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Narcissistic Personality Disorder in Clinical Health Psychology Practice: Case Studies of Comorbid Psychological Distress and Life-Limiting Illness

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Abstract

Narcissistic Personality Disorder (NPD) is characterized by a persistent pattern of grandiosity, fantasies of unlimited power or importance, and the need for admiration or special treatment. Individuals with NPD may experience significant psychological distress related to interpersonal conflict and functional impairment. Research suggests core features of the disorder are associated with poor prognosis in therapy, including slow progress to behavioral change, premature patient-initiated termination, and negative therapeutic alliance. The current manuscript will explore challenges of working with NPD within the context of life-limiting illness for two psychotherapy patients seen in a behavioral health clinic at a large academic health science center. The ways in which their personality disorder affected their illness-experience shared significant overlap characterized by resistance to psychotherapeutic change, inconsistent adherence to medical recommendations, and volatile relationships with providers. In this manuscript we will (1) explore the ways in which aspects of narcissistic personality disorder impacted the patients' physical health, emotional well-being, and healthcare utilization; (2) describe psychotherapeutic methods that may be useful for optimizing psychosocial, behavioral, and physical well-being in individuals with comorbid NPD and life-limiting disease; and (3) review conceptualizations of NPD from the DSM-5 alternative model for assessing personality function via trait domains.

Keywords

behavioral health; clinical health psychology; psychological treatment; personality disorders; narcissism

Introduction

Narcissistic Personality Disorder (NPD) is a psychological disorder characterized by a persistent pattern of grandiosity, fantasies of unlimited power or importance, and the need for admiration or special treatment. Core cognitive, affective, interpersonal, and behavioral features include impulsivity, volatility, attention-seeking, low self-esteem, and unstable interpersonal relationships[1] that result in a pervasive pattern of interpersonal difficulties, occupational problems, and significant psychosocial distress. Prevalence estimates of NPD

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range from 0 to 6.2% in community samples.[1,2] Of those individuals diagnosed with NPD, 50%–75% are male.[1] The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[1] classifies NPD as a Cluster B ("dramatic, emotional, and erratic") personality disorder, a category that also includes Antisocial, Borderline, and Histrionic Personality Disorders.

Individuals with NPD experience significant physical and mental health comorbidities and social problems. Stinson and colleagues[2] found high 12-month prevalence rates of substance abuse (40.6%), mood (28.6%), and anxiety (40%) disorders among participants with a diagnosis of NPD. Core features of NPD that contribute to these mental health comorbidities include a higher frequency of experiencing shame, helplessness, self-directed anger, higher admiration of self,[3] and impulsivity.[4] NPD is a significant predictor of (a) making multiple suicide attempts,[5] (b) using lethal means to attempt suicide,[6] and (c) making suicide attempts in proximal relationship to being fired or experiencing domestic, financial, or health-related problems.[7] Regarding physical health outcomes, individuals with Cluster B personality disorders, including NPD, have demonstrated significantly higher mortality rates due to cardiovascular disease than those without personality disorders, even after controlling for relevant medical comorbidities.[8,9] NPD specifically is also associated with gastrointestinal conditions.[9] Not unexpectedly, NPD is strongly associated with high health care utilization across a variety of services.[8,10] Additionally, provider-patient relationships among individuals with NPD can be challenging due to interpersonal dysfunction marked by dramatic, emotional, and erratic thinking and/or behavior. From a behavioral standpoint, individuals with a Cluster B diagnosis are more likely to have (a) a criminal conviction (b) spent time in prison, (c) a history of interpersonal violence,[8] (d) caused pain or suffering to others,[8] and (e) evidenced overall impairment in social role functioning.[8]

In terms of treatment, a limited body of research has investigated interventions for NPD using randomized controlled trials or other methodologically rigorous approaches. One systematic review published by Town and colleagues[11] found eight studies of "moderate" scientific rigor that demonstrated the positive effect of short-term psychodynamic psychotherapy (STPP). Several researchers have examined the impact of NPD on the psychotherapeutic relationship.[12–14] Tanzilli and colleagues[14] found that individuals treating patients with NPD were more likely to experience negative counter-transference feelings of disengagement as well as feeling criticized or mistreated. These authors highlight the core feature of narcissism—struggle to form intimate relationships—as a significant barrier to positive treatment outcome, due to the patient's potential inability to form a safe and trusting relationship with the therapist. Other researchers have found that individuals with NPD have higher rates of self-terminating treatment.[15]

One proposed treatment method for personality disorders was originally developed with the goal of providing brief psychological services to individuals with substance use disorders or medical nonadherence concerns. This approach revolves around the six-component "FRAMES" technique developed by Miller and Sanchez.[16] This method emphasizes the role of Feedback, Responsibility, Advice, Menu of Strategies, Empathy, and Self-Efficacy. This approach highlights guidelines for the patient and therapist in order to maximize the likelihood of behavioral change and therapeutic progress.[16,17] This strategy creates a

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structure in which the provider can limit the impact of transference and countertransference on the therapeutic process and focus on creating a team-oriented dynamic that is supported by limit-setting, strong boundaries, and minimization of "splitting" with other providers.

Methods

The following case studies describe the particular challenges of working with two adult patients with NPD in a clinical health psychology practice within a large academic health center in the Southeast United States.

Reasons for referral and presenting problems

Mr. X is a middle-aged, Caucasian male who was referred to the Psychology Clinic for assessment and treatment of depression. Medical record review revealed a complex medical and psychiatric history including several acute illnesses, multiple psychological conditions, a history of suicidality and involuntary psychiatric admission, as well as lack of adherence to behavioral recommendations regarding diet, exercise, and medication compliance. Approximately one year prior to his intake at our clinic, Mr. X experienced a life-threatening medical crisis. He noted that he hoped psychotherapy would support him in the goal of finding new meaning in his life.

At the time of his initial intake, Mr. X presented to the Psychology Clinic with an unusually long list of medical and mental health diagnoses. His primary concern during the initial phase of his treatment was depression. Although Mr. X's unique personality was appreciated immediately, it was not until many months into treatment when behavioral patterns suggestive of a personality disorder emerged. After recognizing Mr. X's pattern of volatile interpersonal encounters that was suggestive of either Borderline Personality Disorder or Narcissistic Personality Disorder (according to the guidelines explicated in the DSM-5), other symptoms indicative of NPD began emerging, particularly when standard treatment approaches were met with resistance and individual appointments often turned into crisis management sessions. The most salient features of NPD that interfered with Mr. X's treatment progress were thoughts of grandiosity, need for admiration or special treatment, and fantasies of unlimited power or importance. For example, Mr. X regularly cancelled therapy sessions the same day of his appointment due to vague complaints; when he returned to session, he elaborated on these concerns with excessive detail in an attention-seeking manner. Similarly, his referral physician reported feeling compelled by Mr. X to treat him for unsubstantiated medical complaints.

Mr. X initiated his first session by describing the many "illustrious" mental health providers from whom he had received treatment. He described his goals for psychotherapy, which included growing his religious faith and practice, exploring lifelong questions regarding intimacy, and increasing the size of his social network. Mr. X engaged in two years of individual cognitive-behavioral therapy marked by numerous distractions that impaired his ability to focus on broader values-based treatment goals. Although efforts were made to assist him in gaining insight into the way in which personality factors influenced behavioral patterns and interpersonal difficulties, Mr. X benefitted primarily from concrete treatment

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approaches designed to address specific behavioral problems (i.e., poor adherence to medical recommendations).

Ms. Y is a middle-aged, Caucasian female who was referred by her oncologist for evaluation and management of distress in the context of diagnosis and treatment of cancer. Ms. Y presented for cancer treatment from out-of-state after seeking treatment recommendations from multiple well-known cancer centers throughout the United States. She was reportedly counseled by each facility that seeking multiple opinions would delay treatment and result in disease advancement and shortened survival. One center declined to treat her, as they believed that she did not seem able to engage in a collaborative relationship with medical team members. Once Ms. Y began treatment at our facility, she sought medical care for vague or minor symptoms from almost every department in our medical center. While her cancer diagnosis and potential side effects of treatment were well-documented, Ms. Y demonstrated a pattern of attention-seeking behavior, similar to that displayed by Mr. X, in which hypervigilance about minute changes in physical sensation or function were treated like emergencies that required urgent care. Ms. Y's social history was remarkable for having a young child of whom she lost custody, multiple ex-boyfriends with whom she had tumultuous relationships, a current boyfriend, and a very supportive mother. Ms. Y reported receiving but not completing graduate medical training. Medical record review revealed the additional history that she was dismissed from graduate training and barred from seeking a health care practitioner license in several states due to academic and professional behavior issues.

Features of a personality disorder emerged within minutes of beginning Ms. Y's intake in our training Clinic. Once settled in the interview room, Ms. Y called the trainees "incompetent," and insisted that she would only see "the Attending." Once the Attending Psychologist entered the room, she cried out loudly that she felt as if she had been sexually victimized. Upon clarification, she explained that this was in reference to being asked by a male health care provider to disrobe and change into a medical gown for a CT scan several months ago. This highly atypical and dramatic presentation, in conjunction with her reported history of exceptionally volatile interpersonal relationships, immediately alerted our team to the high likelihood of the presence of a severe personality disorder. Our medical record review and diagnostic interview yielded concrete evidence in support of a personality disorder diagnosis with prominent NPD features. Ms. Y provided a plethora of personal anecdotes, which further supported this diagnosis. Conceptualizing her case from within an NPD framework brought awareness and appreciation of the unique challenges of working with individuals with this disorder. This was a crucial initial step toward assisting Ms. Y with her primary goal of achieving and maintaining the interpersonal stability necessary to complete cancer treatment. Her self-reported history and behavior in the Clinic were consistent with key features of NPD, including relational volatility, excessive demands for special treatment, disdain for others' emotional experiences, and lack of empathy. Moreover, her tendency toward hypersensitivity and negative automatic thought patterns regarding perceived insults from most individuals with whom she came into contact, including medical providers with whom she needed to collaborate in order to obtain life-preserving cancer treatment, resulted in persistently paranoid ideation. These symptoms of NPD caused her distress and served as barriers to obtaining successful medical and psychological treatment.

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As an aside, Mr. X demonstrated similar tendencies toward paranoia in terms of presuming that even subtle changes within the dynamics of existing interpersonal relationships were indicative of negative underlying motivations on the part of others. For both patients, this resulted in volatile relationships in personal and medical contexts.

Interestingly, Ms. Y herself confirmed a prior personality disorder diagnosis—which she referred to as "mixed personality disorder" with narcissistic features—within the context of discussing her history of difficult relationships with medical providers. However, Ms. Y did not provide specific information as to when, by whom, or under what criteria she had received this diagnosis. Ms. Y also disclosed anxiety about maintaining collaborative relationships with her treatment team. She expressed uncertainty about her ability to manage her distress related to her diagnosis, grief over interpersonal losses, and worry about the effects of cancer and treatment on her self-esteem, body image, and sexual functioning. Given that Ms. Y intended to move back to her residence in another state upon completion of her cancer treatment, brief therapy was indicated. The main goal of treatment was to increase Ms. Y's capacity for distress tolerance so that she would be able to complete intensive cancer treatment. A secondary goal was to provide her with a positive psychotherapy experience in order to assist her with transitioning to longer-term psychological treatment upon her return home. She attended four, 50-minute, cognitive-behavioral therapy sessions. She achieved her goal of managing her distress in a manner that allowed her to complete her cancer treatment successfully. Given the brevity of the treatment that she received, we were unable to target major mood disturbance or core personality features. Thus, depression was not significantly reduced. However, she experienced a reduction in hopelessness and a remission in suicidal ideation during the course of her treatment. She also expressed that she had an overall positive experience in therapy and noted that she wished to pursue additional sessions upon return for routine follow-up care.

Results

The following discussion highlights two crucial aspects of understanding NPD within Clinical Health Psychology practice: (1) how NPD manifests within psychotherapy in health care settings, and (2) specific ways in which these cognitive-behavioral patterns interfere with both medical and psychological treatment progress among individuals with NPD. Key ways in which NPD manifests in psychotherapy from a cognitive behavioral standpoint include: superlative self-talk and self-aggrandizement, expectations of special treatment, poor behavioral health adherence and difficult relationships with providers, and low distress tolerance. These aspects of the patients' interpersonal style negatively affected treatment due to: poor boundaries with the therapist, ambivalence about change associated with fragile self-esteem, cognitive distortions (i.e., black-and-white thinking), and help-rejecting behaviors. An additional barrier to treatment progress underlying each of the above issues resulted from both patients' tendency toward hypersensitivity and paranoia in therapy and in their everyday lives; both patients experienced interpersonal instability due to perceived insults and injuries of varying seriousness, which emphasized content that is clearly tied to core beliefs associated with narcissistic pathology.

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Manifestations of NPD in brief and long-term psychological treatment

Superlative self-talk and self-aggrandizement—Mr. X revealed a persistent pattern of self-glorification and a need to highlight his exceptional uniqueness in therapy. Over the course of his treatment, he repeatedly mentioned his "genius IQ," his prodigious talents, and his exceptional ability to help others in need. Early in treatment he expressed concern regarding whether his therapist would be able to handle the complexities of his life story. He displayed a sense of self-satisfaction while relaying shocking, fantastical, or dramatic anecdotes from his life in which he often was the victim of disappointing circumstances or betrayal. He returned often to the idea that he was destined for some great purpose.

Ms. Y evidenced similar self-aggrandizement, including making frequent statements such as "I know I'm brilliant" and "I know more than [my medical providers] about my cancer treatment." Her exaggerated self-worth was evident also in her perception of herself as highly sexually desirable to both men and women, especially those who are of high-status. Consistent with this, she reported a history of engaging in sexualized discourse and sexual relationships with health care providers and other professionals with whom she was under contract as well as a history of being sexually victimized/harassed by such individuals with pending litigation.

Expectation of special treatment—Mr. X repeatedly arrived 20 minutes early to his psychotherapy sessions seeking extra attention and lingering after his check-in to chat with Clinic staff. He frequently requested that the therapist extend his sessions, schedule additional sessions per week, and/or return multiple calls outside of session per week. Throughout treatment, Mr. X reminded the therapist about the celebrated health care providers with whom he had worked. He repeatedly compared his care to the services he received for many years at a prestigious medical school. He also noted even the slightest inconveniences he encountered at the Clinic, such as difficulty finding parking or not having a call returned quickly enough.

During treatment, Ms. Y would call at her appointment time to indicate that she would be 30 minutes late. However, when her appointment was rescheduled for that time, she would then arrive 30 minutes late to that appointment. As noted previously, she declined to receive services from pre-doctoral trainees due to their "incompetence" and expected that she would receive services solely from the Attending Psychologist, whose credentials she closely queried. Although she agreed to be treated by a postdoctoral trainee for therapy, she repeatedly advised the therapist that she found her care in the clinic unsatisfactory due to our department being "weak." Expectations for special treatment extended to her cancer treatment team. Ms. Y demanded to receive cancer treatment on a federal holiday when the cancer center was closed. In addition, she used the oncology on-call service to obtain after-hours consultation about minor, nonurgent concerns, such as losing several tenths of a pound of weight.

Poor behavioral health adherence and difficult relationships with health care providers—Mr. X frequently failed to engage in self-care behaviors that were crucial to maintaining his health, such as dietary restrictions, CPAP usage, fluid intake management,

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consistent medication usage, and the wearing of compression socks. Additionally, Mr. X frequently alternated between idealizing and devaluating his physicians and their teams such that they were either at the top of their fields or completely inept. Mr. X often, to his own detriment, disagreed with his providers' treatment plans and/or the manner in which they delivered care. For example, his cardiologist recommended that he discontinue use of a particular medication prior to completing a cardiac stress test. However, Mr. X decided that it would not be safe to stop using this medication. He also refused to complete the stress test due to concern that he would have a heart attack. Although Mr. X's anxiety about the risks associated with this procedure was abundantly clear, he attributed his actions to superior knowledge of his body as compared to his medical providers.

Ms. Y sought multiple consultations regarding the management of her cancer, both prior to and during her treatment at our facility. She reported that several previous medical providers had discharged her from care due to her inappropriate behavior and an inability to form collaborative working relationships. She reported feeling abandoned by these providers, who she described as incompetent. She also noted that she filed complaints against them with state medical boards. At our facility, she was insistent upon receiving a new, highly specialized, and difficult-to-access cancer treatment. However, the oncology team at our facility did not recommend this treatment for her, which she repeatedly questioned and viewed as incompetence. This pattern of idealization and devaluation was also evident in therapy. When the therapist responded to Ms. Y's suicidal ideation by conducting a risk assessment, Ms. Y stated that this was a waste of time and an indicator that the therapist was incompetent. Although the therapist was able to navigate these conflicts in a way that maintained the therapeutic relationship, Ms. Y continued to criticize the therapist and emphasize her dissatisfaction with her care.

In contrast to Mr. X, who struggled with adherence, Ms. Y was remarkably adherent to her cancer treatment and providers' recommendations. This may have been at least partly due to the fact that her providers engaged her fully in her treatment planning and acknowledged and honored her objectively high level of knowledge about her cancer and its treatment.

Low distress tolerance—Mr. X demonstrated significant difficulty with tolerating ambiguous emotional experiences in which his self-worth was challenged. He frequently referred to difficult emotional experiences as "crises" and appeared to rely on the therapist rather than develop his own internal stress management skillset. Throughout treatment, Mr. X relayed multiple scenarios in which the experience of vulnerability in interpersonal relationships led to a pattern of emotionally charged, rapidly escalating encounters that almost always led to the demise of the relationship in question. Mr. X attempted to replicate this pattern several times with the therapist when he felt threatened by therapeutic challenges and/or boundary setting.

Similarly, Ms. Y was observed to experience difficulties with emotion regulation and distress tolerance. She described the possibility of not receiving the specialized cancer treatment that she was seeking as "the biggest regret of my life." She indicated that routine clinical situations, such as being asked to disrobe and wear a hospital gown, were traumatic and sexually violating. Her affect was intense, dramatic in presentation, and out of

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proportion to events experienced. Her high level of distress prompted her to engage in excessive health care utilization and to expect that her concerns would be addressed immediately and fully. While undergoing medical treatment, she was experienced by clinical support staff on one occasion as aggressive and threatening. Outside of relationships with medical providers, Ms. Y endorsed a long history of volatile relationships with romantic partners, employers, and attorneys.

Challenges associated with NPD in psychological treatment

Poor boundaries—Mr. X frequently challenged normative therapist-patient boundaries. He called the therapist excessively between sessions, requested extra time during his sessions, and insisted on giving the therapist a holiday gift. When presenting the therapist with a box of chocolates, Mr. X stated, "I know you are not supposed to accept presents, but you have no choice and will be taking that home with you." He frequently made comments to the therapist in which he acknowledged a rule or boundary and then appeared to take pleasure in crossing these lines. Mr. X consistently treated the therapist overly informally, often complimenting her clothing, asking an increasing number of personal questions, or cursing during session.

Ms. Y also experienced difficulties with establishing and maintaining appropriate interpersonal boundaries in professional relationships. In particular, her rigidly held beliefs regarding the inferiority of a wide variety of groups of individuals threatened her ability to form respectful and effective relationships with diverse employers and health care providers. During her second therapy session, Ms. Y openly stated that the therapist's country of origin and accent were problematic for her, noting that she had previously received substandard health care from individuals born outside the United States. The therapist used this opportunity to explore with Ms. Y how observing firm, prescribed boundaries with her health care providers could enhance her health care outcomes.

Ambivalence about change—Another prominent theme in Mr. X's treatment revolved around his ambivalence regarding therapeutic change. Mr. X frequently asked the therapist to challenge him in certain ways and then responded negatively upon being challenged. When given therapy homework assignments, Mr. X frequently did not complete them; instead, he insisted on editing published worksheets, and/or amending the guidelines for prescribed exercises. He often identified therapeutic goals but strayed from them when discussions touched on painful subjects. Notably, Mr. X demonstrated particular difficulties with being interrupted. During some sessions, he lightheartedly noted that he was aware of his tendency to be verbose and gave the therapist "permission" to cut him off if he was being overly tangential. However, other times he became defensive and angry when the therapist attempted to redirect him without his permission. Mr. X's inconsistent response to interruptions revealed a sense of ambivalence regarding his participation in the therapeutic process.

In contrast to Mr. X, Ms. Y expressed awareness of her personality structure and articulated strong motivation to mitigate her distress, complete her cancer treatment, and achieve future goals, such as seeing her child graduate from college. The value she placed on the role of

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motherhood, coupled with the life threat of a cancer diagnosis, appeared to be primary motivators for change.

Cognitive distortions—Consistent with firmly held beliefs about his specialness, Mr. X revealed a pattern of negative, all-or-nothing thought processes. He frequently struggled to see multiple perspectives on an issue and devalued others who were not able to see his perspective. This tendency resulted in a vicious cycle of unrealistic goal-setting, feelings of failure, and low mood which often impaired his ability to make progress in treatment.

Ms. Y also expressed a number of distorted beliefs about herself, her world, and her future. Her inflated self-concept did not appear to be grounded within objective academic, employment, or interpersonal histories. Additionally, she held many negative expectations of others based on distorted beliefs about how individuals from various socioeconomic, educational, and demographic backgrounds think, feel, and behave. These beliefs led to significant emotional dysregulation, poor distress tolerance, and interpersonal chaos with her medical providers and others in her life.

Help-rejecting behaviors—Mr. X frequently engaged in self-sabotaging behavior related to treatment goals. He cancelled almost the same number of scheduled sessions that he had completed over a two year period. He often maintained that the cancellations were due to medical exacerbations but later revealed that he was experiencing some sort of psychosocial distress. Mr. X also became angry with his medical providers due to his preoccupation with minor details regarding the speed and efficiency with which they served him. After a particularly emotional session during which the therapist encouraged Mr. X to explore his feelings surrounding one of his greatest life regrets, Mr. X called the Clinic and reported that he needed to speak to his therapist's supervisor and to be assigned a new therapist. Mr. X lashed out at the therapist via her supervisor by questioning her competency. However, after several delicate discussions, Mr. X resumed work with the therapist. He spent months dramatically alluding to difficulties in trusting the therapist and the burden of rebuilding the therapeutic relationship.

Ms. Y's pursuit and then rejection of cancer treatment recommendations from numerous cancer centers across the United States is consistent with help-rejecting behavior that occurs in NPD. However, once she decided to receive care at our facility, she was observed to be adherent to her treatment recommendations and actively engaged in her own care.

Summary of results

These cases demonstrate the complex relationship between manifestations of NPD and challenges to psychotherapeutic progress in a hospital-based clinical and health psychology practice. Mr. X and Ms. Y both demonstrated features of NPD during the course of their treatment. Mr. X indicated during his first session that he sought long-term psychotherapy in response to recovering from a medical crisis and re-evaluating his goals moving forward. Although he experienced many personality-based barriers to progress in psychotherapy, he was able to work through multiple therapeutic ruptures and maintain a strong relationship with the student therapist that was grounded in humor, authenticity, and direct communication. He also demonstrated some growth in personal insight regarding the ways

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in which his tendency toward black-and-white thinking affects his mood and daily function, particularly in terms of his relationships. However, in many ways, his dramatic and avoidant tendencies precluded his ability to make prominent changes in worldview or interpersonal style.

Ms. Y, on the other hand, entered treatment when in the throes of a perceived medical crisis due to distress associated with her cancer diagnosis and a lack of confidence in her ability to manage the complex emotions associated with a potentially life-threatening illness. At the time of her referral, her medical team's primary goal was to reduce her stress and improve her emotion regulation enough that she would be able to engage in an appropriate manner with her medical team in order to successfully complete her cancer treatment. Unlike Mr. X, it did not appear as if Ms. Y sought long-term, deep, existential therapy that would allow her to explore her complex history or goals for the future. Therefore her treatment was more problem-focused in order to reduce barriers to successful cancer treatment.

As previously reflected, treatment challenges for patients with NPD in clinical health psychology include: (1) poor boundaries, (2) ambivalence about change, (3) cognitive distortions, (4) idealizing and devaluing providers, (5) poor behavioral health adherence, and (6) help-rejecting behaviors. Table 1 summarizes psychotherapy treatment challenges related to key features of NPD and identifies how these behaviors were demonstrated by each patient.

Discussion

The cases discussed above highlight many prominent features of NPD as displayed by two patients receiving psychotherapy in a clinical health psychology practice within an academic teaching hospital. These patients shared a lifelong history of distress associated with unmet expectations, unrealized goals, and unfulfilling relationships. Both patients had sought psychotherapy and pharmacologic treatment throughout their lives and both presented to our clinic seeking support while dealing with chronic and potentially life-limiting illnesses. While there were many shared experiences between these two patients, there were some crucial differences. Mr. X explicitly sought long-term supportive therapy, while Ms. Y engaged in brief, problem-focused treatment. Mr. X was socially isolated and estranged from all living family members, while Ms. Y maintained a close, emotionally supportive relationship with her mother. Additionally, Mr. X demonstrated significant resistance to behavior change as manifested by inconsistent attendance, poor homework completion, avoidance of emotionally difficult topics, and lashing out at the therapist when he felt she had offended him. However, Ms. Y was motivated and receptive to treatment. Although her depressive symptoms did not resolve over the course of her brief treatment, her sense of hopelessness and suicidal ideation both decreased.

These cases highlight the complex experiences of individuals with NPD and those who work with them in clinical settings. The similarities in these cases offer support for core features of NPD as a unique condition, while the differences in their life experiences is suggestive of the variability that may affect psychological treatment course and outcomes. Mr. X made some progress on therapeutic goals but continued to be limited in his ability to engage on a

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deeper level due to ongoing medical management issues and psychological avoidance. Ms. Y terminated treatment after four sessions. However, psychological treatment may have played a crucial role in her ability to manage distress while enduring the challenges of cancer treatment.

A prominent challenge in the conceptualization of NPD cases revolves around the heterogeneity in presentation of the disorder and significant symtomatologic overlap with other Cluster B personality disorders. In particular, the DSM-5 Cluster B disorders share significant symtomologic overlap in terms of excessive attention-seeking, emotion dysregulation (i.e., impulsive rage), inappropriate sexual behavior, and unstable views of others (i.e., fluctuating between idealizing and devaluing).[1] Consistent with this, although NPD diagnoses were favored for Mr. X and Ms. Y, both demonstrated features of Histrionic Personality Disorder, Borderline Personality Disorder, and Antisocial Personality Disorder. However, both patients' most prominent, distressing, and impairing symptoms and behaviors were those that are unique to the DSM-5 diagnostic criteria for NPD (i.e., arrogance, grandiosity, and need for admiring attention). Further, both patients demonstrated a relative stability of self-image, a relative absence of deceit, and a relative lack of conduct disorder/criminal history,[1] suggesting an absence of several defining features of Borderline Personality Disorder and Antisocial Personality Disorder. As such, NPD diagnoses appeared to best account for these patients' distress and impairment at the time of presentation for treatment. However, it is possible that other Cluster B disorders may be more prominent for these patients in different circumstances (i.e., health vs. family stressors).

Conclusions

The diagnostic framework used to explore pathological narcissism in the above cases was organized according to the DSM-5 criteria.[1] These criteria were developed with an underlying assumption that personality disorders can be characterized into independent clusters and independent clinical syndromes. Recent consideration has been given to an alternative model. Working under the assumption that personality disorders have significant clinical overlap, the dimensional approach argues that pathological personality features may represent a wide range of fluid presentations that begin with normal personality function. This alternative model is explicated in an appendix to the DSM-5 and describes the ways in which personality function may vary between individuals on four dimensions: Identity, Self-Direction, Empathy, and Intimacy. Additionally, further consideration is made regarding personality function on five dimensional scales: negative affectivity, detachment, antagonism, dis-inhibition, and psychoticism.[1] The exploration of these dimensional scales may allow clinicians to conceptualize patients in a way that they are able to work around limitations in categorical diagnostic criteria in order to improve the likelihood of symptom reduction and improved quality of life.

A brief reconceptualization of Mr. X and Ms. Y's histories from within the new model of personality disorders allows us to examine their personalities within the domains described and to rate their level of dysfunction from 0 (Little or no impairment) to 4 (Extreme Impairment). This system allows clinicians to assess symptoms at multiple levels of emotional function rather than being forced to identify a single disorder that captures the

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entirety of the patient's history and present difficulties. This system is also useful in addressing the problem of overlap among within-cluster disorders.

Overall these case studies and the literature reviewed highlight: (1) the importance of provider familiarity with personality disorder symptom profiles and evaluation, (2) the significance of personality disorders in affecting medical and psychological treatment course and outcomes, (3) the potential impact of treating personality disorders on provider function and well-being, and (4) potential future directions for research on how to improve treatment outcomes for individuals with personality disorders, and NPD specifically, where obstacles to forming the crucial therapeutic alliance may have a critical impact on patient prognosis.

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Table 1

Behavioral examples of treatment challenges in clinical health psychology practice.

Core NPD Feature(s)	Treatment Challenge	Manifestations in Mr. X	Manifestations in Ms. Y
Grandiosity/self-aggrandizement, need for admiration or special treatment	Poor boundaries	*Examples*: excessive calls, asking for extra time during session, requesting personal information about therapist, disregarding professional guidelines for interaction with therapist	*Examples*: discussions about inappropriate topics with medical providers, engaging in sexual relationships with inappropriate individuals involved in her care, expressing racist attitudes toward her therapist
Grandiosity/self-aggrandizement, need for admiration or special treatment	Ambivalence about change	*Examples*: unwillingness to complete homework assignments, inconsistent treatment toward therapist, inconsistent requests about therapeutic approach, avoidance of particularly painful subjects, defensiveness, intentional engagement in activities that are understood to have caused distress in the past	*Examples*: explicit desire to reduce distress and improve interpersonal function while simultaneously demanding special treatment and being personally disrespectful to therapist in a way that impaired her ability to benefit significantly from psychotherapy
Grandiosity/self-aggrandizement, interpersonal volatility, poor distress tolerance	Cognitive distortions	*Examples*: all-or-nothing thinking, unrealistic goal setting, frequent feelings of failure, catastrophic thought patterns related to interpersonal relationships	*Examples*: inflated self-concept, negative thought patterns about certain diverse groups of people, unrealistic expectations for special treatment
Need for admiration or special treatment, interpersonal volatility, poor distress tolerance	Idealizing and devaluing providers	*Examples*: referred to therapist as both exceptionally talented and horribly humiliating, referred to various medical providers as world-renowned and insensitive “jerks,” when particular needs were not met	*Examples*: excessive consultation and second-opinion seeking, inability to maintain positive relationships with medical providers, expressed feelings of “abandonment” and concerns about incompetency when discharged from various clinics for difficult behavior
Need for admiration or special treatment, interpersonal volatility, poor distress tolerance	Poor behavioral health adherence	*Examples*: not adhering to appropriate dietary guidelines, not consistently using CPAP, poor management of blood glucose, unwillingness to wear compression stockings	*N/A* In contrast to Mr. X, who struggled significantly with adherence, Ms. Y was remarkably adherent to cancer treatment and provider recommendations
Need for admiration or special treatment, interpersonal volatility, poor distress tolerance	Help-rejecting behaviors	*Examples*: frequent session cancellations, emotional avoidance, volatility toward medical providers, frequent criticism of providers, lashing out when feeling vulnerable	*Examples*: extensive “doctor shopping” at multiple cancer centers and inflammatory comments directed at her providers, even those from whom she sought treatment