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## DISDAIN: ITS DESTRUCTIVE ROLE IN RELATIONSHIPS, AND ITS TREATMENT

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# INTRODUCTION TO THIS ISSUE

## The Disdainful Patient

In recent years, a great deal has been written about narcissistic personality disorders and narcissistic vulnerability. The etiology of these phenomena has been explored in depth and the dynamics have been elucidated. However, there is still much to learn about overcoming the difficulties peculiar to treating such patients. This issue of the International Journal of Psychotherapy and Critical Thought will address one such difficult situation: the patient for whom disdain is a typical response and may serve such purposes as a defense against narcissistic injury or as a resistance to intimacy. As most of us know, defects in self-esteem and the patient's sense of self are likely to come to the surface over the course of treating even those patients not initially presenting prominent narcissistic features. As depression lifts and fears of losing the "good mother" fall away, some of these patients are likely to manifest a disdainful demeanor toward others as part of their shifting defensive structure. Robert is a case in point.

I care about Robert, not in the way a parent cares about his child, but as one learns to care about another adult with whom one has been "in the trenches," struggling against difficult odds. For over seven years I had been Robert's weekly individual therapist as well as a co-therapist in his psychotherapy group twice per week. At the beginning of therapy Robert was deeply depressed and rarely able to identify his emotions. Grossly limited in his ability to form relationships, he was socially isolated and remained professionally underdeveloped. Now, seven years later, he is married with two children and a new job. Our relationship likewise has gone through many changes as his initial positive transference slowly gave way to a real relationship based on mutual commitment to the reality principle. It was the relationship based on this commitment that remained stable and dependable in spite of positive and negative transference reactions. As his depression lifted, he had become much more alive and his playful smile and powerful, demanding voice had become familiar to me. Nonetheless, he still tended to limit his involvement with others.

Fellow group members liked him very much, extending themselves to help him recognize the many ways he pushed them away. As he became more involved with others in his group and in his life, it became more clear how much he wanted things "his way." Having lived in a withdrawn, socially isolated fashion, he had never developed the patience and skill necessary to resolve conflicts with others, instead finding ways to

either avoid them or to subtly manipulate situations to get what he wanted. As these tendencies were confronted, however, he made use of his new-found freedom to be openly defiant. With a disdainful sneer, he would roll his eyes: "I don't agree with you, Mr. Shultz. That's what you want to see." At such times attempts to engage him in reality-testing were doomed to fail.

In such a case, the patient may seem psychotic-like since the observing ego and the working alliance seem absent. However, Robert's level of anxiety was relatively low, and his reality-testing in all other areas was intact. He had gained the freedom, at long last, to openly behave like a typical two-year-old: "I want to believe what I want to believe, and no one's going to change my mind." Implicit in his manner was a refusal to join in the process of reality testing. His disdain was a dismissal not only of me but of the principles our relationship stood for.

The possibility of counter-transference confusion is great at such a time; there is even a risk that the therapist will unconsciously want to "get rid of" the patient. This issue of the Journal will attempt to address such issues of counter-transference, explore the dynamics underlying disdain, and demonstrate effective approaches for helping patients get beyond this difficulty. With a clear understanding of the issues involved, a clinician is likely to find this so-called "difficult" patient not so difficult after all.

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# WORKING WITH HATE AND DISDAIN IN GROUP THERAPY

David A. Baker, M.S.W.

A conscientious colleague had just heard a spiteful story about himself circulated in the community by a former patient. He shook his head as he reflected back on her treatment.

She had been a seriously depressed, withdrawn, bitter woman when years earlier she had first sought him out for treatment. With hard work in both individual and group therapy, her depression gradually lifted as the underlying hurt and anger came to the surface. Trying to help her work this through, he invited her to express her feelings of rage directly at him in her group therapy sessions, and she eventually did so with venom in her voice and hate in her eyes. This process continued for many months as she became more free to express herself without restraint or fear of rejection.

Then a crisis arose in her therapy, and she terminated without thoughtful observation of her decision. Efforts to reason with her proved futile. She seemed to have lost awareness of the real relationship with her therapist, including a rich history of several years. She had shifted from her depressed state to a more alive but hateful one, and apparently remains there to this day.

What my colleague realizes now, and didn't know then, is that he unwittingly encouraged the hardening of this patient's hatred instead of working it through. In the context of what he believed was a well-developed relationship he invited her to express her hatred directly toward him, as he would have done with other transferential feelings she needed to work through. However, this approach overlooked the fundamental difference between hate and the other emotions. In hate one loses sight of others as human beings and seeks to obliterate them. With disdain, a first cousin of hate, one dismisses other people as if they do not matter. In both cases the foundation of the therapy relationship—basic respect for each other as human beings—is eroded and eventually destroyed [Bar-Levav, 1995].

Unlike the healthy expression of anger in which this basic respect is maintained, hate is a psychotic position which seeks to destroy the other person without concern for the potential loss of a relationship or awareness of the other person's value as a fellow living creature. Hate, not

anger, contributes to the many brutal crimes of passion which fill the tabloids.

The patient's impulse to kill the relationship is what so consistently challenges the therapist's clinical skills. If in the midst of strong feelings the patient loses all awareness that the person sitting before him is his therapist, the therapeutic process stops cold. Instead of working through the transference, the emotions at that moment are being lived out as if they reflect reality. Urgent intervention is necessary to re-establish the working alliance and the real relationship. No further therapeutic work can take place until the real relationship is restored and the psychotic-like process is broken up by reality.

The roots of hate apparently develop in the first year of life; the foundation of disdainful behavior occurs somewhat later. Meissner (1984) described the struggle of the one-year-old child as his primary narcissism is challenged more and more. The child painfully discovers that he is not omnipotent and that his wish is no one's command. In normal development, a steady mothering person supports the ego boundary development by being emotionally available as needed through this time. But according to Mahler (1975), when the experience of impotence comes too suddenly or painfully due to an unsettled or withdrawn caretaker, the child may react in angry outbursts and tantrums. For some children this crisis may even be experienced as emotional dissolution or a loss of self (Horner, 1979).

What can an infant do at such a vulnerable and helpless time? "Destroying" the apparent source of the hurt, the caretaker, is a natural primitive attempt to reduce the panic and agony (Higgins, 1993). The splitting defense allows the infant to also maintain a parallel positive relationship with the caretaker until the psyche can begin to integrate the two powerful emotions. However, when this integration does not occur through the involvement of a responsive, steady, non-punitive caretaker, splitting remains a major defense into adulthood, at a high cost. Such people swing back and forth between idealizing and hating others, and have few real relationships. Pain and disappointment fill their lives. Often they develop a harsh, severe, seemingly angry edge to defend against further experiences of hurt and panic.

Disdain is similar to hate in that the relationship is for the moment broken. The fact that the parent's existence is still acknowledged suggests that disdain develops at a somewhat later stage when object relations are more secure. While not a psychotic process like hate, disdain is more

subtle and at times more difficult to recognize. In disdain a child does not imagine obliterating the parent who is experienced as hurtful but rather dismisses him or her out of hand. Such disdainful dismissal is a defense against feeling pain and disappointment. As adults, overt and covert disdainers live self-righteous and lonely lives, isolated from those good human beings whom they look down upon.

Klein (1975) suggested that anxiety from two sources is at the root of hate. One is the anxiety of the birth process and all the attendant difficulties to which the baby must adapt without understanding; the second is the anxiety stimulated by angry wishes to destroy the mother who seems to cause the unavoidable frustrations of infancy.

Bar-Levav (1988) ties hate more directly to anxiety, noting that the basis for hate is panic:

> Hate packs such a powerful punch because punching is a perfect, if temporary, antidote for panic. The more destructive and dramatic the impact of insane violence, the more useful hate is for plugging up the gaping emptiness and the better it harnesses panic and dread. In panic, people are often frozen in total helplessness, waiting immobilized for the ax to fall. The alternative of picking up an ax and hatefully chopping up the enemy generally seems much more desirable at such moments. (p. 168)

He attributes such a powerful reaction to the most profound and often unconscious panic that people feel. Like a cornered alley cat blindly bites and scratches its way to safety, persons in such panic marshal the "power" of hate to blindly strike out at any and all who threaten their sense of emotional security.

Working clinically with hate requires a very safe setting and a solid therapeutic relationship which has been well-tested over time. Since most people are socialized enough to disguise or hide their hate, some patients initially need guidance and encouragement to express their anger powerfully at the therapist for awhile before daring to show the ugliness of their hate. The psychotherapy group is the best setting for this work since the other patients and a co-therapist can provide needed reality-testing and are often experienced as allies for the patient at the height of the split transference.

Making room for the patient's expressions of rage without opening the expression of hate is a unique and technically refined task. First, therapists must have resolved their own fears or distortions about anger and hate (HarPaz, 1994). Otherwise they will unconsciously discourage their

patients from expressing anger or, on the other hand, carelessly encourage expressions which slip into hatred. The therapist's own personal boundaries must be strong and flexible enough to truly welcome the patient's anger directly at him or her, keeping in mind the panicky "baby" who is often behind the loud fury.

How does one differentiate between necessary expressions of anger and harmful expressions of hate and disdain? Attention to the patient's eyes provides the most obvious clue. When the eyes go "blank" or seem to cloud over, patients must be helped to focus on and to truly see the person in front of them in the here and now. A second clue is language which is disrespectful of the other person, such as contemptuous name-calling. By contrast, the words "I hate you!" or "Damn you!" are not in themselves disrespectful, and occasionally can even be used powerfully to work through anger without losing sight of the real relationship. A third clue is behavior which reflects distortions in the real relationship, such as willfully ignoring the therapist. And a fourth is a curl of the lip or a dismissive toss of the head.

## Case Example 1

Eric, a middle-aged, married businessman with three children, has serious difficulties with impulse control, self-esteem, and judgement. The older of two sons, he describes his mother as critical and self-serving and his father as concerned but passive. His brother still lives in his parents' home. Eric's first marriage ended painfully, and he often feels hurt by his current wife and by his children. Externalization became his trademark in his therapy group.

In one group session Eric increasingly fidgeted and then began to mutter sarcastic comments at one of the therapists. When invited to complain openly, he spoke up and criticized the therapists.

> Eric [loudly]: You people haven't done a thing for me and my problems! I'm still not earning enough money, I'm making mistakes with my children, and I just keep paying you all this money...for what?! I'm furious!
> Therapist [suggesting an exercise familiar to the patient and occasionally used in our groups]: I suggest you express your anger in a word or two toward me. Powerfully.
> Eric [yelling powerfully and deliberately pausing between each statement for a breath]: Damn you! Damn you! Damn you! [pause] Damn you! DAMN YOU! [escalating now] You stingy, bald-headed jerk! You aren't worth a thing as a therapist. You're

a selfish, greedy bastard. You wont get another penny out of me...

Therapist [loudly enough to interrupt Eric and get his attention]: Eric, stop! I can't allow this to continue! [He continued firmly but more quietly.] You are welcome to be angry here but not if you lose sight of who I really am. Make an adjustment! Be angry, but see me.

Eric [catching his breath, pausing, squeezing his eyes shut momentarily]: OK, I understand.

Therapist: Now continue if you can.

Eric [powerfully and angrily]: I want more from you! More! More! More!

For the next few minutes Eric continued to powerfully rage at his therapist, but now he sat taller and sounded more solid as he did so. Several times he caught himself sneering and paused to adjust himself so as not to become disrespectful. His eyes focused steadily on his therapist's eyes without the wild, desperate look from a moment before.

Later in the group session he spoke thoughtfully about what had occurred emotionally for him when he temporarily ignored his observing ego: "I know I feel so powerless to change anything sometimes, and I want someone else to do it. I was feeling very scared about my finances and just wanted to blame you." As a veteran of many previous similar interventions, he was able this time to change his course immediately when firmly and respectfully interrupted by this therapist. But this followed numerous times when he had not stopped so quickly, and then had pouted for the remainder of the session, or threatened to leave therapy when his therapists firmly thwarted his attempts to prevail.

Had the therapist been anxious himself, and expressed it by being overly challenging, Eric would likely have escalated instead of hearing his ally. He would have unconsciously reacted to the therapist as his over-protective mother. And the embarrassment which typically followed such outbursts would have further damaged his self-respect.

## Case Example 2

Mary is a divorced, 45-year-old woman with a history of serious relationship difficulties and an hysterical character. She grew up with a critical, narcissistic mother and an efficient, business-like father whom she admired and with whom she identified. Understandably frightened of real intimacy but longing for it nevertheless, she spent many of her young adult years living communally. Articulate, colorful, impulsive,

and very sensitive to criticism, she developed a strong negative transference toward one of her therapists who consistently set limits regarding her hysterical expressions and refused to gratify her infantile wishes for exclusive attention and approval. At the same time he was realistically supportive of her adult efforts to control her impulsivity, to develop her thoughtfulness and to advance herself professionally.

As Mary began expressing her anger in the early years of her therapy, one aspect of her character came into focus, demonstrated by the following vignette. For the first twenty minutes of one group session Mary had been sitting quietly and staring away from the therapist, her body turned aside and shoulder hunched protectively.

> Therapist: Mary, why do you not say hello to me?
> Patient [bitterly and still staring away]: Why should I say hello to you? Every time we talk I get slammed down again. I'm tired of getting hurt by you.
> Therapist [firmly]: I'm not willing to engage you unless you look at me.
> Patient [rolls her eyes]: I don't want to look at you.
> Therapist [more firmly]: Regardless of your feelings at the moment, I will not continue to talk with you now if you dismiss me.
> Co-therapist: Mary, take a breath. Give yourself a moment before responding.
> Patient [tentatively looking at the therapist and somewhat sarcastically]: OK, what do you want?
> Therapist: I will not respond to your sarcasm. Change your voice if you want me to respond to you.
> Patient [softer now]: I really don't know what you want from me. I really don't understand. [She begins to cry quietly] I guess I wish I could just talk to you sometimes without feeling hurt...
> Therapist [tenderly]: What is this hurt all about? Do you know?

Mary continued to cry quietly for some time. Later in the session she spoke painfully about her unresolved yearnings for her father's attention.

Mary's disdain served as her defense against her pain. By "looking down her nose" at others she defended against feeling vulnerable and disappointed, at a high cost of both loneliness and missed opportunities in her career. Her disdain covered much fear and a self-image battered by self-blame.

## Case Example 3

Margaret, a very depressed 37-year-old accountant, reluctantly came to therapy at her husband's insistence. They had been living together for years as strangers with little communication and no sexual involvement. With an emotionally distant mother and demanding military father who died when she was ten, Margaret grew up to be a competent, hard-working, but dowdy professional who had never known the rewards of close emotional involvement.

She approached therapy with understandable skepticism, a sarcastic bite in her voice, and a hard push away when others attempted to involve themselves with her. The fact that her fellow patients in her group openly disliked or at least avoided her appeared to not faze her in the least. Her therapist patiently tried time and again to gain her trust and to welcome her into the relationship, but her bitter face and heavy ungraceful walk showed little change over several years. It was clear that her fear of emotional involvement remained very high despite the efforts to reach her.

And yet she stayed in therapy, her marriage seemed to stabilize, and she got several promotions. Then, almost imperceptibly, she began to soften. Occasionally she made more neutral comments to her group members, or with help related a personal vignette from her office environment. These breaks from her characteristic way naturally scared her, and sometimes she would retreat to her former bitterness for several weeks before venturing out again.

As she entered the middle phase of her therapy, she began to feel more openly and powerfully the anger which lay beneath the sarcastic tone and bitter comments. She expressed this often in her group and particularly focused on her female therapist who in the transference represented the patient's disappointing mother. Margaret's challenges and raging generally did not rattle her therapist except for one repetitive situation. When the two of them met by chance in the hall or women's rest room, Margaret consistently ignored her, never initiating a greeting and only muttering in reply.

In a situation like this the benefit of a psychotherapy team approach becomes readily apparent. The co-therapist in the group, as well as other therapists in the practice who knew the patient, reviewed the situation to check for counter-transference distortions on the part of the therapist and to plan the next step. In the team conference it was clear that Margaret would need to repair the damaged real relationship with her thera-

pist. She had stepped out of the bounds of basic mutual respect, and her treatment could not continue until that foundation of the therapy, or any relationship, was reinstated.

After much work with her own initial overreactions, the therapist carefully prepared a plan. Her intervention had to be firm but not punitive, and powerful enough to reach through Margaret's defenses, using the health which Margaret had already demonstrated over several years in the relationship.

In the following group session, the therapist sat forward, asked Margaret to do the same, and spoke to her about what had happened between them. A hush fell over the group.

"Margaret, I've been troubled since I saw you in the hall on Tuesday, and you again did not say hello or acknowledge my presence in any way. I have talked with you about this in the past a number of times, but I must tell you something about myself now. I'm not willing to continue to work with you as your therapist unless you correct how you treat me. I expect the same basic human respect which I show to you. You can express your feelings in your sessions as much as you need to. But I will not accept your acting these feelings out when we meet outside your sessions."

Many of the group members were stunned. How often does a therapist speak this way to a patient? But Margaret shrugged nonchalantly. "I guess I'll leave then." It took much hard work in that session to reach the hurt underneath her cool exterior, but eventually she cried as the possibility of losing her therapist sank in. She spoke thoughtfully of how her disdainful behavior had kept her from feeling hurt for many years and how frightening her current involvement with her therapist was becoming. After several sessions of focused work she apologized and made a commitment to more attentively separate her feelings from her behavior.

## Conclusion

In summary, hate is seen here as a defense against very powerful fear stemming from the first year of life. At that very vulnerable time when an infant is forced by the pressing realities of life to give up primary narcissism, the lack of sensitive, firm caretaking can be disastrous. One's very sense of self may be threatened. Disdain, developing as a slightly later time, protects one from feeling shame and embarrassment by projecting onto the caregiver the weakness or incompetence one feels.

To effectively help a patient change such destructive behavior patterns and work through the underlying panic, a very safe psychotherapy setting and well-tested real relationships are necessary. Since hate and disdain usually stir up fear, hurt or anger for the therapist, special care must be taken to not act out these reactions with the patient. Sound supervision along with the use of a co-therapist in a team practice provide necessary guidance and objectivity in this difficult task. In addition, developing the ability to recognize and be appropriately firm in the face of disdainful or hateful behavior requires a specific experiential training over time.

Both hate and disdain are malignant to relationships and a threat to civilized society. When the basis of relationships—mutual respect—is broken, nothing else in human affairs should proceed until that is properly resolved.

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## Background Point of Theory

To dissolve hate and to change persons afflicted with it require that they first experience the fear underneath it as such; this can only happen in the presence of someone with whom they feel secure. Only then does the frozen hate begin to thaw out slowly, eventually turning into rage. This in turn must be neutralized, not merely talked about or recognized as such. Interpretations about the causes and origins of anger are basically irrelevant in this process, since they have no power: They originate in reason and appeal to reason. The heat of fury and the explosive intensity of rage found at the root of hate must be experienced as such, and expressed verbally or vocally at someone willing and able to stand in as a symbolic target. It requires exquisite skill, inner strength, sensitivity, good timing, and enormous patience on the part of very experienced and courageous therapists. The dangerous task becomes completely safe, and success can be achieved, but only in well-designed and well-constructed therapeutic environments...

From R. Bar-Levav, M.D. (1988)
*Thinking in the Shadow of Feelings,* New York: Simon and Schuster, p. 170.