Narcissism in SCI Caregivers: Meyer Gunther Revisited

Meyer Gunther, "Catastrophic Illness and the Caregivers: Real Burdens and Solutions with Respect to the Role of the Behavioral Sciences."

In Bruce Caplan (Ed.), ***Rehabilitation Psychology Desk Reference***. Rockville, MD: Aspen Publications, 1987, 219-243.

Why this presentation?

- To provoke you (this paper discusses some professional unpleasantries in delivering SCI care)
- To discuss the phenomenon of narcissistically based, psychological defenses occurring in rehab
- To stimulate some discussion on whether Gunther's observations are still relevant
- To see how much agreement or disagreement is stirred among you (and over what)
- If some agreement, to wonder/consider what kinds of curricular elements should be included in rehabilitation training programs regarding the ontological experience of catastrophe.

Gunther's observations on staff complaints about patients

- "Patients complain too much."
- "Patients don't have the right attitude about their disability."
- "It really appears that all they want is our attention."
- "At times, they seem to be engaged in a secret war to sabotage their recovery."
- "They delight in defying rules and proving we can't enforce them."

Complaints about other services

- “The administration doesn’t support us.”
- “We don’t have any trouble with patients; only other services do.”
- “Ours is the crucial work in the entire setting.”
- “They don’t understand these patients like we do.”
- “By catering to their (the patients’) childishness and attention-getting tactics, they make it much more difficult for us to do our work properly.”

Patient complaints about staff

- "They're (staff) not interested in us as people; they're interested in our overt performance. That makes them look good."
- "Staff members never seem satisfied with what we do, even when we try our best."
- "Staff members avoid us when we're hurting … and especially when we can't tolerate ourselves. It is as if the worse we feel, the less they want to have to do with us."
- "Staff members play favorites."
- "Why do staff members act like parole officers?"

"The price a dedicated and effective rehabilitation staff pays for significant therapeutic involvement with seriously damaged patients is periodic subjective distress and impaired professional behavior." (219)

Serious SCI (or catastrophic disability in general) …

- Is a "monumentally evocative experience for all participants":
  - Massive psychic trauma
  - Powerful unleashing of our unconscious "stuff" affecting our intentions, dispositions, problem solving, emotional experience
  - Meaning assignation

The psychological fact of the matter is …

- The onset of a serious disability is horrible, catastrophic, and overwhelming;
- "During its initial life-threatening, life-disrupting phase, catastrophic illness makes maximal physical, psychological, and social demands on all who are immediately involved." (219)

Gunther wonders …

- “May there be a universal human tendency on the part of victims, victimizers, and observers alike to disavow awareness of such horrifying traumatic experiences that are of a proportion simply too massive to be encompassed, let alone neatly categorized into existing pigeonholes of experience and understanding?” (226)

What are the emotional/psychological burdens rehabilitationists face?

- Uncertainty and anxiety over outcome;
- Exposure/performance anxiety: "That anyone can see, evaluate, and judge (however foolishly) the result of one's work throughout the rehabilitation process places specialists under unusual self-esteem pressure measured in terms of patient achievement. The result may be a host of anxieties regarding one's professional worth, because one's work is so perpetually on exhibit." (229)

“Anxiety must be avoided at all costs.”

- Feelings of anxiety are inherently unpleasant;
- Intense feelings of anxiety may compromise my performance;
- If the patient picks up on my anxiety, he or she may think I am incompetent—and that would be utterly intolerable. I must communicate competency and excellence.
- Yet, the delivery of health care is an anxiety filled profession.

The Big One: Patient Transferences

- "Patients' loss of major motor control—limbs, tongue, sphincters, even breathing—produces intolerable feelings of helplessness and hopelessness and necessarily generates intense abandonment anxieties … Can you ever value me again? … Seen through the patient's eyes, the staff member exists only for the sake of the patient, to be utilized at the beck and call of the patient. This experience of being treated by patients as if one had no independent existence constitutes a particularly exhausting emotional burden for staff members." (230)

A Bigger One: Countertransference

- How do staff feel about "The patient who consistently frustrates their best therapeutic efforts"? Distress, helplessness, weakness, hopelessness, inner disorganization and confusion …
- "Staff helplessness, frustration, rage, and hatred of the patient sometimes leads, not merely to a therapeutic stalemate, but to the team's self-protectively coalescing in order to exclude the patient, pressuring the physician to discharge that patient as "hopeless and unmotivated, a poor rehabilitation candidate." (231)
- "By provoking or inducing staff to feel about them what they feel about their own injured bodies, these patients partially succeed in getting rid of their own terrible feelings." (231)

Here's where narcissistically based defenses kick in …

- "Both patients and caregivers find it too painful to permit themselves full consciousness of what they are feeling toward one another" because the real feelings may be too intense;
- Coping/defenses may be poor: Avoid troublesome patients and thinking too much; blame others; avoid empathizing; use moral exhortation; guilt-evoking threats
- Goal: "The reduction of emotional discomfort that is a common feature of rehabilitation work."

Levels of narcissistically based responses to threats to the self

- 1st level: evasion, distraction, ignoring, refocusing, or distorting/reinterpreting the event, such that the professional's anxiety is alleviated through distortion;
- 2nd level: lecturing, sermonizing, arguing, threatening, blaming, such that the professional's escalating anger and frustration are alleviated through bullying;
- 3rd level: hatred, hurting, or harming such that the professional's rage is alleviated through causing discomfort or pain.

Why call this “narcissism”?

- These behaviors are essentially self-protective and self-preservative; they derive from the professional’s “self” feeling inadequate and wounded and thus assault the professional’s fantasies of being competent, in control, respected, adored, and perfect
- Categorically unempathic and therapeutically unproductive
- Emphasize the professional’s goals, aspirations, fantasies, needs and wants

The Professional Self

The Professional Self Is Assaulted by the Difficult Conversation!

All narcissists share in the creation of an "idealized" self. Lower level narcissists strive to merge with that self. Prototypical narcissists believe they <u>are</u> that self. Either way, evidence that contradicts the idea that the narcissist is not that perfect or ideal self triggers the narcissist's anxiety or rage.

"What is the resolution of these conflicts?"

#1: Better theory to help rehab professionals understand what is going on

- Understand the dynamics of the unconscious (transference and countertransference)
- Understand the nature of massive psychic trauma
- Understand the human need to make sense out of what is going on
- Understand the nature of empathic conversation

Empathy

- To imagine/gain an insight into what it is like to feel and understand the world as the "other" does
- To confirm and support the patient's psychic reality or feeling self
- To accept/absorb the misery of the patient's illness and disability without that experience disrupting the professional's equanimity
- To learn the techniques of empathic listening, tolerating silence, acknowledging the patient's suffering and feelings of fury and outrage

Empathic Language

- “This must be .... (dreadful, awful, depressing, frightening) .... for you to hear.”
- “This is obviously making you feel very .....”
- “I hear you.”
- “Tell me more about that.”
- “And how did you experience (or feel about) that? What was that like?

More……

- “So, this must have caused/must be causing you a lot of …. (heartache, sadness).”
- “I wonder what you’re feeling right now.”
- “What is it about that that … (worries, upsets) …. you?”
- “What is it about talking about that … (you don’t like? Makes you anxious? Makes you want to talk about something else?”)
- “What would you like to have happen from this?”

More…

- “Anything else?”
- “Now let me make sure I’m understanding you. You’re asking me … (whether or not, how it is that) ….. Is that correct?
- “So, what you’re saying is that … “
- Repeat the other’s last three or four words.

#2: Know Thyself!

- Recognize how one's coping mechanisms may be self-protective at the cost of the therapeutic relationship;
- Recognize the sources of the professional's anger, hate, disappointment, humiliation, guilt or anxiety as stemming from one's inability to square the patient's care with one's ideal self-image.

#3: Better Defenses

- Bad defenses: arguing, blaming the patient, blaming others, refusing to be engaged with others, rationalizing.
- Good defenses begin by realizing: “Some emotional distress for staff members is ubiquitous and recurring—an inevitable outcome of significant involvement with patients. Such distress is not a sign of individual neurosis, but rather a function of universal vulnerabilities stimulated in able-bodied human beings who must assume therapeutic responsibility for persons with severe disability.” (235)

“Above all …

- One must accept patients’ anger and disappointment that staff members cannot restore them to their premorbid condition. One simply must learn to live with patients’ reactions to the team’s inability to accomplish miracles and the guilt that this may produce; rehabilitation specialists cannot abandon patients who may provoke them by expressing their disappointment in staff.” (236)

Further (Banja's) Thoughts on the "Healer"

- Accept the limitations, inexactitude and unpredictability of the therapeutic effort
- Accept the fact that life/nature is unfair and unjust;
- Accept the fact that at best, only a piece of any patient's "reality" is known at any one time
- Recognize that much of what determines the patient's outcome is beyond their control
- Accept the fact that suffering is inevitable and that life is tragically short for everyone
- Is energized by the fact that he or she might be helpful to the individual who is suffering a catastrophic experience

The Opportunity Rehab Affords

- The extraordinary opportunity of having a professional life in rehabilitation consists in how it enhances or makes possible the "capacity for individual professional growth and development." (233)
- The two things everyone wants: respect and vitality.

Little in life is accomplished without narcissism.

Thank you.