Classical Adlerian Assessment of an Adult Child of an Alcoholic: “Queen of the Derelicts”

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Abstract

The author demonstrates the technique of questioning and how to make guesses about a client's psychological movement and lifestyle. A specific case example is provided to illustrate the process of guessing the client's private logic, psychological movement, scheme of apperception, and lifestyle. The conclusion summarizes some of Adler's theoretical constructs used during treatment.

Keywords: Individual Psychology, Classical Adlerian Depth Psychotherapy, Adlerian constructs, adult child of an alcoholic

Most experts in the field of addiction consider chemical dependency a multigenerational family disease. This means that all members of the family are affected, diseased, sick, or neurotic, according to the medical model of health or disease. The physician, not the psychotherapist, is designated as the primary therapist (Brown, 1985). Addiction is “passed on” from generation to generation genetically (predisposition), affectively, and behaviorally. The National Association of Children of Alcoholics (NACOA) states: “There is strong scientific evidence that alcoholism tends to run in families” (www.nacoa.org). All family members need treatment, not only the addict. Although family members of chemically dependent people are not physically addicted to a substance, they exhibit other aspects of the disease, including denial, minimization, and manipulation; issues with control, trust, and emotions; difficulty in intimate relationships; and often a lack of meaningful direction in their lives (Brown, Lewis, & Liotta, 2000). They also may exhibit what addiction professionals commonly refer to as process addictions, such as gambling, overspending, sex, the Internet, and relationships, as well as eating disorders.

The National Council of Alcohol and Drug Dependence (NCADD) estimates that there are more than 23 million alcoholics or alcohol abusers older than age 12 in the United States. This affects approximately one in five families, or 24% of all families. According to the Centers for Disease Control and Prevention, alcoholism is the third “lifestyle-related cause of death in the nation” (CDC, www.cdc.gov). It is estimated that each alcoholic...
affects, on average, approximately four people. Therefore, approximately 92 million, or 29%, of the U.S. population is directly affected by another person’s addiction.

Children of alcoholics are four times more likely than the general population to develop alcohol or drug problems. However, more than half of them do not become alcoholic. They also have a significantly higher risk of behavioral and emotional problems, according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA, www.niaaa.nih.gov). The NACOA estimates that 76 million adult Americans were exposed to alcohol in their family. About 18% of them lived with an alcoholic while growing up. There are currently approximately 26.8 million children of alcoholics in the United States, 11 million of whom are younger than age 18.

Claudia Black (1982/2001) states in her groundbreaking book It Will Never Happen to Me: Growing Up With Addiction as Youngsters, Adolescents, Adults, “Irrespective of the substance or object of the addiction, the behavior of the coaddicted parent follows very common routes[...] . . . the dynamics of giving up a sense of self, or experiencing a diminished sense of self in reaction to an addiction system” (pp. 5–6). What does this mean in terms of treatment from a Classical Adlerian Depth Psychotherapy (CADP) perspective? Dividing clients into dichotomies of chemically dependent or codependent, diseased or healthy, functional or dysfunctional, may be useful for teaching purposes, but doing so oversimplifies the human psyche and is an injustice to the individual’s unique creative power.

Adler stated that alcoholism is a form of neurosis. The early childhood prototype establishes the life style and may include unpleasant, painful, and even overburdening roots. However, childhood abuse, trauma, organ inferiority, pampering, neglect, and so on, are not causes of chemical dependency. They are only probabilities, according to Adler, not reasons for behavior. The resulting inferiority feeling acts as a stimulus for relief, but it cannot dictate the direction of that relief. It may take the form of a positive or negative compensation.

“The theory of Individual Psychology of psychological compensation states that the stronger the feeling of inferiority, the higher the goal of personal power” (Adler, 1923/2004a, p. 18). The psychological movement toward a fictional final goal of personal power that compensates or relieves this feeling of inferiority creates conflict between the client’s private logic and common sense. “All these attempts to strive for elevation, to want power, must according to nature be considered as a form of striving for superiority or dominance,” wrote Adler (1912/2002, p. 35). Difficulties that require developing the self, cooperation, and courage can provoke feelings of inferiority because clients are not prepared. There is a retreat into fantasy, safeguarding, excuses, and private logic to avoid the reality that clients
believe in cooperation—of others toward them. The client has no intention of cooperating with others. The goal is to gain power or superiority over them. This superiority is an illusion based on fantasy and not common sense.

The challenge and creative aspect of CADP for the therapist is to guess what the particular, individual goal of the client sitting with the therapist is moving toward. What is the imagined end point? What would explain the client’s movement, symptoms, and emotional state? What internal (private) logic leads the client in this direction? Guessing the purpose of the client’s movement begins immediately with the first contact. Adler often stated that every movement has a goal. Sophia de Vries repeatedly encouraged her students to always look for the movement.

Perhaps the best example is a case illustration. Given the high incidence of chemical dependency, I routinely confirm or rule out the possibility of substance abuse or addiction as soon as possible. This process is conducted in a Classical Adlerian manner using the Socratic method, as well as traditional chemical-dependency screening tools, such as the CAGE questionnaire (Ewing, 1984). It is imperative to begin looking for the client’s psychological movement and begin guessing what direction it takes from the first contact. In the following case example, the therapist’s guesses regarding movement appear in italics within square brackets.

Case Example

Ms. Q, who has given signed permission to disclose the following case details presented here, first entered treatment at age 24. It was her first attempt at therapy. She remained in therapy consistently for approximately 2 years, when she decided to “take a break” from treatment. She was in and out of therapy with me for the following 20 years, stopping several times as she felt more encouraged to face her difficulties. Ms. Q tried alternative methods of treatment, including eye movement desensitization and reprocessing (EMDR), workshops, acupuncture, hypnosis, yoga, self-help seminars. Sometimes the “break” would be for several months, at most a year. As her life style eventually presented more problems, she experienced the recurrence of symptoms and returned to CADP treatment.

During the course of our work together, in addition to individual therapy she participated in group therapy over several years as well as in five marathon groups (http://www.adlerian.us/dt305.htm). She once volunteered to videotape an abbreviated therapy session on birth order for television with Dr. Henry Stein. After filming she signed an additional waiver to allow the material to be used for training clinicians by the Alfred Adler Institute of San Francisco.
When Ms. Q returned to therapy after the first break, she read *What Life Could Mean to You* by Adler (1931/2009). In discussing what she read, she began questioning the meaning in her life. She became interested in the ways her life style was limiting her personal growth and optimal functioning. The process of loosening and eventually possibly assisting in dissolving a client’s life style is a complex undertaking, which requires rigorous training. It also requires a very high level of cooperation between the client and therapist. Stein (2013) stated: “Classical Adlerian Depth Psychotherapy has the potential of helping a client dissolve his style of life and with it the compensatory goal” (p. 96). The therapist must carefully, patiently, and diplomatically lead the client toward cooperation and away from his or her rigid life style. It is of utmost importance to follow the client’s lead and move at her pace, taking into consideration her level of readiness, insight, and understanding. This process takes time.

Initially, she presented as an intelligent, articulate, attractive single woman who appeared depressed. She is the youngest of seven children. Her family constellation consisted of a brother +15, brother +13, brother +11, brother +10, sister +6, and another sister +5 years older. Economically her family was lower middle class. There is a positive history of alcoholism and addiction. Her paternal grandfather, father, and all her siblings were chemically dependent. Her father left the family when she was 3 years old. He and her mother never divorced because they were Catholic and did not believe in divorce. Her parents lived separately, and Ms. Q rarely saw her father.

Her mother became ill with emphysema as a result of her heavy cigarette smoking; then she contracted pneumonia when Ms. Q was age 14. She remained chronically ill until her death when Ms. Q was 20 years old. Ms. Q was her mother’s primary caretaker. She was enmeshed with and idolized her mother. [Suspect some pampering here—spoiled youngest?] As a senior in high school Ms. Q got a part-time job and bought clothes for her mother. “Whatever she wanted I would get for her,” she said. She says she was not able to grieve and “let go” of her mother.

Her eldest brother is 15 years her senior and a recovering alcoholic. The third oldest brother, 11 years older, died of a heroin overdose when Ms. Q was 22. He depended on her “like a mother” after their mother’s death. [Possible feelings of superiority over dependent and/or weaker men?] Ms. Q felt responsible and guilty because she argued with him for being so high the day he died. She yelled and said: “Will you lay down? You're making me crazy.” [Does she dominate and depreciate him because he is an addict? Is she “better than” him because she is not?] He lay face down and suffocated after this argument. She discovered his body and continued to relive the trauma often. [What is the purpose of reliving this incident? Is it to fuel her depression?] Although the trauma and her suffering are very real, we look for the purpose of her behavior.
Ms. Q’s oldest sister is mentally ill and an addict. She lived on the streets until she was eventually situated in public housing with long-term disability benefits. She has a son whom Ms. Q raised as a single parent. Ms. Q took the boy from her father’s house because her alcoholic father and alcoholic-addict brother (the fourth oldest) were neglecting him and exposing him to inappropriate, drunken behavior. She refused to have the boy taken into foster care or adopted. One of her passions was to “defend the underdog.”

“What is the purpose of this rescuing behavior? What is the goal of superiority? Is it important to be the defender, caretaker, or martyr? Is she the “good” one? Are others “bad”?

As the youngest she was never dethroned by another sibling and had many “mothers and fathers” with so many much older siblings. She had no bedroom and slept in the living room as a young child. After her parents separated she slept with her mother until she was 11 years old and sucked her thumb until she was 12 or 13. Ms. Q was protected by her brothers and spoiled by all. In many ways she is similar to an only child. [Does she want to remain a child? Does she have an eating disorder or addiction? Is she afraid or insecure? What or whom did her brothers protect her from?]

The following case synopsis is based on the Adlerian Client Questionnaire, developed and copyrighted by Stein (http://www.adlerian.us). Guessing freely is encouraged. No guess is too outrageous or wrong. In this way the therapist can begin to access his or her intuition and creative process without editing in order to better serve the client. The guesses are validated or rejected in dialogue with the client as more information is gathered. Most preliminary guesses are not shared immediately with the client but are kept as private hypotheses, waiting for additional impressions.

**Adlerian Client Questionnaire**

Presenting problem: “Dealing with the deaths of my mother and brother, childhood pain, guilt, fear of growing up.” These had been issues for approximately the previous 4 years. [Does she focus on past pain to give an excuse for her depression and avoidance of life tasks? Is she protesting the loss of pampering?]

Strongest interest: Filmmaking.

Occupation: Production assistant. [Is she living in a fantasy world? Does she want her life to be like a movie?]

Long-range career goal: “To get a degree in filmmaking and become a director/producer.” No other career would have been preferred. [Does she want to be in charge and/or dominate? Live in fantasy? Be the center of attention?]

Recent dream: “I have dreams that my mom and brother are still alive and when I wake up I feel depressed when I realize it was only a dream.”
Could this be preparation for her depressed state? Does she wish to go back to a previous paradise?

Most afraid of: "Growing, changing." Why? "Fear of letting go of 20-year-old girl I was when my mom died." [Is it possible that she does not want to grow up? That she wants to keep others in her service?]

If she didn't have the above difficulties: "Hopefully attending school, date, be more social and open with people, lead my life for myself." [These are the tasks of life that her symptom of depression excuses her from conquering. Missing is the idea of making a contribution to others.]

What would make her feel more secure and significant: "Growing more as an individual; discovering who I am and who I want to be." [Is this an idle fantasy or is she willing to put in the necessary work to develop herself? Does she have the level of activity, courage and emotional support required?]

Description of mother: "Martyr, loving, caring, hard worker." [Possible prototype of what it means to be a woman.]

Mother's attitude and/or behavior: "Very loving, always treated me well, made me feel special, overprotective." [The earlier guess of pampering is now given more data.]

Feelings toward mother: "Love, respect" [What does love mean? Does she love only those who pamper her? Does she have mistaken ideas about love?]

Attitude and/or behavior toward mother: "Tried my hardest to treat her the best I could; I too was overprotective of her." [Possible goal of superiority to "mother" her mother.]

Description of father: "Unhappy alcoholic, not extremely involved with family." [Possible prototype of her expectations of men and a subtle depreciation of them.]

Father's attitude and/or behavior: "Didn't treat me bad, didn't treat me good. Middle of the road." [Are men irrelevant? Uncaring? Unfeeling? Unavailable? Neutral? Do they refuse to pamper you?]

Feelings toward father: "As I got older I was embarrassed of him." [A more obvious depreciation of father and/or men.]

Attitude and/or behavior toward father: "I treated him decently." [Withholds expressing any feelings toward him. Is this true in her relationships with other men?]

How parents got along: "Once Dad moved out, they talked on phone; Dad would bring us grocery shopping on Saturdays." Father was "embarrassed of Mom." [Men are at a distance. They have no relevance to everyday life. They come and go. They may provide basic material necessities. They depreciate mother and/or women.]

Discipline: "Dad never disciplined me; Mom usually used guilt." [Men are not involved, at a distance. Women are in charge, manipulate, and play on your emotions.]
As a child she was: “Spoiled, bratty, happy.” [The pampered and/or spoiled attitude is confirmed in the client’s own words. Is she self-indulgent? Aggressive when she doesn’t get her way? Does she pout?] She got along “fine” with all siblings. [Is this because she was pampered and got her way? Was she the center of attention?] Mother’s favorite: “Me.” Why? “Youngest.” [Further evidence of pampering. Does she intoxicate herself with being special, above others?] Father’s favorite: “2nd oldest brother.” Why? “Just like Dad.” In describing her childhood career choice, Ms. Q said she wanted to be an actress. “To make people happy; to be loved.” In our first session together she stated that it was because she could “feel for others, to bring people joy.” She was a “quiet, shy” child and wanted to be an actress on stage, she said, “to let myself out.” [Perhaps wanting others to approach her rather than taking initiative? Does she want to be above others? Is this a way to keep a safe distance from them?] She took acting lessons after graduating from high school but quit after her mother died because “I had died.” [Is this an accusation against this perfect mother? Is it an avoidance of choosing an occupation? Was she afraid that she wasn’t the most talented and/or brilliant actress in the class?] She didn’t go to college in order to take care of her chronically ill mother. [Is this career choice a way to remain a child, live in fantasy, to be loved, to be the center of attention, to control the outcome, to avoid living her own life, to be pampered? Was her mother’s illness an excuse to avoid the task of developing herself by going to college? Was she afraid she wouldn’t be the smartest student there?] Ms. Q states that her mother often told her how “different and smart” she was compared to her siblings. She believes that her mother was the only person who ever loved her. Therefore, she tried to always please her mother and participated in what she called “the good girl syndrome.” [Does she confuse pampering with love? Is there any anger or resentment toward this woman who kept Ms. Q in her service? Does she need to feel smarter than everyone else to feel significant? Is acting like a “good girl” a counter-fiction to disguise her ambition and aggression?] Her brothers would often buy her things. Ms. Q’s father “never gave emotions, only material things.” She was “the baby.” She stated: “I was the youngest and everything revolved around me.” [Does she wait to have others serve her? If this is the mistaken direction in which she is moving, the symptom of depression could serve to keep her radius and activity level low. Is this additional evidence of pampering and her sense of significance being tied to her dependence on being the center of attention? Is the purpose of men to bring her gifts and not expect anything of her?]
She described her family as poor, the house as "a dump, a mess," and her siblings as out-of-control addicts. Her mother didn't teach her simple hygiene, like brushing her teeth. She "always" felt that she was "one person on the outside and another on the inside. We had our own little private world in our house." Everyone kept the secret of the "insanity" of the family. She thought that it wouldn't matter who her family was if she was "proud" of herself. Ms. Q wanted to be "so strong because my family was so weak." She felt embarrassed that others thought they were "poor white trash."

**Assessment of Material**

What follows is an initial assessment derived from the material provided by the client. The conclusions are inferred from the questions formulated while examining the information gathered. It is evident that Ms. Q suffers from multiple inferiority feelings: social, economic, intellectual, and psychological. She has the combination of an overburdening situation of neglect and the underburdening situations of pampering, overprotection, and overindulgence (see Stein, 2013, chart 1, p. 18). She sees herself as a "scared little girl" who stopped growing when her mother died: "To me my mom was it." She indulges herself in the fantasy that "everything would be OK" if her mother hadn't died. "No one understands me," now that her mother is gone. Upon her mother's death, "I became her," she said. Meaning she became the "mother," the family caretaker, and was elevated from "baby princess" to "queen."

There are many clues to her lifestyle, scheme of apperception, counterfiction, and fictional final goal. However, her lifestyle is best described in her own words. In our discussions of ambition and aggression, superiority and inferiority, dominance and submission, and intimacy and cooperation in her relationships with men, she said: "I avoid men like the plague." All her past relationships had been with alcoholic, emotionally unavailable men whom she could dominate, verbally abuse, and feel superior because she is not an alcoholic. As we discussed the purpose of choosing such men (to feel superior) and her movement (to deprecate and rule over them), the question became: What man would want to be ruled? A weak, poor, bad, depressed, idiot? "A derelict. I'm Queen of the Derelicts," she laughed.

A client's basic antithetical scheme of apperception is determined over time by guessing, looking and/or listening for patterns, finding themes in the early recollections, and testing them with the client. For Ms. Q, the major schemes are weak-strong, smart-idiot, good-bad, happy-depressed, understood-misunderstood, guilty-perfect, fear-brave, special-nothing, poor-rich, high-low, rejected-adored, inside-outside, little-big.
Stein (2013) clarifies the relevance of these schemes: "When we examine the history of a client, an antithetical scheme inevitably emerges in varying degrees of intensity and rigidity. . . . The assumption of this antithetical scheme provides a useful psychological fiction, a practical-theoretical 'as if' proposed by Adler that helps us understand a client's unique inner life" (p. 54).

In addition, early recollections provide "a rich source of projective, diagnostic material. Often, a series of recollections suggests the world-view of a client, as well as his self-trained manner of dealing with it. The art of interpreting recollections relies heavily on analysis, synthesis, and intuition. . . . Guesses must be verified by comparing these recollections to all other expressions and psychological movement" (Stein, 2013, p. 98).

Here is an example of Ms. Q's first recollection, at age 3 years, and how to begin the process of guessing: "The whole family was going shopping. I remember walking around in the back of the family station wagon eating a hot dog. As far as I can remember we were all happy." No conclusions were made. When questioned she responded: "I was happy, I was just a kid."

Beginning guesses might be the following: Does she wish to remain a child? Does she always want to be happy? What is her level of activity? Does she have an eating disorder or an addiction to a substance? Are material things important to her? Is she more comfortable in a group than with one person? Does she do things she is not supposed to do? Does she avoid making decisions and/or conclusions?

Given the strength of her inferiority feelings, Ms. Q's compensatory goal of personal power is elevated. She overcompensates for feeling as if she is the "little, bad, weak, stupid, poor, rejected, underdog," and so on, by creating a fictional final goal of power, wealth, and prestige. She is the smart, strong, good queen who is adored by all of her subjects and rescues the poor, rejected, underdog derelicts. As Adler (1930/2004b) reminds us, "No amount of bitter experience can change the style of life, as long as the individual has not gained insight" (pp. 131–132).

**Summary and Conclusions**

This case illustration provides an example of how a Classical Adlerian Depth Psychotherapist approaches diagnosis and treatment. Once guesses about the client's inferiority feelings, form of compensation, life style, fictional final goal, antithetical scheme of apperception, private logic, and other relevant constructs are confirmed in discussions with the client, psychotherapy moves toward deeper insight.

Although Ms. Q did not dissolve her life style before she ended treatment, she made more progress than most clients do. At the termination of
therapy she was at approximately the 11th stage of the Stages and Tasks of Depth Psychotherapy, developed by Stein (2013). As indicative of her lifestyle, she has difficulty "letting go." The awareness of the consequences of her goal and the effects of depreciating others continue to unfold for her. She has developed more self-esteem and courage to face life’s tasks. Ms. Q is struggling to find meaning, purpose, and a means of making a useful contribution. Currently she has moved away from home to take a job in another city; her career is moving forward. For the first time she will be living alone. Ms. Q has signed up for an online dating site and is ready to face the challenge of finding a meaningful relationship with a man. She has developed some close friendships with women and is ready to begin to seriously face her issues related to being an adult child of an alcoholic by returning to Al-Anon. The willingness to attend and participate in a 12-step program like Al-Anon is one measure of her expanded ability to cooperate with others.

It is the therapist’s task to continue to challenge and encourage the client toward common sense and social interest (see Stein, 2013, appendix B, pp. 280–281). Although the direction toward cooperation is similar, the specific encouragement is distinct to each client. It is as unique as every client’s creative life style and goal. This keeps Classical Adlerian Depth Psychotherapists from experiencing burnout, boredom, or fatigue. There is always something to discover or learn, a nuance to interpret, a technique to refine, a deeper understanding to process. It is a privilege to accompany someone on his or her journey of self-development and contribution. It never gets old!

References


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