

THE NEGATIVE THERAPEUTIC REACTION

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Negative Therapeutic Reaction
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ABSTRACT

THE NEGATIVE THERAPEUTIC REACTION

by James C. Lewis, M.S.W.

This paper concerns itself with the syndrome of the Negative Therapeutic Reaction. The syndrome was first described by Freud in "The Ego and the Id" (1923) as a process occurring in "certain people" in the psychoanalytic situation. He referred to it as a reaction in which, when progress has been made or an intervention which should produce relief occurs, the patient reacts with an exacerbation of symptomatology. In other words, the patient gets worse instead of better. Often these patients are described by clinicians as difficult, unmanageable, deeply resistant, hopeless, severely disturbed masochists, and other such adjectives. The Project is an attempt at proposing a new theoretical understanding of the syndrome, its common clinical manifestations, the possible origins in development, and theoretical speculations as to indications and counter-indications for alteration in psychotherapeutic technique.

Chapter I consists of a statement of the author's interest in the subject, an overview of the clinical problem, a proposed tentative thesis of the work, and an overview of the Project.

Chapter II addresses itself to a review of existing literature on the Negative Therapeutic Reaction. Major emphasis is placed on the work of Freud. The papers of five authors are selected as representing the major theoretical work on the subject. These works are presented in historical order to convey a sense of the evolution of theoretical thinking on the subject. From the review, a definition is established, common clinical manifestations clarified, and differences in theoretical issues identified.

Chapter III, *Origins in Development*, is devoted to an exploration of various developmental theories with the intent of clarifying the developmental issues involved. The work of Margaret Mahler is emphasized, as well as Arthur Vallenstein and other writers. It is from this exploration that the thesis of the paper is supported. The thesis of the paper is that the Negative Therapeutic Reaction represents a response in the psychotherapeutic situation in which the transference may be characterized by the activation of numerous painful affects. Its origins in development is viewed as a major fixation in the "practicing" and/or "rapprochement" subphases of the separation-individuation process. The rapprochement crisis subphase is emphasized. The separation process is viewed as disturbed in the sense that it is extremely ambivalent, representing an intense love (symbiosis) hate (separation)

conflict with either a depressed, or rejecting and/or non-nurturing mother. Various types of mothering behavior are explored. Further, the syndrome is considered to represent an attachment to painful affects which symbolically represent the object tie to the mother; the loss of pain is equivalent to feared loss of the mother's love and abject fear of helpless dependence.

Chapter IV addresses itself to issues for psychotherapeutic intervention. Indications for focus of interventions, the therapeutic alliance, counter-transference problems, and indication vs counter-indication for alteration in technique are considered.

In Chapter V a case example is presented. This includes an overview of the case, two case process hours, and analysis of the case in terms of the theoretical material presented in the project.

THE NEGATIVE THERAPEUTIC REACTION

A PDE submitted to the Institute
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the degree of Doctor of Clinical Social Work

by

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I have always been too guilty to be happy. Guilt such as mine threatens life itself. The first task, therefore--and never has there been time for a second--is to fend off an inner accusation that threatens to annihilate. This I have done, by work, day after day after day, and so life has passed, and looking back I can see I've fought my daemons to a draw, or a little better, but where, lost to me, was the music, the laughing in the night?

Allen Wheelis

CHAPTER I

INTRODUCTION

Over the past several years, I have observed in a few of my patients and in cases reported to me by trainees a somewhat strange and bewildering clinical phenomenon. In these instances it seemed when the therapist made an intervention that could be understood as 'hopeful', that was correctly timed and the content accurate, and/or when the therapist expressed satisfaction with the course of the therapy, the patient reacted with an aggravation of the symptoms, a general overall exacerbation of the disorder, and a partial uncontrolled regression. I also observed that a period of 'negativism', in which the patient became rigid and opposed further interventions, followed this reaction. In some cases the negativism was overt, while in others more subtle. In neither case was it accessible to discussion nor exploration.

Needless to say, this rendered the therapist somewhat helpless and usually confused. Some therapists, I observed, reacted with intense countertransference feelings of self-doubt and criticism or anger at the patient. With inexperienced therapists, particularly, the countertransference involved not only self-doubt and criticism but also

guilt over any anger they experienced toward the patient. Frequently, they felt their diagnostic formulation was incorrect, their timing poor, and/or the content of the intervention inaccurate.

With time, my awareness became increasingly alerted to this phenomenon, and I proceeded to study more carefully its occurrence. What first struck me was the patient's experience in the period of negativism. At first, I speculated that some error in technique had been overlooked or some countertransference process had disturbed the therapeutic alliance; particularly since the therapeutic alliance seemed minimal during the period of negativism. At this time, there appeared to be little, if any, access to the patient. Later, my thoughts turned to the possibility that the super-ego processes had interfered with the optimal functioning or full development of the therapeutic alliance. After careful study of a few cases, I dismissed the idea that the patient's response was due to poor technique on the part of the therapist.

On turning to the literature, I discovered that Freud in The Ego and the Id (1923) had referred to the "negative therapeutic reaction" as a process in therapy that occurred in "certain people." A further search of the literature revealed very few articles devoted exclusively to the subject. After reading the few existing papers, it

became clear to me that a patient I had been treating twice weekly for over four years was responding with a negative therapeutic reaction which I would characterize as mild compared to cases mentioned in the literature. However, these readings enabled me to better comprehend her dynamics and my countertransference reactions. Because of a keen theoretical interest and a desire to better understand her condition, I have selected the study of the negative therapeutic reaction as the subject for my Project Demonstrating Excellence at the Institute for Clinical Social Work.

A Statement of the Problem

My reading on the subject to date indicates confusion, lack of clarity, and theoretical disagreement about the nature of the negative therapeutic reaction, its dynamics, and its origins in development. At the 1969 fall meeting of the American Psychoanalytic Association, a panel discussion on the subject, chaired by Dr. Milton H. Horowitz, attracted a large audience and resulted in heated debate, reflecting this confusion and disagreement as well as widespread interest. From Olinick's summation of the discussion (1970), it is hard to discern an unambiguous view or a consensus regarding the concept of the negative therapeutic reaction. The theoretical issues involved are

as complex and difficult as is its clinical management. Metapsychology, drive theory and the development of the ego and super-ego are certainly involved. Furthermore, there is sparse mention of therapeutic strategy or the implications for altered technique. From my vantage point, the likelihood of many persons who suffer such a condition entering psychotherapy is greater than has been acknowledged and thus requires more detailed consideration.

Although a complete definition must be held at bay for the present, the literature, ambiguous as it is, provides some areas of common understanding from which to begin. It can safely be stated at this point that the negative therapeutic reaction represents a deep resistance to getting better. Clinicians would probably describe this resistance with such adjectives as difficult, unmanageable, deeply resistant, hopeless and severely masochistic, to name a few. An intervention that would ordinarily produce feelings of relief, hope, expectation for an improved life instead produce increased resistance, symptomatology and suffering. In other words, the patient becomes worse instead of better in response to appropriate therapeutic procedures. Such writers as Freud, Olinick and Vallenstein agree that in these patients there is an intense need for the illness, for suffering, and for punishment. The illness has the upper hand over the desire to recover.

This presents the therapist with what appears to be an unsolvable problem. The clinician ordinarily relies heavily on the patient's experience of suffering as motivation to undergo the hardships of therapy. In these persons, however, the unconscious motivation urges them to cling to pain, to preserve it, even to nurture it. Hence, the patient's motivation is opposed, even contradictory, to the motivating forces of therapy.

The picture appears even more bleak if one seriously considers Freud's view of the syndrome. In "Analysis Terminable and Interminable" (1937), he attributes the negative therapeutic reaction to a deep-seated unconscious resistance which originates in the super-ego. The aggression of the super-ego toward the ego he views as a derivative of the death instinct itself. The sense of guilt represents the workings of that portion of the death instinct which is "psychically bound by the super-ego." The negative therapeutic reaction, as understood by Freud then, is ultimately based on the prevalence of the death instinct in the economy of psychic life. Freud basically considered the condition to be unanalyzable. Other writers share this dim view and consider the prognosis to be extremely poor due to the inaccessibility and non-verbal nature of the impulse.

The purpose of this paper is to review the existing

literature and related papers on the negative therapeutic reaction with the goal of proposing a new theoretical view of the condition, its common clinical manifestations, and its possible origins in development; also to present theoretical speculations about the indications and counter-indications for alterations in technique. Some therapeutic variables will be explored, for I believe there is hope for persons suffering from this syndrome, even though they are indeed extremely difficult treatment cases.

Clinical social workers often encounter in their practice a broad range of clientele, many of whom can be described as difficult. My hope is to create a broader understanding of some of these patients. Perhaps some clinicians will be able to more easily diagnose the condition and formulate a more adequate therapeutic plan. The project may, as well, be a support to clinicians since some of the confusion may be clarified as to whether the therapy, the therapist, or the difficulty of the patient's problems are at issue.

The Thesis of the Paper

My current working hypothesis states that the negative therapeutic reaction represents a reaction to the psychotherapeutic process because the transference activates numerous painful affects including dread, painful longing, a generalized intense fear of the therapy and

self-disclosure, deep concern that the person will be ridiculed or shamed, and defensive cognitive confusion resulting in a lowered capacity to observe and report intra-psychic processes. Its origins in development are attributed to a major fixation in the "practicing" and "rapprochement" subphases of the separation-individuation process of infancy. The separation process is considered 'disturbed' in the sense that it is extremely ambivalent, representing an intense love (symbiosis) hate (separation) conflict with a mother who manifests any combination of depression, rejection or non-nurturance. Various types of mothering behavior which lead to such a fixation will be explored. Further, the negative therapeutic reaction will be referred to as an 'attachment' to painful affects which symbolically represent the object tie to the mother. The loss of pain (that is, becoming better, improving, experiencing positive feelings) is equivalent to the fear of losing the mother and returning to a state of abject helpless dependence. The activation of the transference through therapeutic procedures stimulates these painful affects and fears, resulting in behavior which appears to be a resistance to 'getting better'.

An Overview of the Paper

In order to develop a perspective from which to analyse the negative therapeutic reaction, I have organized

this paper into four central sections. In the first section, I shall discuss the significant literature to date on the syndrome, placing primary emphasis on the works of Freud. Although the literature is sparse, I have chosen to focus on five authors whose works represent central contributions to an understanding of the syndrome. The primary purpose of this review is to acquaint the reader with a number of different theoretical orientations which influence the way one views the definition, the dynamics, the developmental origins, and the perspectives on the course of treatment. After taking these factors into consideration, I shall present a working definition, specify some of the common clinical manifestations, and compare some of the major differences in theoretical orientation.

In the second section, I shall explore the various developmental theories which contribute to an understanding of the developmental origins of the negative therapeutic reaction. Here I shall rely heavily on the works of Margaret Mahler and her associates and comment on the various theoretical positions of Vallenstein and Riviere, with the hope of supporting my thesis.

In the third section, I shall address the issues involved in treating the patient who suffers from this syndrome. This will include a discussion of the therapeutic interventions, their indication and counter-indication, the therapeutic alliance, and countertransference problems.

In the final section, I shall present two case process hours of a woman I have seen twice weekly over a four year period and who manifests the symptoms of a negative therapeutic reaction. This section will also include a historical overview and an analysis of the case in terms of the theoretical material presented in the previous sections.

In the course of these four sections, I hope to present substantial material to support my thesis and to open speculation which leads to further exploration.

This project will be limited in that extensive research into affect theory, ego disturbances involved in the disorder, and the contribution of pre-oedipal super-ego processes in the transference will, of necessity, be confined. The work of Jacobson, whose contributions greatly enrich the theoretical concepts found throughout the project, are not given a distinct section. Rather, her valuable concepts are interwoven with those of other theorists found throughout the work. The focus of the paper will be on clinical manifestations, possible developmental origins, indications for treatment, and case analysis.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter explores the literature directly related to the negative therapeutic reaction: first, the papers of Freud--primarily "The Ego and the Id" (1923), "The Economic Problem of Masochism" (1924), and "Analysis Terminable and Interminable" (1937)--and then in historical order, the works of Horney (1936), Olinick (1964, 1970), Loewald (1972) and Vallenstein (1973). Hopefully, such an approach will offer the reader a flavor for the common ground and divergent views as they have evolved. Some degree of emphasis will be placed on the concepts of ego development and object-relations theory as they present themselves for purposes of the project.

The purpose of this review is to establish a working definition of the syndrome by noting some common clinical manifestations and speculations about dynamics and developmental origins. The works of other writers, such as Mahler and her associates, will be reviewed in a later chapter as they offer insight and clarification on the condition. In this way, I hope to establish a firm support for this new theoretical view of the negative therapeutic reaction.

The Papers of Sigmund Freud

Freud referred to the worsening of symptoms during treatment in the technical papers of 1913-1918. In the case history of the Wolf Man (1918), he first referred to "negative therapeutic reactions" and commented on the patient's habit of producing transitory "negative reactions" when something had been conclusively cleared up. In other words, aggravation of the symptoms contradicted the results of the therapeutic work.

By 1918, he viewed the increase in symptomatology as an example of negative defiance related to the anal-sadistic phase of libidinal development. He compared it to the tendency in a child to respond negatively to prohibitions which are newly invoked (1918).

By the time Freud wrote The Ego and the Id (1923), his formulations had altered extensively. He came to view this negativism as a refusal to allow the impulses of the id to come forth and he redefined this negativism as a syndrome rather than a symptom.

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 a 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."

There is no doubt that there is something in these people that sets itself against their recovery, and its approach is dreaded as though it were a danger. If we analyze this resistance in the usual way--then, even after allowance has been made for an attitude of defiance towards the physician and for fixations to the various forms of gain from the illness, the greater part of it is still left over; and this reveals itself as the most powerful of all obstacles to recovery, more powerful than the familiar ones of narcissistic inaccessibility, a negative attitude towards the physician and a clinging to the gain from illness (p. 39).

Freud goes on to elaborate by making a distinction between the negative therapeutic reaction and the neurotic disorders of depression, obsession and hysteria by comparing the differing relationships between the super-ego and the ego. In the obsessional neurosis, the sense of guilt is intense but cannot justify itself to the ego. The ego rebels and seeks the aid of the therapist to repudiate the super-ego. In depression, the super-ego is more powerful and gains a stronger hold on the ego, that is, the guilt is more conscious. The ego then submits to the aggression of the super-ego and seeks punishment. Identification with the aggressor, the super-ego, takes place. In hysteria, guilt is simply repressed. In all forms, the true source of the guilt and the impulses involved in the guilt remain largely unconscious. Freud points out, however, that with correct therapeutic intervention, the guilt can

be brought to consciousness and resolved; that is, the super-ego, the true source of the guilt, can be recognized and the ego brought into relation to it. The patient then experiences relief, satisfaction and pleasure which allows libidinal discharge to occur. For persons suffering from a negative therapeutic reaction, the guilt is also unconscious; however, the resolution does not occur--it is avoided. There appears to be a tenacious clinging to the aggression of the super-ego and a corresponding need for punishment. This then forms a "resistance" to the therapist who represents hope.

Although Freud left the dilemma unsolved, he contributed a firm conviction that the problem involved the ego's relationship to the super-ego. He further added that a predominance of aggression existed in the relationship; a predominance which was unconscious and intensely defended against. He speculated that the workings of the death instinct were involved and had gained, for some unexplained reason, dominant control over the libido. He concluded:

The id, to which we finally come back, has no means of showing the ego either love or hate. It cannot say what it wants; it has achieved no unified will. Eros and the death instinct struggle within it; we have seen with what weapons the one group of instincts defends itself against the other. It would be possible to picture the id as under domination of the mute but powerful death instincts, which desire to be at peace and (promoted by the pleasure principle) to put Eros, the mischief-maker, to rest; but perhaps

that might be to undervalue the part played by Eros (p. 49).

In the "Economic Problem of Masochism" (1924), Freud once again addresses himself to the negative therapeutic reaction and strongly connects it to an unconscious sense of guilt (i.e., a need for punishment), moral masochism, and the predominance of the death instinct in the economy of mental life. This is a stated attempt by Freud to resolve a problem in theory. Does the phenomena of masochism contradict the pleasure principle? Of necessity, the dilemma involves the relationship between the death instinct and the erotic life instinct. Here Freud elaborates upon the concept of moral masochism as that form of masochism which assumes a "norm of behavior" and he differentiates it from erotic masochism and feminine masochism. In erotic masochism, pain becomes associated, or equated, with sexual pleasure and release due to a pathological resolution of the oedipal complex. This occurs mainly through an eroticized submission to the father and a need for punishment to alleviate fears of castration. In feminine masochism, the pleasure of release following an increase in biological tension (pain) results in a pleasure-pain association. Moral masochism, on the other hand, Freud views differently:

The third form of masochism, the moral type, is chiefly remarkable for having loosened its connection with what we recognize to be sexuality. To all other

masochistic sufferings there still clings the condition that it should be administered by the loved one; it is endured at his command; in the moral type of masochism this limitation has been dropped. It is the suffering itself that matters; whether the sentence is cast by a loved or by an indifferent person is of no importance; it may even be caused by impersonal forces or circumstances, but the true masochist always holds out his cheek whenever he sees a chance of receiving a blow. One is much tempted, in explaining this attitude, to leave the libido out of account and to confine oneself to an assumption that here the instinct of distinction is again turned inwards and is now raging against the self; yet there should be some meaning in the usage of speech, which has not ceased to connect this norm of behavior in life with erotism and calls these maimers of themselves masochists, too (p. 262).

Freud goes on to connect moral masochism with the negative therapeutic reaction:

True to a habit which has grown out of our technique, let us first consider the extreme, undeniably pathological form of this masochism. I have described elsewhere how in analytic treatment we come across patients whose behavior in regard to the effects of the analysis compels us to ascribe to them an "unconscious" feeling of guilt. I then mentioned the trait by which these people are recognized (the negative therapeutic reaction), and I did not correct the fact that a strong feeling of this kind amounts to one of the most difficult resistances and the greatest menace to the success of our medical and educative aims. The gratification of this unconscious sense of guilt is perhaps the strongest item in the whole "advantage through illness" (which is as a rule composed of many different gains), i.e., in the sum total of the forces which oppose the cure and struggle against relinquishing the neurosis; the suffering that the neurosis involves is the very element which makes it of value to the masochistic trend (p. 262-263).

Freud continues to elaborate his definition of moral masochism by distinguishing it from disorders involving an overly sadistic super-ego. In the latter the

ego becomes a co-conspirator by virtue of the masochism embedded in the ego. The ego seeks punishment from within and from without. Freud saw this as stemming from a fixation in a highly eroticized oedipal stage and resulting in a need for punishment for fantasies belonging to this period. He considers this to represent evidence of "instinct fusion."

Moral masochism thus becomes the classical piece of evidence for the existence of "instinct fusion." Its dangerousness lies in its origin in the death instinct and represents that part of the latter which escaped deflection into the outer world in the form of an instinct of destruction. But since, on the other hand, it has the value of an erotic component, even the destruction of anyone by himself cannot occur without gratification of the libido (p. 268).

"The Economic Problem of Masochism" reflects a growing change in Freud's view of the negative therapeutic reaction. He extended the theory from an unconscious sense of guilt which seeks punishment to an infusion into the ego of the aggressive instincts which represent the operation of the death instinct. At this later stage, the ego then not only submits to attacks from the super-ego but also seeks and invites attack. From this point of view, one can conclude that the negative therapeutic reaction is not just a reaction against the therapist and his interventions, but represents a resistance to improvement itself. According to Freud, improvement represents an abandonment of the life-death struggle in which the

death instinct has held the "upper hand." In terms of prognosis, this reflects a very dim outlook.

In Freud's terms, the negative therapeutic reaction bespeaks a deep-seated unconscious resistance which comes from the super-ego and its relationship to a masochistic ego. Although Freud speculates that the operations of the death instinct are involved, I note that he seems in conflict with the issue and reluctant to definitely connect the negative therapeutic reaction to the death instinct. However, in "Analysis Terminable and Interminable" (1937), he establishes a more definitive connection.

Nothing impresses us more strongly in connection with the resistance encountered in analysis than the feeling that there is a force at work which is defending itself by all possible means against recovery and is clinging tenaciously to illness and suffering. We have recognized that part of this force is the sense of guilt and the need for punishment, and that is undoubtedly correct; we have localized it in the ego's relation to the super-ego. But this is only one element in it, which may be described as psychically bound by the super-ego and which we thus perceive. We may suppose that other portions of the same force are at work, either bound or free, in some unspecified region of the mind. If we consider the whole picture made up of the phenomena of the masochism inherent in so many people, of the negative therapeutic reaction and of the neurotic's sense of guilt, we shall have to abandon the belief that mental processes are governed exclusively by a striving after pleasure. These phenomena are unmistakable indications of the existence of a power in mental life, according to its own aims, we call the aggressive or destructive instinct and which we derive from the primal death instinct of animate matter. It is not a question of an optimistic as opposed to a pessimistic theory of life. Only by the concurrent or opposing action of the two primal

instincts--Eros and the death instinct--never by one or the other alone, can the variety of vital phenomena be explained (p. 245-246).

Freud, then, understood the negative therapeutic reaction as ultimately based on the prevalence of the death instinct in the economy of psychological life. Guilt for one who suffers such a syndrome represents the operations of that portion of the death instinct which are "psychically bound by the super-ego."

Hans Loewald emphasizes that Freud was concerned more with issues that transcend clinical manifestations of unconscious guilt, the need for suffering, and masochism. As Loewald stresses, Freud tried to caution against the pitfalls of a strict division of the psyche into id, ego, and super-ego; instead, he placed emphasis on the roles of Eros and Thanatos in the formation of these provinces of the mind. Indeed, the interrelations of ego, super-ego and id are manifestations of the interaction of Eros and Thanatos (1972:238).

Although most theorists are comfortable with the dual instinct theory when it is formulated in terms of sexual and aggressive drives, most disagree with the concepts of Eros and Thanatos, especially when the death instinct is viewed as operational in the psyche. It is important to recognize, however, that Freud had these theoretical concerns in mind when he wrote about the

negative therapeutic reaction.

In Freud's observations, the major clinical manifestation of this syndrome is a reaction by the patient of increased suffering to an intervention which should produce relief. The major dynamic at work is an unconscious sense of guilt resulting in a need for punishment. Freud identified a special form of masochism, moral masochism, as involved in the syndrome and, significantly, labeled it a resistance. At the base, however, Freud saw this resistance as representative of the operation of the death instinct. His works, then, reflect an attitude of pessimism with regard to a therapeutic resolution to the problem.

With this foundation established, the next sections explore the writings of Horney, Riviere, Olinick, Loewald and Vallenstein for their varied clinical perspectives on the syndrome and their understanding of Freud's dynamic.

The Paper of Karen Horney

Karen Horney's paper, "The Problem of the Negative Therapeutic Reaction" (1936), represents an attempt to broaden Freud's description of the syndrome and to shed increased light on the character structure of such individuals. Briefly stated, Horney notes that the syndrome tends to arise primarily in "masochistic" character types who display an intense need to disparage the therapist and

therapy. She sees the negative reaction as stemming from the patient's "hostile striving for supremacy" which protects him from severe anxiety, especially the anxiety over the loss of affection. Horney agrees with Freud that the reaction is to a hopeful or good interpretation. However, she carries this further:

We see, moreover, that the negative therapeutic reaction follows regardless of the specific content of the problem or solution offered. That is, the reaction does not primarily express a resistance against some particular insight (p. 32).

In order to investigate the underlying motivation for this reaction, she describes five common reactions which characterize the syndrome.

In summary, the first reaction is one in which the patient perceives the interpretation as a stimulus to compete; as if the therapist, by seeing something he had not, is proved more intelligent and thus has asserted superiority over him. The patient then reacts with resentment which expresses itself in many different ways. More often than not, however, the treatment takes the form of belittling or diverting the therapy or the therapist in order to regain a position of superiority. Generally, in daily life, such persons are competitive with everyone, including themselves, and tend to be perfectionists. They disparage all competitors or react defensively with exaggerated admiration. Horney states that this attitude is usually

deeply unconscious. This "striving for absolute supremacy" serves as a protection against severe anxiety; that is, it insures safety through absolute power. Any progress in the treatment represents a triumph for the therapist and a defeat for the patient.

The second reaction, as Horney describes it, is one in which the patient perceives the hopeful interpretation as an exposure of a characteristic the patient believes to be a weakness or flaw of character; in other words, a narcissistic blow. The patient feels humiliated. The discovery that his self-expectations are irrationally high brings not a sense of relief but a feeling that he is imperfect or has failed. Often the patient feels like the therapist is scolding him. The patient, assuming a defensive posture, then attempts to humiliate the therapist by making him feel insignificant, preposterous and ineffectual. One sure method to achieve this goal is to make no progress or, if progress is felt, to withhold reporting it.

The third reaction Horney relates to what she terms a special form of "fear of success." With a hopeful interpretation, the patient actually does respond with a feeling of relief or mastery; however, this relief is not enduring but lasts only a very brief period, perhaps so brief it scarcely figures in awareness.

The underlying dynamic involves a feeling of relief which triggers hope for a "successful" conclusion and mastery of the problem. Since success is unconsciously viewed as dangerous, however, it is equated with defeat or, at the very least, a loss of love and approval. The reverse is also true; if failure occurs, others will view such a person with disdain and lack of respect. In order to ward off these dangers, the patient does not move and, thus, he does not make progress.

The fourth reaction is one in which the intervention is felt to be accusatory. That is, the patient unconsciously views the entire psychotherapeutic situation as a court trial in which he is the defendant; the only difference being that he has no defence attorney to speak for him. The patient hears the therapist's statements as unjust accusations. Horney here agrees with Freud that such a reaction represents an unconscious sense of guilt. To the extent that the patient experiences a sense of guilt, an interpretation, no matter how kindly and considerately given, will evoke feelings of total condemnation. The intensity of the reaction will be in direct proportion to the unconscious feelings of self-condemnation. Defensively, the patient reacts with a counter-attack on the therapist or therapy. In my experience, this reaction is accurate in some cases; however, often there is another

reaction in which the patient throws himself at the mercy of the court, eager to declare guilt. The forthcoming punishment, the patient feels, is deserved. Unconsciously, the patient hopes that by admitting guilt, love will follow. This is akin to, but not the same as, "identification with the aggressor", which will be dealt with in more detail later.

The fifth reaction, closely related to the fourth, is one in which the patient is convinced the therapist is personally rejecting him. This Horney attributes to an "excessive need for affection." Looked at from this dynamic, the patient takes any uncovering of his problems as an expression of the therapist's dislike or disdain, and he reacts with strong antagonism.

Horney does not believe that all five characteristics need be present at any given time, but she does believe they are all related and point to a common underlying dynamic. She contends that the negative therapeutic reaction stems from a basic hostility originating in a deep, intense need for affection which in early childhood was frustrated. Characteristically, the childhood of such patients lacks "warmth and reliability" and is, instead, blurred with fighting, conflict, injustice, and cruelty. The reaction to such a situation is a strong wish for power to ward off internal pain and further attacks from

outside. The dilemma occurs, however, because the desired power is unattainable without fearfully risking a reaction of envy and hatred from others and thereby ultimately losing the very affection one seeks.

The psychotherapeutic situation activates this very dilemma. The patient must ward off interpretations in order to maintain a defensive balance. I am, to some degree, in agreement with this view; however, it is superficial in many regards and leaves many questions unanswered. For one, Horney tends to focus on patients who overly react with negativism and hostility. I contend, rather, that this constitutes perhaps only a small portion of such patients. Similarly, Horney does not speak to the exact nature of the "basic anxiety" or its specific origins in development; instead, she establishes only a basic personal dynamic from which one must surmise the transcendent issues.

Also interesting to note is the fact that all the patients Horney studied were male. She does not speak to the issues surrounding a sex difference in the clinical setting, particularly when the therapist is a female and the patient is a male. Some of the hostile resistance she alludes to could have come from the male's resistance to a passive, dependent position. This might have been particularly true in 1936.

The Paper of Joan Riviere

Joan Riviere, in "A Contribution to the Analysis of the Negative Therapeutic Reaction" (1936), takes a very different approach than Horney. Utilizing Melanie Klein's concept of the depressive position, she draws attention to the inner world of object relations as they relate to narcissism and depression. Rather than focusing on the overt or disguised expression of hostility and the need to protect self-esteem as Horney does, she places major emphasis on the patient's need to control the therapeutic situation and the therapist. The patient's need for control results in a fixed, rigid posture which insures no progress. Riviere considers this the result of a major, fixed resistance against a deep, intense, depressive internal position.

By going to the heart of the matter immediately, she focuses on the forces which must be in operation to allow progress to occur. She speculates that perhaps progress itself constitutes the danger for persons suffering from this syndrome. In questioning the dynamic behind this, Riviere compares the negative therapeutic reaction to other conditions with poor prognoses such as the narcissistic personality and manic disorders. What emerges is her observation that the narcissistic position in these latter

cases protects the person from severely painful anxiety and the distress caused by early internalized objects.

Riviere then speculates that the narcissistic investment in the maintenance of control may have bearing on the negative therapeutic reaction. The control itself serves the defensive posture and fulfills a wish in the patient to impede health. The patient's underlying desire is to preserve the status quo, a condition which has proven more bearable. At root is a compromise; for the patient neither finishes therapy nor terminates. In other words, he has found a degree of equilibrium which he does not wish disturbed. With this perspective in mind, one can see that any indication of praise or hope from the therapist suggests change in the equilibrium and, thus, stimulates the defensive posture.

Riviere accounts for the phenomenon by postulating that the patient's motivation is not to prevent change but, rather, to mistrust the possibility of health. What he really expects unconsciously is not a change for the better but a change for the worse, and that change represents disaster, not only for himself but also for the therapist. Control, and the resulting "inaccessibility" of the patient, is due to the fear of something worse than the original condition happening.

Now what is the still worse situation which the patient is averting by maintaining the status quo,

by keeping control, by his omnipotent defenses? It is the danger of the depressive position that he is guarding himself and us against; what he dreads is that the situation and those anxieties may prove to be a reality, that the psychical reality in his mind may become real to him through analysis. The psychical truth behind his omnipotent denials is that the worst disasters have actually taken place; it is this truth that he will not allow the analysis to make real, will not allow to be "realized" by him or us. He does not intend to get "any better," to change, or to end the analysis, because he does not believe it possible that any change or any lessening of control on his part can bring about anything but realization of disaster for all concerned. I may say at once that what this type of patient ultimately fears most of all--the kernel, so to speak, of all his fears--is his own suicide or madness, the inevitable outcome, as he feels it unconsciously, if his depressive anxieties come to life. He is keeping them still, if not dead, by his immobility (p. 312-313).

In the internalized world of objects, there is only despair: one's loved ones within are dead or soon will be; neediness is a burden; love is an impossible dream; and paradise has been lost forever. Inwardly lies the conviction that one is utterly alone and lost. There is no one to turn to for sharing or help. Unconsciously, the patient feels he is responsible for his love which is burdensome and his anger which is destructive. His attempts to "make things better" are never successful--certain proof of his essential badness. Indeed, because of a deep conviction that he has injured those who love him through his own selfishness and greed, thus depriving them of life's pleasures, he clings to the hope of one day redeeming his failures so his loved ones will be happy. Then only will

he find relief.

Riviere proceeds to the center of the therapeutic problem with the profound observation that therapy itself appears subjectively to the patient to symbolize a "betrayal" of those he has neglected. Thus the damage he has done can never be repaired. When the therapist offers hope and encouragement, the patient sees this as a conspiracy in which he must abandon his task of curing others first in order to put himself before them. Furthermore, to turn his loved ones into enemies and neglect them, to defeat them instead of helping them, is in his eyes sedition. Should he be guilty of such a crime, he cannot escape confirmation of his essential badness. Indeed, such a revelation would leave him in a state of total helplessness and despair. Should he not destroy these wronged loved ones, he must endlessly repay them for his sins, a state worse than the first. Since cure represents such a state of affairs, he must avoid it at all costs. Control, inaccessibility and rigid non-movement are preferable. Riviere postulates that such a person's intense "love for his internal objects" is the true motivation for the guilt. This love, then, represents the "one thread of hope" in the treatment.

Riviere's study contributes an exciting and in-depth broadening of the syndrome which, I feel, is nothing

short of brilliant. Later on, the implications of her views will figure in a synthesis interwoven with the works of other writers. Her theoretical observations have a significant bearing on treatment as well as the dynamic origins of the negative therapeutic reaction.

The Papers of Stanley Olinick

In Stanley Olinick's account of the panel discussion on the negative therapeutic reaction held at the fall 1969 meeting of the American Psychoanalytic Association (1970), he summarizes the discussion and debate. The purpose of the panel was to review the existing literature on the negative therapeutic reaction in order to come to a common definition of the syndrome, its probable dynamic origins, and its clinical manifestations. Particular interest emerged around the treatability of persons suffering from this syndrome and the theoretical implications. Because the discussion was, to all appearances, fast-moving and lively, Olinick's paper is confusing and provides no simple focal point. For this reason, I have chosen to focus on the major issues which emerged during the discussion.

As far as a definition of the syndrome, there appeared to be little debate. Most panel members were in agreement with Freud's original formulation that the

syndrome manifests itself in an exacerbation of symptomatology following an accurate or hopeful interpretation. However, some felt this could occur in any number of persons who suffered from "an unconscious sense of guilt." Confusion occurred when the panel members tried to pin down what characteristics in the clinical picture necessitated a diagnosis of "negative therapeutic reaction." As a means of specifying these characteristics, the discussion turned to speculation about the possible dynamic origins.

Charles Brenner, a panel member, perceived the negative therapeutic reaction as an unpredictable masochistic transference resistance. He postulated that masochistic character traits and fantasies serve multiple functions, including defensive ones. These functions, "multiply determined" by co-existing conflicts and tendencies of ego, super-ego, and id, he believed to be chiefly the legacy of oedipal conflicts related to the hierarchy of dangerous infantile situations, i.e., loss of object, loss of love, castration. He noted that the importance of the early situation, as it relates to the establishment of a defense, varied from case to case. Although special technical difficulties arise in the handling of the sado-masochistic transference, Brenner found no essential differences in the analysis of a negative therapeutic reaction as

opposed to other characterological disorders.

In Olinick's own earlier study, "The Negative Therapeutic Reaction" (1964), he views the syndrome as a component of sado-masochism and as a special case of negativism. Persons prone to the syndrome are endowed with a greater than average fund of aggressive orality and drive energy. This is the result of special stresses in the early mother-child relationship and later in the analytic situation. In early development, mother and child form an ambivalent unit from which the father is excluded, leading to a profound fear of object loss as well as a fear of gratification in the child. The result is a generalized negativism. Such persons also fear the regressive pull to fusion with an early, depressive maternal object. Olinick perceives the problem of the negative therapeutic reaction as arising during periods of latent positive transference; the press of forbidden wishes triggers automatic negativism, denial or negation.

Many panel members were in agreement with Olinick's earlier formulation of negativism as a defense against an early disturbed mother-child relationship. They expressed a degree of commonality in the view that the transference is often characterized by a "projection of the internalized depressed mother into the analyst's psyche." This affirmed one central characteristic: an archaic super-ego identification with a depressed mother.

The ensuing discussion raised the issue of whether the aggression in the super-ego is structured or unstructured (i.e., primary or secondary), a central issue in determining prognosis and treatment posture. Some members, Loewald and Vallenstein in particular, were in agreement with Freud that the aggression is unstructured and, therefore, only derivatives are interpretable. Others, such as Horney and Riviere, maintained that at one time the aggression was directed outward and only secondarily inward. The inward direction, finalized by the resolution of the oedipal complex, thus achieved the status of 'structured'. Still others argued that the pre-oedipal precursors of the super-ego had not achieved structure and, therefore, were inaccessible to therapeutic intervention.

Olinick concludes the report with an overview of the areas of agreement and disagreement. The general areas in which he observed agreement were: the multideterminism and multifunctioning of the ego as collator and synthesizer; the essential importance of aggression, the unconscious need for punishment, and masochism; and the early pre-oedipal mother-infant interaction structured into an incomplete or skewed oedipal situation. He also noticed agreement about a more positive therapeutic prognosis when more elements of the conflict are integrated into the oedipal situation because the structured super-ego can

entertain the possibility of a conscious sense of guilt. He also found the participants agreed that the degree of regression and fixation operative in the patient's psyche directly influences the range and intensity of symptom manifestation. Finally, the panel members viewed the negative therapeutic reaction as originating not from the psychoanalytic technique itself but from a latent positive transference.

Olinick cites disagreement in these areas: the extent of pessimism about the prognosis; the relevance of various aspects of the defense structure including negativism as a central, integrating, organizing pre-oedipal factor. Further, there were doubts about the validity of clinical instances allegedly demonstrating the reaction.

The Paper of Hans Loewald

The work of Hans Loewald, "Freud's Conception of the Negative Therapeutic Reaction, with Comments on Instinct Theory" (1972), represents an effort to re-examine Freud's original concept of the syndrome in terms of instinct theory. Loewald addresses directly the issue of the death instinct, a factor left undetermined by the American Psychoanalytic Association Panel. In addition, he concerns himself with the relationship between theory and prognosis.

Loewald adheres to the concept of the death instinct and the life instinct (Thanatos and Eros) as drives

which manifest themselves in the negative therapeutic reaction. He agrees with Freud that there appears to be an imbalance between the libidinal and aggressive drives in such persons. Since the imbalance is in favor of the aggressive instincts (i.e., the death instinct), the result is perverse masochistic tendencies, an unconscious sense of guilt, and a need for punishment.

Loewald contends that persons suffering the syndrome are not defending against their sado-masochistic or symbiotic needs by not improving but, rather, are "thoroughly masochistic." Improvement represents a lessening of the self-punishment they require. Further, and in accordance with Freud, it represents an abandonment of the life-death struggle in which the death instinct has control. Irrational unconscious guilt feelings and a strongly masochistic attitude toward a sadistic super-ego, Loewald speculates, may be expressions of this slanted imbalance. In more severe cases, this imbalance is rooted in problems with the precursors of morality, conscience, and guilt which pre-date the oedipal complex and the formation of the super-ego. In other words, destructive forces predominate and affect the person before structuring can occur. This view is in keeping with Kernberg's theory that a predominance of aggressive affect prevents the establishment of object constancy (1976:62).

Loewald, aligning himself with Olinick, Mahler, Spitz, and Winnicott, believes instincts are not just in-born givens but arise out of an early mother-infant dyad. He acknowledges a relationship among the aggressive-libidinal drives, early ego development, and the mother-child dyad. In this sense, the negative therapeutic reaction represents an early disturbed relationship between infant and mother in which the aggressive drives predominate. The death instinct, then, cannot be viewed as an independent variable; rather, it is interwoven with the mother-child dyad.

The intensity of destructive tendencies and of their narcissistic entrenchment in the negative therapeutic reaction would depend, predominantly, on early interactions which favor a distorted organization of both destructive and libidinal, destructive and creative, drives, and favor a lack of balanced coordination of them (p. 242).

The Paper of Arthur Vallenstein

Vallenstein, in his paper "On Attachment to Painful Feelings and the Negative Therapeutic Reaction" (1973), proposes that at the core of the syndrome is the patient's attachment to painful affects which originate in very early life experiences. Such experiences take place within the tie to the primary object as it develops out of the "objectless" stage of primary narcissism, the period immediately after birth when self and object are in no sense differentiated. Furthermore, the painful affect of this

object tie is reinforced through all the psychosexual stages of development. In other words, the earliest painful experiences, as well as the later ones, with the mother dominate the relationship and come to form the core of the patient's identity. To give up pain is the equivalent of giving up part of the self and the internalized mother. This view corresponds to Loewald's formulation that the origin of the dominant aggressive drive is in the early mother-infant dyad.

Vallenstein then proceeds to examine the development of affects as they relate to objects. He acknowledges a state of incompleteness in the theory of affects, particularly as they relate to self and object. With this in mind, he proposes an extension of Hartmann's adaptation theory by considering affects as a means of "communication" to the self and others in the environment about adaptation-al needs.

Very early in life, motor-responses reflecting affective distress began to have communicational meaning for adaptation. In general, a whole range of affects, whether affection, anger, guilt, remorse, sadness, despair, etc., convey meaningful action-reaction mobilizing information to the self, as well as to others; often with the implicit or explicit intention of promoting adaptively helpful environmental intervention (p. 316).

Essential to a healthy development is a response to early affect messages in a manner which promotes need satisfaction, that is, pleasure. Vallenstein calls this a "good" mother-child fit."

He points out that the lability of drives in an infant and the fluidity of response to objects is attributable to inherited biological processes because they occur independent of the caretaking activities of the mother. If a mother of an uncomfortable and restless infant adds to a pre-existing mother-child misfit through either her own incompetency or reciprocal difficulties, the result is an increased structuralization of a "set toward pain," the predominant affect connecting self and object. If the affects of the mother-child dyad take a predominantly painful direction, then a set is established in the child in which painful feelings connote the self and/or object relationship. In other words, a 'pained' identity is formed.

As regression deepens in the psychotherapeutic process, affect shadings or colorings of pain begin to emerge and dominate the clinical picture. Because these painful affects originate in the pre-verbal developmental stages, they lack cognitive representation and are not easily accessible to therapeutic process. On the other hand, conflicts in the oedipal stage and those pre-oedipal conflicts originating post-verbally are accessible to secondary process consideration and interpretation; hence, therapy is possible. Vallenstein observes that giving up painful affects is equivalent to the patient's relinquishing a part of the self and/or the self-object relationship

which the affect represents. This, he feels is asking a "bit much" of any patient; therefore, he considers the prognosis poor.

All of the writers reviewed here, except Horney, indicate that treatment of the syndrome presents, at the very least, great difficulties and view the prognosis as very poor. Vallenstein, in particular, takes this stand because, he contends, the quality of the self-object tie is "from the beginning" filled with a predominance of painful affect. He, as well, considers persons suffering from the syndrome to be "more than neurotic." This implies that persons responding with a negative therapeutic reaction are borderline, even if they are, so to speak, healthy borderlines. I take issue with this as the syndrome also appears in persons with neurotic defense organization, even though they may be very ill neurotics. In a later chapter, I shall discuss the issue of diagnosis in greater depth.

Vallenstein's work reflects an evolution in theory from a primary drive orientation to an object relations and affect theory orientation. In my view, such a focus confirms Riviere's work and is not in contradiction to Freud or Loewald, whose work definitely points in the direction of Vallenstein's formulations.

This concludes the review of the most essential works on the negative therapeutic reaction. With this

background on the syndrome and the theoretical issues, my hope is to move toward a definition, a grouping of the common clinical manifestations, and a formulation of possible origins in development.

Definition and Common Clinical Manifestations

Toward a Definition

Most writers, as we have seen, are in agreement with Freud's original conception of the syndrome. Differences begin to appear in areas of focus, particularly around the importance of dynamics and their developmental origins. I also tend to agree with Freud's original formulation with some minor additions and emphases.

As I see it, the negative therapeutic reaction can be defined as a recurrent and often acute painful reaction to a therapeutic intervention which is correct in content, timing, and terminology and which ordinarily produces a lessening of symptomatology, relief of suffering, mastery, and increased insight. For a person who suffers such a reaction, there is instead an exacerbation of symptoms, further regression accompanied by painful feelings, and increased resistance often reflected in covert or overt negativism or obstinacy. This resistance can assume the form of cognitive confusion, lack of ideation, and fear or inability to verbalize intrapsychic processes (i.e., conscious or unconscious withholding). There are

sado-masochistic features in the clinical picture and the patient is prone to depression. Most dominant is an inability and/or avoidance of the experience of pleasure. The syndrome represents a major transference resistance stemming from the super-ego and its precursors.

Although this definition basically does not deviate from Freud's formulation, there are fine points in the elaborations which call for clarification. First, in the opening sentence, the term 'intervention' replaces the term 'interpretation'. This is a more inclusive term signifying any statement made by the therapist, whether it be a comment, clarification, demonstration, or interpretation of genetic, content or connective value. In other words, any intervention which could produce hope results in pain. Second, this definition places emphasis on the activation of the painful affects in the regression. Potentially, regression can be pleasurable in the sense that the trust between the therapist and the patient can lead to the revealing and reliving of past experience and, thus, result in mastery. This does not occur when the syndrome is at work. Next, most writers emphasize overt negativism as a resistance. This definition includes the covert aspect along with the addition of cognitive confusion, lack of ideation, and fear of verbalization. Finally, this orientation gives emphasis to the inability and/or

avoidance of the experience of pleasure. Since these differing emphases and additions will figure in the broader clinical picture and the formulation of a new theoretical posture, they deserve careful attention.

Clinical Manifestations

The above definition states or alludes to various clinical manifestations of the syndrome. The literature also points out many other manifestations. For the present, however, my focus will center on a few central manifestations. First is the inability and/or avoidance of the experience of pleasure. From the patient's report of himself in the clinical picture, there appears to be an obvious absence of verbalizations of pleasure. Frequently, the presenting complaint is one of depression, low self-esteem, or vague fears of impending disaster. There are often derogatory statements regarding the self and an accentuated level of self-criticism. In my experience, the patient avoids criticism of others, at least in the beginning stages of therapy. On the other hand, the patient often tends toward inward negative ruminations about others which are characterized by affect colorings of despair. Expressions of hopelessness about himself and therapy may be present from the beginning. In reporting personal history, the patient tends to focus on events that are depressing to him. Statements about immediate pleasant activities,

such as an enjoyable hobby, are usually verbally unacknowledged. There may also be intense reluctance, either overt or covert, to talk about his dismay and/or fear that the therapist will react if he does venture into such pleasant experiences. This leads to a predicament for the therapist because it is difficult to discern what exactly troubles the patient. Indeed, everything appears black.

Another outstanding feature of the syndrome, which I shall term a 'fear of acknowledging the presence of the therapist', is the appearance that the patient is talking to himself. This is evident in the tendency toward a deep inward preoccupation frequently accompanied by long periods of silence. The patient generally avoids any reference to feelings about his talking, or not, to the therapist. Thus, he shuns any transference comments and lapses into a state in which ideation is absent (blank states); there is difficulty moving from one association to the next (a form of frozen cognition); or there is the incomplete presentation of material necessary for the therapist to understand the content. Often, clinicians describe such a state as a form of negativism. In some instances, this may be true. On the other hand, this may well reflect an acute fear of being in contact with (i.e., in relationship to) the therapist.

A third major manifestation describes the patient's response to interventions by the therapist as an activation

of various types of painful affects including fear, denial, despair, sadness, panic, painful longing, loneliness, anger, impotent rage, and the like. The patient may or may not express these affects to the therapist, depending on the state of the therapeutic alliance, the stage of therapy, and the nature of the defense processes in operation at the moment. In general, I have observed that the expression of these painful affects are in large measure withheld until late in the therapy. At any point, the patient will respond with a 'pained' expression, become silent, or rapidly move to another subject without addressing the intervention. Frequently, the patient does not hear the real message of the intervention but, instead, experiences the comment as attacking or having meaning which produces a narcissistic wound. In the case example presented later, the patient feared the sound of the therapist's voice. In other words, there is internal readiness for the internalization of criticism.

These three major manifestations often interlink in the negative therapeutic reaction to form a major resistance to the loss of control. I am in strong agreement with Riviere that control is the central clinical feature of the syndrome. In the eyes of one who suffers from this reaction, control of self and the therapist must be maintained at all costs. The patient appears to experience absolute terror at the possibility that loss of control,

even if for one brief moment, could result in disaster of the worst kind, not only for the patient but also for the therapist. This terror is almost always unconscious and becomes manifest in the rigid psychological posture of strict control. Indeed, even verbalizing often symbolically reflects a loss of control; for what is 'put out' can never be retrieved and can potentially produce the worst consequences. One might describe such a posture as 'inaccessible'. Needless to say, this makes for an extremely difficult situation in which the therapist seems to be of little help.

The last clinical manifestation particularly noteworthy is the pervasive masochistic tendency which occurs both in the psychotherapeutic process and in the patient's daily life. The inability and/or avoidance of the experience of pleasure is the telling sign. The patient may seek out unpleasurable experiences or just subjectively experience daily occurrences as painful. More often than not, the seeking out of painful experiences reflects an undoing of a fortunate event or a 'happy occurrence'. Depression, sadness, and a pessimistic attitude accompany this masochistic orientation.

In summary, the major clinical manifestations of the negative therapeutic reaction are: (1) an inability and/or avoidance of the experience of pleasure; (2) a fear of acknowledging the presence of the therapist; (3) an

activation of painful affects in response to an intervention; (4) a posture of control of self and the therapist resulting in inaccessibility; and (5) a masochistic orientation underlined by depression. I believe any patient suffering from a negative therapeutic reaction has in operation, on some psychological level, all five characteristics. Some manifestations may overshadow the personality more than others at a particular time. In combination, they form a major resistance to psychotherapeutic intervention.

Summary

As we have seen, writers on the subject noticeably disagree about the dynamics and their developmental origins. To recapitulate, Freud perceived the negative therapeutic reaction as reflecting tension between a sadistic super-ego and a masochistic ego. Later, he reformulated his opinion to include the combination of the aggressive instinct which gathers energy from the death instinct in the economy of psychic life. Horney spoke of the dynamic in terms of the patient's need to disparage the therapist; a situation stemming from the patient's narcissistic and hostile strivings for supremacy as a protection against severe anxiety. Riviere, utilizing Melanie Klein's concept of the depressive position, focused on the ego's connection to the inner world of object relations, a connection integral to narcissism and depression, especially depression

expressed in terms of annihilation, desolation, and abandonment. Olinick's report of the American Psychoanalytic Association's panel reflected agreement among panel members about certain important factors in the dynamic: aggression, the need for punishment, and masochism. He cited some panel members, however, who viewed the disorder as basically rooted in the oedipal stage with a background of early developmental conflicts, while others contended the syndrome originated in early mother-infant conflicts. Loewald focused on early developmental conflicts in the mother-child dyad which result in a predominance of aggressive drives in the economy of psychic life. Last, Vallenstein postulated that the negative therapeutic reaction constitutes an attachment to painful affects which represent the self and/or object tie to the mother. He stated that a disturbed mother-infant relationship "from the beginning" accounts for this attachment.

The next area for consideration is the exploration of various developmental theories with the hope of clarifying the developmental and dynamic issues involved. My major emphasis will fall on the work of Margaret Mahler and her associates with the works of other developmental theorists being interwoven as necessary. By integrating Mahler's theories with the works of Riviere and Vallenstein, both of whom are essential in the development of my hypothesis, I hope to establish support for a new theoretical view of the condition.

CHAPTER III

ORIGINS IN DEVELOPMENT

In summarizing the literature on the negative therapeutic reaction, a major diagnostic question presents itself. Just where in psychological development does the dominant fixation occur? As we have seen, writers are in disagreement about this. Some believe that the fixation occurred when the ego at the oedipal stage, for whatever reason, regressed to an earlier stage of conflict. Others view it as something which happened predominantly in the oral or early anal stage of the mother-infant relationship. To struggle with this question of origin calls up for investigation the extent of the illness in persons suffering this reaction and throws a different light on the possibility of a hopeful prognosis.

Vallenstein and Lœwald give indications that such persons may be borderline and rely on primitive object splitting as a defense. Implicit in such a viewpoint is a lack of object constancy or object internalization due to a predominance of the aggressive drive in the economy of psychic life. The other writers consider the mother-infant relationship disturbed in some fundamental manner but insufficient enough to create interference with adequate

internalization of the mother. I stand with this group and contend that object constancy in the vast majority of cases has occurred; however, the quality of the internalization, a primary factor, is questionable.

The prognosis or the 'hopefulness' of any given case depends upon when the conflict first occurred and the degree of intensity. The writers presented here are consistent with Olinick's panel members who consider the syndrome multidetermined, the aggressive drive dominant particularly against the self, and the pre-oedipal situation influential in skewing the child's oedipal development.

I have postulated that the syndrome is a product of an intensely ambivalent love (symbiosis) hate (separation) conflict with a mother who, in the early stages of the child's development, manifests any combination of depression, rejection or non-nurturance and which results in a disturbed separation process. This indicates that the dynamic originates in the practicing and/or rapprochement subphases of the separation-individuation process. Furthermore, the disturbance at this stage results in an 'attachment' to painful affects which symbolically represent the object tie to the mother. Thus, the loss of pain is equivalent to the fear of losing the mother. In addition, the painful attachment to the mother defends against an ever more dreaded and painful fear, that of abject helpless dependence.

I view this fear not as a direct fear of the loss of the internalized mother but as a deep unconscious conviction that the person can no longer 'reach' mother because she has turned her back, so to speak, and no longer hears the 'cry' of her child. In this unconscious state, the person cogently feels that he cannot minister to his own needs and, more important, his needs are 'bad' in themselves. The deep and intense 'longing' characteristic of such a person corresponds to the young child's intense love for the mother and his wish for reunion in love with her. One product of this dynamic is a structuralization of the loss of the mother's love in a perfectionistic and grandiose ego-ideal within the super-ego. Such a state of affairs I call 'paradise lost'.

In order to describe and clarify the developmental processes which crystalize in the formation of the negative therapeutic reaction, let us turn to the works of Margaret Mahler and her associates as well as back to those of Vallenstein and Riviere.

The Works of Margaret Mahler and her Associates

In Margaret Mahler's work, The Psychological Birth of the Human Infant (1975), she describes four subphases in the separation-individuation process: differentiation, practicing, rapprochement, and consolidation of individuality. Prior to this stage, the infant experiences the

"symbiotic" phase in which primary narcissism and the sense of omnipotence predominate. In the separation-individuation phase, the infant, usually between four and thirty or thirty-six months old, has as a primary psychological task the establishment of a sense of separateness from, as well as a relationship to, a world of reality. Especially significant in this period is the child's experience of his body and the "primary love object," the principal representative of the world as the child sees it. Ideally, the process culminates in an individual "sense of identity" (consolidation).

Mahler sees separation and individuation as two complementary developments "intertwined" but not identical. Separation urges the child to emergence out of the symbiotic fusion with the mother; while individuation marks a developmental achievement in which the child can assume his own individual character. Although they may proceed divergently, ideally, these two pulses move in parallel. In a normal process of separation-individuation, the mother allows her child to achieve a level of separate functioning while she remains present in the background and emotionally available. At the same time, the child experiences minimal threat of object loss.

Disturbances in this process are of particular concern in studying the developmental origins of the negative

therapeutic reaction. At what subphase does this disturbance occur and what is the nature of the disturbance? In accordance with my belief that object internalization has occurred, I assume that the person suffering from this reaction has experienced a 'relatively normal' symbiosis; otherwise, we would observe a more extreme pathology. Likewise, I propose that the child, although some conflict slightly exceeding normal may have existed, did not experience a major or intense trauma in the differentiation phase, the first stage of the separation-individuation process. Since the last phase, the consolidation of individuality, can only take place when the child has successfully completed his separation out of the symbiosis with the mother and established some degree of individual identity, the problem must be in the practicing and/or rapprochement subphases.*

Before embarking on an expedition into these two subphases, I wish to state my view of 'trauma' since it figures often in this discussion. I define 'trauma' as an event, whether originating internally and/or externally, which produces overwhelming stimulation for the ego in any developmental stage. Due to the overwhelming nature of

*Since a lengthy discussion of the symbiotic and separation-individuation phases exceeds the limits of this paper, it is assumed the reader is familiar with Mahler's terminology and concepts. Should further explanation be necessary, refer to Mahler, 1975.

the stimulation, assimilation and integration of the event are difficult, if not impossible. As Freud points out in "Inhibitions, Symptoms, and Anxiety" (1926), trauma is in essence "an experience of helplessness on the part of the ego in the face of an accumulation of excitation, whether of external or internal origin, which cannot be dealt with" (p. 81). From such events, pain associated with an event is born as well as painful anxiety, the anticipation of the recurrence of the event.

In exploring the practicing and rapprochement sub-phases of the separation-individuation process, I wish to draw attention to the types of mother-child interaction in which such traumatic events, of whatever magnitude, are possible. I contend that it is from such experiences that the internal emotional aura surrounding the sense of self and self-object draws its tone. This, in turn, significantly influences the degree of intensity in the negative therapeutic reaction.

The Practicing Subphase

Mahler and her associates divide the practicing subphase into two parts. The first is an early practicing subphase beginning about the sixth to eighth month and lasting through the eighth to tenth month. At this time, the child's earliest ability to physically move away from mother by crawling, paddling, climbing, and supported

standing ushers in a new awareness of his separateness. The expansion of locomotor abilities exposes the child to a broader world in which there is more to see, to hear, and to touch. Mahler observes that the child begins to venture further away from the mother, often becoming so absorbed in his own activities that for some period of time he appears oblivious to her presence. Periodically, he returns to her, seemingly to re-affirm her physical proximity. At this point, the child requires freedom to explore his surroundings at some distance from the mother without her intrusion; however, at the same time, he needs ready access to her as a home base.

In the second part, the practicing subphase proper, the child's capacity for free upright locomotion noticeably increases. Greenacre terms this time from the tenth or twelfth month to the sixteenth or eighteenth month the child's "love affair with the world" (1957:214). The child's plane of vision changes dramatically, allowing for a greatly expanded field of perception and experience. The practice of motor skills and the exploration of the environment require a libidinal investment on the part of the child; thus, he becomes more involved in the world of objects.

Independent of mother, the child concentrates on practicing and mastering his own motor skills and autonomous capacities. Mahler speculates that the elation seen in

children during this subphase has to do not only with the exercise of newly acquired capacities but also with the relief of escape from inundation by the mother. Thus, Mahler characterizes "good mothering" as gentle urging of the child to master his newly acquired skills. Such mothers take delight and joy in the children's activities and, although watchful and never far away, do not intrude upon their explorations.

Another characteristic common to children in this part of the practicing subphase is, what Mahler calls, "low-keyedness." When the child becomes aware that his mother is not physically nearby, he appears to be in a "state of self" in which he "images" the absent mother. Mahler and her associates believe this to be reminiscent of a miniature anaclitic depression. "Some children transiently appeared quite overwhelmed by fear of object loss, so that the 'ego-filtered affect of longing' was in danger of very abruptly turning into desperate crying" (1975:75). They draw the conclusion that in children of this age, there is a dawning awareness that the symbiotic mothering half of the self is missing. I would further emphasize that such an awareness constitutes a major loss when it is associated with painful depressive affect.

Mahler and her associates made another very important observation. In children where the symbiotic relationship has been unduly prolonged, or already

disturbed, the 'longing' for the state of well-being seems absent. Similarly, where unpredictability and impulsiveness from a partly engulfing and partly rejecting mother characterize the symbiotic relationship, this 'longing' for a state of well-being appears "diminished and irregular." This points to the fact that symbiosis and differentiation must proceed at least somewhat smoothly for object internalization to take hold, the point of departure for the major stages in the separation-individuation process.

Patterns of Mother-Child Interaction in the Practicing Subphase

In relation to the negative therapeutic reaction, certain types of mothering behavior during the practicing subphase seem to foster the development of the syndrome. The first type is the overprotective, fearful mother who may inhibit and discourage the child's new adventures. She may attempt to do too much for the child by indicating danger where danger is minimal or does not exist, discouraging or refusing to participate in his explorations, responding with apprehension or sad expressions to the child's ventures away from her, or manifesting any such behavior which gives the child the overall message 'remain with me or you or both of us will be hurt'. In addition, the child hears the unspoken message that he must not take pride in his accomplishments because they constitute danger. Such a state does not allow the possibility of selfhood apart from the mother;

thus, the loss of omnipotence at the discovery of mother's absence does not bring 'elation'. Furthermore, under these conditions, the probability is great that an attitude of 'stay with me or you're bad' will take root; thus, the longing for, and joy in, the experience of separation takes on affect shades of 'badness'. Here the layering of aggressive rejecting affects begins to form in order to protect this young person from the fear of object loss.

The second type of mothering behavior involves the depressed mother who may demonstrate either overprotectiveness as in the first type or physical and emotional unavailability. Unlike the overprotective mother, this latter type is ambivalent and neither encourages nor discourages exploration. She is, in some relative degree, simply 'unavailable' to her child. Such an environment exposes the child to real dangers and/or frequent experiences of panic at the discovery he is alone. He may react with "imaging," panic crying, clinging, longing, or other similar behavior. Joy in his explorations and the narcissistic investment in his motor abilities become dangerous as they become associated with the mother's absence. If the child reacts aggressively to his frustrations about mother's unavailability, his situation may become even more precarious because, unlike painful longing, an affect the child can acceptably experience, an aggressive expression means damage to the mother, a threatening feeling at best.

A third type of mothering behavior involves the mother who overtly ridicules, rejects or criticizes her child's demonstration of his new abilities. This reaction probably stems from the mother's fear of separation from her child because of a narcissistic identification with him. Such behavior on the mother's part can result in a seriously damaging impact to the child's narcissistic balance and create intensely fearful affects which envelop his desire to separate and enjoy his new freedom; thus, affect shadings of foolishness, stupidity, and clumsiness color his self-representations. The child's rage at being attacked leads to the experience of impotence, a powerful motive for the development of the defensive posture characterized as 'turning against the self'. The later pathology will reflect severe object splitting and/or a deep regression if the mother's rejection is severe. If her rejection is milder, problems with the differentiation between self and object will hamper the child's successful mastery of this stage.

Although it is doubtful, an observer would find these three patterns of mother-child interaction so clearly differentiated in reality or, if so, only infrequently, establishing observable categories helps to stimulate speculation. Certainly many variables such as birth order, availability of mother substitutes or the father, the degree and constancy of pathological behavior in the mother, and

other such considerations influence the outcome in each individual case. The one common variable present, which appears to activate a later negative therapeutic reaction, is the lack of an empathic connection between the mother and the child. In other words, the mother is to some degree inaccessible to the child in his time of need. If the child has a high level of aggressive drive energy, grave difficulties cloud the horizon. Such a perspective is in keeping with Løewald's formulation which, we have seen, indicates that the dynamic origins of the negative therapeutic reaction take root in an early disturbed mother-child dyad in which the aggressive drive predominates (1972).

When the child has experienced difficulty in establishing a rapport with his mother, one can expect certain common responses in the child. Foremost among these, is the expression of a painful longing for a positive nurturing mother, positive in the sense that the mother is available and enjoys with her child his newly acquired skills. Next, the child comes to view separation as charged with potential, if not real, danger to himself and/or his mother. Third, because of this distorted view of separation, the child inhibits and becomes conflicted about his narcissistic investment. Finally, because the child experiences the awakening of his aggressive drive toward his mother prior to the establishment of secure self-object

boundaries, his inner and outer world are not differentiated enough for him to know whether he really directs his aggression toward himself or his mother; thus, self and self-object affect connections absorb negative coloration. Since all of these responses to some extent and/or combination are observable in a person who suffers a negative therapeutic reaction, one must give considerable thought to the child's experience and achievements in this practicing subphase.

The Rapprochement Subphase

The last stage of the separation-individuation process, Mahler calls the rapprochement subphase, beginning about the eighteenth month and continuing into the thirtieth and thirty-sixth month. Because the child has become more aware of, and can make better use of, his physical separateness, object awareness begins to stimulate representational thinking, symbolic play, and the early beginnings of speech. Occurring parallel to the growth of his cognitive abilities and emotional differentiation is a lowering of nonchalance about his mother's whereabouts and an increase in anxiety when she is not nearby. This means that the relative lack of concern about the mother's presence in the practicing subphase shifts to a "seemingly constant concern" about her 'location'. Indeed, as the child's awareness of his own separation grows, he seems to experience an increasing need

to be with his mother and share with her his experiences. 'Turning back' to the mother, as opposed to turning away from her, is a primary characteristic of this subphase.

Mahler comments:

One cannot emphasize too strongly the importance of the optimal emotional availability of the mother during this subphase. It is the mother's love of the toddler and acceptance of his ambivalence that enables the toddler to cathect his self-representation with neutralized energy (1968:59).

Also:

During the rapprochement subphase, we observed separation reactions in all our children. We venture the hypothesis that it was among those children whose separation reactions had been characterized by moderate and ego-filtered affects in which the libidinal valence (love instead of aggression) predominate that subsequent development was most likely to be favorable (1975:77).

Another primary characteristic of this subphase is, what Mahler terms, "shadowing and darting away." When the child closely follows or imitates his mother, he is said to be "shadowing" her. "Darting away" is just that--a running away from mother. Such behavior reflects the child's ambivalence over whether to 'push' mother away in order to maintain autonomy or whether to cling to her for reassurance that her love is still available to him. During the early period of the rapprochement subphase, the child simultaneously realizes that he does not have omnipotent power and control; that is, he cannot do everything on his own, and he is, in fact, a being separate from his mother. This conflictual realization that he is small, relatively

helpless and yet separate, that he cannot automatically secure relief just by feeling the need for it, is difficult and painful. The result is an intense conflict in the child over autonomy vs dependence. This creates a demanding and insistent attitude in which the child attempts to control and protect his separateness by rejecting (saying 'NO' to) aid and assistance. Negativity, ambivalence, and demandingness thus characterize the rapprochement subphase.

Mahler also points out that the less emotionally available the mother is at this time, the more insistent, even to the point of desperation, the child becomes about gaining her attention. Now instead of a "low-key," quiet reaction to the mother's absence as in the practicing subphase, the child becomes increasingly active and restless. Mahler contends that the child's activity at this point is equivalent in nature to this earlier "low-keyedness," that is, the child becomes aware that his union with the mother is ruptured. With the further realization of his separateness, the affect coloring of sadness emerges--sadness over loss of union with the mother and loss of his omnipotent powers. Now love of the mother becomes 'all important' as a substitute and as a compensation for what has been lost in terms of union with her. At this point, fear of losing the mother's love, rather than fear of losing her per se, enters and overshadows the child's psyche. Increased activity at this point then becomes a defense against this sadness and

fear of loss.

Mahler and her associates divide the rapprochement subphase into three periods: (1) beginning rapprochement, (2) the rapprochement crisis, and (3) the individual solution to the crisis. Since the above overview points out the tasks which begin to confront the child in the beginning period, our attention can turn immediately to the second and third periods in which the crisis presents itself and requires resolution. The crisis which generally occurs somewhere between eighteen and twenty to twenty-four months has particular significance with regard to the negative therapeutic reaction, for it is one possible solution to the crisis.

The rapprochement crisis has many faces. Chief among these is the child's increasing resistance to reminders that he cannot manage on his own. Because this desire for autonomy and omnipotence is in opposition to his expectations that mother will magically fulfill his needs, even though he does not totally grasp that her actions actually do bring help, the child finds himself in conflict. Thus, an alternating desire to push mother away and to cling to her, a situation Mahler terms "ambitendency," characterizes the child's wish to use the mother as an extension of himself in order to deny the 'painful' awareness of separateness.

Another characteristic of this crisis, which I

believe is of great importance in understanding the nature of the transference in the negative therapeutic reaction, is the child's non-recognition of the mother. This is noticeable when the child becomes suddenly anxious and fears that his mother has left even though she is still present. Conversely, after a brief absence, the child shows "non-recognition" of his mother. Mahler speculates that this is a forerunner of projected negative feelings, for the child's desire for separation and independence (i.e., his desire to leave mother) becomes associated with the thought that mother might wish to leave him. Such reasoning occurs in the introjective-projective stage of internalization. Partial internalization appears to be one way the child copes with and defends against his feeling of vulnerability as his awareness of his own separateness grows. This makes the mother's overall behavior and emotional reaction to this period of crisis all the more important. Likewise, the implications for super-ego development are significant.

Another type of behavior observed during these last two periods is the child's wish not to be passively left behind when the mother leaves; instead, he wants to cling to her. Consequently, the child tends to deflect his rage at being left onto others in order to preserve the good mother image he carries. The child "longs for" the good mother, but she seems to exist in "fantasy only." At the mother's return, the child may wish to reach her as quickly

as possible but at the same time hesitate because of a desire to prevent further disappointment. Thus the clinging carries conflicting implications which can lead to a depressive mood.

The characteristics noted in children in this sub-phase are highly similar to the clinical manifestations of the negative therapeutic reaction. For one, the person suffering from this syndrome tends to fear acknowledgement of the therapist. This coincides with Mahler's observation that the child, after a brief absence from the mother, appears not to recognize her. This seems to be a defense on the child's part to ward off further disappointment as well as the feelings of helplessness and rage. Perhaps this explains the strange quality in the transference when the patient, who obviously places great importance on the therapist, responds as if he did not. The patient's "inaccessibility" might also spring from this same source. In the case example presented later, my patient stated that when she left the office, it was as though I, the therapist, was no longer "available" to her. In the same vein, she had difficulty "picturing" me except in the office. Later it surfaced that she associated various vague and painful feelings which she had difficulty describing to these comments.

Another clinical manifestation apparent in persons who suffer this reaction is the insistence upon control. It is as though the patient must magically control himself and

the therapist in order to avoid disaster. By applying the dynamics of the rapprochement subphase, this sense of disaster represents, as it does for the child, an activation of painful feeling, such as helplessness and rage, at an unavailable mother. "Imaging," or painful attempts at imaging, may well reflect an inner defense against these painful feelings.

Finally, the overall masochistic and depressive features apparent in persons who experience a negative therapeutic reaction probably manifest the realization that they are small, helpless, and dependent--a feeling close to that of the small child whose omnipotent powers have left him. The masochistic element may reflect the internalization of an unavailable and/or hostile mother as a defense against rage. The avoidance of pleasure and the activation of painful affects which limit a response to therapeutic intervention are yet accounted for.

Patterns of Mother-Child Interaction in the Rapprochement Subphase

As Mahler earlier emphasizes, the emotional availability of the mother during the rapprochement subphase is of supreme importance. Of equal and related importance is the mother's capacity to tolerate and endure the child's ambivalence. The patterns of mothering behavior at this point which express this emotional unavailability and low tolerance are basically the same as in the practicing

subphase: overprotectiveness, depression, and rejection or criticism. Since these patterns of behavior are already familiar to the reader from the discussion of the practicing subphase, my emphasis will fall on the mother-child interaction in each behavioral type which activates painful affects that come to symbolize the tie to the mother.

The overprotective mother takes the position that the child can 'return to her' but 'not leave her'. On one side of the conflict for the child is the reality that mother not only endures but encourages his clinging. In all probability, this constellates in the child a very loud 'NO' and heightened 'push away' behavior. Because mother discourages autonomy by emotional withdrawal, such as a hurt or worried expression or overt punishment, the child's heightened aggressive response in the service of autonomy calls forth in many instances a fear of damaging mother and/or a fear of her abandonment. This interaction promotes within the child's psyche the defense characterized as 'turning against the self', a denial of the wish for autonomy, and later extreme self-doubt about his abilities.

In the therapeutic setting, the clinician would most probably describe a depressed, inhibited, self-doubting individual. However, it is doubtful he would see a negative therapeutic reaction emerge unless the overprotective mother, for some reason, did not allow the child to 'return to her', i.e., she withdrew her love. This seems somewhat unlikely

from a mother who from the beginning has had little tolerance for separation. More highly probable is a childhood situation in which the clinging behavior and lowered interest in exploration has carried over from the practicing subphase into the rapprochement subphase.

On the other hand, a mother who has been depressed from the beginning of the child's experience of the separation-individuation process is more likely to be unavailable or withdraw her love from the child. In both subphases, the child's clinging behavior is noticeably exaggerated; however, in the latter subphase, there is additionally an increase in ambivalence and the signs of depression due particularly to the child's experience of a heightened feeling of aggression and its danger. Accordingly, the child will later show signs of a deep longing for what he never had, or had in too small a measure.

In some instances, the mother may have become depressed, for either intrapsychic or external reasons, just before or during the rapprochement subphase. If this is the case, the child will in all probability associate the experience of abandonment and emotional unavailability with aggression and his wish to separate. In other words, he reasons that his emotional dependence has disturbed his mother and 'hurt her'. This chain of events between the mother and the child heightens the ambivalence in the child and places a greater burden on the mother, who is already

inadequately available. The child may turn to fantasies about a good object in order to protect himself against the bad, unavailable object, his mother. Depending on the degree of unavailability, such a response could interfere with the fusion of good and bad objects and later influence the quality of object constancy. In addition, an outcome unfavorable to the child's later stability would include narcissistic injury and the heightening of the aggressive drives. The degree of pathology, of course, depends upon many variables, including the availability of mother substitutes and the father, the overlap of other behavioral types, the extent of the disturbance in the mother, and other such conditions.

In the rapprochement subphase, the mother who overtly rejects or criticizes her child presents him with considerable ambivalence and conflict. Mahler observes that this subphase becomes "greatly exaggerated" when the mother is either dissatisfied with her child or reacts adversely or with aloofness to his separation. The child tends to act out his ambivalence by excessive "shadowing and darting away" or excessive wooing of his mother with alternate extremes in negativity. Whatever the degree of acting out, the child experiences an outer push into a precocious level of independence but feels inwardly an intense conflict around dependence-independence issues. The result is heightened aggression against self and the self-object as

well as sadness over the loss of the mother. An intensely ambivalent painful state surrounds the child, who both desperately longs for his mother and fearfully backs away from her because of the disappointment and rage he has already experienced. Indeed, this is rich soil for the cultivation of a negative therapeutic reaction.

Again, I wish to emphasize that the above categories serve to stimulate speculation about the influence of mother-child interaction on the dominance of painful affect in the self and self-object relationship. Indeed, it would be clinically unusual to find a pure case of any one type. Whatever the mothering behavior or the combination thereof, great importance rests with the mother's unavailability: its degree, its origin in time, and its duration.

As Ritvo and Solnit (1958:72) observe, an unreciprocating mother-child relationship creates certain consequences. Foremost among these is the fact that the child internalizes the distance between himself and his mother. Because he internalizes the unresponsive mother as part of himself, a fixation at the point of the mother's absence results. This means that a constant longing for mother as well as a feeling of rage toward her marks the child's developing personality. He experiences either internal emptiness or internal rejection or some degree of both. This leads to a deep underlying depression marked by masochistic tendencies.

Super-ego Precursors and Internalization

In the rapprochement subphase, the child's primary fear is loss of love of the object and abandonment. This runs parallel to the internalization of approval-disapproval by the mother. Introjection, the internalization of prohibitions, is the primary mode of internalization at this point. As Mahler and her associates contend, in one sense the child introjects the mother to guard against loss of her love and to avoid his awareness of his state of helplessness, smallness, and lost omnipotence. In another sense, he utilizes introjection as an aid to agree with or be like his omnipotent mother; thus, he guards against narcissistic injury.

If the child in the rapprochement subphase must contend with an unavailable or critical mother, I would speculate that the introjective process becomes highly accentuated; certainly the entire internalization process is affected. Annie Reich in her paper, "Early Identification as Archaic Elements in the Super-ego" (1954), agrees with this formulation. The quality of harshness in the internalized prohibitions will range in intensity according to the degree of 'absence' of the mother, particularly if the mother is also rejecting and critical. Accordingly, I view introjection in the case of the negative therapeutic reaction as an attempt to maintain the presence of the 'lost mother'. Thus, introjection is a primary defense

mechanism used to rescue her presence and love.

Likewise, the mother's unavailability and rejection affect the development of the ego-ideal. In Jacobson's paper, "The Self and the Object World" (1954), he states that behind this concept is the development of a dynamic in which the ego-ideal serves to transform magical self-images and images of love objects into a structural unit later part of the super-ego proper. This indicates that the internalization of parental prohibitions and demands later serves the formation of super-ego identification and self-critical super-ego functions. Jacobson states:

This double face of the ego-ideal, which is forged from ideal concepts of the self and from idealized features of the love objects, gratifies indeed the infantile longing of which we said that is (sic) never fully relinquished; the desire to be one with the love object (p. 107).

I would further postulate that a person who suffers a negative therapeutic reaction experiences a greater 'distance' between his ego-ideal and his ego's perception of itself. Since the child in the rapprochement subphase perceives the 'distance' between his mother and himself as painful, his developing ego-ideal becomes an internalization of the state of union with his lost loving mother. Furthermore, the person who suffers this syndrome becomes conflicted because the ego, in recognizing the distance between its ideal and its reality, blames itself for the distance and yet also raises a loud 'NO' to this blaming

voice. The result is an attempt to cling to omnipotent powers he has already lost. If one accepts this point of view, one can account for the many narcissistic, masochistic, and depressive features manifested in the syndrome.

The Work of Vallenstein Re-examined

As we have seen, Vallenstein proposes that the negative therapeutic reaction represents a self and self-object internalization which is bonded by painful affect. Furthermore, giving up the painful affect is equivalent to relinquishing a part of the self and the self-object which the affects represent (1973).

In Vallenstein's view, pain is a sensation or emotional state of an uncomfortable, unpleasurable, and distressful nature. The patient experiences aches, suffering, worry, misery and agony, discontent, depression, grief, and/or anguish. Fear of anxiety or rage directed toward others or the self and expressed in the form of guilt, longing, frustration, loss, helplessness and/or hopelessness are all part of the experience of pain.

Vallenstein believes affects provide not only an internal communication medium from the instincts to the organism but also an environmental communication system from the infant to the primary caretaker. The successful ministrations of the primary caretaker, that is, the mother's

ability to receive and respond to the infant's communicated needs, is crucial to the maintenance of optimal levels of psychological equilibrium in the infant. From such 'good' caretaking and a matching reciprocal fit between mother and infant comes the internalization of a pleasurable self and self-object representation. If this is true, the opposite could also be true. In other words, negative affects from a poor or unreciprocal mother-child interaction could result in an unpleasurable (painful) self and self-object representation. Vallenstein considers this to be the case "from the beginning" of the mother-child interaction. It is at this point that I disagree with him.

The Work of Riviere Re-examined

To return now to the work of Riviere (1936), we have seen that her emphasis is on the patient's defense against a primary "depressive position." Indeed, his need for control and his narcissism are in the service of this defense. The patient who suffers a negative therapeutic reaction responds negatively to interventions because he has "no faith" in getting better. For him to lose control or to love the therapist would result in the "worst disaster" because such an alliance would result in ultimate helplessness, madness, and suicide from which there could be no rescue.

In this precarious defensive state, according to

Riviere, the patient perceives that his loved ones within are dead or lost to him. He lives in "desolation" and, in addition, blames his own selfishness for their injury as though he were the cause of their demise. In an effort to "put things right," he clings to the hope that some day his efforts will restore happiness to his loved ones who will then love him. In order to repair the harm done by his own selfishness, as he perceives it, he endeavors to place others before himself. Most surely, if he were to know happiness before he had saved his loved ones, whom he perceives he did not "love enough," they would require of him endless repayment for his essential badness. In Riviere's view, the person's intense "love for his internalized objects" is the motivation behind such guilt and pain. One could speculate, then, that the denial of the person's disappointment in his internalized loved objects is a motivating force behind his refusal to allow himself the experience of pleasure and happiness before he has rescued his loved ones.

The Thesis of the Paper Re-examined

In order to allow for the added insights of Mahler, Vallenstein, and Riviere, it is appropriate at this point to take a second look at my original definition of the negative therapeutic reaction and to restate the thesis upon which my observations rest.

As we have seen earlier, I define the negative therapeutic reaction as a recurrent and often acute painful reaction to a therapeutic intervention which is correct in content, timing, and terminology and which ordinarily produces a lessening of symptomatology, relief of suffering, mastery, and increased insight. For a person who suffers such a reaction, there is instead an exacerbation of symptoms, further regression accompanied by painful feeling, and increased resistance often reflected in covert or overt negativism or obstinacy. This resistance can assume the form of cognitive confusion, lack of ideation, and fear or inability to verbalize intrapsychic processes (i.e., conscious or unconscious withholding). There are sado-masochistic features in the clinical picture and the patient is prone to depression. Most dominant is an inability and/or avoidance of the experience of pleasure. The syndrome represents a major transference resistance stemming from the super-ego and its precursors.

In addition, my work rests upon the hypothesis that the negative therapeutic reaction represents a reaction to the psychotherapeutic process because the transference activates numerous painful affects, including dread, painful longing, a generalized intense fear of the therapy and self-disclosure, deep concern that the person will be ridiculed or shamed, and defensive cognitive confusion resulting in a lowered capacity to observe and report intra-psychic

processes, i.e., the self. Its origins in development are attributed to a major fixation in the practicing and rapprochement subphases of the separation-individuation process of infancy. The separation process is considered 'disturbed' in the sense that it is extremely ambivalent, representing an intense love (symbiosis) hate (separation) conflict with a mother who manifests any combination of depression, rejection or non-nurturance. This conflict results in an 'attachment' to painful affects which symbolically represent the object tie to the mother. The loss of pain (that is, becoming better or experiencing positive feelings) is equivalent to the fear of losing the mother and returning to a state of abject helpless dependence. The activation of the transference through therapeutic procedures stimulates these painful affects and fears, resulting in behavior which appears to be a resistance to 'getting better'.

In light of Mahler's developmental observations, this definition and thesis become clearer and more precise. For one thing, I propose that the negative therapeutic reaction can be traced back to the crisis period of the rapprochement subphase when a 'painful' reaction on the child's part to the perceived loss of the mother's love occurred. The 'quality' of the experience in the practicing subphase may pre-condition the intensity of the trauma when it occurs in the rapprochement subphase; however, if

we consider the possibility of the major fixation actually happening in the latter subphase, a number of specific dynamics stand out. The most significant is the child's feeling of loss of love upon his 'return to mother'. Instead of loving, open arms, he experiences a non-receptive or cold and rejecting mother. His problem is not that he cannot leave the mother but once he has left her, he cannot return. In this case, the practicing subphase probably progressed smoothly enough because the mother felt either relieved by the child's detachment behavior or deeply rejected as a mother, a later cause for retaliation. Although each case may differ, the major feature is the child's feeling, for whatever reason, that his mother has abandoned him and he has no home to return to.

Such a situation evokes many painful feelings in the child. Especially powerful is the awful realization not only that he is separate but also that he is separate without the affirmation and encouragement of a loving mother. This is cause for a major narcissistic blow to his feelings of omnipotence and for the activation of a state of panicked fear over his need for dependence. Indeed, as Riviere so descriptively points out, the world is "without love because love has died" (1936:319). The child feels no help, no relief from suffering, and no hope. What remains is a deep 'longing' for what has been. Even the distress

of anger cannot bring her back because his rage at his mother would only serve to drive her further away and leave him with impotent rage. Subsequently, a deep disappointment in the mother overshadows the child's experience. In summary, the affects associated with the loss and the narcissistic wounds are: panicked fear of dependence, hopelessness, longing, impotent rage, and deep disappointment.

A person could not undergo such an agitated state of painful affect without a shattering of the ego's intactness. Certainly regression can be expected and, in some cases, indicates the intensity of the original trauma in the crisis period of the rapprochement subphase. In the most extreme cases, the end product is severe good-bad object splitting or psychosis. In other cases, the person creates strong defensive methods as a protection. One such defensive maneuver requires that the person believe he has done something wrong which he hopes to right and, thereby, restore the mother's love. Certainly a child could easily imagine this. Indeed, he has pushed mother away; he has been ambivalent; he has been aggressive toward his mother's caretaking. Accordingly, there must be some accountable reason for her non-receptivity and/or rejection: what other could there be but what he has done or not done? Thus, introjection of parental demands and prohibitions, the primary mode of internalization in this period, acts as a primitive precursor to the super-ego.

This formulation, in all probability, accounts for the primitive functioning of the super-ego in the person suffering a negative therapeutic reaction as well as the appearance of depression and masochism. Furthermore, there is an enormous investment of the ego-ideal in narcissism. Another way of looking at this is to observe the underlying message: "If only I could do enough; if only I would not disappoint mother, she would restore her love."

The use of control as a defense then becomes necessary, for the child must be hyper-alert in order to avoid any occasion which creates further distance. His magical belief that his control will somehow bring mother's love back creates the hope for reunion; indeed, this hope keeps him going. On the other hand, to give up control activates all his concerns that he has driven mother away and his fears of abject helpless dependence.

Another likely defense posture is a massive suppression of the pain the child experiences at the loss of mother's love and its contingent evocation of painful feeling. Here the child simply denies the pain of needing his mother's love and of acknowledging its absence. Stated another way, he says to himself: "I'm here and needy but I'm not. Mother's there and not receptive to me but she is not. I have approval even though it's not there." Such an attitude may appear in the clinical setting as the unacknowledgement of the presence of the therapist: "The therapist

is important but he is not. I am here but I am not." Once again to acknowledge this painful state of affairs activates fears of abject helpless dependence, the affective memory traces of mother's absence, and feelings of total helplessness and hopelessness.

I have yet to account for the avoidance of the experience of pleasure found in the negative therapeutic reaction. Vallenstein contends that a disturbance in the mother-child interaction was present "from the beginning." I contend, however, that the major trauma occurred much later in the crisis period of the rapprochement subphase. Such a position calls attention to the idea that prior to the rapprochement crisis, the child most probably experienced pleasure in his interactions with his mother. I would further speculate that in the earlier period, the degree of pleasurable experiences was proportionately greater than the degree of unpleasurable experiences; that is, the child loved his mother, perhaps even intensely so. The child would then experience the mother's unavailability and/or rejection in this later period as even more traumatic and painful for it represents a sudden and abrupt turn of events from pleasure to pain.

The question still remains: why the avoidance of the experience of pleasure? I propose that the affect, pleasure, activates the affective memory traces linked with its loss and subsequent pain, especially the fear of abject

helpless dependence. Accordingly, as long as one clings to pain, there is hope of regaining mother's love. To experience hope, relief, and pleasure is a reminder that the original love once received from mother is lost, never to be regained.

From a technical point of view, painful affects bind the self and the self-object representations into an internalization after pleasurable affects have been internalized. However, these painful affects are not as consolidated as postrapprochement crisis internalizations. The defenses enacted against awareness of the pain of the loss of mother's love create a structure which prevents the realization of loss. Since pleasure serves to stimulate the affective memory traces of loss (i.e., pain), the investment in the defense structure is enormous. This accounts for the rigid resistance in the therapeutic situation and the adverse reaction to 'hopeful' interpretations.

In the cases I have treated, the association between the affect states of hopefulness and longing give further clinical evidence for this formulation. The patient clings to a tenuous feeling that perhaps 'something' will change, even though he believes this 'something' will, of necessity, require a major miracle. To simply feel a little better or to experience a few moments of pleasure, he regards as a monumental task requiring much of him. Still, he clings to the dim hope that something may happen:

he may say or do something or the therapist may provide an insight which will change everything. Thus, he links this dim 'hopefulness' to his feeling of painful longing; "If only 'it' will come to pass but, alas, it will not." This mysteriously shrouded 'it' is ultimately the restoration of his mother's love.

In conclusion, the developmental concepts of Mahler and her associates as well as Vallenstein and Riviere's postulation of the dynamic origins add continuity and specificity to my own understanding of the syndrome. In the light of these added insights, I view the negative therapeutic reaction as a syndrome in which the transference activates numerous painful affects. The major resistances include: (1) avoidance of the experience of pleasure, (2) fear of acknowledging the presence of the therapist, (3) activation of painful affects in response to therapeutic interventions, (4) control of self and the therapist, which results in inaccessibility, and (5) a masochistic, depressive orientation, which results in a need for punishment. The developmental origins center around conflicts which the quality of the mother-child interaction in the practicing subphase influences but which ultimately occur in the crisis period of the rapprochement subphase. These conflicts reflect a traumatic experience of the loss of the mother's love at a time when the child first becomes aware of his separateness. Whether the mother's unavailability

takes the form of rejection or inaccessibility, the child responds with painful longing for the lost love of the mother and with futile attempts to restore her love. In such a situation, the internalization of parental demands, i.e., a heightened use of introjection, results in an ego-ideal which demands perfection and, later, in a primitive structuring of the super-ego. In summary, I see the syndrome as a flight from pleasurable affects which activate a self and self-object internalization representative of the painful loss of love and associated with fear of abject helpless dependence.

The degree of psychopathology in any given person diagnosed as suffering a negative therapeutic reaction is contingent upon the outcome of the rapprochement crisis. Mahler believes the following factors influence this outcome:

- (1) the development toward libidinal object constancy;
- (2) the quantity and quality of later disappointments (stress trauma);
- (3) possible shock trauma;
- (4) the degree of castration anxiety;
- (5) the fate of the oedipus complex; and
- (6) the developmental crisis of adolescence -- all of which function within the individual's constitutional endowment (1975:111).

I am in agreement with all six determinants, particularly with regard to the nature and resolution of the oedipus complex. I would further add that the availability of the father or the presence of mother substitutes (including siblings) is of crucial importance. The presence of other

nurturing figures likewise crucially influences the degree of pain activated by the transference and significantly affects the prognosis.

CHAPTER IV

ISSUES FOR PSYCHOTHERAPEUTIC INTERVENTION

Little appears in the literature about appropriate therapeutic interventions in the treatment of the negative therapeutic reaction. Indeed, in my readings, I have uncovered no article dealing with this aspect of the problem. Even the issue of prognosis comes up only briefly in a few articles. For this reason, I have devoted this entire chapter to an examination of the various issues involved in psychotherapeutic interventions and techniques relevant to the treatment of this syndrome. This covers an examination of the focus behind the therapeutic interventions as well as possible errors in focus; the therapeutic alliance and its relevance to the interventions; common countertransference problems and the importance of empathy; and indications, as well as counter-indications, for alterations in technique. Because of the scarcity of relevant literature, my own speculations, ruminations, and limited experience in treating the syndrome provide the foundation for this chapter. By its very nature, this chapter is brief and limited. Nonetheless, I hope, at least, to assist other clinicians in identifying treatment problems and possible methods for intervention.

An Examination of the Focus Behind
the Therapeutic Interventions

The therapist who finds himself treating a person suffering a negative therapeutic reaction is up against a number of unavoidable obstacles. We have already seen that the person approaches therapy with a number of rigid resistances: the avoidance of the experience of pleasure; fear of acknowledging the presence of the therapist; activation of painful affects in response to therapeutic interventions; a need for absolute control, which results in inaccessibility; and masochistic, depressive tendencies which result in a need for punishment. These combined with a fear of therapy and self-disclosure describe an obstacle formidable enough to paralyze any therapist. Indeed, the patient himself feels paralyzed, for he experiences a dilemma with literally "no exit." Certainly a major part of the dilemma is the very experience of transference feelings which activate painful memories from the very beginning of treatment.

Usually, the patient experiences early in treatment a fear that therapeutic insights will only provide more evidence that he is really as evil, bad, disappointing, shameful, disgusting as he already believes he is. In addition, he expects the therapist will come to think and feel about him as he already thinks and feels about himself.

Martin Stein in his essay, "Self Observation, Reality, and the Superego" (1966), lays a groundwork for

understanding this rationale by postulating that the super-ego, as well as the ego, is responsible for evaluation of external and internal reality. When the patient manifests this distorted rationale, he is listening to the super-ego processes which have interfered with his evaluation of himself and, as often happens, presented him with an alternate evaluation. Consequently, the patient becomes frozen or paralyzed and enters a state, as I have previously noted, called 'cognitive confusion' and fear of self-disclosure. Now what the therapist is dealing with is a manifestation of resistance which hinders communication between the patient and the therapist and, by implication, between the self-observing functions of the patient's psyche and his other mental processes. Thus, this resistance interferes with that portion of the reality function which is at the center of the therapeutic process, namely, the capacity to observe and evaluate one's inner life.

For example, a patient talks vaguely about some life event--so vaguely that the therapist has little idea what he is attempting to communicate. If the therapist, sensing a resistance, comments, "You are speaking vaguely, leaving out information needed for me to comprehend your problem," the patient, feeling that the therapist is being critical of his attempts to verbalize, will respond internally with guilt. The patient's ego cannot perceive the therapist's intervention as an observation of difficulty in and

of itself nor can he perceive that the therapist's actions are meant to help him with his problem. Some patients will handle such a situation by lapsing into silence or hesitating to express the guilty feelings; others will react with depression or the feeling they are being attacked or misunderstood. In any case, the major issue rests with the fact that the patient's ego cannot evaluate the content of the therapeutic intervention; instead, he experiences these as dangerous because they represent, in some form, a threat to his personality.

What, then, is the central therapeutic task with such patients? The psychotherapeutic situation, being a regressive state, exposes how blurred the differentiation is between ego and super-ego functions. Nunberg in his paper, "Transference and Reality" (1951), carries the problem even further by observing that the super-ego must sanction the conscious perception of the ego before such perceptions acquire full uncontested reality. This means that the super-ego not only affects the sense of reality (in this case, the content of the therapeutic interventions) but also gives the ego permission 'to know'. Accordingly, the patient easily distorts the therapist's comments into messages from the super-ego. The patient cannot 'hear': he cannot distinguish inside from outside and fantasy from content. This is a point for major emphasis.

The therapist must attempt to help the patient

recognize, understand, and evaluate his own mental processes rather than judge them. In the above example, the therapist, not by persuasion but by allowing the patient to understand that he has confused inner and outer, can lead the patient to recognize that what he has heard is not fact but fantasy. Of course, this requires many months, and even years, of persistent endeavor on the part of the therapist. The patient must achieve at least a partial distinction between the 'inner super-ego fantasy' and the 'factual content of the intervention' before an uncontaminated therapeutic alliance can form. When this occurs, the patient will be able to speak about his inner processes as inner processes and to struggle with what he 'hears' the therapist say as opposed to what he thinks the therapist meant. Such an achievement represents a major therapeutic gain.

Another resistance requiring special focus is the patient's 'inaccessibility', that is, his insistence upon control of the therapy and the therapist. This phenomenon is closely related to the foregoing discussion of super-ego intrusion into the ego's evaluative processes. The patient, as we discussed in an earlier chapter, must control in order to avoid disaster. He is already convinced that giving up control will not result in aid but in tragedy for himself and/or the therapist: he controls, then, to prevent harm and pain. Above all, he controls to avoid the painful experience

of realizing his own separateness, his intense need for the therapist's love, and his fear that these needs will anger, damage and/or harm the therapist. In addition, the patient feels guilty about his inaccessibility and controlling manner. He feels he is 'not working', not producing, and whatever he does, or neglects to do, is wrong. In his perception, this burdens the therapist or makes him angry.

In my experience, such a situation warrants a therapeutic posture which allows for, and gives, the patient 'implicit' permission to control. In other words, the therapist must focus on the 'discomfort' the patient experiences around maintaining control. For example, the therapist may comment, "You seem uncomfortable about being vague (not knowing what to say, being confused, etc.). It is as though there is something else you should be saying. Can you say more about this discomfort?" The focus then falls on the patient's guilt over needing control, a subject which allows examination. As the guilt becomes more ego-dystonic, the therapeutic situation becomes a 'safe' place for the patient to assert and maintain control (i.e., to utilize his defense). In the meantime, it becomes a safe place in which to relinquish the defense and verbalize more freely.

This approach is in keeping with the work of Weiss (1971), who believes that if the patient feels it is safe to use control, then it may be safe to give it up. This

process is usually long and entails a great deal of testing on the patient's part around both maintaining control and partially giving up 'pieces' of it. The pay-off is the strengthening of the therapeutic alliance because the patient does not feel condemned for using a central defense. In my experience, the temptation to ask numerous probing questions and to encourage free speech is definitely counter-indicated, for the patient only experiences this as an intrusion as well as an indication he is doing something wrong. The super-ego processes would, thereby, become exacerbated.

The same therapeutic position applies when the patient avoids acknowledging the therapist's presence. In this instance, distance, which involves a rigid denial, acts as a supportive measure in the maintenance of control. The therapist's task is to focus on the need for distance and the discomfort associated with it. I have found it helpful to emphasize and label affects such as 'fear', 'fright', 'worry', etc. in order to specify the nature of the discomfort. The desired outcome in using such an approach is to highlight the fantasies of danger without giving the impression that the therapist is asking or demanding the patient to experience the relationship should he find himself involved. I recommend no intrusion into the patient's distancing measures no matter what form they may take. The patient needs distance for safety and self-comforting

purposes. Certainly a person suffering a negative therapeutic reaction needs solace, no matter how he achieves it or how conflicted he is over the methods he uses to acquire it. Relatively speaking, such a person is best left alone when he is experiencing an intense need to establish distance.

Loewald (1972) agrees with Freud that hope for success depends upon the therapist becoming a more benign super-ego introject which, of course, includes the ego-ideal. To promote this process, the therapist must focus on how extreme and irrational the patient's demands on himself actually are. If the patient is not to feel ridiculed for having had such self-expectations in the first place, the therapist must employ skill, tact, and a keen sense of timing, for the tyrannical nature of the ego-ideal is invested with large amounts of narcissism. This is a slow, delicate process requiring a great deal of time. The therapist's posture of acceptance and calmness is never of more importance than in such cases.

Because of its importance in our understanding of the therapeutic focus, I wish to digress for a moment to the dynamic origins. I have stated, in the re-examination of the thesis, that the syndrome originates in the crisis period of the rapprochement subphase. Primary in this subphase is the child's ambivalence, which colors his realization of separation from his mother. Because he both

needs mother and needs to assert his autonomy, mother's availability and support are crucial to the child's healthy resolution of the conflict. Similarly, in the psychotherapeutic process, it is of crucial importance that the therapist be in empathic contact with the patient's intrapsychic experiences, that is, his approaching or backing away behavior. In order to allow the patient to 'come forward' or 'back away' at his own pace and as he needs to, the therapist must not interfere with either behavior. Empathy, I believe, is the capacity necessary to perceive and allow this behavior.

As Greenson notes in his article, "Empathy and Its Vicissitudes" (1960), empathy means to share the experience of feeling with another person. In the psychotherapeutic process, this sharing of feelings is temporary because the therapist partakes of the quality and not the degree of feeling, the kind and not the quantity. It is, in this process, a preconscious phenomenon. The primary motive is to achieve an understanding of the patient. This requires a split and a shift in the therapist's ego functioning. He must be able to feel with and share in the emotional state of the patient; while still observing, analyzing, remembering, and judging. By means of this facility, the therapist stands available to perceive the patient's intrapsychic processes at any given moment and to synthesize the data into useful formulations and interventions. The therapist

must employ his empathic skills in order to know whether the patient is approaching or distancing, to attend to the conflicts issuing from the patient's ambivalence, and to focus more keenly on the source of conflict. In addition, this 'sharing of feelings' helps to promote the introjection of the therapist as a more benign super-ego figure. The therapist's ability to empathize tends to aid the entire dynamic by making more ego-dystonic the disturbing super-ego processes and interfering with their projection onto the therapist. This, in turn, facilitates the formation of a therapeutic alliance.

In summary, the primary focus behind therapeutic interventions should center around the super-ego processes and their projection onto the therapist. The therapist must allow room for control and distance in order to safely encompass the patient's discomfort after an intervention. This slowly promotes the creation of a larger range of safe intrapsychic experience. Empathy becomes important as a monitor for perceiving and framing the patient's ambivalent behavior.

The Therapeutic Alliance

In order to explore the difficulties a therapist may encounter in establishing the therapeutic alliance, a perspective on the nature of this alliance seems an appropriate beginning for this section. Although Greenson (1967)

first coined the term "working alliance," writers have used many different labels to describe this same phenomenon. With few exceptions, the therapeutic alliance has followed second in importance to the transference and received attention separate from transference reactions. Greenson used the term "working alliance" (i.e., therapeutic alliance) to describe the relatively non-neurotic, rational rapport the patient has with the therapist. Within its reasonable and purposeful confines, the patient can work effectively on his conflicts and allow them to come to resolution. The reliable core of the alliance comes from the patient's motivation to overcome this neurotic pain and his sense of helplessness by consciously and rationally cooperating in his own healing and by contributing his insights, even the painful insights, for the sake of his own growth. Patients unable to set apart a reasonable, observing ego will not be able to maintain such an alliance.

The working alliance may contain elements of the infantile neurosis, that is, the wish for gratification, which the therapist must eventually interpret. When the alliance interferes with the full development of the transference neurosis, it represents a resistance to regression. Overall, the working alliance represents the internalization of the therapist's patience, his exploring attitude, his acceptance, and his willingness to understand. Slowly, the identification with the therapist increases until the

patient responds to himself in a similar manner. This process is extremely retarded in persons suffering a negative therapeutic reaction. For these persons, the establishment of such an alliance, indeed, becomes one of the major therapeutic goals.

The most outstanding obstacle to the development of a therapeutic alliance is the patient's super-ego processes and their projection onto the therapist. Because of the super-ego interference, the patient either feels ashamed, ridiculed, judged or condemned or perceives that the therapist thinks and feels about him as he, the patient, thinks and feels about himself. This keeps him too afraid to form an alliance of much enduring strength. Indeed, he is more acutely aware of his fear than the therapist's desire to help him. Because his problems are overwhelming to him, he believes they will also overwhelm the therapist should he tell him. More often than not, he feels the therapist is angry with him for having his particular problems. This usually reflects an unconscious projection of the patient's earliest experiences of separation from his mother. It is only after a long period of therapy that any form of alliance resembling Greenson's description is even remotely possible. The therapist must put considerable energy into laying a groundwork by utilizing procedures and techniques which encourage the patient to acknowledge the absence of the therapeutic alliance.

Another difficulty revolves around the patient's resistances which make it hard to determine the quantity and quality of the alliance when it is present. This means that the patient's inaccessibility, insistence on control, and fear of acknowledging the presence of the therapist result in a lack of material from which to draw a determination about the presence or absence of the alliance. Of course, an added difficulty is the possibility that the therapist will misjudge the state of the alliance and make interventions which either prove inappropriate or traumatize the patient. Furthermore, because the patient may not report his reactions, the therapist may be unable to ascertain the extent of his misjudgment.

As Riviere (1936) so pointedly emphasizes, the patient's unconscious love of the therapist constitutes a hope for a successful therapeutic outcome. By its very nature, the therapeutic alliance acts to both frustrate and stimulate the patient's latent love of the therapist. Certainly both present therapeutic hazards. The alliance becomes important as a vehicle for a non-emotional, objective, analytical rapport with the therapist. Within its confines, the patient recognizes that his unconscious wish for gratification will not be met but, rather, explored and understood. For many patients suffering a negative therapeutic reaction, this symbolizes rejection, unavailability, and everlasting longing for the return of mother's love.

This inhibits the development of the therapeutic alliance, for the patient would rather cling to the hope that one day the therapist will in fact love him and put things right. On the other hand, any pleasurable relationship, even one issuing from an objective, analytical stance, stimulates desires for more or 'something else!'. This activates painful longing and the fear of abject helpless dependence. For both reasons, the alliance is slow to form.

As essential as the therapeutic alliance is to the successful outcome of treatment, when dealing with a person suffering a negative therapeutic alliance, the therapist must constantly observe and acknowledge its relative absence and retarded development. Indeed, its very monitoring can prove therapeutic, for the therapist can remain in contact with the patient and better determine when and how to intervene.

Common Countertransference Problems

By this time, one can well imagine the many personal difficulties the therapist encounters in treating a person suffering a negative therapeutic reaction. Rather than attempting to categorize and explore these difficulties in depth, I shall present a general overview of the more salient problems.

As we have seen, such a patient suffers conflicts on numerous levels which render him inaccessible, controlling,

fearful, and, in general, extremely resistant. A major portion of this resistance derives from the super-ego processes and the super-ego precursors; that is to say, there is extreme and intense conflict between the ego and the super-ego. Frequently, this very conflict is contagious, particularly if the therapist, to whatever degree, experiences a similar tension.

This contagion can manifest itself in many ways. Foremost among these and, I believe, particularly applicable to many clinical social workers, is the chronic feeling that one has not done enough, has not treated the patient properly, or has not seen some theoretical point which would help the patient. Such guilt leads the clinician to alter his treatment plan, as well as his formulations, and focus in a different area, all with the hope the patient will 'get better', trust more, verbalize easier, and experience more pleasure. Of course, to frustrate matters even more, the last thing the patient will do is report progress and this only near the end of treatment. Needless to say, altering the treatment usually fails, and the patient becomes even more resistant. Thus, the therapist finds himself in a vicious circle, addicted to the pursuit of new areas of focus, yet more and more alienated from the patient. Most often, this leads to either the therapist or the patient deciding upon termination as the only appropriate option.

As well as feeling inferior and incapable, the therapist may, consciously or not, become very angry with the patient for not improving, or at least not recognizing his hard efforts. If the therapist displaces his anger, turns it against himself, or in a passive-aggressive manner acts it out against the patient, the patient, who is already highly sensitized to anger, will feel his own worst convictions confirmed. This would constitute a major trauma for him and, subsequently, a major treatment crisis.

When the therapist's efforts do not produce the anticipated progress in the patient, a potential for narcissistic injury to the therapist is present. Paradoxically, when the therapist is most correct in his interventions, the patient will become worse--certainly a bewildering circumstance. If this were to happen often enough, the therapist could easily become doubtful of his capacities and depressed at the lack of progress. Subsequently, he may withdraw from the patient or de-emphasize his importance to the patient in order to protect himself. This merely reinforces the patient's already existing pathology.

Whatever the therapist's feelings, empathy--the essential ingredient for a successful therapeutic outcome--is diminished. Because empathy is, to some extent, a two-party relationship, the other's resistance or openness to empathic understanding often influences one's readiness to empathize. Patients eager for empathic understanding evoke

empathy in the therapist and all runs smoothly. On the other hand, patients suffering a negative therapeutic reaction, consciously or unconsciously, want to remain misunderstood, even dread understanding, because it implies destruction and disclosure of their 'morbid' motives. With these patients, the therapist must continually maintain empathic contact, although limit its expression. This requires patience and the highest form of artful self-awareness and restraint.

The Question of Alteration in Technique

The question of alteration in technique does not jeopardize the stated recommendation for a focus behind therapeutic interventions; indeed, the two are not related. This question, instead, brings up the issue of when and how, if ever, to shift out of the position of neutrality. Certainly one temptation for the therapist is to lend himself to the patient as a more positive gratifying object with the hope of neutralizing the harshness and strictness of the super-ego and its precursors. This in actuality means that the therapist takes a supportive posture by emphasizing the positive and discouraging or avoiding interventions when the patient manifests his aggressive drives. I warn against such a posture, primarily because this tempts the patient's latent love for the therapist and unconsciously activates his painful memories about his

earlier rejection by a loved object. In fact, the patient could perceive such a posture on the therapist's part as cruel rejection. If not this reaction, then, he could become unduly guilty about his need for control and thus increase his resistance and guilt. In another instance, because he feels undeserving and in need of pleasing the 'bountiful' therapist, he may feel overly obligated to him for his concern and care. This, in its turn, would activate the patient's need for autonomy and his pull toward a regressive symbiosis. Since the therapy cannot offer unconditional love, the end result for the patient is deep disappointment equal to yet another trauma.

In conclusion, I believe the neutral position is the most therapeutically advantageous because it allows the patient to control his own ambivalence. Within his domain, then, is the right to move closer and love and, equally, to insist upon distance and autonomy. Also, the patient can experience the internal consequences of either position and hopefully come to a point of mastery. Only through slow and painful attempts on both sides to love and to allow autonomy, will a lasting integrated insight evolve. After all, the therapeutic hope rests with the patient's capacity to love intensely and deeply as a separate individual.

CHAPTER V

A CASE STUDY OF THE NEGATIVE THERAPEUTIC REACTION

This clinical case study of a woman suffering a negative therapeutic reaction is of necessity selective and intended as an illustration of the preceding theoretical discussion. Certainly a person who has a proclivity for pain will manifest masochistic features in her character structure. I shall not directly address this issue in this case study nor discuss in depth the defense structure, the narcissistic elements or the multiple resistances, since they are evident throughout the case. I wish primarily to focus upon the development of the case over time, the underlying developmental issues with special references to the patient's attachment to pain, and the nature of the transference. In order to preserve the right of confidentiality, I have altered the factual data and chosen to refer to this patient by the fictitious name Ann.

The format leads me to break the chapter into three sections. First, I shall present an overview of the case, which includes Ann's presenting problems, my diagnosis, her developmental history, and the development of the psychotherapeutic process. Two case hours will follow this

section and provide a limited illustration of some of the dynamics. Finally, I shall present an analysis of the case, including a commentary on the two case hours.

An Overview of the Case

I have worked intensively with Ann for approximately six years with one 18 month break after the first 100 hours. She was in her mid-twenties when she first began therapy and had just completed one year of weekly psychotherapy with a clinical psychologist. She complained to him of sexual frigidity. At the time I began seeing her, she had been married five years. She held a Bachelor of Arts degree in mathematics and was employed part-time. She planned to enter graduate school in counselling psychology and followed through on these plans. She is presently working toward a doctorate in clinical psychology.

Her presenting problem to me was "sexual frigidity" and frequent migraine headaches which, she knew from consultation with a neurologist, had no organic base. Because she feared the side effects of the medication, she refused the neurologist's treatment plan. The headaches, which occurred about twice weekly for about two days in duration, especially bothered her on weekends when she and her husband were together. Even at these times, she refused aspirin because, as she saw it, any drug was "unhealthy." In talking about her pain, she frequently verbalized feelings of

guilt: "My headaches make my husband unhappy"; "I bring it on myself"; and the like. She stated she had no sexual desire for her husband; indeed, she had sex with him because she felt "guilty over being a poor wife." In intercourse, which occurred about twice monthly, she experienced no pain but was unable to become sexually aroused.

Ann is small and slender with delicate features, long hair, and a potential for being attractive. She at one time wore make-up. Her dress is consistently Levis and "Hush-Puppy" shoes. Her voice, which has improved over the last few months, is faint because she does not project it.

During the first four years of therapy, Ann appeared continually frightened and moved as if she were confined or constricted. In the first year of therapy, she sat in a rigid position, hands clutching the chair arms and staring starkly at me. Because her associations were blocked, she had extreme difficulty verbalizing, which resulted in very long periods of silence. She was able to state that she was afraid but she did not know what frightened her. At her request, she began twice weekly therapy sessions in the third month of treatment.

Ann's developmental history reflects a life filled with painful experiences and little joy. She is the youngest of two daughters in a family of Jewish ancestry. Her sister, three years her senior, holds a doctorate. Her mother, about thirty-five years old when Ann was born, also

holds an advanced degree and has worked throughout Ann's life. Her father has only a high school diploma and has made money only periodically.

The family managed in a routine and orderly fashion under the dominance of a mother who tended to set most of the family rules, including those affecting the father's behavior. The mother held sway by constantly reminding her husband, in front of the children, friends, and relatives, that she made more money than he. I frequently have a strong impression that the mother did not really want children but allowed social convention or some other factor to motivate her. She actively discouraged any dependent behavior from the children and frequently criticized Ann's expression of her dependency needs. Ann learned quickly not to ask for anything. Although the mother overly encouraged independent behavior, she rewarded only Ann's sister for this behavior.

Neither the mother nor the father ever bought their daughters feminine toys or clothing, such as dolls or ribbons for their hair. These their grandparents and relatives brought on special occasions. Ann cannot even recall her mother brushing her hair. She played with her dolls quietly in her bedroom with the door closed as if to hide from her parents' humiliating remarks: "You're too old for that stuff." or "You've more important things to do."

Ann describes herself as "stupid, selfish,

unreasonable, insatiable, cold, removed, unfriendly." These are, in fact, her mother's labels for her behavior, especially when she, as a child, exposed her dependency needs. For instance, Ann remembers asking her mother if she loved her and receiving the response "Don't be stupid." At other times, her mother told her "If your feelings are hurt, it's your own fault. You're too sensitive." or "Only babies cry." Ann's earliest reported memory is of a time when she was lying in bed alone, crying, and wishing one of her parents would come in to console her. She remembers no response on her parents' part.

A strong theme in her history, and in the transference, is Ann's feeling that her mother blamed her for her mother's own unhappiness. She apparently considered Ann's mere existence an intrusion upon her life. On the other hand, she apparently needed Ann as an object on which to project and externalize her own dependency needs.

The older sister seemed to escape much of the criticism. My speculations indicate that this older sister, for the most part, learned to comply with her mother's unconscious rules early while denying and repressing her own pre-oedipal needs. An ego-split in the mother aided this scheme. The mother looked on the older child as independent, capable, strong and good. The second child she saw as dependent, stupid, helpless and needy: "She will need a man to take care of her." The mother told Ann she should go to

college, not for its own sake but in order to meet a man who could support her.

By proving a vulnerable object for her mother's projections and externalizations, Ann served as an aid in the maintenance of her mother's defense structure. This helped her mother ward off her dangerous impulses around her own dependency needs. Thus, her mother could punish and deprive her youngest child as a means of mastering her own internal conflicts. Such behavior indicates the mother's deeply unconscious narcissistic identification with Ann.

The father defended the mother when Ann complained, but he was not as critical and showed a capacity, though limited, for warmth and nurturing. The mother, however, competed with Ann for her husband's affection and frequently interfered with their interactions. Her father viewed females as "stupid, irrational, manipulative, clumsy, dependent." For example, when Ann asked him to play catch (baseball) with her, his response was "You're a girl. Girls are clumsy." If he did concede and play with her, he laughed at her movements and criticized her when she dropped the ball. In high school Ann received almost straight A's in mathematics and chemistry as a way of gaining her father's support and praise. He, however, believed girls were incapable in these areas and, although she longed for his approval, he never acknowledged her academic achievements.

I speculate that due to the mother's neglect and overt rejection, Ann turned to the more receptive father for satisfaction of both her pre-oedipal and oedipal needs, but she suffered intense disappointment because he was apparently too restricted and too fearful of the mother to respond. This situation facilitated Ann's regression to the stage of separation from her mother and allowed the fixation to fasten here where the mother's projections were most vulnerable to activation.

Ann inwardly withdrew from her family in latency, pledging to herself: "I'll never need them again." Of course, outwardly this was unsuccessful and she would, after a long period of time, openly express her need for them, only to be rebuffed. Again she would withdraw with the same inner pledge, ridiculing herself for hoping it could be otherwise. This became a strong transference theme in therapy. She longed for my acceptance, yet criticized herself harshly for needing it. Thus, at all cost, she maintained control.

She dated little in high school and college. She met and married her husband in his junior year. He is extremely obsessive and critical. He puts her down with such comments as: "If it weren't for you, my life would be all right."

Originally, because there was a great deal of evidence for it in the clinical picture, I diagnosed Ann as a

chronic obsessive compulsive neurotic character disorder. I observed symptomatic behavior patterns of rigidity in body movements, rigidity in her daily activities, low tolerance for unstructured time, and avoidance, if at all possible, of any anxiety-provoking situation. Ann had an operative and well-integrated defense system which included intellectualization, isolation, doing-undoing, rationalization, and denial. Because the turning against herself was intense and dominant, it led me to formulate the presence of a deep underlying depression.

Her super-ego functioning was extremely harsh and strict. From my experience in the transference and her reports of daily intrapsychic activity, I noted that she seemed to use introjection as a means of maintaining control. This, as well as an extremely perfectionistic, ego-syntonic ego-ideal, led me to believe her super-ego processes were predominantly based on the super-ego precursors. Much of her super-ego processes were based on introjections and internalizations of her mother's critical attacks. Consequently, this impaired her ego capacity for self-observation.

Developmentally, I formulated that a fixation had solidified in Ann's psyche during the oral and anal stages. She, I speculated, entered the oedipal stage well-equipped to handle sexual conflicts, but her father's severe rejection and humiliation promoted a rapid regression to the

anal withholding stage, thus, solidifying a fearful obstinate position. An attacking primitive super-ego, the representative of her mother's critical voice, was the internal response to Ann's oral needs. The ego, living in fearful dread of the super-ego and the possibility of regression, adamantly insisted upon control.

The migraine attacks, I observed, originated in a denial and repression of her rage toward her parents which she had turned against herself. Furthermore, she seemed to use the rage as an excuse to discharge anger at others (that is, spoiling her husband's good times). Ann achieved a secondary gain by a pleading hope that someone would respond to her pain.

The problem of sexual frigidity, I formulated as based on a fear of regression and a low tolerance for the anxiety surrounding any need state, sexual or otherwise. In addition, Ann used her lack of sexual arousal as a means to frustrate others and to discharge her hostility. In this way, she used the mastery mechanism of turning passive into active: "I'll deprive others of what others have deprived me of." I have not, in and of itself, changed this perspective, but I have added a new dimension, that is, an attachment to pain as a representative of the painful attachment to the mother. More will be said of this later.

The course of therapy has been slow and arduous. As I described, Ann, in the earliest stages, was frozen and

rigid in posture and presentation and experienced extreme difficulty in verbalizing. On occasion, she experienced muscular convulsions making no association to her anxiety state. Somewhat anxiety producing for me was her 'wide-eyed stare' which seemed to reflect extreme apprehension. It was as though she could not take her eyes off of me out of fear of being slapped or physically abused in some way. Indeed, later in the treatment, a fantasy emerged that I wanted to hit her. Somewhat later, she elaborated on this as a fear of my approaching her from the rear and striking her on the back of her head. My initial stance was warm and accepting, though neutral, and focused on her 'fear of showing herself' so that I could 'see' her thoughts. Ann experienced this as guilt over her failure to conform to my expectations. In other words, she perceived that I wanted her to talk as opposed to her wanting to talk herself. In fact, she projected her expectations onto me as the therapist and experienced them as my expectations.

This extremely rigid posture continued well beyond the 100th hour. My interpretations focused on her "fear of letting anything out." We also did a great deal of work on her feelings of shame and self-disregard. My overall intent was to try to repair portions of super-ego functioning so Ann could relax more and verbalize more freely. Her super-ego judgments were extremely intense and almost entirely ego-syntonic, but I hoped through continued

therapeutic interventions to create more distance in the intense 'marriage' between the super-ego and the ego. I was very idealistic in those years.

My countertransference feelings during this period were ambivalent: I both liked and disliked her. Frequently I felt as if I were either pulling teeth or being defeated in my attempts to help her. This was, indeed, part of the therapeutic dynamic, because she desired that I make a "fool" of myself in order to avoid feeling as though she were making a "fool" of herself. On a much deeper internal level, I wished to free us both of the agony of useless guilt. I felt: "If only I could save her, I could save myself." A long time elapsed before I realized my deep identification with her pain and her feelings of hopeless striving.

Stage two began when I noticed some progress in the separation of the ego from the super-ego. Ann began to relax; the stark stare diminished; her bodily movements became less rigid; and her verbalizations flowed with more freedom and richness of content. With this emerged an intense transference reaction in which Ann accused me of being cold, distant, and indifferent. Hourly she made it clear that she was "not being helped"; she was "getting worse" and not better. A strong, intense syntonic fantasy emerged of another therapist who liked her, directed her, consoled her, held her. Accompanying this were her frequent charges

that the "form" of therapy was not right for her: she needed a more "powerful" type of therapy; thus, she began to study primal therapy. She complained more and more bitterly about her pain and my lack of understanding. I could feel strong pulls in myself to "do something," yet my intuition kept me, for the most part, from over-activity. There were times, in spite of this, when I found myself more active than usual. When I finally realized I was trying to ease Ann's pain, especially around her guilt ("I am doing so little. I should care more, then she would get better."), I noticed an increase in her somatic complaints and her fantasies that "some other therapeutic method would help me more." This confused me, and I wondered if I could treat her.

At this point, I was called away from my practice for a week due to an illness in my family. Upon my return, Ann told me she had signed a contract with the Primal Therapy Institute and had made a \$1,000 deposit for three weeks of intensive therapy and 49 weeks of follow-up. She again explained: "I am getting nowhere." Immediately I began interpreting her feelings of guilt over "leaving me," the feelings that I might disapprove of her actions and expect her to remain with me even though she still suffered. She did terminate with many painful and ambivalent feelings. I viewed this difficult termination as an expression of the intense super-ego repercussions Ann experienced when she

tried to separate from her parents. Although I had little faith in primal therapy and was concerned that it might do her more harm than good, I maintained as non-judgmental a stance as possible.

At this time, I began to see my identification with her deep and intense longing for someone to care for her. Over the eighteen months in which we had no contact, I concluded that my increased activity, no matter how minimal, had resulted in making Ann feel she was obligated to repay any care I had given her. By implication, she experienced her dependent longings as a burden to others which could cause them harm. Additionally, I speculated that she felt she had succeeded in "forcing me to give" to her, which increased her guilt and fear of retaliation.

Stage three began when, after eighteen months, I received a call from Ann in which she stated she needed my signature for hours of personal therapy to complete her licensing application--something her primal therapist could have done. I agreed and arranged a time, which she promptly kept. I signed the paper and she left. A month later, she called requesting an appointment because "I have unfinished business with you." I gave her an appointment and she resumed twice weekly therapy.*

The predominant theme during this period was her

*The first of the two case process hours occurred about one year after her return.

intense fear that I felt "disdain" for her because she had terminated therapy. Similarly, she feared that I looked upon her as "foolish, stupid, and unappreciative!" She often verbalized that I must be bored with her and disappointed that she made so little progress. This stimulated an intense fantasy that at any moment I would either terminate our work or not know what to do with her. All during this stage she spoke of feeling she was "not in the same room with me." Outside of our sessions, she thought of me frequently, but it was as though I did not really exist. Her headaches increased and usually began the morning of the day of her appointment.

She invariably opened the session with a description of her pain and its intensity, only to drop the subject and move to another rather rapidly. With my consistent interpretation of her "fear of receiving disapproval or rejection from me," her regressive fantasies of needing to be held by me, to cuddle in my lap, to escape judgment, and to experience a haven away from expectations grew more intense. After such a disclosure, Ann backed into a period of intense resistance which took the old complaining form: "I'm not making progress. My pain is increasing. Everything is getting worse." This time, an affect state of depression surrounded the statements, and I heard anger, longing, and bewilderment that I had not done something to positively change her situation. Inwardly she interpreted

this as my not wanting or caring to help her.

Alternating with these intense periods of resistance was the emergence of early childhood memories of her mother as someone who sat in judgment over her need for dependence and who insisted she become more independent. Ann also alluded to a "vague wordless fear of something inside." This led me to speculate that her migraine pain and her emotional pain were of the same source and represented Ann's attachment to her mother who withdrew her love. Thus, she feared relinquishing her pain because at least in pain she could connect with someone; without it there was no one to whom she could turn. Her increasing references to "wordless" affect states, led me to believe that perhaps the major fixation occurred at a time when she was first beginning to learn the use of words.

A little over a year ago, in the spring of 1977, stage four began in which the entire clinical picture seemed to expand. Ann became more animated, spoke freer, used richer ideation, and increased her reports of early childhood memories. She also spoke more often and in more detail about her husband. The accompanying periods of intense resistance had a briefer duration and the therapeutic alliance seemed much stronger. I speculated that this stage began when Ann was able to internalize me as a more benign super-ego introject. With this support, she was better able to differentiate her transference fantasies

from me as the therapist and from the therapeutic process. Consequently, she was more able to observe and report her inner processes.

The major themes throughout this stage included expressing the affect state of longing, associating her pain with her feelings of loss, allowing the emergence of latent transference love, and recalling early childhood memories. In the early fall of 1977, Ann began to associate and label the affects she once experienced only vaguely. The most pronounced of these was a terrifying feeling of "longing."

She reported this following a dream in which I was with her, holding her and stroking the back of her head. This made her content and assured her of my care: she felt "totally safe from harm." The dream suddenly changed in emotional tone and I began to "drift away" from her. She could not reach me. Although she "struggled" to grab for me, I disappeared. She reported feeling totally alone, isolated, and helpless. She tried to "scream for me" but she had no voice. She awoke terrified and filled with a "horrible deep longing."

In the succeeding sessions, Ann once again spoke of feeling she was "not in the same room with me." She verbalized her feeling that if I were with her, it seemed I was "too far away." This statement brought on muscular convulsions and her hands visibly shook. She broke into deep

mournful sobs. As the hour neared a close, she reported feeling the onset of a headache, which she associated with her feelings of having to leave me. Later she stated that it was "easier" to keep me out of the room, for to acknowledge my presence activated her painful state of longing and increased the intensity of her migraines. This went back to a powerful feeling of "having lost something" she could never regain. She verbalized a deep inner conviction that she could never have anything she wanted.

Whenever I made interventions which felt good to her, the next session she would distance herself considerably. For example, a week after she had increased her sessions from twice weekly to three times weekly, she had a particularly 'good' session in which she was very animated and reported "feeling better." The next session she reported having a severe migraine which she associated with a dreadful fear of something happening to her. She had forgotten the content of the previous hour until near the end of the session when she remembered only fragments of how good she felt. I interpreted the situation as one in which her good feelings activated a painful feeling of longing as well as a feeling of hopelessness.

The association of Ann's pain with her feelings of loss, another major theme, followed closely upon her painful feelings of longing. Whenever Ann did, indeed, "feel better," achieve some goal, or secure for herself something

she desired, she developed a severe migraine. Often she denied her accomplishments, either those in therapy or in her life, and focused instead on her failures, her lacks, and her fear of horrible things happening to her. She had a deep attachment to pain which she protected at all costs.

In the early winter of 1977, Ann once again consulted a neurologist about her headaches and received confirmation that they had no organic base. This time, however, she accepted the medication which included a mild anti-depressant and five milligrams of valium a day. This she feared would "take something from" her and render her "mindless". In conjunction with the medication, the neurologist coordinated a program of relaxation education in which Ann received "deep tissue massages." This was a period in which Ann declared a massive attack on her pain. She reported after one massage feeling relaxed and "wonderful." Immediately after, she developed a muscle spasm at the base of her neck which made her head shake violently from side to side in a 'no' manner. At this point, she recalled the fantasy in which I had left her.

As the intensity of her migraines diminished, her fears of being totally helpless increased. She reported a fantasy in which she was totally paralyzed, unable to move, see, hear, or talk but able to experience her thoughts and feelings. She could not communicate with those upon whom she was totally dependent and, as a result, they "gave up"

on her and treated her "mechanically." This fantasy, strongly connected to her desperate feelings of longing, seemed to stem from a fear of being mindless and unable to accomplish her tasks in school.

The theme of emerging latent transference love eventually came into the limelight as Ann more confidently verbalized her fears and risked the experience of affect states surrounding her painful feelings of longing. She reported thinking of me more often outside of the sessions. For the most part, her fantasies, which she at first reported very reluctantly and vaguely, were pleasant and involved my taking care of her, rescuing her from danger, and accepting her. Because she associated these fantasies with feeling she was "foolish, stupid, and deserved being laughed at," she would quickly change the subject or ridicule herself for bringing up such material. Apprehensively she watched me for signs of rejection and, after reporting her pleasant feelings, acquired a headache. Frequently, in subsequent hours, she reported pain and dreadful fears. I viewed her attempts to tell me about her fantasies as 'approach behavior' and meant partly as a test to see what my reaction might be. When she did not experience humiliation, she became even more frightened than usual and expressed feeling that I was teasing her or taunting her into disclosing parts of herself. She felt I would ultimately reject her at the moment when her "hopes" were

highest. This again brought on a migraine headache.

With the emergence of this latent transference love, Ann began to recall more and more of her early childhood memories. These, for the most part, centered around her bitter disappointment in her father. She recalled feeling very lonely as a child and desperate for someone to "notice" her. Her father, however, teased her when she turned to him for a "hoped for" expression of affection. Often he slapped her with a wet towel or tickled her to the point of pain. Ann's return for more he never recognized as an anguished need to "cuddle" in his lap. In addition, she remembered more instances in which he spoke degradingly of femininity. Inwardly, Ann continued to maintain that her father loved her and to 'hope' that one day she could secure his affection, an attitude which at times kept her going. Furthermore, she longed for him to protect her from her mother's critical assaults, but not at her mother's expense. In all these hopes, Ann was bitterly disappointed. In particular, she recalled the fear of hearing her parents talk in their bedroom because she was terrified her father was discussing with her mother matters she had meant only for him. In reality, this appeared to be the case, for whenever she disclosed a private concern to her father, her mother found out and humiliated her, usually in front of her father.

In addition to these memories of her father, Ann

also began to elaborate on situations in which her mother was cruel to her. When she spoke about these instances, she acted as though she were pleading with a 'higher court' to believe her. In her eyes, I was thinking that she was exaggerating or lying in order to convince me that these painful events had actually occurred.

Generally, in this last and current stage of therapy, Ann's material has grown richer and deeper. She more clearly relates to her transference feelings and more easily communicates them. She presents herself more as an individual, disclosing more freely of herself, and taking a somewhat more distant view of her masochism. She is progressing in her life, nearing academic achievement, and experiencing improvement in her marriage. Her relationship to pain, which she now refers to as a process of which she wishes to rid herself, has changed dramatically. Her struggle, however, to relinquish her pain still remains with her.

The Case Process Hours

The two case process hours presented below are taken from random sessions with Ann. The first case hour, which is about the 275th, represents a particularly resistant session in which Ann is struggling with her need, and the verbalization of this need, to have me intervene and assist her. She defends against a latent positive

transference and the feeling of hope with self-ridicule and confusion. She expresses feeling attacked because of her dependency needs. I, as therapist, assume a confrontive and interpretive stance. In the second case hour, which is about the 350th, Ann expresses her intense guilt over an accomplishment and her experience of pleasure. More important, she demonstrates her flight from pleasure and her clinging to pain. Unfortunately, only a limited number of hours were recorded and these at times do not reflect as clear an example of the dynamic as I would like. I hope, however, the two hours presented will give the reader some feeling for the underlying dynamics as they occur in the therapeutic hour and as they interweave and color the relationship between the therapist and the patient, thus influencing the course of treatment.

The First Case Hour

Patient: It's really frustrating; my life is so full of pain. I woke up with a really bad migraine this morning. I couldn't sleep. I've been feeling more hopeless about it. Everything keeps getting worse. My migraines are a lot more frequent. I've been feeling really strange, very foggy and removed. It hit really strong yesterday at noon. I met with this professor; he's meeting with each one of us to give us a basic review, and I was really apprehensive about the meeting because I really feel very uncomfortable

around him. I'm quiet and talk less in that class than any other. I find myself faking, laughing at his jokes. I wasn't surprised at all by his comment that I should get more in touch with my unconscious process, and yet it really hurt because I know I'm not at all in touch with myself. If someone says I have a good sense of humor, it seems as though that's "out there." I don't feel it inside. I feel the opposite. I don't see how anyone could think me humorous. That coupled with feeling more and more removed from things--I guess I feel as though I have a lot of stuff going on inside and, uh, my body is reacting to it. Yet I'll feel numb inside and yet I don't know how to get it out. I feel some relief from it--to get a feeling of being in touch with something. I wish I could change it. It's like things are getting worse instead of better. All my symptoms are coming out at the same time. I get rashes when I get uptight. A rash on my arm from '68 to '72 and I haven't had it since, yet suddenly I've got it again. All this stuff is going on. I don't know what to do about it. Again everything is getting worse instead of better. I feel really removed from everything, tense and I just don't know what to do. I wish you'd say something or give me some encouragement. I wish you would support me in something. Encourage me. I need so desperately to cling on to that. It's going to change. It's really hard to function, like I had to go to a class today and in the middle of it, I found

myself in a lot of pain and it just took every bit of energy just to get through it. I had to get up an hour early just to get there and the tears...it's just awful. But I made it. I felt better by the time I got there. But I can't live like that. Well, I say to myself, "menstrual cramps, well, it's just once a month." I never know when that's going to happen. When I have them together, migraines and cramps, it almost drives me crazy. Here I am sitting here complaining. That never gets me anywhere.

Therapist: You certainly want me to know what a great state of distress you're in.

Patient: (crying) I want some help. I don't know how to get it. I keep thinking about having exploratory surgery done on my cramps and then I realize I can't afford it even if I wanted to. I don't know where to turn. (Cries) It keeps coming back to me. I've got to do it. But I don't have anything to do it with. I must be doing this to myself and I can't stop it. Today was the last class I'll have until September, so this week I've been socializing but feeling SO REMOVED from everybody. It feels like I don't have any friends. It's strange, I start my internship on Friday and usually I would be worried about that, but I'm not. I just feel so removed from everything. I'm just going on and on with how miserable I feel. I just want you to help me. But I'm doing this to myself, all I do is

complain.

Therapist: You seem to think I'm mad at you.

Patient: No. I feel you're just disinterested.

Therapist: You're certainly mad at yourself.

Patient: I feel so out of it. I must be, but I can't see it. I just feel so drained--that there's nothing left. I feel like I could get mad at myself because there's no place to turn, and it all comes back to, I have to do something. You don't have a magic cure and neither does anyone else out there. I feel just spaced out. If only I were in touch, I could do something. I could get some relief.

Tuesday, I lay on my bed and tried to get into a primal. As usual, I couldn't get anywhere. I can't do it by myself.

Therapist: You've said this many times before.

Patient: I do have to do it all by myself.

Therapist: It seems as though you feel I'm demanding that you do something, something for me, change in some way for me. Yet for two weeks now, you've been preoccupied with thoughts of me, worrying that I'm suffering some kind of emotional distress.

Patient: Yes. I've been obsessing about you all week. I made up a story.

Therapist: A story?

Patient: Yes. I made up that your wife had a sick relative in Los Angeles. Someone died, and she went to the funeral. I didn't see your car around all last week.

Therapist: So my distress is over my wife's distress.

Patient: Yes. But in my second story, you have marital problems. You've always spoken of your wife in such glowing terms, so it is she that is causing the problem, and you don't know what to do (nervous laugh). Since that time I've had a migraine and haven't been able to sleep. I want to know everything's okay.

Therapist: With me?

Patient: Yes, and it's frustrating because I know you wouldn't tell me. It accentuates the formality of the relationship. You're playing a role in here, not being yourself. Not giving of yourself. When I noticed you'd gotten your hair cut, I thought that maybe things weren't so bad. I was also fantasizing that the reason you've been so quiet is that something is wrong and you just can't talk.

Therapist: And somehow you must do something for me, maybe help me.

Patient: Yes. I've been thinking that I shouldn't burden

you with my problems. If I do, I'm not satisfying some of your needs. Selfish.

Therapist: It's clear that you think I'm in some grave emotional distress. And in such a state I can't give you anything, not even my attention. Maybe you feel you'll get even less if something happens to me.

Patient: (after a long pause) There is a professor at school who has a strange relationship to all of his female students at school. He was real sensitive before he got his divorce. Since then he has been manipulative and uses women. Maybe I fear that if you're having problems with your wife, you'll begin to have problems with all women, maybe not like them. Maybe I'm afraid you'll be angry with me. Like, whenever I talk about my sexual problems, I'm afraid you're thinking if that were your wife, you'd hate her. That you identify with Ed (long silence). It's all connected with this horrible fear that I'm this horrible person that is just testing and testing your patience, seeing how long I can frustrate you, not make any changes, have things get worse, till finally you kick me out. I'm so awful, AWFUL.

Therapist: You are disgusted with yourself.

Patient: I don't like myself at all. Like I'm such a horrible person to be around.

Therapist: All because you need, want, something from me.

Patient: (long silence) I feel like I'm so awful you won't want to help me. You'll do nothing.

Therapist: But, at the same time you're very worried about me. You feel that you should be sensitive, kind, understanding and helpful, all these qualities you admire in yourself. Yet you need the same from me, so you call yourself all kinds of names. You're feeling your needs to be enormous. YOU call them insatiable. It's as though only one of us can be giving. It seems your only alternative is to put a lid on your needs and develop a migraine.

Patient: It all feels so self-destructive because I'm not going to allow myself to get anything.

Therapist: It seems as though you're very frightened of rocking our reasonable analytic boat.

Patient: (smiles) I feel like you don't want the boat rocked. I feel I'll look like a fool if I express anything to you. Why should I move? You'll never change. You're just like a god-damned rock. Nothing will move you. I'm feeling really helpless in getting anything from you. I can't move you. But I don't tell you what I need. Part of it is that I don't know specifically what I need; part of it is that I want you to come up with the specifics. I'm

scared that if I'm clear on any specifics, you'll laugh at me. I feel like a fool. The only way I can get anything from you is for you to offer. That way, I know you want to give it.

Therapist: Yes, you must be quiet about yourself. Not demand or ask for anything from me. Then, hopefully, maybe I'll come through. But if you get anything, it almost seems as though you really drain me, or that while I'm not looking, you take it from me without asking. Then you feel guilty.

Patient: I don't have to call all the shots. It feels so lonely. Like I used to go up to my mother and say, "Do you love me?" And if she said yes, I wouldn't feel as though it were genuine.

Therapist: When you get something here, perhaps it feels that way, as though you forced me to give to you.

Patient: Yes, like you do it out of guilt or just to shut me up. I don't want to have to plead for something. I think I've been pleading all day. It's so bad. It's as though I created all this pain just to justify myself. It's as though if I have enough pain, you'll hear me. Then maybe you'll put those 35 patients out of your mind and hear me. Then I feel as though I'm banging my head against a wall. I think of going to another therapist, someone who'll

do something.

Therapist: You seem to be very afraid of expressing your need to be taken care of. It's as though, at the least, I'll be indifferent or, at worst, angry and throw you out.

Patient: I feel like you'll then start pointing out the realities and I'll feel like a complete fool. You'll get mad at me. I need all these reasons to have these needs. If I ask for help, you'll walk away. At least if I have migraines, maybe you won't. It feels so stuck. I want you to do something. Give me an exercise or something, something that will give me permission.

Therapist: We'll take it up here on Thursday.

The Second Case Hour

Patient: I feel tense. Been feeling like this for the last two hours. I had a patient from 3:30 to 4:30 and it's the first time that I felt like it interfered and, well, I don't think it interfered but I was really aware of my tension. I had to hold my neck still, which I have not had to do for awhile, and I was trying to figure out what was going on. I wanted to do something for myself. And some of it may be related to the fact that she mentioned she may be moving, and she's the most exciting patient that I've had with respect to coming in without any major problems. Just there to grow. And the transference was real clear

and she talks about it real easily and, uh, and she was talking about that today and her fear of her getting too close to me. She had all these questions about me and fantasies about me but, uh, I know some of it wasn't related to her.

I had an appointment with the professor on my committee that I'm at odds with. Oh God, he's a creep. I can't think of a better word. I wrote out the statistics I was going to use, and he didn't want me to do it the way I designed it. And he started going back to the original plan, and he asked me: "Where are you going to get the equipment to do the biofeedback?", which he originally had offered--the equipment and the patients and his computer. And then he took away the patients and so suddenly I didn't know if he was taking away the biofeedback equipment. So I answered a few questions he had asked me specifically, and he was vague. Finally I was able to get him to say he wasn't going to deny me use of the equipment. But he was not real strong in saying it was mine. So, just another frustrating experience with that man. But the more I get into it, the more scared (I am) of giving him up because I'm designing my study around what he wanted and his equipment. And one of the major tests I'm going to use is one he loves. And the program is already fed into his computer to calculate the data. And I'm going to have a huge number of variables from this test. The computer is already

programmed so it's really frustrating (one minute silence). I'm in this big bind of not knowing whether to get rid of him or not. I just keep seeing more of his problems. Like he sounded real interested and now he seems to have lost interest in my study, and he says: "Well, I guess I have." It started by him saying something like "Well, it's your study" and I asked him a question about did he think that it was a good thing to do if it was just my study. I told him it seems like he's lost interest (45 second silence). It feels like I should just make a decision and go with it. Probably the best one would be to get rid of him and start again (two minute silence).

My husband mentioned last night he really would like to see his therapist twice a week, and he's using money as the excuse not to. But there is some validity to that and with me coming here three times a week. And then the other part of me doesn't want to give it up because it feels so good. So it goes unresolved, and I was really struck with how good it does--how I don't feel this huge lapse in time.

Therapist: You worry about your good feelings by being worried about what you're depriving your husband of?

Patient: Yes, but there is some reality to it though I'm the one that's more aware of the finances. I know where we stand with me coming three times a week. He doesn't know

about money, so I know to some extent that it's a defense he's using. But it seems again like I'm taking away from him--not being fair. I'm shocked that he's considering twice a week. It really surprises me. It's going through my head, well, he knows we can't afford for him to go twice a week, that it's not safe to consider it now. It's a real battle between meeting my needs and letting myself feel my need and feeling selfish and I'm taking something away from him.

Eventually I'll feel you're bored with me coming a third time of the week, but that hasn't come up yet (one minute silence). In fact, I'm feeling how unguilty I felt about the time I'm getting now, and some of your other patients making a change in their schedule. And I really wasn't feeling responsible and guilty, and I know it was your decision (one minute silence). I'm so shaky, it's as if I didn't take a valium (three minute silence). It's really frustrating. I noticed yesterday that I was shaking and had tremors which are coming back. They died down for awhile. I don't know whether that's because I'm on medication (30 second silence). I feel uncomfortable like there's something that's causing this nervousness.

Therapist: What's happening?

Patient: (30 second silence) One thing that's on my mind is, I don't know if it's related to this feeling but, uh,

I'm feeling uncomfortable knowing that my husband is going to a therapist who apparently is very attractive. There is something, I guess. I'm scared that he's not going to be interested in me anymore. There's something I never thought about before (one minute silence).

I had a brief fantasy of what it would be like to have a child and the child would show, not my parents but, the rest of the family what I've done. They would be excited. It would be the first baby in this generation. The child would get attention, or the fantasy was that the child would get attention, which in some way means I would get attention (one minute silence). That feeling came up with one of the women at school I know. She mentioned last week that her daughter is expecting, so she's going to be a grandmother. And she is so depressed because she's into her career, and she's not going to be a grandmother like grandmothers are supposed to be. So she's trying to separate herself from her children; fighting her children off a bit. And I thought how totally opposite that is from my parents. I'm thinking of my mother, feeling that if I had a child, that would give something to my mother she could talk about in her bridge club. That's all it would mean to her. That's all that's important to her.

Therapist: You're preoccupied, it seems, with what you're not doing for others.

Patient: Also, what I'm not getting.

Therapist: But, you are getting.

Patient: (one minute silence) Yes. It feels like I've got to die (brief silence). I've put so much energy into that man and every contact I've had with him. I walk away so angry that I yell at him once I'm in the car and driving. Today my reaction was, he's acting like a little boy; that if he isn't getting his way, he withdraws and plays games with me. It's so hard to deal with him. I haven't gone away feeling bad about my lack of assertion with him, which feels good--that I have expressed that to him. I ask him questions straight, but, he obviously can't deal with that. But, I need something from him. He promised me certain things, and I went ahead. I've been working for months based on what he promised, and he's slowly taking it back. Not directly, he's not doing anything that's direct.

Therapist: It seems hard for you to talk about this.

Patient: (30 second silence) I don't know if you're asking what it's like.

Therapist: Not necessarily. It's hard to ascertain what it's like for you to talk about him. You seem very worried and I don't mean about your dissertation but about talking about your difficulties with this man.

Patient: (I) feel so uncomfortable with my needs. I need something from him and I'm not really getting anything in return. In our very first meeting, I asked him what he was getting out of working with me, and he told me what he was going to get, but, apparently, he feels he's not going to get that anymore, even though I haven't done anything different from what we agreed upon. For some reason, he's in a different place. And with my husband...I'm confused about my needs.

Therapist: How did he respond to your coming three times a week?

Patient: First, he just didn't respond at all. I had to question him to get a reaction. Finally, he said he's concerned about the money. He implied that's what he's thinking, and he made a few comments about how much of our money goes to therapy; that we're supporting therapists. There is some truth to that. A lot of our money goes for therapy. It doesn't feel good. It feels like I know he's mixed up and part of him is unhappy about it. I feel my needs are different from his. I feel okay about my needs--well, some of the time. But, I need his support as well. I mentioned to him last night that it feels really good to be coming three times a week, and he said sarcastically that it seemed I really wanted him to know that. It's like I have to put him aside in order to allow myself to do what I want to do.

I feel like I have to push down a lot of guilt and anger with him for his having different needs than mine in order to get my needs met (two minute silence). I guess it feels especially bad now when he's not happy. But he doesn't really like doing anything, yet, that's the old pattern. If he doesn't feel good, it's my fault. More and more, I keep pushing at him that I'm not at fault. It's the only strength I have.

Therapist: It's as though if you receive something, like the equipment to do your study, or money to come here, or money for tuition, people are going to move away from you because of it. Apparently, deep in your heart of hearts, you feel to blame--that you've taken something away that is essential to their well-being.

Patient: That they will be very angry with me--like I'm using them. It's really hard for me to be at a more real level. I just keep feeling horribly selfish. I was really aware when I made the agreement about the equipment to ask him what he was getting out of this. I haven't broken my agreement, but he's broken his.

Therapist: That must frighten you. Someone offers something and then lets you know they are regretful or whatever. Your usual response is to scrutinize yourself and consider it automatically your fault. It seems, no matter how hard you try, you can't convince yourself otherwise.

Patient: It's the most confusing with my husband. With him, I feel... Yes. He felt it would be good to go to school. He knew the tuition. I had many long talks with him about money. I needed him to know. He said he wanted me to go to school. He's ambivalent now. Even though I do feel guilty, it is a major part of our income. I could have gone into another field that required less education. I could have worked with computers and made a lot of money. In some ways, it's like I'm doing everything for myself, not considering anyone. That's true. I'm going to school and I'm enjoying my classes now and the clinical work. My husband is doing everything for me, it seems. If he did enjoy his work, it would be so much better for me. I feel bad that he feels bad.

Therapist: Your life has more pleasure in it. You've found the profession that you really want to be in, and it's turning out right for you. You seem to be afraid to think about the pleasure your work brings you. Immediately your mind turns to how you are depriving others. These thoughts are some of the most painful for you. Yet, the moment you find yourself feeling good, those are the very thoughts which begin to preoccupy you.

Patient: I get so angry at him at times. He just doesn't like anything. Whenever I get something I want, it's like I'm taking it from him. Anything I get that I want, it's

like I'm making him mad at me. They do, my mother and my husband. I'm setting it up that way somehow. Like even all my nervous symptoms come back when I started seeing you three times a week. I take valium and it's like I haven't taken it. It's like I have to be in pain to keep you (one minute silence). I'm really afraid of all I need from you. I can't stand it if too many days go by without seeing you. I'm frightened when I say that. This is the only place I feel safe, but somehow it's dangerous if you know that. It's like you'll be so mad at me you'll throw me out. I feel you're going to go away. And at times I'm convinced I need your help so badly, but you're not to know.

Therapist: Yes. I'm not to know or I'll leave you. It's the end of the hour and that convinces you. We must end now.

Patient: See you Saturday?

Therapist: Yes. See you then.

An Analysis of the Case Process Hours

These two case hours represent a limited view of the case and its dynamic development; however, the case in total represents an example of how the negative therapeutic reaction functions in the therapeutic situation. The clinical manifestations I have previously described are all present here. For one, Ann uses any possible means to

avoid the experience of pleasure. Whenever the hope of relief from her pain brightens the horizon, she develops exacerbated symptomatology in the form of migraines and obsessively ruminates about the possibility that some dreadful event will befall her. Similarly, Ann intensifies her attacks upon herself when she imagines she has transgressed the needs of another person, particularly her husband, who can be quite critical. These she usually associates with memories of her mother's critical attacks and her father's way of humiliating her. Both her husband's attitude and her parents' painful interaction with her are, for the most part, ego-syntonic. In other words, the husband's critical attacks serve to activate her ego's identification with the introjects and internalizations of her parents. Whenever I, the therapist, intervene and offer relief, Ann tenaciously clings to the pain, no matter what its origin.

Another clinical manifestation present in this clinical picture is Ann's obvious fear of acknowledging my presence. In spite of her feelings that therapy is of the utmost importance, she avoids transference feelings, even to the point of seemingly disconnecting herself from the therapy. This emerges when she has difficulty imagining me as a real person outside of the session and when she feels distant from me during the hour. This phenomenon is particularly noticeable when, in the second process hour, Ann

mentions how difficult it was for her to see me only twice a week. Also, for over two years, Ann was almost completely reluctant to talk about her feelings about me or the therapy. When she did allow this, she verbalized it in a highly rational manner. By closely reading the process hours, other examples quickly stand out.

A third clinical manifestation is Ann's negative response to my therapeutic interventions. She either denies their impact or experiences the activation of her painful memories and/or symptoms. Even the sound of my voice, no matter what its tone, Ann can take as rejection, criticism, indifference or overt hostility. This internalization either triggers painful affects especially around her longing for acceptance and nurturing or stimulates the onset of a migraine headache. She sometimes acts as if she has lost forever the hope of being cared for. Indeed, the hope itself is for her bad, evil, and destructive. Throughout the therapy, the predominance of pain, the reluctance to hope, the expectation of humiliation, and an extremely pessimistic attitude prevail. Any hopeful intervention on my part leads to regressive ruminations about her pain, its anticipation or its experience. Indeed, she quickly negates any positive response to an intervention by feeling acute pain which takes the form of intense self-blame.

Throughout the history of the case, the fourth clinical manifestation, control of self and the therapy, is

evident. During the first years of therapy, when Ann experienced cognitive confusion and a 'blank' state, her inability to report about herself controlled the therapy. In the first case process hour presented here, this control is particularly noticeable when Ann, in her opening remarks, implies that even the thought of losing control frightens her. If this should occur, she anticipates only the worst and most dreaded disaster befalling her. Of special significance is her fear that I might terminate the therapy. This reflects Ann's unconscious feeling that control is related to the hope of approval and the avoidance of the most dreaded danger, finding herself in a state of abject helpless dependence.

Needless to say, the composite clinical picture shows an extremely masochistic and depressed woman. Ann consistently avoids almost all pleasure and anticipates the worst possible outcome for any situation. Even her movement toward her desired goals, she denies because any positive feelings about her accomplishments activate painful memories. At moments when she has achieved a goal, received recognition, or experienced pleasure, she returns almost immediately to feelings of dread, guilt, and self-recrimination. Her mood is often flat, her associations few and lacking richness, and her guilt pervasive.

The clinical manifestations, then, confirm my diagnosis that Ann suffers a negative therapeutic reaction.

In Ann's case, I speculate that the fixation occurred in the late practicing subphase and the crisis period of the rapprochement subphase. Apparently nurturing in the earliest stages, her mother abruptly turned rejecting and highly critical when Ann began the process of separation. Her mother dealt severely with clinging and shadowing behavior--Ann's way of expressing her dependency needs. Perhaps Ann's separation aroused a narcissistic wound in her mother which activated her ego split. After this, the first daughter represented the good; the second, the bad. Whatever the situation, the mother rejected any expression of a need for dependence.

When Ann approached her father for comfort and found only humiliation because she was a girl, her last hope disappeared. Accordingly, she developed a painful feeling of longing and of hope for nurturing as both a wish and a defense. As a wish, she sought loving reunion with her mother; as a defense, she tried to ward off her fear of abject helpless dependence in which her painful needs went unheeded. Ann's fantasy of being blind, speechless, deaf, and paralyzed reflects this feeling, for she feels herself the victim of an insensitive caretaker who treats her like a machine.

Hopeful interventions which prove helpful activate both the wish and the defense. Because Ann feels 'drawn to' me as the therapist and, yet, wants 'to flee' from my

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presence, she literally freezes in a position of hope which she cannot relinquish; yet hope activates painful feelings of longing for what once was and is no more. Ann's fixation on pain represents her painful attachment to an absent mother. To give up pain unconsciously symbolizes giving up hope of ever restoring her mother's love. The absence of this mother love facilitates the development of the early super-ego precursors which exact absolute perfection. This conflict has colored all Ann's developmental stages. Her entry into a therapeutic relationship once more activates this conflict.

Some Concluding Remarks

I am tempted, at this point, to again summarize and try to arrive at a logical, nicely packaged conclusion for this project. I do not believe this is possible, however. Throughout the paper, I have struggled with the suffering I continually see in my patients and with the nature of the suffering in the history of humanity. We, as therapists, are said to be experts in suffering. It is the very nature of our work and its alleviation our primary concern. However, the negative therapeutic reaction perplexed Freud and led him to conclude that some forms of suffering are irreversible. Indeed, hope springs eternal, but not in all cases. Our own life histories and our daily experience of pain attest to this. But, we say, it cannot be true;

nothing is hopeless. Social work values proclaim that growth is a potential in every person, no matter how severe the condition. Thus, with this dilemma, we enter therapeutic relationships with persons who suffer an attachment to pain. There is at present no unique innovative technique nor new theoretical material which offers a solid solution. We remain with the puzzle. Sometimes we catch a glimmer of light in a dark sky and reach for some new perspective, as in this paper. In the end, however, my conviction rests with the belief that the therapist's basic good will, his patient endeavors, and his intense wish to understand form the kernel upon which hope is sustained.

I wish to warn against assuming that what may appear to be a negative therapeutic reaction in some clients may instead be the manifestation of severe and chronic conditions of cultural deprivation and/or discrimination. In many clients who have suffered the misfortune of developing and living in conditions that did not or continue to not provide the 'minimally necessary' ingredients for trust in the environment, hope for a possible better future, and faith in their individual capacity to influence the outside environment, there may appear behavior which resembles the clinical features of the syndrome. Chronic mistrust, inaccessibility, the activation of painful affects in response to 'hopeful' intervention; and a posture of control of self and the therapist, could reflect a life of painful

experiences not originating within the family but from the culture at large. In such cases, deprivation and discrimination have created a response of deep lack of trust in self, others, and the larger cultural group. The affect of hope, in such cases, often could stimulate the memory of and/or recognition of one's painful and very real plight. As well, frustration and its accompanying aggression are daily realities to such persons. The expectation of a better internal life and opportunity for a safe, comfortable and expanding life would be viewed as an empty dream. To many persons in our own culture and others, this is a daily reality.

Rather, in terms of the thesis of this paper, the negative therapeutic reaction is viewed as originating in the practice and primarily in the crisis rapprochement subphases of development. It primarily involves a disturbed object relationship with the mother figure. To speculate, one differentiating variable between a negative therapeutic reaction and what I will call cultural traumatization, is that in many culturally deprived or persecuted groups, they still maintain the capacity to experience genuine pleasure in interpersonal relationships. This quality is for the most part absent in persons suffering the syndrome of the negative therapeutic reaction.

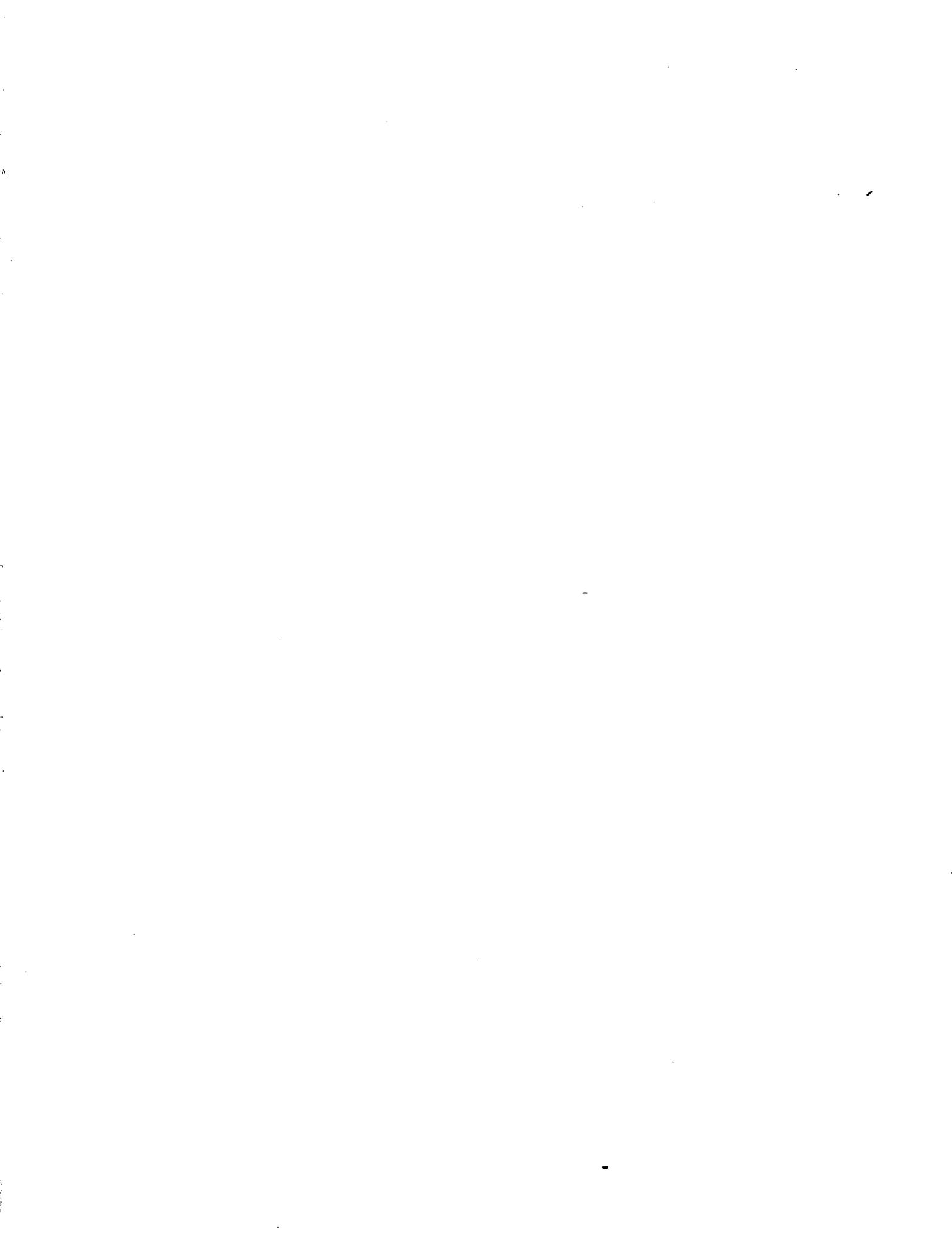
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