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Theory of Egotistical Capability in Psychotherapy: Impact of Therapists' Narcissistic Traits, Tendencies, and Egotism Manifestations Toward Patients

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Abstract

This study aimed to explore three distinct aspects of ego satisfaction within psychotherapy: a) The patient's ability to comprehend the therapist's communication and the condition of the patient's mental state concerning their ego stability, b) The self-esteem and confidence accumulated by the therapist through personal life experiences, and c) The therapist's capacity to either temporarily soothe agitated patients unable to listen and implement advice effectively or provide objective advice and treat patients effectively and impartially, even when the patient's issue involves their own ego, egotism, or narcissism. This article delves into potential scenarios in psychotherapy, analyzing them for instances of professional misconduct while also examining the ethical dilemmas they present. Although the entire psychotherapeutic process is centered on the patient's well-being, the effectiveness of psychological treatment methods – such as cognitive-behavioral therapy and psychodynamics – can significantly diminish without a stable and adequate sense of ego satisfaction. This study underscores the importance for therapists to find means of mitigating their ego, egotism, and narcissism for the sake of ensuring the patient's safety and fostering their confidence.

Keywords: psychotherapy; narcissism; clinical psychology; ethics; philosophy.

Introduction

Among many situations that challenge therapists in meeting their patients' needs, two will be comprehensively discussed, highlighting each participant's insufficient ego satisfaction:

1. When the patient has had a frustrating day before their therapy session.
2. When the therapist has undergone numerous harsh life experiences.

Consequently, the patient may struggle to listen to the therapist during the session due to the former situation. Regarding the latter, the therapist might find it challenging to temporarily calm the patient, especially when they share the same issue

as the patient. This similarity can trigger the therapist's ego, compromising their ability to temporarily pacify the patient or provide objective advice when the patient cannot listen effectively.

It is crucial to differentiate between scenarios 1 and 2 and their potential consequences. We must distinguish between the therapist's basic survival needs and their requirement for a sense of ego satisfaction that aligns with their life circumstances. This distinction is essential for therapists to ensure they can provide a conducive environment for successful psychotherapeutic intervention.

Mordecai (1991) asserted that empathic failures are common in human relationships and, in certain situations, could potentially benefit the patient. However, there are two significant exceptions to this. Firstly, the potential to assist the patient does not justify the occurrence of empathic failures. It is not acceptable to justify a negative action by suggesting that something positive might result from it. Additionally, the therapist's pure intention, focused entirely on aiding the patient at that moment, is ethically crucial.

Secondly, it is uncertain whether empathic failures will actually benefit the patient because the resulting advantage is not guaranteed. Moreover, the same issue could reignite the therapist's hostility if it triggers their ego simultaneously. The therapist can discuss it with the patient only if their ego remains unaffected. Furthermore, the therapist expressing their stimulated egotism towards the patient is unethical and can undermine the therapeutic alliance (Talbot, C. et al., 2019).

Hence, countertransference, despite extensive discussions over the years (McAuley, 1989; Clarkson, 1991; Ens, 1998; Hughes & Kerr, 2000; Hayes et al., 2018; Gabbard, 2020; Tishby, 2021; Aasan et al., 2022; Prasko et al., 2022), is an ethical transgression committed by the therapist, as it can harm the patient, as will be elucidated through examples. Therefore, in psychotherapy, it is an illegitimate action, even when its cause (transference) originates from the patient.

However, due to therapists' reluctance to publicly critique themselves, empirical literature lacks sufficient information or discussion regarding the ethical and practical consequences of their manifestations of ego, egotism, and narcissism towards the patient, even in explorations of the concept of the wounded healer (Jung, 1951). This paper aims to address this gap, rooted in several fundamental ethical principles, with the primary emphasis on the therapist's duty to always provide the patient with a secure environment.

Given this, I propose a revision to the English proverb, "Give someone a fish and feed them for a day; teach someone to fish and feed them for a lifetime": before individuals can provide for themselves, they must nourish and strengthen themselves. Only when they are sufficiently robust and capable of learning should we teach them to fish, ensuring their sustenance for a lifetime.

Therefore, I argue that when therapists endeavor to treat patients, it is paramount that these patients can effectively listen and apply therapy, irrespective of any underlying difficulties causing hindrance, although no prior studies have been conducted to substantiate this assumption.

Methods

Ego Satisfaction State as a Cup-like Function

The ego satisfaction state is illustrated as the following equation, a novel formula devised by the author:

$$f(V, C, M) = \frac{(C * M)}{V}.$$

Here, V represents the volume of the cup, signifying its capacity to contain the necessary ego satisfaction for a person to achieve a tranquil mind. C denotes the content within the cup, indicating how content this individual is in terms of ego in practicality, while M represents the material composing the cup, depicting the strength of this individual's character in containing quantities of ego satisfaction (see Figure 1).

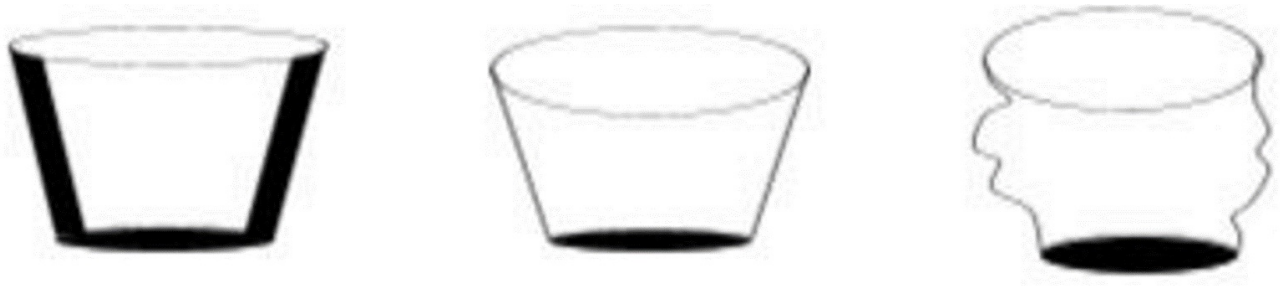

Fig. 1. An exemplification of the difference between the three types of ego satisfaction states.

For instance, consider a hypothetical scenario: if an individual theoretically possesses a volume of 10 units of ego satisfaction and their cup contains 8 units, with the cup crafted from sturdy material, say at a strength level of 0.9 out of 1, their overall ego satisfaction state would equate to 0.72 out of 1. Conversely, if the individual's ego satisfaction volume is 10 units but the content within their cup measures only 2.5 units, even with a cup material strength rating of 1, their ego satisfaction state would merely be 0.25 out of 1.

Consequently, this would inadequately satisfy their ego (these values are theoretical and not empirically obtained). In light of this, therapists are unlikely to have a sufficient ego satisfaction state, making it improbable for them to temporarily calm a patient unable to listen or provide objective advice concerning matters involving their own ego, egotism, or narcissism.

Kohut (2009) asserts that in the process of self-formation, an infant fundamentally requires three types of self-other relationships: mirroring, idealizing, and twinship. Failure to fulfill these needs leads to ongoing self-worth doubts, driving individuals to address their own deficiencies, consequently impeding their ability to recognize the needs of others.

Furthermore, Neff (2015) contends that while statistically, the probability of achieving excellence is low, Western culture stresses individual centrality, fostering unrealistic expectations for personal excellence. It is more pragmatic, as Burns (1999) suggests, to embrace being "average" rather than perpetually striving for an unattainable sense of worth.

However, in an exceedingly competitive society, this situation can lead to mental instability. When individuals feel their egotism is threatened, some may become a danger to others (Bushman & Baumeister, 1998). The pursuit to fulfill their

egos might result in actions that come at the expense of others. An unsatisfied ego, when triggered, attempts to find satisfaction through its own reservoir of ego satisfaction.

As a one-dimensional entity cannot autonomously replenish itself, especially when being depleted concurrently, if this reservoir were indeed exhausted, it would inherently diminish, leading to futile attempts to refill it. Conversely, if the ego satisfaction in their cup is at its maximum (at a strength level of 1 out of 1), the reason why it doesn't decrease is not because it can replenish itself, but rather because it doesn't necessitate replenishment, unlike the former state where it cannot self-replenish and diminishes due to attempts at self-restoration.

In practical terms, another reason for the diminishing of this reservoir is ego itself, akin to a state of vulnerability. Just as a person feels shame and the urge to conceal their nudity when exposed, an individual exhibiting egotistical behavior in public may feel ashamed of their actions and wish to conceal them swiftly. Similarly, a person experiencing financial hardship might feel shame when resorting to panhandling, despite their dire need for money.

Regarding ego, when an individual publicly displays egotistical behavior, they might feel ashamed of their actions. Consequently, if a patient demonstrates egotistical behavior in the presence of a therapist – such as asserting, "I'm not like that" (a common yet ineffective defense of ego) or emphasizing their prior knowledge when responding with, "Yes, I already knew that!" – the therapist's ethical responsibility should not be to reply dismissively with phrases like "Okay" or "Well, if you say so," irrespective of whether such remarks from the patient provoke ego or antagonism in the therapist.

This situation would likely make the patient feel exposed, akin to someone catching sight of their concealed egotistical behavior, leading to feelings of shame, drawing parallels to the analogy of being exposed naked. Similarly, when an individual lacks ego satisfaction, they might feel ashamed of this state of deficiency.

Regarding the appropriate response, which lies with therapists rather than patients, in a scenario where the patient's ego satisfaction state is inadequate to heed the therapist, three crucial objectives must be accomplished after listening to the patient and allowing them to express themselves freely: (1) making the patient feel acknowledged, covering their embarrassment by indicating awareness of their prior knowledge; (2) accomplishing this without acknowledging their assertion of prior knowledge; and (3) ensuring that the patient feels their egotistical behavior went unnoticed. An example of an appropriate response in such a situation could be: "Now, let me provide you with even more information."

The therapist's responsibility is to prioritize the patient's well-being, refraining from shaming them, and ensuring that the patient's ego satisfaction state and mental state enable receptiveness. Nonetheless, the therapist should also take note if the patient frequently responds with statements like "I know/Yes, I know!" as this behavior could potentially lead to dislike, antagonism, and avoidance in real-world interactions. Ensuring the stability and sufficiency of their own ego satisfaction state beforehand and avoiding insulting the patient is equally important.

Similarly, if a patient expresses fear to their therapist about feeling undervalued because someone else's accomplishments overshadowed theirs, the therapist should avoid responding with phrases like, "Why do you always seek attention and brag? You need to work on your ego. Being a bit more humble wouldn't hurt you (Watson, J. C., 2016)." Such a response could not only insult the patient but also further diminish their self-esteem by socially deeming their

manifestation of egotism as inferior.

Furthermore, if the therapist aims for the patient to display more modesty, they should create an appropriate environment (ensuring the patient can listen and apply advice effectively) not just to temporarily calm the patient but also for their own efficacy. A suitable response could be, “Your achievements are noteworthy enough to be showcased.” A tranquilized patient will foster a more conducive environment, enabling better adherence to the therapist’s guidance.

Consider a scenario during a therapy session where a patient eagerly shares a brief text they’ve read with their therapist, and the therapist responds by expressing inadequacy in comprehending the content’s sophistication, claiming an inability to grasp its complexity. In response, the patient tries to reassure the therapist of their intelligence, and the therapist then responds with “Well, now you’re calming me down!” (being aware that they are the one supposed to calm the patient down, which destabilizes the therapist's own well-being, ultimately leaving the patient vulnerable).

However, if the therapist’s intentions are genuine and aimed at therapeutic benefit, an appropriate response would be to express gratitude for the patient’s contribution instead of implicitly blaming them for attempting to assist. In this case, the therapist's stimulated egotism interferes with their duty to create a space that is safe for their patient their own well-being, ultimately leaving the patient insulted and unsafe.

Consequently, this situation might prompt the patient to redirect the therapist’s attention to the session, coercing the patient to attempt to calm the therapist for the patient's initial endeavor to pacify them. Irrespective of whether the therapist attempts to use humor when addressing the patient’s actions, the therapist’s comments regarding the patient’s response are inappropriate and unethical. Patients should feel secure and at ease expressing any concerns to their therapist, be it a problem or something that inadvertently triggers egotism towards the therapist.

In this unfortunate circumstance, if the patient manages to calm down the therapist without compromising their self-esteem or confidence, they would continue assisting the patient. However, if the patient’s attempt to calm the therapist triggers the therapist’s egotism or narcissism, their willingness to assist the patient would significantly diminish. They might temporarily compose themselves due to formal ethical obligations, with the potential response of stating, “Well, now you are calming me down!”

Another instance of narcissistic behavior towards the patient occurs when the patient suggests a foot race competition between themselves and the therapist, and the therapist retorts with, ‘You stand no chance against me,’ accompanied by a hostile facial expression. Here, the therapist fails to assess the patient’s need for temporary reassurance in their competitive nature, leaving them feeling insulted and vulnerable.

The therapist should recognize such situations, adjust to the patient’s mental state, offer the necessary comfort, or alternatively, clarify the inappropriate nature of engaging in a race due to treatment boundaries (Eubanks, C. F. et al., 2018). Additionally, if the patient’s egotism or narcissism remains unsettled, they might attempt to discuss it with their therapist. If the therapist responds by saying, ‘I wish you could beat me in a race,’ or ‘Sure, do you want me to say you’d win?’ – it fails to address the issue effectively. Even if the patient exhibited passive egotism towards the therapist through

competitiveness (rather than active aggression or intentional insults), engaging in discussions about who might win or mocking the patient for displaying vulnerability is inappropriate.

The patient deserves to have their agitation alleviated, a distinction crucial to note from reinforcing their egotism, an unequivocally incorrect approach. The objective is to temporarily soothe the patient and stabilize their mental state, facilitating their receptiveness to therapy – an adaptation from the fishing proverb. Ultimately, the aim is for the patient to learn how to sustain themselves rather than receiving endless handouts, which would equate to bolstering the patient's egotism.

However, overlooking narcissistic traits in the patient should not be disregarded. According to Seligson (1992), therapists tend to handle the narcissistic pathology of their patients with considerable leniency, manifesting in their acceptance and validation of narcissistic behaviors displayed by both the patients and sometimes even mirrored in the therapists' clinical work. This leniency stems from therapists' empathy towards behaviors they identify with, leading to restricted interpretations, as they hesitate to confront narcissistic patients due to fears of causing a narcissistic injury that could prompt the patient to abandon treatment.

In response to the vulnerability of narcissistic patients, narcissistic therapists often refrain from interpreting the patient's behavior as narcissistic, emphasizing their emotional distress instead. Particularly when the patient's behavior causes a narcissistic injury that affects the therapist's own self-worth, this process becomes pertinent.

This situation raises crucial ethical concerns regarding therapists' prioritization and the adequacy of therapeutic interventions. The focal ethical issue does not revolve around the limited interpretations resulting from therapists' reluctance to confront narcissistic patients, fearing abandonment might condone the patients' narcissistic behaviors. Instead, the question remains whether therapists should condone narcissistic behaviors exhibited by their patients in any circumstance.

Seligson (1992) highlighted that therapists' hesitance to confront narcissistic patients due to potential abandonment can lead to the inadvertent condoning of harmful narcissistic behaviors. This acquiescence is treated as an established fact, which, although irrelevant to the issue at hand, presents a contradiction.

One might argue that this could force therapists into handling situations beyond their capabilities, questioning their ability to manage such occurrences. However, it is the responsibility of therapists to navigate these situations effectively, not the patients'.

Moreover, in a subsequent session, the patient might assert that a well-known politician (or another figure admired by the therapist) is foolish. Consequently, if the therapist's ego is provoked, they might confront the patient, questioning the basis of their argument (while previously acknowledging their admiration for the politician's intelligence).

Arguments have a place in psychotherapy, however, only when relevant and helpful to the patient, not when it relates to the therapist's personal affairs. The entire treatment concerns the patient and what they feel; therefore, it is indisputably inappropriate for therapists to start an argument with patients about their political opinions.

Furthermore, the therapist might assert their humanity as an excuse for their reaction. However, because rationality comprises both intent and rationale (see Figure 2), the therapist cannot justify hurting the patient's feelings by simply citing human fallibility as an excuse. If one queries, "Why did the therapist err?" or "What motivated and justified the therapist's error in causing the patient distress?" – the answer remains the same: "Because they made a mistake."

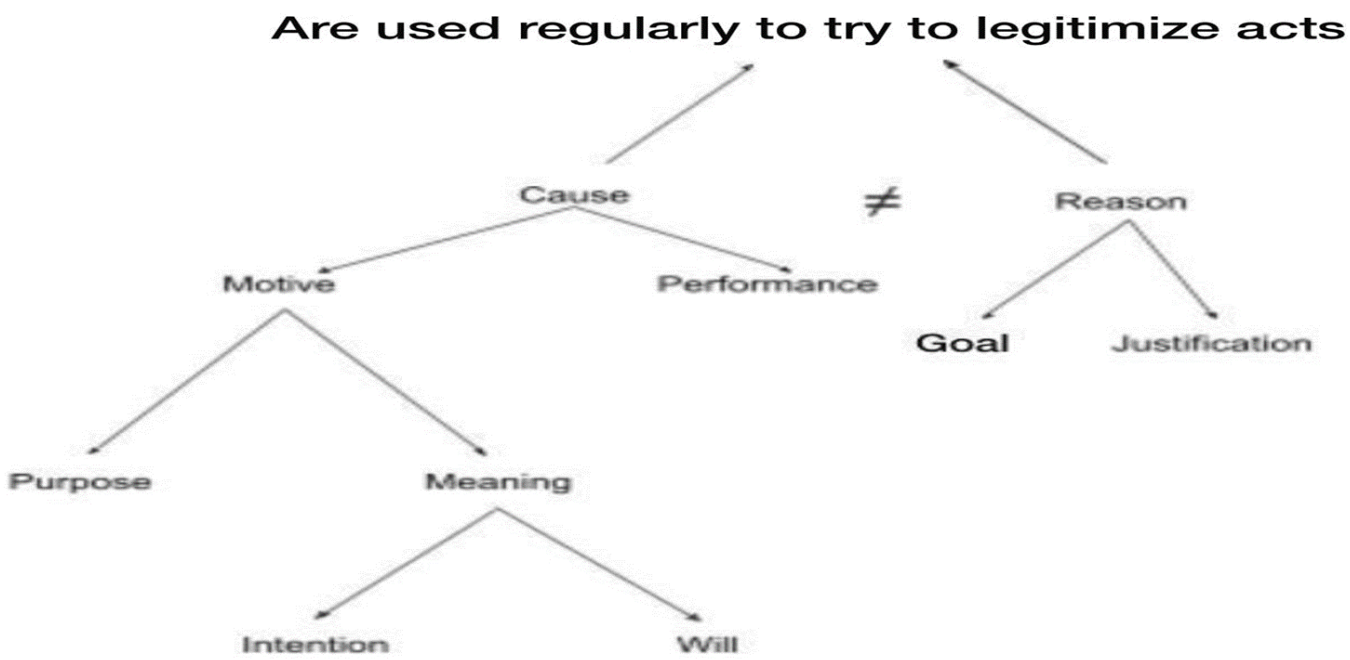

Fig. 2. The difference between reason and cause is illustrated through a diagram of their component parts.

However, this fails to address the question since the answer doesn't constitute a goal, rendering the action illegitimate. Similarly, therapists may exhibit egotism in situations such as when a patient requests them to read a text in the therapist's bilingual language. Subsequently, the therapist, while reading, might ask the patient, 'Did I pass the test?' This can evoke feelings of insecurity in the patient, undermining their trust in the therapist's stability.

Additionally, if a patient touches on a sensitive subject for the therapist – like questioning whether the therapist views them as unfortunate or fortunate – the therapist must prioritize the patient's well-being. They need to set aside their own unresolved issues, especially if neglecting to do so compromises the patient's welfare. Conversely, the patient doesn't bear such an obligation.

Especially when holding a position of power in relation to the patient (Zur, 2009), exhibiting egotism towards them – such as claiming, "I'm not like that," or insinuating, "You always seek special treatment, don't you?" – may indicate temporary or lasting mental instability. It's impermissible for the therapist to project their instability onto the patient. Furthermore, therapists must avoid exploiting their positional power through boasting, condescension, teasing, or patronizing behavior.

According to Kahneman's (2011) theory, successful navigation involves cooperation between two mental abilities: "System 1," innate mental activities present from birth, and "System 2," the slower, analytical mode governed by reason, which

should ideally dominate over emotions.

That assertion might be interpreted as a justification for therapists causing harm to their patients (as Kahneman (2011) contends that emotions often supersede reason). Nevertheless, therapists cannot excuse prioritizing their emotions over reason and using this to justify their display of egotism towards the patient.

If one were to inquire, “Why did the therapist allow emotions to override reason?” or “What motivated and justified the therapist’s emotional response, leading to hurt feelings for the patient?” – the answer would still circle back to the notion that emotions commonly override reason. However, this response fails to address the question, as it doesn’t constitute a goal, rendering the action illegitimate.

According to Boisvert, C. M., & Faust, D. (2002), mental health professions effectively alleviate personal distress and provide treatment. However, unethical therapeutic interventions, often inflicted by overloaded therapists and their related iatrogenic effect, can have catastrophic consequences, not just for the patient but also for their family and surroundings.

Patients are permitted to display passive ego, egotism, or narcissism towards the therapist, such as through competitiveness or antagonism, but not actively, through deliberate insults or violence. Conversely, therapists must refrain from displaying passive ego, egotism, or narcissism in response to the patient.

One might argue that the therapist would prevent the patient from learning how to handle challenging experiences if they adapted to the patient’s mental state (or ego satisfaction). However, aiding the patient in managing these experiences should be deliberate; the therapist must prioritize the patient’s well-being and ensure the patient benefits. If the therapist disregards the patient’s benefit, the resulting benefit is neither assured nor intentional. Hence, therapists must avoid empathic failures altogether.

One might question why an individual displays egotistical behavior despite knowing its social inferiority. The answer aligns with why someone drowning would instinctively seek to breathe. These needs have distinct origins, and the primary need precedes the secondary, irrespective of the outcome.

Consequently, a person lacking sufficient ego satisfaction would struggle to exhibit modesty in situations that trigger ego. They inherently seek to replenish their ego, particularly when the cup remains unfilled. Moreover, an unfilled cup often prompts the display of egotistical behavior from a socially inferior standpoint, directly correlating with inadequate ego satisfaction. The manifestation of egotism from such a place indicates either insufficient ego satisfaction or a sudden stimulation of it.

Given society’s competitive nature, most individuals aspire to stand out, seeking peace for their egos. Yet, achieving this inner peace remains elusive for many, as Neff (2015) proposes solutions that might not necessarily exist. Rogers (1951) emphasizes the disparity between the “ideal self” and the “actual self,” highlighting that expecting more than one can achieve leads to diminished self-worth. He suggests improving self-image by either setting more realistic goals or enhancing the current self. Lowering the ideal self is one way to alleviate the issue, akin to artificially reducing the need for ego satisfaction within the cup-like function.

However, if the cup's capacity is significant while its contents remain meager, merely lowering the ideal self may not effectively fulfill the need for ego satisfaction. Presently, numerous coaches attempt to gratify their patients' egos through methods lacking practical efficacy.

A sufficient ego satisfaction state enables individuals to maintain a peaceful mind. Those lacking a robust character struggle to fulfill their cups, incapable of containing ego satisfaction regardless of its presence or absence. Even without its entry, they suffer mental instability, failing to attain practical ego satisfaction. Consequently, a therapist lacking a stable ego satisfaction state won't effectively calm their patient in need or provide objective advice during ego-triggering situations, regardless of their cup's content.

Enabling an act and making it possible for the act to be possible differ. Facilitating an act's possibility does not guarantee its execution but only makes its possibility feasible. Similarly, accomplishing an act doesn't ensure it is necessarily performed, only rendering it achievable. Individuals with robust characters may possess a stable cup, yet may not always have adequate ego satisfaction. While having a stable cup makes achieving a satisfactory state possible, the state itself may remain unattainable. Possessing a stable and sufficient ego satisfaction state is crucial.

While some may deserve to satisfy their ego, those lacking the character strength to contain it should not. In essence, everyone deserves happiness, but not all deserve to achieve it by fulfilling their ego satisfaction states. For instance, if someone's cup holds a volume of 10 and its content measures 9.5, but the cup's material strength is only 0.2, their character lacks the strength to contain ego satisfaction, potentially affecting their mental state. Although this situation is regrettable, the alternative – a deficient ego satisfaction state – might lead to mental instability.

Inverse Psychological Projection

Freud (1894) defined "psychological projection" as a defense mechanism wherein individuals attribute negative aspects of their personality to others, allowing them to overlook their own flaws and problems. The inverse form of this concept occurs when someone repeatedly, often angrily, advises others to ignore or pay no attention to someone or something. This behavior typically signifies the person's experience of inverse psychological projection: if their needs were disregarded in the past, it reflects in how they advise others. However, this advice is pertinent only in specific cases, such as trivial ridicule. If a mentally ill person insults someone's appearance, ignoring them may be the best response.

However, if the type of hurt involves causing harm (e.g., public humiliation, contempt, invasion of privacy, incitement, threatening behavior, discrimination, abuse, sexual or ordinary harassment, violence, annoyance) or if what was said had already hurt the other, advising to ignore or pay no attention to the mentally ill person disregards the inflicted damage. This defense mechanism might surface in individuals who previously struggled to cope with similar types of hurt or mental damage, or if their ego is provoked by the same issue. This stimulation might cause shame in acknowledging their ego, considering it socially inferior, or difficulty in empathizing with the other's hurt feelings (or containing their bruised ego).

As a result, they deny the problem's existence and advise others to ignore it. This action might aim to release their

antagonism towards others or demonstrate superiority over the issue (or over the person to whom they advise). Moreover, in contrast to classic psychological projection, in which a person attributes negative aspects of their own personality to others when they are unable to deal with these aspects (so they can ignore them), in its inverse form, a person attributes the quality that they would like to but cannot demonstrate/be able to succeed in (which relates to their ability to efficiently manage issues or problems that provoke their own ego), so that they can avoid dealing with these issues or problems. Self inverse psychological projection occurs when people who are not able to cope or deal with their own issues or problems in general (and matters that provoke their own ego in particular) advise themselves to ignore or pay no attention to those matters, issues, or problems.

In similar situations, inverse psychological projection might involve phrases like “I don’t care what you think or say” or “Who cares what people think or say?” “I will not stoop to your level,” “Don’t let them influence you,” “Don’t give them the satisfaction,” “Don’t give them a platform,” “They aren’t worth it,” “Ignore the background noise,” or “What do you expect from them?” (one must distinguish between “expect” and “predict” as these two possess different responsibilities). Alternatively, when discussing a television show, one may say, “Who even watches it?” and in the context of social media, “Don’t feed the trolls” or “Haters gonna hate.”

The relevant discussion is not whether one should theoretically/logically be hurt by someone else's actions, but whether they were actually hurt by those actions. This is because the damage (for which it is indeed appropriate to address the harm caused by the person who had done those actions or pay attention to that person) is determined according to whether the victim was actually harmed by those actions, and not according to whether anyone should theoretically/logically be harmed by them, which leads to the question: Shouldn't one address the damage someone else caused them (when the other person indeed inflicted harm) because they shouldn't be hurt by them in the first place? It doesn't make any sense. However, people may still advise others (or themselves) to ignore or pay no attention to someone who has harmed them. This advice, although irrelevant to the issue at hand, presents a contradiction.

Additionally, individuals might inadvertently project their negative emotions onto those seeking help. For instance, a hungry person tells their friend about their hunger, and the friend, also hungry, responds with something like, “Wow, you probably crave a good hamburger or a tasty pizza with olives and mushrooms.” This response fails to address the problem of hunger and can worsen the pain of the person seeking help by reflecting their own hunger on their already hungry friend, thereby making them hungrier.

Similarly, the expressions people use to dismiss others can also turn inward, reflecting a broader pattern of psychological defense. Phrases such as ‘I don’t care what you think or say’, ’Who cares what people think or say?’, ‘I will not stoop to your level’, ‘Don’t let them influence you’, ‘Don’t give them the satisfaction’, ‘Don’t give them a platform’, ‘They aren’t worth it’, ‘Ignore the background noise’, ‘What do you expect from them?’, ‘I shouldn’t let this bother me,’ and ‘It’s not a big deal,’ along with similar ones, are common in both forms.

These phrases specifically illustrate how an individual might minimize (or even cancel) their own feelings or problems. For example, after receiving criticism at work (including work as a therapist), someone might tell themselves ‘I shouldn’t let this

bother me,' attempting to suppress their valid distress instead of addressing the situation. Irrespective of how the criticism is perceived (whether as fair or unjust), dismissing it (or personal setbacks generally) by thinking 'It's not a big deal' can prevent individuals from confronting their feelings or seeking help, thereby prolonging unresolved issues and emotional discomfort. These expressions, whether directed at others or internally voiced, illustrate and elucidate how individuals attempt to dismiss concerns that challenge their self-image or provoke their ego (and that they are not able to cope or deal with in general), highlighting the pervasive use of these defense mechanisms across different contexts and life situations.

In the context of psychotherapeutic treatment, a therapist affected by this psychological projection struggles to show empathy towards their patients. This issue isn't one-sided; it impacts both the therapist and the patient. If, for example, a patient complains about distressing OCD thoughts, therapists should not dismiss these thoughts as insignificant, as this undermines the patient's challenging experiences.

Inverse psychological projection, including the self-directed form, has unfortunately become a widespread phenomenon in today's society, observed in various everyday situations and social media interactions. This tendency is more likely to manifest in individuals whose ego satisfaction state remains unfulfilled.

Results

Calming a patient down temporarily when the subject involves the therapist's ego, egotism, or narcissism, and advising the patient objectively in a similar context while considering the therapist's own feelings regarding this matter, is feasible only if the therapist's ego satisfaction state is sufficient concerning that particular subject or if the subject doesn't trigger unresolved issues for them. Addressing the therapist's personal experience of ego regarding this issue should take precedence.

Therapists have an obligation to refrain from displaying ego towards the patient as their primary role involves attentiveness to their patients' needs. Despite this responsibility resting on the therapist, situations may arise where unresolved issues provoke ego manifestation. It might become impossible for therapists to avoid such manifestations due to an inadequate ego satisfaction state. This raises questions about assigning guilt for actions deemed impossible to prevent.

Therapists are mandated to avoid egotistical behavior and narcissistic manifestations towards patients not because it's always possible, but because it aligns with their role as therapists, centered on prioritizing patient well-being. Therefore, if it were unfeasible for therapists to evade ego manifestation in certain situations, their responsibility wouldn't be relinquished. However, if they were not fulfilling the role of a therapist, this responsibility would no longer apply.

However, the obligation to refrain from exhibiting ego, egotism, and narcissism towards patients doesn't arise due to the possibility of doing so, but rather because of their role as therapists, where their primary focus is always the welfare of their patients. Therefore, this responsibility wouldn't be relinquished even if it were impossible for them to avoid

demonstrating ego towards the patient. Consequently, since their responsibility stems from their professional role, if they were not in the capacity of therapists, this responsibility would be absolved.

It's crucial to highlight that the capability of certain therapists to temporarily calm their patients or offer objective advice regarding matters involving their ego, egotism, or narcissism is the same reason why others might be unable to do so; it all ties back to the satisfaction level of ego. Therefore, the primary reason for the failure of various treatments (and why certain professionals fail to fulfill their responsibilities towards their clients) is rooted in individuals not fulfilling their fundamental need to satisfy their egos. This shortfall can lead to breakdowns in communication and professional misconduct when their egos are either triggered or undermined.

When a therapist's ego satisfaction state is fulfilled, allowing them to effectively calm the patient or offer objective advice on a matter involving their ego, egotism or narcissism, it signifies that the therapist is functioning appropriately, and consequently, no harm will be caused to the patient. Blame should only be ascribed based on actual harm inflicted, disregarding the underlying reasons for the absence of harm, which are analogous to the reasons causing harm in the alternate scenario.

Discussion

This study aimed to illustrate how an inadequate or unstable ego satisfaction state can impact therapists' ability to effectively address their own issues while treating patients. The primary conclusion of this study highlights that a significant discrepancy between therapists' ethical commitments and their practical behaviors may often be rooted in inherent human weaknesses. While previous research has explored how threatened ego and egotism across various domains negatively impact life aspects (Baumeister et al., 2000; Bushman & Baumeister, 1998; Leary et al., 2009), this study delves deeper by revealing the ethical consequences of ego, egotism, and narcissism manifestations.

Since this issue stems from inherent human tendencies and pertains to patients' rights, the solution should focus on prevention. This might raise concerns about the proficiency of certain therapists, which can be addressed through clinical supervision or by refraining therapists with unstable or insufficient ego satisfaction states from treating patients. Future studies should delve into this further by thoroughly evaluating the stability and sufficiency of therapists' ego satisfaction states before granting them licenses. Additionally, research should explore how these inadequate and unstable ego satisfaction states affect professionals' readiness to fulfill their duties, investigating practical implications for patients and clients.

Limitations

This study encountered three significant limitations. Firstly, it primarily relied on pure logic instead of empirical data due to a lack of relevant existing literature. Secondly, there was no involvement of human subjects to test the presented hypotheses. Addressing the first limitation in future studies could complement the second, and vice versa, as pure logic

and adherence to ethical rules apply universally, regardless of sample size. Additionally, due to the absence of empirical data (such as randomized controlled trials or general empirical studies), there might be a necessity to conduct qualitative research into therapists' actions and methodologies. One potential approach could involve conversation analysis as an analytical method.

Moreover, there might be a need to further refine the proposed formula to adapt its application beyond therapeutic environments. Recent research in artificial intelligence has suggested using functional magnetic resonance imaging (fMRI) as a non-invasive decoder, capable of generating understandable word sequences and deciphering meanings from perceived or imagined speech (Tang et al., 2023). While additional research is likely required, future studies could refine and implement the suggested formula and its derived uses more effectively. Utilizing fMRI's capabilities to interpret how manifestations of ego, egotism, and narcissism correlate with cortical semantic representation, and how fMRI reconstructs continuous language, could be beneficial.

Furthermore, like patient samples utilized for professional benefit, despite ethical concerns (Martineau et al., 2020), future studies should consider including samples of therapists. Even if a future study incorporates a small sample size or no sample at all, it may still need to rely on pure logic, irrespective of empirical literature coverage. Lastly, the scenarios depicted in this study represent potential occurrences in psychotherapy, categorizing the study type as not evidence-based or cumulative research. However, this limitation can be addressed as the arguments resulting from these occurrences do not necessitate testing on human participants; they delineate what therapists should do when facing such situations, stemming from their ethical commitment to patients, thus making them incontrovertible.

Conclusions

Psychotherapy has been a pivotal element in patients' recovery for over three centuries, with successful therapist-patient interaction being indispensable. Contemporary efforts persist in seeking the ultimate treatment method, engaging in a productive debate to determine the most effective approach. This quest is akin to a doctor seeking a remedy for a severe illness. However, even the most potent medication would be futile if the patient lacked a vessel to drink it from. In this analogy, for the doctor to offer a cup to the patient, they must possess a cup themselves.

According to Winnicott (2000), the therapist requires a similar nurturing and protective environment, much like a mother providing care to her infant. Nonetheless, this should never compromise the therapist's stability during practice, a stability that must not be jeopardized at the patient's expense. Reason, delineated into goal and justification, exemplifies that the doctor cannot be excused for failing to provide the patient with a cup.

If one inquires, "Why did the doctor not provide the cup?" or "What was the doctor's intention and reasoning for withholding the cup?" or even "If the goal was to withhold the cup, was it justified?" The answer remains constant: "Because they lacked a cup in the first place." Yet, this response does not suffice as it doesn't represent a goal, rendering the act illegitimate. Similarly, the therapist cannot justify their failure to meet this need based on the lack of resources.

Hence, it seems that ego satisfaction is not inherently negative but rather essential. Both therapist and patient can attain peace of mind and functional capability in ego-stimulating situations due to an adequate ego satisfaction state. However, they are not equally obliged to function optimally for the same reasons. The therapist bears a therapeutic duty to the patient, necessitating a stable and sufficient 'cup,' whereas the patient lacks such an obligation toward the therapist.

Additionally, therapists, being human, possess their own egos, making it more manageable for them to adapt to a patient's ego satisfaction state when the patient is in a socially inferior position. Yet, if the patient's issue directly involves ego itself, the therapist will find it challenging (and often impossible) to temporarily calm the patient or offer objective advice, especially when the matter stimulates the therapist's own ego, egotism, or narcissism.

Moreover, it's crucial for therapists to treat patients impartially with the right intention. When the therapist's ego remains unaffected, they can successfully soothe the patient temporarily or offer objective advice. However, if the therapist's own ego becomes triggered, they'll be unable to fulfill their obligation, causing the patient to suffer.

Considering the therapist's will, which relies on the sufficiency of their ego satisfaction regarding the discussed matter or its stimulation, and acknowledging the significance of will in shaping meaning (see Figure 2), it can be deduced that without a complete will or when it is absent, the meaning cannot function effectively, even with a genuine intention. Consequently, the therapist lacks a pure motive and cannot adequately assist the patient in crisis situations.

The therapist's commitment to the patient persists, rooted in their professional obligation rather than their ability to surmount the issue. In conclusion, ego satisfaction, if not to the patient's detriment, should serve as a means to an end, not an end in itself. Prioritizing ego satisfaction as an end-goal may come at the patient's expense.

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