Interactional Psychotherapy

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Table of Contents

CORRECTIVE EMOTIONAL EXPERIENCE

TRANSFERENCE

EGO THERAPY

THERAPEUTIC INTERACTION

BODY LANGUAGE

THE THREE PHASES

INTERPRETATION

DIRECT GUIDANCE

THE LEVELS OF DETERIORATION

SUICIDAL PATIENTS

SUMMARY

REFERENCES

Interactional Psychotherapy

One can distinguish three basic types of social interaction: “taking,” which is *instrumental,* “taking and giving,” which is *mutual,* and “giving,” which is *vectorial.* People are born *instrumental* in their attitude, that is, they are “selfish”; the child in utero is a taker, and the mother’s body is the giver. As the child grows, it gradually learns that peer relationships are *mutual;* one must give and take. In adult life the relationships of friendship, love, and marriage are all mutual interactions based on giving and taking. Taking care of one’s children is *vectorial;* the parent gives without thought of reciprocation. Well-adjusted adults function in all three dimensions; they are *instrumental* in their breadwinning activities, *mutual* in their friendships and marriage, and *vectorial* in their parenting and in the pursuit of idealistic purposes (Wolman, 1958).

There are three types of psychosociogenic mental disorders. Some individuals, rejected in childhood, develop an extremely selfish attitude; they are *hyperinstrumental sociopaths.* Children forced to worry about their overdemanding parents, who reverse the social roles and expect their children to function as caretakers, become *hypervectorial schizotypes.* Children exposed to a seesaw of parental acceptance-rejection attitudes become *dysmutual depressives* (Wolman, 1973).

CORRECTIVE EMOTIONAL EXPERIENCE

One can treat dysmutual-depressive patients in many ways, as described in the chapters of this volume. In developing the interactional method of psychotherapy I was influenced by the ideas of Alexander and French (1946), who introduced the concept of "corrective emotional experience." Adults who come for help are mature in many areas of their lives, but in some areas they retain childlike emotions and attitudes. A certain part of their personality remains infantile— "fixated," or "regressed" to the early stages of development (Freud, 1919/1962).

In psychotherapy the process of regression is facilitated by the inevitable dependence of the patients on their therapists. This dependent patient-therapist relationship was named "transference" by Freud.

TRANSFERENCE

People seek psychotherapy when they are unhappy about themselves and/or about their life. They go to someone who they believe can help them. Seeking psychological help and guidance resembles a child's dependence on its parents, and patients tend to *transfer* their child-versus-parent emotions onto their psychotherapists (Fenichel, 1945; Langs, 1976; Mendelson, 1960; Tarachow, 1963; Wolman, 1972).

The type and intensity of transference depend on the type and intensity of the disorder. The schizo-hypervectorials tend to develop intense and lasting transference. The sociopathic-hyperinstrumentals tend to develop superficial transference or no transference at all. The depressive dysmutuals tend to develop intense transference that swings from positive to negative attitudes toward the therapist (Bemporad, 1976; Lewin, 1959; Wolman, 1984).

The initial reaction of depressed patients to the therapist is blissful euphoria. "Finally," they say, "I have found someone who understands me and cares for me." They tend to believe that the therapist is an omnipotent and benevolent person, and they ascribe to him or her all the virtues their parents never had. The usual therapeutic signs of friendliness are interpreted as evidence of great love. Most of their symptoms disappear temporarily, and they tend to love themselves, the therapist, and everyone else. However, quite soon their euphoria comes to an end, and the patients' love turns into resentment. As Wolberg (1954)

put it:

> Psychotherapy is also very difficult with depressed patients because their demands for help and love are insatiable. No matter how painstaking the therapist may be in supplying their demands, they will respond with rage and aggression.

(p. 628)

Woe to the therapists who allow themselves to be caught in the web of their patients' insatiable demands. Therapists must state their position clearly, when male or female patients ask accusingly: "You don't love me, do you?" My answer has always been: "I care for your wellbeing. My responsibility is to help you and not to please you."

Depression can be *exogenous* if it is caused by real misfortunes, such as a serious disease, the loss of someone beloved, financial catastrophe, and so on. When the exogenous depression is related to the patients' neglect or error, it requires a realistic appraisal of the situation and a rational search for remedies. *Endogenous* depression is not related to any true setback or defeat. Sometimes a patient says, "I have no reason to complain, but I feel miserable. Everything bothers me and I don't know why." Endogenous depression requires a more thorough investigation of the patient's personality.

Reassurance does not work, and showing compassion makes the situation worse because, if the doctor is so concerned, it must be very bad. Instead, a calm

and steadfast attitude in the therapist is reassuring because it shows that there is no reason for alarm.

Depressed patients try to use the therapist's reserved attitude to make themselves more unhappy. A female patient told me, "I know that you don't love me anymore. You're right. I don't deserve to be loved. I'm a terrible person. Everybody hates me; I hate myself too."

One must adjust one's therapeutic method to the particular needs of a particular patient. Once, when a patient said, "I wish you would love me," I counteracted the need to be loved by a realistic remark: "What would you gain by my love? What would my love contribute to your life? Suppose you saw not me, but another therapist; should that therapist love you too? What for?"

One of the main tasks of psychotherapy with depressed patients is to increase their love and respect for themselves. Quite often, depressed patients practice willful regression and self-defeating behavior, hoping to get more attention and love from the therapist, instead of trying to act in a constructive manner. Their *resistance* is quite persistent. Their emotional involvement with the therapist, that is, their transference, may become a source for *resistance* and a wish to stay in therapy as long as possible.

EGO THERAPY

Interactional psychotherapy *aims at strengthening the patient's ego,* and the therapist's strategy must be adjusted to the level of mental disorder. At this point it is necessary to introduce the concept of *interindividual cathexis.* A lot of nonverbal communication goes on in psychotherapy, and the therapist's attitude is usually more important than his or her words. The therapist's friendly and reassuring attitude cathects (invests) loads of neutralized libido. It makes patients feel accepted and conveys the therapist's concern for the patients' well-being and the determination to help them.

Psychotherapy, following Alexander's definition, should be a "corrective emotional experience," and transference on too deep a level must be prevented, especially in depressive disorders (Schuyler, 1983; Wolman, 1984). Too deep a transference makes the patients overdependent on the therapist and slows down their progress toward depending on themselves.

THERAPEUTIC INTERACTION

I have called my method of treatment of mental disorders *interactional psychotherapy* because psychotherapy is *always a two-way relationship.* In a dentist's or opthamologist's office the patients are passive recipients of treatment. In psychotherapy the patients' active participation is essential, and no psychotherapist can help a patient without his or her cooperation.

Freud (1919) realized that a totally passive attitude may not be appropriate and in some instances the psychoanalyst ". . . must help the patients by interpreting to them their unconscious." In Freud's relatively stable era, direct help was an exception from the abstention rule, but today no therapist can abstain from direct guidance. Several psychoanalysts have introduced significant modifications to psychoanalytic theory and practice; among them are Jacobs (1983), Langs (1976), Selesnik (1967), Stone (1961), and Tarachow (1963). Eissler (1953) introduced the concept of "parameters," which implies giving direct guidance to the patients. Zetzel (1965) suggested a far-reaching deviation from the classic psychoanalytic detachment attitude. According to Zetzel, the psychoanalyst should ". . . respond at all times to affects which indicate the patients need to feel respected and acknowledged as a real person." In other words, the psychoanalyst should give up the "evenly hovering attention" and convey an expression of friendliness and sympathy.

Interactional psychotherapy applies some psychoanalytic concepts, but it

definitely advocates *direct intervention* in patients’ lives, for the job of psychotherapy is to *help people who need help.*

BODY LANGUAGE

My modifications of the psychoanalytic treatment method are related to years of clinical experience. Some instances deserve to be mentioned. For years I used the psychoanalytic couch with all patients except schizophrenics, whose anxiety state demands to be able to look at the therapist (Wolman, 1966).

The radical change came about when I taught resident-psychiatrists in a university hospital. One resident-psychiatrist was treating a female patient behind a one-way screen, while the other residents and myself watched his work. The patient was on the couch, and the young psychiatrist asked her a question, to which she responded briefly, "Okay, I agree." The psychiatrist could not see her face, but those of us behind the screen could clearly read her facial expression of dismay and anger. Obviously her face communicated her true feelings, whereas what she said was intended to appease the young doctor.

I have realized that the use of a couch deprives the therapist of nonverbal communication. In several instances of one-way screen observation and from my own experience, I have learned a great deal about body language. When I subsequently became involved in supervising private practitioners of psychology and psychiatry, I guided them to use not only their ears, but their eyes as well.

THE THREE PHASES

The therapeutic strategy must be adjusted to the personality of the patients and the level of their mental disorder. There are five levels of mental disorders: (a) neurosis, (b) character neurosis, (c) latent psychosis, (d) manifest psychosis, and (e) total collapse of personality structure. The interactional psychotherapy is applicable mainly to depressive neurosis and depressive character neurosis. On these two levels of depression, interactional therapy operates in three phases: *the analytic phase, the search for identity, and becoming: self-realization.* The three phases can overlap one another (Krauss & Krauss, 1977; Wolman, 1972, 1978, 1982, 1984).

The first task of the analytic phase is to analyze the etiology and symptomatology of depression. The analytic phase probes the mental obstacles that prevent the patients from attaining emotional maturity. It deals with the patients' past experiences and helps them to cope with their problems in a rational way. Not all patients are capable of going beyond the analytic phase but those who are move on to the second phase, where they become aware of their own potentialities, and then to the third phase—inner harmony and full realization of what they wish and can accomplish.

INTERPRETATION

Communication and direct guidance are the two main methods of the analytic phase. Communication is the indispensable tool used in all psychotherapeutic methods; there is no psychotherapy without two-way communication. The patients communicate their worries, anxieties, inner conflicts, and guilt feelings, and the psychotherapist interprets them, thus helping to solve their problems and enabling the patients to cope with both their inner and social hardships. Awareness and understanding of one's problems are the first steps leading to their solution. Moreover, depressed patients quite often respond well to the interpretation of their unconscious processes, but this response does not necessarily lead to immediate changes in their emotions and behavior. Interpretation and insight are important therapeutic tools, and their usefulness can be substantially increased by treatment of transference and resistance (Mendelson, 1960).

Interpretation of unconscious material, and especially of dreams, requires considerable caution; premature interpretation may cause more harm than help, and interpretation of emotionally loaded dreams should not start at the beginning of psychotherapy.

A realistic appraisal of oneself and one's life situation is a highly relevant element of mental health. A great many depressed patients underestimate their own resources and overestimate the hardships and dangers they face;

occasionally, in an elated mood, they may also overestimate resources and underestimate hardships as well. Therapeutic interpretation helps them to see things as they are and makes them aware of their potentialities, but their resistance can be formidable.

DIRECT GUIDANCE

As a rule, therapists should not tell patients what to do, but depressed patients often act in an immature and irrational way that could cause harm beyond repair to their careers and personal relationships. Thus, quite often, the following five behavioral rules must be repeatedly explained to them.

1. The first and foremost method of fighting depression is *testing reality and counteracting guilt feelings and anxiety.* Have you really done all the wrong things you blame yourself for? Are your fears justified? Are you really helpless? What can you do to cope with whatever adversities you are facing?

2. Passivity fosters depression and increases the foreboding feeling of disaster. *Active life reduces depression, and constructive efforts enhance the person's feeling of power and self-esteem.* Active pursuit of goals presents a challenge: victory will bring joy, but even failure need not affect self-esteem; it is easy to be proud in victory, but even in disappointment a person can be proud of his or her courage and tenacity. Thus, never give up; go on fighting against all odds.

3. Depressed people are often self-defeating as if hoping to win approval and love by their own misery; many are often accident-prone. One can fight depression by rejecting infantile dependence on others and by *building self-reliance and self-respect.* What's good in trying to have others love you? Even the Bible says, "Love thy neighbor as thyself"—that is, *love for oneself comes first.* You cannot please everybody, but you must please yourself.

4. Depressed people tend to withdraw from social contacts and perpetuate their depressive moods. Life is with people; loneliness increases depression, *social interaction reduces it.* Depressed individuals must force themselves to be with people.

5. Choose *"S-D" for self-discipline, not self-defeat.* Infants are unable to control their impulses; they cry in pain, scream in anger, and fall asleep when tired. Mature adults exercise *rational control* over their behavior.

THE LEVELS OF DETERIORATION

The five rules of direct guidance with patients on neurotic levels should be adjusted to the more severe levels of depression. On the character neurotic level one must pay attention to the evasive defense mechanism of character neurotics who tend to hide their depression behind a smoke screen of humor and self-satisfaction. They often deny that anything bothers them and that they are depressed. A female patient tried to convince me (and herself) that "everybody has some problems" and "everyone should keep smiling." It took a while before she admitted, crying, that she was spending sleepless nights in a state of acute anxiety and worry about her future. She needed a great deal of reassurance and emotional support before she could admit this. She was afraid that the therapist, like everyone else she knew, would be critical of her. "I had to pretend to be strong," she explained, "to impress people and to win their approval. I was afraid to admit my weaknesses." For a while she resisted therapeutic interpretation, but ultimately her neurotic character defenses were removed, and we could follow the above described five rules of direct guidance.

The latent depressive psychotics require a more cautious approach, as a therapist's errors can throw a patient into a iatrogenic psychosis. Latent psychotics can barely hold onto their defenses and are exceedingly sensitive; however, as long as their ego keeps functioning and retains contact with reality, it is a *latent* and not a *manifest* psychosis. In many cases the interpretation of

dreams could be counterproductive or even harmful. When unconscious and morbid fears and wishes break through the weak defenses, therapeutic interpretations can cause a collapse of personality structure and turn the latent depressive psychosis into a manifest depressive psychosis. Some cases of manifest depressive psychosis may need, at least temporarily, pharmacological help and hospitalization (Denber, 1977; Wolman, 1983).

SUICIDAL PATIENTS

As a rule, the more severe the depression, the greater the danger of suicide. The psychotherapist's task is to teach people to swim in the stormy waters of life, but a cautious lifeguard does not teach drowning people how to swim; the main obligation is to save the person's life. Apparently, in suicidal cases direct guidance is an absolute necessity (Shneidman, 1976; Wolman & Krauss, 1976).

Whenever patients have communicated suicidal thoughts, or whenever I have the slightest suspicion that the patients harbor suicidal thoughts, I confront them in more or less the following way:

> Our work is a two-way street. It is my moral obligation to help you, but I need your help. Please help me to help you, for I cannot help you without your help. We must have a two-way commitment; I will not let you down, and you will not let me down. Whenever you have suicidal thoughts, you must call me. Whenever possible, I will cancel another patient to see you immediately. If I cannot do that or you cannot reach me, you will not do anything—you will wait until you see me. I demand your word of honor, or I refuse to work with you.

I have never failed. In forty years of practice I have treated several suicidal patients; some of them tried to kill themselves before I saw them, but in my entire practice I have not had one suicide on my conscience. I prevent suicides by building self-respect and moral commitment. "Suicide," I tell my patients, "is a murder of someone who cannot defend himself or herself." If the patient lives at home, I take additional precautions and make sure that family members keep a

close watch on the patient 24 hours a day, 7 days a week, and I give them all my phone numbers where they can reach me at any time.

SUMMARY

1. There are two parties in combating depression: the therapist and the depressed person. Psychotherapists should be aware of the fact that their job is *emotional re-education.* Physical or chemical treatment can remove the symptoms but cannot remove the causes of depression and bring a complete cure.

2. In working with depressed patients the psychotherapist must avoid the pitfalls of the patients' masochistic love-hate manipulations. A good therapist must get involved with the patients' case without ever getting involved with the patients' person. The therapist must always retain the *professional distance* separating the helper from the one who is being helped. Depressed patients often play on their therapist's sympathy; should they succeed, the therapist's work is rendered useless.

3. The therapist should help the depressed person to see things as they really are. Exaggerated notions and distorted perceptions must be corrected; a firm grip on *reality* is an indispensable prerequisite of mental health. *Testing reality* is especially important in depressed people, who tend to underestimate themselves and overestimate the potential odds and dangers.

4. Low self-esteem and continuous self-deprecation and self-accusation must be therapeutically corrected. A fair, objective, and realistic appraisal of one's abilities and potentialities will contribute toward healthy and balanced *self-esteem* and *self-confidence,* which will successfully counteract the feelings of inadequacy and inferiority.

5. The patients' feeling of helpless anger, directed mostly against themselves and those who do not love them, must be channeled across the two channels of love and hate. People who have adequate love for themselves do not need so much love from others. Thus, *"love yourself* and you'll not need so much love from without" is an important therapeutic approach.

6. Passive and idle life perpetuates depression. Passivity deepens the feelings of weakness and facilitates the morbid Cinderella mentality, always waiting for salvation from without. *Active life and constructive efforts* improve self-esteem. Success has always been a good doctor.

7. *Social involvement* is a necessary antidote to depressive isolation. Depressed people tend to brood and imagine nonexisting dangers. Being actively involved with other people gives them the chance to face real hardship, instead of imaginary misery.

8. To live with a depressed person could overtax one's patience. *People close to a depressed person need guidance* to avoid infantilizing compassion and/or rejecting impatience. They must remain cool in the face of demands of "great love" and accusations of rejection. The family members of a depressed person may need therapy themselves (Wolman & Strieker, 1983).

9. Depressed patients *must actively participate in their own recovery* through either self-discipline or self-defeat. They must be willing to renounce their infantile, bittersweet masochism and look forward to the adult feelings of responsibility, self-esteem, and self-confidence.

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