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The Negative Therapeutic Reaction

I encountered a relatively simple negative therapeutic reaction in a new patient, and realized at once that it derived from an Attack Self script. In the psychoanalytic literature, negative therapeutic reactions have been related to a variety of dark psychic forces: *Thanatos* (the death drive), the compulsion to repeat, and the dread superego. I wanted to share my observations because they demonstrate the theoretical and therapeutic power of Tomkins's system as fine tuned by Nathanson. We have been taught that the elegance of a theory can be told from its power to explain a phenomenon more simply. And in this case, also from its power to heal.

My patient is a 68-year-old white male who called a few days before my three-week vacation. His voice was deep and slow, as if he were just able to find the energy to talk. His complaint was that he was suffering from apathy. He had been diagnosed with cancer of the colon, second stage, and had undergone surgery in December. He was then put on chemotherapy, but his reaction was so severe he had to be hospitalized and taken off the treatment. He had been told that his chances of survival more than two years were 20%. And then his beloved sister died of breast cancer in February. He had been resting at home since his operation, worried constantly about his cancer, and was prevented from sleeping by steadily increasing agitation.

Sensing that he felt in urgent need of assistance, I informed him that I was about to leave town for three weeks, and that the best I could do for him was to refer him to an excellent and readily available colleague. To my surprise, he refused my offer, saying "You were so highly recommended, doctor, I would rather wait for you." This was a disquieting form of flattery that made me more uncomfortable than pleased. I repeated my recommendation with emphasis. Again he refused. So I agreed to see him when I got home.

When he came in, he was indeed agitated, full of worries about his illness, and completely apathetic about life. He was haunted by the fact that without the chemotherapy his chances of survival were even lower than his oncologist had projected. In short, he talked and looked like a man who had accepted a death sentence.

I decided to begin with some cognitive work to change his belief about his chances for survival. We discussed the theoretical basis of statistics (no more complaints from me about all those dreary classes on the subject) in order to disabuse him of the notion that statistics could "predict" his unique mortality. Probability does not exist – is not an entity – until someone asks a question about a chunk of information drawn from a large number of events. Then I reframed his situation as a life-passage in which he needed to integrate his new awareness of his personal mortality, so that he could live his

remaining years exactly as he would like. As part of this transition, I suggested he would need to experience the loss of his sister fully. Fortunately, his daughter is now pregnant with his first grandchild; I was able to highlight this chunk of hope as an authentic part of the new identity now in the process of development. All of which he greeted with one sigh of relief after another, and he thanked me over and over for helping him clarify and articulate what he had been experiencing. His mood lifted noticeably. He became animated and joined in the conversation like a new man.

Finally, I gave him some "homework" both as an activity to carry him through the week within the context of our healing relationship, and also to help to relieve his anguish. First I asked him to keep a journal in order to make concrete this process of integration and growth, writing no more than fifteen minutes a day. Explaining the importance of massage both because it feels good and also because it can undo some of the somatic expressions of chronic distress-anguish, I asked him next to visit a massage therapist for two massages during the week. Third, I taught him a simple technique for meditation, which we both practiced briefly, and asked him to meditate for ten minutes once a day, and twice if he began to enjoy the experience. He said he was excited to realize that he could do so much to help himself, and it made him feel so much better about himself.

He has since been back for two further sessions. The first week he had not followed a single one of my suggestions. All he would discuss was business problems ("I am not producing anything.") and the son-in-law who is not making a living. I allowed him to ventilate and suggested that the son-in-law would most likely make his own living if withdrawn from the gracious support provided by the patient. He could not possibly think that way, he said, because he felt responsible for taking care of his pregnant daughter. Then he announced that his wife had gone to see a therapist because she could not take it anymore. "Take what?" I asked in some surprise. "The way I am," he said. Now he returned to the subject of his apathy and anguish and agitation, much in the same way he had presented those symptoms in our previous session. As gently as possible, I reminded him of the suggestions made a week earlier. "I know, I know," he said, "but where can I find the time for everything!" He was angry at me, I was perplexed, and our time together was over.

He came into his third session complaining again, and announcing once more that he had not been able to do anything I suggested. Now I really did begin to feel angry, thinking "if he's so miserable, and if he thinks so highly of me, why won't he do anything I suggest?" Recognition of a classical negative therapeutic reaction followed the ah ha! of Surprise-Startle and the rather positive curiosity of Interest-Excitement.

Why would somebody reject the help for which consultation had been sought? Could this be a way to punish himself? Now another ah ha! as the contours of an Attack Self script emerged from the fog. Well, then, what was he so ashamed of? A series of memories passed through my mind, all about with friends who had been ill with cancer and who complained that so many of their circle had rejected them because they had the disease. I remembered reading Susan Sontag's book on that subject, and I thought of the many AIDS patients I have helped, all riddled with shame because they had this illness. To Jules Masserman is attributed the comment that insight was the happy coincidence when the patient shared the analyst's delusion about his case. Where was I to go with mine?

I began to ask what he thought about cancer, and how he thought and felt about having had cancer. All of a sudden, what came tumbling out was deep and corroding shame. To have cancer was to be a loser. His doctor was a loser because he had not prevented the illness by doing a colonoscopy five years ago; he was a loser because he had chosen this inept doctor. But most of all he was a loser

because who else gets cancer? Doesn't our culture preach that if you live well and guard your health you don't get cancer?

Well, he continued, who would want to have anything to do with a loser? Not he, of all people. He had always been a winner. A list of his many and significant adventures and accomplishments in life was offered as proof of this point. Here was a man who had always lived to the fullest. And so we learned that since he had now been shown to be a loser he would, could, and should not lift a finger to help himself. It was okay if I went ahead. But he would not be part of the process. He had lost respect for himself, and he warded off this intense shame by punishing himself.

As we worked through this material I began to smile at the memory of a dream once told me by a patient, one that defined perfectly this script for a negative therapeutic reaction. A devoutly orthodox Jew, for whom the practice of his religion meant everything, dreamed that his congregation was moving from their old synagogue to a new one, across the street. He had been given the signal honor of being asked to carry the Torah from the old to the new building. Unfortunately, he tripped just as he was stepping off the sidewalk, and horror of horrors, the Torah fell from his arms, where he was carrying it like a baby, and rolled into a pile of shit. Totally humiliated, he carefully picked it up in his arms again and carried it to the entrance of the new synagogue. And who should be standing there, waiting expectantly, but myself. He turned to me with the Torah and said "It's your job to wipe off the shit."

Absurdly enough, another patient, also in a negative therapeutic reaction, actually enacted this script in my office by walking into his session tracking fresh dogshit onto the carpet. What I did not see immediately came to my attention from its stink. My patient remained oblivious of the odor and I waited patiently to see what would happen. In fact, nothing did until I pointed out the situation. At first he disclaimed any responsibility. But when he saw the evidence on his shoes, he said, "Well, I guess you can clean it up when I leave."

My point is that the term "negative therapeutic reaction" is one used by therapists who cannot understand shame psychology. It represents the situation in which a patient cannot accept responsibility for taking care of himself because he feels so deeply ashamed for being "shitty." Shit smells bad, it arouses disgust, and when exposed in public it arouses feelings of shame and humiliation in the bearer. A patient who indicates that he feels like shit, or is covered with shit, or leaves a trail of shit where he goes, and cannot do anything about it, is paralyzed by feelings of self-disgust, self-dissmell, and humiliation, the triad of fused innate affect mechanisms Tomkins saw as the basis for the adult emotion of shame (Nathanson, 1992). By attacking himself the patient finds a way to avoid these powerful negative affects that have become attached to the concept of a self with which he wants no connection. Least of all is he willing to help himself, or able to use what the therapist offers as self-enhancing assistance. Refusal to work in therapy is yet another way of validating his awfulness. His only hope? Somehow the therapist can clean him up without his cooperation, the way a good parent takes care of a helpless baby who has shit all over himself. Were he able to put all of this into words, rather than act it out, he might say something like "Please wipe off these awful feelings that I have about myself so I can smell good, taste good, and be worthy of another's interest and enjoyment."

Meanwhile the conscientious therapist cannot understand why all these helpful interventions are going nowhere fast. And being all too human, the tuned-in therapist begins to get mad at the patient. If the therapist concludes that this is a lousy referral, a hopeless case, and one worth ejecting from the private, cherished space of the therapist, then the negative therapeutic reaction would end in a form of punishment that fit the internalized "crimes" of the patient.

So what allowed me to catch myself in time to recognize what was happening? It was my awareness that I was both angry at my patient and that I had no personal reason to be angry at him. Nathanson has often commented that "Ninety-five percent of the anger we encounter in daily life is triggered by shame," anger as an attempt to override shame. Might I have been ashamed of my failure to help him? No. I was convinced that I was doing a competent job. I concluded that I was experiencing his disavowed anger at himself through the phenomenology of affective resonance and the empathic wall (Nathanson, 1986, 1992), anger expressed as the Attack Other pole of the compass. All at once, the path to his shame was open and a new therapeutic course available.

I hope this proves helpful to others who become perplexed by the apparent failure of their best therapeutic efforts. Not *Thanatos*, not repetition compulsion, not even the fiendish superego. Just the normal sender and receiver functions allowed by the affect system, and the normal range of therapy made possible by a secure understanding of shame psychology.

References:

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