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When Kindness Falls Apart: The Disrupting Effect of Dependency, Perfectionism and Narcissism in Adjusting to Cancer

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Key Points

1. Personality disorders represent an understudied comorbidity in cancer patients.
2. This study provides the first data on an at-high-risk personality organization based on overdependence, perfectionism, and vulnerable narcissism.
3. The described pattern unexpectedly reports different forms of dysregulation and reduced compliant.
4. The cancer team may benefit from the specific assessment we describe in this paper.
5. Further studies are needed in order to explore the incidence of such pattern and of the reported dysregulation.

Dear Editor

Little is known about the impact of premorbid personality disorders (PDs) and their functioning on Quality of Life (QoL) in cancer patients. On the one hand, few studies explored the relation between PDs and QoL, highlighting a negative correlation[1]. On the other hand, many researches have tried to identify possible organizations of personality (OPs) as risk factors for cancer and have reported no evidence[2]. Clinically speaking, to understand how a PD or an OP may affect patients' distress and compliance seems to be a crucial issue. For example, Borderline Personality Disorder, as a PD at high risk of dysregulation, self-destructive and aggressive behaviors, has received attention in terms of specific management aimed at increasing QoL and adherence to treatments[3].

The aim of this study is to describe the presence, in a cases series of five cancer patients, of an inhibited OP defined by destructive overdependence[4], multidimensional perfectionism[5] and vulnerable narcissism[6] [7]that seems to be at high risk for dysregulation and reduced compliance. We hypothesize that the reason is twofold. Since dependency and perfectionism are frequently associated with prosocial behaviors such as kindness, submissiveness, and self-discipline, relatives and professionals may overestimate patients' resilience. Although cooperation is a fitness strategy, it may become maladaptive[7]. The described OP seems to be characterized by a dysfunctional social signalizing process where patients' tendency to mask inner feelings reduces their likelihood to receive attention and support[8]. At the same time, patients may feel overwhelmed by negative emotions and stressors that, in turn, may lead to dysregulation and self-destructive behaviors due to perfectionism[5], vulnerable narcissism[6] and destructive overdependence[4]. Even though a person may exhibit recurrent prosocial behaviors, the perception of a social threat - albeit an unexpected insight - may lead to different types of dysregulation as

a sort of humiliation-response[7]. If I expect the world to be right, and if I am at the mercy of cancer, a significant invalidation of my worldview could lead to dysregulation.

Methods

Sample: Five cancer patients were recruited retrospectively from a wider study whose aim was to test a novel mindfulness-based intervention[9]: (i) Mary (female; 26 yy) was in follow-up after a cervical cancer; (ii) Louise (female, 47 yy) was under treatment for a breast cancer; (iii) Susan (female; 62 yy) was in follow-up care after a colon-rectal cancer; (iv) Mark (male; 44 yy) was under treatment for a lung cancer; (v) Karen (female; 38 yy) was under treatment for a breast cancer.

Procedures: The study was conducted according to the Declaration of Helsinki; the institutional review board approved the protocol. Eligibility criteria were: (i) presence of destructive overdependence, perfectionism, vulnerable narcissism; (ii) at least one episode of emotional and/or behavioral dysregulation; (iii) being able to give informed consent.

Measures: We explored the OP through the Structured Clinical Interview for DSM-5 Alternative Model for personality Disorders[10].

Psychopathological Conceptualization

There are no available data on the incidence of described OP. The recruited subjects were the 2.84% of the patients accessing to same psycho-oncology service during the first semester of 2018. Two different oncologists referred Mary and Karen to the psycho-oncology services, and reported how the patients exhibited aggressive behaviors and declared the intention to interrupt either cancer follow-up (Mary) or treatment (Karen). Louise and Susan asked for psychotherapy, describing how they unexpectedly found themselves showing aggressive verbal and non-verbal behaviors against members of their social networks. Mark declared during the first session he was ruminating on the idea of killing his former girlfriend and then committing suicide.

What made these stories astonishing was the contrast between the different types of dysregulation and the over-controlled, inhibited and kind self-presentation strategies the patients used. Moreover, they progressively presented, during the intervention, a sort of three-leveled structure of psychopathological dimensions. First, they reported a pattern of submissive and clinging behaviors, a recurrent need of approval, and difficulty in making decisions. Even though they were not diagnosed with Dependent Personality Disorder,

they fulfilled many of the criteria and highlighted a general overdependence, significantly compromising their relationships. This destructive overdependence seemed to be especially focused on a few significant members (i.e. relatives; partners; etc.), rooted in early insecure attachment styles, and evolved through the construction of a helpless self-concept and a recurrent disconnection from their own needs and aspirations[4].

Second, by exploring the patients' personal histories and their recurrent self-presentation strategies we realized how the psychopathological dimension at the core of their suffering was perfectionism, as a multidimensional and maladaptive trait of personality[5]. The OP we are describing seems to be channelized by a twofold pattern of early and repetitive experiences of unmet psychological needs and the failures in controlling - in a perfectionist manner - patients' own lives and relationships. Despite the different components of their perfectionistic traits and self-presentations strategies, they were consistently showing an approach to life that makes stressors and failures not only more aversive and distressing, but also more likely to occur[5].

Third, a better understanding of patients' personalities and how they functioned while facing adverse events, subjectively experienced in terms of humiliation and social/life threats, highlighted a covert narcissist vulnerability. The OP defined by perfectionism and overdependence seems to overlap with many features of vulnerable narcissism: aggression against self and others; low self-esteem; shameful affects; interpersonal distress[6]. Many studies have reported how distressful events and traumas may act as precipitating factors or aggravate narcissist traits, leading to adverse reactions such as aggressive or self-destructive behaviors [6].

We assume that a recurrent internalizing OP may be described in three-levels of psychopathological dimensions, namely: (i) destructive overdependence; (ii) multidimensional perfectionism; (iii) narcissist vulnerability. Persons with this OP seem to frequently exhibit maladaptive overcontrol, experiential closeness and social disconnection, and a sort of difficulty/inability in expressing their own needs and suffering[8]. When they are faced with a chronic distress such as cancer, a single traumatic event, especially in the interpersonal domain, may serve as a precipitating factor, causing a general increase of psychopathology and an exacerbation of maladaptive personality traits and unexpected dysregulation. Karen, for example, reported how she felt insulted by how the oncologist minimized her psychological suffering, whereas Mary by her mother's request to take care of brother's problems rather than her rehabilitation.

Assessment Strategy

In order to explore a multifaceted OP, the SCID-5-AMPD is an effective assessment strategy. In applying standard diagnostic models, a clinician may incur in comorbidity. The alternative diagnostic model allows for a

general comprehension of personality functioning (Criterion A), a personalized definition of a patient's traits (Criterion B), and a standard revised categorical diagnosis. In Appendix (see supplemental materials) we summarize Criterion A and B, additionally three specific measures of dependency, perfectionisms, and vulnerable narcissism were assessed. We may consider three different diagnostic levels:

I. Clinical interview may serve as a first step aimed at evaluating the symptoms and potential high risks behaviors. During the first session, Louise reported having punched a friend, Mark having had suicidal ideation, and Mary having considered interrupting the treatment.

II. The SCID-5-AMPD is a second level assessment that may orient the clinician in understanding the OP. Criterion A describes the level of personality functioning, whereas the Criterion B guides a deeper understanding of the patient. All of the patients demonstrated a PD in Criterion A. Five facets of Criterion B (mostly referring to the negative affectivity dominion) define the OP: submissiveness; withdrawal; perseveration; rigid perfectionism.

III. Specific measures represent a way to confirm the psychopathological hypotheses and rate the severity of the defined maladaptive dimensions. All of the patients reported high levels of overdependence, perfectionism components, vulnerable narcissism.

Conclusion

An intervention for cancer patients should offer a flexible strategy aimed at reducing distress, increasing awareness on maladaptive strategies and developing adaptive ones[9]. The OP we described urges professionals to explore traits or behaviors that may compromise the course of psychotherapy and cancer treatment, and then to assess the personality through dimensional models such as SCID-5-AMPD. The recurrence of negative affectivity and perfectionism suggests that the therapists should not to force the patients to revolutionize his/her own standards, but instead to shift from achieving an unattainable perfect self to experimenting with here-and-now adaptive strategies[5;8]. The described traits represent a vulnerability that, when facing specific stressors, may express dysregulation. The therapist should involve the referral oncologists by:

- Promoting an understanding of patients' dysfunctional mechanisms;
- Explaining patients' need for emotional validation and open communication;
- Increasing awareness about oncologists' automatic biases in response to patients' prosocial behaviors.

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APPENDIX

Assessment Procedure

The standard assessment procedure of our team is aimed at exploring changes in behavioral, emotional and interpersonal dominions. Once a patient exhibits severe forms of psychopathology he/she is referred to a more extensive evaluation, that is performed by an expert in mental health assessment. Finally, the intervention is defined on the base of the assessment and may involve the mental health services. When patients exhibit sever psychopathology they are treated through a broader psychotherapy in respect to our standard psycho-oncological intervention. For the purpose of the present study, we included in the assessment procedure different measures: (i) Structured Clinical Interview for DSM-5 Alternative Model for personality Disorders (SCID-5-AMPD) (First, Skodol, Bender, & Oldham, 2018); (ii) Relationship Profile Test (RPT) (Bornstein, & Languirand, 2003); (iii) Multidimensional Perfectionism Scale (MPS) (Hewitt & Flett, 2004); (iv) Pathological Narcissism Inventory (PNI) (Pincus, 2013). In table 1 and 2 I summarize Criterion A and B of SCID-5-AMPD, accordingly to the results discussed in the paper. Subjects were assessed at the beginning of the study and received an 8-session mindfulness-based individual intervention (see Cheli et al., 2019). Finally, two patients accessed to mental health services, three patient access to an extra 8-session mindfulness-based individual intervention.

TABLE 1 – Level of Personality Functioning

	Mary	Louise	Susan	Mark	Karen
Self					
Identity	3	2	2	3	2
Self-direction	3	2	2	3	2
Interpersonal					
Empathy	2	2	2	2	2
Intimacy	3	2	2	3	3
Global Level of Personality Functioning	*2,75*	*2*	*2*	*2,75*	*2,25*

Legend. Impairment scores refer to Criterion A of SCID-5-AMP: Level 0 = little or no impairment; Level 1 = some impairment; Level 2 = moderate impairment; Level 3 = severe impairment; Level 4 = extreme impairment. Global Level of Personality Functioning is defined as the sum of the scores at the four dimensions divided by 4.

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TABLE 2 – Severity of Personality Traits

Facets	**Mary**	**Louise**	**Susan**	**Mark**	**Karen**
Emotional lability	***	*	**	***	-
Anxiousness	***	*	-	***	*
Separation insecurity	-	*	-	*	-
Perseveration	***	**	**	**	****
Restricted affectivity	*	*	*	*	*
Submissiveness	***	***	**	***	**
Withdrawal	***	**	*	**	**
Anhedonia	**	-	-	-	**
Depressivity	*	-	-	*	*
Intimacy avoidance	**	-	-	-	**
Suspiciousness	*	-	-	-	*
Manipulativeness	-	-	-	-	-
Deceitfulness	-	-	-	-	-
Grandiosity	-	-	-	-	-
Attention seeking	-	-	-	-	-
Callousness	-	-	-	-	-
Hostility	*	-	*	-	-
Impulsivity	-	-	*	-	--
Irresponsibility	-	-	-	-	-
Risk Taking	-	-	-	-	-
Distractibility	*	-	-	*	-
Rigid perfectionism	***	***	**	**	***
Eccentricity	-	-	-	-	-
Perceptual dysregulation	-	-	-	-	-
Unusual beliefs	-	-	-	-	-

Legend. Impairment refers to the Criterion B of SCID-5-AMPD: Absent (-), Low (*), Moderate (**), High (***).

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