childhood Family Information

Family Constellation

Each child in the family seeks a place for himself within the family and wants to be valued by his parents and siblings. The potential for competitiveness and discouragement is made apparent by reflecting on one's own family experiences. The parents, in their relationship to each other and to their children, provide models for caring and cooperation or for hostility and conflict. The child observes the family pattern and tries to find a place for himself, initially on some positive basis. If he becomes discouraged, he then resorts to some negative means of gaining status. The attitudes and behaviors developed by the child for coping within his family become a part of his personality and are then applied to other life situations.

The patient's family constellation includes the parents, children, and others living in the home during his childhood. The family constellation may be obtained by asking: "Who was in your family when you were growing up?" List parents and other significant adults and all children in descending order, including deceased siblings. Indicate other children's age differences from the patient (see case study).

Sibling Relationships

The two issues to consider are birth order and sibling interaction. Each place in the birth order is commonly associated with certain advantages, disadvantages, and methods of coping. The firstborn usually has special status, but may subsequently suffer the threat of being displaced by, and having to share with, younger siblings. It is not surprising that firstborns are often highly competitive and achievement-oriented. The middle child may feel "lost in the shuffle." Without the advantages of being oldest or youngest, he may race to catch up, or seek status outside the family. The youngest, as the "baby of the family," commonly gets special service; he may feel little and incapable in comparison to siblings, and he may seek to charm and amuse others rather than to pursue independence.

Groupings among siblings are suggested by age differences and by inquiry into alliances, rivalries, and special status. The following questions are pertinent: "Who played with whom? Argued? Fought? Who was 'special' by virtue of achievement, sex, illness, misbehavior, etc? How did you get along with each of your siblings? What kind of a child were you?"

Parents

The issues here are the parents' values and methods of relating to each other and to their children. What kind of a person was the father? Mother? What kind of relationship did they

have? How did each parent relate to the patient? To the other children? What must be understood is how the parents dealt with individual differences, affection and support, power and decision-making, conflict, and communication.

2. Early Recollections

Theory

A person's recollections of his early life experiences can be very revealing because a person selectively recalls those past experiences which are consistent with his life-style. Early recollections are important not as historical events but as experiences that are recalled because they describe the individual's present view of himself in relation to life. These memories are selective reminders for each person of his own limits and of the meaning of circumstances. Early recollections in a very real sense tell "the story of my life, as I see it."

Technique

The patient is told, "I want you to think back as far as you can. What is the first incident you remember?" What is needed is a specific incident, not a generalized memory; something the patient recalls himself rather than a story he has heard his parents tell about him.

In recording, use the patient's own words as much as possible. For each recollection ask: "How old were you?" "What one scene or action stands out in your mind's eye?" "How did you feel at that point?" It is best to obtain at least two such recollections as a basis for interpretation.

Interpretation

The recollections are interpreted by searching out the major themes regarding the patient's self-concept, his expectations of life and others, and his rules, "shoulds" and goals. I am. . . . I should be. . . . Life is. . . . People are. . . . Men/women are. . . . The "high point" and its associated feeling most specifically reveal the patient's concept of where he stands in life and with people, and how he feels about it. One gets a sense of the person's orientation toward optimism or pessimism, activity or passivity, success or failure, superiority or inferiority, cooperation or competition, getting or giving, controlling and manipulating, and pleasing or suffering.

Impressions and insights are verified with the patient right away. His interpretations are as important as the physician's. The patient is revealing who he is and why. As Osler said, "Listen to the patient; he is telling you the diagnosis." The exchange between doctor and patient is within the model of cooperative problem solving, involving equality and mutual respect. The patient is involved as an equal collaborator in the shared task of understanding and solving the problem.

Case Study

Kay, age 18, has the following problems: joint pains, headaches, neurodermatitis, and depression. She has a history of asthma in childhood and a period of alcohol and drug use in high school. At present she is married, the mother of a one-year-old son. She is enrolled in a vocational rehabilitation school to become a bookkeeper. Her marriage is stable at the moment, although she complains that her husband is temperamental and demanding. She says all her friends are "rip offs." Physical and neurological examinations were negative. Laboratory screening and tests for arthritis were also negative. A Life-Style Analysis was done when her depression became evident.

Family Constellation

Father	
John	Died at 51 of cancer of lung (1971)
Mother	
Joan	53
Siblings	
Janet	31 (+13)
John	30 (+12)
Tom	21 (+3)
KAY	18
Joel	15 (−3)
Betty	11 (−7)
Jeff	7 (−11)

Sibling Relationships

Kay was the middle child in a subgroup including Tom and Joel. Tom and Kay both had asthma. She played and fought a lot with Tom. The mother would side with Tom against Kay on everything. "He was a goodie two shoes." Kay reports that Tom constantly tried to intimidate her and put her in his service using physical force or threats. The oldest sister, Janet, had the responsible, good girl, mother's helper role. Kay therefore decided she had to go a different way to count. She found her place by making mischief.

Kay described herself as being skinny and little as a child and afraid that people were going to "beat up on" her. She had only one close friend. She was rebellious and more punished than the others, but would never admit she was wrong. She wet the bed until age 10.

Parents

The father was a packing house foreman, a recovered alcoholic who was strong willed and concerned about and respected by the family. Kay did more things with Dad than the other children did. He often took her fishing with him, and "he encouraged the good things I did."

Kay's mother was a helpful, protective, hard-working housewife, outgoing, honest, strong, "sweet and sour both." Kay felt criticized and rejected by her mother. "I felt that in Mom's eyes I didn't do anything right."

Kay described her parents' relationship as "loving." They shared the decision-making but Father had the last word.

Early Recollections

1. Age five. Mom used to pick me up at kindergarten at noon and take me to the baby-sitter. One day she didn't come. I got worried and thought I had missed her, so I got on the bus and went to the baby-sitter's by myself.
HIGH POINT: Seeing the roof of the baby-sitter's garage, because it showed me I was there.
FELT: Independent and proud.
INTERPRETATION: In this recollection Kay finds herself alone, but rather than emphasizing desertion and fear she focuses on her coping with the situation, her activity, and independence.
2. Age six. I fell off the sliding board. Fell over the top. My brother picked me up. He's big.
HIGH POINT: His carrying me.
FELT: Really secure.

INTERPRETATION: Kay is active again in this recollection, but falls (fails). The focus is not on her pain, but on the helpfulness and support of an older male and the feeling of security which this provides.

3. Age three or four. I was going in my Dad's coat pockets when he came home from work. He'd always tell us to go in his pocket and see what was there. Usually we'd find a surprise, candy or gum. This time it was a dog. When I got my hand in there and felt something lick my hand it scared me. It looked like a rat. It was a Chihuahua puppy.

HIGH POINT: Seeing the dog.

FELT: Excited and happy.

INTERPRETATION: Again, in this recollection, good things come from men, but the story raises the question of her need to "get" from men in order to feel good.

4. Age seven. I had an asthma attack when Mom was going somewhere. She had to stay home. I was upset because I kept her from going, and the asthma kept getting worse. Nothing helped. Mom called the doctor and got some different pills that finally helped.

HIGH POINT: Apologizing, crying, telling her I was sorry.

FELT: Really bad, like it was my fault. (I had a cold, had had some asthma attacks in the days before but kept going outside when I wasn't supposed to).

INTERPRETATION: When Kay is sick Mother stays with her and cares for her, but unsuccessfully. The emphasis is on Kay's being upset and feeling guilty about disobeying and causing her symptoms. Finally, the doctor's pills bring relief.

Summary of Life-Style

Kay places a high value on independence and active coping, but distrusts her own resources. Her recollections show her taking care of herself or being cared for by others, but never caring for another. She feels cheated and a victim and consequently is resentful and rebellious. She is proud when she can make it on her own, but often feels like the "scared, skinny little kid" or like the "sickly upset child" that only the doctor could fix with his pills. As a middle child, she went her own way. She failed to establish strong friendships with her siblings, strived and succeeded in becoming special in her father's eyes and rebelled against her mother.

Kay sees men as stronger than women and as necessary for security and gratification. This is complicated by some fearfulness that she might be abused by men. Women are not seen as a potential source of support; rather, they are seen as a source of disappointment, criticism, and rejection. The death of her father was a great loss to her. The relationship with her mother further deteriorated after that. This led to more abuse of alcohol and drugs, dropping out of high school and leaving home.

From her husband, she gets some support and gratification but sometimes feels dominated and victimized, for example, when he asks her to wait on him. Naturally, she resents and sometimes resists this.

As a mother, she admires her son's emerging competences but is frustrated and angry when he cries or makes demands. Because she feels cheated by her own mother, she may have problems being a mother and will need support in this area. She probably will not be able to draw on the friendship of other women for support.

Kay has difficulty dealing with her dependent needs, fearfulness, and resentment in a straightforward fashion. Instead, she acts self-sufficient but is basically lonely and discouraged. Many of her physical symptoms are indirect ways of expressing depression and asking for help.

Kay is hoping for support from her physician, as from her father in the past. She will have difficulties utilizing such support because of her mixed feelings regarding men. The physician can use his understanding of Kay supportively to help her challenge her pessimistic outlook, to recognize the range of feelings she has, to express feelings verbally rather than somatically, and to encourage more constructive interactions with other people.

Conclusion

The holistic psychology of Alfred Adler is presented as one which fits well with the philosophy of family practice. It is practical in its focus on evaluating the patient's life-style in relation to his current situation. The emphasis is on understanding the private logic by which the individual seeks to gain significance in relation to family members and others. A life-style analysis can provide critical insights into:

1. the origin or purpose of the patient's symptoms
2. his private expectations and goals
3. what he is seeking from his physician
4. the nature and severity of his personality problem
5. the kind of help he may need.

The Adlerian way of viewing people and their problems tends to increase the understanding and enthusiasm with which the physician approaches his emotionally troubled patients. Empathy and respect increase as we realize that the patient is pursuing, though in a discouraged way, the same goals pursued by us all.

Annotated References

1. Ansbacher HL, Ansbacher RR (eds): The Individual Psychology of Alfred Adler. New York, Harper and Row, 1964
A well-organized, presentation of Adler's ideas with liberal editorial comment. The editors point out the sequence in development of Adler's theories and also compare them with those of Freud and other psychiatrists.

2. Dreikurs R: Psychodynamics, Psychotherapy and Counseling. Chicago, Alfred Adler Institute, 1967
A collection of articles on Adlerian principles and techniques in psychological diagnosis and therapy oriented toward medical practitioners. Articles include: "Psychodynamic Diagnosis," "Psychological Interview in Medicine," "Differential Diagnosis of Psychological and Somatic Disturbances," and "Techniques of Psychotherapy."

3. Mosak HH: Life-style assessment: A demonstration focused on family constellation. J Individ Psychol 28:232-247, 1972
This article describes the process of doing the life-style interview. The interview highlights the techniques of life-style analysis and demonstrates the use of interpretation in the context of a developing relationship.

4. Mosak HH: Early recollections as a projective technique. J Project Techniques 22:302-311, 1958 (Also available as a monograph from the Alfred Adler Institute of Chicago)
A guide for the interpretation of early recollections with many specific examples clearly explained.

5. Nikelly AG (ed): Techniques for Behavior Change: Applications of Adlerian Theory. Springfield, Ill, Charles C Thomas, 1971
This collection of articles by Adlerian practitioners from many fields provides detailed information on assessment, therapeutic techniques, group techniques, special syndromes including drug addiction, delinquency and suicide, and on educational techniques.

6. Castelnuovo-Tedesco P: The Twenty Minute Hour. Boston, Little, Brown, 1965
A guide to brief psychotherapy for the physician. A fundamental plan for use by non-psychiatric physicians in treating selected patients with situational relationship problems. A limit of ten sessions of 20 minutes each is recommended. A good answer to the complaint that "I don't have time to do psychotherapy."

Continued from page 244

These diagnostic and management problems do not have a great deal of relevance to the family physician, who will undoubtedly refer most of them to a consultant. The book is obviously designed for internists and dermatologists.

William L. Stewart, MD
Southern Illinois University
Springfield

Cardiac Emergency Care. *Edited by Edward K. Chung. Lea and Febiger, Philadelphia, 1975, 347 pp., $14.50.*

This is a relatively small book of large print and easy reading. As Dr. Chung says in the preface, "It is not the purpose of the book to discuss in depth various subjects in medicine or to describe in detail all possible emergency medical events. The primary intention is to describe the common cardiac emergencies that are frequently encountered in our daily practice."

This book resembles a seven course meal prepared by different chefs; certain of the offerings are of considerably greater interest than others. For instance, the chapters on the coronary care unit and the pre-hospital management of acute myocardial infarction are chiefly compilations of statistics of the morbidity and mortality of cardiac emergencies. This type of presentation did not interest me as much as many of the other sections of the book.

The book is aimed primarily at the practicing physician and House Officer audience. The detail is sufficient to lead the relatively well-informed physician into an understanding of the various problems presented and their management. The names of the chapters read like a list of the common emergencies that we all are faced with from time to time. This includes acute pulmonary edema, cardiogenic shock, embolus, arrhythmias, cardiopulmonary resuscitation, infectious heart disease, pericardial tamponade, hypertensive crisis, and digitalis intoxication. In addition, several of the chapters are helpful in keeping the family physician on his toes as to the state of the art in the referral areas of cardiac care, including the surgical approach to cardiac emergency, cardiopulmonary emergency care in infancy and childhood, and artificial pacemaking modalities and indications.

Each paragraph has ample cross-references and the major points are summarized at the end. The organization of the individual chapters makes it quite easy to find the specifics when they are desired. There are a considerable number of electrocardiograms demonstrating the problems discussed.

In summary, this small volume is current, with diagnosis and therapy of the major cardiac emergencies well described. Even in a time of extremely rapidly changing medical knowledge, it is my impression that the techniques described will be of considerable use for a number of years.

Paul L. Bower, MD
Harbor General Hospital
Torrance, California

Management of Trauma: Pitfalls and Practice. *Edited by Alexander J. Walt and Robert Wilson. Lea and Febiger, Philadelphia, 1975, 626 pp., $30.00.*

This is a carefully planned review, by a number of contributing authors, of the problems of trauma in emergency care. It is centered around experience in an Emergency Room in Detroit, Michigan. Carefully prepared descriptions, sometimes of personal experiences, deal with the preparation and evaluation of an Emergency Room and the emergency department of a hospital, the general care of the patient within the Emergency Room, and evaluation and treatment of specific kinds of trauma. Outline form is extensively used, and the text is interspersed with axioms and pitfalls which are set off within the chapter headings to draw attention to specific items of care or diagnosis which should not be overlooked.

Highly readable, this book would be a valuable review for the physician in family practice who sees trauma as a part of his practice. Physicians who spend a good deal of time in the emergency wards of hospitals would be most interested in this type of book. Office treatment is less well covered.

The book is organized to facilitate quick reference to specific subjects. Axioms and pitfalls are also helpful in emphasizing certain principles of emergency care. All graphs are readable and add to the clarity of the text. Illustrations are effectively used, and line drawings are particularly helpful.

The authors intended this book to give, within a single volume, a broad approach to the management of patients with severe trauma requiring Emergency Room care. Designed to point out common errors and to suggest solutions to common problems, the book has certainly achieved the intended result. One could hope for a similar approach to the management of trauma of less severity. This volume could well serve family physicians, residents, medical students, and other individuals interested in family practice. It is a useful addition to the bookshelf of attending physicians involved in emergency work, and should be available in Emergency Rooms of hospitals receiving major trauma cases.

Richard C. Barnett, MD
Santa Rosa, California

Chronic Illness and the Quality of Life. *Anselm L. Strauss. The C.V. Mosby Company, St. Louis, 1975, 160 pp., $5.75.*

Like Gaul, this book is divided into three parts: first, a discussion of some of the major and complicated problems of living with chronic illness; second, a series of vignettes of some chronic conditions and their management; and, finally, a section devoted to aiding health care teams in obtaining historical data on the patient in order to afford him proper and understanding care.

That the writing of this treatise was a labor of love is evident in the reading. It is written with compassion and a comprehension of the nuances of the subject. It is extremely well organized and data are presented in a straightforward manner and with ample illustration. Much of the information is common knowledge in the field, but this volume goes far to meet the needs of health care providers. It should serve well as a reference for some time to come.

Thomas M. Hart, MD
York, Pennsylvania

Continued on page 292