Clinical Reflections On The Negative Therapeutic Reaction

When Freud first discussed the negative therapeutic reaction in *The Ego and the Id* he gave both a clinical description of it and a psychological explanation. In this paper I want to suggest that the clinical phenomenon and the psychological explanation may not be as intrinsically connected as Freud thought.

Freud does not give actual case material, but his clinical description is as follows:

"There are certain people who believe in a quite peculiar fashion during the work of analysis. When one speaks hopefully to them or expresses satisfaction with the progress of the treatment, they show signs of discontent and their condition invariably becomes worse. One begins by regarding this as defiance and as an attempt to prove their superiority to the physician, but later one comes to take a deeper and juster view. One becomes convinced, not only that such people cannot endure any praise or appreciation, but that they react inversely to the progress of the treatment. Every partial solution that ought to result, and in other people does result, in an improvement or a temporary suspension of symptoms produces in them for the time being an exacerbation of their illness; they get worse during the treatment instead of getting better. They exhibit what is known as a 'negative therapeutic reaction'." (Freud, 1923, p. 49)

Freud had already touched on a similar sort of phenomenon in one of his papers on character, "Those Wrecked by Success". (Freud, 1916)

Freud's explanation of the negative therapeutic reaction is that it occurs because of an unconscious sense of guilt, or need for punishment. Indeed, he drew attention to the clinical phenomenon mainly because he thought it provided evidence for the usefulness of the concept of the superego. This is how he puts it:

"In the end we come to see that we are dealing with what may be called a 'moral' factor, a sense of guilt, which is finding its satisfaction in the illness and refuses to give up the punishment of suffering. We shall be right in regarding this disheartening explanation as final. But as far as the patient is concerned this sense of guilt is dumb; it does not tell him he is guilty; he does not feel guilty, he feels ill. This sense of guilt expresses itself only as a resistance to recovery which it is extremely difficult to overcome." (Freud, 1923, pp. 49-50)
He discusses this theme further in "The Economic Problem of Masochism" (1924) and in "Analysis Terminable and Interminable" (1937) and relates it to moral masochism and the destructive or death instinct.

From Freud's original thesis two main lines of thought have developed, the first concentrating on the clinical phenomenon and the second on the psychological explanation. The main authors of the first group are Abraham (1919), Horney (1936), Klein (1957), and Rosenfeld (1975); all these authors emphasise the role of envy and/or narcissism in the negative therapeutic reaction.

The main author of the second line of development is Rivière (1936). She relates the negative therapeutic reaction to the patient's fear that progress in analysis and in life will make him aware of the desolate state of his attacked and unrestored internal objects and that he will feel intolerable guilt and pain. Bion (1953) and Segal (1956) give relevant clinical material. Rivière, like Freud, focusses on guilt and depression, but her explanation of the role of guilt in the negative therapeutic reaction is somewhat different, because Freud regards the negative therapeutic reaction as an expression of guilt, whereas she regards it as a defence against guilt.

Recently there has been an increasing number of American papers about the negative therapeutic reaction which follow, more or less, the second line of development in that they deal with patients who are dominated by unconscious guilt and moral masochism. Only a few of these papers give specific clinical material, but it is my impression that these depressed and sado-masochistic patients show many types of resistance and negativism in addition to the negative therapeutic reaction. (See: Feigenbaum, 1934; Gero, 1936; Eidelberg, 1948; Bernstein, 1957; Brenner, 1959; Olinick, 1964 and 1970; Loewald, 1972; Valenstein, 1973; Asch, 1976; Spiegel, 1978)

The fact that these two separate lines of thought have developed from Freud's original formulation already suggests that the clinical phenomenon and the psychological explanation may not be as closely associated as he thought. I want to go further, to suggest that the clinical phenomenon Freud described is usually found to be associated with envy and narcissism, whereas unconscious guilt is likely to give rise to many sorts of generalised resistance and negative reaction, of which the negative therapeutic reaction is only one. Further, when patients dominated by unconscious guilt do show a negative therapeutic reaction, it is likely to be much disguised and defended against.

I will first discuss Freud's clinical definition of the negative therapeutic reaction and then describe two clinical examples of it. The first case fits Freud's clinical description but not
his psychological explanation; the second fits his psychological explanation but is not so clear-cut an instance of the clinical phenomenon.

Freud's clinical definition of the negative therapeutic reaction

Freud's clinical definition is unfortunately imprecise, which has allowed the term to be interpreted in many ways. Several authors bemoan a current trend to use the term in a very general way, often to mean any sort of intractable resistance that the analyst finds great difficulty in coping with (Olinick, 1964; Sandier et al, 1970; Loewald, 1972; Baranger, 1974). Every now and again an analyst suggests that we should stick to Freud's original definition (or to the particular author's interpretation of Freud's original definition) but these injunctions have not had much effect, for the trend towards loose usage continues. Several analysts have also pointed out that negative responses by the patient are a function of the interaction between patient and analyst, not just a function of the patient's psychopathology (eg Langs, 1976); some analysts are very critical of the concept because they think it is used as an excuse for bad technique (W. Reich, 1933; Salzman, 1960). I do not want to discuss this aspect of the concept further except to say that I think the loose usage and misuse of the concept have been caused not only by imprecision in the original definition but also by the tendency to assume rather than to investigate the causal connection between the clinical phenomenon and the psychological explanation.

There are three elements in Freud's original clinical description.

First, the analyst speaks hopefully about the progress of treatment, or there is a partial solution which in other patients would lead to improvement. This part of the definition is crucial because it outlines the situation in which the negative therapeutic reaction occurs. Freud's description is somewhat unsatisfying, for what is to happen if the analyst does not speak hopefully about the progress of treatment, and who is to say that the patient should have improved or that another patient would have improved in similar circumstances? I think it helpful to add that there should be some tacit or explicit recognition of progress by the patient himself. Of course using the patient's own definition of progress does not free the situation from problems of judgement, for patients can be as mistaken, secretive, and defensive about their own progress as analysts can be. But I think this criterion is of some help in distinguishing the negative therapeutic reaction from other forms of resistance.

Second, the patient goes back on his progress in some form or other, usually including a worsening of symptoms. This element of "backtracking" also distinguishes the negative therapeutic reaction from other forms of resistance.
In emphasising the sequence of these two elements - the patient's own definition of progress followed by going back on it - I follow Klein, who described the sequence as characteristic of envy, which she regards as intrinsic to the negative therapeutic reaction (Klein, 1957, pp. 184 and 222). This stress on envy, especially unconscious envy, is her distinctive contribution to the analysis of the negative therapeutic reaction.

Third, there is an element of attack on the analyst. Freud thinks this attack is not the real issue, for he says that the explanation about unconscious guilt is "... a deeper and juster view . . .", implying that the attack on the analyst is a by-product rather than an intrinsic part of the negative therapeutic reaction. Klein, on the contrary, stresses the attack on the analyst as a central component of the negative therapeutic reaction. I think the actual clinical examples given in the literature support her view, as do the two clinical examples I describe. In one of my cases the attack was open; in the other it was heavily defended against, but in both cases the attack was definitely there.

In brief, then, I am defining the negative therapeutic reaction as a sequence of behaviour in which a tacit or explicit recognition of progress by the patient is followed by a worsening of his condition and an open or disguised attack on the analyst.

**Case material**

*First patient. An openly expressed negative therapeutic reaction by a patient who was not dominated by unconscious guilt.*

The material of the first patient is very similar to that of patients described by Rosenfeld in his papers on the negative therapeutic reaction (1975) and "delusional narcissism" (1971), except that my patient was less ill than most of those described by Rosenfeld. Rosenfeld's formulation of this sort of negative therapeutic reaction is that an omnipotent, arrogant aspect of the self makes an envious attack on the analyst and on a trusting, infantile part of the self which has been allowing progress to occur in the form of letting itself be helped by the analyst; the usual state of affairs in this type of patient is that the trusting, infantile part of the self is dominated by the omnipotent, arrogant aspect of the self, thus achieving a form of narcissistic self-sufficiency. Here is the material of my patient.

He was the eldest of three children of a Catholic family in a Latin country. He worked as a biologist and suffered, among other things, from difficulty in realising his considerable talent, especially in designing and following through original research. However, for some months before the bit of material I want to report, he had been effectively at
work completing his first independent research project. From time to time he realised, though rather incidentally, that his analysis was helping him to become more effective and constructive in his work. Eventually he finished his research and several people complimented him on it. He began to feel worse and worse. The research was no good, he said, not truly creative or original; he did not belong anywhere; he felt utterly inert; he was fed up with me and analysis because I was not helping him to feel more alive in himself. In one session he had a sudden fantasy, which he described as grandiose, of developing his so-called ‘small’ research into a major undertaking, with a special grant from an American foundation, a large staff of assistants, housed in a special wing of a new University building, etc. I said he was telling me this plan in a way designed to lure me into making some sort of punitive interpretation about omnipotence as if he wanted me to belittle and ignore both the validity of his research and the work we had done together to make the doing of it possible. He proceeded to talk about something else as if he had not heard what I had said. He was being as lofty towards me, in other words, as he was in his research plan.

In the next session he reported the following dream. He was on his way home to his own country for a holiday. On the way he saw an accident but no one was badly hurt. Once home, he heard from a casual acquaintance that his close friend Mario had got married. Mario had not invited the patient to the wedding, and he felt dreadfully left out. He woke feeling life was not worth living and nothing was enjoyable. He was utterly incapable of taking pleasure in anything. Most of his associations centred around his opinion that Mario was someone probably incapable of marriage or any kind of deep relationship.

I said I thought Mario represented that part of himself that had been incapable of any sort of relationship with me, but that in recent months this Mario aspect of himself had come into contact with me more and more, which he described in the dream as a marriage. It was even producing "children" in the form of his research. I suggested that the non-Mario part of himself felt terribly left out of the growing alliance between Mario and me and it had been trying to re-assert its control over both of us.

He thought about this and then said he could not see why he should feel so left out by his getting better. After a short silence he said that Mario's mother was an immaculate, attractive woman, very nice to all Mario's friends, and in fact she had hinted to the patient that she wished Mario were more like the patient. He thought Mario's mother wanted Mario to be successful and to get married, but only to prove that she was a successful mother, not for Mario's sake. I said he seemed to be saying that my growing relationship with the Mario aspect of himself was not to be trusted because I only wanted Mario to grow up and develop so that I could congratulate myself on being a successful analyst.
In subsequent sessions he was gradually able to recognise himself in the qualities he attributed to me and to Mario's mother—especially his narcissistic self-centredness and his grudging attitude towards his own and my enjoyment of the analysis and of his success.

Second, patient. A woman dominated by unconscious guilt, but showing a hidden and defended form of negative therapeutic reaction.

This patient suffered from the sort of unresolved depression and moral masochism that Freud and many later authors think characteristic of patients who exhibit the negative therapeutic reaction. Although she was cooperative in the analysis, she was at this time locked in recurrent attacks of self-punishment, persecution, remorse, and identification with damaged internal objects, especially her mother. Clearly defined negative therapeutic reactions were not characteristic of her material. It was much more usual for her to nip a negative therapeutic reaction in the bud, so to speak, by not having enough therapy for there to be a negative reaction about. Even the instance of negative therapeutic reaction I describe here was at first difficult to identify.

Some time before the sessions I want to describe I had had a minor illness. In the first session the patient described a dream in which there had been an ill woman; the patient realised that she could not help the woman very much herself; the right person to ask to help the woman was her boss, who was a highly qualified person but not overly conscientious. I interpreted this as a move towards recognition that in spite of his deficiencies father was the right person to look after and repair damage to mother, that the patient could not do it all herself. (It was her internal parents we were talking about; her real parents had died years before.) I also suggested that she felt I was the ill woman who needed looking after and whose care and cure she was trying to relinquish control of. Right near the end of the hour the patient told me she had received a minor promotion at work. She managed to say it in such an offhand way that I almost overlooked it.

In the next session, a Friday, she felt bleak and had a memory of feeling utterly desolate when she had been sent away to boarding school. At first I did not think of her desolation as a negative therapeutic reaction, for she had already played down her bit of success so much that I had not realised she was tacitly thinking of it as success. At first I linked her desolation with the weekend, though that did not seem to make sense of the extent of her feeling. Then I suggested she was feeling more grown up, in that she was trying to give up her insistence that she was the one who had power over me by looking after me, but that made her feel abandoned, as she had felt when she had been thought grown up enough to be sent away to school. In her way of experiencing things, the reward for progress in analysis or in work was that she had at school. But I still felt there was something about
this session I school. I said she was warning me that she could not stand yesterday's minor successes, either the success at work or in analysis; she had to fail now as she had at school. But I still feel there was something about this session I did not understand. (What I did not see until several weeks later, when the theme came up again, was that she was also feeling overwhelmed and confused by an identification with an ill, fragile mother who experienced every bit of growth by her child as an abandonment of her.)

On Monday she was in a very different mood, rather excited. She had had three dreams. In the first she met one of my male patients, who found her sexually interesting. I interpreted this as her way of getting control of her feeling that I had abandoned her at the weekend to be with my partner. In the second dream one of her former university professors told her about a new university department that was opening nearby where she might do a special course. In the third dream a junior colleague was telling her that she was overexcited. Eventually I suggested that she was my junior colleague warning me that if I was able to open a new department for her so that she could enjoy a bit of success, she would get overexcited, and the excitement would turn into triumph directed against me and her analysis. With some reservations she agreed with this. I said she evidently felt she could not enjoy any success without its turning into a triumph.

On Tuesday she felt desolate again and on Wednesday she was once again excited, as she had been on Monday. I did not see it at the time, but I think she was repeating the sequence of the "low" session and the "high" session in order to show me that there was a lot I had failed to understand. I think the "low" response had two roots. The first was that unconsciously she felt guilty because she felt she had attacked her mother by improving, which meant leaving her; she punished herself by identifying with this fragile, attacked mother who could not let her grow up and "go to school". Second, the low response was a way of avoiding making an envious, resentful attack against me for threatening to help her grow up. The excited, rather seductive mood of the "high" sessions was more an expression of triumph over me for having missed the meaning of the "low" sessions than an expression of triumph because of her improvement the week before.

Discussion

If one compares these two patients, it is clear that the first gave a much more direct expression of the negative therapeutic reaction than the second, although I think both reactions fit the definition I have given above.

The first patient was openly envious and resentful about his own progress and my contribution to it, even though he was not actually conscious of being envious. His
progress hurt him, and he could only just bear to recognise it. Contrary to Freud's thesis, however, he did not suffer acutely from unconscious guilt or moral masochism. At this stage of his analysis he was mainly persecuted by his internal objects rather than concerned or guilty about them, for he was projecting into them the envy and self-centredness that he could not recognise in himself.

The second patient, on the other hand, was dominated by guilt and unresolved depression. According to Freud's formulation she should have been a clear case of the negative therapeutic reaction, but in fact her reaction was much less open than that of the first patient. It consisted of defences against envy and destructiveness rather than open expressions of them, and although she got "worse" in the low sessions it was not easy at first to relate her depressed feeling to the preceding recognition of progress. She was more depressed than the first patient and it was her capacity for concern for her objects that prevented her from making an openly envious attack. She had loved her fragile mother and could not accept her own wishes to attack her. Similarly she had strong positive feelings about me and had difficulty in recognising her wish to attack me. She spared me and her mother by attacking herself. But she was not only trying to spare her objects when she did herself down; she was also trying to avoid accepting responsibility for her own enviousness and aggressiveness. In trying to avoid pain and responsibility by attacking herself she of course caused more damage than if she had made a direct attack in the first place; she kept her mother fragile, and she also made it hard for me to find out what was going on, especially when she compounded the confusion by getting triumphant over misleading me.

My general conclusion from these two cases, from my practice as a whole, and from the literature is that open expressions of negative therapeutic reaction are likely to be a prominent and recurrent feature in patients of narcissistic and envious character structure, but that in patients who suffer from unresolved depression, especially persecutory depression (Klein, 1957), the negative therapeutic reaction is likely to be heavily disguised, as in the case of my second patient. General resistance, negativism, and avoidance of success are more typical of such patients than is the sharp backtracking of the negative therapeutic reaction. Freud's clinical phenomenon and his psychological explanation, in other words, are not as closely linked as he thought.

What, then, is one to conclude about the negative therapeutic reaction? Is it a useful concept? I think it is, for it alerts the analyst to the presence of an acute conflict about progress, whatever the character structure of the patient. It may be, of course, that a patient reacts negatively not to progress in analysis and in life but to mistakes by the analyst and deprivation in his life, a possibility that should be explored as openly as possible by analyst and patient together. Assuming that the progress is genuine and the
interpretations reasonably accurate, an openly expressed negative therapeutic reaction means the patient is protesting about the disturbance of his status quo and the indignity of being helped by an analyst, which is, after all, hardly surprising. In mild and transitory forms it is surely very common.

But what of patients dominated by unconscious guilt? Should one describe their chronic resistance, failure to thrive, and avoidance of success as negative therapeutic reaction? You will have read Dr Sandler's paper and noted that he thinks it most unwise to widen the concept of negative therapeutic reaction to include chronic resistance of this sort. In a way I agree, for there is an obvious empirical difference between the open negative therapeutic reaction and chronic resistance. Nevertheless, one cannot escape a feeling that Freud was right in saying that unconscious guilt stops patients from getting better. In the long run, chronic resistance and the negative therapeutic reaction are not so very different from each other. Patients who suffer from unconscious guilt get stuck in their illness and misery; very occasionally they improve a bit and allow themselves to recognise the improvement, and then they have to resort to a relatively open negative therapeutic reaction to restore their status quo. Usually, however, they express a sort of hidden negative therapeutic reaction all the time, which is unconsciously designed to prevent open improvement, with the result that an open negative therapeutic reaction is unnecessary.

So, in conclusion, where Freud suggested one clinical phenomenon, I would suggest two: an open and a hidden negative therapeutic reaction. And where Freud suggested one explanation I would suggest two: envy and narcissism associated with the open negative therapeutic reaction, and unconscious guilt associated with the hidden negative therapeutic reaction.

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