Borderline Personality Disorder with Narcissistic Features

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Choice Point Index

1. Framing observations about narcissistic problems
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Case Introduction

Andrew is a 26-year-old man who has come to you because his girlfriend of 5 years insisted that he seeks treatment to address his lack of gainful employment, or else she eventually would break up with him. He tells you that he finished a master's program in education 3 years earlier and obtained a teaching position in a high school but was fired in the middle of the first semester after a heated argument with his school's principal over the best way to prepare his students for an upcoming state-mandated examination. When he felt criticized by his girlfriend for being fired, Andrew said that he sat on the window ledge of their upper story apartment. Terribly frightened, she called 911. He was discharged from the emergency room the next day to a day treatment program, where he spent the next 6 months even though he now calls it "completely useless." Since then, he has had a few interviews for teaching positions and has occasionally worked part time as a tutor. His girlfriend has been paying the rent; he receives intermittent financial support from his father.

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Andrew describes chronic feelings of inferiority and depression with treatment that began in his teenage years when his parents were divorced. Although he continued to live in the same home in an affluent neighborhood with his mother and younger brother, financial circumstances were far more constrained, and he felt inadequate and envious of his friends and classmates. He calls his father "a narcissistic jerk" for being grudging about child support payments despite having significant wealth, and he says that he is determined to never be like him. During that period and over the next years, Andrew would bang his head against the wall repeatedly if he felt angry or low. Many times, he would cheat on girlfriends, including his current girlfriend, when he felt hurt by something that they said or did, and afterward, he would be plagued with shame.

He tells you about having tried many medications without any benefit. He speaks in a derogatory tone about past psychiatrists and therapists, emphasizing that none of them have helped, and he accuses them of applying rote techniques without really caring about him except for their income from treating him. Meeting most of the criteria, he had been diagnosed with borderline personality disorder (BPD) in addition to Major Depressive Disorder and been referred to a dialectical behavioral therapy (DBT) skills group. He is especially scornful telling you about that experience. Andrew agrees, however, that BPD is an accurate diagnosis for him. Abruptly, he becomes tearful and says that maybe *he* is the problem: that he is terrible and untreatable.

Choice Point 1

For each choice point, choose H: "helpful," U: "unhelpful or harmful," or P: "perhaps helpful, with reservations."

How would you make use of your understanding of the importance of narcissistic problems in Andrew's evaluation?

1. Avoid discussing it with him, because the lack of evidence-based treatments for narcissistic problems makes it not worth the risk of him becoming hurt or angry.
2. Avoid discussing it with him, because it would be preferable to develop more of a treatment alliance first.
3. Explain your concern that he may have narcissistic problems in addition to BPD, and suggest reviewing the DSM-5 criteria for narcissistic personality disorder (NPD) with him.
4. Introduce that you have noticed that he seems to have fluctuations in self-esteem with feelings of inferiority – low self-esteem being most prominent – and ask him what he thinks about this.

Discussion

Your initial evaluation is already full of valuable information. The presence of BPD may explain the lack of response to medications despite his history of major depressive disorder. In the evaluation, the patient has shown possible extremes of self-esteem at multiple points including: excessively low self-esteem characterized by

shame, badness, inferiority, and envy; and excessively high self-esteem characterized by superiority, righteousness, and using others.

The comorbidity of BPD with other personality disorders is high, and although robust epidemiological data are lacking, NPD may be seen in 15% of BPD patients [1]. NPD is the most obvious type of narcissistic problem, characterized by grandiosity; it has been described as "thick-skinned" narcissism. The other major type of narcissistic problem is "thin-skinned" narcissism, characterized by vulnerability and fragility with somewhat more covert superiority and grandiosity [2]. This patient has the more vulnerable form of narcissism, perhaps at least partly explaining his nonresponse to DBT, an evidence-based treatment for BPD.

There is no current evidence-based treatment available for NPD or narcissistic problems. Expert opinion advises the adaptation of evidence-based treatments for BPD (considered to be a "near neighbor disorder") to address NPD and narcissistic problems [2]. Choice 1 is accurate about the lack of evidence-based treatments for narcissistic problems, but it is important to be aware of these problems to be able to address them with adapted treatments for BPD. As with BPD, it is best not to defer diagnostic efforts as described in Choice 2. Instead, a tactful inquiry about these problems may help a patient feel understood even in the initial meeting. Because terms such as "narcissism" and "narcissist" often have pejorative connotations, Choice 3 may be helpful for some patients as a form of collaboration in diagnosis but lead to a strong negative reaction in others. It is advisable to use language that most patients will find acceptable (such as "self-esteem fluctuations" in Choice 4) with a bid for feedback and participation from the patient [2].

Answers

1. U
2. U
3. P
4. H

Principles and Clinical Pearls

1. Narcissistic problems are common in BPD and can present in multiple ways, including with a prominence of inferiority and fragility notably different from NPD described in the DSM-5.
2. Evidence-based treatments for BPD can be adapted to address narcissistic issues.
3. Diagnostic discussion of narcissistic problems can be done using language that is more acceptable to the patient.

Case Continues…

Andrew readily agrees to the idea of self-esteem problems, especially inferiority and low self-esteem. When you tactfully ask him whether he thinks that there is any possible evidence of superiority or high self-esteem, even if hidden, he quickly

refers to his girlfriend paying the rent and having cheated on her. Then, in a tone that is both somewhat plaintive and somewhat aggressive, he asks, "So, are you saying that I'm a narcissist just like my father?"

Choice Point 2

How would you respond to Andrew's pressing you on the question of whether you think he is a narcissist?

1. Reassure him that you do not, because you do not think he meets full DSM-5 criteria for NPD.
2. Confirm that even though you doubt he meets full DSM-5 criteria for NPD, you think he likely does have significant narcissistic problems.
3. Ask him what he means by "narcissist" preliminary to discussing with him how self-esteem problems can augment the interpersonal hypersensitivity of BPD.

Discussion

More important than obtaining agreement from a patient about the diagnosis of NPD or acceptance of the terms "narcissism" or "narcissist" is agreement about the presence of a self-esteem problem, and how it might be addressed in a potential treatment. Choice 1 may be accurate that the patient does not meet full criteria for NPD, but it would be incomplete to leave the patient's self-esteem problems unaddressed, especially given the past history of treatment failures to which the self-esteem problems likely contributed. Choice 2 acknowledges the presence of narcissistic problems, but many patients will experience the use of terms like "narcissistic" as attacking, leading to difficulty collaborating in a discussion of diagnosis and treatment. Choice 3 models effective collaboration with a patient, starting with curiosity and interest about their understanding of terms like "narcissist." This then naturally leads to the clinician being able to offer an understanding of self-esteem problems.

Clinicians without extensive training in specialty treatments for BPD can make use of the simplified approach to psycho-education about interpersonal hypersensitivity offered by good psychiatric management (GPM) for BPD [1], one of the evidence-based treatments for BPD. In the GPM model of interpersonal hypersensitivity, patients with BPD exist in a fragile state of "connectedness" that is constantly threatened by interpersonal stressors, especially feelings of being rejected by others. If a patient feels rejected, states of "feeling threatened" and "aloneness" can emerge, and unless the patient is rescued by support, "despair" may result, possibly requiring ER visits or hospitalization. Even when "connectedness" is restored by additional support or the containment of a hospital stay, this will always be a fragile state because it is based on an idealized view of others. In GPM for BPD, much of the work of psychotherapy is focused on helping patients to develop more effective interventions in this cycle of self-states.

This GPM model can be adapted for patients with narcissistic and self-esteem problems by discussing how they have *intra*personal hypersensitivity in addition to interpersonal hypersensitivity [3]. This can be explained as having excessively high internal standards that allow them to feel "connectedness" to themselves in an idealized way with elements of superiority. This is fragile, however, because any failure to meet these standards can lead to severe self-rejection. The movement from "connectedness" to "feeling threatened," "aloneness," or "despair," does not necessarily require the participation of someone else: it can happen entirely within the patient's mind. When "connectedness" to self is lost, feelings of inferiority and shame may flood the patient, and all standards, not just excessively high standards, may be abandoned. They may need the participation of another person (or the ER or hospital) to recover the fragile, idealized state of "connectedness." As in GPM for BPD, psychotherapy for narcissistic and self-esteem problems will focus on helping the patient find better solutions and coping strategies to interrupt this cycle of self-states.

Answers

1. U
2. P
3. H

Principles and Clinical Pearls

1. Diagnosis of narcissistic problems or NPD should be done collaboratively with the patient, and the patient's acceptance of the diagnosis may not be necessary if the patient accepts the importance of attention to self-esteem problems.
2. The model of interpersonal hypersensitivity to rejection in BPD can be modified for patients with significant self-esteem or narcissistic problems to include intrapersonal hypersensitivity to rejection, in which failure to meet internal high standards can lead to extreme self-rejection.

Case Continues…

Andrew agrees to a treatment that is focused on addressing interpersonal and intrapersonal hypersensitivities leading to problems in work and in his relationships. His girlfriend comes to his second session and seems concerned and supportive. At your next meeting, Andrew tells you that they had an argument. His supervisor at the study center where he has done part-time tutoring of community college students offered him a full-time clerical position. His girlfriend was angry that he plans to turn this job down because he feels a clerical role to be beneath his level of education. Afterward, he felt like banging his head, which he avoided, but he sent a text to a woman with whom he had been sexually involved 2 years earlier. He also

mentions being contacted a month ago by a former colleague who is now in charge of substitute teachers for the local school district. She encouraged him to submit a resume directly to her. He has started to work on his resume many times but has made little headway on it. He wonders whether it would be best to work on communication skills with his girlfriend and put off the job search for now.

Choice Point 3

How would you respond to learning about Andrew's work opportunities?

1. Suggest he bring in a copy of his resume for you to look at together.
2. Let him know that it is okay to wait for a job opportunity that he finds to be acceptable, especially if he is having problems with girlfriend.
3. Tell him that his unwillingness to take a lower level job is probably a manifestation of his self-esteem problems and that it would be best for him to try to overcome his reluctance, especially because all work is worthwhile.
4. Bring up the possibility that although he is qualified for higher level jobs, it might be helpful for him to initially pursue a lower level job so that he can work on his interpersonal and self-esteem problems in a lower pressure setting.

Discussion

For patients who have narcissistic problems in addition to BPD, the importance of making efforts to address work problems may be even greater than for patients with BPD alone. Aside from a lack of functional improvement in work and relationships, they may also be less likely to have symptomatic improvement, possibly because successfully engaging in productive work is an important source of self-esteem for most people. It would be unwise to suggest waiting to address work problems as in Choice 2, especially because for most patients, it may be easier at first to tackle emotional problems in the work setting, which may not be as charged or stressful as problems in relationship settings. Although Choice 3 is accurate, it has a critical or moralizing tone that might turn some patients off, and it does not include an explanation of how the stimulus of work might help patients to address their underlying self-esteem problems. Choice 4 accurately describes a painful reality that patients with self-esteem problems often face: a lower level job (which itself can be a blow to self-esteem that will have to be managed in treatment) may be the best option initially.

The direct use of case management techniques including help and guidance in gaining employment (like jointly reviewing a resume as in Choice 1) is important for patients with BPD alone and for patients who also have narcissistic problems. A patient with self-esteem problems may avoid doing a resume because his work history does not meet his high internal standards. Similar to facing a lower level job in

Choice 4, the self-esteem blow of needing help on a resume may also have to be discussed in treatment.

Answers

1. H
2. U
3. P
4. H

Principles and Clinical Pearls

1. Patients with self-esteem problems are unlikely to improve in relationships prior to addressing their problems in work, and lower level work settings may be appropriate initially.
2. The use of case management techniques may be useful and even necessary for patients who seem to be capable of functioning at a higher level, and this can be conceptualized as self-esteem problems interfering with the expression of a patient's full talents and abilities.
3. Having self-esteem problems that lead to limitations can further worsen self-esteem and require attention in treatment.

Case Continues…

Andrew brings a draft of his resume to the next session. His sense of shame and humiliation at having a checkered work history seems to be alleviated by discussing these feelings with you. He quickly has ideas about how to complete a good enough resume. After the session, he sends the resume to his former colleague. He is invited for an interview and then is offered a position on the roster of substitute teachers. He is told that it likely could be a full-time equivalent job if he wants it to be. At a subsequent session, he is concerned about how demanding this teaching role might be, and he wonders if it might be better to pursue the clerical position at the study center, even though he feels it to be beneath him. Somewhat confrontationally, he asks you, "Which one should I take?"

Choice Point 4

How would you respond to Andrew's question about which job to take?

1. Advise him not to take a job below his level of education because that might exacerbate his feelings of inferiority and shame.

2. Advise him not to take the more demanding job because there might be a higher likelihood of failure that could exacerbate his feelings of inferiority and shame.
3. Suggest that it would better for you not to be the decision maker but for the two of you to review the pros and cons of each job opportunity.
4. Explain that you think he should make the choice because otherwise his sense of inferiority would be reinforced.

Discussion

Choice 1 avoids the difficult reality, as discussed previously, that lower level positions may make sense for patients to consider as initial work opportunities as they work on interpersonal and self-esteem problems that might make higher level positions more challenging. In addition, although supportive advice is often a component of successful treatments for BPD, clinicians must be careful not to assume a role of omniscience that patients may desperately want. They can elicit feelings of inferiority and shame that might lead us to respond in excessive ways ourselves. They may expect us to be perfectly knowledgeable and caring to help them meet impossible internal standards. It is important to address this as a problem because any help from you will only provide fragile support until you inevitably disappoint them with your lack of perfect knowledge and care. Choice 2 may contain an accurate assessment of risk, but along these lines, it would be best to help the patient decide whether he wants to take that risk or not. It is true, as described in Choice 4, that looking to others for decision making may provide only temporary relief and perpetuate ideas of weakness and inability that harm self-esteem in the longer run. However, Choice 4 does not offer the collaboration found in Choice 3 that helps patients not feel alone in their difficulties.

Answers

1. U
2. U
3. H
4. P

Principles and Clinical Pearls

1. Clinicians may struggle with feelings of inadequacy when confronted with the demands of patients with narcissistic and self-esteem problems.
2. Clinicians must be careful to avoid responses to patients that might reinforce expectations of perfect care.

Case Continues…

Andrew seems to be agreeable to the idea of working together to consider the pros and cons of each job opportunity. But he arrives at the next session looking hostile and withdrawn. When you ask about this, he angrily berates you for leaving him in the lurch with his job decision. He says the delay of a week might mean neither job is still available. He tells you he was so upset that he banged his head the night after your last session, and he sarcastically adds, "But don't worry, there's no injury, so you don't have to be concerned." He says that he cannot understand why he thought treatment with you would be any different, because now it seems as pointless as with everyone else before.

Choice Point 5

How would you respond to Andrew's outburst?

1. Discuss with him how he is being overly hopeless and aggressive, and seems to be forgetting how he has benefited from working collaboratively with you in the past.
2. Apologize for not answering his question, and now tell him what you think would be the best job for him to take.
3. Apologize for not answering his question, but reiterate that you do not think giving a direct answer is in his best interest.
4. Express concern about his anger toward you, and wonder whether his anger may be an understandable consequence of feeling unrescued by you from a difficult decision.
5. Acknowledge his anger, and ask him to tell you more about how you disappointed him before inquiring about any changes in his self-esteem associated with his anger.

Discussion

The model of interpersonal hypersensitivity in BPD predicts that patients will have strong negative reactions when their state of fragile "connectedness" is lost. These include anger, devaluation, and help-rejection. Although Choice 1 is accurate, by itself it may not provide enough concern and support to be heard by a hostile, withdrawn patient. Clinicians should be comfortable apologizing to patients as demonstrated in Choices 2 and 3. This is especially important in working with patients who have significant self-esteem problems because it reminds them that you are not perfect, in addition to modeling for them comfortable acknowledgement of one's imperfections. However, Choice 2 represents an abandonment of collaborative

decision making in the face of the patient's anger. When a patient expresses contempt, rage, and domination toward us, we may react with feelings of shame, inferiority, and submission. Ideally, we will try to be aware of these feelings, as well as any covert contempt, rage, and domination which these patients are likely also to elicit in us. Awareness and acceptance of these challenging feelings in ourselves help us to avoid acting in overly submissive or dismissive ways. Choice 2 probably includes an attitude of submission in reaction to the patient's anger, and Choice 1 may contain a small amount of reactive dismissiveness. Choice 3 accurately repeats your concern about decision making, but Choice 4 is best because it expresses concern as well as empathically and nonjudgmentally inviting an exploration of why the patient might have become angry with you.

Choice 4 allows revisiting the model of interpersonal and intrapersonal hypersensitivity with the patient. Patients who are angry may still be able to listen, although perhaps grudgingly. An example of a more complete response, during which you would be attentive to the patient's verbal and nonverbal reactions, might be:

"You hold yourself to very high standards, and so this choice can be very difficult. On the one hand, you are drawn to the higher level job because you expect to feel bad otherwise. On the other hand, you are afraid it will be too challenging for you. And the reality is that there is no way to know what is the perfect decision, and I'm guessing that this is leaving you indecisive. I think you're probably hoping I can save you from this difficult problem, but I can only help you make your decision as best as possible. And I think this leaves you really disappointed with me. You don't just hold yourself to high standards, you can hold other people to them, too, including me. And that means that when we are disappointing to you, you can feel that we are useless as you can feel yourself to be useless. I think this is a problem for us to work on, because when there is something that is not perfect but maybe just okay, you can completely dismiss it as no good at all. What do you think?"

Choice 5 is also appropriate and may lead to the same points made in the paragraph above; but it demonstrates slightly more curiosity about the self-esteem fluctuations underlying the anger. Further questions emerge from the assumption that making a choice between two equally viable (but imperfect) options led to an important internal experience that elicited rage and avoidance. The session could focus on that experience, including what Andrew imagines are your motives in having suggested a pro/con approach to examine his problems . For example, if Andrew imagines that you are critical of him for his indecision and is reacting defensively, you may want to make your position more clear. You might reassure him that acknowledging a problem can feel like a criticism, but your goal is to help. Or if Andrew imagines that you stop caring about him when he struggles with indecision, you could look at how his perception of you fluctuates along with his self-esteem. Helping him to learn how to recognize these fluctuations – and his changing experience of other people in these moments – could be quite helpful.

Answers

1. P
2. U
3. P
4. H
5. H

Principles and Clinical Pearls

1. Clinicians are likely to experience feelings similar to those in their patients, including both devalued and inflated states. It is important for the clinician to be aware (and accepting) of these feelings to minimize acting out on them and to have a chance to use them in helping patients understand their own difficulties.
2. The model of interpersonal (and intrapersonal) hypersensitivity is useful in examining difficult treatment interactions with patients who have narcissistic and self-esteem problems.

Summary of Clinical Approach

This case illustrates important principles of treating patients with BPD and narcissistic problems. Initial assessments should include evaluation and discussion of narcissistic and self-esteem problems, using language that is acceptable to patients. This allows treatment planning that considers evidence-based treatments for BPD, adapted for focusing on difficulties related to narcissism and self-esteem fluctuations. For clinicians without specialty BPD training, the most useful treatment approach may be built on the model of interpersonal hypersensitivity in BPD. This simplified approach can be modified to address intrapersonal hypersensitivity, in which patients reject themselves (and others) when they fail to meet excessively high internal standards. This treatment builds on principles helpful for patients with BPD alone, including use of case management techniques, emphasis on collaboration, focus on work functioning initially, and examination of problems using the lens of interpersonal hypersensitivity. The concept of intrapersonal hypersensitivity provides guidance in difficult treatment situations that arise when patients elicit powerful reactions in their treating clinicians.

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