Narcissistic Rage and Addiction: Adlerian Theory and Intervention

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Abstract

An alternative to the biomedical model, psychiatrist and psychoanalyst Dodes (2009) proposed a psychological theory for the treatment of addiction and the prevention of relapse, describing, substance use as a compulsive act of displacement. This paper will outline Dodes' theory, and describe the psychoanalytic base thereof. It will present the major concepts of Adlerian theory and from that viewpoint, examine parallels or contrasts between Dodes' theory and Adlerian theory. Both classical and contemporary Adlerian views on chemical dependency treatment will be summarized. Finally, this writer will propose individual and group interventions for Adlerian psychotherapy for the treatment of addiction based on these conclusions. These interventions will include the writer's own attempt to connect Pew's priorities to specific core emotional vulnerabilities. Also, it will outline the writer's original use of the "empty chair" technique as a method of determining and ranking the client's psychological priorities in order to facilitate treatment.

Keywords: addiction, narcissistic rage, narcissistic injury, Adlerian theory, psychoanalytic theory, object relations theory, compulsion, displacement, compensation, psychological priorities
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Narcissistic Rage and Addiction: Adlerian Theory and Intervention

In his book *The Heart of Addiction*, (2002, p. 20; 2009, p. 383) Dodes established a connection between narcissistic rage, or rage at helplessness, and addiction. Dodes proposed that substance use is an attempt to reverse intolerable feelings of helplessness brought on by situations that trigger an individual's particular emotional vulnerabilities, narcissistic injuries, or attacks to the self-esteem (Dodes, 2009, p. 383; Kernberg, 1992; Kohut, 1972).

Dodes went on to further clarify, that even the act of deciding to later choose to alter mood or emotional state with substances restored the individual to a sense of power in the present moment (Dodes, 2009). Dodes (2009) reasoned that feelings of helplessness produce a rage at the individual's inability to control their current circumstances. Dodes (2009, pp. 382-383) proposed that it is this narcissistic rage (Kohut, 1972), that is strong enough to override reason, that drives addiction.

**Linking Compulsion and Displacement with Addictive Acts**

Dodes (2009) argued that when narcissistic rage cannot be assuaged by actions which are for whatever reason presently unacceptable, substance use becomes the replacement. A compulsion to use substances to relieve the feeling of helplessness develops over the course of the addictive process (Dodes, 2009). Compulsions are described as repetitive behaviors that are "strongly driven" and difficult to control (Dodes, 2011, p. 40).

In general, whatever (chemical use or behavior) is chosen to displace those feelings names the addiction (Dodes, 2009, p. 383). Dodes describes displacement as an act of substitution (Dodes, 2009). This substitution eventually is used to describe the type of addiction (Dodes, 2009). For example, if blackjack is what is chosen to relieve helplessness, it would manifest in a gambling addiction (Dodes, 2009); if crack, a cocaine addiction; if ice cream, a food addiction. It follows that one type of addiction can be replaced quickly by another when
addiction is viewed as an act of displacement (Dodes, 2009). The above model provides an explanation for the often witnessed ease in which addictive behaviors can be switched (Dodes, 2011).

**The Role of Psychological Compromises**

Dodes (2003, p. 57) viewed addictive behaviors as *psychological compromises* between not acting, and taking a direct action when feeling helpless. This action compensates for what the individual has chosen not to do, or can be looked at as an internal prohibition of a less acceptable behavior (Dodes, 2003).

**Avoidance of Distress**

Lombardi (in Sperry & Carlson 1993, p. 420) described alcohol as "a convenient pain killer," with pain coming potentially from multiple sources, including when the needs of the ego have been frustrated. The psychological roots of addictive behaviors are powerfully embedded in the individual's conflictual thought processes (Dodes, 2003). Behavioral habit patterns develop around what individuals find painful or personally meaningful to avoid (Dodes, 2003). A system for helping clients zero in on what those personally meaningful triggers are will be covered later on in the paper. Having awareness of such triggers will help prevent relapse while working on the underlying issues (Dodes, 20003).

**Narcissistic Rage versus Narcissistic Personality Disorder Diagnosis**

Going back to the source of narcissistic rage, *narcissistic injury* is found to be related to avoidance of reenactment of a previous injury in the area of psychological issue(s) most relevant to the individual (Dodes, 2009, p. 383; Kohut, 1972). It is important to note that Dodes is not labeling those who struggle with addiction as narcissists; and that any psychopathology could be at the root of addiction (Dodes, 2009).
Dodes makes the distinction, as does Kernberg (1992), that narcissistic rage is not necessarily related to a diagnosis such as Narcissistic Personality Disorder (DSM 5, 2013). Kernberg (1992, p. 238) proposed that all character defenses (Kernberg, 1992, p. 238) are narcissistic in nature as they protect the self-esteem. These defenses can be present in the absence of a narcissistic personality structure (Kernberg, 1992, p. 238).

**Dodes' Psychoanalytic Pathway to Addiction Summarized**

To summarize the chain of events and reactions that characterizes Dode's (2009) theory:

- Narcissistic injury, sustained during childhood development, predisposes the individual to psychological vulnerability in areas specific to that person. Narcissistic rage is triggered by current circumstances that resemble or activate the memory of the narcissistic injury and produce feelings of powerlessness, helplessness, or lack of control (Dodes, 2009). The individual wants to empower themselves through action, but chooses to constrain themselves to socially or morally-acceptable behaviors (Dodes, 2009). Substances or behaviors are used as a displacement and compensation rather than the unacceptable defensive action that would relieve the feeling of helplessness (Dodes, 2009). And therefore, the engendering rage negates the individual's powers of reason in the decision to use (Dodes, 2009).

**Powerlessness: A Clarification of Terms**

The first step of the Alcoholics Anonymous (AA) 12 steps, "we admitted we were powerless" (Alcoholics Anonymous, 2010, p. 446), means breaking through denial and fully accepting the level of decimation addiction has fostered in the individual's life.

Dodes, in his third book *The Sober Truth* (2014, p. 83), disagreed with the message he felt was being portrayed by this AA step. He posited the first step's wording hints at a moral deficit on the part of the addicted person (Dodes, 2014). Rather than a moral deficit, Dodes
(2014) instead wished to underscore the physiological reaction of *tolerance* (when the body becomes used to processing the chemical) that is taking place. When the chemical use ceases, tolerance is followed by physical symptoms of *withdrawal* (where the body now has to process the absence of the chemical it formerly tolerated) (Dodes, 2014).

Thus Dodes (2014) differentiated between physiological tolerance and addiction by reminding us that people go back to using after they have detoxified from physical addiction. Dodes also noted that behavioral addictions do not have the physiological component involved (Dodes, 2014). What Dodes (2014, p. 82) calls *true addiction*, is psychological rather than physiological in origin, saying that people do not become addicts unless the need to use is psychological in origin and fulfills an emotional need.

Dodes (2014) made the distinction between a psychological compulsion and a compulsion that is physiological in origin. Dodes (2014) surmised that symptoms of OCD that respond to medication such as Prozac were physiological in nature. Dodes summed up this part of his discussion by calling addiction a psychological compulsion focused on alcohol, and drugs.

Dodes (2014, p. 85) emphasized the emotional *function* of addiction, which would include behavioral addictions. This writer sees a correlation between Dodes' (2014, p. 85) theory of the psychological nature of addiction, with Adler's teleological, purpose-driven behaviors (Ansbacher & Ansbacher, 1964).

In general, this author believes that when Dodes in his many works (summarized in his 2014 book), used the term *powerlessness*, he was not referring to the familiar AA terminology (Mate, 2012), but to feelings of helplessness originating in a former narcissistic injury. To illustrate again in the words of Dodes (2014), "The psychological function of addiction is to reverse the sense of overwhelming helplessness."
The Path to an Adlerian Comparison

This author is attempting to undertake the task of using Dode's underlying concepts towards an understanding of the path of addiction development. This attempt will be followed by the formation of a hypothesis towards successful treatment and sustainable recovery from an Adlerian psychotherapeutic viewpoint.

Basic psychoanalytic theory will be summarized first below, followed by Adlerian theory, in order to enable the process of comparing and contrasting the two types of theories. It is necessary to note that Adlerian terminology appearing in the psychoanalytically-focused sections will be explained in further detail in the Adlerian section of this paper.

The Psychoanalytic Building Blocks of Dodes' Theory

Sigmund Freud

The ideas generated by Sigmund Freud have influenced nearly every area of contemporary thought (Giraldi, 2014). Freud, like Adler, grew up in Vienna, was descended from a Jewish family (Snowden, 2006). He reportedly embraced the culture of Judaism without the religious aspect thereof (Snowden, 2006). He became a neurologist, specializing in histology, the study of tissue structure (Snowden, 2006, p. 5). His studies in the area of hysteria, (Cogan et al., 2007, p. 698) a nervous complaint linked to a "preoccupation with sexuality" led him to formulate his theories on psychoanalysis (Snowden, 2006).

Freud and the Unconscious Mind

Freud surmised that the unconscious mind was made up of mostly sexual material, repressed, or buried ideas; or sublimated or redirected instinctual drives that could not be dealt with by the conscious mind, lest people act out in chaotic and impulsive ways (Snowden, 2006,
Displacement, Defense Mechanisms and Repression

According to Freud, defense mechanisms are created to protect us from feelings of anxiety or stress (Snowden, 2006). Displacement is a type of a defense mechanism (Kahn, 2002, pp. 134-135). In displacement, when feelings cannot be realized or experienced, they are stored and later redirected on an unrelated target which does not seem as dangerous (Snowden, 2006). Repression is Freud's term for a sort of memory loss, a denial of reality that locks painful events into the unconscious (Snowden, 2006).

"Turning against the self" is the term used to describe what happens when the self is the target of displacement (Snowden, 2006). Feelings deemed too hard to deal with turn into self-destructive acts (Snowden, 2006, p. 111). Mohiyeddeni et al. (2013, p. 1) cite Chance (1962) and Sgoifo et al. (2003) purporting that displacement behaviors can temporarily "cut-off" the ability to attend to a threatening situation, thereby reducing the "negative arousal associated with the stimulus." Congruent to the above, Mohiyeddeni et al., (2013) go on to note that if the individual is less negatively aroused by the stimulus they may cognitively experience the situation as less stressful.

The "Self" and Object Relations Theory

Many and varied terms and theories abound regarding development of the mind, psyche, "self," personality, character, life style, and temperament. A complete study and comparison of the above would be beyond the scope of this paper.
Object relations theory. Object relations theory is the base of many theories on narcissism (Symington, 2006). Object relations theories and psychoanalytic theories are interrelated and difficult to separate out (Cashdan, 1988). Cashdan (1988) denied the existence of a unified theory of object relations. Cashdan (1988) even noted that the word object did not hold the same meaning from theorist to theorist. Kernberg related "object" to "human," while Freud was more interested in the libidinal drive and the energy attached to an object, be it human or anything else (Cashdan, 1988, p. 3). Self-object to Kohut, meant significant people who become a part of the self; while Kernberg, used the hyphenated term self-object to mean an internal type of representation, not necessarily based on an actual person (Cashdan, 1988, p. 21).

Cashdan (1988) compared object relations theory to psychoanalytic drive theory, explaining the former as attributing the development of the psyche as arising from human interaction, rather than the latter’s biological motivation to reduce tension. Cashdan (1988) felt that contributors to the field of object relations theory, such as Klein, Mahler, Kernberg and Kohut; each with their own individual nuances to add; had one thing in common, that of emphasizing the importance of human relationships in the development of the psyche. However, Cashdan (1988) felt that the therapeutic practices that have evolved out of those theories have since become more psychoanalytic in nature.

Cashdan (1988) advocated a goal of therapy based on object relations that emphasized a relational pathology, or an inability to form or maintain healthy relationships. In such therapy, Cashdan (1988) maintained, healing would occur through the therapeutic relationship itself.

Adler and object relations theory. Although Adler's life style development theories are also based on humans' need for each other, the difference would seem to this writer to be in the element of creative choice. Adler emphasized the mother as being a key figure in the child's
developing ability to cooperate with others, but after that the child's decision making process takes over, influenced by environment and experiences, as well as the child's perception of circumstances and situations (Ansbacher & Ansbacher, 1964).

**Freud's Id, Ego, and Superego**

Freud began the mind debate with a "dynamic model of the mind" that he termed the *id* the *ego* and the *superego*, a sort of arrangement of the *psyche* (Snowden, 2006, p. 103). The id was the unconscious, primitive, impulsive and need-based area of the mind (Snowden, 2006). The ego is what one thinks of as the self (Snowden, 2006). It is the rational, self-observatory area of the mind that unconsciously develops defense mechanisms as protection from threats to the self-esteem (Snowden, 2006). Anxiety is noted as both produced, and experienced as self-protection, by the ego (Snowden, 2006). Freud proposed that the superego, like a parent to the other parts of the mind, is where the conscience is developed (Snowden, 2006).

Freud coined the term Narcissism after the myth of Narcissus who, fell in love with his own reflection. He used the term for patients who became so stuck in their own ego they could no longer relate to others. He found he could not use the insight provided by *transference* (when patients project elements of former relationships on the therapist) to treat these patients (Snowden, 2006). Freud felt that was because the *libido* (sex drive) of the narcissistically-impaired individual was entirely self-directed (Snowden, 2006, p. 63).

In object relations theory, the subject and the object can't be explained without each other (Symington, 2006). The object is "the part of the self that is in relation to the other;" the subject is the "other" part of the self (Symington, 2006, p. 18).

It was not Freud, but his colleague who fell from favor, Jung (Ansbacher & Ansbacher, 1964), who elaborated on object relations theory (Symington, 2006). Symington (2006) proposed
that the different parts of the self are capable of functioning separately. Symington (2006) noted
that emotionally, individuals experience shame because of this inner conflict between the
disintegrated parts.

**Adler on the ego.** In comparison to Freud, Adler (1935, as cited in Shulman, 1965, p. 14)
said "What is frequently labeled 'the ego' is nothing more than the style of the individual." He is
here referring to his concept of an individual's world view or *life style*, discussed in detail later in
this paper (Ansbacher & Ansbacher, 1964).

**Drive Theory**

Freud's drive theory casts mankind in a negative light, describing human behavior as
based on the satisfaction of (mostly sexual) drives (Carlson & Maniaci, 2012). According to
Kahn (2002, p. 38), Freud posited that children's sexual development goes through six
overlapping and consistently influential stages, *oral, anal, phallic and Oedipus Complex I,
lateness, Oedipus Complex II or puberty*, and *genital*. The developing child's reactions, as well as
their caregivers' reactions, to these stages, make these psychosexual stages either difficult or
gratifying for the child (Kahn, 2002). When chastised or forbidden, Freud believed the child's
superego would banish these stage-appropriate bodily interests to the unconscious, there to
become the drive's influence on behavior (Kahn, 2002).

Adler, while still in the process of developing his own theory, used Freud's ideas to
formulate a theory on aggression as a drive (Griffith & Powers, 2007). He later abandoned this
theory in favor of the *striving for overcoming* portion of his holistic theory on the *striving for
superiority* (Griffith & Powers, 2007, p. 3).
Narcissism

Trauma versus Phobia in Theories on Narcissism

Symington (2006) condensed the theories regarding narcissistic development into two basic viewpoints, trauma versus phobia. Symington (2006, p. 110) himself was in the trauma theory of narcissism category, along with, in his opinion, "Fairbairn, Winnicott, Tustin, and Kohut." Symington (2006, p. 73) posited that a "narcissistic way of functioning" is formed originally by trauma and is a defense against further re-occurrence of trauma. Symington (2006, p. 110) related that a narcissistic situation is caused by a traumatic external circumstance.

In the theories of Melanie Klein and those who followed her, internal anxiety is projected into an external object and the external object is then fled (Symington, 2006). Klein, according to Symington, (2006, p.101) believed the source of anxiety was a congenital death instinct, or fear of annihilation.

Adler’s theory on narcissism could be identified as trauma-based as well, but with a significant difference (Carlson & Maniaci, 2012; Symington, 2006). Carlson and Maniaci (2012) pointed out that narcissism is not an innate phenomenon, but one that progresses through development. As will be discussed later in this paper, that development though trauma based, is fueled by the creative powers of the individual, at work, beneath the level of their awareness (Ansbacher & Ansbacher, 1964). Carlson and Maniaci (2012) said that the development of narcissism is through the exclusion of social relationships, or the inability to form them.

Shock and Trauma

Symington (2006, p.74) pointed out that shock is another term for trauma. According to Adler (Carlson & Maniaci, 2012, p. 201), "the impressions of the external world," along with the bodily condition, are the building blocks of the personality.
Adler in *What is Neurosis* (Carlson & Maniacci, 2012, p. 201) described nervous symptoms (in contrast to physical manifestations) as *psychic shocks*; such as anxiety, obsessions, depressive symptoms, compulsive actions, and "nervous headaches." Adler found a connection in the development of these symptoms to the avoidance of tasks that would uncover the individual's lack of social preparation and fear of exposure. The problem results in a shock, and the shock produces an effect. The shock is a sign of neurosis, but becomes neurosis when it chronically leads to avoidance. Unprepared for life's task, the individual can no longer move forward (Carlson & Maniacci, 2012).

Paradoxically, it would seem, the shock is embraced as a way of seeking distance, a safeguard (Carlson et al., 2008). The shock causes the individual to sort of freeze in place, at the point where they were last adequately cared for (Carlson et al., 2008). A logic is established, that if they never have to go past that point, they will never have to re-experience the shock or trauma (Carlson et al., 2008). Safeguarding develops around the shock, for example an intense experience of humiliation, may be safeguarded by a tendency to control situations, themselves or other people in order to not go back to that experience (Pew, 1976).

Using the above logic path, a chronic alcoholic with an academically successful older sibling, raised in an environment that values high grades, may be *nonconsciously* (Carlson et al., 2008, p. 61) safeguarding their fear of failing at academics through remaining stuck in their inability to stop drinking.

**Narcissistic Disturbances and Narcissistic Injury**

According to Billingham et al. (1999), narcissistic injuries are "disruptions in development or maintenance of a cohesive self" which cause narcissistic disturbances. In this
Before the age of five, the child expects to be cared for much as he or she was in the womb (Gottschalk, 1988). When this sense of safety or protection is challenged beyond the child's capacity to process it, narcissistic injury can occur (Gottschalk, 1988). When a child feels overwhelmed or rejected, or caretakers are cruel or exploitive, it can predispose the child to future **dissocial** behaviors, including substance use disorders (Gottschalk, 1988, p. 7). Gottschalk related narcissistic injury at this developmental stage to the sense of entitlement towards giving themselves what they did not get in childhood and felt deprived of, often observed in those who struggle with addiction (Gottschalk, 1988).

**Development of Narcissistic Injury**

At ages five to ten, even in a child from a nurturing environment, having grown up with *unconditional* love, will have encountered the *conditional* love of the outside world through school experiences (Gottschalk, 1988, p. 7). Narcissistic injury caused by diverse factors during this time period can result in low self-esteem and self-defeating attitudes and behaviors; or their opposite, grandiosity (Gottschalk, 1988).

During the adolescent years, 11 to 20, the life tasks and expectations on performance and conformity increase profoundly (Gottschalk, 1988). A teen is expected to integrate with peers; become aware of sexual roles and responsibilities; explore and acquire skills towards vocational aspirations; formulate identity; learn to appropriately love and be loved; learn physical and mental self-care; and cement a sustainable system of existential belief. Wide fluctuations in the teen's hold on normal healthy narcissism are a given under the demands of Western society. This can range broadly from suicidal ideation as escape or revenge, to healthy achievement.
Conversely, teens can go overboard towards grandiose thoughts and behaviors (Gottschalk, 1988).

It should be noted that Gottschalk (1988) goes on to discuss narcissistic injury throughout the lifespan, but this paper focuses on the injuries sustained through the developmental years. Dodes (2003) explained that it is reasonable to believe that intense, repeated experiences of helplessness occurring during childhood lead to the development of a mechanism to deal with them. This also explains that re-experiencing similar situations would manifest as re-injury in that vulnerable area (Dodes, 2003).

**Narcissistic Rage**

The term narcissistic rage was originated by Kohut in 1972 (Dodes, 2009). According to Ornstein, (2009) Kohut originated the concept of reactive anger in a vulnerable self. Ornstein (2009, p. 140) goes on to say" the essence of the pathology is the underlying structural deficiency of the self - its vulnerability and periodic transient collapse in response to certain types of injury."

Lowen (1985) highlighted the difference between rage and anger. Proportional to whatever incident provoked it, Lowen (1985) described anger as constructive, as it initiates action towards the resolution of the issue. Lowen (1985) felt rage instead, is not rational, it is excessive to the amount of provocation that instigated it, and it is destructive rather than constructive. Lowen (1985) postulated that narcissistic rage is based on repressed experiences of humiliation received in childhood which initiated feelings of powerlessness. Current frustrations that make the individual feel powerless spark outbursts of this expression of rage (Lowen, 1985).

Dodes (2003) explained narcissistic rage (as it relates to addiction) as the drive behind the action taken to relieve the threat of feeling trapped, disempowered or helpless in a situation.
Focus narrows to escaping the threat, shutting out normal judgment or future consequences (Dodes, 2003). The qualities of self-preservation inherent in normal narcissism are behind this action (Dodes, 2003; Gottschalk, 1988). The emotional survival instinct that moves people to take whatever action available towards preserving a sense of self is what keeps prisoners who survive captivity from falling into depression, or death (Dodes, 2003).

Kohut's *Thoughts on Narcissism and Narcissistic Rage*

Kohut's 1972 article *Thoughts on Narcissism and Narcissistic Rage* was pivotal to Dodes' (2009) development of his theories. Kohut had already published extensively on the subject of narcissism before the article was written. The above-referenced paper (Kohut, 1972) focused on the connection between "narcissistic imbalance" and aggression. Kohut was interested in the interplay between the child and the environment, specifically the role the parent's response plays in narcissistic development (Kohut, 1972). Kohut (1972) saw value in narcissistic development, particularly its "mature, adaptive, and culturally valuable attributes;" a functional rather than defensive viewpoint.

Kohut noted the relationship between early narcissistic injury to later vulnerability towards narcissistic sensitivity (Kohut, 1972). He touched briefly on Adler's concept of *organ inferiority* (Kohut, 1972, p. 372) in regards to the shameful and self-conscious feelings generated by other people's reactions to one's physical defects.

Kohut presented narcissistic rage on a continuum. Comparing it to the fight or flight reaction, he noted that in the face of what is perceived as a threat towards narcissistic injury, individuals react by the flight response of withdrawing into shame; or conversely with the fight-based response of narcissistic rage (Kohut, 1972). Kohut (1972) singled out narcissistic rage from other forms of aggression: "The need for revenge, for righting a wrong, for undoing a hurt
by whatever means, and a deeply anchored, unrelenting compulsion in the pursuit of all these aims which gives no rest to those who have suffered narcissistic injury” (Kohut, 1972, p. 380).

Here Kohut gave Japanese society (drawing on the work of Benedict, 1946) as an culturally-based example of the transformation of a narcissistic injury to narcissistic rage cycle (1972). Benedict (Kohut, 1972, p. 380) noted that in the above culture, children are raised with ridicule, the "threat of ostracism," and a rigid expectation of behavioral decorum. These narcissistic injuries can be triggered to erupt into aggressive acts at provocations as slight as an insult (Kohut, 1972). Kohut (1972) reported the individual who fears shame reacts to the threat of narcissistic injury by narcissistically injuring others. Kohut (1972) took note of the irrational, often intensified reasoning that can take over in individual's vengeful acts.

The term catastrophic reaction (Kohut, 1972, p. 383) is used to explain the rage that emerges when a deficit in thought processes, or lack of control in mental acuity occurs. Kohut explained that this is experienced as a loss in the area of the self. He used brain injury due to stroke; the inability to locate the correct word when expressing oneself; and slips of the tongue as examples of situations that would cause a catastrophic rage reaction. A second related phenomenon presented in a child's reaction of disbelief to the experience of being slightly physically injured (Kohut, 1972).

A shame-prone individual, whose grandiose, perfectionistic self-image causes him to react to a perceived affront with rage and vengeful actions, is contrasted to one who can exhibit healthy aggression in the article. Healthy aggression is explained as goal-oriented, and therefore limited in scope (Kohut, 1972). The expectations the narcissistically unbalanced place on themselves and others are for the maintenance of self-esteem in a "narcissistically perceived reality" (Kohut, 1972, p. 386).
Kohut (1972) noted that angry and embarrassed reactions to narcissistic injury are normal. But, the shamed-based individual narcissistically injured in childhood, overreacts, as the integrity of the very self is at stake for them in incidences that are out of their control (Kohut, 1972).

Kohut (1972) emphasized that lack of empathy in vengeful acts towards offenses of the narcissistically unbalanced is related to narcissistic rage. He also noted that resistance during psychoanalysis in these individuals is related to the perception of therapy as narcissistic injury, because of an assumption that "one should be in control of one's own mind" (Kohut, 1972).

**Anxiety and Addiction**

Rollo May (1977) maintained that addiction is a negative or destructive way of dealing with anxiety. Negative means (such as substance use) serve to allay, avoid, or evade the anxiety without resolving the underlying conflict. Substance use becomes a compulsion when it is the habitual choice to alleviate anxiety, highlighting the external effect of the substance use instead of any other motivation for its use. Anxiety is activated when substance use is. When the use of substances releases the immediate tension but does not resolve the conflict that lies beneath, a compulsion neurosis is activated. Then the tension-relieving activity must be continuously repeated in order to continue relieving the tension because the conflict remains unresolved (May 1977). Dodes (2002) extended the above when he related the power to relieve tension to the mere decision to use substances at a future time.

**Summary of Introductory Section**

To summarize the above introductory section before moving on to Adlerian Theory; Dodes' theory is outlined linking compulsive addictive behaviors to acts of displacement which are used to a compensation for actions that would violate the individual's value system. The distress caused by an emotional trigger personally significant to the client is avoided through the
addictive act. Narcissistic rage is defined in comparison to Narcissistic Personality Disorder. Dodes' use of the term powerless is contrasted to the AA use of the term. The psychoanalytic building blocks of Dodes' theory are briefly summarized, including a short overview of object relations theory which is often tied to narcissistic development. Kohut's article, *Thoughts on Narcissism and Narcissistic Rage*, pivotal to Dode's development of his theories, is summarized, as are the concepts of narcissist disturbance and injury, and anxiety and addiction.

**Alfred Adler**

A contemporary and associate of Freud's (though 14 years his junior) and Jung's, Alfred Adler split off on his own after disagreeing with Freud's libido-based drive theory (Ansbacher & Ansbacher, 1964). Adler was a physician, a psychologist, a philosopher, educator, and speaker (Carlson et al., 2008). Though a friend of Trotsky's who wrote a paper on "The Psychology of Marxism" he was philosophically humanistic, believing in equality and relational democracy (Carlson et al., 2008). He overcame childhood accidents, loss, illness, and academic discouragement, and believed in the ability of the individual for self-efficacy and progress Carlson et al., 2008). In contrast to Freud, Adler advocated for social equality and championed equality for women (Ansbacher & Ansbacher, 1964).

**The Individual Psychology of Alfred Adler**

Adler's viewpoints were based on the philosophies of Kant and Vaihinger (Watts & Carlson, 1999), espousing the power of the individual to be both the artist and the picture *created* by the artist (Ansbacher & Ansbacher, 1964). Shulman (1985, as cited in Watts & Carlson, 1999, p. 2). stated, "Because of this creative power, people function like actors writing their own scripts directing their own actions, and constructing their own personalities."
Holism

Holism, is central to Alfred Adler's Individual Psychology, stemming from the idea "the whole being more than "the sum of its parts"" (Oberst & Stewart, 2005, p. 10). The creative force is seen as a central motivator within this whole (Oberst & Stewart, 2005, p. 10). In contrast to psychoanalytic thought, which places childhood trauma at the root of psychological issues, Adlerian theory, purports that individuals both create their own lives and have influence over their circumstances (Oberst & Stewart, 2005). As is emphasized elsewhere in this paper, individuals make themselves unaware of creative choices in order to serve goals which are below the individual's level of awareness (Carlson et al., 2008).

Unconscious versus Un-understood or Nonconscious

Adler veered away from psychoanalytic thought regarding the unconscious, in favor of the notion of that which is un-understood (Griffith & Powers, 2007, p. 15), or nonconscious (Carlson et al., 2008, p. 61). Adler believed this area of the mind was just that which the person has not yet fully grasped or formulated a clear understanding thereof (Griffith & Powers, 2007, p. 15). As people are often unaware of these un-understood motives, a collaborative effort towards insight is an important aspect of the therapeutic process (Griffith & Powers, 2007).

This author has encountered the writing of Adlerian authors that continues to use the term unconscious (Carlson et al., 2008, p. 61), although this author believes it to then hold the same meaning as the above mentioned un-understood, rather than Freud's blocked, inaccessible unconscious (Snowden, 2006). Carlson et al. (2008) noted that individuals prescreen input, and ignore that information which does not fit their goals.
Ansbar and Ansbarher, (1964, p. 1) noted that the goal or self-ideal is unknown and not understood by the individual. Adler's way of using the term unconscious regarded "the unknown part of the goal".

**Fictionate Goal**

The creative movement towards a fictionate goal lies in the realm of the un-understood, as people, in our fallibility, weakness, and imperfection do not possess complete understanding of our physical and mental beings (Ansbacher & Ansbacher, 1964). Oberst and Stewart (2005) reinforced this by saying that we create fictions as lenses through which we see ourselves, other people and our environments. This view in turn influences (Oberst & Stewart, 2005) thoughts, feelings and behaviors. These fictions are maintained if useful, and perceived to fulfill the (un-understood) purpose of the fictional goal (Oberst & Stewart, 2005).

Our personal truth, the way we "make sense of our experiences" may not actually be right or wrong, but must exist in service of our individual purposes (Oberst & Stewart, 2005, p. 14). Psychologically healthy and unhealthy people both maintain fictional goals; the individual suffering from neuroses-induced psychological problems maintains a fiction that is inexpedient or as Adler would say, useless (Oberst & Stewart, 2005, p. 14).

**The Tasks of Living**

The tasks of living are Adler's constructs that described movement as categorized into types of goals. Adler originally described three tasks, work, love and community (Oberst & Stewart, 2005). This author would summarize by saying these mean to create a life partnership with another person, to contribute to the greater good by sharing your gifts and strengths in a way that benefits oneself, others and the economy; and becoming an integral and useful part of society, which includes friendships (Oberst & Stewart, 2005).
Mosak and Dreikurs (1967, as cited in Mosak & Dreikurs 2000) presented a fourth task which they called "coping with oneself," with Oberst and Stewart (2005, p. 202) adding "developing the sense of self" and "getting along with self" as further clarification. Mosak and Dreikurs (2000) proposed a fifth task, in the form of a spiritual quest or an existential search for meaning.

As individuals move towards a sense of completion, what Maslow called self-actualization (Ansbacher & Ansbacher, 1964, p. 123), they need to attempt to conquer the life tasks as well. This author believes Maslow might fit this into his pyramid by explaining that basic needs, such as the first three tasks) would have to be met first (Ansbacher & Ansbacher, 1964; Oberst & Stewart, 2005). Oberst and Stewart (2005) also felt the individual's lifestyle should be constructed in such a way that both of the above goals could be realized.

**Social Interest**

*Social Interest* is Adler's way of describing the social nature of humans, which is both innate and fostered through primary caregivers (Oberst & Stewart, 2005). Humans have to, directly from birth, rely on each other. Humans flourish in bonding with others and not in isolation (Carlson & Maniaci, 2008). People learn from each other as well as their own experiences. The belonging and acceptance of the group or family of origin is essential for survival. Individual responsibility and contribution lead to survival of not only the individual but the group. Personal success is correlated with the level of contribution to the general welfare of the group (Carlson & Maniaci, 2008). An absence of the cultivation of social interest becomes pathological later on, showing up in a vertical striving for power "against" the others (Oberst & Stewart, 2005).
An individual's degree of social interest is an indicator of mental health (Modzierz et al., 2007). Socially-interested individuals are participants and contributors. They feel appreciated and appreciate, and accept other people (Oberst & Stewart, 2005). They are able to love and be loved (Oberst & Stewart, 2005). Our actions, if socially-interested, should not just be for our own benefit but the benefit of others and even "the whole of humankind" (Oberst & Stewart, 2005). A person can only succeed on a personal level by contributing to the general welfare of others (Carlson & Maniacci, 2008). The person is always viewed in context, relationally; indivisible within themselves, and with others (Oberst & Stewart, 2005). Character (Adler's term for "personality"), is then formed in the context of society (Oberst & Stewart, 2005, p. 18).

**Movement and Teleology**

Adler saw behavior as purposeful and goal-directed or *teleological* (Oberst & Stewart, 2005, p. 10). Teleology espouses *movement* towards a goal, Adler (Ansbacher & Ansbacher, 1964, p. 87) said "all is movement." Mammals, unlike root-anchored plants, move; and movement needs a goal, something to move towards (Adler, 1927; Ansbacher & Ansbacher, 1964). In Adler's case a self-constructed *fictional goal*, is the organizing factor behind a person's thoughts and behaviors (Ansbacher & Ansbacher, 1964). This makes the individual, in Adler's words "both the picture and the artist" as they create their lives and influence their circumstances towards that goal (Ansbacher & Ansbacher, 1964, p. 177).

Freud's drive theory was lacking, Adler believed, in a direction for the drive to focus on. Adler argued that humans are wired for movement, and that that movement is toward a goal, "from a minus to a plus" position; or specifically, the goal of success, superiority or overcoming (Carlson & Maniacci, 2012).
Usefulness and the Vertical and Horizontal Plane

The term useful is applied within the context of teleology and behavioral purposefulness (Rasmussen, 2003). Rasmussen (2003) explained that behaviors have adaptive purposes whether they are consciously comprehended by the individual or not. The attainment of a desired outcome is the "felt plus" (Ramussen, 2003, p. 345).

Dreikurs posited that the desire for self-elevation was not a natural one, but socially imposed and fostered by inferior feelings (1957, p. 153). The uncompensated desire to be useful is instead driven by social interest towards the wellbeing of others (Dreikurs, 1957). Sicher (as cited in Dreikurs, 1957) introduced the idea of movement on the horizontal and vertical planes p. 153). Dreikurs (1957) explained that competitive movement is vertical, where socially-interested movement is horizontal. Contribution on the horizontal plane creates fulfillment for self and others, striving on the vertical place can never be satisfied as the competition has no end (Dreikurs, 1957).

Life Style

Life style is the Adlerian concept of unified personality development. This psychological blueprint to fulfill the tasks of life is self-created and self-refined (Watts & Carlson, 1999). It is developed in the child before the age of four or five (Griffith & Powers, 2008). The life style governs the development of values and rules for living within a social context (Watts & Carlson, 1999). "All the components of the mind spontaneously organize themselves according to individual self-set goals." (Gomez et al., 1994, p. 290). The sense of self is created relationally in the context of the family constellation or the family of origin's structure, dynamics and values. That first environment frames the individual's future interpretation of the world (Watts & Carlson, 1999).
Organ Inferiority, Aggressive Drive and Masculine Protest

Adler believed all behavior (which includes "thinking, feeling and doing") is purposeful and goal-directed (Carlson & Maniaci, 2012, p. 117). Adler began with theories on organ inferiority, meaning that a child born with inferior organs initiates compensatory behavior. He briefly espoused an offshoot of drive theory using aggression as the primary focus and move away from drive theory when he developed the concept of masculine protest. Masculine protest is the need for competency and mastery focused towards male superiority in both boys and girls because of the context of a male-dominant society (Carlson & Maniaci, 2012).

Inferiority

Teleology was emphasized as Adler combined the above three theories of organ inferiority, aggression drive, and masculine protest into a unified theory of holism (Kottman & Heston as cited in Carlson & Maniaci, 2012, p. 117). Adler concluded through the observation of organ inferiority that "any psychological trouble is a consequence of 'inferiority'" (Oberst & Stewart, 2005, p. 22). Individuals strive for superiority to compensate for feelings of inferiority (Oberst & Stewart, 2005, p. 201). Inferiority feelings are obstacles to the development of social interest (Dreikurs, 1945).

Discouragement and inferiority. Feelings of inferiority can arise from discouragement with many underlying sources (Oberst & Stewart, 2005, p. 23). For example, discouragement could arise from not being loved, being pampered, neglected, abused, inadequately cared for, or born with or later develop poor health. If positive self-esteem is not established, the self-concept is challenged when the child compares themselves to others who are deemed somehow superior (Oberst & Stewart, 2005). A private logic or maladaptive schemata can develop incorporating these inferior feelings (Oberst & Stewart, 2005, p. 138). The neurotic will likely have these
feelings of worthlessness deeply buried within themselves. This private logic is contrary to "common sense," and can manifest in self-defeating behaviors (Oberst & Stewart, 2005, p. 25).

Discouraged individuals strive for superiority through vertical power-seeking, and the desire to outdo others. They move towards superiority in useless ways that defeat themselves and do not enhance the lives of others. Unconscious strivings that seek to obliterate inferior feelings, will show up as symptoms (Oberst & Stewart, 2005). These neurotic symptoms are an excuse to be let out of the responsibility of social interest (Oberst & Stewart, 2005). "Yes, but" is another way of describing how the individual will behave in relation to this, for example "I want to do __________, but I am too anxious, so I can't" (Oberst & Stewart, 2005).

**Pampering and Neglect**

A pampered child did not have to put forth any effort to get his or her needs easily met (Ansbacher & Ansbacher, 1964), but learned to look to others for success and achievement. Pampered children have learned to devote their interests to themselves and did not learn how to benefit from cooperating with others. There is an attitude of entitlement to receive without effort. When tasks become difficult as the pampered child ages, neurotic symptoms begin to appear (Ansbacher & Ansbacher, 1964).

Pampering does not just mean being spoiled or doted on by caregivers. A neglected child (or the child who perceives him or herself to be neglected) can also adapt an entitled or pampered life style (Ansbacher & Ansbacher, 1964). To clarify, one could say that instead of being pampered, the individual instead desired to be pampered. The creative force is at work in the development of the pampered life style (Ansbacher & Ansbacher, 1964).
Safeguarding

When a symptom is unconsciously used to protect the individual from the discovery by self and others of being inferior, it is called safeguarding (Oberst & Stewart, 2005, p. 27). Safeguarding would be comparable to a defense mechanism in psychoanalytic terms (Oberst & Stewart, 2005). An offshoot of the above would be a hesitating attitude, in which the movement is backwards, "back and forth" or stands still (Oberst & Stewart, 2005, p. 27). A hesitating attitude manifests as indecision, useless, non-productive busyness, self-doubt and the discernment of a constant barrage of obstacles in the way of success. Guilt can also be a safeguarding behavior (Oberst & Stewart, 2005).

Compensation

The fictional goal serves the purpose of compensating for inferiority feelings (Ansbacher & Ansbacher, 1964). The larger the feelings of inferiority the greater the need to compensate through safeguarding tactics. If the child is deprived the sense of lack is internalized and the child orients themselves towards gain. The helpless or insecure child will move towards a means to satisfy needs for power and security (Ansbacher & Ansbacher, 1964).

Tricks of Self-deception

The "but" portion of the "yes, but," is a trick, lurking just below the surface of awareness (Oberst & Stewart, 2005, p. 30). The individual uses this trick to deceive themselves (Oberst & Stewart, 2005). The suffering, such as the misery alcoholism produces, provides a way out of fulfilling the tasks of life and disguises the "striving for superiority" (Oberst & Stewart, 2005, p. 30). The pain of feeling worthless, unlovable, inferior, or like a failure, lies beneath the suffering. The pain produced by the symptom is easier for the individual to face than the suffering lurking beneath. In situations that the individual finds unfavorable, this trick of self-deception provides
compensation for feelings of inferiority and at the same time an appearance of triumph (Oberst & Stewart, 2005).

**Differentiation, Private Logic and Common Sense**

Dreikurs felt there was often little distinction between normal and neurotic behavior (1945). When facing conflict, a neurotically-inclined person tends to choose to hide their illogical choices from themselves. Private logic then unconsciously reigns over common sense when it serves the purpose the individual has chosen to move towards. Excuses or alibis cover the need to comply with the promptings of conscience. The neurotic recognizes their degree of conflict, and their need for help, and can benefit from psychotherapeutic help (Dreikurs, 1945).

Dreikurs (1945) explained that between neuroses and psychoses the difference is structural rather than quantitative, although lines between the two dynamics can get blurred. Psychotic behavior differs in that private logic has now completely taken over. Self-deluded, there is no longer *inner conflict* as social interest in the psychotic has been abandoned in support of their newly constructed world with its own self-serving value system, which ignores the values of others (Dreikurs, 1945, p. 39). The psychotic is generally conflict-free, does not ask for help or benefit from treatment (Dreikurs, 1945).

**Adlerian Psychodynamics**

**Neurotic Psychodynamics**

Adler differentiated between *neurotic* and *psychotic psychodynamics* (Carlson et al., 2008, p. 94), as patterns which govern behavior. Psychotic behavior according to Carlson, et al (2008), and Carlson and Maniacci, (2012) is uncooperative, aggressive and forward moving. Neurotic behavior on the other hand also is lacking in cooperation, but in a rear-facing, retreating pattern of movement which seems more in line to this writer with unproductive acts of
displacement (Dodes, 2009). Adler remarked that "...the nervous state is connected with a life of intensified affect" marked by acute sensitivity (Carlson & Maniacci, 2012, p. 199). He traces this heightened sensitivity to feelings of inferiority (Carlson & Maniacci, 2012).

A healthy person (defined as socially interested, encouraged, and able to use common sense rather than private logic) can have a "yes, I can" attitude about life. Highly sensitive to criticism, neurotically-inclined people respond to challenges with a "Yes, but I am sick " attitude, which excuses them from potentially exposing their inferiority (Carlson et al., 2008).

Strong-willed children fall into "yes, but" behavior, as they want to get their way while still maintaining support and approval (Carlson et al., 2008). These children behave compliantly, but pursue their own agenda. Obedience creates a feeling of oppression in them which they will assuage using illness or injury to justify non-compliance. Through their symptoms, they rationalize (through symptoms) reasons why they could not do what they really did not want to do anyway. A strong connection to their personal agenda conflicts with their desire to be approved, or to insure connection (Carlson et al., 2008).

**Psychotic Psychodynamics**

Perhaps originating in organ inferiority, Carlson et al., (2008) posited that the use of psychotic psychodynamics is rooted in escapism. Common sense is present but trumped by more favorable private logic. Instead of "yes, but" their answer to life's challenges is "no." Fearful of being challenged, they retreat into a safe secure inner world when demands present themselves (Carlson et al., 2008).

**Personality Disordered Psychodynamics**

Safeguarding through being aggressive towards and depreciative of others, personality disordered individuals are also very strong-willed. They are always right and everyone else is
therefore always wrong (Carlson et al. 2008). "Yes, but I will do it my way is their response to challenges (Carlson et al., 2008, p. 97). They believe that their private logic is common sense, therefore all who disagree with them are wrong. Where the neurotic and psychotic feel inferior from the start; the personality-disordered individual cannot empathize with others; but gets angry when challenged, gets into conflict and then feels inferior. While neurotic and psychotic behavior can lead back to common sense eventually, personality disordered individuals have no stable base to return to. They therefore will continue to butt heads with the "wrongness" of others, conflict after conflict (Carlson et al., 2008).

Adlerian Psychodynamics versus the DSM IV

Carlson et al., (2008) compared the three psychodynamic categories above with the DSM IV (American Psychiatric Association, 2000) classifications. They put anxiety, dysthymia, dissociative and somatoform disorders in the neurotic category; schizophrenia, bipolar, major depression with psychotic features, and delusional disorders in the psychotic category. Personality disorders would stay within the DSM categories such as Antisocial Personality Disorder (American Psychiatric Association, 2000; Carlson, et al., 2008).

For the purposes of this paper (regarding addictive responses in general), this writer would chose a neurotic psychodynamic theoretical basis. That is not to say that those using psychodynamic or personality disordered psychodynamics cannot become addicted or use substances or behaviors as displacements. However, it seems possible to hypothesize that those individuals would be harder to treat for substance use disorders using Dodes' theory.

Processing Styles in Neurodynamics

Forgus and Shulman (1979) summarized in Carlson et al., (2008) highlight styles in which people process information, one of which is locus of control. These theories of internal-
external control were researched by Rotter, (1966). Individuals with an internal locus of control, see action located internally, and those with an external locus of control see action located externally (Carlson, et al., 2008, p. 48). Externals believes their circumstances to be under the control of others, internals are able to find a connection between their own responsibility and actions (Rotter, 1966).

For example, data gathered on young children of alcoholics shows them having greater degrees of externality (Post & Robinson, 1998). They feel they have less control over the circumstances (Post & Robinson, 1998). Post and Robinson (1998) report these children lack initiative in attempting to impact their circumstances, which could later hamper achievement. Helping them overcome these difficulties entails moving them towards an internal locus by teaching them they are responsible for their own behavior not their parents, by giving choices, and fostering autonomy (Post & Robinson, 1998).

An external locus of control can become a built-in line of defense (Hochreich, 1975). All failures then become the fault of externally originated factors. In that case, there is no need for repression or denial. Hochreich (1975) divides those who truly believe in an external governance of their situations, and those who use it to their advantage is specific circumstances, such as explaining away a failure. Hochreich calls the first group true or congruent externals (1975, p. 541) and finds they exhibit a passive acceptance of their situation. The second group is called defensive externals, ambitious individuals who project blame when they don't receive favorable outcomes (Hochreich, 1975, p. 541). Hochreich (1975) concludes there is a relationship between goals that are highly valued or individual needs that have gone unmet and the projection of blame.
Considering the above information, this author would hypothesize that partnering with the client in moving towards an internal locus of control would be helpful in the reorientation away from compulsive displacement reaction in the face of threats to the self-esteem.

**Symptoms**

**Neuroses and Symptoms**

The opinions formed regarding self, others, and the world that an individual bases his or her movement upon are generally beneath their level of understanding, and often require psychotherapeutic insight to access. The *style of life* is based on the self-imposed laws that govern the individual's movement (Ansbacher & Ansbacher, 1964, p. 195), their subjective evaluation or perception of circumstances. Adler posited that "the pressure of the earliest situations in the child's life," (Ansbacher & Ansbacher, 1964, p. 93) channels the movement towards a *fictional goal*. This goal may not survive a reality check and is therefore based in the individual's *private logic*, or *schema of apperception* (Carlson et al., 2008, p. 24).

Dreikurs (1945) explained that neurotic symptoms originate in the face of circumstances, situations, or precipitating events; discouragements that causes difficulties the individual finds themselves inadequate to handle. The type of situation or event will vary with the individual and their life style. The direction of the neurosis can be determined by the use of "the Question," which is detailed later in this paper as an intervention. An example might read, "What would you do, or how would your life change if you were well?" The client is sick because they unconsciously want to avoid whatever they answer (Dreikurs, 1945), as they believe they are unequal to the tasks at hand and if attempted they would suffer too great a blow to the self-esteem.
It should be again pointed out, that they client is not aware that their symptoms are an excuse that enables them to avoid responsibility (Dreikurs, 1945). Dreikurs' (1945, p. 41) explanation for the use of symptoms reads thus, "a human creation built after the image of a disease." But, because the individual believes this construct, and the symptoms are actually being experienced, "he really is sick, for all practical purposes" (Dreikurs, 1945, p. 41).

**Psychic Shock**

The private logic may be skewed by what Adler calls *psychic shock* (Carlson & Maniacci, 2012, p. 201). When a child is unprepared to meet life's problems or tasks which Adler (Carlson & Maniacci 2012, p. 15) divided into the areas of relating to others, love, and work; shocks or difficulties which persist and become chronic, block forward movement (Carlson & Maniacci, 2012).

**Adler on Narcissism**

When connection with others is denied, the child turns upon himself as the love object (Ansbacher & Ansbacher, 1964). This author finds these words of Adler's descriptively influential, "When a child sees himself as if in enemy country and believes he cannot accomplish anything anymore" (Carlson & Maniaci, 2012, p. 27). "Weakness, inferiority, lack of social interest, the seeking of ease, an exclusive self-reference, and lack of obligation towards others, are ways that Adler describes the narcissistic temperament (Carlson & Maniaci, 2012).

**Adler on Compulsion Neurosis**

A neurotic reaction to a perceived problem results in a *compulsion neurosis*. A compulsion neurosis, according to Adler, is caused by *discouragement*, and is used to create distance between the individual and necessary decision making (Ansbacher & Ansbacher, p. 305), creating a block between themselves and forward movement. Compulsion neuroses compel
the individual to take an action which they are able to recognize as absurd, but which they perform in order to relieve anxiety (Ansbacher & Ansbacher, 1964).

This author believes that neurotically compulsive behavior could be correspondent with drinking when you are in recovery even though you know the consequences. The feelings of insecurity and inadequacy, or of "not being able" posited by Adler, can be correlated to Dode's feelings of helplessness (Ansbacher & Ansbacher, 1964, p. 305).

Adler goes on to say that compulsive neurotics divest to a "secondary field of action" where all of their energy is expended (Ansbacher & Ansbacher, 1964, p. 305). Therefore, the primary problem goes unsolved. Looking at addiction as a compulsion neuroses, we might speculate that this secondary field of action is addiction. Life for the compulsive neurotic is full of anxiety building demands and unsolvable problems that become constant reasons for concern (Ansbacher & Ansbacher, 1964).

Ultimately, a neurotic compulsion is the feeling of incompetence to face life's realities and evade failure (Ansbacher & Ansbacher, 1964), as failure threatens the self-esteem. Adler said, "All forms of failure are movement forms of an inferiority complex." (Ansbacher & Ansbacher, 1964, p. 185.)

**Interrelated Phenomenon**

**Shame, Anxiety, Perfectionism, Abandonment and Worthlessness**

This writer believes the emotional experiences of shame, anxiety, and perfectionist tendencies are of relevance when examining the connection between narcissistic rage and addiction, as they are related to the identification of the psychological triggers individuals struggle with that lead towards addictive actions. These areas of relevance will be later compared to Pew's psychological priorities, with appropriate interventions following.
Shame

"The experience of shame is a fundamental sense of being defective as a person, accompanied by fear of exposure and self-protective rage" (Kaufman, 1974, p. 568). According to Kaufman (1989, p.5), shame is central to the development of conscience, identity, self-esteem, self-image, body-image, and "the source of feelings of inferiority." Kaufman believed shame begins pre-language, when a relationally significant figure such as the parent, breaks what he calls the *interpersonal bridge or emotional bond* between people (Kaufman 1974, p. 568, 570). Kaufman (1974) relates this emotional tie or bond to the development of trust. This injury can be sustained through *inappropriate responses* to the child by the care-giver, or displays of anger towards the child (Kaufman, 1974, p. 568). This is most impactful when the relationship is ongoing (Kaufman, 1974), and takes place in early childhood when the bond is needed for survival.

Though experienced differently by different individuals, shame's common factors seem universal; such as physical symptoms, intrusive thoughts, sapped spirit, and beginnings of behavior issues (Potter-Efron, & Potter-Efron, 1989). Physically, those in the grip of shame might experience downcast eyes, thumping heart, a cold feeling in the gut, or a shrinking feeling of smallness (Potter-Efron & Potter-Efron, 1989).

Actions taken to alleviate feelings of shame can include paralysis, stolen energy or weakness, desire to escape, and withdraw from situations, perfectionistic tendencies, becoming quickly critical of others, and suffering rage attacks (Potter-Efron & Potter-Efron, 1989).

Spiritually, shame can make a person feel worthless to the point of doubting their right to exist. In addition, shame can leave a person with a hollowed out feeling and contribute to the projection of an identity-lacking mask, and conversely, lead to an arrogant persona (Potter-Efron

**Shame and Rage**

Kaufman (1974) outlined the path to a rage and shame connection. Kaufman (1974) related a story of a boy wanting attention from his tired father when he comes home from work. When the father did not appropriately connect to the boy's need, the boy felt bad, perceiving the incident as proof of the inappropriateness of his neediness. The boy isolated himself in order to protect and distance himself from possible further injury. When the father figures out the boy had a need he did not address and goes to find him, the boy reacts with rage. The incident is in the area of that emotional bond, and the boy's rage is internal towards his own feelings of badness and external to protect him from further shame. The child does not have the capacity to repair the bond, and rages against the repair further intensifying the problem. If the father reacts with his own rage as his son's behavior taps into his own shame, a difficult battle will ensue (Kaufman, 1974).

Parental anger also severs the emotional ties, and the adult needs to begin the repair by being sensitive and responding appropriately to the child's needs (Kaufman, 1974). Especially important in this process is the response to the child when the child reaches out after an angry incident. If the child reaches out to be held, the adult, even if still angry, must comply, or the child's establishment of autonomy will be threatened (Kaufman, 1974). Kaufman (1974, p. 572) related this counterintuitive maneuver of holding the child at this time "...powerfully reinforces the self-affirming capacity within the child that lies at the heart of a secure identity".
This writer feels that it is important for the clinician to be aware that shame is often concealed, or even beneath the level of the client's awareness (Morrison, 1989).

**Adler on Shame**

Adler stressed the psychological dominance of inferiority-based feelings of incompleteness or imperfection (Ansbacher & Ansbacher, 1964). Adler correlated distressing life circumstances such as loss and disappointment to the following globally experienced emotional states: "anxiety, sorrow, despair, shame, shyness, embarrassment, and disgust" (Ansbacher & Ansbacher, 1964, p. 117). Adler noted that these inferiority feelings can lead to productive outcomes when the individual is motivated by social interest. This writer would surmise from the above that feelings of shame are related to feelings of inferiority, and could be treated by fostering appropriate social interest (Ansbacher & Ansbacher, 1964).

**Anxiety**

Kernberg (1992) referred to an intolerance for anxiety as a non-specific aspect of *ego weakness*. Any anxiety in addition to that which is usually experienced will trigger an attempt to change the situation, *ego regression*, and additional presentation of symptoms (Kernberg, 1992). The ego, according to Snowden (2006) is what the individual would call the self. "...it is not the degree of anxiety which is important here, but how the ego reacts to any additional anxiety "load"" (Kernberg, 1992, p. 22).

Rollo May summarized that fear in children develops and increases along with them as they mature (May, 1977). May (1977) draws on the work of Jersild (1933) in stating that children's fears as they mature seem related to imaginary dangers such as ghosts; and animals they have never seen such as wolves or tigers (May, 1977).
May (1977) posited that underlying anxiety is the culprit when children's fears vacillate away from an identified stimulus. In the case of these free floating fears, May (1977) noted, verbal reassurances become ineffective to calm the child. Instead the anxiety-based fear will move to a new object. May (1977) goes on to say that within the family structure, the anxious parent's disruptive pattern of relating to their children, causes the children to be more fearful and anxious in turn.

As the child ages and moves out of the home into society, competition-based fears evolve, including "loss of prestige, ridicule and failure" (May, 1977, p. 103). The latter types of fears are highlighted when adults remember childhood incidents, which is not the case when children that age are questioned about similar situations (May, 1977). May (1977) related this to the phenomenon of adults linking their matured fears to their childhood experiences.

**Adler on Anxiety**

Adler used anxiety to describe symptoms such as phobias. He later began to label anxiety as a safeguarding maneuver, taking the individual away from inferiority feelings (Ansbacher & Ansbacher, 1964). In highlighting similarities between the work of Adler and Horney, Oberst and Stewart (2005, p. 124) remarked "basic anxiety represents the experience of feeling alone and vulnerable in a harsh and unforgiving world." The authors then related this to Adler's concept of social interest, in that the need for a supportive community and the developmental lack thereof creates basic anxiety that is calmed through neurotic, safeguarding means (Oberst & Stewart, 2005).

**Shame and Perfectionism**

Kaufman (1974) also correlated shame with perfectionism. It is the process of comparison that highlights the differences between people. This comparison then takes on a
value judgment of if this is good than that is bad, or if this is better than that is worse (Kaufman, 1974). Through this process people begin to value themselves as defective or deficient. This has to be interrupted by relationally important people in our lives placing value on our uniqueness (Kaufman, 1974).

**Perfectionism**

According to Lombardi, Florentino and Lombardi (1998) the purpose of perfectionism is to avoid failure, by being the absolute best at everything; by not trying at all, rendering failure impossible; or by concealing mistakes and deficiencies from others. The authors believe anxiety and depression are also related to perfectionism. Anxiety manifests when a perfectionistic individual cannot achieve perfection; and depression when guilt or sadness over unmet expectations of perfection occur (Lombardi Florentino & Lombardi, 1998). The Adlerian authors (Lombardi et al., 1998) related psychopathologies including neuroses, alcoholism, addiction, and suicide to perfectionism.

Adler saw the striving for perfection as, as an innately felt, developmental urge, (Carlson & Watts, 2012). Adler related that perfectionism is inherent in all upward striving (Carlson & Watts, 2012, p. 48). Adler noted that some people, in their striving, leave the life tasks unsought and therefore uncompleted, in order to not fail in their unattainable goal of perfection (Carlson & Watts, 2012). There can be an attempt to exclude life’s difficulties when the child feels too inferior to have the strength to deal with them (Ansbacher & Ansbacher, 1964, p. 399).

**Abandonment**

A 2005 study was done by Waller and Barter on subliminal abandonment cues and eating behaviors. Waller and Barter (2005) cited previous studies that linked subliminal cues of abandonment to binge eating patterns. The authors (Waller & Barter, 2005) related, that as these
subliminal cues are beneath the level of cognitive awareness, cognitive behavioral therapy may not be able to help the individual access the cues in order to be able to challenge the thoughts.

The authors (Waller & Barter, 2005, p. 159) referenced Gerard et al. (1993), Meyer and Waller, (1999) and Patton (1992) in linking "preconscious abandonment related information" to the activation of abandonment schemas. Waller and Barter (2005, p. 159) also referenced Klosko, Weishaar, and Young (2003), noting that "escape behaviors are used to block conscious awareness of that schema-level information and its affective consequences." While the escape behavior in the above presented study (Waller & Barter, 2005) was eating, this author joins Dodes (2209) in relating this to addictive behaviors in general.

This author was unable to find any specific Adlerian ties to the subject of abandonment, or bonding, although, this author feels topic of neglect is probably closely linked. In Ansbacher and Ansbacher (1964, p. 242), Adler noted that the pampered style of life is the child's creation, and the symptoms such as a neurotic "weakness and need for support," created out of it could stem from a history of neglect just as readily as from a history of being pampered.

Worthlessness

This author believes that a distinction between feelings of worthlessness and feelings of shame can be made. Adler emphasized that the suffering caused by neurotic patterns resulting from psychic shock are real, paralyzing in regards to movement patterns, and unwanted by the client. Unconsciously, the symptoms are suffered rather than the exposure of worthlessness. A desire to be rid of their painful symptoms, an underlying fear of being exposed as worthless or without value, and the desire to achieve this without effort on their part seem to coexist in these clients. The client cannot comprehend freeing himself through his or her own action. As that underlying fear of exposure might trigger suicidal ideation in clients with more active movement
patterns, caution is to be observed in treating these clients. The client must not be coerced or treated severely, but prepared gradually through encouragement to tackle their underlying feelings of worthlessness (Carlson & Maniaci, 2012).

**Review of Classical Adlerian Addiction and Treatment Theory**

**Adler on Addiction**

Alfred Adler (1932, p. 16) referred to therapists who treat addiction as a "fellowship of lifesavers" (Carlson & Slavik, 1997, p. 241). Ansbacher and Ansbacher (1964) contains Adler's original views on drug addiction and alcoholism. Adler felt that exposure to drugs could arise from outside sources, but it is the insoluble life problem that he claimed activates the addiction (Ansbacher & Ansbacher, 1964). "In all cases of addiction we are dealing with people who are seeking alleviation in a certain situation" (Ansbacher & Ansbacher, 1964, p. 423).

With drug addiction, Adler observed less movement than with alcoholism. Adler noted that a predilection towards addiction begins with behaviors like, shyness, hypersensitivity, irritability, impatience, a preference for isolation; and in the neurotic category, depression and anxiety, and sexual symptoms. Adler noted that chemical use creates a feeling of relief from burden, or from the oppression caused by inferiority feelings (Ansbacher & Ansbacher, 1964).

**Dreikurs on Addiction**

Dreikurs (as cited in Mosak, 1990, p. 210) noted that the whole person who struggles with addiction must be taken into consideration during treatment, and reminded Adlerians that the "law of individual life style" would apply to the manifestation of their addiction. Dreikurs (as cited in Mosak, 1990, p. 210) blamed addictive thinking on a lack of social interest combined with a pleasure-seeking attitude (that Adler had previously termed *sweet-toothedness*), leading to a tendency to shirk responsibility.
Dreikurs quoted Adler (1990, p. 210) in noting that alcohol and drug use can be seen as an evasion of disappointments, humiliations, work problems, and relationship issues; and can bring about a feeling of a jovial *pseudo-community* that displaces real community. Responsibility can be avoided in the same manner as neurosis, while blaming the symptom of addiction (Dreikurs, as cited in Mosak, 1990) for the failure of the ability to succeed.

Addiction is then treated as other neuroses would be, by examining the life style that has rejected social interest and looks at mankind as the enemy (Dreikurs as cited in Mosak, 1990). Dreikurs (as cited in Mosak, 1990) espoused abstinence during treatment and group therapy to help maintain sobriety. Similar to the twelfth step, (Alcoholics Anonymous, 2001), Dreikurs felt those who can find ways to help others stay sober will help themselves as well (Mosak, 1990).

Mosak highlighted Dreikurs’ inclusion of possible organ inferiority contributing to addiction in his preface to Dreikurs’ article (Mosak, 1990). He noted that Dreikurs did not comment again on this physical connection to addiction to the best of his knowledge (Mosak, 1990).

Dreikurs also referenced drugs and alcohol functioning as *temper* in the way that it is used to portray superiority and create fear in others whom the individual wishes to control (Dreikurs, as cited in Mosak, 1990). Dreikurs (as cited in Mosak, 1990) noted blaming, as well as feeling pressured by the environment, to be common behaviors related to addiction. To this author, that seems to echo the above referenced inferences of an external locus of control (Hochreich, 1975; Rotter, 1966) in relation to addiction.
Review of Contemporary Adlerians on the Treatment of Addiction

Adlerians on the Disease Model

In agreement with Dodes (2014, subtitle); who attempted to "debunk the bad science behind the 12-Step Programs and the rehab industry" in his latest book The Sober Truth; most of the 16 Adlerians responding to a poll created by Carlson and Slavik (1997), did not agree with the disease model of addiction. Dodes (2014) maintained that Alcoholics Anonymous embraced the disease model, (originally comprised by Jelinek who later steered away from it), as it fell in line with their concept of the uncontrollable nature of addiction and their own definition of powerlessness over substances, which differs from Dodes' helplessness.

Adlerians on AA's Powerlessness

On powerlessness versus self-determination, the contemporary Adlerians polled either rejected powerlessness from the Alcoholics Anonymous point of view, or looked at the concept as a trick or ploy that paradoxically allows for change to occur. Some of those polled thought it could be used to help decide towards health, others saw no conflict between the viewpoints (Carlson & Slavik, 1997).

Problem Drinking versus Physical Dependence

Carlson and Slavik (1997) differentiated between problem-drinkers and alcoholics, from the standpoint of whether or not the client is physically dependent on the substance. In Carlson and Slavik's opinion (1997), problem drinkers (not physically dependent) should be allowed to take part in a program that does not embrace total abstinence, unless they cannot achieve their individual and socially appropriate goals.
Abstinence

Regarding continuing abstinence from mood altering substances, this writer would here interject non-agreement with Carlson and Slavik's (1997) viewpoint in this area. Sperry, cited in Carlson and Slavik (1997), reminds the reader that the biopsychosocial approach to treatment is in line with Adler's concept of holism. To this writer, an experienced, licensed drug and alcohol counselor, Sperry's point is a valid argument for advocating abstinence, as she agrees with Adler (Ansbacher & Ansbacher, 1964) that the body and mind are integrated.

Adler observed that "It is always necessary to look for these reciprocal actions of the mind on the body, and of the body on the mind, for both of them are parts of the whole with which we are concerned" (Ansbacher & Ansbacher, 1964, p. 225). This integrates with Adler's theories on organ dialect which tied somatic symptoms to mental attitudes (Griffith & Powers, 2007). Because of this, it would seem to this writer that a mental trigger would consistently remain associated with a physical trigger to use substances. Consequently, the level of dangerousness and possible lethality that relapse can bring, is in this author's opinion too great a risk to advocate a return to substance use.

Treatment Recommendations for Alcoholism

Carlson and Slavik (1997, p. 236) reviewed their recommendations for treatment of what they term problem drinkers. In this section, the authors (Carlson & Slavik, 1997, p. 236) again differentiate between those they term problem drinkers who are not physically dependent on alcohol, and alcoholics, who they describe as physically dependent. Drug addiction is not mentioned in these above passages (Carlson & Slavik, 1997).

The promotion of prosocial goals in order to replace the goals of chemical use is the focus in the area of social interest. The purpose of drinking and the need for the individual to
establish personal goals is the teleological aspect (Carlson & Slavik, 1997). Looking at the client holistically is espoused, rather than labeling with the name of the addiction (Carlson & Slavik, 1997). The above authors believe the client should use self-determination in their choices regarding continuing to use alcohol in the future (Carlson & Slavik, 1997, p. 237). The experiential uniqueness of the individual and their circumstances is emphasized in the area of phenomenology (Carlson & Slavik, 1997, p. 237).

Understanding the patient is key, and Carlson and Slavik (1997, p. 237) recommended this process be enhanced through identifying mistaken goals and beliefs in conjunction with alcohol use; determining what is gained and what is avoided by the use of alcohol (Brown, 1991, as cited in Carlson & Slavik, 1997, p. 237); and using Adler's Question (described later in this paper).

Also included in Carlson and Slavik's (1997) personal interpretations for treatment, were the use of Adlerian treatment principles including focusing on the life tasks, and aligning clients goals with treatment, rather than fighting denial. Also proposed were the establishment of coffee house-type social outlets for like-minded discussions and sober intellectual pursuits (Carlson & Slavik, 1997).

**Treatment Recommendations for Drug and Alcohol Addiction**

Cooley (Carlson & Slavik, 1997) espoused several time-honored interventions in the treatment of addiction, including Alcoholics Anonymous attendance, group therapy, and individual therapy for chemically dependent clients.

Of note, Cooley (Carlson & Slavik, 1997) cautioned therapists against moving too quickly into interventions that dug up the client's past, such as Adler's life style. Cooley reminded practitioners of the fragility of the client during the first year of abstinence, which may
be hidden under an appearance of competence, and confidence (Carlson & Slavik, 1997). Cooley (Carlson & Slavik, 1997, p. 245) highlighted the chemically dependent client's use of denial, in the service of protecting their relationship with the substance. She reminded therapists that recovery is a grieving process, as well as a time of physical healing from damages incurred by use (Carlson & Slavik, 1997). She championed the involvement of family members whom she believed should attend sessions separately from the client.

Cooley (Carlson & Slavik, 1997) warned therapists of bipolar-like symptom cycle clients can exhibit while weaning off of chemicals and cautioned not to turn to medication prematurely in those cases. Cooley related these three cycles in the following way. During the first stage the client may be artificially calm or euphoric (Carlson & Slavik, 1997). During the second stage, withdrawal, the client may exhibit fearful anxieties or reactive depression (Carlson & Slavik, 1997, p. 247). During the third stage, Cooley chronicles "manic anticipatory build-up toward the next chemical episode" (Carlson & Slavik, 1997, p. 247). The exceptions (indicators for medication therapy of chemically dependent clients in Cooley's opinion were); if the client's moods continue to be destabilized after a period of abstinence, if the client is psychotic, or during medically monitored hospital stays for withdrawal purposes (Carlson & Slavik, 1997).

**Paralleling Dodes' Theory: An Adlerian Etiology of the Addictive Process**

Referencing Adlerian theory, this writer will place addiction into the category of neurosis (Ansbacher & Ansbacher, 1964). The self-image is formed in the interaction between the child and their early caregivers. Thus, if social interest is not adequately fostered during that period, the self-image is inadequately formed. Hindrances to the fostering of adequate self-image and social interest might be severe parenting, pampering, neglect or abuse or parental busyness, and other types of psychic shock. The child becomes discouraged, and develops feelings of
inferiority (Ansbacher & Ansbacher, 1964). The child will continue to seek superiority in any manner they find works for them in order to compensate for what they have lost (Oberst & Stewart, 2005). In this process, the child self-creates a neurotic life style (Carlson & Maniacci, 2012). Adler said, "The condition of the body and the impressions of the external world are the building materials which the child uses for the construction of his personality" (Carlson & Maniacci, 2012, p. 201).

Private logic is formed beneath the level of awareness that supports thoughts and behaviors that help the individual avoid failure and inferiority feelings (Carlson & Maniacci, 2012). Whatever fits in with the private logic and life style is used, and whatever does not fit is discarded (Watts & Carlson, 1999). Powerlessness is now equated with whatever makes the person feel inferior, or as Adler referenced, Nietzsche's "will to power" (Ansbacher & Ansbacher, 1964, p. 244).

Hypersensitivity to slights, despising or discounting others are safeguarding techniques to protect the self-esteem. Exogenous factors continuously threaten defeat (Carlson & Maniacci, 2012). "This state of heightened emotion always springs from the fear of a final defeat" (Adler cited in Carlson & Maniacci, 2012, p. 204). Adler cautioned, however, that fear might not be the operative feeling under all neurotic symptoms (Carlson & Maniacci, 2012). The symptoms found in those displaying neuroses and psychoses are either inborn physically or acquired psychically (Ansbacher & Ansbacher, 1964). These factors are always intertwined and influence each other (Carlson & Maniacci, 2012). This writer speculates that anxiety-catalyzing narcissistic rage could be classified as fear of being discovered as worthless.

Overcoming through socially interested behavior may seem an insurmountable problem to those with established addictive or neurotic patterns. Meeting the tasks of life is difficult when
unprepared for socially interested behavior, and exogenous factors compound the problem (Carlson & Maniaci, 2012). Addiction becomes the side-show that prevents the individual from failing if they try to succeed (Wolfe, 2001, p. 36). The suffering of addiction is the price paid (Ansbacher & Ansbacher, 1964). Hypersensitive to stress and obligations of responsibilities, addicted individuals safeguard the threat to their self-esteem through symptoms (Ansbacher & Ansbacher, 1964). Emotions are coopted in service of the symptoms with the purpose of safeguarding through avoidance (Carlson & Maniaci, 2012). For example, fearful of possible loss of license, an alcoholic on probation gets drunk the night before court hearing for driving under the influence, subsequently failing her crucial urinalysis. Thankfully, "everything can also be different" (Ansbacher & Ansbacher, 1964, p. 194), and Adlerian therapy espouses hope, optimism, and encouragement towards successful recovery (Carlson & Maniaci, 2008).

In summary, influenced by caregiver interaction and training, as well as exogenous events, the individual creates a private logic-inspired neurotic life style (Ansbacher & Ansbacher, 1964). The neurotic symptom is a protection against "loss of prestige" (Ansbacher & Ansbacher, 1964, p. 266). The individual becomes hypersensitive to threats to superiority, or has a heightened feeling of inferiority (Carlson & Maniaci, 2012). Symptoms are developed as safeguards against threats to the self-esteem and life’s problems. “...The oppressive feeling of inferiority is temporarily removed... The immediate effects of the drug often give the victim a feeling of being unburdened” (Ansbacher & Ansbacher, 1964, p. 423). Emotions, such as rage, are coopted into the service of neurotic symptoms (Carlson & Maniaci, 2012).

Heightened inferiority leads to “exaggerated feeling of being slighted,” and an “attitude of defiance” develops (Ansbacher & Ansbacher, 1964, p. 423). This defiance can be acted out passively in “dishonest obedience,” in which inferiority is challenged through “compensatory
protest” (Ansbacher & Ansbacher, 1964, p. 423). Compulsion to use substances is the neurotic detour into the “secondary field of operation,” the “counter compulsion in opposition to the compulsion of social demands” (Carlson & Maniacci, 2012, p. 227).

**Treatment Speculations**

This writer questioned how the knowledge revealed in this study can integrate with and add Adlerian-based insight into the treatment of addiction. This writer would focus, like Dodes (2009) on helping the client find insight into the function of addiction (“the reversal of helplessness”) and the drive behind addiction (the narcissistic rage), and the compulsive additive acts as displacement.

Putting the above more into an Adlerian perspective, would mean taking a more holistic view (Ansbacher & Ansbacher, 1964). This process might start with assessing the addicted client’s life style; uncovering the mistaken beliefs that lead to feelings of helplessness, or feeling powerlessness over circumstances; helping them towards an understanding of anger as both a reaction to powerlessness, and an attempt to overcome powerlessness (Ansbacher & Ansbacher, 1964; Carlson et al., 2008). Additional insight would be to help the client see that a compulsion to use substances or addictive behaviors to assuage these feelings has been developed, and that addiction is the *sideshow* taking them away from the real underlying problem (Ansbacher & Ansbacher, 1964; Stein, 2004, p. 17).

This writer sees a correlation between Dodes’ focus on that which is psychologically or emotionally meaningful to the client, and Pew's psychological priorities (Dodes, 2009; Pew, 1976). Therefore, to treat the client who struggles with addiction, an Adlerian clinician might find the following interventions to be of value.
Adlerian Interventions

Life Style Analysis

The lifestyle interview is useful to the process of understanding the individual (Carlson et al., 2008). Carlson et al., (2008) described the lifestyle interview as a somewhat structured way to ascertain the influences of the individual's developmental experiences on the lifestyle. A lifestyle assessment can be done using prefabricated forms such as developed by Shulman and Mosak (1988), or free form (Carlson et al., 2008).

The first nine sections of a lifestyle assessment pertain to what Adler named family constellation or the way the individual's family of origin operated (Griffith & Powers, 2007). The aforementioned covers birth to puberty (Carlson et al., 2008). The last section is early recollections, and that focuses on life up to the age of ten (Carlson et al., 2008). The sections are described as sibling array; physical development; school experience; sexual development; parental influence; neighborhood and community; other role models and alliances (Carlson et al., 2008, p. 116).

Though most are self-explanatory, this writer feels the first in the series needs to be described. In regards to sibling array, the authors (Carlson et al., 2008, p. 116) referred to descriptions of the client and any siblings, with each being rated on a list of traits. Questions are then asked of the client such as "Which of your siblings is most like you in the area of school achievement?" (Carlson et al., 2008).

Areas of relevance for treatment from the lifestyle interview. From the lifestyle interview, ten areas of relevance can be gleaned which will be therapeutically useful in the client's treatment (Carlson et al., 2008). Birth order can give the therapist the client's current vantage point (Carlson et al., 2008, p. 121). This can help the therapist understand the client's
approach to life and challenges. For example, oldest children will see themselves as leaders, middle children as peacekeepers, etc. (Carlson et al., 2008). It should be noted that this is not meant to be their actual ordinal position, but it is a guess, based on the client's perception of their position. For example, children born with a lot of space in between could each develop a view of themselves as only children. Each child, by being born into it, changes the dynamics of the family (Griffiths & Powers, 2007).

*Family Values*, are formed when both parents agree on what is important in the family. This can be an indication of which psychosocial stressors are bringing the client into therapy. They are coming against what is important to the family, and therefore belonging in that family is threatened by not adhering to those values (Carlson et al., 2008).

Carlson et al., (2008) describe family atmosphere as "the prevailing emotional tone of the home." For example if chaos was the norm at home, a client may be stirring up chaos unknowingly to recreate what felt normal growing up.

*Gender guidelines* could influence the client's viewpoints in their expectations of gender-related behavior (Carlson et al., 2008). Times can also be anticipated in relation to client stress. For example, if a same-sex parent died at the age of 40, the client may reach a puzzling crisis point when 40 approaches.

The concept of the *place made by the client* can highlight behaviors and safeguarding mechanisms the client may choose to repeat in adulthood (Carlson et al., 2008, p. 121). The same would apply for the *place made by siblings* in relation to current significant others (Carlson et al., 2008, p. 121). This will create in a client the desire to find or create people or groupings who will fit into their expectations in friendship and work situations (Carlson et al., 2008, p. 121).
Other role models and alliances are those who stood in the gap for the client's family of origin's deficiencies, such as teachers, neighbors, extended family members, mentors, or others (Carlson et al., 2008, p. 121. These areas of hope in a bleak world may be the way to begin helping clients who are hesitant about treatment (Carlson et al., 2008).

The neighborhood and community can be windows into the client's capacity to empathize. If they have never been exposed to poverty or discrimination for example, they may not have the same empathy for those in those situations as others who had been exposed to it at a younger age might.

How intimacy has been established in the area of adolescence and sexuality could be an indicator for future intimate relationships and expectations (Carlson et al., 2008, p. 122). Clients may perceive these early sexually intimate encounters as shameful (Carlson et al., 2008).

Constitutional and biological factors help the therapist clue into the way the client views their bodies or themselves (Carlson et al., 2008, p. 122). A girl could perceive being tall as an asset because she wants to model or play basketball, for example; or a disability if she was always the tallest girl in class and she felt that boys have avoided her because of it.

Early Recollections

Early Recollections are an assessment tool devised by Adler to help the therapist see the way in which the client perceives and creates their world (Kern, Belangee, & Eckstein, 2004). People have a tendency to remember what has become personally meaningful to them and reinforces their lifestyle. Early Recollections are predictive of future movement patterns, hinting at developmental issues and revealing areas of interest. Early recollections can be positive, negative or neutral (Kern, Belangee, & Eckstein, 2004).
Some clients report they cannot come up with any early recollections. Kern, Belangee, and Eckstein (2004, p. 133) attribute this to "poor goal alignment between the client and the therapist," or early trauma experienced by the client that has remained unreported.

A report differs from a recollection in that the incident has been fed to the client by someone else, such as a parent or older sibling who may have witnessed or heard about the incident. Reports can be differentiated from recollections by whether or not the client can attach a feeling to the scene (Kern, Belangee, & Eckstein, 2004).

Asking the client to make up an Early Recollection can be just as useful as an actual recollection, because these will be created in the present from the perspective of the client's private logic (Kern, Belangee, & Eckstein, 2004, p. 134). Asking instead for a dream, favorite comic book superhero story, or fairy tale, may be just as effective, as regardless of the stimulus, the client will reply out of their private logic in alignment with their lifestyle. All of the above techniques would provide insight into the client's perspective of their current situations, as well as how the client would like them to be instead (Kern, Belangee, & Eckstein, 2004).

Therapeutic alliance can be strengthened through early recollections as the clinician can better estimate the type of relationship that would be the best fit for the client. For example, if a client's early recollections involve a theme of rejection, the clinician might take extra care to establish a safe, nurturing environment. Early Recollections can help lead to an understanding of somatic complaints; they can help isolate client's problem solving strengths. Collecting Early Recollections can help crystallize the extensive information gleaned from the life style interview, and if contradictory to what is gathered, can establish a more truthful, less biased picture of the situation (Kern, Belangee, & Eckstein, 2004).
Collecting early recollections. Early recollections are collected by asking the client to relate their earliest memories, especially before age ten, choosing single incidents, not something regularly occurring such as a weekly family outing. Practitioners then ask for feelings related to the recollection. It is important not to lead the client with clarifying questions, but to gather and record verbatim as much unedited information as possible. Ask them to take a mental snapshot of the most vivid part of the memory and to identify the most vivid feeling associated with that snapshot (Kern, Belangee, & Eckstein, 2004).

Interpreting early recollections. Interpreting the early recollections will become a collaborative effort with the client. The clinician will ask the client questions like "Could it be this?" as they arrive at an interpretation through partnering with the client. Each therapist will evolve their own style of assessing the recollections (Kern, Belangee, & Eckstein, 2004).

Observe the client for a recollection reflex such as a smile, a nod. A confused look will lead to further questions for identification. Watch for recurring themes and similar types of feelings. Making note of who is included in the scene, and who is left out; genders, numbers of people included, could point toward degree of social interest (Kern et al., 2004). Asking for the feeling associated may highlight the conclusions the client has made from the incident (Kern, Belangee, & Eckstein, 2004).

Psychological Priorities

According to Pew (1976, p. 1), a psychological priority is "...a set of convictions that a person gives precedence to;" it is a value established by order of importance or urgency that takes precedence over other values." It is a way the individual interprets their world that gives insight into the lifestyle. Pew (1976) noted that this information was not to be used to categorize or label, type, classify or predict client's behaviors, as people are complex, unique individuals.

The priorities are instead to be looked at as tools to promote understanding on both the
part of the clinician and the client (Pew, 1976). The number one priority according to Pew (1976) was a stand-alone concept, and not meant to be a replacement for preexisting Adlerian concepts. The number one priority gave insight into core values, promoting understanding in the therapeutic alliance, and understanding of hindrances in intimate relationships (Pew, 1976).

Kefir (1971, as cited in Pew, 1976) outlined four of these types of mistaken priorities' (noting this as an oversimplification). Kefir's (in Pew, 1976) priorities were: comfort, control, pleasing, and superiority. They answered the questions "What is most important in my quest for belonging?" (Pew, 1976, p. 4). And, "What must I most urgently avoid?" (Pew, 1976, p. 4). The two are correlated in terms of the individual's movement pattern (Pew, 1976). It could be listed as such: "Important to my belonging:" "Comfort, pleasing, control, superiority." "To be urgently avoided:" "Stress, rejection, humiliation, meaninglessness" (Pew, 1976, p. 5).

These priorities are self-created and consistent, and the one main priority chosen takes precedence over all the others (Pew, 1976). For example, if a person chooses superiority, they would have to have meaning in their life to feel they truly belong, and nothing would feel worse for them then to have life without meaning. Another individual might choose rejection and would avoid it "at all costs" (Pew, 1976, p. 5), only feeling they belong if they are pleasing others in order to avoid rejection.

According to Pew (1976) the number one priority dictates short term goals but keeps individuals from actualization, by its limiting effect on social interest. The non-chosen priorities are not excluded, but rank beneath the number one priority (Pew, 1976), every behavior would be governed by that chosen priority.

Each priority contains positive and negative qualities (Pew, 1976). For example those who avoid rejection and move towards control are leaders, doers and organizers, persistent, law
abiding, and responsible. But, on the negative side they can be bossy, and overbearing. Those who avoid rejection might tend to seek control in the areas of other people's. Those who avoid rejection might control their own emotions, or completely avoid being controlled by anyone else (Pew, 1976).

**Determining the number one priority.** The number one priority can emerge through lifestyle interview; through questioning those intimate with the client regarding their observations of the client's behaviors; or through listening to the client discuss the events of their day (Pew, 1976). This author will propose another way of determining and ranking the client's psychological priorities later in this paper.

It is to be noted that although there is a number one priority the others rank beneath it in descending order. Therefore the lesser priorities may be seen as being used to achieve the number one priority. For example if someone's number one priority is superiority, they may use control or pleasing to achieve their aim (Pew, 1976).

**The psychological priorities as an intervention for addiction.** How can the psychological priorities be used in the treatment of addiction in conjunction with Dodes' theories? This writer's thinks that the psychological priority seems to fit the best with Dodes' theory is comfort (Dodes, 2002; Pew, 1976). Pew (1976) notes that linking the priorities to Adler's movement theory, those with a number one priority of comfort would rank lowest on the spectrum, on the short term end. Moving towards long term, pleasing would come next, then control and superiority (Pew, 1976).

Pew, (1976, p. 6) connected a "goal of immediate release from pressure" to a number one priority of comfort. Avoidance tactics would seem to this author to fit a low movement type solution for a stressor in this case. This is not to say that a client could not express a different
priority, this author believes the process of determining the priority should be a collaborative effort with the client.

Manaster and Corsini (1982) referenced in Griffiths and Powers (2007, p. 103), see the prioritized behaviors not as goals, but as "safeguards of the self-esteem." These safeguards are practiced as protection against a reoccurrence of a previously sustained "traumatic event" (Griffiths & Powers, 2007 p. 103). This seems to this writer to correlate more directly with Dodes' theory.

**Emotional Vulnerabilities and the Number One Priority**

Looking for the source of a client's "emotional vulnerabilities" (Dodes, 2002) could be enabled through the process of establishing their number one priority. This writer, thinking about the core issue beneath the priorities, would equate them in this manner: Seeking comfort and avoiding stress with the core issue of anxiety; pleasing and avoiding rejection with the core issue of abandonment; control and avoiding humiliation with the core issue of shame; and superiority and the avoidance of meaninglessness with the core issue of worthlessness.

Therefore, a client whose number one priority was comfort would study, together with the clinician, the type of situations that cause them the most anxiety. The therapist and client in turn might then, through the process of a topical Early Recollections enquiry, ferret out childhood incidences that provoked feelings of anxiety. It would follow then, in turn, for those with the number one priority of control to seek out Early Recollections that elicit feelings of shame; those with the priority of pleasing, abandonment; and superiority, worthlessness.

The clinician and client could then do some brainstorming exercises to see what imagined types of situations the client would anticipate causing the most difficulties in their particular
area. Then, non-chemical use strategies could be worked on and even role-played in advance in order to help the client regain power in those types of situations.

Lowen's (1985) bioenergetic work included locating feelings in the body that correlated with narcissistic injury. As the client works with the clinician on early recollections focused on particular feelings or emotions, clients could practice awareness of where physical sensations are being experienced in the body. A general discussion on core issues and where they are experienced in the body might also prove useful. Questions could be asked such as "When you feel shamed or shameful, where is that located in the body?"

This writer has taught recovery-focused yoga in treatment settings and found that most of the students had very poor body awareness. Once the client has trained themselves to be aware of these sensations, they could learn to notice when these physical sensations arise as an indicator of a situation in which a core issue might present itself.

This writer feels it may be problematic in the establishment and ranking of psychological priorities if the client lacks self-awareness, or presents a protective false self in treatment, often indicators of a developed shame base (Potter-Efron & Potter Efron, 1989). In that case, this writer feels a technique along the lines of the "empty chair" technique (Carlson et al., 2008, p. 139) could be tried in order to help find their number one priority.

**An Empty Chair Intervention to Ascertain and Rank Psychological Priorities**

An adaptation of the *Empty Chair* technique, outlined in Carlson et al. (2008, p. 139) can be used as a way to help identify the client's number one priority (Pew, 1976). This is slightly different then the way the term is traditionally used in Gestalt therapy, but used similarly to "externalize the introject," or enable clients to become aware of dissociated feelings (Corey, 2013, p. 228).
To initiate the above variation of the intervention, two chairs would be set out with two more standing ready (Carlson et al., 2008). Label them with the short term and long term opposite avoidance priorities, beginning with the pairing of "comfort" and "pleasing" (Pew, 1976). Allow the client to move from chair to chair, telling the clinician what they feel to be the favorable aspects of each, until they feel "done" (Carlson et al., 2008, p. 139). Note which one they end up on (Carlson et al., 2008). Then do it again with "control" and "superiority" (Pew, 1976). Then, pair the winners of each round up and let the client's decision to be "done" in this third round indicate their winning priority (Carlson et al., 2008, p. 139; Pew, 1976).

This writer believes, as a way of further ordering or ranking the priorities; and as a way of confirming the client's number one priority, this next step could be taken (Carlson et al., 2008; Pew, 1976). Now put all four chairs into the circle and instruct, "You are going to have to continue sitting in one of these chairs for the rest of your life." Then, let the client know chairs could be removed from the circle one at a time when they answer this repeated question: "Which one would you want to have removed first (second, third)?" Make note of the order of the priorities that emerge as the number one avoidance should end up leaving the circle first (Pew, 1976). See if their number one priority matches with the last chair they chose in the first session. Then process the session and the concept of the number one priority and its applications with the client.

"The Question"

Adler questioned clients (Ansbacher & Ansbacher, 1964), p. as a way of finding out what individuals were trying to avoid through the manifestation of a symptom or behavior. Dreikurs (1973, as cited in Griffith & Powers, 2012, p. 87) labeled this intervention The Question. For the treatment of addiction, the question might read "If you could stop drinking what would change in
your life?" (Carlson & Slavik, 1997). This has been described as being used to determine if the problem was organic in nature, such as a physical ailment (Griffith & Powers, 2012).

It can be surmised that The Question (Griffith & Powers, 2012, p. 87), might be able to be used to determine whether or not the client was physically dependent on alcohol. In this case their answer might be "I wouldn't get sick anymore, or have to go through these horrible withdrawals, or be afraid of seizures anymore." Therefore, if the client was what could be called a problem drinker (Carlson & Slavik) instead, the answer might turn out to be something like, "I could get my family back," or "I could get and keep a decent job," or "I could finish my doctoral dissertation."

Determining Values as an Intervention

As it has been presented earlier in this paper, values that are important to the client are highlighted in emotional reactions to situations and in compensatory behaviors. Driekurs (1957) lines values up with mindsets that support socially-interested behavior, as all the problems of life as viewed through the lens of social interest, are social problems.

Helping the client define and clarify their values would be advantageous to treatment. For example, clients brought up with highly moral religious convictions might perceive the former to be of great importance not to violate, in any situation, regardless of how those situations make them feel. And, shame at their inability to feel the way they perceive they should feel about the person or situation; might prove intolerable, and lead to useless or addictive behaviors.

To illustrate the converse value situation, here is another example. A child brought up with similar religious morals to the above child, may instead attribute hypocrisy to the contradictory behaviors they have observed in others. This child may then feel they are above
compliance with those standards, and then self-righteous rage over what they think they are seeing in the situation, might be the drive behind their plans for chemical use.

Looking at the *convictions* that emerge in the life style assessment such as "shoulds" (Shulman & Mosak, 1995, p. 5) will help to solidify these mindsets both for the clinician and the client. For example, with the first of the above illustrated client examples, "I should always obey the Ten Commandments," and "people ought to have better morals." For the second client example, "I should do what is best for myself depending on the situation," and self-righteous people should keep their mouths shut, because they don't live up to their own standards."

**Emotional Reorientation Intervention**

Rasmussen (2003) proposed a way to help clients identify emotional reactions that lead to useless behaviors. Rasmussen (2003, p. 345) noted that what is adaptive in the moment is not necessarily the ultimate solution to the intended purpose of seeking a *felt plus*. Some seek immediate reward and immediate relief which supersedes future consequences (Rasmussen, 2003).

Rasmussen (2003) proposed that emotions are oriented towards the outcome anticipated by the individual from the purposeful behavior. When a client has come to understand the purpose of their emotions, through life style analysis and the interpretation of the above, work in that area can commence. This purpose is described as helping the client meet life's challenges. As example, Rasmussen (2003) gives the purpose of depression, anxiety and anger. Depression keeps us from fighting wars we can't win; anxiety alerts us to possible environmental threats; and anger is used to remove obstacles towards goal attainment, particularly if we believe we have a right to those goals (Rasmussen, 2003).
Connecting the goals to the client's private logic is the next step. Emotions tell us about how things are going and tell other how things are going for us, what Rasmussen (2003, p. 349) terms personal feedback and interpersonal communication.

A third role of emotions is that of catalyst towards goal achievement or behavioral stimulant (Rasmussen, 2003, p. 349). Equipped with new awareness, Rasmussen (2003) feels the client can now move towards identifying emotions and their purpose, and making appropriate choices (Rasmussen, 2003). Should the substance use disordered (SUD) client's psychologically relevant area be the avoidance of shame, then this author believes helping see ways to recognize shame and to restructure behaviors and reactions in anticipation could be the goal.

Rasmussen (2003, p. 352) assigned homework with a prepared take-home chart worksheet containing columns reading left to right labeled emotion felt; subjective unit of distress, feedback (what does the emotion say about life); private logic violation; message conveyed; behavior energized, alternative display; and outcome of alternative display.

The assignment related to Rasmussen's (2003) worksheet, is for the client to catch themselves in the expression of their emotions as often as possible and record the outcomes. A one to ten, or one to 100 Likert-type scale could be devised to rate the subjective level of distress. If they have been able to make behavioral changes, the last two columns become relevant. Both positive and negative emotions could be tracked, if that is in line with the client's therapeutic goals (Rasmussen, 2003).

Additional Interventions

Group Counseling Interventions

Group counseling, as such, was not practiced by Adler (Ansbacher & Ansbacher, 1964), however because of its socially cooperative nature, it would seem to be a good fit with Individual
Psychology's practices. A closed group with a set number of sessions would seem to be the ideal way to conduct group therapy (Yalom, 2005). But having worked for a while in the field, this writer feels that that is seldom a realistic expectation. Even in inpatient chemical dependency treatment settings, clients come and go as they are admitted and complete or discharge prematurely. Therefore a number of standalone sessions (with an orientation session done with each individual before joining the group to do any preliminary work) would seem to be more efficacious to this writer.

Group therapy can add a social experience which reveals coping and defense mechanisms. Group therapy presents an opportunity for multiple transferences with family-like interactions developing beneath the client's level of consciousness (Scheidlinger & Porter, as cited in Karasu & Bellak, 1980). Early Recollections can be used as interventions in a group therapy setting (Olson, 1979).

*Reality testing* becomes easy in the group counseling setting, as the individual therapy setting can be somewhat regressive (Scheidlinger & Porter, as cited in Karasu & Bellak, 1980, p. 430). The social support of peers with similar problems can help the client normalize their situations. The support can eliminate bias, foster self-esteem as the clients learn to help each other and become a motivation for them to take therapeutic risks. The authors note that clients tend to be more accepting of confrontation from peers than alone in individual sessions with their therapist (Scheidlinger & Porter, as cited in Karasu & Bellak, 1980).

Not everyone is a good fit for a group counseling venue (Scheidlinger & Porter, as cited in Karasu & Bellak, 1980). Contraindicated are "classical psychoneuroses" and some "borderline, psychotic and masochistic patients" (Scheidlinger & Porter, as cited in Karasu & Bellak, 1980, p.436). In addition, Scheidlinger and Porter cited in Karasu and Bellak (1994, p.
434) warn how clients might feel who have already been seen individually at the suggestion of joining a group, including "feelings of rejection, narcissistic injury, separation anxiety, and sibling rivalry." Care should be taken on an individual basis as to what stage in therapy a client should be introduced to a group (Scheidlinger & Porter, as cited in Karasu & Bellak, 1980).

**Psychoanalysis versus Adlerian Therapy**

Both Adler and Dodes advocated treating addiction through psychotherapy (Ansbacher & Ansbacher, 1964; Dodes, 2002). Adlerian therapy recognizes four "phases of counseling and psychotherapy" (Oberst & Stewart, 2005, p. 54). The first phase is "establishing the therapeutic relationship." The second phase is assessing and understanding the life style. The third phase is insight and the fourth phase is reorientation.

The psychoanalytic relationship between client and clinician has the power and insight resting in the clinician's chair. Transference, a stalwart of psychoanalysis, is not used in Adlerian therapy. Adlerian therapy is instead, a partnership, or collaboration of. Insight is gently arrived at through enquiry and suggestion, with the aid of the client's opinions and input, interacting with the clinician's ability to observe the client's reactions and offer options towards new insight (Oberst & Stewart, 2005).

Psychoanalysis can be a lengthy process, though some such as Sifnaos and Davaloo have constructed more short term psychoanalytic interventions (Oberst & Stewart, 2005). In contrast, Adlerian psychotherapy may work both on intervening in the reconstruction of personality as well as helping guide clients towards more immediate solutions to pressing current problems through counseling and psychotherapeutic techniques (Oberst & Stewart, 2005).

The Object Relations theory of personality construction has already been summarized in the above paper. Adlerian theory is somewhat similar in that both view healthy interpersonal
relationships as a barometer of general emotional health (Oberst & Stewart, 2005); and emphasize the importance of early developmental relationships, such as between mother and child (Ansbacher & Ansbacher, 1964, Oberst & Stewart, 2005). However, in practice, Object Relations theorists return to the transference relationship, which is not practiced by Adlerian therapists. Adlerian therapists work within the real relationship, through encouragement, and appropriate challenging of the client, while avoiding antagonism and provocation (Oberst & Stewart, 2005, p. 130). Focus on behavioral patterns the client originally developed in childhood to move away from feelings of inferiority, now would be refocused on unproductive or useless current relationship patterns (Oberst & Stewart, 2005).

**Discussion**

This author's years working as a licensed drug and alcohol counselor in an inpatient chemical dependency treatment facility, led to the conclusion that though a complex issue, addiction could be viewed simply as well, as way of coping with life's problems. As client's histories unfolded, stories of traumas from minor to horrific emerged, revealing what looked like a correlation between a traumatic history and addiction. Life experience, combined with the work of Gerald May, led this writer to a compassionate outlook towards treating clients who battle addiction.

The discovery of Dodes' work, which linked psychic (narcissistic) injuries during the individual's developmental period to later addictive patterns of behavior, reinforced the author's beliefs in the psychological roots of addiction. Adding Adlerian studies to the mix, opened the development of addiction up to holistic view based on the teleological, creative power of the individual. Further readings in Dodes' work uncovered parallels between his thinking about addiction and the Adlerian viewpoints this author has come to espouse.
In regards to treatment, the insights gained from this paper are confirmation of addiction as a psychological problem, that this author believes needs to be treated primarily by psychotherapeutic means.

The key concept that emerged through this literature review was that of narcissistic injury, or psychic shock and its link to addictive behaviors. This author feels these injuries are probably unavoidable, and that it is the creative aspect of the life style (Ansbacher & Ansbacher, 1964) that leads one person who has sustained narcissistic injury or developmental psychic shock, towards disabling addiction; where another has the ability to circumvent disablement with productive, socially-useful behaviors (Carlson et al., 2008).

The individual's degree of rigidity or degree of inflexibility of conviction towards their ideal, may be what makes a shock event traumatic in the individual's perception (Carlson et al., 2008, p. 92). Individuals then get stuck at that point and tend to embrace the shock as a way of seeking distance, therefore establishing safeguards for the injured self-esteem (Carlson et al., 2008).

An example might be a person who experienced being given up for adoption as a developmental shock (Carlson et al., 2008). They created a life style supporting belief that in order to belong, or have a place in the world, they should never be or feel rejected, abandoned, alone, separated from others, or even try to exist outside of a relationship (Carlson et al., 2008). The individual now believes bad outcomes occur when people are independent or separate from others. They experience terrible anxiety even thinking about such a thing. So, they make themselves indispensable, stay in abusive relationships, care-take, people-please, or become co-dependent in order to avoid rejection. All the above being nonconscious movement behaviors in the service of their private sense of what it means to belong (Carlson et al., 2008; Pew, 1976).
If the person believes they should "never be alone or lonely," situations that hint at abandonment in some way such as an argument with their partner, might become so anxiety-producing to the individual that they drink (use drugs, or behave in addictive patterns), to numb those feelings. As this tends to work for the individual, the chemical use or behavior becomes the compulsive act of displacement that compensates for the inability to always be inseparable from others. When rejection threatens, planning to drink, use drugs, or behave in addictive ways compensates until able to do so (Dodes, 2009).

An external locus of control feeds into a hypersensitive alertness, or perception of others as continually sabotaging their striving for superiority; or the feeling that others can be blamed for keeping the individual from getting their needs, (in this case of connection), met.

The establishment of real friendships (which contain natural ups and downs and give and take) might be too anxiety provoking, as the fear of rejection if they said or did the wrong thing might be too great. Doing shots with their drinking buddies at the local bar; or a twelve pack in front of the artificial camaraderie of the television set, becomes their compensation for real friendship.

As each person who struggles with addiction is unique, the shocks, traumas, psychological triggers, priorities, or situations of emotional relevance that lead to feelings of helplessness or powerlessness (stemming from those original narcissistic injuries) will vary from person to person. Some of these injuries could stem from situations which led the individual to experience shame, humiliation, fear of failure, lack of control, discomfort or distress, abandonment, meaningfulness or worthlessness, feelings of inadequacy and inferiority (Ansbacher & Ansbacher, 1964).
Helping the individual see the relationship between the desire to use chemicals (or perform addictive behaviors) to the identified psychological triggers that create feelings of helplessness, powerlessness, or lack of control, is an important insight. Adlerian tools such as life style analysis, the Pew priorities, and Early Recollections will help the client identify those psychological triggers. Because of the developed patterns of compulsion, displacement and compensation, and physical tolerance and withdrawal, and dysfunctional support systems, the therapy does not, however end there.

This author noted, as Carlson and Slavik did, that physiological addiction versus problem drinkers is an issue that needs to be taken into consideration in treatment. This author supports abstinence for clients who struggle with addiction, and alerting the client to be on the lookout for the displacement of the compulsive need to safeguard to other types of behaviors such as disordered eating, shopping, or gambling. This author finds following the phases of Adlerian therapy outlined above relevant to treating addiction (Oberst & Stewart, 2005). The relationship should be a collaborative, encouraging one, aimed at fostering and supporting change and social interest (Carlson et al., 2008).

It is beneficial to remember, that addiction served a purpose in the client's life, the benefits of which they may be fearful of and reluctant towards giving up. This author found recognizing the universality of addictive thought and behavior, what Gerald May (1988) refers to as attachment, (for May, meant more in a spiritual sense than one originating in developmental psychology) helpful in coming alongside the client in their struggle.

The listed interventions, as well as those beyond the scope of this paper such as family and/or couples therapy, and targeting attachment disorders and depression will be helpful in continuing the client and clinician's partnership towards sobriety. This author's particular
contributions are in noticing a possible link between Pew's psychological priorities and safeguarding psychic shock through particular emotional reactions and behaviors. And, secondly, using a modification of the empty chair technique to identify and rate the priorities.

To recap, the links between psychological priorities and core emotions noted in the above paper, occurred in four areas. These links were noted between the psychological priority of comfort-seeking and the avoidance of stress or distress and underlying anxiety, and generally avoidant behaviors. The link between control-seeking, and the avoidance of humiliation and embarrassment with an underlying psychic shock in the area of shame, and perfectionistic practices. The link between people-pleasing and the avoidance of rejection to an underlying fear of abandonment; and the seeking of superiority or meaning, and the avoidance of meaningfulness, with being stuck in the shock of feeling worthless.

Using the psychological priorities to uncover these safeguarding methods and the injuries beneath them, can be used as a tool to help the client find avenues of healing. This author believes further research in the area of these aforementioned links is warranted and results would be helpful in the adding insight into the struggle to treat the complex problem of addiction.

**Limitations and Further Directions**

This paper covered the development of narcissistic rage in the individual, the development of theories that support the idea of narcissistic rage, and the connection between narcissistic rage and addictive behaviors. The interventions presented, mostly addressed the identification of underlying psychological/emotional triggers behind the rage reaction; leading to neurotically compulsive behavior, which has been seen to play out in acts of displacement, and compensation (Ansbacher & Ansbacher, 1964; Dodes, 2009). Non-specific psychotherapy to treat addiction has been Dodes' (2014) recommendation. This author agrees that specific
therapeutic suggestions besides the interventions posited above, are largely beyond the scope of this paper.

Because narcissistic injury occurs predominantly in the developmental stages, and hinders attachment; this author feels that the next step in the inquiry into the connection between narcissistic rage and addiction, is working with the clients specific narcissistic injuries that underlie their problem. Work in the area of attachment disorders would be the direction this author would suggest should be explored next.

The above treatment recommendation was affirmed by the work of Bedi et al., (2013) on object relations and psychopathology in child abuse survivors. Bedi et al. (2013, p. 238) reminded readers that personal relationships were at the root of the painful trauma experienced by these survivors, and therefore recommended that symptoms should be targeted though relational pathways. These adult children with abusive pasts, have learned to relate to others in a suspicious, mistrusting way in expectation of being rejected, punished or judged. Establishing trust in the therapeutic relationship is then thought to be key (Bedi et al., 2013).

Related to attachment issues would be encouraging family or couples counseling as adjunct therapies to individual and group counseling for the addicted individual. Adlerian couples and family therapy is a strong tradition going back to 1922 in Vienna. Adlerian family and couples counseling should take the uniqueness of the individuals involved into account when planning appropriate interventions (Carlson et al., 20008).

The work of Steven Stosny, Robert T. Muller, and co-authors Laurence Heller and Aline LaPierre, would seem to be valid recommendations for continuing exploration in the area of attachment disorders. The afore-mentioned Stosny, wrote Treating Attachment Abuse: A Compassionate Approach (1995), and works in the area of domestic abuse (for both the abusive

Also outside the scope of this paper is the addition of holistic wellness principles to the treatment of addiction. This author worked for years as a yoga instructor and integrative yoga therapist, helping individuals and groups with a shared spectrum of symptoms reclaim their bodies as a part of their individual uniqueness. As a part of this work, this author taught incarcerated youth, and clients, in both residential and outpatient chemical dependency treatment centers, recovery yoga.

Adler acknowledged the need to for holistic viewpoint in treatment (Ansbacher & Ansbacher, 1964), and emphasized the interrelatedness of the body and the mind. This author believes it is essential to guide the recovering individual towards reclaiming and reintegrating the lost territory of the body that they have knowingly or unknowingly hated, shut off signals from, ignored, or abused with chemicals or irresponsible physical or sexual behaviors.

Behere et al. (2009) reported the need for further gathering of evidence regarding the implementation of Complementary Alternative Therapies (CAM) in chemical dependency treatment, due to the difficulties in standardizing procedures for research on mind/body therapies. Behere et al. (2009) did report that mind /body therapies have shown efficacy in early studies, and are thought to be otherwise benign. It should be noted that Dodes (2014) is opposed
to the use of CAM therapies in the treatment of substance use disorders, advocating for the efficacy of individual and group psychotherapy alone. This author, strictly from personal experience at implementing yoga therapy in treatment settings, feels mind/body therapies can be an appropriate adjunct to group and individual psychotherapy.

Depression, as it relates to addiction, was purposefully omitted from this paper due to its scope. But, like topics of perfectionism, abandonment, shame, and anxiety, its link to addictive behaviors and their treatment, warrants further investigation.

**Conclusion**

In his article *Addiction as a Psychological Symptom*, psychoanalyst Dodes (2009) spoke of the function of addiction as the reversal of helplessness and the attainment of a sense of control over situations in which the individual feels helpless or powerless.

Adlerians Oberst and Stewart (2005) spoke of safeguards, or behaviors and ways of thinking chosen to protect the individual from threats to the self-esteem triggering feelings of inferiority. Oberst and Stewart (2005) went on to say that anticipated failure can trigger that need to safeguard. One way of safeguarding the above authors presented, was through the avoidance of threatening obstacles (Oberst & Stewart, 2005). Oberst and Stewart (2005) recommend clinicians attempt to ascertain whether substances are being used by clients to cope with situations, or even to extend situations as a way of avoiding responsibility or reducing cooperation. The authors (Oberst & Stewart, 2005) then reinforced the use of symptoms as a means to hide feelings of inadequacy and perception of any limitation or sense of shortcoming.

While Dodes spoke of using drugs or alcohol or addictive behaviors compulsively to displace actions that cannot or should not be taken, Adler spoke of being compelled to a expend
one's energies in a "secondary field of action," instead of solving one's problems directly (Oberst & Stewart, 2005, p. 42).

Where Dodes uses narcissistic injury Adler would say psychic shock. And, where Dodes (2009, p. 383) speaks of the "drive behind addiction" as narcissistic rage, Adler called anger a disjunctive emotion which becomes purposeful when other options to reach the goal of superiority seem impossible (Ansbacher & Ansbacher, 1964, p. 227).

It seems to this writer as if Dodes reached into Adler's holistic view of the individual who has become addicted, and pulled out a portion of the picture to place under closer examination. And that on in depth examination the theories are as a whole, very compatible.

**Closing Insight**

An essential part of this author's journey into the counseling and therapy of those who suffer with addiction and mental health issues was discovering the equalizing work of psychiatrist and theologian Gerald May, author of *Addiction and Grace* (1988) and *The Awakened Heart* (1993). Eschewing an "us versus them" view point, May (1988, pp. 3-4) boldly proclaimed addiction to be a universal part of human nature saying, "... the psychological, neurological and spiritual, dynamics of full-fledged addiction are actively at work within every human being. The same processes that are responsible for addiction to alcohol and narcotics are also responsible for addiction to ideas, work, relationships, power, moods, fantasies, and an endless variety of other things. We are all addicts, in every sense of the word."

Dreikurs'(1945) words regarding neuroses echoed the sentiments expressed in May's work. We all live out of our private logics to some degree, and make excuses for ourselves when they butt up against common sense (Dreikurs, 1945). Dreikurs said, "...we are all neurotic fundamentally and structurally. It is then only a question of degree whether our alibis and our
lack of social participation are more, or less, conspicuous and impressive. The line between normal and pathologic is very indistinct” (1945. p. 38).

If we all suffer from some degree of neurosis, and neurosis is the underlying issue beneath addiction, it is not a huge leap to find the answer to whether or not a therapist, not themselves in recovery, can truly understand, and successfully treat those who struggle with addiction. With May's and Dreikurs' words in mind, how can we not treat with compassion and awareness another whose struggles are in essence no different from our own?
References


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