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Basic Psychoanalytic Concepts: VII. The Negative Therapeutic Reaction*

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The clinical concept of the *negative therapeutic reaction* has been included in this series for a number of reasons. It is a concept of particular importance in the history of psychoanalysis, for it represents the clinical phenomenon chosen by Freud (1923) to illustrate the workings of an 'unconscious sense of guilt' and to indicate the existence of what he conceived of as a special mental agency—the *superego*. Moreover, it is a concept widely used in clinical psychoanalysis, although little has been written on the subject since Freud's original formulation of it. Unlike such concepts as *transference* (Sandler, Dare and Holder, 1970) and *acting out* (Sandler, Holder and Dare, 1970a) it has not been extensively applied outside clinical psychoanalysis. This may be regarded as surprising in view of the fact that it would seem to be readily capable of application without alteration to a wide variety of clinical situations.

The phenomenon of the negative therapeutic reaction in psychoanalytic treatment was first described and explained by Freud as follows (1923): '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.'

Freud linked this with the operation of what he saw as an unconscious sense of guilt, due to the operation of the patient's conscience (an aspect of the 'superego'). In these cases the illness can be regarded, in part at least, as serving the function of allaying or reducing the patient's sense of guilt. His symptoms may represent a need for punishment or suffering, an attempt to appease an unduly harsh and critical conscience. It follows that recovery, or the promise of recovery, represents a particular type of threat to these patients, viz. the danger of experiencing acute and perhaps unbearable feelings of guilt. It is suggested that in some way the state of being well, of being free from symptoms, must in such patients represent the fulfilment of unconscious childhood wishes, the gratification of which is felt to be internally forbidden.

Shortly afterwards, in writing on masochism (1924), Freud added that the 'unconscious sense of guilt', which could lead to the negative therapeutic reaction, might in some cases be reinforced by a concealed unconscious masochistic tendency. This would lead to a further gain from the suffering due to the illness, and present an increased resistance to recovery. He suggests that 'The suffering entailed by neuroses is precisely the factor that makes them valuable to the masochistic trend' and added that 'contrary to all theory and expectation . . . a neurosis which has defied every therapeutic effort may vanish if the subject becomes involved in the misery of an unhappy marriage, or loses all his money, or develops a dangerous organic disease. In such instances

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one form of suffering has been replaced by another . . .'

It may be of some interest that Freud suggested in this paper that the idea of an unconscious sense of guilt is one which is difficult to explain to patients and which is in fact psychologically incorrect*. He remarked that the idea of a 'need for punishment' aptly covers the observed state of affairs.

Freud thus used 'negative therapeutic reaction' as (i) a *description* of a particular clinical phenomenon, i.e., the worsening of the patient's condition following some encouraging experience (e.g. the analyst's expression of satisfaction with the progress of the analytic work or the patient's own realization that progress had been made through the elucidation of some problem). This occurs when we might normally expect him to experience relief.

(ii) an *explanation* of the clinical phenomenon in terms of a psychological mechanism, i.e., a reaction, which takes the form of getting or feeling worse instead of better, aimed at reducing the guilt feelings evoked by improvement. In people who show this reaction, improvement can be thought of as representing the gratification of an internally forbidden wish, and is consequently experienced as a threat.

The negative therapeutic reaction was seen by Freud as being a characteristic of certain types of patient in analysis, and it is of interest that he had, some years earlier, described essentially the same mechanism in an entirely different context. In 1916 he had included, in the description of a number of different character types, 'those wrecked by success.' Beginning from the comment that neurosis originates in the frustration of an instinctual wish, he goes on to comment 'So much the more surprising, and indeed bewildering, must it appear when as a doctor one makes the discovery that people occasionally fall ill precisely when a deeply-rooted and long-cherished wish has come to fulfilment. It seems then as though they were not able to tolerate their happiness; for there can be no question that there is a causal connection between their success and their falling ill'. Freud illustrated his thesis by reference to the case of a woman who had lived happily with her lover for many years, seeming only to need legalization of their union to achieve complete happiness. When, finally, she and her lover were married, she went completely to pieces, developing an incurable paranoid illness. Freud also cites the case of a teacher who had for many years cherished the wish to succeed the master who had initiated him into his studies. When he was in fact chosen as the successor, he developed feelings of doubt and unworthiness, and succumbed to a depressive illness which lasted for some years.*

'Analytic work', said Freud, 'has no difficulty in showing us that it is forces of conscience which forbid the subject to gain the long hoped-for advantage from the fortunate change in reality' (1916).

Apart from an increasing recognition of the clinical importance of the negative therapeutic reaction, the psychoanalytic literature on the specific topic is relatively sparse. A paper by Feigenbaum (1934) describes a relevant clinical fragment, but two papers published shortly afterwards attempt to extend Freud's original concept to include a number of different mechaisms. In 1936 Joan Riviere pointed out that the negative therapeutic reaction as described by Freud did not mean that the patient was always unanalysable. The patient who reacts in this way does not always break off treatment, and changes may be brought about in the patient through appropriate analytic work. Riviere went on to suggest that 'Freud's title for this reaction, however, is not actually very specific; a negative therapeutic reaction would just as well describe the case of any patient who does not benefit from a treatment'. Riviere appears to have treated the concept more broadly than did Freud, and included a number of types of severe *resistance* to analysis (in particular refractory cases). In common with

* Freud maintained that feelings cannot appropriately be described as 'unconscious' (1923, 1924) but believed that the same factors which produce conscious feelings of guilt can operate outside conscious awareness, and that the concept of an 'unconscious sense of guilt' is useful in spite of philosophical and semantic objections to it.

* Freud also cited Lady Macbeth as well as Rebecca West in Ibsen's *Rosmersholm* as examples.

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a number of later authors (e.g. Rosenfeld, 1968) she included certain forms of resistance in which the patient either explicitly or implicitly rejects the analyst's interpretations. Much of Riviere's discussion relates to what we have described as resistances due to the threat of the analytic work to the patient's self-esteem and resistances due to 'fixed' character traits (Sandler, Holder and Dare, 1970b). Other aspects relate to the absence of an adequate *treatment alliance* in certain types of patient.

In contrast to Riviere, an important technical paper by Karen Horney (1936) begins with the formulation that the negative therapeutic reaction is not, indiscriminately, every deterioration of the patient's condition. She suggests that only those instances ought to be included in which one might reasonably have expected the patient to feel relief. She goes on to say that in many cases of negative therapeutic reaction 'the patient very often actually feels this relief distinctly, and then after a short while reacts as described', e.g. with an increase in symptoms, discouragement, a wish to break off treatment etc. A definite sequence of reactions appears, in principle, to be present. First, the patient experiences a definite relief, followed by a shrinking back from the prospect of improvement, discouragement, doubts (about himself or the analyst), hopelessness, wishes to break off, and makes remarks like 'I am too old to change'.

Horney suggested that the negative therapeutic reaction is embedded in persons with a particular type of 'masochistic' personality structure. In such persons the effect of a 'good' interpretation by the analyst (in the sense that the interpretation is felt by the patient to be correct) may be considered to be of five kinds. These are not always present nor equally strong, but may exist in different combinations.

1. Such patients receive a 'good' interpretation as a stimulus to compete with the analyst. The patient is resentful of what he feels to be the analyst's superiority. Horney considers competitiveness and rivalry to be above average in such patients, who are extremely ambitious. Fused with their ambition is an inordinate amount of hostility. They often express their hostility and their sense of defeat by belittling the analyst and attempting to defeat him. The patient's reaction in this case is not to the content of the interpretation but to the skill shown by the analyst.

2. The interpretation may also be regarded as a blow to the patient's self-esteem when it reveals to him that he is not perfect and has 'ordinary' anxieties. He feels reproached and may show a negative reaction in an attempt to turn the tables by reproaching the analyst.

3. The interpretation is followed by a feeling of relief, however fleeting, and the patient reacts as if the solution means a move towards recovery and success. This reaction would appear to embody both a fear of success and a fear of failure. While on the one hand the patient feels that if he attains success he will incur the same sort of envy and rage that he feels towards the success of others, on the other he fears that if he makes a move towards ambitious aims and fails others will crush him as he would like to crush them. Such patients recoil from all aims involving competition and impose a constant inhibiting or checking process on themselves.

4. The interpretation is felt as an unjust accusation, and the patient constantly feels as if the analysis is a trial. The interpretation reinforces existing feelings of self-condemnation, and the patient reacts by accusations directed against the analyst.

5. The patient feels the interpretation to be a rebuff, and takes the uncovering of his own difficulties as an expression of dislike or disdain on the part of the analyst. This type of reaction is related to a strong need for affection and an equally strong sensitivity to rebuff.

These types of reaction are elaborated on by Horney, and we have mentioned them here at some length because of their obvious clinical importance. However, in spite of her initial precise description of the negative therapeutic reaction, Horney (like Riviere) includes other 'negative' responses based upon different underlying psychological processes. While these are important from the point of view of the treatment of patients with 'narcissistic' and 'masochistic' personality structures, they differ in quality from the negative therapeutic reaction as described by Freud. The patient who shows

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this reaction *deteriorates* when he might be expected to improve, and this is quite different from the patient who *resents* a 'correct' interpretation, or who shows some form of aggressive 'contrariness'.

Clinical evidence of the existence of a negative therapeutic reaction in patients who have strong guilt feelings and a 'need for punishment' may sometimes be gained from the paradoxical reaction of such patients to interpretations which are felt by them to be an attack, criticism or punishment. This is shown in a case of a very masochistic patient described by Sandler (1959). 'Much of her silence and difficulty in association was meant to provoke me to anger and being relatively inexperienced at the time, I occasionally... betrayed my irritation with her either by my comments or in the tone of my voice. Whenever this happened, she would relax and the following session would be a "good" one; she would associate well and new material would emerge. This I understood at the time as being a result of having involuntarily satisfied her "need for punishment"...'.

The psychoanalytic writings on this topic (e.g. Feigenbaum, 1934; Riviere, 1936; Horney, 1936; Ivimey, 1948; Cesio, 1956, 1958, 1960a, 1960b; Greenbaum, 1956; Salzman, 1960; Arkin, 1960; Olinick, 1964; Rosenfeld, 1968) have added little to our knowledge and understanding of this mechanism, provided that we retain the specific description of the reaction put forward by Freud. Much of the published literature deals with more general types of resistance and 'negativistic' attitudes, and contributes to the further understanding of these. However, it seems worth while to retain the term 'negative therapeutic reaction' for the mechanism as originally described by Freud and linked by him with the need for the patient to protect himself against guilt feelings associated with the possibility of success or improvement.

Inasmuch as we can regard the propensity for negative therapeutic reactions to reside in the character of the individual, rather than being a function of the psychoanalytic treatment situation, these apparently paradoxical reactions to the threat of recovery or success can be regarded as occurring equally in other clinical situations. Thus it is to be expected that they can be detected as responses in certain individuals to progress (or to expressions of satisfaction by the therapist) in treatment of any sort. It would also follow that the previous histories of these individuals would indicate similar 'negative' reactions to experiences of success and achievement (Olinick, 1964).

It should be pointed out that there are a number of other reasons for a patient relapsing in situations in which improvement has occurred. These are quite distinct from the negative therapeutic reaction as described by Freud. For example, at the time of the termination of treatment a return of symptoms may occur. This is observed in other treatment situations, as when discharge from hospital or suggestion of cessation of outpatient attendance is discussed with the patient. Some relapses may be thought of in such terms as unresolved dependency of the patient upon the person of the doctor. Similarly, relapses may also represent attempts to deal with fears of breakdown after cessation of treatment which are now coped with by falling ill again before the end of treatment.

It is perhaps worth emphasizing that there is a multitude of causes for treatment failing or being ineffective which do not constitute negative therapeutic reaction. We have tried in this paper to distinguish a concept which seems capable of precise definition and is not simply an excuse for faulty technique or inappropriate interventions.

In conclusion, we can summarize by saying that the term 'negative therapeutic reaction' is used in the following ways:

(i) As a description of the situation in which worsening follows an awareness by the patient or expression by the therapist of improvement.

(ii) As an explanation of this clinical phenomenon, in which a worsening of symptoms is ascribed to the operation of guilt engendered by the atmosphere of encouragement, optimism, or approval.

(iii) The phrase has been extended in the literature to describe a character reaction of 'negativism' or contrariness that becomes manifested in a clinical setting as opposition to, or failure to accept benefit from, treatment.

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Such patients may, of course, improve during treatment, but they do not admit to it. This does not seem to us to be a useful extension of Freud's concept.

(iv) It has been used, in our view incorrectly, to include many other forms of resistance to the process of psychoanalytic treatment.

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