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The Positive Therapeutic Reaction

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The psychotherapeutic process depends on the existence of a personalised relation developing within the reality of the analytic interchange of free association and interpretation. A major technical problem is the analysand who is in a state of unrelatedness, or in a false or conventional relation. The analytic task is then to analyse this state so as to enable the patient to move to a state of authentic relation. The analyst's sense of pleasure and success when this occurs leads me to call this move a *positive therapeutic reaction.*

Freud's *negative therapeutic reaction* (Freud, 1923) had a paradoxical quality in that the analyst expected improvement but found deterioration. The *positive therapeutic reaction* is similarly paradoxical in that what is actually an improvement can seem like a deterioration in the working alliance. This is because the overt patient response, the development of a negative transference, occurs with such an immediacy and intensity of conviction. The reaction is "positive" because an impasse resolves, therapeutic work occurs and the negative transference responds to interpretation.

THE THREE PERSPECTIVES OF THE OBJECT-RELATIONS MODEL

The *positive therapeutic reaction* may be described and understood in a theoretical framework developed elsewhere (Kinston, 1980, 1982, 1983). This framework can only be briefly reviewed here.

Early psychoanalytic writers, including Freud, imagined narcissism as inherently dual. It embraced on the one hand the person's sense of him-

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self and his self-feelings (especially self-esteem) and on the other the person's relation to others insofar as they were used for his own psychological purposes without due recognition of their particular qualities or needs. On this basis, a most complicated and often contradictory literature arose (Pulver, 1975). However, psychoanalysts tended to divide according to which of the two originally identified faces of narcissism they focused upon. Controversy inevitably arose over which group had the correct emphasis. Previous papers of mine have attempted first, to articulate the duality, and second, to demonstrate that the duality was a dialectic, each side requiring and implying the other. This development is schematized in Figure 1.

Because each theoretical stream was empirically-based, each deserved its own distinguishing label. The labels I chose were "self-narcissism" and "object-narcissism". Definitions of these concepts were developed in a *functional* form as inference of this type is a natural mode for the psychoanalytic observer. Thus:

> Activity, mental or physical, is defined as self-narcissistic insofar as it serves to maintain a self-representation which is integrated, has continuity over time and can be given a positive value.
>
> Activity, mental or physical, is defined as object-narcissistic insofar as it serves to maintain a primitive object relationship in which separateness is denied, the object representation is destroyed and the emotional dependent needy part of the person is deprived of support and nourishment.

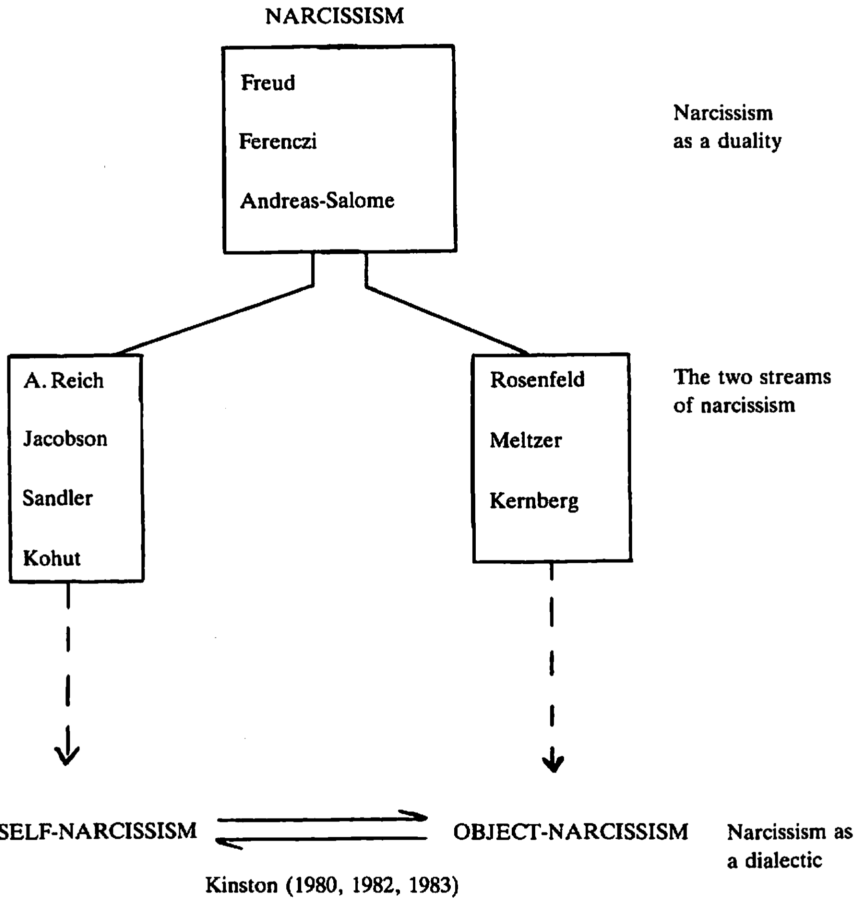
Both definitions lie within object-relations theory and hence a third definition was required to articulate another form of relation, which can be referred to as self/object relations:

> Activity, mental or physical, is defined as a self/object relation insofar as it serves to maintain libidinal, aggressive or dependent interactions between a self-representation and an object-representation.

These then are the three clinically interlocking perspectives of object-relations theory. Some distinguishing features have been laid out in Table 1.

The question still remains as to how self-narcissism and object-narcissism form a duality. It proved possible to appreciate the dialectical nature of these mental activities by reconstructing the individuation process in early childhood when the mother has a narcissistic disturbance. In such

Figure 1. Development of the literature with respect to the dual orientation of narcissism.



cases, the mother accepts the child only insofar as the child is an extension of herself or serves her needs, and hence rejects the child in its uniqueness (Figure 2). This leads to two states within the early dyadic relationship, states which the child himself can observe and manipulate (Figure 3).

The interpersonal relation is painful, horrible and traumatic for the child. Should he exist as himself, he is subjected to rejecting and invalidating attitudes, and finds that he causes pain, depression and resentment in the parent. Should he comply with the parental projection, he must destroy his own experience. The former course is associated with

Table 1: Some distingushing features of the three perspectives of object relations theory

Perspective	Quality of object relations	Key concepts	Symptomatic forms	Phenomena in therapy
Self-narcissism	Negatively-valued self-images	Continuity, integrity and value of self-representation	Low self-esteem, self-doubt, sense of inferiority, feelings of uselessness	Valuation of analysis and analyst; vulnerability to analyst
Object-narcissism	Fusion of self- and object-images	Dehumanisation of self, or other; self cut off from relatedness and nourishment; denial of need	Self-sufficiency, indifference to meaningful other	Confusion with the analyst; indifference to analysis/ analyst; collusive pseudo-analysis
Self/object relations	Self-image and object-image separate and linked by an affect-laden wishful bond	Instinctual and non-instinctual wishes from self	Phobias, obsessions, conversions	Sexual, aggressive, dependency and other wishes in relation to the analyst

low self-esteem, identity disturbances and problems in self-regulation. The latter course results in a spurious sense of well-being due to the receipt of (false) approval and love, and the absence or psychic destruction of personal need, frustration or conflict. It is the basis for states of mindlessness, unrelatedness and meaninglessnes.

Oscillation between states of self-narcissism (with or without self/object relations) and object-narcissism are frequently observed during psychoanalytic therapy. Some aspects of such transitions have been examined in the earlier papers. This paper is particularly concerned with the transition from object-narcissism.

Figure 2. Mother-child dyad from the perspective of the mother with narcissistic disturbance.

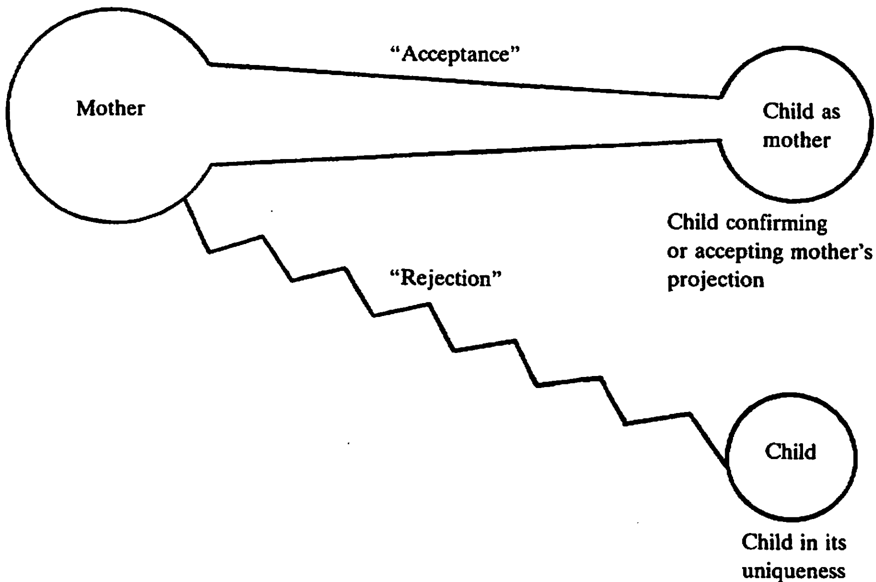
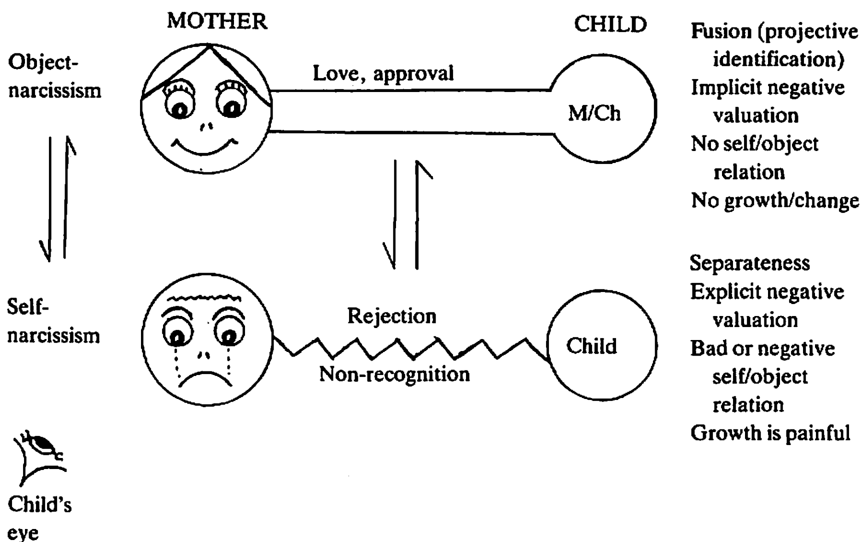


Figure 3. The schema of narcissistic development.



OBJECT-NARCISSISM

Object-narcissism is not a simple defence but a state of mind which acts against all human experience. In a psychoanalysis, it may be expressed ego-dystonically by the patient as a state of being a robot, automaton or zombie, with affects such as deadness, blankness, nothingness, flatness, emptiness. Alternatively, the experience may be ego-syntonic, for example, self-satisfied comfort, blandness, trivialization of the analysis, and maintenance of ordinary social conventions. It is a persistent cocoon-like state which, for all its destructiveness to the person or the analysis, reflects a determined effort for survival and attachment.

Any genuine relatedness is the expression of an affect-laden wishful bond between a discrete self-image and an object-image. Object-narcissism may be described as a form of pathological object-relation (Rosenfeld, 1964) or even as pathological self-narcissism, as Kohut (1971) in effect does (Kinston, 1983). However it is useful theoretically to distinguish the three perspectives as self-/object relations, self-narcissism and object-narcissism; and the clinician will find it helpful to recognise these during an analysis.

Conventional interpretative activity depends on the existence of self/object relations in the transference. Possibly because of this, much of the unspoken technique of the analyst aims to give the analysand a sense of safety, continuity, integrity and value, in other words it unashamedly aims at bolstering self-narcissism. The patient in touch with a valued self naturally wants a relation with a "good object" and defends against any other relation; and this is the basis of the assertion that the chief fear observed in analysis is the "return of the bad object" (Fairbairn, 1952).

However, it appears that the "return of the bad self" is even more distressing. Patients dominated with such fears simply avoid all experience and all relating. In other words object-narcissistic states are preferred to disturbed self-narcissistic states. Insofar as the analysand with such a difficulty feels coerced into justifying his presence in the analytic room, a pseudo-relation may develop. The patient may speak without being behind his words, or may produce a screen of dreams or associations or may relate by presenting a self which is, psychologically, a "delegate" to discuss his problems with the analyst. If coercion is not felt, the patient may simply refuse to speak or miss the majority of his sessions. In the absence of an activated self-image, no form of relating is possible and the patient may appear to be grossly out of touch with reality in the consulting room. The analyst who lacks a theoretical framework which can encompass such phenomena usually experiences analysis as meaningless, has an intense wish for the patient's behaviour to change, and searches in vain for interpretations which will work.

Thus the underlying problem in those patients described as having a narcissistic disturbance is that object-narcissism is preferable to self/object relating. Analysis typically reveals that any self/object relation is pain-filled and dependent on the acceptance of a negative self valuation together with an unbearable awareness of the exploitative actions of a parent.

RESOLUTION OF OBJECT-NARCISSISM

There is no one method for resolving persistent states of object-narcissism. A common method, often adopted more out of desperation and the lack of an alternative than anything else, is the deliberate confrontation of the patient with some aspect of reality. By and large this must be regarded as a last-ditch approach. The usual result is the release of narcissistic rage, which derives from the infantile reaction to impingement.

Another method is a controlled emotional expression or even outburst by the analyst. When well judged, it may result in the patient engaging more personally (Coltart, 1980).

It is this author's observation that skilfully administered interpretations of the disturbed self-narcissistic state can move patients from object-narcissism to self/object relating (Kinston, 1980, 1982). The analyst thus remains functioning in a professional and inexorably psychoanalytic mode. By and large, the analyst should not need to enforce reality any further than occurs naturally via weekend or holiday separations, accidental events, and the notion of an end to the analysis. These are powerful statements of the analyst's existence as a separate person and of an external reality, and so act as crucial levers in the interpretative work with narcissistic patients.

Instead of directly enforcing separateness and self/object relations, the analyst may assist the patient by interpretations which focus on the patient's disturbed and painful self-narcissism. When this is performed successfully, there is a release of the negative transference, often in the form of accusations. Winnicott (1950) described how the move from a state of fusion to a state of personalised existence is associated with the release of spontaneity. In the narcissistic patient, the spontaneous gesture is the complaint about a pathological and futile mother-child relation which failed to recognise the child's experience, labelled it negatively, and so led to his expedient adoption of object-narcissism.

CLINICAL ILLUSTRATIONS

Example 1: Miss A

Miss A. was one of my first patients from whom I learned a great deal. The positive therapeutic reaction was particularly noticeable because it followed several hundred sessions in which she presented as grossly compliant, false and difficult to work with.

> Miss A used to cough after every interpretation and complained bitterly that everything I said was "negative": this was so, no matter how apparently innocuous the content of my comment. After discovery of the value of interpreting the disturbances in self-narcissism (Kinston, 1980), I proceeded one day as follows. I suggested that she found the whole of herself worthless and unacceptable. As my interpretations were reflections of herself, or even felt as parts of herself, she automatically rejected them. After this session, she had her first genuine

silence in the analysis and then accused me with great conviction of being irresponsible and inadequate as an analyst. This manifestation of the genuine negative transference resolved naturally with conventional interpretation of her relationship with her mother.

The transition from object-narcissism through self-narcissism to negative transference is clearly illustrated. Miss A confirmed my diagnosis of object-narcissism a few sessions later by revealing that she used to attend on the basis that everything I said could be screened out. In the longer term, the technical problem of how to make interpretations which were empathic and did not impinge diminished, as did the reflex coughing.

Example 2: Mrs. B
This next example demonstrates the full sequence of the positive therapeutic reaction occurring within a single session. The session occurred in the final weeks of a successful but incomplete analysis which had been characterised by many silences and missed sessions.

Mrs. B:	(Entered and sat down) (35 minutes silence) When I leave here, I'm going to be unhappy about this silence – guilty. To come here and say nothing ... But I can't say anything. (Silence) Nothing matters here.

The patient is in a state of object narcissism and is reflecting about it. She is aware of the destructiveness of her state of mind. In view of this, I attempt a conventional type of interpretation phrased to minimise any sense of it being imposed upon her.

Dr. K:	Could it be that it matters very much?
Mrs. B:	Yes, of course that's true – but I can still feel that nothing matters.
Dr. K:	That is to avoid the pain.
Mrs. B:	You say that as if it's intentional – as if it's my decision.
Dr. K:	It was your decision in childhood. Were you going to face what was going on at home? You said to yourself: this has got nothing to do with me – nothing matters. It was probably useful then to do that.

Mrs. B: Are you saying that I'm stuck with this rule? No, of course I can change rules – but what a leap!

The patient responded to my interpretation but maintained the object-narcissistic state by denying intention. The childhood reconstruction gives her enough distance to accept that the material of the session is indeed hers and that she has a personal responsibility for the maintenance of old ways of functioning. She has moved to a state of self-narcissism.

> I continued by noting that she had been repeating the old rule when she really needed to remember it. Mrs. B. then turned on me with mockery, attack and accusation. She complained that I handed her platitudes, "psychoanalytic greeting cards", and concluded "I can't handle these comments of yours".

This is the *positive therapeutic reaction.* Having come into existence, she experiences the sense of being overwhelmed by her mother's ministrations which were a mockery of appropriate care.

> I continued by interpreting that in her childhood, she couldn't handle the reality of her family life. She had attacked her mad mother and the family life that did not take her into consideration – just as she now wanted to do to me. Her task is to face the reality of her childhood and not confuse it with present reality. She seemed relieved to hear this.

Example 3: Mrs. C

This is a more extended example of the positive therapeutic reaction taken from the middle phase of an analysis of a relatively healthy woman. Mrs. C attended because of inhibitions and difficulties in her contacts with people. Early in the analysis her use of object narcissism became apparent, and she revealed that this mental state is experienced psychically as death.

> Any interpretation which she found threatening threw her into a confusional state. When she became aware of the way analysis worked, she presented dreams without being personally involved in them. This phenomenon was often represented in dreams where she was a watcher of events which also apparently involved her. For a long time she brought material and was satisfied with the analysis even though my comments were ignored or not heard. This phase of the analysis concluded with a dream of a baby held by a pair of hands and eating its

own faeces. She easily recognised this as her behaviour in the analysis.
Some weeks later she recalled a lost memory. *When I was young and everything was so hard for me, I read that people committed suicide by cutting their veins. I thought of doing that but it disgusted me, so I decided to do it in my mind.*

Keeping Mrs. C in touch with her emotional self was not too difficult because she had a genuine love of truth and a sense of responsibility for herself. When I did make contact, she would sometimes cry, much to her chagrin. The following extract illustrates the *positive therapeutic reaction* as it developed over several sessions.

On one occasion after crying, she revealed a dream. *One of my pigeons came back to me and I was very happy. But then it followed me everywhere I went – behind me. I tried hiding in the most amazing ways.* She acknowledged that this reflected the analytic experience and I interpreted the act of hiding as a dream expression of her sense of shame (Kinston, 1983). She became confused and I suggested that she was frightened by her shame. She then asked why she should feel shame. I responded by indicating that the important thing was to be aware that it was her experience and she really did feel it.

Mrs. C had moved to a state of self-narcissism and I had concluded the session with a powerful affirmation of the value of her own experience. The following session revealed that I had enabled her to make contact with the self-narcissistic disturbance.

Mrs. C: I had a dream. I was washing my dress by going into the bath with it on. This seemed natural.
(Silence)
Do you know the game "Chinese Portrait"?

Dr. K: No.

Mrs. C: People divide into two groups and one picks a person. Then the other has to guess who it is by asking questions like "If he were a book, what would he be?" They did one of me and the question was "What sort of piece of furniture?" The answer was an antique armchair which invites you to sit in it but is very dangerous. I thought of this when looking at that Chinese painting on the wall.

Dr. K: My armchair is old and it is equivalent to me. It is very inviting for you to relax and talk with me and be yourself, but

it is very dangerous. Your dream is connected with feeling you are dirty, and wanting to hide your body; so it seems that the danger for you in relaxing with me is that I will reject you.

Mrs. C then produced a series of questions.

Dr. K: My comment has left you feeling helpless and vulnerable.

Mrs. C: Yes, but you could still answer the questions.

Dr. K: It's a magic way of feeling better which depends on me – what about when I'm not around?
(Silence)

Mrs. C: The painting makes me think of a big problem I have in combining literature and painting. In the marriage of these two, one is like – how do you say in English – a man who needs sticks to walk? ...?

She waited for me to say the word "cripple". I was sure this was a magical way of making me the crippled one. I was silent and she looked round at me from the couch as she did occasionally.

Mrs. C: Do you pity me?

Dr. K: You feel awful about yourself.

Mrs. C started rubbing her eyes and after a few minutes she said "I cry without making any noise". She then cried more obviously for about five minutes.

Mrs. C: To cry like this is the most awful thing that could happen to me.

Dr. K: We must stop in a minute ... when you feel awful about yourself, you cry.

The disturbance in this patient's self-narcissism consisted of a self-image of being dirty, and crippled. Her crying at the end suggested to me that Mrs. C was in touch with herself in my presence and if she were to activate self/object relations in the transference, these would be aggressive. In addition, her question about pity implied that she was attempting to deal with activated sadistic urges.

The next day she was extremely angry and reported that someone outside my consulting rooms had said "Hello" to her, and, Mrs. C asserted, knew she was a patient.

I took this as a communication that her self-narcissistic disturbance was activated (i.e. she was a patient, a damaged person, rather than just a visitor) and the anger suggested that the positive therapeutic reaction was indeed in process. I assumed that a more detailed self/object relation would come to the surface in the transference.

> The following week the atmosphere in the sessions was black and ugly. She insisted that everything I said was wrong, became quite sadistic and expressed an intense wish to swear at me. She announced with much hostility that she was taking off two months from the analysis, but refused to discuss this. The state resolved at the end of the week with interpretations of her experience of my not fitting in with her needs and wishes, and not responding to her personally in a way that vividly reminded her of her childhood.

DISCUSSION

This paper has used clinical material to develop and illustrate a theory of narcissism described in more detail elsewhere. The nature of object-narcissism and the transitions from this state to self/object relating have been briefly examined. Several examples of a characteristic clinical pattern, which I have called the *positive therapeutic reaction,* have been described. The paper concludes with a brief review of the clinical phenomena and relates the theoretical position to that of Rosenfeld, whose early clinical descriptions remain as classics in the field.

Clinical

The *positive therapeutic reaction* is a specific pattern of events occurring within the analytic process. Its identification requires the analyst to have evidence that the patient is in a state of object-narcissism, and afterwards that the expression of aggression is part of a negative transference which reflects a childhood self/object relation. The move is associated with emergence of self-narcissistic disturbance. This may occur either through direct interpretation or spontaneously as a result of the analysand's personal decision or as a response to other events or interventions affecting the object-narcissistic state.

A patient already in a self/object relation may express aggression for a variety of reasons. Similarly, a patient in object-narcissism may express rage as a reaction to impingement. Neither of these are included within the notion of a *positive therapeutic reaction.* One particular cause for

aggressive release may be a source of clinical confusion. Awareness of self-narcissistic disturbance may result in the evocation of a sense of inferiority (Alexander, 1938). This results in hostility, which may be repressed or overt as "humiliated fury" (Lewis, 1971). Such a reaction deserves analysis in its own right. However rather than increasing a sense of relatedness, it tends to diminish it, and increases suspicion and distrust of the analyst. In the case of Mrs. C, it is likely that some hostility stemmed from awareness of a sense of inferiority.

The case of Mr. X described in Kinston (1980) demonstrated a further complication in that the initial release of hostility was part of a negative therapeutic reaction. Only after this was interpreted did the *positive therapeutic reaction* complete. The sequence in that case was: object-narcissism, interpretation of self-narcissism, well-being, negative therapeutic reaction, negative transference. The essential characteristic of the negative transference as a creative and constructive expression of hostility is that it resolves with interpretation and reconstruction of early parent-child interaction. This is in contrast to the meaninglessness of aggressive release within object-narcissism and the uselessness of interpretations of that state phrased in the form of self/object relating, i.e. conventional transference interpretation.

Theoretical

This paper can be seen as building on the work of Rosenfeld (1964). First, the clinical phenomenology of object-narcissism as described in this and my other papers owes much to the work and inspiration of Rosenfeld and other Kleinian analysts, including Segal, Meltzer, Joseph, O'Shaughnessy, and Brenman. Second, Rosenfeld's classic paper reported in detail a patient probably manifesting a *positive therapeutic reaction.* He described a patient whose narcissism (apparently "object-narcissism") was repeatedly interpreted until the patient stated he wanted to make contact with the analyst (in terms used here: to activate self/object relating). He then produced a dream, which, as well as being filled with self-narcissistic and object-narcissistic references, expressed intense virulent hostility to the analyst (p. 173-174). This led Rosenfeld to regard (object-) narcissism as a defence against hostility; elsewhere he has derived it from the death instinct (Rosenfeld, 1971).

The clinical phenomena of his case resemble those described in this paper. It is worth noting, however, that the approach offered here has different emphases. Three issues can be briefly highlighted.

First, narcissism as object-narcissism is not a problem simply of extremely disturbed patients as often suggested or implied, but a facet of the analysis of all patients. The reason for this is that it is not seen here to be an expression of, or a reason to believe in, the death instinct. Instead, it is regarded as an intrapsychic manifestation of the childhood tension between individuation and maturation on the one hand and parental care and enforced socialisation on the other.

Second, object-narcissism is regarded as a defence against *all* experience; it is a global state of mind involving the self-representation, and not simply a defence against hostility. A defence against an affect or drive must be distinguished from a defence against a relationship to account for the clinical phenomenology. The appearance of hostility with the move from object-narcissism is regarded as evidence of the intrapsychic object relations which result from a particular early parent-child relationship.

Much self-pathology is described in specific clinical detail by Rosenfeld (e.g. the analysand's fear of the analyst's rejection) but ignored or minimised in his theoretical construction. Detailed and accurate clinical observations of self-narcissism pathology are also noted by Rosenfeld but either not incorporated in his theoretical formulations, or as in the phenomenon of self-idealization, handled solely via instinct theory. The importance of the concept of self-narcissism and the emphasis on object-relations theory is therefore the third distingushing feature of the theoretical stance taken here. In this view, when a parent persistently values and approves compliance and false behaviour on the part of the child and is emotionally regulated by this, the scene is set for the child simultaneously to feel deeply crushed, humiliated and deprived on the one hand and genuinely to experience omnipotence and idealization on the other. Instincts are seen to contribute within this context.

CONCLUSION

Psychoanalysis appears to need two central theories, although the relation between these is yet to be explicated fully. An instinct-based theory is necessary for phenomena like the oedipus complex, and a relation-based theory is required for narcissistic phenomena. The theoretical and clinical material presented in this and earlier studies suggests that narcissism should be conceptualised in terms of states of mind (psychostatics) whereas the oedipus complex concerns mental processes (psychodynamics). Particular states of mind are constituted by and affect mental

processes, and transitions between mental states are associated with characteristic intra-psychic dynamics. One such transition, the positive therapeutic reaction, has been described in this paper.

SUMMARY

The positive therapeutic reaction is a characteristic pattern seen during psychoanalyses and consists of unrelatedness, interpretation or emergence of negatively-valued experience, and immediate appearance of the negative transference. The analyst who is aware of it will not experience confusion or distress in the face of what may be a most intense and unexpected onslaught from the analysand. He will, instead, be in a good position to do a useful piece of analytic work and strengthen the patient's self-tolerance and capacity for self/object relations. The phenomenon is explained using a recently developed theory of narcissism and illustrated with clinical material.

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