tremendous strains on the individual as he integrates loving and hating feelings towards the same object. Riviere sees this as the task from which the patients who show a negative therapeutic reaction are fleeing. They show a manic denial of a terror they fear, the depression that would overwhelm them. There is no better description of depression than the one given here. To read it is to understand the most powerful fears: the patient's unbearable pain and guilt, his conviction that he needs to sacrifice his life for his objects, that cure will lead irrefutably to his death. Manic omnipotence masks such fears, and the persecutory component in the depression of patients who suffer the negative therapeutic reaction is tyrannically in evidence.

A contribution to the analysis of the negative therapeutic reaction (1936)

In this contribution my aim is to draw attention to the important bearing recent theoretical conclusions have on the practical side of the problem of the negative therapeutic reaction. I mean the latest work of Melanie Klein, and in particular her Lucerne Congress paper (1934) on the depressive position.

To start with, it is necessary to define what is meant by the negative therapeutic reaction. Freud gave this title to something that he regarded as a specific manifestation among the variety of our case-material, though he says that in a lesser measure this factor has to be reckoned with in very many cases. When I referred to Freud's remarks on this point, I was interested to find that actually they are not exactly what they are generally remembered and represented as being. The negative therapeutic reaction, I should say, is generally understood as a condition which ultimately precludes analysis and makes it impossible; the phrase is constantly used as meaning unanalysable. Freud's remarks on the point are almost all in *The Ego and the Id* (1923b), the last eighteen pages of which deal with the problem of the unconscious sense of guilt. He says, 'Certain people cannot endure any praise or appreciation of progress in the treatment. Every partial solution that ought to result, and with others does result, in an improvement or temporary suspension of symptoms produces in them for the time being an exacerbation; they get worse instead of better'. This last sentence might imply that they are unanalysable; but he does not actually say so, and has just said the exacerbation is *for the time being*. He says the obstacle is 'extremely difficult to overcome'; 'often there is no counteracting force of similar intensity'; and that it must be honestly confessed that here is another limitation to the efficacy of analysis'—but he does not say a preventive. Clearly the point is merely one of degree, and he might concur in the general attitude taken up. He is not, however, actually as pessimistic about it as people incline to suppose; and this interested me, because it is not intelligible why one reaction should be thought more unanalysable than another. The eighteen pages in *The Ego and the Id* (1923b) are in fact part of his contribution towards analysing it; and our understanding of it has now been very greatly advanced by Melanie Klein.

Freud's title for this reaction, however, is not actually very specific; a negative therapeutic reaction would just as well describe the case of any patient who does not benefit by a treatment; and it would describe those psychotic or 'narcissistic' patients whom Freud still regards as inaccessible to psycho-analysis. It seems to me that this specific reaction against a cure described by him may not differ so very greatly in character from those more general cases of therapeutic failures I men-

Read before the British Psycho-Analytical Society, 1 October 1935. Reprinted by permission of The Institute of Psycho-Analysis from: Joan Riviere, 'A contribution to the analysis of the negative therapeutic reaction', *International Journal of Psycho-Analysis, 17* (1936): 304–320.

tioned, and that the difficulty may be due to some extent to the analyst's failure to understand the material and to interpret it fully enough to the patient. The common assumption is that even when the analyst has fully understood and interpreted the material, the superego of certain patients is strong enough to defeat the effects of analysis. I shall try to show that other factors are at work in this severity of the superego that until recently have not been fully understood and therefore cannot have been sufficiently or fully interpreted to our patients.

It will be clear now that what I propose to talk about is in fact the analysis of specially refractory cases. I do not think I can go much further in defining the type of case to which my remarks refer, partly because any one analyst's experience is necessarily limited, even of refractory cases; moreover, my expectation is that similar unconscious material may probably exist in other difficult cases of a kind I have not personally met with. I would say this, however, that the cases in which I have made the most use and had greatest advantage from the new understanding have been what we call difficult character-cases. The superego of the transference neurotic, it must be remembered, has always been placated by his sufferings from his sense of guilt, and by his symptoms, which are a real cause of inferiority and humiliation to him, whatever epinosic gain he has from them; the character-case has never placated his superego in these ways; he has always maintained the projection that 'circumstances' have been against him. After some analysis he may guess that he has punished others all his life and feel that what he now deserves is not 'cure', but illness or punishment himself; and he unconsciously fears that that is what analysis may bring him if he submits to it. Of course we find these motives for or against co-operation in all cases; I merely suggest that in character-cases they may have peculiar strength.

With reference to this matter of character-resistances I shall recall to your minds a paper of Abraham (1919) in which he described and commented on a certain type of difficulty in analysis, that he virtually names the *narcissistic type* of character-resistance. He tells us that such analyses are very lengthy and that in no such case did he obtain complete cure of the neurosis, and we can see that the degree of negative therapeutic

reaction in this type is what led him to distinguish it. The narcissistic features of this type are, shortly: that they show a chronic, not merely occasional, inability to associate freely, in that they keep up a steady flow of carefully selected and arranged material, calculated to deceive the analyst as to its 'free' quality; they volunteer nothing but good of themselves; are highly sensitive and easily mortified; accept nothing new, nothing that they have not already said themselves; turn analysis into a pleasurable situation, develop no true positive transference, and oust the analyst from his position and claim to do his work better themselves. Under a mask of polite friendliness and rationalization they are very mean, self-satisfied and defiant. Abraham shows the relation of all these features to anal omnipotence, and he especially emphasizes the *mask of compliance*, which distinguishes this type of resistance from an open negative transference and renders it more difficult to handle than the latter. And '*These patients*', he says, '*shut their eyes to the fact that the object of the treatment is to cure their neurosis*'. Incidentally, I do not suppose that Abraham was guilty of it, but I feel that analysts themselves are not always incapable of shutting their eyes to a fact too, namely, that when a patient does not do what he ought, the onus still remains with the analyst: to discover the cause of his reaction. In my opinion the patient was entirely in the right who said, 'Yes, doctor, when you have removed my inhibitions against telling you what is in my mind, I will then tell you what is in my mind', and the situation is similar in regard to getting well.

This paper of Abraham's suggests what I take to be a generally valid proposition, that in specially long and difficult analyses the core of the problem lies in the patient's narcissistic resistances. One surmises, further, that this narcissism may not be unconnected with the inaccessibility to treatment of the 'narcissistic neuroses', as Freud has called certain psychoses. There is nothing very new, or immediately helpful, in the idea that narcissism is the root of the problem—for what is narcissism? I will mention only two general points in this connection. One—the old one—is that any marked degree of narcissism presupposes a withdrawal of libido from external objects into the ego, and secondly, the newer point, that ego-libido can now be recog-

nized, especially in the light of Melanie Klein's more recent work, to be an extremely complex thing. Freud speaks of the secondary narcissism derived from the ego's 'identifications', which most of us here now regard as including the ego's *internal objects*. And Melitta Schmideberg (1931) suggests that love for the introjected objects is a part of narcissism. And now the significance of the ego's relations to its internalized objects shows clearly that this great field of object-relations within the ego, within the realm of narcissism itself, needs much further understanding; and it is my belief that more light in this direction will do much to explain such hitherto inexplicable analytic resistances as the narcissistic ones of Abraham and the superego ones of Freud.

The concept of *objects* within the ego, as distinct from identifications, is hardly discussed in Freud's work; but it will be remembered that one important contribution of his to the psychology of insanity is built up almost entirely on this conception—I mean of course his essay on 'Mourning and melancholia' (Freud, 1917e [1915]), dealing with the problems of *depressive* states. His discussion in *The Ego and the Id* (Freud, 1923b) of the unconscious sense of guilt, too, is closely interwoven with aspects of the melancholic condition. This brings me to my second point. Observations have led me to conclude that where narcissistic resistances are very pronounced, resulting in the characteristic lack of insight and absence of therapeutic results under discussion, these resistances are in fact part of a highly organized system of defence against a more or less unconscious depressive condition in the patient and are operating as a mask and disguise to conceal the latter.

My contribution to the understanding of especially refractory cases of a narcissistic type will therefore consist in the two proposals: (a) that we should pay more attention to the analysis of the patient's inner world of object-relations, which is an integral part of his narcissism, and (b) that we should not be deceived by the positive aspects of his narcissism but should look deeper, for the depression that will be found to underlie it. That these two recommendations are not unconnected might be guessed from Freud's paper, which links the two, and from Melanie Klein's view that the internal object-situation in this position is of

supreme importance. The depressive position might be described as a miscarriage of introjection, she says; and *this* is the unconscious anxiety-situation that our narcissistic patients are defending themselves against and that should be the true objective of analysis in such cases.

Now this particular anxiety-situation, the depressive, has its own special defence-mechanism, the manic reaction, of which Melanie Klein also gives a general outline. The essential feature of the manic attitude is omnipotence and the *omnipotent denial of psychical reality*, which of course leads to a distorted and defective sense of external reality. Helene Deutsch (1934) has pointed out the inappropriate, impracticable and fantastic character of the manic relation to external reality. The *denial* relates especially to the ego's object-relations and its *dependence on its objects*, as a result of which *contempt* and depreciation of the value of its objects is a marked feature, together with attempts at inordinate and tyrannical *control and mastery of its objects*. Much could be written about the manic defence, and I hope will be, for in my opinion the future of psycho-analytic research, and therefore of all psychology, now depends on our belated appreciation of the immense importance of this factor in mental life. It is true that we have known of many of its manifestations and even had a name which would have represented it, if we had known how to apply it—the word omnipotence—but our knowledge and understanding of the factor of omnipotence has never yet been organized, formulated and correlated into a really useful theoretical unit. Omnipotence has been a vague concept, loosely and confusedly bandied about, hazily interchanged with narcissism or with phantasy-life, its meaning and especially its functions not clearly established and placed. We ought now to study this omnipotence and particularly its special development and application in the manic defence against depressive anxieties.

It will not be difficult to see how characteristic the most conspicuous feature of the manic attitude, omnipotent denial and control by the ego over all objects in all situations, is of our refractory patients with their narcissistic resistances. Their inaccessibility is one form of their *denial*; implicitly they deny the value of everything we say. They literally do not allow us to

do anything with them, and in the sense of co-operation they do nothing with us. *They* control the analysis, whether or not they do it openly. If we are not quick enough to be aware of it, too, such patients often manage to exert quite a large measure of real control over the analyst—and can even do this when we are quite aware of it. So far, it seems to me, we have not known, or not known enough, exactly where to place this tendency or how to relate it to the rest of the analytic context and so—we have not been able to analyse it. We have tended to see it as a negative transference and as an expression of aggressive attitudes towards the analyst. We have understood these as defences against anxiety, but we have not realized that a *special* fear lay beneath this special way of attaining security. I think Abraham's whole description, with every detail of the 'narcissistic' resistances he describes, in fact presents an unmistakable picture of various expressions of the manic defence—the omnipotent control of the analyst and analytic situation by the patient—which yet, as he points out, is often enough extremely cleverly masked. The conscious or unconscious refusal of such patients to produce true 'free associations', their selection and arrangement of what they say, their implicit or explicit denials of anything discreditable to themselves, their refusal to accept any alternative point of view or any interpretation (except with lip-service), their defiance and obstinacy, and their claim to supersede the analyst and improve on his work all show their determination to keep the upper hand and their anxiety of getting into the power of the analyst. Free association would expose them to the analyst's 'tender mercies'; love for the analyst, a positive transference, would do the same; and so would any admission of failings in themselves. Along with their self-satisfaction and megalomanic claims, their egotism is shown in pronounced meanness, and often in an absence of the most everyday acknowledgements of generosity. Certain patients of this type especially withhold from us all 'evidence' of an indisputable character in support of our interpretations. They leave us with dreams, symbols, voice, manner, gesture; no statements, no admissions from themselves. So we can say what we like, nothing is proved—yet of course they accept the help they get, but refuse us all help and all acknowledgements. Abraham

interprets this trait as anal omnipotence. Beside this connection, it signifies especially their need to reserve and preserve everything of any value, all good things, to themselves, for various reasons, and especially for fear that others (the analyst) will gain in power by means of them. Above all, however, the trait of *deceptiveness*, the mask, which conceals this subtle reservation of all control under intellectual rationalizations, or under feigned compliance and superficial politeness, is characteristic of the manic defence. This mask owes its origin undoubtedly to the specialized dissimulation of the paranoiac; but it is exploited in the manic position not as a defence in itself but as a cover for the defence of securing exclusive control. To this description of this type of patient I would here add an important further detail: they show a quite special sensitiveness on the point of consciously feeling any anxiety; it is quite apparent that they have to keep control so as not to be taken unawares by, and not to be exposed to, a moment's anxiety. Abraham comments on their lack of affect, and this in my view is to be taken first as a dread of *anxiety*-affect. But their complete incapacity for any feeling of guilt is equally astonishing and is of course one of their most psychotic traits in its lack of the sense of reality: they deal with guilt-situations entirely by projection, denial and rationalization.

Now it might be objected here that no analyst worth his salt has failed to interpret these manifestations in precisely this way time and again in his practice, and this of course is true; but in my view there is all the difference in the world between what may be called single isolated interpretations, however correct and however frequent they may be, and the understanding and interpretation of such detailed instances as part of a general *organized system of defence* and resistance, with all its links and ramifications spreading far and wide in the symptom-picture, in the formation of character and in the behaviour-patterns of the patient. Analysis has to concern itself with daily details because only the immediate detail of the moment has affect and significance for the patient, but the analyst has to be careful not to become too affectively interested in working out detailed interpretations: he has to be careful not to lose sight of the wood for the trees. He must aim, not merely at understanding each detail

in itself, but at knowing where to place it in the general scheme of the patient's mental make-up and in the continuous context of the analytic work. Of course, what have been called 'spot-analyses' or snapshot interpretations have long been condemned, and Ella Sharpe, for instance, once led a crusade against meaningless *ad hoc* symbol-interpretations which do not form part of a whole picture. What I am urging now is only a further application of this principle. I suggest that the common tendency we often see in patients to control the analysis and the analyst is even more widespread than we suppose, because it is largely masked and disguised by superficial compliance, and that it forms part of an extremely important general defensive attitude—the manic defence—which has to be understood as such.

Now what is the specific relation between this special line of defence and the negative therapeutic reaction; why does the need to control everything express itself so particularly in not getting well? There are certain obvious answers to this, all of which would show that not getting well is an unavoidable indirect result of these resistances. For instance, I have just suggested that hitherto these tendencies in patients to usurp all control have been regarded as expressions of a negative transference and hostility to the analyst. This interpretation, so far as it goes, is certainly correct; the patient is extremely hostile; but that is not all. Things are not so simple. The very great importance of analysing aggressive tendencies has perhaps carried some analysts off their feet, and in some quarters is defeating its own ends and becoming in itself a resistance to further analytic understanding. Nothing will lead more surely to a negative therapeutic reaction in the patient than failure to recognize anything but the aggression in his material.

The question why the defence by omnipotent control leads so characteristically to the negative therapeutic reaction cannot be answered fully until we consider the anxiety-situation underlying this defence; but I think there is one direct connection between the two which may be stated here. There actually is a kind of wish in the patient not to get well, and this wish is itself partly in the nature of a defence. It comes from the desire to preserve a *status quo*, a condition of things which is proving bearable. It is built upon many compromises; the patient does

not finish the analysis, but neither does he break it off. He has found a certain equilibrium and does not intend it to be disturbed. To my mind, this is an important general explanation of the phenomenon Freud comments on. He says (1933a [1932]), 'A few words of praise or hope or even an interpretation bring about an unmistakable aggravation of their condition'. If the patient is changing, or is being changed, he is losing control; the equilibrium he has established in his present relation with the analyst will be upset; so he has to reinstate his former condition, and regain his control of things. Actually, this anxiety-reaction to the idea of making progress often disappears on being itself interpreted; and of course not intepreted *only* in this general way, but the detailed connection of the immediate resistance to the immediate anxiety made clear. Incidentally, there are many ways in which this aspect of the defence by control (namely, that of prolonging and maintaining the *status quo*) verges on and merges into the obsessional technique of prolonging in time and preserving in space certain distances, always maintaining a relative, never an absolute or a final relation. But the connection between the manic and the obsessional forms of defence is not part of my subject here.

If the patient desires to preserve things as they are and even sacrifices his cure for that reason, it is not really because he does not wish to get well. The reason why he does not get well and tries to prevent any change is because, however he might wish for it, he has no faith in getting well. What he really expects unconsciously is not a change for the better but a change for the worse, and what is more, one that will not affect himself only, but the analyst as well. It is partly to save the analyst from the consequences of this that he refuses to move in any direction. Melitta Schmideberg said something of the same kind in the paper quoted already: 'Inaccessibility in patients is due to a fear of something "even worse" happening'. Now what is the still worse situation which the patient is averting by maintaining the *status quo*, by keeping control, by his omnipotent defences? It is the danger of the *depressive position* that he is guarding himself and us against; what he dreads is that that situation and those anxieties may prove to be a reality, that that psychical reality in his mind may become real to him through

the analysis. The psychic 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 the 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 other 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, as it were, by his immobility. Patients I have analysed have felt this dread of losing the manic defence quite consciously during the analysis of it, have both threatened and implored me to leave it alone and not 'take it away', and have foreseen that its removal would mean chaos, ruin to himself and me, impulses of murder and suicide; in other words, the depression that to some extent supervenes as the defence weakens. But I need hardly say the analyst has not this despair, for as the capacity to tolerate the depression and its anxieties gradually increases, very notable compensations accompany it, and the capacity for love begins to be released as the manic stranglehold on the emotions relaxes.

The content of the depressive position (as Melanie Klein has shown) is the situation in which all one's loved ones *within* are dead and destroyed, all goodness is dispersed, lost, in fragments, wasted and scattered to the winds; nothing is left *within* but utter desolation. Love brings sorrow, and sorrow brings guilt; the intolerable tension mounts, there is no escape, one is utterly alone, there is no one to share or help. Love must die because love is dead. Besides, there would be no one to feed one, and no one whom one could feed, and no food in the world. And more, there would still be magic power in the undying persecutors who can never be exterminated—the ghosts. Death would instantaneously ensue—and one would choose to die by one's own hand before such a position could be realized.

As analysis proceeds and the persecutory projection defences, which are always interwoven with the omnipotent control position, weaken along with the latter, the analyst begins to see the

phantasies approximating to this nightmare of desolation assuming shape. But the shape they assume is that of the patient, so to speak; the scene of the desolation is himself. External reality goes on its ordinary round: it is *within himself* that these horrors dwell. Nothing gives one such a clear picture of that inner world, in which every past or present relation either in thought or deed with any loved or hated person still exists and is still being carried on, as the state of a person in depression. His mind is completely and utterly preoccupied and turned inward; except in so far as he can project something of this horror and desolation, he has no concern with anything outside him. To save his own life and avert the death of despair that confronts him, such energy as he has is all bent on averting the last fatalities within, and on restoring and reviving where and what he can, of any life and life-giving objects that remain. It is these efforts, the frantic or feeble struggles to revive the others within him and *so* to survive, that are manifested; the despair and hopelessness is never, of course, quite complete. The objects are never actually felt to be dead, for that would mean death to the ego; the anxiety is so great because life hangs by a hair and at any moment the situation of full horror may be realized.

But struggle as he may and does under his unconscious guilt and anxiety to repair and restore, the patient has only a slenderest belief unconsciously in achieving anything of the kind; the slightest failure in reality, the faintest breath of criticism, and his belief sinks to zero again—death or madness, his own and others', is ever before the eyes of his unconscious mind. He cannot possibly regenerate and recreate all the losses and destruction he has caused, and if he cannot pay this price, his own death is the only alternative.

I think the patient's fear of being forced to death himself by the analysis is one of the major underlying factors in this type of case, and that is why I put it first. Unless it is appreciated, many interpretations will miss their mark. All his efforts to put things right never succeed *enough*; he can only pacify his internal persecutors for a time, fob them off, feed them with sops, 'keep them going'; and so he 'keeps things going', the *status quo*, keeps some belief that 'one day' he will have done it all, and *postpones* the crash, the day of reckoning and judgement. One

patient had woven this into a lifelong defensive pattern: his death would be exacted, yes, but he would see to it that this was postponed until his normal span had elapsed. He had reached a position of success and recognition in his own department of the world's work, so in old age his obituary notices would eventually serve him still as last and final denials and defences against his terrible anxieties and his own fundamental disbelief in any real capacity for good within himself.

I said before that understanding of these refractory cases lay on the one hand in our recognizing that the narcissistic and omnipotent resistances were masking a depressive position in these patients. This has been my own experience, but I might substantiate this theoretically in a simple way. The patient does not get well. The analysis has no effect on him (or not enough), because he resists it and its effect. Why? Now analysis means unmasking and bringing to light what is in the depths of his mind; and this is true in the sense both of external conscious reality and of internal psychic reality. What he is resisting, then, is precisely this: becoming aware consciously of what is in the depths of his mind. But this is a truism; all of us and all patients do this, you will say. Of course that is true; only these patients do it *more* than the others, for the simple reason that in them the underlying unconscious reality is more unbearable and more horrible than in other cases. Not that their phantasies are more sadistic; Glover has often reminded us that the same phantasies are found in everybody. The difference is that the *depressive position* is relatively stronger in them; the sense of failure, of inability to remedy matters is so great, the belief in better things is so weak: despair is so near. And analysis means unmasking, that is, to the patient, displaying in all its reality, making real, 'realizing', this despair, disbelief and *sense of failure*, which then in its turn simply means death to the patient. It becomes quite comprehensible why he will have none of it. Yet, with what grains of hope he has, he knows that no one but an analyst ventures to approach even to the fringes of these problems of his; and so he clings to analysis, as a forlorn hope, in which at the same time he really has no faith.

The patient's inaccessible attitude is the expression, then, of his denials of all that the analyst shows him of the unconscious contents of his mind. His megalomania, lack of adaptation to real life and to the analysis are only superficially denials of external reality. What he is in truth concerned to deny is his own *internal reality*. Here we come to my second point: the internal object-relations which are an integral part of his narcissism.

When we come to close quarters with the importance of the intenalized objects in this connection, one general aspect of the situation will at once become clear in view of what has already been said about the depressive position. The patient's conscious aim in coming for analysis is to get well himself: unconsciously this point is relatively secondary, for other needs come first. Unconsciously his aim is: (1) on the paranoid basis, underlying his depressive position, his task is something far more urgent than getting well; it is simply to avert the impending death and disintegration which is constantly menancing him. But more even than this (for the paranoid aspect of things is not the most unbearable), unconsciously his chief aim must be (2) to cure and make well and happy all his loved and hated objects (all those he has ever loved and hated) before he thinks of himself. And these objects now to him are within himself. All the injuries he ever did them in thought or deed arose from his 'selfishness', from being too greedy, and too envious of them, not generous and willing enough to allow them what they had, whether of oral, anal or genital pleasure—from not loving *them* enough, in fact. In his mind every one of these acts and thoughts of selfishness and injury to others has to be reversed, to be made good, by sacrifices on his own part, before he can even be sure that his own life is secure—much less begin to think about being well and happy himself. Our offer of analysis to make him well and happy is unconsciously a direct seduction, as it were, a betrayal; it means to him an offer to help him to abandon his task of curing the others first, to conspire with him to put himself first again, to treat his loved objects as enemies, and neglect them, or even defeat and destroy them instead of helping them. On his paranoid level, this is all very well, and he wants nothing better; but there is always something more than the paranoid position; there is the only good thing he has, his buried core of love and his need to think of others before himself at last, to make things better for them and so to make himself better. And the

analyst's offer to help him seems to him unconsciously a betrayal of them—of all those others who deserve help so much more than he. In addition, he does not for a moment believe that any good person really would be willing to help him before all the others who need it so greatly; so his suspicions of the analyst, and of his powers and intentions, are roused. One might suppose one could perhaps allay these suspicions by emphasizing how others will benefit by his cure; but on this point of technique I must here make an important digression. It will have struck you how incongruous and contradictory this picture of the patient's unconscious aim—one of them—(to make all his objects well and happy) is, compared with his manifest egoistic behaviour. But its incongruity is of course no accident; the terrific contrast of extreme conscious egotism as against extreme unconscious altruism is one of the major features of the defence by denial. In order to disprove one underlying piece of reality, he parades its opposite extreme. So I have to remind you that his unconscious aims are really *unconscious* and that we cannot use them directly as a lever to help on the analysis. We cannot say, 'What you really want is to cure and help other people, those you love, and not yourself', because that thought is precisely the most terrible thought in all the world to him; it brings up at once all his despair and sense of failure—all his greatest anxieties. Any such imputation, if at all plainly and directly expressed, has the immediate effect of producing a paranoid resistance as a defence; because, when we see through his denials, the manic defence has failed him. We have to be as guarded about directly imputing any altruistic motives to such patients as about imputing sadism or aggression to a hysteric. Nevertheless, when we know the unconscious situation, we know how to watch our steps; and even if we cannot use this lever ourselves for a very long time at least, we know it is there and can bring into play any indications of it there are, in subtle, indirect and gradual ways which do not rouse instant and unmanageable resistances.

This difficulty—that the patient unconsciously feels himself utterly unworthy of analytic help and, moreover, feels he is betraying the only good side of himself in accepting analysis, the

side which would devote his life to making his loved ones happy—can only be got over in one way, namely, through the possibility that analysis, by making him better, will in the end make him at last capable of achieving his task for others—his loved ones. His *true* aim is the other way round—to make *them* better first and so to become well and good himself; but that is indeed impossible, both externally and internally, for his sadism is still unmanageable. The nearest hope is this reversal, again on the lines of a contradiction, or this compromise—to be cured himself in order then to cure others. It is only on this understanding, so to speak, unconsciously, and by placing all responsibility on the analyst, that such patients accept analysis at all; and I think this hope, and this only, is the ultimate source of the endless time, suffering and expense that such patients will bring to continue analysis. We have to recognize that they do this much, even if they do not get well. Why they do it has not hitherto been fully understood. This single unconscious motive then, that he is to be cured in order at last to be capable of fulfilling his task to others, and not for his own ends, is the one slender positive thread on which the analysis hangs. But we can see at once how impotent this motive can remain, how it is weakened, obstructed and undermined by innumerable counteracting forces. For one thing, the patient does not for a moment believe in it; his fear of his own id and its uncontrollable desires and aggression is such that he feels no sort of security that he would eventually use any benefits obtained through analysis for the good of his objects; he knows very well, one might say, he will merely repeat his crimes and now use up the analyst for his own gratification and add him to the list of those he has despoiled and ruined. One of his greatest unconscious anxieties is that the analyst will be deceived on this very point and will allow himself to be so misused. He warns us in a disguised way continually of his own dangerousness.

Further, over and above this anxiety of accepting analysis on false pretences and deceiving and betraying his good objects again by it, there is an even greater fear, one which concerns the ego's fear for itself again, and links up with the fear of death unconsciously so strong in his mind. This is the dread that if he

were cured by analysis, faithfully and truly, and made at last able to compass the reparation needed by all those he loved and injured, that the magnitude of the task would then absorb his whole self with every atom of all its resources, his whole physical and mental powers as long as he lives, every breath, every heartbeat, drop of blood, every thought, every moment of time, every possession, all money, every vestige of any capacity he has—an extremity of slavery and self-immolation which passes conscious imagination. This is what cure means to him from his unconscious depressive standpoint, and his uncured *status quo* in an unending analysis is clearly preferable to such a conception of cure—however grandiose and magnificent in one sense its appeal may be.

I hope that while I have spoken of the patient's unconscious aim of making others well and happy before himself, you will have borne in mind that the others I refer to always are the loved ones *in his inner world*; and these loved ones are also at the same moment the objects of all his hatred, vindictiveness and murderous impulses! His egoistic self-seeking attitude corresponds accurately enough to one side of things in his unconscious mind—to the hatred, cruelty and callousness there; and it represents his fears for his own ego if the love for his objects became too strong. We all fear the dependence of love to some extent.

I have spoken, too, of the contrast and incongruity of his love and need to save with his egoism, his tyranny, his lack of feeling for others. This egoism *is* his lack of a sense of reality. For his object-relations are not to real people, his object-relations are all within himself; his inner world is *all* the world to him. Whatever he does for his objects he does for himself as well; if only he could do it! he thinks; and in *mania* he thinks he *can*. So it is the overwhelming importance of the inner world of his emotional relations that makes him in real life so egocentric, asocial, self-seeking—so fantastic!

The unconscious attitude of love and anxiety for others in the patient is not identical with Freud's unconscious sense of guilt, though the feeling that the patient deserves no help till his loved ones have received full measure corresponds to it. This unworthiness finds atonement, as Freud says, in the illness, but only some atonement; the illness or the long analysis are compromises. To my mind it is *the love for his internal objects*, which lies behind and produces the unbearable guilt and pain, the need to sacrifice his life for theirs, and so the prospect of death, that makes this resistance so stubborn. And we can counter this resistance only by unearthing this love and so the guilt with it. To these patients if not to all, the analyst represents an internal object. So it is the positive transference in the patient that we must bring to realization; and this is what they resist beyond all, although they know well how to parade a substitute 'friendliness', which they declare to be normal and appropriate and claim ought to satisfy us as 'not neurotic'. They claim that their transference is resolved before it has been broached. We shall be deluded if we accept that. What is underneath is a *love* (a craving for absolute bliss in complete union with a perfect object for ever and ever), and this love is bound up with an uncontrollable and insupportable fury of disappointment, together with anxiety for other love-relations as well.

In Freud's remarks on the difficulties of the negative therapeutic reaction he has a footnote which in this connection is extremely interesting. He says that this unconscious sense of guilt is sometimes a 'borrowed' one, adopted from some other person who had been a love-object and is now one of the ego's identifications. And, 'if one can unmask this former object-relation behind the unconscious sense of guilt, success is often brilliant'. This is the view I have just stated; the love for the internal object must be found behind the guilt (only Freud regards the love as past and over). He adds a link, too, with the positive transference. 'Success may depend, too', he says, 'on whether the personality of the analyst admits of his being put in the place of the ego-ideal'. But Freud's suggestion that the guilt is 'adopted' from a now internal object shows us that the brilliant success rests on a *projection* (or localization) *of the guilt on to an object, through an internal one*; and this is an extremely common feature of the manic defence (which may of course have been built up on some facts in experience). And his suggestion that the personality of the analyst determines whether or not he

plays the part of [the] ego-ideal indicates that consciousness and external circumstances are being allowed to blur the issue—exactly as the manic patient employs them to do if he can. The analyst *is* unconsciously the ego-ideal, or prototype of it, already to these patients; if they can rationalize their overmastering love and idealize it, then they can to some extent realize it without analysis; and this is in part a reparation, of course. The true aggressive character of their love, and their unconscious guilt of that, is still denied. Freud admits that this is a 'trick method' which the analyst cannot use. But the patient tries his utmost to trick us in this way. A great deal of our therapeutic success in former years in my opinion actually rested, and still may do, on this mechanism, without our having understood it. The patient exploits us in his own way instead of being fully analysed; and his improvement is based on a manic defensive system. Nowadays I regard this possibility as a danger, even if it was not so formerly; for the analysis of primitive aggression now rouses severe anxieties, while recognition and encouragement by the analyst of the patient's attempts at reparation (in real life) allay them merely by the omnipotent method of glossing over and denying the internal depressive reality—his feeling of failure. The result is that the patient may develop a manic defensive system—a denial of his illness and anxieties—instead of a cure, because the depressive situation of failure has never been opened up. In my experience the true analysis of the love and guilt of the depressive anxiety-situation, because they are so deeply buried, is far the hardest task we meet with; and the instances of success Freud quotes seem to be last-minute evasions of it by the patients' chosen methods of projection and denial.

The most important feature to be emphasized in these cases is the degree of unconscious falseness and deceit in them. It is what Abraham comments on; he, however, did not connect it with an unconscious sense of guilt. To us analysts both the full true positive and true negative transference are difficult to tolerate, but the *false* transference, when the patient's feelings for us are all insincere and are no feelings at all, when ego and id are allied in deceit against us, seems to be something the analyst can see through only with difficulty. A false and treacherous transference in our patients is such a blow to our narcissism, and so poisons and paralyses our instrument for good (our understanding of the patient's unconscious mind), that it tends to rouse strong depressive anxieties in ourselves. So the patient's falseness often enough meets with denial by us and remains unseen and unanalysed by us too.