

Transference Focused Psychotherapy for Patients with Comorbid Narcissistic and Borderline Personality Disorder

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Clinical experience involving the treatment of patients with comorbid borderline and narcissistic personality disorders suggests that this patient population is among the more difficult to treat within the personality disorder spectrum. In this article, we present refinements of Transference Focused Psychotherapy (TFP) based on our clinical experience with and research data on patients with comorbid narcissistic personality disorder/borderline personality disorder (NPD/BPD). We briefly review object relations formulations of severe narcissistic pathology, as well as recent research in

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attachment and the allied concept of mentalization, which have provided a new lens through which to view narcissistic disorders. The research findings from two randomized clinical trials demonstrating the efficacy and effectiveness of TFP are presented. The data from the two Randomized Clinical Trials (RCT) allowed for the study of the characteristics of the subgroup of borderline personality disorder patients who have comorbid NPD/BPD. Findings on comorbidity, attachment status, capacity for mentalization, and level of personality organization of borderline patients with comorbid NPD/BPD, compared with borderline patients without comorbid narcissistic pathology (BPD), are presented. Clinical implications of the observed group differences are discussed, with a focus on refinements in the technique of TFP. Clinical case material is presented to illustrate the specific challenges posed by narcissistic patients to carrying out TFP in each phase of treatment.

For the past 20 years, a group of psychoanalytic clinicians and clinical researchers at the Personality Disorders Institute (PDI) at Weill Cornell Medical College have been working to develop a psychoanalytically oriented psychotherapy, Transference Focused Psychotherapy (TFP), for patients with severe personality disorders. The tactics and techniques of TFP, along with its theoretical underpinnings in contemporary object relations theory, have now been systematically described in a series of treatment manuals (Yeomans, Clarkin, and Kernberg, 2002; Clarkin, Yeomans, and Kernberg, 2006; Caligor, Kernberg, and Clarkin, 2007). There is now substantial evidence that TFP results in significant clinical improvement in symptomatology (e.g., symptoms of depression and anxiety, suicidality, service utilization), personality organization, including improvements in mentalization (i.e., the capacity to reflect on behavior in terms of intentional mental states; Fonagy et al., 2002), and increased integration in the concept of self and significant others (Clarkin, Foelsch, Levy, et al., 2001; Clarkin et al., 2004; Levy, Meehan, et al., 2006; Doering et al., 2010; Levy et al., in preparation). Although our group's previous work has focused largely on the study and treatment of borderline personality disorder, the basic principles of TFP are designed for treatment of the broad range of personality disorders organized at the borderline level (Yeomans and Diamond, 2010).

Recently, we have turned our attention to the applications of TFP to patients with narcissistic pathology, particularly those with comorbid narcissistic and borderline personality disorders (NPD/BPD). Based on our own research and clinical investigations at the PDI, we have found that patients with more severe forms of narcissistic pathology pose formidable clinical challenges, and may have a more guarded prognosis than all other personality disorders functioning on the borderline level (Clarkin et al., 2006; Kernberg, 2007; Diamond, Yeomans, and Levy, 2011), a finding that has been confirmed by a number of other clinical investigators (Stone, 1989; 1990; Clemence, Perry, and Plakun, 2009). Previous research has found the cooccurrence of narcissistic and borderline personality disorders with rates of comorbidity ranging from 10% (Barone, 2003) to 17% (Clarkin et al., 2007) to 80% (Pfohl, Coryell, Zimmerman, and Stangl, 1986; see Levy, Reynoso, Wasserman, and Clarkin, 2007 for a review). The recent NIMH Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions study, in which a representative sample 35,000 Americans were asked if they had experienced symptoms of NPD over the course of their lifetime, researchers found that the prevalence of NPD was 6.2%. In addition, 37% of individuals with NPD were also diagnosed with BPD; 62.9% of those with NPD were diagnosed with any other personality disorder (Stinson et al., 2008). Thus, previous studies have shown a high degree of cooccurrence of NPD with other Axis II disorders, especially those in

cluster B, i.e., borderline, antisocial, and histrionic personality disorders (Fossati, Beauchaine, Grazioli, Carretta, Corinovic and Maffei, 2005; Zimmerman, Rothschild, and Chelminski, 2005). The co-occurrence of narcissistic and borderline pathology has been shown to be a complicating factor for both accurate diagnosis and for psychotherapy continuance and termination (Kernberg, 1984; Stone, 1990; Hilsenroth et al., 1998; Diamond and Yeomans, 2008; Diamond et al., 2011). However, there has been surprisingly little empirical research investigating the cooccurring personality characteristics and clinical presentation of these patients, and how these features might pose particular challenges with respect to treatment course and outcome.

In this article, we first present a brief overview of TFP, followed by our model of narcissistic pathology drawing on both object relations and attachment theory. We then review empirical evidence that demonstrates the efficacy and effectiveness of TFP for severe personality disorders, including recent findings on comorbidity and attachment patterns of patients with NPD/BPD. Next, we review the proposed mechanisms of change in TFP and how these are particularly relevant for NPD/BPD patients. Finally, we illustrate the modifications of TFP for NPD/BPD through the presentation of clinical case material.

TRANSFERENCE FOCUSED PSYCHOTHERAPY (TFP)

TFP is a twice-weekly psychoanalytic psychotherapy grounded in a psychoanalytic object relations theory of the structural organization of personality (Kernberg, 1984, 2007). TFP has also been increasingly informed by neurocognitive and attachment research with personality disordered populations (Levy, Clarkin et al., 2006). The theoretical model informing TFP posits a dynamic interaction of temperament (individual differences in affect activation and regulation and motor reactivity), environmental factors such as abuse or neglect, an insecure working model of attachment, deficits in mentalization, low effortful control, and other neurocognitive deficits that predispose BPD individuals to affective dysregulation, particularly in interpersonal situations (Bender, Farber, and Geller, 2001; Posner et al., 2003; Adolphs, 2003; Depue and Lenzenweger, 2005; Clarkin et al., 2006; Gabbard, Miller, and Martinez, 2006; Silbersweig et al., 2007; Fertuck et al., 2009; Bender, Morey, and Skodol, 2011; Zaki and Ochsner, 2011). Although our understanding of patients with severe personality disorders is informed by these multiple perspectives, our theory posits that such disorders, including BPD, are characterized, at root, by identity diffusion, i.e., the lack of a coherent, integrated sense of self and others. The work of TFP is to facilitate the reactivation, under controlled circumstances, of the dissociated internalized object relations in the transference relationship to observe the nature of the patient's split polarized internal representations, and then, through a multistep interpretive process, work to integrate them into a fuller, richer, and more nuanced identity (Caligor et al., 2009).

TFP combines elements of standard psychoanalytic technique (e.g., attention to unconscious processes, a focus on transference, and interpretation), with a higher level of therapist activity, a dual focus on both the patient's internal world and external life, and an emphasis on a set of mutually agreed upon behavioral parameters designed to limit acting out and promote the unfolding of the patient's full emotional experience and psychic life in the treatment setting (i.e., the treatment contract, discussed in the following). The ultimate goal of TFP is thus to promote the increased differentiation and integration of split, polarized representations of self and others, and in doing so help the patient to tolerate negative affects (e.g., aggression, anxiety, envy, guilt)

that were previously dealt with by acting out or projection and sustain meaningful engagements in work and interpersonal relationships.

Although we emphasize transference interpretation as a central technique leading to therapeutic change, it is only one among many elements of the treatment. In TFP, change is hypothesized to occur through a series of treatment interventions that begin with a contract-setting phase that establishes a clearly structured treatment frame within which patient and therapist may address and reflect on how to best contain the range of intense and often stormy affects that lead to self-destructive acting out and that may be aroused in the treatment situation. Once the management of behavioral parameters, and other issues related to the frame of the treatment (e.g. session times, payment, attendance, vacations, etc.), have been agreed upon, the treatment begins. After setting the treatment frame, TFP proceeds through a phase that consists largely of identifying the dominant object relational configurations that emerge for the particular patient. Through the techniques of clarification, confrontation, and interpretation, the therapist links these object relational patterns to the patient's fluctuating affect states, and to the role reversals that occur in treatment as each pole of the self-object dyad is lived out in the transference relationship. In the later stages of TFP, the therapist also interprets the splitting of idealized and persecutory aspects of self into different dyads, offering hypotheses as to unconscious wishes, fears, and motivations that drive this primitive defensive process.

TFP thus involves a stepwise interpretive process modified for more severely disturbed patients, one that is designed to increase the patient's capacity to cognitively represent and contain his/her affective experience, which, in turn, leads to improvements in reflective function or mentalization, and the capacity to symbolically manage and reflect upon his/her experience in the transference (Levy, Meehan, et al., 2006; Kernberg, Yeomans, et al., 2008; Caligor et al., 2009). The specific stages, tactics, and techniques for TFP and the ways these have been modified for NPD/BPD patients are delineated more fully in the case material that follows.

MODEL OF NPD: THE CONTRIBUTIONS OF OBJECT RELATIONS AND ATTACHMENT THEORY

It is now generally recognized that pathological narcissism spans a spectrum of pathology from higher functioning (neurotic) to lower functioning (borderline) levels of organization (Kernberg, 1975, 1997, 2010; Ronningstam, 2010; 2011). Individuals with narcissistic pathology, even in the context of borderline organization, may initially present as higher functioning, or may be diagnosed with Axis I disorders, but NPD is missed. Hence, it is especially important to distinguish how narcissistic pathology manifests itself at different levels of personality organization. Here we are concerned with narcissistic pathology organized at a *borderline level*, which includes individuals who show the typical manifestations of narcissistic personality disorder; that is, excessive need for admiration from others, attitudes of entitlement and exploitativeness toward others, lack of empathy, and excessive envy. These narcissistic patients operating on an overtly borderline level also present with an unstable and unintegrated sense of self (i.e., identity diffusion), lack of anxiety tolerance, poor impulse control, and often drastic fluctuations in self-esteem, all of which result in chronic failures in spheres of love and work (Kernberg, 1997, 2007).

Although patients with borderline and narcissistic personality disorders share core structural features, they also show specific variants of those features. First, whereas both borderline and

narcissistic personalities evidence a rupture between idealized and devalued aspects of the self, in the case of BPD patients with comorbid NPD (hereafter referred to as NPD/BPD patients), there is a condensation of highly idealized aspects of self and others with real aspects of self, a condition that creates both a *pathological grandiose self*, and a devalued object world in which resides all the projected negative aspects of self, e.g., feelings of inferiority, envy, vulnerability, aggression, and incompetence. The grandiose self is a compensatory structure that, in the case of individuals with comorbid NPD and BPD, is prone to breakdown so that the individual vacillates between a grandiose overestimation of his or her worth, often to the point of distortions of reality, and a sense of worthlessness. Such vacillations can lead to severe disruptions in the spheres of work and intimate relationships (Kernberg, 1975, 1984, 2007) and serve as a formidable resistance in the treatment process. The systematic devaluation of others, in turn, interferes with the internalization of others, leading to difficulties with dependency and limiting one's depth of involvement with others, including the therapist. To the extent that the pathological grandiose self protects against an intolerable sense of inferiority, it may lend the illusion of stability to those with NPD, particularly in the case of the overt or thick-skinned narcissist (Rosenfeld, 1964, 1971).

Second, NPD and BPD patients are both characterized by disturbances in the realm of identity or identity diffusion, which involves the lack of integration in the representational world, reflected in the inability to assess self and significant others in depth, and the inability to read the subtleties of interpersonal situations. In the case of the patients with NPD/BPD, individual identity disturbances also involve excessive reference to others for self-definition and self-esteem regulation (Ronningstam, 2011).

Third, although severe pathology of object relations characterizes both BPD and NPD patients, the object relations of NPD patients are often characterized by superficial connectedness to devalued individuals who, nevertheless, are exploited for the self-regulation and admiration they provide the patient. Alternatively, there may be a seeming lack of investment in interpersonal relations altogether, which often masks investment in highly idealized powerful, punitive internal objects. Finally, both groups of patients show transient failure of reality testing, particularly under stress, but for the NPD/BPD patients such reality distortions may be ego syntonic and severe, if less glaring and impairing than those of the BPD patients without NPD. We suggest that a reason for this is that for the NPD individual, reality is viewed through the stable, but distorting, prism of the grandiose self, which may present as a stable albeit superficial adaptation to reality, one that blocks a deeper, more flexible sense of consensual reality (Kernberg, 1975, 2007).

Despite impairments in all of the foregoing dimensions, narcissistic patients, even those with comorbid borderline pathology (borderline personality disorder and/or borderline personality organization, cf. Kernberg 1984), may not have the acute symptoms of some other personality disorders—although they often suffer from depression, anxiety, and suicidality. They often, however, show a gradual decline toward self-destruction, particularly in the latter part of the life cycle, when their unrealistic expectations of self fail to be met, and their relationships are often eroded by their attitudes of exploitativeness, entitlement, and lack of empathy—leading to deterioration in spheres of both love and work (Ronningstam and Maltzberger, 1998).

Such deterioration is particularly severe in individuals characterized by the syndrome of malignant narcissism, a more severely pathological form of NPD that is marked by (1) prominent narcissistic features, (2) ego-syntonic aggression, (3) intense paranoia, and (4) antisocial traits (Kernberg, 1984). For such individuals, the grandiose self is not only infiltrated with aggression,

but also is sustained through identification with punitive, primitive, and powerful introjects that provide the illusion of triumph over pain, death, and limitations through relentless attacks on the self. This pathological form of narcissism includes a particularly intense level of envy that can lead to the need to triumph over others as the principle source of gratification, causing negative therapeutic reactions in which the patient may engage in self-destructive actions, even suicide, as a means of defeating the therapist (Kernberg, 1984).

Our formulation that a compensatory grandiose self is at the heart of narcissistic pathology, distinguishing it in character and severity from other personality disorders, has been given empirical support by the investigations of Ronningstam and Gunderson (1991) who found that, compared with BPD patients, NPD patients were found on the Diagnostic Interview for Narcissism (Ronningstam and Gunderson, 1991) to have a more unrealistic sense of uniqueness and superiority, to be more preoccupied with grandiose fantasies, and to endorse more self-centered, self-referential, and boastful or pretentious behaviors. In fact, grandiosity is the criterion that best discriminates patients with NPD from those with Borderline Personality Disorder (BPD) and Antisocial Personality Disorder (ASPD) diagnosis in three previous studies (Plakun, 1987; Morey, 1988; Ronningstam and Gunderson, 1991). More recent investigations (Akhtar, 2003; Kernberg, 2007; Ronningstam, 2010, 2011) have noted that although grandiosity is the characteristic that most distinguishes NPD from other disorders including BPD and ASPD, grandiose self-enhancement may be covert and exist primarily in hidden fantasies of specialness and uniqueness.

Although grandiosity distinguished NPD from BPD initially, Ronningstam and colleagues (1995) found that it did not predict stability of the disorder NPD over time, suggesting that perhaps the grandiose self of the NPD patient is unstable and may shift its presentation from grandiose to vulnerable, particularly over the course of treatment (Cain, Pincus, and Ansell, 2008). The variability of defensive grandiosity over time may provide one explanation for the variable presentations of those with NPD. Both empirical and clinical psychoanalytic investigations have identified subtypes of narcissistic disorders, including an grandiose or thick-skinned type characterized by self-aggrandizement and denial of dependency, and a thin-skinned or self-effacing, vulnerable type characterized by extreme narcissistic vulnerability, which often masks grandiose fantasies (Bursten, 1973; Gabbard, 1986; Rosenfeld, 1987; Gersten, 1991; Wink 1991; Cooper 1998; Pincus and Lukowitsky, 2010; see Cain, Pincus, & Ansell, 2008, for a review). Interestingly, other studies have shown that individuals with both grandiose and vulnerable levels of narcissism tend to be characterized by high levels of entitlement and exploitativeness on self-report measures, interviews, and ratings by significant others, suggesting that there may be a core pathology that characterizes both types of narcissistic disorders, the grandiose and vulnerable, and that finds different manifestations (Dickinson and Pincus, 2003).

THE CONTRIBUTIONS OF ATTACHMENT THEORY AND RESEARCH TO UNDERSTANDING NARCISSISTIC PERSONALITY DISORDERS

From an attachment point of view, the manifestations of pathological narcissism devolve from insecure internal working models of attachment, particularly dismissing avoidant states of mind with respect to attachment figures who were experienced as consistently rejecting and or emotionally unavailable (Bowlby, 1988). Bowlby (1988) hypothesized that attachment theory and

research would contribute to the understanding and treatment of severe personality disorders. He wrote that those with avoidant-dismissing internal working models of attachment might “attempt to live his life without the love and support of others,” and that such individuals might later be diagnosed “narcissistic” (Bowlby, 1988, pp. 124–125). In fact, narcissistic disorders have been associated with dismissing-avoidant attachment status in both clinical and empirical investigations (Rosenstein and Horowitz, 1996; Levy, Blatt, and Shaver, 1998; Westen, Shedler, and Bradley, 2006; Westen and Shedler, 2007), using different methodologies including the Adult Attachment Interview (AAI; George, Kaplan, and Main, 1998), self-report measures of attachment including the Experience of Close Relationships Questionnaire (ECR, Brennan, Clark, and Shaver, 1998), and Relationship Questionnaire (Bartholomew and Horowitz, 1991), as well as clinician ratings. Individuals with dismissing internal working models of attachment may describe attachment figures with contemptuous derogation and/or brittle idealization that is not substantiated by specific or episodic memories of childhood experiences, or alternately, may show loss of memory of childhood experiences altogether.

Although dismissing mechanisms are often primary for such patients, our investigations, along with previous research in both clinical (Hamilton, 2000; Bender, Farber, and Geller, 2001; Barone, 2003; Levy, Meehan, et al., 2006; Diamond et al., 2012, 2013) and nonclinical populations (Dickinson and Pincus, 2003; Smolewska and Dion, 2005, Otway and Vignoes, 2006), suggest that narcissistic patients may also be characterized by preoccupied attachment status, in which the individual remains angrily or passively enmeshed with attachment figures (see Meyers & Pilkonis, 2011, for a review).

Investigations of the relationship between subtypes of narcissism and attachment dimensions of anxiety and avoidance indicate that vulnerable narcissism was significantly associated with attachment anxiety (Smolewska and Dion, 2005). Another study indicated that those with vulnerable narcissism showed high self-report ratings of fearful-avoidant attachment, yet those with grandiose narcissism endorsed a secure attachment style, or secondarily a dismissing attachment style (Dickinson and Pincus, 2003). In our research (Diamond et al., 2013), the majority of individuals with NPD/BPD were found to be characterized by dismissing or cannot classify attachment, a disorganized attachment category in which individuals oscillate between different attachment states of mind (e.g., typically between dismissing devaluation and angry preoccupation) on the AAI. Thus, individuals with NPD/BPD may exhibit multiple, unintegrated attachment representations, leading to contradictory transferences and defenses that make these patients particularly challenging to treat.

Deficits in Mentalization in NPD/BPD

The mechanisms of insecure dismissing and preoccupied attachment that are associated with severe narcissistic pathology may also truncate the narcissistic individual’s capacity for mentalization, i.e., the capacity to make sense of and interpret the behavior of self and others in terms of intentional mental states. We concur with Fonagy and his colleagues (Fonagy et al., 2002), believing that deficits in mentalization for patients with severe narcissistic pathology may pose formidable impediments to treatment. Conversely, as our research investigations indicate, improvements in mentalization may be a key mechanism of change in psychodynamic psychotherapy with patients with severe personality disorders (Bateman and Fonagy, 2004; Levy,

Meehan, et al., 2006; Kernberg, Diamond, et al., 2008). Fonagy and his colleagues have suggested that mentalization is “intrinsically linked to the development of the self, to its gradually elaborated inner organization, and to its participation in . . . a network of human relationships with other beings who share this unique capacity” (Fonagy et al., 2002, p. 3). For the patient with severe narcissistic pathology, the rigid organization around the pathological grandiose self may distort and erase awareness of their own minds and the mind of others, and even of thinking itself (Bion, 1967), posing major impediments to the development of mentalization.

In our view, the severe deficits in mentalization observed in narcissistic patients organized at a borderline level may be seen as the distortion of their internal world of object relations—which is the focus of our treatment. We believe it is sometimes difficult for them to comprehend that the grandiose self is a mental state among other mental states that characterize the self. Furthermore, the grandiose self serves a defensive function in terms of protecting the individual from understanding the mental states of the self and the other, who historically may have been experienced as cold, exploitative, shaming, or overindulgent in ways that may have compromised the development of the individual (Otway and Vignoles, 2006).

Attachment concepts alone cannot explain the nature of these patients’ identification with and attachment to punitive, primitive, and powerful introjects. For that, we must turn to object relations theory. As Sandler (2003) noted, “We can speak of attachment between a person and a fantasy object just as we can speak of attachment to the real external objects in the person’s life” (p. 16). Interestingly Kernberg (2007), Rosenfeld (1971, 1987), and others have observed that there is a greater destruction of the internal world of object relations and a greater dismantling of interpersonal relationships in patients with more severe forms of pathological narcissism than in those with borderline personality organization alone. The conscious narrative of the grandiose self allows the individual a sense of wholeness, but one that is so fragile and brittle that it does not tolerate intimate contact with external reality, leading to a protective shallowness or rigid withdrawal from interpersonal relations, which often masks intense involvement with hostile introjects (Steiner, 1993; Diamond and Yeomans, 2007).

RESEARCH FINDINGS

The research endeavors on the effectiveness of TFP have been based on a well-delineated model of treatment development (Kazdin, 2001). In this section, we summarize the findings on three studies, an open trial, a randomized clinical trial (RCT) (the Cornell-NY RCT) conducted by the members of the PDI at Weill Cornell Medical College, and a RCT by the Vienna-Munich TFP group (V-M RCT), to investigate the impact of one year of TFP upon symptomatology, attachment status, mentalization, social adjustment, utilization of psychiatric and medical services, neurocognitive functioning, and mechanisms of change in all of these dimensions in patients with BPD and borderline personality organization. These studies have been described in detail in previous publications (Clarkin, Foelsch, Levy, et al., 2001; Clarkin et al., 2007; Doering et al., 2010). We provide an overview of the studies here and then describe further investigations comparing the subset of borderline patients with and without comorbid NPD. Despite the high rates of comorbidity of NPD/BPD and the plethora of theories about its etiology and treatment, there have been few empirical studies that might help illuminate the etiology, course, and treatment response of NPD/BPD patients. Data from the two RCTs (Clarkin et al., 2007; Doering et al.,

2010) allowed for the delineation of the characteristics and clinical differences of the subgroup of patients with combined and borderline personality disorders (NPD/BPD), compared to BPD patients without NPD.

The Initial Study

In the initial study (Clarkin, Foelsch, Levy, et al., 2001), 23 women who met DSM-IV criteria for BPD who had at least two incidents of suicidal or self-injurious behavior in the previous year were selected for one year of TFP treatment, and their clinical condition at the end of the year of TFP was compared to their clinical condition prior to the treatment. It should be noted that in the initial diagnostic assessment, 70% of these patients were diagnosed with comorbid BPD and NPD based on the SCID II (DSM-IV) based criteria.

After one year of TFP, there were significant changes in a number of dimensions, including a significant decrease in the number of patients who made suicide attempts, in the average medical risk of parasuicidal acts and improvement in the average physical condition following these acts, and significantly fewer emergency room visits, hospitalizations, and days hospitalized (Clarkin, Foelsch, Levy, et al., 2001). In addition, there were significant changes in the BPD diagnosis in that after 12 months of treatment, 52.9% of the subjects no longer met criteria for BPD. Finally there were significant changes in ratings of reflective functioning (RF; as assessed by the Reflective Function Rating Scale; Fonagy et al., 1998) after one year of TFP, along with shifts from disorganized to more organized forms of attachment for the majority of the subjects (Diamond et al., 2003; Levy et al., in preparation).

The Randomized Clinical Trials

To assess improvement in TFP, as compared with other manualized treatments, a randomized clinical trial was conducted at the PDI (the Cornell-NY RCT; Clarkin, Levy, et al., 2004; Levy, Meehan, et al., 2006; Clarkin, Levy, et al., 2007) in which 90 patients (84 women and 6 men) who met DSM-IV criteria for BPD on the International Personality Disorder Exam (IPDE, Loranger, 1999) were randomly assigned to one of three year-long outpatient treatments: TFP; Dialectic Behavioral Therapy (DBT; Linehan, 1993), an empirically supported cognitive behavioral therapy; and a manualized supportive psychodynamic therapy, which, although psychodynamically based, did not use transference interpretation (Appelbaum, 2005). This study combined aspects of effectiveness and efficacy studies in that patient assessment and recruitment were done in a standardized way in a hospital setting and therapists were trained and carried out manualized treatments; however, the treatments were carried out by clinicians in the community and there were few exclusion criteria for therapists (Levy, Meehan et al., 2006; Kernberg, Yeomans et al., 2008; Levy, Meehan, and Yeomans, 2012).

In terms of primary outcome measures, TFP and DBT were significantly associated with improvement in suicidality; TFP and supportive psychodynamic therapy were associated with improvement in anger. Although TFP and supportive therapy were each associated with improvement in facets of impulsivity, only TFP was significantly predictive of change in irritability and verbal and direct assault. With regard to secondary outcome measures, patients in all three treatment groups showed significant positive change in depression, anxiety, global functioning, and social adjustment (Clarkin, Levy et al., 2007).

We also hypothesized that RF may be the primary mechanism by which patients with personality disorders improve, and that because of the nature of the treatment, RF would improve in TFP but not in DBT or supportive psychotherapy. The results supported this view, with only patients in the TFP group evidencing a shift in RF, moving from low RF, in which reflection on mental states of self and other was banal, simplistic, overelaborated, or canned, with little capacity to think about behavior in terms of intentional mental states, to an adequate RF, in which there is explicit reflection on mental states and how they affect behavior (Levy, Meehan et al., 2006). For patients in TFP, but not DBT or supportive therapy, there was also a significant increase in the AAI subscale of narrative coherence, the best predictor of attachment security among the AAI subscales (Waters et al., 2001). After 12 months, there was also significant (three-fold) increase in the number of patients classified with secure attachment in TFP, but not for DBT or supportive psychotherapy (Levy, Meehan et al., 2006).

It should be noted that security of attachment on the AAI is characterized by a well-organized, undefended discourse style in which emotions are freely expressed and by a high degree of narrative coherence, regardless of how positively or negatively attachment figures and experiences are portrayed (Main and Goldwyn, 1998). The increased ability to reflect on one's own and another's mind in addition to the movement toward attachment security shown by patients in the TFP group has clinical consequences in that it may curtail the inaccurate attribution of negative intentions to others that is typical of patients with BPD. Benign or positive events would be less likely to be seen as malevolent and the patient would be more able to avoid the downward spiral of misinterpretation and engendering of negative responses.

The third study, conducted independently by the V-M RCT (S. Doering, P.I) was a randomized clinical trial of 104 female patients who met DSM-IV criteria for BPD on the SCID-II. In this study, patients were randomized to TFP or to treatment by community psychotherapists with experience treating BPD (ECP; Doering et al., 2010). This study found TFP to be superior to treatment by ECP, with TFP patients evidencing significantly fewer suicide attempts, higher BPD remission rates according to DSM-IV SCID-II criteria, greater improvements in psychosocial functioning and personality organization, and fewer psychiatric inpatient admissions. In addition, there were significant shifts from insecure and disorganized to secure and organized attachment states of mind in patients treated with TFP but not those in ECP (Buchheim et al., 2012). Thus, in both the Cornell-N.Y. RCT and the V-M RCT's the AAI was found to be a useful instrument to capture structural change in BPD patients. Significantly, only patients in TFP in the two RCT's showed an increase of flexible integration and coherence in attachment representations on the AAI.

Comparison of NPD/BPD and BPD Groups on Comorbidity, Attachment and RF

Data from the Cornell-NY and V-M RCT's described previously (Clarkin et al., 2007; Doering et al., 2010) also allowed for the study of the characteristics and clinical differences of the subgroup of patients with combined narcissistic and borderline personality disorders (NPD/BPD), compared to borderline patients without NPD (BPD). Our goal was to investigate the nature of comorbid narcissistic and borderline pathology by reexamining the data on a number of dimensions including comorbidity, attachment status, and RF. The two studies yielded a combined sample of 188 patients, 25 of whom met criteria for NPD/BPD (13.3% of the sample), and 163 met criteria for BPD. In the Cornell-NY RCT 17.9% ($N = 15$) of patients met criteria for

NPD/BPD; in the V-M RCT, 10 % ($N = 10$) fulfilled both diagnoses. The patients were 100% women between 18 and 51. In both studies, all patients met DSM-IV criteria for BPD as noted, and in the V-M RCT for borderline personality organization. Note that all patients in both of these studies were treated for a minimum of one year in private offices by experienced therapists with advanced postdoctoral or psychoanalytic training, who were in supervision with expert TFP therapists regularly.

With the new subset from the pooled samples of NPD/BPD patients compared to BPD patients, we examined Axis I symptoms, Axis II symptoms, self-harming and suicidal behaviors, global function, attachment status, and RF. Measures of these dimensions were obtained at admission and after one year of TFP. Our goals are to (1) to compare Axis I and Axis II comorbidity, general functioning, self-harming behavior, and mental health service use in NPD/BPD patients compared to BPD patients at baseline; and (2) to investigate attachment classification and mentalization (RF) for these two patient groups at the beginning of treatment and after one year (see Diamond et al., 2012, 2013 and Hörz et al., 2012, 2013 for a full description of the study procedures, measures, and sample characteristics).

Our findings indicate that, compared to the BPD group, the NPD/BPD group had significantly fewer Axis I disorders, a larger number of comorbid Axis II personality disorders, and met more criteria in several Axis II disorders. Specifically, the NPD/BPD group fulfilled more diagnostic criteria for BPD and histrionic personality disorders (both Cluster B), as well as paranoid personality disorders and schizotypal personality disorders (both Cluster A) than did the BPD group. In addition, significantly more of the NPD/BPD group (44%) met full criteria for histrionic personality disorder than did the BPD group (14%). There was also a trend toward significance between the groups on antisocial personality disorder, with the NPD/BPD group more likely to meet criteria for antisocial personality disorder. In addition, there were significantly fewer hospitalizations and days in the hospital in the NPD/BPD group compared to the BPD group (Hörz et al., 2012, 2013). Although examination of the data revealed that the NPD/BPD group reported less self-harming behavior than did the BPD group, this difference did not reach statistical significance.

In sum, the higher levels of Axis II comorbidity in the context of significantly less Axis I pathology noted in the NPD/BPD group, along with fewer hospitalizations may indicate either the stabilizing aspects of the grandiose self discussed earlier (Ronningstam and Gunderson 1991), and/or the tendency to experience and report fewer symptoms. The rigid organization of the grandiose self may protect NPD/BPD patients to some degree from experiencing overt Axis I symptoms of anxiety or depression and from the need for hospitalization (Hörz et al., 2013; Simonsen and Simonsen, 2011). However, this hypothesis is speculative and needs to be examined in a study with a larger N and inclusion of an NPD only comparison group.

The findings also suggest that, in the context of BPD, NPD may cooccur with more malignant features: paranoia, a trend of more antisocial personality features and behaviors, and more distortions of reality or variable reality testing (schizotypal features). The triad of paranoid and antisocial features (trend) along with more distorted reality testing that characterized our NPD/BPD patients provides empirical support for Kernberg's conceptualization of malignant narcissism as a subgroup of NPD diagnosis (Kernberg, 1984, 1997, 2007; Hörz et al., 2013).

A combined sample of 151 patients from the Cornell-NY and V-M RCTs allowed us to compare the attachment status and RF of the NPD/BPD and BPD groups. This sample included only those patients who received the AAI (hence the reduction in number from 188 to 151). The

sample was divided into two groups: One included 129 participants who met DSM-IV criteria for BPD but not NPD (BPD), and another included 22 that met DSM-IV based criteria for both BPD and NPD (NPD/BPD). In both RCTs, the AAI was administered at entry into the study and after one year of treatment (see Diamond et al., 2013, Doering et al., 2010; and Levy et al., 2006, for a full description of the study procedures, measures, and sample characteristics). Examination of the data revealed that the largest AAI classification for the NPD/BPD patients was dismissing (32%), suggesting that mechanisms of devaluation, dismissal, and/or idealization of childhood attachment experiences and relationships represent a significant strategy to regulate narcissistic pathology. However, that 23% of NPD/BPD patients were categorized as cannot classify, in which there is oscillation between opposing attachment strategies, and 18% as preoccupied, indicates that dismissing mechanisms may alternate with preoccupied mechanisms in NPD/BPD patients (Diamond et al., 2013). The small sample size did not permit statistical analysis of the within group differences in attachment status.

We expected that compared with the BPD group, the NPD/BPD group was significantly more likely to be categorized as either dismissing (characterized by idealization/devaluation) or cannot classify (e.g., characterized by oscillation between opposing attachment strategies) on the AAI, while the BPD group was more likely to be classified as either preoccupied or unresolved for loss and abuse than was the NPD/BPD group. The hypothesis about classification of the NPD/BPD group was based on previous research and clinical investigations that have linked NPD with grandiose self-states in which others are systematically dismissed and devalued, as well as with fluctuating mental states of grandiosity and vulnerability that have been linked with dismissing and preoccupied attachment status respectively (Levy et al., 2007, see Meyers & Pilkonis, 2011 for a review).

The relative rates of AAI classifications in these groups was as hypothesized (Diamond et al., 2013). Interestingly, both NPD/BPD and BPD groups showed evidence of disorganized states of mind with respect to attachment. The NPD/BPD group was more likely to show the oscillation between opposing attachment states of mind, most typically between dismissing and preoccupied attachment strategies throughout the AAI that is characteristic of the cannot classify category. By contrast, the BPD group was significantly more likely to show drastic and focal breakdown in the monitoring of reasoning and discourse, often involving the intrusion of compartmentalized and dissociated states of mind, in response to specific questions about loss and abuse that is indicative of the unresolved classification. These findings suggest that the NPD/BPD group may be more resilient and/or better defended than the BPD group in the processing and containment of attachment trauma, although this hypothesis is speculative and suggests further research investigation. It is important to note that both diagnostic groups had low RF ratings suggesting that they both had deficits in mentalization with respect to early attachment experiences and relationships.

Thus, with the combined samples from both RCTs, no differences in levels of RF and narrative coherence were noted between the two groups at the beginning of treatment (as expected), and both were in the low range (Diamond et al., 2013). Change in RF over the course of one year of therapy for the two groups has been examined only for the Cornell-NY RCT sample. Although statistical analyses were not possible given the unequal *N*s and small sample size, examination of the data for the Cornell-NY RCT indicates that the group of patients with comorbid NPD/BPD were more likely to show improvement in RF only in TFP (but not DBT and supportive therapy) after one year of treatment (Diamond, Yeomans, Levy, et al., 2011). These preliminary findings

suggest that there is change in RF for NPD/BPD patients only in the TFP group, reflecting the overall study findings reported earlier (Levy, Meehan et al., 2006). However, the ratings of narrative coherence changed minimally for the NPD/BPD patients in all three treatment groups (e.g., TFP, DBT, and STP)—a finding that does not reflect the shift in narrative coherence of all patients in TFP reported earlier. It should be emphasized that these changes involve examination of patterns of the data in the Cornell-NY sample only, which is too small for statistical analysis, and thus must await further analyses of changes in RF and coherence on the combined sample which are in process.

Because clinically we have noted that narcissistic patients tend to have difficulty considering the grandiose self as one among many self-states, with the concomitant difficulty viewing others with any complexity, the improvement in RF that we see in our NPD/BPD patients in the Cornell-NY RCT sample after one year of TFP is encouraging. Although our clinical observations suggest that it may be generally true in exploratory therapy that RF changes before coherence with BPD patients, it may be more relevant for NPD/BPD patients whose narrative is dominated by the defensive functioning of the grandiose self.

CONSIDERATIONS RELATED TO CLINICAL TECHNIQUE

Based on the foregoing research findings and our reflection on our narcissistic cases in our supervision group, we have identified the following modifications of TFP technique for treating patients with combined NPD/BPD patients.

Treatment Contract

The essence of TFP is to create a treatment frame through the treatment contract that allows the patient's internal representations to unfold in the relationship with the therapist (Clarkin et al., 2006). With the narcissistic patient, contract setting is more difficult because the setting of responsibilities confronts (poses limits to) the grandiose self and hence is often initially rejected or tested in ways that may threaten the continuance of treatment. The contract and frame are particularly important in cases in which the patient's grandiosity has kept him from functioning in the real world. Such patients often receive significant secondary gain from the disorder in the form of assistance from family or the social service system (Diamond, Yeomans, and Levy, 2011; Stern et al., 2012).

Before any discussion of a contract, a careful assessment of the patient's capabilities and life circumstances will help establish the degree to which secondary gain threatens therapeutic improvement. For a patient to attend two therapy sessions per week without engaging in other productive activity is not therapeutic. The requirement in TFP that the patient must engage in some form of productive activity (e.g., volunteer or paid work and school) poses a challenge that serves the dual purposes of bringing to the surface some of the conflicts the patient may avoid through isolation, and provides the patient with the opportunity to discuss in session the anxieties evoked by engagement with the larger world. This is often a highly contentious issue in setting up a treatment contract with NPD/BPD patients, the resolution of which is prognostically significant. Therefore, we have modified our tactics with these patients to provide more latitude for the rigid defense of the pathological grandiose self, i.e., a more protracted period of negotiation with

the patient to function in some productive capacity, while addressing aspects of the grandiose self (e.g. perfectionism, etc.) by means of interpretation that keep the patient in a paralyzed and/or isolated state.

Defining the Dominant Object Relations

The typical dominant object relational dyad of the narcissistic patient is that of the omnipotent grandiose self in relation to an insignificant devalued other. However, the initial identification of the object relational dyads for the narcissistic patient is more difficult because there is an inability to take an observing distance from the grandiose devaluing part of the dyad in the case of the grandiose narcissistic patient, or from the insignificant devalued part of the dyad in the case of those with vulnerable narcissism. Hence, clarification of the dominant affects and associated object relations, the first stage of the interpretive process, is more difficult because the affects of humiliation, envy and fear of dependency that devolve from the grandiose self are rigidly defended against. Thus, identifying the object relations dyads is more gradual and problematic because the patient has difficulty decentering from the grandiose self to explore other aspects of self (e.g., weakness, humiliation etc.) Alternatively, the therapist may be included in the patient's grandiosity so that he or she remains rigidly idealized.

To counter this, we have modified our interpretive technique with narcissistic patients to rely more heavily, particularly in the early stages of treatment, on what Steiner (1993) called *therapist-centered interpretations*. These interpretations are designed to identify the predominant affects that the patient is experiencing in the moment-to-moment relationship with the therapist, without making any linkages to the patient's dynamics, or to his or her history (Steiner, 1993; Caligor et al., 2009; Diamond et al., 2011). Insofar as the patient is phobic of perceiving flaws in the self, one aspect of technique is to focus more on negative feelings, such as humiliation, weakness, or shame as they are projected onto the therapist. Conversely, the patient's grandiosity may be projected onto the therapist who, at times or in some cases, is seen as the idealized figure who can magically fix the patient. Such object-centered interpretations—therapist-centered interpretations—are particularly important with narcissistic patients who initially cannot tolerate seeing flaws in themselves, but may be able to observe them in the therapist and thus can reflect on what it is to have limitations. This is a stage of the interpretive process at which many therapists struggle, unable to either disentangle themselves from the patient's idealization or succumbing to the patient's omnipotent control by working under fear, conscious or not, to be the perfect idealized object for the patient. Therapists also tend at such points to either become overly defensive or to engage in countertransference enactments, struggling to tolerate the patient's devaluation and understanding it as an aspect of the patient's internal world of self and object representations and associated affects.

Working in the Transference

Interpretation of role reversal in the transference, a phenomenon characteristic of BPD patients without comorbid NPD, is complicated with narcissistic patients because of the rigid defensive nature of the grandiose self, which makes the expected oscillation of grandiose and deprecatory self states less prevalent in certain cases, although one can see oscillation between grandiose and deprecatory self states in all narcissistic patients (Roche et al., 2012), particularly those with

vulnerable presentation. With BPD patients without severe narcissistic pathology, the dominant object relations are usually readily activated with the patient oscillating between identification with the self or object poles of the dyad in rapid succession in both the extra-transferential and transference relationship.

Work in the transference relationship is particularly difficult with NPD/BPD patients because of the patient's inability to acknowledge or invest in an object relation with the therapist. Instead the therapeutic relationship may be eclipsed by the patient's investment in the grandiose self, with the therapist at times included in the patient's grandiosity and at other times ruthlessly excluded and devalued for being worthless, particularly if the needs for admiration and desires for endless and perfect caretaking are not met.

Once the dominant relationship pattern has been identified between patient and analyst, enactment of complementary patterns can be discerned in split-off aspects of what the patient is saying or doing. In tracking the self-object dyads as they emerge in the treatment process, the therapist must also be mindful of the layering of dyads, i.e., which dyad on the surface defends against another at greater depth. For the NPD/BPD patient, such layering typically takes the form of a negatively-valenced dyad of the *self-sufficient, grandiose self* in relation to a *devalued object*, which defends against a deeper, positively-valenced, idealized dyad, that of a *dependent, perfectly nurtured self* linked with longing to an *admiring, caring parental figure*. Similar to the negatively-valenced, persecutory dyads often encountered on the surface, the defended-against idealized dyads are equally extreme in their characteristics, and equally influential in the patient's distorted experience of reality. Reflection on the relationship between these two contradictory polarized object relations paves the way for a more realistic and integrated view of self and others. In the final phase of the interpretive process in TFP, the therapist explores hypotheses about the meanings of the patient's experience in the transference, focusing in particular on splitting operations and the anxieties motivating dissociation and denial. Interpretation and working through of the anxieties motivating primitive defenses flows naturally into exploration and interpretation of conflictual aspects of the patient's psychological life that have been repressed.

The following case example indicates how the cooccurring personality features might pose particular clinical challenges and affect the course and outcome of TFP treatment.

CASE ILLUSTRATION

Marta, a single, unemployed Latin American woman, was referred for TFP at age 33 after many years in other treatments. Her condition had worsened to the point where she spent the 6 months prior to beginning TFP isolated in her apartment, lying in bed with chronic suicidal ideation and binge eating, and only rarely bathing. She was the middle of three siblings in an upper middle-class family that immigrated to the United States so that her father could pursue advanced professional training. She described her mother as extremely controlling, "pushing us to the limit." She felt chronically rejected by her mother, who was often depressed, suicidal, and unable to care for her children. She felt that mother gave her "mixed signals," at times clinging to her when she was lonely and in states of depression, but at other times shutting her out, locking her in a car alone on one occasion and frequently sending her to room for punishment. She stated that she often felt that she did not really have a mother and that "I just remember being disciplined; I don't remember comfort." Marta described her father as emotionally absent

and preoccupied with his legal career, but she also experienced him as obsessed with his children's educational performance to the point of abusing them verbally and sometimes physically if they did not perform up to expectations. She felt that she "lost" her father when she was not doing well in school. When she was upset or distressed or when she was being punished, she would go to her room where she would "play, pretending to be teaching, and living in this fantasy world."

The patient dropped out of college, and then held a series of secretarial jobs in law offices but was repeatedly fired. Although she believed she was fired because of racial prejudice, her descriptions of her interactions, as well as her in-session behavior, suggested that her belligerence played a role. Eventually, she could no longer find employment. Marta had no history of sexual relations, except for one occasion when a man she had dated three times began to make love to her. She panicked, stopped the interaction before intercourse, and later brought formal rape charges against him. Notably, Marta reported having fantasies of sexual promiscuity. Although she had a limited history of overt self-destructiveness, cutting herself superficially on occasion, she described persistent wishes to kill herself. Marta had had three psychiatric hospitalizations, had been diagnosed with an affective disorder, and had been on many medications, all of which were discontinued during the first year of TFP.

In the research evaluation, she met criteria for not only BPD, but also narcissistic and avoidant personality disorders on the IPDE (Loranger, 1999), and she met SCID-I (First et al., 1996) criteria for current dysthymia. Finally on the Inventory of Personality Organization (Clarkin, Foelsch, and Kernberg, 2001), a self-report inventory designed to assess level of personality organization, she scored very high on identity diffusion and primitive defenses, and evidenced compromised reality testing and elevated aggression scores.

On the AAI, she showed contradictory and inconsistent states of mind with respect to attachment, shifting chaotically between dismissing devaluation of early attachment figures, and angry preoccupation with parental objects with whom she was emotionally entangled, leading to an attachment classification of Cannot Classify, with mixed Preoccupied and Dismissing states of mind (CC/E2/D2).

From the earliest sessions, Marta's interactions with her therapist were characterized by a nonstop monologue through which she entirely blocked his participation in the therapy and eliminated any possibility of dialogue or reflection. Marta's stream of discourse consisted mainly of vociferous complaints about how others treated her with aggression and disrespect. She interrupted and talked over her therapist if he tried to speak. Although, on a superficial level, Marta seemed to seek validation of her narrative from the therapist, her treatment consisted, in fact, of haranguing him while dismissing and criticizing him as doing nothing for her. When the therapist attempted to draw her attention to this behavior, Marta became more forceful in her efforts to control him, becoming increasingly aggressive, agitated, and, at times, overtly abusive. Her haughty, derogatory, or withdrawn attitude seemed to empty out the therapeutic relationship of any meaningful human contact, leaving the therapist feeling in the countertransference alternately controlled, shut out, mistreated, helpless, and/or infuriated.

The therapist's initial response was to tolerate the confusion and frustration that such a stance engendered in him as he was effectively silenced by her grandiosity, aloofness, and arrogance. After some time, the therapist chose to tactfully address Marta's style of communication. Focusing on the nature of their interaction and on her experience of him, as well as his of her, he pointed out that Marta's barrage of words and rejection of anything he offered might function

to control him, immobilize him, and keep him at a distance. In addition, he commented on the apparent discrepancy between this and Marta's regular and punctual attendance at her sessions. With time, Marta became more aware of her own behavior and, the therapist was able to raise the question of what might motivate her to interact this way.

In the course of these discussions, the underlying object relation coloring Marta's experience began to take form in the transference. As Marta talked about the father who rigidly monitored her, the racial discrimination she reported, and her general sense of rejection and criticism from others, it became clear that the dominant dyad being enacted was one of a controlling dominating figure suppressing a subordinated trapped figure. This highly concrete experience of herself and the therapist had initially been split off from her awareness and defended against by Marta's enacting the omnipotent and dismissing stance. The therapist saw Marta's flooding him with material as both an effort to control him, but also to establish contact. However, every time he made forays into discussing this, she disregarded him or ridiculed him. This behavior suggested that the need to be in control, and powerful and right, masked her dependency issues.

In the initial sessions, the omnipotent object relation of the controller and the controlled but-tressed the patient's self-esteem, but at the expense of any genuine investment with the therapist who might offer help, and also functioned to protect her from envy directed toward the therapist—the potentially good object (Rosenfeld, 1964). Her dismissing devaluation of the therapist was punctuated by envious attacks on him. She periodically referred to the therapist's accomplishments and publications, which she looked up on the Internet, but then would interject comments such as, "You're supposed to be an expert! You don't do anything!" As these primitive object relations began to emerge, her experience of the transference was concrete, highly affectively charged and confusing and anxiety provoking for therapist and the patient. In addition, the patient accused her therapist of being interested in her only because he was gaining something for himself—scientific knowledge from a research participant—and that there was no possibility for an authentic human relationship based on trust and reciprocity.

The therapist's efforts to identify an object relation was experienced as shameful and humiliating because it evoked a relationship that she could only imagine would be harmful and exploitative. However, his interpretation of the patient's representation of herself as "a guinea pig" and her therapist as an exploitative experimenter focused on the affect embedded in this dyad, namely the distress of the neglected, discounted child who is longing for caring, with the idea that the affects related to this dyad (longing, fear of neglect, criticism, and abandonment) might underpin the predominance of the controlling/controlled dyad. Focusing on the internal working model characterized by neglect and exploitation that came through in her comment about feeling like a guinea pig, the therapist said,

We might have the answer to why you behave with me the way you do right here in your last comment. You may be convinced that I'm not interested in you, that I don't care, and that I have a negative opinion of you. You feel that you're always doomed to neglect. Someone who believes that might want to control the interaction for fear that if she weren't in control, she'd be mistreated by the other person or lose him altogether.

Marta burst into tears and replied, "Of course if I don't control you, I'd lose you—like everybody else. Even my parents weren't interested in me, so why should you be?"

Her therapist's comprehension of the affects and anxieties that underlay her grandiose controlling behaviors momentarily broke through her conviction that he was indifferent, neglectful,

and critical. Thus, in the early stages, the therapist made use of his countertransference in conjunction with Marta's verbal and nonverbal communications to organize her experience in the transference in his own mind and then to put it into words. When Marta confirmed that this was, indeed, how she experienced him, the therapist added that viewing him in this way understandably left her feeling upset and angry. Thus, in the early stages, one sees the example of therapist-centered interpretation (Steiner, 1993), which focuses on elaborating what the patient is experiencing toward the therapist in the moment, and only gradually expanding awareness of that to an object representation that was part of the patient's self.

Such therapist-centered interpretations provided cognitive containment of Marta's experience of the transference, offering her the possibility of being understood, and an experience of a therapist who might genuinely empathize with a part of her that was split off and only obliquely visible. The situation itself, catalyzed by the therapist's empathic comment, was a challenge to her belief system and thus an invitation to reflect—a confrontation in action.

The therapist pointed out that Marta did not generally allow herself the chance to find out if he was interested in her. By controlling the interaction to create a semblance of interest, she supported the belief that he was not really interested in her. In this process, she devalued him but could not avoid experiencing herself as devalued. He further suggested that while attempting to hold him in her grip, she was actually remaining distant from him, because her monopolizing the interaction did not allow him to be present in the room as an independent other. Marta subsequently could acknowledge that she did not allow her therapist to exist independently because of her fear that he would treat her badly or leave if she left him to his own devices. It became clear that this strategy left her alone in relation to others—a condition for which she historically blamed others, but which served the function of keeping the attachment system deactivated, as is the case with those where dismissing states of mind with respect to attachment are dominant. Marta gradually understood that her need to control in an omnipotent way was one state of mind about self and other, and she gradually questioned this fixed position as she began to sort out what feelings came from whom.

With a clearer articulation of her experience of self and other, she began to occasionally notice that, although she chronically complained of others treating her harshly and rejecting her, she could treat others, including her therapist and herself, in a similar way, and that this interaction was linked to an internal dyad involving a harsh critic and the object of the criticism. So, in the initial phases of therapy Marta became able first to articulate how she saw the therapist and consider that he might have a different state of mind than that which she attributed to him, and then to recognize that she could behave in the way she had attributed to him.

The patient's recognition of alternating between identification with the self and object poles of a particular dyad infused with a particular affect led to an expanded capacity to think in mental state terms, in that it enabled her to recognize that her mind is representational in nature; that is, that her experience of self and others was shaped in part by myriad mental models of self in relation to others. Interpretation of Marta's attempt to control the supposed rejecting other led to an awareness of rejecting and critical elements in herself and of the identification with both poles of the dyad, enabling her to take back the projection. Her recognition of this pattern cleared the way for a more libidinally charged gratifying experience of the self in relation to the therapist to emerge, setting the stage for the integration of her disparate experiences of self and object. This stage also poses challenges for the patient with severe narcissistic pathology in that it involves the analysis of aspects of the grandiose self including ideal self and ideal other, triggering awareness

of dependent wishes with the therapist and others. Inevitably, narcissistic defenses of envy and devaluation are activated to protect against the humiliation experienced in a genuine need of and connection to another, as the patient decenters from the rigid identification with a hostile but stabilizing introject.

In a session that took place six months into the first year of therapy, Marta showed an increased capacity to take an observing perspective from a rigid identification with a hostile punitive introject. She was able to reflect on the interaction and consider other perspectives even as, at times, she reverted to her hostile, controlling stance. Marta was angry and suicidal in anticipation of her therapist's vacation. The therapist suggested it may be humiliating to care so much about him when she felt he did not care about her.

Marta: You say the same thing to every one of your patients! I'm not like all of them!

Therapist: You feel like you're one on an assembly line.

Marta: [with sudden change of affect, from angry to sad]: I don't feel that I deserve to be here. . . . I don't know [patient covers her face with her hands]. I just feel badly that I have to walk around with other human beings. I just don't feel like . . .

Therapist: I think you don't want me to see you in the longing that you feel. You don't mind if I see you in your anger and your rejection of me. You don't want me to see the longing, because you think I'll just use that to humiliate you, by rejecting, by turning away from you.

Marta: I just feel like the tragedy of everything, of all of this, is that I have help available.

In this session, one sees several major developments in the therapy: First her need to control the other as a means of controlling a critical rejecting object representation—here through the suicide gesture—alternates with an opposite object relation of a self longing for affection from a loved other. Here the therapist, moving into the more advanced stages of interpretive process, begins to link the dissociated positive and negative transferences, leading to an integration of the mutually split-off idealized and persecutory segments of experience. As Marta shifted from her discussion of wanting to kill herself to what she was feeling toward her therapist—something she could do only after he named the split-off libidinal dyad, she moved from the dyad imbued with negative affect that served defensive purposes (the harsh critical object rejecting the helpless unworthy self) to the one imbued with positive affect (the longing self and loving object). The therapeutic work focused on clarifying which part of her experience belonged to the other person and which part to her self. Marta felt rejected and humiliated by the therapist's planned absence, while presenting with rejecting behavior. As the session progressed, Marta described a fantasy she had had of humiliating her therapist in the waiting room.

The therapist pointed out that it was difficult for her to experience or reveal the longing she felt, that she was more comfortable retreating to fantasies of humiliating him to avoid the rejection and abandonment and longing. Marta continued, "I guess there's a longing in a way, 'cause I did come on time; I didn't really want to come, but I do long to come here, in a way, I guess I do."

This material, by necessity highly condensed, also shows the beginning of the dissolution of the grandiose self, which is devolving into object relations that were internalized but not integrated. The splitting between idealized and persecutory object relations in the transference (e.g., he is the longed for but unattainable fantasy figure and also the person who is indifferent to her, who treats her like "one on an assembly line," functions as a regression on the way to integration; Kernberg, 2007). Such paranoid micro regressions, or even suicidal tendencies, in patients with severe narcissistic pathology can occur in the context of the deepening of the transference as the patient begins to experience real dependency, gratitude, and fears of losing the therapist. These

affects replace the earlier deadening omnipotent control, emotional vacuousness, and envious devaluation of the relationship that correspond to the grandiose self. In this session, the therapist noted role reversals in the transference, whereby the patient identified with both aspects of the object relationship: the abandoner or humiliator and the abandoned and humiliated. Marta was able to acknowledge the significance of the therapeutic relationship that such role reversals entail, moving beyond her fixed attitude of grandiose superiority, that devolved from her identification with a hostile introject and served as a retreat from a range of object relations, internal and external.

The therapist's interventions in this session illustrate the third phase of the interpretive process, in which the patient is made aware of the split representations that characterize his or her experience of the transference and how certain core object relations and drive dispositions defend against others. These interventions are intended to foster integration, even though they do not yet focus on underlying motivations for such defensive operations, by bringing together dissociated aspects of the patient's disparate experience. They also foster the patient's capacity to appreciate the symbolic or constructed nature of his or her experience in the transference and to reflect on his or her experience across different mental states and across time.

Toward the end of the first year of treatment, Marta's complaints of mistreatment by others decreased. She reported less anxiety and more positive interactions in her volunteer work setting, where she was offered a paid position. With regard to intimate and sexual relations, an erotic transference emerged fitfully during the first year of treatment, first in moments of seductive posture and only rarely verbalized. Her mention of sexual feelings alternated between shame and a sense of danger, replicating her early sense of "being a little scared" by sexual feelings for her father as a young child and adolescent that she articulated on the AAI. In the course of treatment, she progressed in taking back projected anger and hostility as she gained awareness of the roots and consequences of her own aggression, and could both accept and also feel remorse for previous aggressive attacks on self and others. The decrease in her projection allowed her to experience others with less paranoia, strengthening her capacity for increased mutuality and trust. In the course of treatment, she started a relationship with and eventually married an appropriate partner.

Although the patient's reflective functioning increased significantly, as rated in the AAI after one year of TFP, the therapist reported variability in her capacity for mentalizing (from below average to average RF) in the therapy sessions. His impression was that the patient was more capable of reflection in situations of stability, but would regress more quickly and drastically than most to unreflective thinking under the influence of primitive defense mechanisms in threatening situations, where her own intolerable mental states could not be separated from those of others. The therapy continued to strengthen her integration.

As the therapist repeatedly interpreted the anxieties about rejection and abandonment that motivated her sequestering of loving from hateful feelings, there was an increased integration of these two spheres of her affective experience and with that the deepening of depressive anxieties around responsibility and concern. The recognition that the individual can have completely opposite feelings towards the same person – feelings that he or she may have previously attributed to that person – enables the him or her to experience and tolerate a sense of responsibility, concern and guilt about aggressive or negative feelings or states, instead of having to project them (Klein, 1946, 1957).

SUMMARY AND CONCLUSION

Our research and clinical findings suggest that patients with NPDs functioning on a borderline level show a specific configuration of personality disorder comorbidity, psychopathology, and of representational states with respect to attachment, when compared to patients with BPD without narcissistic pathology. The clinical and empirical investigations reported in this article converge to suggest the stabilizing effect of the grandiose self, as well as the predominance of ego-syntonic dismissing/devaluing defenses in NPD/BPD individuals, emphasizing the need to focus first on these aspects of self and interpersonal functioning in clinical work. Interestingly enough, however, compared with the BPD group, the NPD/BPD group was more likely to include *cannot classify* attachment states of mind, which are most often characterized by oscillation between dismissing devaluation and angry preoccupation. It is important to note that the AAI, in Main's words, is designed to "surprise the unconscious" (George, Kaplan, and Main, 1998, p. 3), revealing the full panoply of attachment states of mind that may emerge in more layered fashion in the clinical situation. The case of Marta illustrates how dismissing devaluation is mobilized to defend against preoccupied states of mind involving angry, conflicted, overwhelmed, and passive dependent states of mind which emerge later in treatment.

The case material also illustrates how, after one year of TFP, patients show significant improvement in their capacity for mentalization (as indicated by increases in RF ratings described above), and a decrease on measures of aggression (Levy, Meehan et al., 2006). Our hypothesis is that the improvements in the complexity and integration of the RF ratings are a result, in part, of the interpretive process described herein, that is unique to TFP. For patients with severe narcissistic disorders, this interpretive process leads to the gradual dismantling of the grandiose self into its component ideal self and object representations, and the gradual integration of disparate, split off self and object representations into an overarching stable concept of the self and objects. We propose that the consolidation of identity that occurs with the integration of the internal world, in turn, fosters mentalization in that it provides a stable and consistent working model of self and others against which momentary mental states, even those that are grandiose or devaluing, affect or drive laden, can be assessed. Our clinical case illustrates the therapeutic challenges, as well as changes in the course of TFP with an individual with narcissistic pathology functioning on a borderline level.

Future studies need to examine in larger samples the characteristics of this complex patient population, study how they further differ in their clinical presentation, as well as neurocognitive characteristics from BPD patients without NPD, and test in longitudinal designs how these cooccurring personality features might affect the course and outcome of treatment, particularly change in attachment states of mind and the capacity for mentalization.

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