

NEGATIVE THERAPEUTIC REACTION AS A RELATIONAL PHENOMENON

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Summary

The aim of the article is to analyze the patient's paradoxical response to therapy observed and defined by Freud in 1923 and known as the negative therapeutic reaction. In the majority of available books touching on the subject of psychoanalysis, the occurrence is described as a phenomenon stemming from the patient's psychological construction. In this paper I intend to present the negative therapeutic reaction as a relational phenomenon – a reciprocal process in which the patient and the psychotherapist experience things and react to them in a specific way. Helplessness, shame and/or anger pose the risk of establishing a sadomasochistic collusion between the patient and the analyst or placing the temptation in the psychoanalyst to provoke the patient to quit the therapy. In such circumstances both the psychotherapist and the patient unconsciously aim to develop a state which can be described as negative therapeutic reaction.

This article may prove helpful in understanding and preventing the occurrence of a negative therapeutic reaction. To better illustrate the subject, the described theoretical conceptions are supported by clinical material. The last part of the article is devoted to author's observations and perception of negative therapeutic reaction.

Key words: private practice, negative therapeutic reaction, psychoanalytic psychotherapy, therapeutic relationship

Introduction

In its 90-year history [1–4] the phenomenon of negative therapeutic reaction was defined in many different ways, which posed the danger of blurring the idea and depriving it of its clinical utility. To make it even more complicated sometimes it is difficult to differentiate between the negative therapeutic reaction and psychological resistance or negative transference. Before we move onto defining the negative therapeutic reaction we should try to make a clear difference between the three above mentioned phenomena. The first difference between the three experiences described above is the fact that the psychological resistance or negative transference always occur, at different intensities, at different stages of a therapy. Of course not in every therapeutic modality they are the subject of interpretative work. The negative therapeutic reaction, on the other hand, occurs less often. Secondly, in case of negative transference the patient does not necessarily need to suffer during the therapy or act self destructively (and it is not very likely to happen), while the basis of resistance is to avoid suffering. On the contrary, the patients experiencing negative therapeutic reaction use suffering to communicate important messages during the therapy hoping they are clearly heard.

I personally believe that the reason why the idea of negative therapeutic reaction was criticized and distrusted was the fact it was often used as an easy excuse for therapist's lack of knowledge or explanation of countertransference reaction such as anger or dislike to continue the therapy with a particular patient. My opinion is that the negative therapeutic reaction stems from the personalities of both the patient and the

therapist. Whether it is going to fully evolve in the therapy or not, depends on the type of responses the therapist, whose interventions will be implicated by his personality, gives to communicating the given aspects of patient's personality.

Negative therapeutic reaction – problem outline

The idea of negative therapeutic reaction was first introduced in 1923 in Freud's "*The Ego*" and "*the Id*". Freud [1, p. 254] writes as follows: "There are certain people who behave 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*."

Let's try to analyze Freud's definition. He mentions the fact that patient's condition deteriorates during the therapy. Surprisingly, even though he treats the patients with the same symptoms in the same way the reactions are significantly different. Instead of improvement and progress in the therapy (related to symptoms withdrawal) we observe deterioration (symptoms exacerbation). At the first sight we could think we came across the negative transference (in Freud's evolving theory understood and referred to as "defiance") or "gains from the illness" (secondary gains). However, Freud himself answers the question by stating: "such people cannot endure any praise or appreciation, but that they react inversely to the progress of the treatment." The question is why? What determines this phenomenon?

Freud [1, 5] also answers this question. He compares the fear of improvement with the fear of danger. He takes the argument a step further by saying that owing to illness the patient's sense of guilt is satisfied – through suffering, which is a sort of punishment, such person redeems from sense of guilt. Freud presents an example of the above mentioned mechanism [1, 6] – he describes the unconscious sense of guilt, the intensification of which can push a man to commit a crime. [1, p. 256]: "In many criminals, especially youthful ones, it is possible to detect a very powerful sense of guilt which existed before the crime, and therefore it was not its result but its motive. It is as if it was a relief to be able to fasten this unconscious sense of guilt on to something real and immediate."

I would like to focus here on that mysterious mechanism. Mrs. X helped me to fully understand it. For more than a year we were trying to win the deadlock in her therapy. Mrs. X had a vague feeling that her life could not be happy. She first expressed it at our initial session preceding the therapy when she suddenly stated: "My parents planted a weed and now they seem to be surprised that it did not turn into a beautiful flower." I believe that it is related to the state of mind in which the patient has a sense of guilt and thinks that he/she should be punished (conscious part) but it is not clear where the sense of guilt is coming from (unconscious part). Mrs. X often claimed she had a feeling she did something wrong. After some time when during the supervision I was listening to the recorded session I got surprised at the tone of my voice.

Although the comments I made seemed to be supporting and understanding, there was a sort of irritation and rancor in my voice. When I started to analyze this tone I managed to associate it with one of the statements the patient did during our initial consultation. I wanted her to flourish, to praise this beautiful flower, but she felt she was not meeting my expectations. She was not the person I wanted her to be and thus she felt guilty. It prompted her to think about the relationship she had with her mother. After one year of regular meetings she went to visit her aunt to ask her whether she had any idea what she had done wrong in the past (she had no courage to ask her mother). After the moment of silence the aunt stated that the patient's mother always wanted to become a nun. She only changed her mind and decided to get married after she had been raped. This "double original sin" – as Mrs. X tended to call it, though not named for years – was present in the relationship not only with her mother but also with her father, who found it difficult to get truly involved in her upbringing. The unconscious part was related to naming the reasons, however, the peculiar emotional climate was too consciously present in her life. From the very beginning she knew she did something wrong. Her symptoms – the belief that her body was being devastated by cancer – were a sort of atonement for the above mentioned "double original sin". The therapy could not end in success as long as the patient rejected to touch upon this sphere of her emotional life as well as therapist's emotional life – the approval of who she was – the flower which grew from a weed.

The relational character of negative therapeutic reaction stems from the fact that the therapist responds to the above mentioned "defiance" or "gains from the illness." What actions do the therapists take driven by their emotions considering they are interpreted in the proper way? The language used by Freud leaves the space for fantasies about their feelings and emotions. However, it will be easier for me to invoke my own emotions and experiences gained during my work with Mrs. X. Disappointment and irritation that the therapy was not bringing positive result, was clearly reflected in the tone of my voice – full of non-verbal resentment. When Mrs. X heard the irritation in my voice, which she was particularly sensitive about, she felt guilty. In consequence it led to deterioration of her symptoms which were a sort of punishment in her emotional life for wrong doing on me. Only after I associated the two things, did we manage to change our relationship and the patient herself started to change.

Later numerous authors such as Stuart S. Asch [2] or Joan Riviere [3] were touching on the subject of negative therapeutic reaction. In his article *Varieties of negative therapeutic reaction and problems of technique* Asch made a thorough study of analytical literature in order to find the reasons of negative therapeutic reaction. Apart from the above mentioned concept of "unconscious guilt" developed by Freud, he mentions the phenomenon of masochistic ego. It is a malformation of ego ideal resulting from specific ego-ideal pathology. Malformed ego ideal causes the development of masochistic aim in a person. Those people indicate persistent tendency to search for love from subjects which are rather sadistic than loving. It is a direct consequence of long-term internalization of such an object.

Mr. Y. came to my office with a feeling that "he went wrong somewhere in his life." He had everything required to achieve a professional success – such as intelligence and education – yet, year by year, as he claimed, he was "falling behind his mates." Although he was very talented and engaged in his work, the company he was running could hardly generate the profit that would allow him to make ends meet.

As it transpired after brief interview his father, who was a football coach, was obsessed with turning everything into competition and winning with his son (Mr. Y). When with time Mr. Y. started to win during the games, which were the main form of their contact, his father was punishing him by expressing his anger and limiting their contact. In transference, despite his full engagement in the therapy, he was trying to convince me that things were getting worse. He fantasized about my business and alleged successes, about my wife who seemed to be better than his fiancé or about my car which was much better than his own. Although his state was exacerbating rather than improving, he still declared his willingness to participate in the therapy, which seemed to bring more harm than good. One day before the session we met at the car park. When the fantasy was confronted with the reality which revealed the fact his car was better and more expensive than mine, he panicked. The above mentioned situation turned to be a chance to put together the material collected during the sessions. It brought to light the fact that in transference with me the patient was recreating the relationship he had with his father and was looking for the above mentioned love from subject which was rather sadistic than loving. The worse his state was getting, the more I could triumph over him in his fantasies, and owing to it he could get closer to me in a way that he knew from previous relations with men and which gave him a certain sense of security. Not until I fully understood the situation, were we able to initiate the process of change. I had to refrain myself from triumphing over him, as this triumph was a form of bribe offered by Mr. Y for a chance to maintain our relationship. By accepting the “bribe” I would strengthen the negative therapeutic reaction.

As one of the reasons for negative therapeutic reaction Asch [2] describes the situation in which the progress in therapy is blocked by defense against fantasies about anal subordination or oral fusion. It appears when during the therapy the patient ascribes the therapist with certain intentions. We encounter a case of defense against fantasies related to anal subordination when the patient suspects our actions are aimed to dominate over them and gain control over their lives. On the other hand, in case of fear of oral fusion the patient is afraid that the actions taken by the therapist stem from their will to satisfy their narcissistic needs and the refusal to fulfill those requirements expressed by failure in therapy allows the patient to keep their autonomy from the therapist and to suppress the passive desire of being absorbed and unified with the same.

In her article *A contribution to the analysis of the negative therapeutic reaction* Joan Riviere [3] refers to the theory of Melanie Klein. Klein [7, 8] describes a vital development experience – the integration of subject’s love and hate to object which is a composition of depressive position. Conscious experience of one’s aggression accompanied by the love to object leads to sense of guilt and concern for the beloved object. Initially in relationship with mother, and in the course of the therapy with therapist, the patient experiences their own helplessness, dependency and jealousy towards them. The depressive position cannot be reached when the fear that our aggressive behavior could harm or destroy the beloved and needed object is too strong. According to Riviere such state may contribute to negative therapeutic reaction in a significant way. It triggers manic defenses – the patient fantasizes about control over the object, triumphing over it, despising it. Owing to manic defences the patient avoids the fear associated with the dependency and the sense of helplessness. Any chance for change in the therapy is confronted with dependence on the therapist and patient’s weaknesses, which requires assistance, and when the relevant assistance is received from the

therapist – with gratitude. Some patients perceive the change as a loss of control and for that reason they often try to keep the existing status quo by bearing the bad mood and thus harming themselves. The consequence of loving the object, inspiring the aggressive impulses, is sorrow, and the result of sorrow is the feeling of guilt. The love to an object in those patients arises such a great sense of guilt that they are not able to bear it. They need to adopt manic defense as they believe that without it their life will change into total chaos and murderous and suicidal impulses will appear. They feel that the therapy bares their minds. Still, even the slightest “grain of hope” makes them continue the treatment even though they do not believe in its success. It is not that those patients’ fantasies are more sadistic than those of other people but the problem lies in the fact that they do not believe in remedy or compensation for a grievance done either in real life or in their fantasies. It instigates despair. Despair and lack of faith in rectifying their state forces them to maintain manic defenses. According to Riviere the only hope for those patients is the situation in which they manage to love the object despite the existing sense of guilt.

Z. came to my office accompanied by his mum. He was 16 and had some recurring problems at school. He was expelled from few schools due to his absences and aggressive comments made towards the teachers. The comments were to mark his independence as well as to express his disagreement with teachers’ and mother’s intention, projected in his mind, “to curb him and prevent him from expressing his own opinion.” When we first met he immediately assumed that I had exactly the same objective. He was assigned a probation officer because of his absenteeism in school. His mum wanted him to have individual teaching at home. Only if Z. joined the therapy would his psychiatrist provide him with relevant certificate to arrange it. I did not make any conditions to the therapy. I only set the time of our meetings and the number of proposed sessions (10) which he could but did not have to attend. We agreed that after the planned cycle the three of us (patient, his mum and I) would meet again. He missed the two first sessions but decided to attend the third one. I informed him I had some paper work to do, but at the same time expressed my willingness to start the conversation once he was ready for it. He said nothing so to his surprise I continued with my work. At next session, his fear of losing control and being dominated by me was much smaller. Once the fear faded out also his defense against it expressed by his arrogant attitude got weaker. He seemed to be much more fragile than during the initial consultation. During the following sessions he talked (without going into details) about the closeness between him and his mother until he was 13. I realized that after the divorce his mother used this closeness to harness her own emotions, and the fear of being dominated or even fully united with his mother, forced him to intensify the defenses (against loss of identity, fantasies about incest, and the sense of guilt for his aggressive impulses). The intensified defenses were perceived by surrounding people as behavioral disorders. We were getting surprisingly well until our tenth session. When the three of us met to discuss the progress of his therapy his mother seemed to be very satisfied. During the conversation she advised that “thanks to the meetings they again got closer to each other after a long break.” After the session he refused to continue the therapy. His mother phoned me to communicate the message.

I believe that the reason why Z. quit the therapy was the fear of losing his identity or of being absorbed by symbiotic relationship which would make him disappear. As long as he continued to be arrogant, he believed he controlled his life and avoided facing his weaknesses and dependence. This type of

manic defense averted the devastating sense of guilt for wrongs done to the beloved (and hated at the same time) objects, which he truly depended on. Although from the very beginning I suspected that Z. himself had to regulate the level of closeness in relationship to conquer his fear of disappearing (his dependence upon me and his own fragility), the therapy unfortunately turned to be a missed chance to analyze his fears.

Apart from the above mentioned patients' types, there is one more group which poses a challenge of creating negative therapeutic reaction in the relationship with the therapist. These are the patients who, by identifying themselves with parent presenting masochist attitude, apply masochist role model themselves. Even more importantly, those patients show the therapist how strong they are and how much they can stand which creates a temptation to enter into sadomasochist relationship and tease each other in that correlation, if the real situation is not diagnosed on time. I encountered this type when I started to work with Mrs. Q. She was a talented 30-years old woman. Her mother provided for the family, as her father was unemployed and wasted vast majority of their budget on alcohol and parties with his friends. A strong believer as she was, her mother claimed that her marriage was a trial sent from God. The more her husband spent, the more she got engaged in her work and limited her expenses to make the ends meet. She also expected Mrs. Q. to resign from many things. As a result from the early childhood Mrs. Q. found it difficult to interact with her peers. She helped her mother at home after school while her friends were playing outside; she never went on a school trip. When her mother died, she supported her father, who spent most of his time drinking (wasting the money provided by Mrs. Q.) until he died. It was six months before she joined the therapy. She came to me to fight the fear of falling asleep. She had recurrent nightmares. She dreamt about a bug eating her bowels. The psychiatrist she visited gave her some medicine which made her feel "more lively and carefree." But the feeling scared her so much that she stopped taking drugs. I quickly noticed that Mrs. Q. was not looking forward to change in the therapy. With the exception of the initial consultation she never mentioned the symptom that pushed her to join the therapy. It became apparent that by attending the sessions Mrs. Q. was trying to get back to the state of her life disrupted by her father's death. She was providing for another men in her life and did not expect or wish to change it. Week by week, she was trying to prove me how strong she was, how much she was able to sacrifice to pay me for the therapy which she did not expect to bring any positive result. Before I realized it for few months I had a sense of guilt (that I cannot help her) mixed with irritation (that Mrs. Q. does not want to accept my help).

Implications for the therapy

It is worth asking what the meaning of patient's suffering in our relationship is. Why do patients wish to suffer, and why we, as therapists – if we feel the need – try to do our best to dissuade patient from it. In case of negative therapeutic reaction the patients do not gain pleasure from suffering as they do in sexual masochism. To be even more precise the key question in negative therapeutic reaction is "Why do those people have to suffer?" or even bluntly speaking "why do those people need to destroy their lives?". I used the word "need" for purpose as the choice only appears once we have a full insight into reasons causing the state. If the aforementioned questions remain unanswered the therapy will inspire a lot of frustration for both sides. As a result in therapies with patients, whose psychological construction forces the therapist to establish negative therapeutic reaction, the analyst paradoxically have to accept the fact that the patients' state, at least

in early stages of the therapy, will deteriorate. Patient's bad mood is a sort of message that needs to be clearly heard. It is only possible if we take our patients as they are without excessive need to satisfy own ambition of therapeutic success (understood as a quick progress and improvement in patient's state during the therapy). What is good while dealing with vast majority of patients – eagerness to make them feel better in short time – when working with this group, needs to be changed into thorough investigation of reasons why the patient needs to suffer. The reason behind it is not to triumph over them or accuse them of masochist inclinations, but to help them understand the unconscious sense of their suffering and to encourage them to think about it. When during the therapy we succeed in answering the above questions, there is a chance for change in the therapy or agreement to make a choice, even if the choice itself is suffering in the name of something more important to sufferer. Sometimes it happens that one suffering protects us against the other. By reconstructing some important aspects from her relationship with father, Mrs. Q. could move away the great sorrow she felt after his death. As long as I symbolized him she did not feel as an orphan.

Without full comprehension of the existing status quo, the change in the therapy will never be possible, which can be easily illustrated by the 16-year old patient introduced above. It was too late when I realized that his mother's joy from progress will shatter hopes of success in the therapy and lead to its premature end. The excessive urge for therapist's success may make the patients feel used and ignored. The lack of proper understanding of the phenomenon of negative therapeutic reaction poses high risk of emotional helplessness, sadness, anger and discouragement in therapist when dealing with patients experiencing this response. This in consequence may result in dismissing the patient and classifying them as "non-analyzable" or create a temptation to provoke them to quit the therapy. Luckily this patient-therapist relationship can be properly understood. Unfortunately, before coming to my office majority of described patients attempted to change their fate by joining various therapies which proved to be unsuccessful. The relevant insight is required for both the patient and the therapist in order to deal with suffering but bearing it seems to be patients domain.

The therapy may be long and complex process. Its length is highly influenced by the time the therapist needs to clearly understand messages send by the patient and establishing his own goals in the therapy or proper attitude towards patient's persistent suffering.

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