The Use of Countertransference in Response to Narcissistic Defenses of Group Members.

by

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Abstract

Narcissistic defenses constitute the most powerful obstacle to the patient's development, both in the individual and group setting. These defenses often push analysts and psychotherapists to the limits of their emotional resources. After a brief review of the pertinent literature, this paper discusses the clinical characteristic of narcissism and the psycho-dynamic processes underlying narcissistic defenses. It explores the typical countertransference responses to such defenses as well as ways of transcending the analyst's and psychotherapist's own narcissism which, together with the patient's narcissism, accounts for much of the painful impasses in the work. Finally, clinical material from a long-standing therapy group is presented as an illustration. This includes a brief outline of the narcissistic defenses of two of its members and an account of how these defenses were employed by the group in a recent session.

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Although Bion relied heavily on his countertransference reaction to group process, not much has been written about specific countertransference reactions to narcissistic patients in a psychoanalytic group therapy setting. However, there is a large body of literature on working with narcissistic patients in analysis and individual psychotherapy. A number of papers (Alexander, 1981; O'Shaughnessy, 1981; Reisenberg-Malcolm, 1981; Steiner, 1993) give detailed accounts of the course of analysis with difficult narcissistic patients, including the analyst's countertransference difficulties. In this paper I want to understand some specific countertransference responses to the narcissistic patient's most typical defenses and to explore how one can use this countertransference in order to better help the patient. I hope to extrapolate to the group psychotherapy situation what has been learned from individual analysis of these patients. After a brief review of the pertinent literatureI will discuss the clinical characteristics of narcissism, the psychodynamic processes underlying narcissism, and some of the technical difficulties and countertransference responses in the treatment of these patients. Finally, I will present material from a psychoanalytically oriented therapy group, including a brief outline of the typical narcissistic defenses of two of its members and an account of how these defenses were employed in a recent session.

Brief review of the literature

Finell (1985) observed that personal analysis does not always resolve or attenuate narcissistic problems. The narcissistic tendency toward splitting and idealization is a universal pitfall, not only found in the patient population. The designation of narcissistic personality disorder provides professionals with the opportunity to project their own narcissistic tendencies and then defensively

disavow them in themselves by finding them in one's patients. Some research evidence from the Menninger Clinic suggests that training and technical skill, while necessary, are not sufficient for a high level of performance in an analytically oriented therapist. The research team evaluated the skill of the therapists and the way in which the therapist's personality interacted with that of the patient in furthering or limiting the therapeutic goals. They found that "...the whole complex of traits associated with narcissistic orientation interfered with the optimal application of good therapeutic technique..." (Horwitz, 1971, p.18). Low-competence therapists "often showed an insufficient capacity for concern and empathy, were easily frustrated when gratification was not forthcoming, and often became authoritarian and controlling. They tended to care more about their own performance than about the plight of the patient and were hampered by an attitude of therapeutic omnipotence" (p 18). In line with this research Lieberman, Yalom, and Miles (1973) carried out an extensive study of casualties from a group experience and found that the high-risk leaders of these groups tended to be charismatic, intrusive, and confrontative, as seems also to be the case for leaders of organizations. For Kernberg (1991) the most serious and damaging type of pathological character structure in a leader is that of the narcissistic personality disorder. This observation is corroborated by the study of political leaders who manifest pathological narcissism. Post (1993) concludes that the mirror-hungry personality of the leader complements the idealization hunger of his followers. Sometimes leaders can strengthen the cohesiveness and stability of their own grandiose self by idealizing a group of followers whom they then include in an idealized extension of themselves (Volkan, 1980). They then attack a segment of the population that represents disowned and devalued aspects of themselves, reinforcing their split-off valued grandiose selves.

In trying to maintain a desired self-image of the "selfless helper", most analysts find it difficult to examine their own egocentric propensities (Saretsky, 1980; Welt & Herron, 1990). Therapists with marked narcissistic vulnerabilities find it difficult to tolerate negative transference, criticism, and devaluation. In an effort

to counteract their hostile reactions they often become unduly nurturant and/or fail to confront patients with their acting out or resistances. Grandiose therapists believe that they are imbued with special therapeutic powers and their mere presence is capable of “healing” the patient. They tend to use oracular pronouncements which invite unquestioning acceptance. They also like to convey to their patients that nothing ever takes them by surprise (Ticho, 1972). As Horwitz summarizes, “The all-knowing therapist may provide a measure of comfort to the ideal-hungry patient, but it also impedes personal growth and development”
(1995, p. 21).

Forces in a therapy group tend to exacerbate countertransference reactions generally and narcissism in particular. The analyst’s difficulties in responding to negative transference is accentuated in a group. As Horwitz explains, “The transference component of the group’s attacks and criticism are more difficult to recognize when they come from more than one person since we are accustomed to gauging the reality of an event in terms of consensual validation” (1996, p 23). Whether negative expressions by group members are justified or not, there is an increased pressure on the therapist’s narcissistic vulnerability. The group therapy situation highlights the members’ egocentrism and self-absorption. Members typically confront each other with failures of empathy, lack of commitment to the group, or a tendency to monopolize. Analysts who are struggling with their own narcissistic issues may overreact to the member’s narcissism by being excessively critical or by confronting the member prematurely. The therapist may also experience an inhibition in making transference interpretations that highlight the therapist importance. Thinking of oneself as the central person in the group may constitute a threat to an unconscious wish to be the center of attention.

Clinical characteristics of narcissistic patients

Narcissistic patients have a highly idealized self image coupled with feelings of

extreme inferiority. They often complain that nobody understands them and expect others to understand them even if they have not revealed much about themselves. They use excessive self- references in their communications and experience an excessive need to be loved and admired, but the effect of the strokes they receive from others does not seem to last. Their need for admiration suggests that they are highly dependent, but they are truly unable to depend on others. Narcissistic patients have great difficulty accepting help and especially accepting criticism. They are inordinately envious of others and defend against their painful envy with devaluation and spoiling of what others have or do, leading to a chronic sense of emptiness and boredom. They idealize those who seem to have the supplies they need and are contemptuous of those from whom they expect nothing. Their relationships are thus often exploitative or parasitic. They often pair up with other narcissists with whom they exchange strokes. On the surface they can be charming and engaging, but soon their coldness and ruthlessness becomes apparent. Their work may seem creative, but it is often superficial.

Narcissistic patients are deeply antagonistic to self-knowledge. There is an active wish not to know and a terror of looking inward. They experience a hatred of being small, being at the beginning (Symington, 1995), which leads to self-hatred and sadism directed against the infantile self that needs to start at the beginning. Their omnipotent defenses against their infantile self and against depending on an object catapult them into a pseudo-maturity. Narcissistic patients do not initiate action but instead take a passive stance geared to get others to act. Their source of action stays on the surface rather than coming from within the self, and therefore they need others to stimulate them. Because they try to present a facade appearance of being "together," they are often afraid of being found out and complain of feeling like a fraud. They speak in order to block communication rather than to convey something about themselves to others. Their speech pattern seems to interfere with the thought process of others, who find themselves derailed by their communications.

When frustrated by the other or when they have to wait their turn, they often turn off with an attitude that “It doesn’t matter, don’t bother” and devise elaborate revenge against the other. They have an idealized view of the analyst as someone who “knows,” but this feeling dovetails with intense hatred of the analyst because he or she has knowledge and can be of help. Narcissistic patients spend a great deal of effort hiding from the reality of the situation. They cannot face anything unpleasant and take flight into self-stroking. If reality presents the need to delay gratification, the narcissist will choose the narcissistic option of withdrawal from the source rather than choosing to wait and stay connected. Choosing the life-giving object has built-in risks that the situation might turn out badly, that the life-giving object might reject them or love someone else. The analyst is often not only not used as a source but as a toilet to receive the patient’s undesirable feelings or parts of the self. On the other hand, they often assimilate other people’s values or ideas and declare them to be their own. For example, they easily learn their analyst’s theories which they use for defensive purposes (Symington, 1995). The unconscious devaluation or destruction of what they receive from others accounts for a chronic sense of dissatisfaction with what they are receiving from others.

Psychodynamics of narcissism

Freud was already making use of the concept of narcissism before he introduced it in 1914 in a paper entitled, “On Narcissism: An Introduction”. The term refers to the myth of Narcissus, whose love was directed towards the image of himself. Freud postulated a seesaw balance between ego-libido and object-libido. The more love is turned toward the self the less is available for others.

The first contemporary theory of pathological narcissism within the Kleinian framework was presented in four papers by Herbert Rosenfeld between 1964 and 1978. He gave a detailed clinical description of narcissistic patients as well

as their transferences. Rosenfeld distinguishes the libidinal aspects of narcissism, with its overvaluation and idealization of the self, from the destructive aspects in which the omnipotent destructive part of the self is idealized and submitted to. The destructive aspect captures and traps the positive dependent aspects of the self. The whole narcissistic structure is committed to self-sufficiency and is directed against any object relatedness. These patients hate everything that is good and valuable in others and also hate their own dependent selves. They feel secure and triumphant when they have frustrated the efforts of those who love them. In the case of libidinal narcissism the destructiveness comes into the open early in the treatment and can be worked with. In destructive narcissism the pervasive destructiveness is difficult to bring into the open as envy of the object is more violent and more difficult to face and the turning away from the object is more entrenched. The omnipotent destructive part of the narcissistic patient is directed against any positive libidinal relationships and any libidinal part of the self which experiences the need for an object and the desire to depend on it. This omnipotent destructive part remains disguised or split off, so that there is an apparent indifference toward external objects, which are constantly being devalued. In the transference, the patient experiences resentment and revenge at being robbed by the analyst of his omnipotent narcissism. There is an overwhelming wish to destroy the analyst, and sometimes the patient becomes frightened of his or her own destructiveness. At other times violent self-destructive impulses appear, and the patient spoils his own professional success or personal relationships becoming depressed and suicidal. At these times death may be idealized.

Occasionally these patients experience shame but only minimal guilt because very little of their libidinal self is kept alive to feel concern for the object. The destructive process manifests in its most virulent forms in severe narcissistic conditions. Rosenfeld (1971) distinguishes between a highly organized narcissistic defensive organization and a surreptitious deadly and hidden force that often creates a chronic and paralyzing resistance, the death instinct proper.

The latter lies behind the narcissistic defensive organization and supports it. The analyst needs to draw attention to the patient's paralyzing behavior, the secretiveness and the terror of something unknown. Eventually the murderous force appears in dreams.

The narcissistic patient omnipotently introjects an all good part-object or projects his own self into such an object. There is thus no true separation between self and object and therefore no need to depend on an object. The moment there is an awareness of a separate frustrating "other," this other is intensely envied and hated. Progress in the analysis leads to negative therapeutic reactions when the patient becomes aware of receiving something good from the analyst that results from the envy and devaluation of the analyst. External objects and especially the analyst are often used as toilets for the projection of undesirable parts of the patient. The patient often assimilates the analyst's values and ideas and declares them to be his or her own.

Kernberg (1984) classifies narcissism into normal adult, normal infantile and pathological narcissism. In pathological narcissism the patient's self is identified with an idealized object while the patient's infantile self is projected into that object. The functions of self and object are thus reversed; the patient becomes the all-knowing analyst, and the analyst becomes the infantile part of the patient. According to Kernberg, what we call the narcissistic personality is a type of character pathology centered on the presence of what he calls a "pathological grandiose self". The narcissist's unconscious grandiosity incorporates both the masculine and feminine aspects of their object so that the narcissist seems to have become immune to sexual needs. The deepest pre-oedipal source of envy is the envy of the other sex, and a prominent aspect of the narcissist's sexual difficulties is an unconscious rejection of a "one sex only" identity and an unconscious narcissistic fantasy of being both sexes simultaneously.

To Kernberg, these patients reveal the typical conflicts of the borderline

personality beneath the protection of the pathological grandiose self. At the most severe level, despite the defensive functions of the pathological grandiose self, these patients present overt borderline features: lack of impulse control, lack of anxiety tolerance, no capacity for sublimation, chronic rage or paranoid distortions. When primitive aggression directly infiltrates the pathological grandiose self, we have what Kernberg calls “malignant narcissism.” These patients experience triumph over inflicting fear and pain in others. Their self-esteem is enhanced when they experience sadistic pleasure. Kernberg believes that these patients may find in the treatment situation an outlet for aggression that militates against structural psychic change.

Along with Fairbairn (1940) and others, Symington (1995) considers trauma as the source of narcissistic pathology. The trauma may be seen only after one gets through the defensive barrage of these patients. Symington equates trauma with shock; stability based on an expectation of steadiness has been shattered, and the tempo of the necessary detachments of psychological growth is suddenly disrupted. The arrogance and cruelty of the narcissist can be explained by postulating that the infantile traumatized child is projected into the other while the narcissist becomes the traumatizing agent. This process is akin to identification with the aggressor so typical in situations of abuse. Sometimes one finds not a single trauma but instead the cumulative trauma inflicted by the parents’ emotional character. The younger the patient is when the trauma occurs, the greater the pull toward narcissism. The grandiose part of the self smothers the infant part of the self. On the other hand, we find that trauma can pull somebody out of narcissism (Symington, 1995). The psychoanalytic situation can be traumatic when it reproduces the frustrations of the infant with a caretaker, and these earlier traumas are relived in the transference.

References to narcissism as such are scarce in Bion’s writings. In his preoccupation with psychosis and a theory of thinking, Bion appears to have overlooked the role of narcissistic defenses. However, a concern with narcissism is implicit in the notion of the basic assumption. Bion (1959 b) ends

“Attacks on Linking” with, "The main conclusions of this paper relate to that state of mind in which the patient’s psyche contains an internal object which is opposed to, and destructive of, all links whatsoever from the most primitive (which I have suggested is a normal degree of projective identification) to the most sophisticated forms of verbal communication and the arts. In this state of mind emotion is hated; *it is felt to link objects and it gives reality to objects which are not self and therefore inimical to primary narcissism"* (p. 108) (italics mine). A question could be raised as to what constitutes the narcissistic defense of the group as a whole. Insofar as it opposes understanding and development one can see a relationship between Bion’s basic assumption group (1959 a) and the individual’s narcissism, which is also opposed to self-exploration, understanding and development. The narcissism of the group revealed by the basic assumption mentality gives way, through interpretation of its anxieties, to the work group in which curiosity leads to exploration and learning from experience. One could then say that in the group situation narcissistic defenses are dealt with both at the group and the individual level. This is only the case if the analyst attends both to the group and to the individuals in it.

Treatment considerations

The aim of the treatment is to help the patient find and rescue the dependent sane part of the self from its entrapment inside the narcissistic structure and to help the patient become conscious of the split-off destructive part of the self. Omnipotence is deflated when the patient is helped to recognize its infantile nature. The patient comes to distinguish between his own angry and murderous feelings against external objects and the threat of the murderous inner attack. Thus it is important that patients recognize that the drama they are carrying out is an internal one.

Rosenfeld distinguishes between the “thin skin” and the “thick skin” narcissist. The thin-skin narcissist is hypersensitive and easily hurt. The positive side of this patient’s narcissism is its role in keeping the personality stable. According

to Rosenfeld, the analyst should not emphasize the destructiveness of the thin-skin narcissist since it can continue to traumatize the patient. On the other hand, the thick-skin narcissist is well defended from the effect of others and appears insensitive to deeper feelings; these patients need to be confronted with their destructiveness.

The breakdown of narcissism brings about paranoid delusions. The patients become aware of their attacks on their objects and expect retaliation from them. These delusions can be overcome by interpretation so that the patient advances toward true dependency, into the depressive position and the experience of oedipal conflicts. “Narcissistic rage” or paranoid reactions may be part of the therapeutic process in patients whose grandiose self is not infiltrated with aggression and is a sign that the projected infantile self is being brought back into the self. The entitled infantile part of the patient is enraged at his or her own need for the object or at recognizing his or her value. Sometimes the dependent self is lured into a psychotic omnipotent dream state where the patient loses his or her sense of reality and capacity for thinking. At these times there is danger of a psychotic break.

Rosenfeld (1987) suggested modifications in technique with some narcissistic patients at times of severe regression One of these is the need to interpret both the positive and negative transference. For Kernberg the pathological grandiose self presents the more intractable resistance to treatment. He suggests that analysis is indicated for patients in the middle range of narcissistic pathology, but patients with a grandiose self are not good candidates for analysis. When pathological grandiose self is activated during the treatment, it shows as a distance, an emotional unavailability, a subtle but chronic absence of a “real” relationship between patient and analyst. The role reversals whereby the analyst is the child and the patient, the analyst, constitute a recurrent transference pattern. The pathological self-idealization alternates with a projection of self idealization onto the analyst as if only one ideal person can be in the room. The analyst, if allowed to be the analyst, is supposed to be brilliant

but not so brilliant to stimulate envy. This situation alternates with periods of unconscious rage and devaluation of the analyst represented by the frequent complaint that nothing is happening. Patients often engage in self analysis, treating the analyst as an absent person. Their corrupt superego is projected into the analyst, who is then perceived as merely having a number of tricks the patient needs to acquire. There is always a paranoid distrust of the analyst.

According to Kernberg, it takes about three years of analysis to dismantle the pathological grandiose self. In the course of the treatment the patient enacts with the analyst his real self, ideal self, real object and ideal object until these objects can be integrated. During advanced stages of the analysis there is an oscillation between idealization of the analyst and the negative transference. Narcissistic idealization is replaced by higher levels of idealization in which the analyst is seen as an ideal parent or parental couple who can now tolerate the patient's aggression. The patient experiences guilt for his attacks and gratitude for what he is receiving, signaling depressive position functioning. The dissolution of the pathological grandiose self and of narcissistic resistances permits the emergence of normal infantile narcissism and the capacity to depend on the analyst. Jealousy appears as a new emotional capacity indicating an entry into the oedipal phase of development .

In summary, narcissism is a protection against psychic pain. When the spirit breaks, the person opts for the narcissistic solution that protects just as the autistic shell covers a black hole of despair (Tustin, 1981). We analysts ask the patient to give up the way he or she defends himself or herself. The analyst supports the struggling life-enhancing side against the narcissistic refuge. The emergence of hatred is a sign that a reversal of narcissism is taking place. Hate indicates an acknowledgment of the other as other and a breach in the illusion that there is no other but the self. This hatred of the other is accompanied by a hatred of the infantile self that is trying to come out. The movement toward others can reverse narcissism and is fiercely resisted with a desperation stronger than any other obstacle in treatment. Bion (1965) has pointed out the

patient's resistance to self-discovery or what he calls "being what one is." He believes that it is important to help narcissistic patients discover their hatred of analysis because analytic work leads to awareness of emotions that counters the patient's megalomania.

Countertransference reactions

Bion states that "In group treatment many interpretations, and amongst them the most important, have to be made on the strength of the analyst's own emotional reactions" (1959 a, p.149). The analyst functions, in effect, as the recipient of the projective identification described by Klein (1946). This process provokes emotional reactions in the analyst. Bion was one of those who in the 1950's encouraged the use of countertransference as the starting point for interpretations. They conceived of the countertransference as a research tool, since the analyst's emotional response could be a means of access to the patient's consciousness. Bion was the first to demonstrate, in 1952, that projective identification was as valuable a concept for the group analyst's countertransference. Much later the idea was taken up by both Racker and Grinberg in Argentina.

There are two basic groups of countertransference responses to narcissistic patients: some form of anger or hostility and some form of boredom. Anger is the most typical countertransference response to the narcissistic patient's arrogance and omnipotence while boredom is the general countertransference response to the patient's emotional withdrawal. The narcissistic patient's feigned self-sufficiency and arrogance awaken strong countertransference reactions in the analyst and group members. One patient projects his small, incompetent, ineffectual infant into the other while the first one becomes all-knowing and superior. In the group situation the other members receive the patients' projections and, by counterprojective identification, may come to feel temporarily incompetent and ineffectual. This "becoming" the infantile part of another by projection leads to angry attempts to free themselves of the

projections and restore the *status quo*. The analyst may want to assert his or her authority while group members may try to restore equality with the arrogant member by angry confrontation. In this arrogant state of mind, the narcissistic patient typically refuses to receive help either from the analyst or from group members. A typical “yes but” response is the rebuff to other members’ attempts to help.

Perhaps the worst case scenario of this kind occurs when the narcissist announces that he or she is leaving the group either because the group is not helpful or because he or she no longer needs the group. Attempts to challenge the member’s omnipotence often elicit an angry response and a threat of leaving the group. A frequent response to go along with what the patient is saying reveals a fear of the patient’s rage at having the analyst or the group members disagree with him or her and challenge his or her omnipotence. On the other hand, the analyst’s hurt at the patient’s criticism may reveal the analyst’s own narcissism, especially when the criticism is genuine and not an expression of destructive narcissism. A *tit for tat* response from the analyst can lead to punishing interpretations. The question analyst and members have to face is how to overcome the natural *tit for tat* response to a narcissistic patient and help him or her take back the sane projected infantile part.

The narcissistic patient withdraws from a relationship in various characteristic ways, which create slightly different countertransference reactions. The narcissistic patient consciously wants to find out about himself or herself but unconsciously wants to avoid knowledge. This avoidance of knowledge may be manifest when the patient seems to carry out his or her own analysis; the analyst who has become superfluous becomes bored. The deadening effect is also experienced in the group, which becomes stale and lifeless as members become bored and distracted. The analyst can experience a loss of a sense of identity when the patient projects his or her own non-existent self. Similarly when the patient dissociates as a way to avoid a relationship with and others and does not want others as sources of information, an unconscious retaliatory

response is elicited in the group members who begin to withdraw their attention from the patient and attempt to move on to someone else.

A related attitude is revealed by the patient's talking aimlessly and "drifting." This behavior seems to express hostility toward twoness, toward the idea that there is more than one person in the room. In these cases the patient's speech seems designed to frustrate contact. The analyst's inattention, another unconscious retaliatory response, becomes a collusion with the patient's denial of twoness. Sometimes the analyst experiences a deep void in response to the patient's mindlessness and withdrawal. Group members withdraw and become irritable while the analyst may find himself or herself renewing efforts to rescue the patient from the narcissistic cocoon through interpretations. Another response to the patient's drifting is the analyst's drowsiness, which seems to be a response to the patient using empty words in an effort not to communicate (Alexander, 1981). The problem is to change the analyst's clouded consciousness into curiosity about what is going on in the patient's mind and in his own.

The analyst often has to carry the *élan vital* for the passive narcissistic patient who seems dominated by the death instinct. At times there is a tug of war between analyst and patient when the analyst tries to pull the patient out of this cocoon. In other situations the analyst feels shut out when he or she is not treated as someone else in the room. The analyst's own narcissism leads to angry feelings toward the patient and the wish to use interpretations as retaliation. Anger and defeat are also countertransference responses when the patient does not acknowledge or appreciate the analyst's containing function. In the group therapy situation we maintain the idea that the person can take chances to alter the quick fix of the pseudo-adulthood of the narcissistic option. At one point or another many of the narcissistic ploys are revealed and interpreted, along with the underlying anxiety about depending and needing the other members and the analyst.

In my work with groups I make interpretations to the group as a whole as well as to its individual members (Safán-Gerard, 1991). Along with Bion (1959 a), I consider the group's psychotic anxieties as clustering around three basic assumptions: dependency, fight-flight, and pairing. When the members are caught up in one of these basic anxieties, they collectively oppose understanding and development. The group does not recover its intellectual curiosity and its capacity to learn from experience until they become what Bion calls a "work group". My attention therefore is focused on the group when a basic assumption mentality is present and on the individual members when the group has properly become a work group (Safán-Gerard, 1996). As Bion (1959 a) states, "The more disturbed the group, the more easily discernible are these primitive fantasies and mechanisms: the more stable the group, the more it corresponds with Freud's description of the group as a repetition of family group patterns and neurotic mechanisms" (p.165). Even a stable group can be pervaded by basic assumption phenomena, and at these times my attention will shift to the group as a whole. I therefore keep in mind at all times both the individual and group perspectives. I will not be dealing here with my countertransference to the group as a whole but with countertransference to the individual members and the reactions of members of the group to that member. I am assuming that the member in question is the spokesperson for the group's anxieties and defenses.

Clinical illustration

After seven years of existence this group of six patients can be considered "stable," although basic assumption mentality is by no means absent. As Symington (1995) reminds us, we are all narcissistic to a greater or lesser degree and rely on various defenses when we have to depend on an object. None of the six members of the group I am going to discuss is pathologically narcissistic, but each responds at times with various narcissistic defenses which I hope to illustrate. Although the membership of this group has changed over the years, it has been in existence for seven years with three of the original

members still in the group.

I am going to focus the clinical material on two members, David and Jill, even though their narcissistic features are no more salient than that of the other four members. I have chosen them because they tend to elicit strong countertransference reactions in me. David illustrates very well one of the features of narcissism, the hatred of self exploration. When properly confronted, however, he is able to resume the work and recover his capacity for insight. Jill also illustrates well the reluctance of narcissists to find out about themselves. David tends to withdraw and project his infantile self onto other members, whereas Jill uses denial, projection and often manipulates other members into carrying out the work for her or into expressing disowned aspects of her personality. My main countertransference response to Jill is irritation and annoyance at her manipulative behavior. In fact, my irritation and annoyance are clues that what she is doing represents a threat to my own narcissism insofar as she is not relating to me with consideration but as an object to be used, fooled and controlled. Trying to avoid acting out my irritation I tend to become silent, but if I remain silent I would be colluding with her manipulative behavior. Remembering the moments when she has broken down in tears while talking about her feelings of abandonment and loss helps me overcome my irritation and retain my capacity to think and interpret. Other members' countertransference feelings have become evident when they angrily and ruthlessly confront Jill with what she herself has come to call her "act".

David is easily hurt and often complains about having been left out. He usually appears withdrawn and sleepy. When confronted, his communication is not meant to communicate but to obscure. He seems to drift as a defense against contact or need. Other members try to get to his true feelings and get impatient and irritated that he is not coming forth to meet them. Typically, after close examination, his withdrawal can be traced back to a point in the session when he experienced intense envy or jealousy of someone in the group. By his withdrawal, David is defending against an awareness of others and the feelings

they elicit in him. When I lose track of the pain he is defending against and only see the skill with which he evades knowing about himself, I feel the impulse to shake him and confront him. This impulse is a clue that my narcissism is engaged. He is evading the work and in so doing he is no longer relating to me. I overcome my impulse to harshly confront him by reminding myself of other situations when we have uncovered the pain.

In one session another member, Gina, tried to get David out of the withdrawn state. He skillfully tried to avoid talking about himself, turning the tables on her by asking Gina what was behind her wish to rescue him. Finally David admits that when Gina said to another member, John, "You represent my father and my brother," David claimed to have felt, "And what about *me*? Am I not even the dog in Gina's mind?" He tells the group that at that point he began to make his own connections and decided, "I don't need these guys. I can do it myself." David associates to a situation at work. He had thought that his business partner, toward whom he is quite competitive, was proceeding in the wrong way. But he found himself withholding information, and when the project wasn't working out he had intense inner pleasure in thinking that he had known all along that it wasn't going to work. He lost quite a bit of money by withholding the information, but the need to feel superior to his partner was all that mattered. After this association David became evasive and abstract, and it was hard to follow him. He was taking himself away from contact with the group and with me and my narcissism was triggered once again: he was not acknowledging my presence. In my effort not to act out my annoyance at his evasiveness by retaliating with a somewhat harsh intervention, I interpreted to the group that David was representing the wish of the group not to know. David picked up the criticism implicit in my interpretation and became irritated at me saying, "What *else* is there? I can't access anything else!" Consistent with a frequent identification with me, John encourages him to speak his truth but David is still vague. Somewhat recovered from the threat that his evasiveness poses to my narcissism I am able to bring David back to his "what about *me*" feeling in response to Gina, reminding him that he tends to defend against painful

feelings of exclusion by becoming superior in his own mind, where he doesn't need anybody. David now tells the group how he identifies with his son, who never asks for anything. His daughter gets people to do all kinds of things for her. David says he tries to push his son to ask, but it doesn't work! I interpret that the son may have also learned to cope with feelings of exclusion by retreating and feeling superior. David would like to have the son change, not knowing yet how to effect a change in himself. David remembers an old dream where some lions were coming up and he was placating them by caressing them. But there was no end to the task because so many more lions kept coming up. He didn't want to caress them anymore. I interpret that the group members and I were all lions who contained his aggression and that he felt compelled to quiet us down by placating us as he does in many occasions. If he kept putting his aggressive self into others, these others might appear much more aggressive than they really are. He had found that the only way to deal with this situation was by withdrawing into the cocoon of a withdrawn state where these aggressive lions could do no harm. We were now talking about his destructive self whereas before we were talking about his helpless baby. He didn't want to be in touch with either.

Jill started with the group at its inception, left for two years, and came back three years ago. She complained that this group was not as good as the earlier version where she had managed to make alliances with other members. A few months ago she complained that she felt detached from the group, but it was clear that this was a ploy to get attention. She is a skilled communicator who often becomes a manipulator. In the sessions she talks very slowly and deliberately, and this pace seems unconsciously designed to interfere with the other's capacity to think. Members find themselves drifting in response to her slow delivery and seem unable to confront her. My narcissism is engaged as I feel my competence being challenged. I find myself becoming increasingly irritated and being tempted to retaliate by withdrawing attention from her and turning my attention to other members. She is mildly critical of my interventions in such a way that is very difficult to point out to her that she spoils them out of

envy. She often replies, “Yes, it could be that, but don’t you think that it could also be...?” She attempts to carry out her own analysis, resorting to superficial cliché explanations as long as they differ from mine. Jill had complained of being abandoned by her mother, but a year and a half ago she recalled that when she was three years old her mother was kissing her feet and she kicked her mother in the head. This memory has represented the beginning of her understanding that she played a role in creating her mother’s distance by her envious feelings and in understanding her own aggression toward her mother and toward me in the group.

In one session Jill entered into an early discussion about sibling rivalry by saying that she and her two sisters got off on their competitiveness and could laugh at it. Others reminded her that this was not the case with her oldest sister, with whom there was quite a bit of hidden and not so hidden hostility, of which she has spoken. It was clear that the flippant way Jill used to enter the discussion had nothing to do with a need to communicate something but was a way to claim “her space in the group.” My irritation was a clue that my own narcissism had been threatened. Jill’s ploy was predicated on my being conned and treated as a fool. Once I recognized that my own narcissism was at stake I was able to put aside my irritation and interpreted to her that becoming part of the group seemed to be so essential for her that even an inaccurate statement seemed a legitimate vehicle to enable her to become central in the group. She smiled mischievously, admitting to having been caught and expressed relief. A bit later while John and Gina, two other members, were exploring their difficulties with one another, Jill seemed detached. Then she said she felt that they had taken the stage away from another member, Sylvia. In this way she got Sylvia to speak for her need to hold the attention of the group and to attack John’s and Gina’s relationship. I was able to confront Jill with her new ploy. She admitted she had felt impatient with the conversation between John and Gina and had to tell her impatient “child part” to wait. Elaborating on this she added that she felt there was no space between John and Gina for her to enter. I interpreted that in her mind John and Gina had become the parental couple that

were doing exciting things with each other and excluding her. She was reacting like a child who not only feels entitled to be in the middle of the parent's life with each other but driven to break their relationship. This was in contrast to an acceptance of the parents' relationship with each other and her role as the child. It is interesting to note that David said he felt this interpretation also applied to him.

A session two weeks later

I will now present a more recent session with this group that seems to illustrate narcissism as a defense of the group. Group members take turns splitting off and projecting the infantile part of their personality or their omnipotent, grandiose selves, into other members. John was out of town and did not attend this session. Mara started by telling the group that her boss at work, with whom she had had so many difficulties, quit the job. There is no longer a need for Mara to look for another job. She is smiling and remains silent for most of the session. People in the group comment that Gina took John's seat, the rocking chair, and that leads them to discuss the Kennedy auction and the fact that a rocking chair went for $400,000. They all laugh and talk at the same time, but David is not laughing. He begins to say that the whole situation makes him sick, that we live in a society where values are upside down, all those homeless people.... Jill argues that some of the buyers at the auction may also give quite a bit of money to charity. David counters that those buyers give to charity to get a tax deduction but they don't create new jobs for people. Jill asks him how this affects him personally, and David claims to be feeling strong today but says that two to three years ago he was in a desperate financial situation. He continues to talk about "this society," but now he mixes it with comments about his own sense of deprivation. There is a pause, and Gina says she feels an impulse to laugh. David's comments make her think about beggars. She sometimes gives them money, and at other times she extends her hand as if to ask "What about *me*?" The group members seem struck by Gina's comment and start questioning her. David says he doesn't understand where Gina was coming

from with the laughter. For Sylvia, Gina's comment to David was a hostile one, and listening to this Gina smiles mischievously. Gina is talking fast, displays anger at one moment and smiles the next moment. David says he doesn't understand how Gina can put her hand out to a beggar. He would never do that. Gina replies that David sounds very judgmental toward her and that he is making her angry. David immediately denies he was being judgmental but later admits that there may have been something of that because her laughter at him had hurt him.

I interpret that David seems to experience society as not caring in the same way he feels that Gina doesn't care. He seems to have been projecting this uncaring society into Gina who, with her laugh, is very good for the part. She is now the embodiment of that society with the wrong values. I interpret to Gina that, on her part, she seems to have gotten rid of her rejected child into David and that she is mocking and laughing at that part of herself now in David. She is also very conflicted about beggars because she immediately puts her child into them and feels compelled to give to them. When she extends her hand, however, she is trying to bring the child back into herself and turn the beggar into a mother who should give her something. At this point I remind Gina of a story she told a while back about a rip-off artist who wanted $2,000 from her and how compelling it was to help him once she had put into him the helpless needy infant part of herself.

David says, "Yes. And I don't understand how come you can give $2,000 to a con artist and refuse money to a beggar". Gina again accuses him of being judgmental. He argues that he isn't, and a bickering about this ensues. Jill comes to David's defense and says she didn't experienced him as judging Gina. I interpret that David continues to put the uncaring society with the wrong values into Gina and that Jill seems to be doing something similar. Jill expresses fear that Gina will mock her someday the way she mocked David. She claims to have identified with David's helpless infant and relates it to a long-standing fear of hers of becoming a bag lady, something it is hard for her to

admit to. Sylvia refers again to Gina's hostility and the way she sometimes zaps a response in an unexpected way.

I interpret that the group seems to be putting their omnipotent and arrogant selves who mock the baby part of their personality into Gina who, with her laughter and beggar story, seems to be mocking the helpless infant in them. I tell Gina that she has put into David the helpless infant that she is trying to get away from and mocking it in Daniel. Gina agrees that this may be the case because she has been feeling an impulse to rescue Mara from her silence. I interpret to Gina that Mara's silence made her a good target for Gina's helpless child, and she then feels compelled to go to her rescue. Sometimes she mocks her helpless infant, and at other times she feels compelled to come to its rescue.

David now says that he was thinking that in fact his comment to Gina as to how come she gives $2,000 to a con man and a mocking gesture to a beggar had turned out to be an indictment of her. He had realized that he hates this aspect of himself that can be ruthless to someone inferior but butters up someone superior to him. He thought that was Gina's way too. I interpret that when he asked the question, "How come....etc.,? he was projecting this unsavory part of himself into Gina and judging that part of himself in her.

David tells the group that the reason he was feeling strong today is that instead of being silent and letting his partner at work make a mistake while he was silently judging him and thinking, "I knew it all along," he had confronted his partner and told him what needed to be done to complete the job. The partner listened and did it. David says he immediately felt stronger. Sylvia and Gina remind him what he did only two weeks ago when his arrogant self had won over his needy self. David laughs, remembering the earlier incident with his partner, an incident he had completely forgotten.

In this session group members seem to take turns disowning and projecting the helpless, infantile part of their personality into a suitable target. Gina's laughter

at David's ruminations about this unfair society made her a target for various members' projections. In turn, Gina had also projected her infantile self into various other members, sometimes mocking her infant self in others, sometimes coming to her rescue in them. Gina and David provide the best examples of the use of narcissistic defenses and a pathological grandiose self -- Gina by mocking David or rescuing Mara, both containing her projected infant self, and David by silently enjoying his partner's failure. The partner stands for David's infant self while David retains the grandiose self who "knew it all along." As the various dynamics are interpreted during the session some of these projections of the infant self are taken back with the corresponding strengthening of the members' personalities. This process is best represented by David's more recent account of his different approach to his partner at work.

Conclusion

I hope it has become apparent that if the therapist is not aware of his or her own narcissistic defenses or has a limited understanding of them he or she will be at great peril that his or her countertransference will constitute an impediment in treating such patients, which means most patients. The danger is that the therapist might be unable to sort out what belongs to himself or herself and what is being projected by the patient. The risk is the same in the therapy group where members project into the therapist as much as into other members. If the therapist is unable to recognize and interpret what is being projected and its effect on the target member, the therapist might enter an unnecessary confrontation with group members, leading to an impasse in the treatment. In an effort to avoid confrontation, the therapist might opt to go along with the members' actions, in which case their development is arrested. I have attempted to show how the patient's narcissistic defenses activate the therapist's own unresolved narcissistic defenses. In their attempts to transcend these defenses therapists may benefit personally in the interchange with group members by potentially overcoming those defenses. This is in line with Bion's (1959) contention that group therapists grow and develop as a result of the

interchange with the group (p. 119). If we are to be able to help group members get closer to what they are, as Bion put it, it is imperative that we as therapists do the same.

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