Case report

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Countertransference in a Patient with Narcissistic Personality and Secondary Gain

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Keywords

Countertransference; shame; narcissism; acting out; malingering

Abstract

Aim: This paper discusses countertransference in the context of its broader definition. It is about the overall reactions of psychotherapists when working with patients with narcissistic personality structures who expects secondary gain. **Case report:** The emergence of the negative side of the countertransference reaction and the feeling of discomfort in the psychotherapist was observed during the treatment of a narcissistic patient who expected to be on sick leave primarily because of the illness for which she was being treated. Through clinical work and supervision, the authors have learned to observe every manifestation in the patient as a symptom. This meant accepting the patient's expectation of secondary gain as one of the forms of acting out. The authors own countertransference helped them to better understand the patient's personality. **Conclusion:** A negative countertransference reaction, aggression towards the patient and discomfort in treating such patients is an expected reaction in younger and less experienced psychotherapist's. The occurrence of the described countertransference also indicates that these are more regressive personalities, using primitive defence mechanisms and with more severe ego damage, whose treatment can benefit significantly from the carefully guided supervision of an experienced and empathic supervisor, especially in novice psychotherapist's or those who have not yet resolved their own narcissistic longings.

Introduction

"If you want to overcome the whole world, overcome yourself"
Fyodor Dostoevsky

Countertransference refers to the entirety of the psychoanalyst's unconscious reactions to the patient's personality, particularly regarding their transference [1]. In 1910, Freud introduced the concept of countertransference and defined it as "the result of the patient's influence on the unconscious feelings of the therapist". Many authors, following Freud, have explored the phenomenon of countertransference [2]. While some define countertransference as everything that the therapist experiences during the analysis, others, like Daniel Lagache, consider it to be solely the analyst's response to the patient's transference [3]. Countertransference is an obstacle to analysis and thus should be minimized. However, it can still be useful in analysing the patient's unconscious expressions. Countertransference reactions include feelings of love, anger, and indifference expe-

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rienced by psychotherapist towards their patients [4]. Shame is a risk factor for psychopathology that transcends specific disorders, representing a concept that is important for effective psychotherapeutic treatment [5].

Personality structure impairments that are closely linked to the formation of object relationships and early attachment styles are believed to stem from early childhood [6].

Pathological narcissism is defined as involving significant regulatory deficits and maladaptive strategies for coping with disappointments and threats to a positive self-image [7]. They tend to evoke strong reactions in the therapist, challenging the therapeutic alliance, and countertransference reactions that become negative (anger, rage, and somatisation) [8]. Narcissistic vulnerability refers to a fragile self-image and is reflected in experiences of anger, envy, shame and avoidance of interpersonal relationships. It appears to be more strongly related to interpersonal forgiveness than narcissistic grandiosity [9].

Secondary gain is often used as a term and it's defined as an unconscious advantage achieved from a physical or mental illness that allows the patient to avoid a particularly noxious activities. These symptoms may contribute to the syndrome of social breakdown [10]. Patients who exhibit secondary gain can elicit negative countertransference reactions in their psychotherapist. It is important for the psychotherapist to recognise these reactions and address them through supervision. Negative feelings may arise as an unconscious response to the patient's transference, and may be based on a difference in values or beliefs. It is important to acknowledge that therapists are not immune to the effect of countertransference [11].

Case report

The 45 year old primary school teacher presented with anxio-depressive dissorder and a range of somatic symptoms and vegetative signs employed as a primary mechanism of defence. She is married and has a 14 year old daughter. The patient grew up with divorced parents and endured traumatic memories of their tumultuous relationship, heated arguments and a prolonged and painful divorce. The patient began experiencing symptoms eight years ago, coinciding with her husband's departure for an extended period of work overseas. These symptoms resurfaced each time he subsequently left. The patient presents with a narcissistic personality structure. Although she attempted to work on several occasions, she found it overwhelming and eventually ceased working. Instead, she took long-term sick leave due to depression. Despite her young age, it is obviously that she has desire to retire due to illness and disability. She received both individual and group psychotherapy. Regarding pharmacotherapy she is currently taking clonazepam 0.5mg 4 times a day and vortioxetine 15mg once a day.

During group therapy, she initially took on a more passive role as an observer. However, with encouragement from the group and the psychotherapist's guidance, she gradually became more actively engaged in the group's work. In a group environment, her narcissism manifests as she critiques and demeans members. She considers them as inferior and inadequate. The group initially endures her conduct, but as her behaviour worsens, other members grow increasingly impatient and commence confronting her bluntly about her actions and flaws within the group setting. It is noted to her that her job at school is not to her liking, and this may be the reason for her health issues and desire for sick leave. The patient responds to these confrontations in an unsuitable manner, reacting aggressively. The psychotherapist metabolizes her aggression and remains calm. In the following session, she accuses the therapist of favouring others, rudely telling other group members to be quiet. The patient was absent from the following two sessions with no explanation provided to the group or psychotherapist, which provokes the sense of guilt. In next sessions the patient exhibited passive-aggressive behaviour, remained silent during group discussions, appeared offended, and did not engage with other group members despite their efforts to involve her in the group activities.

During individual therapy, the patient disclosed distressing childhood trauma, the painful divorce of her parents and her feelings of shame due to her parents divorce. This disclosure triggered boredom and a desire to avoid sessions in the psychotherapist. After consulting with an experienced supervisor, the psychotherapist recognised his negative countertransference towards the patient and processed it. In subsequent therapy sessions, the psychotherapist urged the patient to dig deeper into her childhood recollections. It became evident that she distinctly recollected her mother's tears upon her father's remarriage, as well as the sense of shame and dejection her mother felt upon her father's remarriage and the birth of another daughter from his second marriage. She always provided unconditional support to her mother, but as her mother began seeing another partner after two years, the patient felt neglected. Furthermore, she felt completely isolated and unsupported when her mother gave birth to her younger brother. After addressing the distressing emotional states that arose from childhood trauma, the patient no longer experienced painful emotions during individual therapy sessions. Several months later, the patient returned to work. Individual sessions are reduced to check-ins every 3 months. Additionally, she no longer experiences any health issues and works at school without encountering significant difficulties what provokes positive countertransference in psychotherapist and his secundary gain.

Discussion

"Our life is what our thoughts make it"
Marcus Aurelius

To effectively manage countertransference, recognition is the key [12]. The case presented highlights the

crucial role of having an empathetic and high-quality supervisor for young psychotherapists [13]. Countertransference can manifest as psychotherapist anger or boredom towards such patients. Patients with secondary gain were often labelled as lazy individuals evading their obligations [14]. The most notable countertransference pitfall is the psychotherapist's indifference, which intertwines with the imperative of their neutrality. The psychotherapist's sense of guilt and excessive interpretations could signify unresolved narcissistic issues in the psychotherapist [15].

Acting out comprises various forms of problematic conduct within psychoanalytic psychotherapy and analytical work, usually stemming from early childhood trauma and the transmission of trauma [16,17]. Acting out involves a regressive attempt to convert thoughts into action. It is possible to intervene with acting-out personalities provided that the psychotherapist has a considerable tolerance threshold [18]. In these patients, escape is demonstrated through their presentation rather than verbalization of conflicts. Avoiding therapy and acting out can damage unresolved narcissistic structures [19]. In psychotherapeutic practise with patients displaying narcissistic personality any desire for secondary gain must be viewed as a symptom of their distress [20]. Such symptoms, seen as forms of resistance and acting out, require understanding and should be used in therapy [21].

Individuals with narcissistic tendencies may exhibit a fragile and inadequate capacity for regulating their own self-esteem. Pathological narcissism may also increase in response to positive life events. However, when the idealization is not fulfilled, it may turn to complete devaluation, leading to tendencies towards depression and shame due to unattainable fantasies of grandiosity not being translated into realistic goals and ideals [22-24].

The psychotherapist, cognizant of the potential adverse effects of the therapy and the patient's propensity to withdraw and exhibit rigid resistance, acknowledges the necessity of prolonged treatment management. They confront the patient with past traumatic and distressing experiences from childhood that resulted in the creation of a powerful sense of shame and a narcissistic personality structure [25]. The psychotherapist acknowledges the patient's basic transference and subsequent displacement of aggression towards her parents [26]. A psychotherapist who understands the patient's narcissistic personality structure is prepared to accept their "aggression" and is optimistic that a supportive approach and timely, gentle confrontations will aid the patient's progress [27].

Overall, working with patients who exhibit narcissistic personality structures and secondary gain can be challenging, even for experienced psychotherapists. While patients of this nature may engage in acts of secondary gain, these behaviours represent only one of many complex and difficult issues that can arise during therapy.

Psychotherapists may perceive instances of secondary gain as aggressions directed at their own therapeutic approach. They have the responsibility of acknowledging their negative countertransference towards such patients and utilizing it for diagnostic purposes, especially regarding narcissistic structures. Additionally, during therapy, the psychotherapist must endure aggressive transference and countertransference and correct it over a prolonged period to improve the patient's relationship with the object.

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Conflict of Interest

None to declare.

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