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# Change in Attachment and Reflective Function in Borderline Patients with and without Comorbid Narcissistic Personality Disorder in Transference Focused Psychotherapy



*Abstract*. Research has consistently found high rates of comorbidity between narcissistic personality disorder (NPD) and borderline personality disorder (BPD). Patients with this complex clinical presentation often present formidable challenges for clinicians, such as intense devaluation, entitlement, and exploitation. However, there is a significant gap in the literature in identifying the clinical characteristics of these NPD/BPD patients. In this article, we present recent research describing patients with comorbid NPD/BPD, as compared with patients with BPD without NPD (BPD), from two randomized clinical trials for the treatment of borderline personality disorder, with a particular emphasis on attachment status and mentalization. We anchor our discussion of these patients in object relations and attachment theory, and we describe our treatment approach, transference focused psychotherapy (TFP). We conclude by using case material to illustrate our research findings, highlighting the significant differences between patients with NPD/BPD and BPD/non-NPD in terms of their attachment classification.

*Keywords:* narcissistic personality disorder, borderline personality disorder, attachment, comorbidity, adult attachment interview, reflective function

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## Introduction

After several years of outpatient treatment, a formerly highly suicidal patient with both narcissistic and borderline pathology said, "I'm better but I can't admit it because your success is my failure." Another patient, who sought therapy to deal with a relationship crisis, began by saying that he fully expected that the therapist would not be able to tell him anything he didn't already know about himself, as was the case in his previous four-year analysis. Likewise, another patient berated her therapist by saying, "I've been on the Internet and I don't think you talk enough about my narcissism." Such statements taken from intensive and ultimately productive treatments highlight the formidable clinical challenges posed by patients with cooccurring narcissistic and borderline pathology. Their devaluation of therapy, their presentation of self as special and entitled, and their tendency to provoke, alienate or even deskill their therapists, along with their high dropout rate (over 64% in one study; Hilsenroth, Holdwick, Castlebury, & Blais, 1998), have led some to speculate that these patients are at the limits of treatability and may be among the most difficult patients to work with in the personality disorder spectrum (Stone, 1990; Kernberg, 2007; Clemence, Perry & Plakun, 2009; Diamond, Yeomans & Levy, 2011).

In an attempt to further understand the formidable challenges these patients pose, clinicians and, increasingly, clinical researchers have focused on the diverse and often contradictory clinical presentations, internal complexity, and subjective distress of individuals with narcissistic personality disorder (NPD; Levy, Reynoso, Wasserman, & Clarkin, 2007; Ronningstam, 2010, 2011; Levy, 2012). The plethora of theories and treatment approaches to narcissistic pathology (Kohut, 1971, 1977; Kernberg, 1975, 1984, 1997, 2007; Bach, 1985) that reflect the diverse presentations of NPD have been downplayed in the current DSM-IV criteria, which privileges overt grandiosity without taking into account the ways this symptom may be expressed covertly in fantasy or may mask internal distress and suffering. There is now a consensus that the DSM criteria do not address the complex manifestations of narcissistic pathology or how it may manifest itself at different levels of severity and in the context of other disorders. Clearly further research on the theory, diagnosis, and treatment of NPD is warranted (Ronningstam, 2011).

In this article, we will report on recent work evaluating the characteristics of patients with comorbid narcissistic and borderline pathology, how

they may differ in their symptomatic and clinical presentation from borderline patients without narcissistic pathology, and how these cooccurring personality features might pose particular treatment challenges with respect to psychotherapy process and outcome. Data from two randomized clinical trials (RCTs) comparing transference focused psychotherapy (TFP) to three other psychotherapies for borderline personality disorder (dialectical behavior therapy [DBT], supportive psychodynamic therapy, and treatment as usual by experienced clinicians in the community; Levy et al., 2006; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010) allowed for the study of the characteristics of the subgroup of borderline patients who had comorbid narcissistic personality disorder. Our work has compared patients with borderline personality disorder (BPD) with and without comorbid narcissistic disorder (NPD/BPD vs. BPD) on a number of dimensions, including comorbid Axis I and Axis II disorders, suicidality and self-harm, hospitalization, and service utilization. In addition, in order to further understand the representational world of individuals with severe narcissistic pathology, we have also investigated attachment status (with the Adult Attachment Interview [AAI]; George, Kaplan, & Main, 1985) and the capacity for mentalization (e.g., the capacity to understand behavior in terms of intentional mental states such as feelings, motivations, beliefs; Fonagy, Gergeley, Target, & Jurist, 2002) using the reflective function (RF) Scale (Fonagy, Target, Steele, & Steele, 1998), and the ways they change over the course of one year. In this article, we will first present our model of narcissistic pathology based on object relations and attachment theory, and will then present our research findings and their implications for understanding and treating patients with comorbid NPD/BPD with a focus on our treatment model, transference focused psychotherapy (TFP). We will then summarize AAI data on two cases to illustrate the differential attachment representations of NPD/BPD and BPD/non-NPD patients.

## Background

Because the concepts of pathological narcissism and borderline conditions were first identified and systematized by psychoanalysts such as Kernberg (1975), Kohut (1971, 1977), Bach (1985), and A. Stern (1986), it was generally recognized that narcissistic pathology is a fundamental aspect of borderline conditions and indeed may be found across all

personality disorders (Kernberg, 1975, 1984; Ronningstam, 2010; Bender, 2012). The object relations framework that initially guided the conceptualization of both borderline and narcissistic disorders suggested that both disorders share core structural features, including impairments in identity, self, and interpersonal functioning; maladaptive patterns of mentally representing self and others; deficits in affect regulation; and reversion to "primitive" defensive strategies for the unconscious regulation of intolerable self-states and affects (Kernberg, 1975, 1984, 2009, 2010).

Subsequent research has borne out the theoretical linkage between borderline and narcissistic disorders. A number of studies have shown particularly high rates of comorbidity of NPD with BPD, with rates ranging from 17% (Clarkin et al., 2007) to 80% (Pfohl, Coryell, Zimmerman, & Stangl, 1986; see Levy et al., 2007, for a review). The recent Wave 2 National Epidemiologic Survey on Alcohol Survey on Alcohol and Related Conditions (NESARC) study, in which a representative sample 35,000 Americans were asked if they had experienced symptoms of NPD over the course of their lifetime, found a prevalence rate of 6.2% of NPD, with 37% of individuals with NPD diagnosed with BPD, and 62.9% of those with NPD diagnosed with any other personality disorder (Stinson et al., 2008). Gunderson, Ronningstam, and Smith (1995) found that the rate of cooccurrence of NPD with other personality disorders exceeded 50%. These high rates of comorbidity make it likely that patients with other personality disorders will also have significant narcissistic pathology that may affect their diagnostic and clinical presentation, including treatment course and outcome (Kernberg, 1984; Diamond & Yeomans, 2008).

The characteristics of NPD first observed by psychoanalytic clinicians (Kernberg, 1975, 1984; Kohut, 1971, 1977) and later systematized in the DSM from 1980 (American Psychiatric Association, 1980), have now been largely confirmed by empirical research (Levy et al, 2007; Cain, Pincus & Ansell, 2008). Ronningstam and Gunderson (1991) found that compared with BPD patients, NPD patients were found to have a more grandiose sense of self (i.e., an 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, although grandiosity was found to fluctuate with vulnerable self states over time (Ronningstam, 2010). As Kernberg (2009) put it, individuals with NPD are vulnerable to "bouts of insecurity disrupting their sense of grandiosity or specialness" (p. 106). A recent study with daily diary cards showed that pathological narcissism was linked with intra-individual fluctuations

of both shame (vulnerability) and hubris (grandiosity) over eight days (Roche, Pincus, Conroy, Hyde, & Ram, 2013). Thus, prior research and clinical investigation have identified two dominant presentations of NPD: Grandiose, involving self-aggrandizement, and ruthless exploitation of others who are systematically devalued; and vulnerable, characterized by self-effacement in the context of covert grandiose fantasies that are curtailed by hypersensitivity and shame proneness. However, whether these are distinct phenotypic presentations of the disorder, or fluctuating mental states, remains unclear (Levy et al., 2007; see Cain et al., 2008 for a review).



### *Attachment, Mentalization, and Personality Disorders*

The identification of the insecure and disorganized working models of attachment as risk factors for the development of narcissistic and borderline disorders (Bowlby, 1988; Meyer & Pilkonis, 2011) has provided another theoretical framework and research paradigm with which to understand and investigate the overlap and divergence of the two disorders. Bowlby (1977) stipulated that the quality of childhood attachment experiences determined the "later capacity to make affectional bonds as well as the whole range of adult dysfunctions," including "neurotic symptoms and personality disorders" (p. 206). Specifically, Bowlby (1988) hypothesized that individuals with avoidant-dismissing internal working models of attachment were likely to have been continually rebuffed by attachment figures when seeking comfort and protection, and might "attempt to live life without the love and support of others ... to become emotionally self-sufficient ... and may later be diagnosed as narcissistic or as having a false self of the type described by Winnicott (1960)" (p. 125).

The development of the AAI (George et al., 1985) has provided a tool to link the attachment representations of adults with their developmental antecedents and, specifically, with parent–child attachment behaviors in the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978). The Adult Attachment Classification System developed by Mary Main and colleagues (Main, Hesse, & Goldwyn, 2003) examines the structural and discourse characteristics of autobiographical narratives about attachment experiences and relationships in adults. Parents' AAI representations of attachment have been found to predict infant attachment status in over 18 international studies in a meta-analysis (see van IJzendoorn, 1995). Main

et al. (2003) identified three major adult attachment classifications characterized by different representational states with respect to attachment. The secure/autonomous classification is characterized by well-organized, fresh, and spontaneous discourse, indicative of free and autonomous states of mind with respect to attachment and an internally consistent and integrated portrayal of relationships. The dismissing classification is characterized by devaluing or idealizing states of mind with respect to attachment, or by lack of recall for attachment related events and experiences altogether. These individuals are judged to have low coherence of mind because of the inconsistency between vaguely positive generalizations and "leaked" evidence to the contrary. The preoccupied classification is characterized by enmeshed/entangled states of mind with respect to attachments figures, with much evidence of current preoccupying anger or passive overwhelmed states in relation to attachment figures, and/or an oscillation between extreme positive and negative states of mind with respect to attachment. Subsequent research has identified a "cannot classify" (CC) category in which there is oscillation among two or more opposing attachment states of mind, and an "unresolved for loss and abuse" classification, in which there are lapses in the monitoring of reasoning and discourse in response to questions about loss and abuse. These first three AAI classifications, which were developed on nonclinical samples, correspond to the attachment patterns first identified in children by Ainsworth et al. (1978), and are considered to be organized categories in that they involve specific identifiable and consistent strategies for regulating emotion in the context of attachment relationships. By contrast, the "unresolved" and "cannot classify" categories, which were identified later by Main and colleagues in both adults and infants through high-risk as well as low risk groups (Hesse & Main, 2000; Hesse, 2010), bespeak breaks and discontinuities in both behavioral and discourse strategies, indicating lack of integration and psychological disorganization (see Buchheim & George, 2011).

Thus, both the secure/insecure and organized/disorganized axes of attachment provide dual lenses that significantly sharpen and expand our view of the attachment antecedents and related internal working models of attachment, which Bowlby (1977) predicted would be major determinants of personality organization and pathology. Borderline personality disorder has been associated primarily with the preoccupied and unresolved (disorganized) attachment categories (Patrick, Hobson, Castle, Howard & Maughan, 1994; Fonagy et al., 1996; Rosenstein & Horowitz,

1996; Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Levy et al., 2006; Bakersman-Kranenburg & van IJzendoorn, 2009), and secondarily with dismissing and cannot classify attachment status (Barone, 2003; Levy et al., 2006). By contrast, narcissistic disorders have been associated primarily with dismissing-avoidant attachment status (Rosenstein & Horowitz, 1996; Blatt & Levy, 2003; Westen, Nakash, Tomas, & Bradley, 2006), using both interview and self-report measures of attachment. Other studies of both clinical (Barone, 2003; Levy et al., 2006; Diamond et al., in press) and nonclinical groups (Dickinson & Pincus, 2003; Smolewska & Dion, 2005; Otway & Vignoles, 2006), suggest that individuals with narcissistic pathology may also be characterized by preoccupied (anxious), fearful, and in a minority of cases, secure attachment status.

Thus, attachment researchers have amplified our understanding of borderline and narcissistic pathology by linking these disorders primarily with variants of insecure and/or disorganized attachment, thereby shedding light both on the heterogeneity among these patients, and potentially identifying common developmental risk factors. Recent research has shown a movement from insecure to secure, and disorganized to organized attachment status in borderline patients over the course of psychoanalytically oriented psychotherapy (Levy et al., 2006; Buchheim, Horz, Rentrop, Doering, & Fischer-Kern, 2012).

Fonagy et al. (2002) have also linked narcissistic and borderline disorders to deficits in mentalization, defined as the capacity to reflect on behavior of self and others in terms of intentional mental states. Such deficits are thought to stem from specific distortions of the early parent–infant mirroring relationship, involving non-contingent (e.g., based on the caregiver's emotional needs and responses rather than the emotional state of the child), and/or unmarked (e.g., not elaborated on in ways that catalyze symbolic or second order representation) mirroring. Both of these types of incongruent mirroring have been associated with insecure and/or disorganized attachment (Fonagy & Target, 1997; Fonagy et al., 2002), and thus set the stage for the development of borderline and narcissistic pathology (Fonagy et al., 2002).

The capacity for mentalization in attachment relationships, as measured by the reflective functioning scale (Fonagy et al., 1998), has been found to be a protective factor in individuals with histories of trauma or abuse linked to insecure/disorganized attachment. Fonagy et al. (2002) found that individuals with a history of abuse were less likely to develop BPD if they had high RF on the AAI. Other studies have shown that mothers

classified with lack of resolution of loss or trauma were more likely to have children classified with secure attachment if they (the mothers) had high AAI RF ratings, whereas their counterparts with low RF ratings were more likely to have children classified with disorganized attachment status (Grienenberger, Kelly, & Slade, 2005). Thus, the capacity for RF may moderate the negative impact of a traumatic early attachment history and potentially guard against the transgenerational transmission of insecure disorganized attachment patterns. In addition, a number of studies have indicated that just as deficits in mentalization are fundamental to severe personality disorders, improvements in mentalization are a key mechanism of change in psychodynamic psychotherapy with such patients (Bateman & Fonagy, 2004; Levy et al., 2006).

### *Clinical and Research Innovations*

To address the aforementioned gaps in the literature, a group of psychoanalytic clinicians and clinical researchers at the Personality Disorders Institute (PDI) at Weill Cornell Medical Center have been working to advance the clinical and research literatures on understanding and treating borderline and narcissistic disorders. We have developed and evaluated a manualized psychoanalytic therapy for patients with severe personality disorders (Clarkin, Yeomans & Kernberg, 2006; Levy et al., 2006; Clarkin et al., 2007). Recently we turned our attention to refining techniques to more effectively work with patients with comorbid narcissistic and borderline pathology. Our clinical formulations have been described in previous publications, and are beyond the scope of this article (Diamond et al., 2011; B. L. Stern, Yeomans, Diamond, & Kernberg, 2011; Diamond et al., in press). Here we give a brief summary of the treatment and of our research findings to date in order to place our more recent work in its broader context.

*Transference focused psychotherapy (TFP).* TFP is a manualized psychoanalytic psychotherapy designed for patients with severe personality disorders organized at the borderline level. The tactics and techniques of TFP have been systematically described in previous publications (Yeomans, Clarkin, & Kernberg, 2002; Clarkin et al., 2006). 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. The goal of TFP is thus to promote the development of increasingly integrated, differentiated, and mature representations of self and others, and in so doing to improve tolerance of negative affects (e.g., aggression, anxiety, envy, guilt), which are interlinked with the split polarized internal world and concomitant primitive defenses characteristic of BPD. In addition to improving symptoms and the integration of the representational world, TFP also aims to foster meaningful engagements in work and interpersonal relationships, and hence the therapist keeps close tabs on the external reality of the patient.

The theoretical model informing TFP posits a dynamic interaction of temperament (individual differences in affect activation and regulation and motor reactivity), environmental/family factors such as abuse or neglect leading to a working model of insecure/and or disorganized attachment, deficits in mentalization, and other neurocognitive deficits that predispose borderline individuals to affective dysregulation, particularly in interpersonal situations (Yeomans & Diamond, 2010). Our understanding of patients with severe personality disorders is informed by these multiple perspectives. The focus of the therapy is on targeting the maladaptive, unintegrated, and polarized representations of self and significant others, which underlie the identity diffusion, affective dysregulation, and deficits in self and interpersonal functioning that characterize severe personality disorders. The work of TFP is to facilitate the reactivation, under controlled circumstances, of the split, polarized internal representations in the transference relationship and then, through a multistep interpretive process, to develop more integrated, differentiated, and complex mental representations that form the basis for a more coherent identity (Caligor, Diamond, Yeomans, & Kernberg, 2009). TFP 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 or her affective experience, which in turn leads to improvements in reflective function or mentalization, or the capacity to symbolically manage and reflect upon his or her experience in the transference (Levy et al., 2006; Caligor et al., 2009). Another way to think about this process in terms of attachment theory and research is that the treatment situation in TFP, with its dyadic intimacy and intensity, activates primary internal working models of attachment—which in the case of more severely disturbed patients are likely to be insecure, multiple,

contradictory, and conflictual in nature (Diamond et al., 2003; Fonagy & Bateman, 2005)—with the goal of moving the patient toward increased attachment security.

*Summary of research findings on the efficacy of TFP.* Several studies, including two randomized clinical trials, one conducted at the Personality Disorders Institute at the Weill-Cornell Medical College (the Cornell-NY RCT), and another conducted independently by the Vienna-Munich TFP group (the V-M RCT), have now demonstrated the effectiveness and efficacy of TFP for borderline pathologies. A full description of the method and findings from the two RCTs can be found elsewhere (Levy et al., 2006; Clarkin et al., 2007; Doering et al., 2010; Fischer-Kern et al., 2010). Here we will describe the procedures and findings that are relevant to our more recent work on comorbid narcissistic and borderline pathologies.

In the Cornell-N.Y. RCT, conducted by Clarkin et al. (2007), a total of 90 patients diagnosed with BPD were randomly assigned for one year to one of the three manualized outpatient treatments: twice-weekly TFP, dialectical behavior therapy (DBT; Linehan, 1993), and supportive psychodynamic therapy (Appelbaum, 2005). Results showed that all three groups had significant improvement in both global and social functioning, and significant decreases in depression and anxiety. Both patients treated in TFP and DBT, but not SPT, showed significant improvement in suicidality, depression, anger, and global functioning. Only the TFP-treated group demonstrated significant improvements in verbal assault, direct assault, and irritability (Clarkin et al., 2007). Further, changes in attachment organization and reflective function were evaluated as putative mechanisms of change in treatment (Levy et al., 2006). We had hypothesized that increased integration and coherence in the representational world, as measured by AAI classification (Main et al., 2003) and Reflective Function (RF; Fonagy et al., 1998), would be found in TFP but not the other treatments. In fact, after 12 months there was a significant (threefold) increase in the number of patients classified as secure with respect to attachment for individuals in TFP but not the other two treatments. In addition, significant changes in the AAI subscale of narrative coherence, the best predictor of attachment security among the AAI subscales (Waters, Treboux, Fyffe, & Crowell, 2001) and in RF were also found as a function of treatment, with TFP showing increases in both constructs during the course of therapy.

The V-M RCT conducted independently by Doering et al. (2010) in Germany and Austria provides further data establishing TFP as an

efficacious treatment. Doering et al. conducted an RCT comparing one year of TFP to treatment by experienced community psychotherapists (ECP). Although patients improved in both treatments, patients randomly assigned to TFP evidenced lower drop-out and showed significantly greater reductions in number of patients attempting suicide, number of inpatient admissions, and BPD symptoms, and significantly greater improvements in personality organization and psychosocial functioning after one year of treatment. Both groups improved significantly in depression and anxiety and the TFP group improved in general psychopathology, all without significant group differences. Self-harming behavior did not change in either group. In addition, Buchheim et al. (2012), as part of the V-M RCT, found significant shifts from insecure to secure, and disorganized to organized attachment states of mind in patients treated with TFP, but not those in treatment with experienced community psychotherapists (ECP). Thus, in both our (Cornell-NY) RCT and the V-M RCT, the AAI was found to be a useful instrument to capture structural change in BPD patients. It is significant that only patients in TFP in the two studies showed an increase of flexible integration and coherence in attachment representations on the AAI.

*Summary of research findings on NPD/BPD.* We recently began to explore attachment and reflective function in borderline patients with and without comorbid narcissistic personality disorder (Diamond et al., in press). To accomplish this, we evaluated all participants in the two aforementioned RCTs who received the AAI. The combined sample of 151 patients was divided into two groups: one included 129 participants who met criteria for BPD and another included 22 who met both BPD and NPD, according to the DSM-IV-based criteria of the International Personality Disorder Exam (IPDE) and the SCID-II (Loranger, 1999). In both RCTs, the AAI was given upon entry into the study and after one year of treatment (see Hörz et al., 2011, 2013 and Diamond et al., in press) for a full description of the study procedures, measures and sample characteristics).

The NPD/BPD group showed less Axis I pathology and more Axis II pathology compared with the BPD group. As expected, NPD/BPD patients showed significant comorbidity with all cluster B personality disorders including borderline, histrionic and antisocial (trend)– a finding that corresponds to a number of previous investigations (Zimmerman, Rothschild, & Chelminski, 2005; Stinson et al., 2008). In addition, the NPD/BPD group met significantly more criteria for paranoid and

schizotypal personality disorders than the BPD group. The triad of paranoia, schizotypal, and antisocial criteria in NPD/BPD patients suggests that these patients may be characterized by a more pathological form of narcissism (termed malignant narcissism by Kernberg, 1984, 2007; see also Ronningstam, 2010), in which there is poor reality testing; ego-syntonic aggression that is systematically projected onto others, leading to paranoia; and anti-social features (lack of empathy and exploitation of others).

Finally, 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.

The two groups also showed different representational states with respect to attachment. As expected, we found that compared with the BPD group, the NPD/BPD patients were significantly more likely to be classified as dismissing (characterized by idealization/devaluation) or cannot classify (e.g., characterized by oscillation between opposing attachment strategies) on the AAI, whereas the BPD group was significantly more likely to have preoccupied (angrily or passively enmeshed with attachment figures) or unresolved for loss and abuse AAI status than was the NPD/BPD group (Diamond et al., in press). This 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 associated with dismissing and preoccupied attachment status, respectively (see Meyers & Pilkonis, 2011, for a review). It should be noted that because of the small sample size and uneven numbers within each attachment classification, in these analyses we aggregated the AAI classifications into larger groupings (e.g., dismissing with cannot classify for the NPD/BPD group and preoccupied and unresolved for the BPD group), deemphasizing claims about the relative prevalence of specific attachment categories, while maintaining the essential claims regarding between group differences in those categories.

In sum, both clinical groups show evidence of a lack of integration in internal working models of attachment, but in the NPD/BPD group this

took the form of oscillation between opposing states of mind with respect to attachment relationships, most typically between dismissing and preoccupied discourse strategies throughout the interview. By contrast, in the BPD/non-NPD group there was more severe but focal breakdown in the monitoring of reasoning and discourse in response to specific questions about loss and abuse, indicating the intrusion of "peculiar and even partially dissociated states of mind" (Hesse, 2010, p. 570) associated with childhood trauma.

These findings raise the question of whether the NPD/BPD group experienced *less frequent* childhood trauma, or whether they were *better defended* and/or or *more reflective about* childhood loss and trauma (less unresolved AAI status and higher RF). However, as expected we found that both groups were in the low/questionable range of RF (3 or below), with either simplistic, truncated RF capacity (e.g., one-dimensional, naïve concepts of mental states), or with hyperactive mentalization (e.g., overinterpretation of motivations, feelings and beliefs of self and others). In addition, in the Cornell-NY RCT only, we found no differences between the groups on retrospective self-reports of the frequency of childhood abuse, including emotional, sexual and physical abuse, and emotional neglect, with a trend towards the differences between the groups in physical neglect (Diamond et al., 2012). The comparable amounts of childhood trauma in the context of low RF (for the Cornell-NY sample) suggests that that the NPD/BPD individuals may have the capacity to mobilize working, if not rigid and primitive defenses, to contain and limit disorganization in the face of childhood trauma. Thus, our findings to date suggest that narcissistic pathology may have a stabilizing effect in the context of borderline organization. Also relevant to this point is that NPD/BPD individuals were found to drop out significantly less often from all outpatient treatments in both studies; had fewer hospitalization or inpatient days, as well as less unresolved childhood trauma on the AAI; and in the U.S. study, less self-harming behavior (Diamond et al., 2012). In sum, our findings suggest that NPD, in the context of BPD, may be a protective factor that helps these patients to stay in treatment and limit self-destructiveness (Diamond et al., in press; Simonsen & Simonsen, 2011). This hypothesis remains speculative and needs to be examined with a larger sample that includes longitudinal analyses of the AAI and RF ratings at the beginning of treatment, and how they change over the course of one year for the two groups, as well as perhaps an NPD only comparison group. However, the following two cases, in

which we present the AAI and RF data at admission to the study and after one year of TFP, provides a clinical illustration of the differences in attachment representations and RF between the two groups.

*Case 1: NPD/BPD Patient*

Sara, a single, unemployed Latin-American woman, was referred for TFP at age 34 after a number of failed inpatient and outpatient treatments. Her condition had worsened to the point where she spent the six months prior to beginning TFP isolated in her apartment, lying in bed with chronic suicidal ideation, binge eating, and only rarely bathing. She was the middle of three daughters in an upper middle-class family, which immigrated to the United States so that her father could pursue advanced training as a medical researcher. She described her mother, who was trained as a teacher, as extremely controlling, the kind of mother who was "always running around with us, taking us to ballet class, and you know pushing us to the limit." Her first memory of her mother was punishing her for taking her sister's milk bottle when she was four or five years old. She stated that her mother, who was chronically depressed and suicidal, and alternatively overprotective and neglecting, gave her "mixed signals. . . . . At times she was lonely and she did love us, but there were—most of the time she was really frantic, like what would happen to us, and she was careful to guard us from other people."

Sara described her father as largely emotionally absent and preoccupied with his academic career, but she also experienced him as an intrusive and overcontrolling parent who pressured his children to achieve 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 wasn't doing well in school. "He just kind of abandoned me . . . like he's doing now." 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."

Sara's Initial AAI was rated as cannot classify, with mixed preoccupied and dismissing/devaluing states of mind. As is typically the case with cannot classify she showed contradictory states of mind with respect to attachment, shifting between dismissing strategies, with devaluation of attachment relationships and experiences which she had difficulty recalling, and preoccupied strategies in which she showed a high level of current overwhelming anger with attachment figures who were described in extreme negative and positive ways. On the AAI at the beginning

of treatment there are indications of oscillatory evaluations of parental figures, with an "element of struggle, ambivalence and indecisiveness" (Main et al., 2003, p. 170) that is typical of preoccupied speakers. For example, the first adjective that Sara gave to the interviewer (in italics), and then immediately retracted, was that her mother was "loving":

> So you want me to say adjectives. That's not a fair question, because you know, I mean of course I'm going to say loving and kind, because I love them, I mean, I did—*Do you want to say that, then?* Well, I want to say it, because, I mean, does—is there anyone who doesn't feel love for their parent? Or you know I mean you feel something, you know? I mean, I did love them, you know? I mean I—but—you want to know how—*Well I'd like it if you could just give me five words or phrases that describe your relationship.* You know what? You better erase loving, then. *Excuse me?* You better erase loving. Cause I don't remember that. I just know I loved her, but I don't remember that, being in a loving relationship. It was more like "I'm the teacher, you're the student, do as I say," that type of thing. It was controlling, I would say. So, you erased loving, right?

These first associations to the request for adjectives was split-off material—about loving and positive feelings about mother that were immediately replaced by negatively valenced words, "controlling, emotionally abandoning, confusing, and sad and weak bond." Her elaboration on "weak bond" illustrates the activation of mechanisms of dismissing devaluation.

> I only say it's a weak bond because when you're asking me about remembering about my mother, it's difficult for me to remember ... cause I don't remember bonding with my mother.... I don't remember doing things with my mother that children do for fun.... You know being with my parents, I swear to God it was like being with a schoolmaster. That's what it feels like.

The above passages are characterized by an attitude of cool, active devaluation and derogation, which alternates with an inability to recall, in any significant detail, autobiographical memories to support her generalized description of the relationship with mother—both of which are typical of dismissing attachment states of mind. Lack of access to memories serves in the case of dismissing speakers to limit access to attachment memories and experiences, but in Sarah's case this quickly breaks down.

It is interesting that she gives a similar adjective to describe father, "nonexistent bond," and although she begins her elaboration of this word with dismissing mechanisms, she quite quickly reverts to preoccupied strategies in which there is much evidence of current involving anger and enmeshed, entangled states of mind as the following passage indicates.

> I would say practically a nonexistent bond. I didn't feel a bond. I don't know, I didn't feel bonded to him. And umm, it was such a weak bond, I swear to God, I can't even think of three other adjectives to describe it. Umm, I don't remember my father. I swear to God I don't. I don't remember him.... I remember what my mother has told me but I don't remember him.... I remember he kind of joked around with us. Sort of, but—you know, especially with me, and I know that—I don't know if this makes sense, okay but—just tell me if it makes sense. Like, you know when you're a child you still don't know the relationship, you still—you—you, I don't know like the concept of dad and father. As a very small child, you don't understand what that means. And my father would like play with me, or tickle us, tickle me, whatever. And play with me. And I would run away scared, but I felt some sort of a sexual thing—I know it sounds weird, I know. But it is what I felt. And it's also, I know I felt this feeling of wanting to masturbate—this is the truth, and I told this to Dr. K. [former therapist] at a really really really really really early age. Umm, so I felt this sort of sexual thing with my father, and I was scared of him.

The above passage is full of long conversational turns, run on sentences and violations of relevance as she becomes entangled and confused in her own conflicted feelings about father. This passage also shows the tendency to get caught up in episodic memories and the disturbing feelings they evoke such that she is unable to provide an objective or coherent elaboration of such memories at the semantic level.

Thus, in these examples one can see how she shifts between two contradictory discourse strategies that are associated with two divergent states of mind with respect to attachment: a dismissing state that is linked to an internal working model of a rejecting, cold and intrusive other (the schoolmaster) and an overcontrolled, rejected self; and a preoccupied state that is linked to an internal working model of an alternately tantalizing and rejecting object and an overstimulated, but neglected self.

Although her primary attachment representations of parents were of figures who could only relate to her in a rejecting/controlling (mother) or overstimulating/eroticized manner (father), there was also evidence of positive, if somewhat idealized, representations of parents as protective and caring and of herself as special. For example, one of the words she used to describe her relationship with her father was "teacher's pet," which she elaborated as follows: "I would say a fairly strong relationship with my father. I mean, not—fairly strong .... I mean I was his you know ... the teacher's pet ... the one he sort of protected in a way." She also describes how in moments of distress or perceived abandonment she would take books from her parents' room and pretend "... to be the teacher, ok I was the teacher of the school ... and I pretended to hand the books out to my imaginary students. That was a way for ... I used to get control." Thus, this passage highlights how Sara retreated to a world of autistic fantasy to cope with attachment trauma, which may have curtailed her level of disorganization. "You deal with it by going into a fantasy world and pretending you have control," she stated.

It is not surprising, however, given the dominant representation of her father's intentional mental states in relation to her as fear provoking ("I would run away scared"), Sara's reflective functioning (RF) score prior to the initiation of treatment was minus one (−1), the lowest possible rating indicating active repudiation of mental state thinking and/or bizarre/inappropriate statements in the face of questions designed to elicit reflection. For example, she responded to the question "*How do you think your childhood experiences have affected your adult personality?*" by saying:

> I mean, I think that if somebody had been in my room, put me to sleep, and assured me that there was nothing bad going to happen, I think a lot of this stuff would have gone alright, I don't think I would be talking about all of this .... You know, like even to the point that um—my dad and I, we went to a movie once ... and it was a movie about this woman who was I'll tell you what it was about, actually, it was—it was a 1977 movie, and um, the woman that I remembered upset me a lot. And I was about, maybe third or fourth grade then. It was about this woman—she's married, and she goes to this party, and um, her friend—an—and her husband doesn't come with her to the party. And her friend says, well you know, like this

> guy, he'll take you home, you know, so you [laughs] and so, the guy takes her home. He doesn't exactly take her home. He rapes her.

The above passage shows the confusion and disorganization that ensues when the interviewer attempts to initiate reflection so that one is "almost 'shocked' by the utterances," which are inexplicable and bizarre or inappropriate (Fonagy et al., 1998, p. 43).

*Change after one year of TFP.* After one year of TFP, Sara shifted from a disorganized cannot classify attachment state of mind with chaotic alternation between two insecure attachment strategies (dismissing and preoccupied) to an organized, if still insecure, attachment classification (preoccupied, angry conflicted subtype). At the end of treatment on the AAI, there was no longer the chaotic alternations between cool devaluation of, and angry preoccupation with, early attachment figures, or between lack of memory for early attachment experiences and a tendency to be caught up in and overwhelmed by them. Rather, Sara had organized around angry, conflicted feelings about early attachment objects and experiences, and although she still presented as mentally entangled with attachment figures, her tendency to become lost in past malignant experiences was diminished. For example, when asked to elaborate on the adjective "unemotional," which she used to describe her father at the end of treatment, her response shows much evidence of angrily preoccupied speech and long entangled run on sentences, but without the chaotic intrusion of erotically and aggressively charged language, images, and fantasies, as was evident at the beginning of treatment as the following passage indicates:

> I mean you know the thing was when I forged his signature, and he hit me a lot he did hit me he was a really angry um, and that's also an example I think of a distant relationship I think he really didn't really talk to me I think. I don't exactly remember yeah I don't think he was very angry um, but—instead of trying to understand me he wasn't emotional, you know he just hit me and don't do it again, will you ever do it again, that type of thing where you had to say no I won't cuz you wouldn't you know. Um and I was about 8 or 9 I think when I did it.... Unemotional in the sense that ... you know there wasn't that closeness when I'm with my father everything feels like you're with a professor or something, doesn't feel like we were with a father you know, he doesn't bond, doesn't know

> how to bond unless you are reading the new—you know he only bonds if you talk about *The New York Times* or stuff like that he doesn't bond if its just regular . . . . I mean I think that's why I feel this pressure to always be like I have to talk about something and appear like I'm smart and put this self image out . . . because I couldn't just be me, cuz that's not good enough . . . . I have to show people how smart I am and so whatever, and I don't think most people want to see either one, they just want you to be, you know, regular. I don't know how to do that. So he was unemotional.

Improvement was also quite dramatically evident in her reflective capacity on the AAI, where she moved from an RF rating of minus one (−1), or repudiation of RF to a rating of 6, which indicates the capacity to form multifaceted mental models of the mind, but also some indications of complex and original thinking about mental states of self and others. At one year, her response to the AAI question "How do you think your childhood experiences have affected your adult personality?" illustrates the dramatic increase in her capacity for mentalization.

> Oh my God, my adult personality . . . I really don't buy that argument that . . . . I was born overly sensitive I don't think so . . . . Not when I can remember experiences as far back as like three years old and my parents not being there . . . . They didn't take an interest in us . . . . I didn't live up to my potential . . . so I may have had dreams and wishes and I had the potential to do it but I just couldn't do it like now . . . certainly my life is so much better now . . . . I regret the fact that I'm 35 and I only found this program at 34.

Likewise, reflecting on the impact of her parent's style of parenting on her subsequent development, she states, "I really didn't live in the real world growing up, I lived in a fantasy world the way I wanted to see the world I really didn't interact with the world, the way my father didn't interact with me . . . . So I don't think I felt any compassion for people."

In addition, her moderate to high RF after one year is evident in her capacity to understand, contextualize, and contain her emotions in terms of the fluctuating mental states that precipitate and sustain them, as the following passage indicates.

> I've learned that the world is not as hostile as I thought it was. I've learned that people are not two dimensional, they're three-dimensional and they

> want to be treated that way the way I want to be treated three dimensionally. I've learned that um ... that's a huge one that I've learned the world isn't as hostile um even though this is a bad week coming in. Um I've learned that ... people don't necessarily abandon you .... People can be mad with you for a while, but that doesn't mean that they're gunna abandon you .... it's possible for people to be mad with you and still like you.

Thus, the above passages illustrate the capacity for a transactional and intergenerational perspective on mental states, involving an understanding not only of how her behaviors and attitudes were influenced by her parents' mental states but also a recognition of the role her own mental states played in her past and current choices and behaviors.

In sum, this case illustrates the opposing representational states with respect to attachment (dismissing and preoccupied) that we have found to be characteristic of patients with comorbid narcissistic and borderline pathology (Diamond et al., in press), with their associated defenses and modes of affect regulation, particularly in the face of childhood attachment trauma. In addition, the case illustrates the ways in which improvements in RF may precede shifts to security of attachment and, in fact, be a mechanism of change towards reorganization of mental representations of attachment (Levy et al., 2006). It should be noted that after one year, the patient's psychosocial and occupational functioning were both stronger and healthier. As part of her initial contract, she volunteered in a lawyer's office and was quickly offered a regular job as a paralegal. She began to date, and although her initial relationships were somewhat problematic, she eventually developed a mutual, loving relationship.

### *Case 2: BPD/Non-NPD Patient*

At the time of beginning TFP Helena was a 38-year-old Caucasian woman, with a history of severe early trauma, chronic suicidality, and turbulent, abusive relationships. She was raised by her mother, along with a brother 11 years her senior. Her mother worked at a series of menial jobs after her father left the family when she was 6 years old. Later in childhood she describes being a "latchkey kid" and taking on parentified roles, both in terms of chores, due to her mother's long work hours, as well as emotional roles, such as setting limits with the father on behalf of the mother. She reported first being seen by a psychiatrist when she was

8 years old, and prescribed multiple medications by the age of 10, as well as several hospitalizations.

Helena described a history of paternal rejection and abuse from a very young age. Her father, a veteran and plumber by trade, was on disability at the time of her birth. Upon learning his wife was pregnant, he strongly advocated for her getting an abortion. He was so angry at the pregnancy being allowed to come to term that he refused to go to the hospital at the time of her birth. Thereafter he refused to sleep in the couple's bedroom, and instead slept in the baby's room. Because her mother worked full-time, Helena was often left in the care of her father, who emotionally, physically, and sexually abused her.

At time 1, Helena receive a primary attachment classification of unresolved, as a result of such lapses in the monitoring of reasoning and discourse around experiences of abuse, and a secondary classification of preoccupied. A notable feature of her AAI interview was that her discussion of the sexual abuse often came up in unprompted, associative streams of thought.

> I was in denial, I had no idea what was going on with me um, I didn't know that, 'cause my mom always had to work, so I was left at home with my father, but um I was pretty much totally in denial of what was going in the house and the fact that my father slept in the baby room um, and my brother used to tell me that he would um, sleep in the nude and that like sometimes he would get really angry with, at my father cause, so my father walk around the house saying, I'm going to kill her, I'm going to kill her, you know and um, at the same time, when Christmas rolled around, um, you know, I got the whole store for Christmas and my brother would only get one or two gifts and when he tried to ask why does she get all of this and I only get a shirt and tie, you know, they would, they would practically tell him it's none of his business and he was physically and emotionally abused by my father and I was physically, emotionally and sexually abused and the only reason um, I guess that I, I have any memories of any of this except my mother would tell me and then um, as far as the um sexual abuse, what I always felt was very strange was when I was three years old I would remember how I would take out my dolls and I would put them in sexual positions, and then I would say to, like I'd take my male doll, say to the female, you gotta do this, you gotta kiss me, if you don't do this I'm going to kill you, you know, and she's like, no no no; I know how angry I was inside and I didn't understand all of this.

Evident in this passage is the fluidity with which traumatic material enters and leaves her discourse, such that she is discussing disparities in Christmas gifts one moment and being abused the next. It is also notable that she displays a flash of good RF at the end of the passage, noting her affective experience and yet lack of understanding around it. However, she does not appear to be able to mobilize her RF in the service of providing distance from and perspective on this traumatic material. Rather, the trauma permeates every aspect of her narrative with only the gentlest of prompts—the interviewer had simply said, "help me get oriented to your early family situation."

Thus, the suddenness with which violence pervades her consciousness parallels the suddenness with which she describes violence being perpetrated against her. When asked about past experiences of abuse, she shows much evidence of the typical (for U AAI status) lapses in the monitoring of reasoning and discourse, including irregular speech patterns, psychologically confused statements, and incoherent speech with the intrusion of visual-sensory images—all of which are illustrated in the following response to the question, "*Do you have any memories of being overwhelmingly frightened with him or feeling terrified?*"

> . . . [4 seconds] Probably that one day that I ended up down at the end of the stairs there was something so, Alfred Hitchcock about that moment. It was really, I was terrified, terrified. Um. . . . [4 seconds] not too many other memories of, of pure terror like that time, um, memories of him being home, with say my mother, my, my emotions turn to, um, I hate you, you disrespect, why don't you go somewhere and die.—But being alone, [unintelligible, 2 seconds] and died. *Do you have, do you have a specific memory of him pushing you down the stairs?* I remember a foot—pushing me.

Indicative of her secondary preoccupied status, there were also many moments of oscillation and role reversal in the interview, in which she would be in a more powerful role and her father was portrayed as the helpless one as the following passage indicates.

> He would call my mother and say, um, you know, I need some money or something, I remember like 8 years old getting on the phone, I'm like, you're a loser, you're this, you're that, you're supposed to be going out and earning money for our family and you pathetic excuse for a human being. I remember I used to tell him off like that all the time." At a later

> point describing similar incidents she said, "He would call and uh ask for money or—I, you know, um, you know, there were just points of where I knew in a sense that, in certain ways I was manipulating and controlling him, and just the fact that, um, if my child spoke to me like that, I wouldn't, I mean come on—they need a slap in the face and—he just took it 'cause he knew it was true.

In the section of the AAI inquiring about people lost through death, Helena discussed the death of her grandparents. When pressed on additional deaths she had experienced she remarked, "I've been to eleven funerals and I'm trying to figure out did one really affect me? Yes, one affected me." She subsequently reported the loss of a friend. Despite repeated prompts, Helena neglected to mention the death of her father, which was only revealed when she was later asked about her adult relationship with him. Unlike the other losses, her discussion of this death was notably sparse. "*How would you say that loss affected your adult personality?.* . . . [5-second pause] I still struggle with his torture, but I no longer hate him, because I know that um, I know that God is healing me . . . . But I hope that um . . ." [trails off to silence].

The above passage illustrates that Helena shows some partial understanding of her own mental states, but RF remains somewhat clichéd, banal, or canned. Her statements remain diffuse, her insights unintegrated and her capacity for reflection on the complexities of mental states quite limited, leading to a rating of low RF at both the beginning and end of treatment. For example, when asked to reflect on how her childhood experience with her parents has affected her adult personality at the beginning of treatment she gave the following response:

> Well, 'bout . . . yeah, about eleven years and a few months ago I became a Christian, born-again Christian, I gave my heart to Jesus Christ and um, he has uh, done a remarkable job in healing—you know, I can, I can do all things with Christ he strengthens me and that whatever was in this past life is dead, it's gone and whatever my parents told me I was, is not. Um, the experiences that I had of the abuse is gone. And I need healing, as I was talking to you earlier and you were asking about my childhood and I just started to breakdown, I just started thinking in my head, Jesus, this is so painful and I can really understand why people choose to go through life without having to deal with their past and kind of go on with their life the way it is because even if they are suffering because you know, it Really takes a lot to go back, so that you can go forward, and, it involves a lot of

> pain. I know that this pain now is like a healing pain, because I'm having to go back, um, and I'm not alone now, before a new outlook on life, like with Christ and everything, I had no, a very insecure um . . .

The above passage is full of naïve, simplistic statements, combined with more genuine reflection on the excruciating emotional pain she experiences when she reflects on mental states of self and parents who abused her, causing her to retreat to religious preoccupations. Although faith may function as an organizing construct around which painful and traumatic experiences may be understood, in the present context religion seems to serve a defensive function in which posttraumatic growth is externally located, bad parental objects are replaced with a good one, and the traumatic experience remains unintegrated.

*Change after one year of TFP.* After a year of treatment Helena's AAI was notably different, with a primary classification of organized insecure (preoccupied) and a secondary classification of disorganized/unresolved. Whereas in the first interview Helena opened the interview with a long, entangled response to the interviewer asking "help me get oriented to your early family situation," by the end of a year of treatment she responded with a succinct description of her early family context. Further, she referenced the fact of the abuse without a loss of mooring in the details of it. Whereas in the first year of treatment there were intense flashes of preoccupying anger amidst the disorganization, now her more terse narrative seemed organized around the anger, which notably seems to helps her contain the experience.

> *So now I'd like you to try and describe your relationship with your parents as a young child.* I hated them both. Very angry—um—I don't remember that about my mother so much—my father, I didn't have um . . . I couldn't—I felt I couldn't depend on them and I felt I was not loved. L-later on like when I was about—when my father left home, um just uhh, aneurysm amount of anger started coming out, you know, just like enough to blow my brain out, um—at at [age] 5.

Further, role reversal, a typical manifestation of preoccupied states of mind, was even more pronounced in the follow-up interview, with Helena more consistently presenting herself in an empowered position vis-à-vis the father. Again referring to the father calling to borrow money, she said, "my father would call—and he would ask for my mother—and

I would say you can't—I don't want you talking to her or something like that and I would tell him off at—7, 8 years old, just basically curse him out over the phone. You're a bum, you're not gonna be calling here asking for some money—so forget it."

Notably, she at no point spontaneously discusses her experience of sexual abuse. When asked directly by the interviewer she acknowledges the abuse experiences, but again in a contained and organized manner. It is remarkable that she even jokes with the interviewer in a light manner—she notes that during childhood she would have strong reactions to cues that vaguely reminded her of the trauma, in ways she did not quite understand; for example, becoming upset at warm milk due to its association to semen. In the course of discussing this she quips, "Yeah, I mean never—don't ever put—you know, warm milk—in front of me. *I'll try to remember that.* No-o-o. [subject chuckles] I'm okay. [subject and interviewer laugh]—I'm okay now."

When asked about loss through death, Helena again neglects to mention the death of her father until later in the interview when she is asked about their adult relationship. However, unlike the notably sparse and dissociative quality to discussing the father's death in the first interview, there is now significant detail about tension leading up to the time of his death.

> I didn't keep in touch with him, he didn't want to keep in touch with me. Umm—I did write him a letter when I was 22—begging him to—talk to me, let's talk it out, let's get together, let's—you know, let's try to reconcile. I'm a liar. *(He said that to you.)* Yeah—he, well, he told my mother 'cause he didn't talk to me. And then when I was 25 and I had began the therapy with—you know—um—she said you know you need to—in a constructive way let your parents know that, you know, you've been angry with them and—you know—da-da-da-da-da. So—I—called him—I don't know what you're talking about, and—I did this and—you blah-blah-blah.—You know, I don't know what you're talkin' about, you're lying.—Okay! bye!—six months later he was dead. Had a heart attack, went into a coma and never came out.—Died like a week later.

The description of their relationship prior to his death is marked by preoccupying anger. However, the anger appears to serve an organizing function—she no longer trails off and loses her train of thought, and is able convey a linear progression of events. Clearly her work in

psychotherapy is not over, and it is noteworthy that neither RF nor coherence changed after one year. However, the resolution around the trauma affords some degree of distance from and perspective on this disorganizing material. It is from this more solid foundation that the work of integration can begin.

## Discussion

This article fills a gap in the literature in that it presents research and clinical findings on the attachment status and reflective functioning of borderline individuals with and without comorbid narcissistic pathology and how they change differentially over the course of one year of TFP. First, research findings from two RCTs were presented to illustrate group differences between the attachment representations and RF of NPD/BPD and BPD patients at the beginning of treatment, and second, two cases (from the Cornell-N.Y. RCT) were presented to illustrate changes in attachment and RF over the course of one year of TFP. In sum, both the NPD/BPD and BPD patients were classified with insecure/disorganized attachment states of mind at the beginning of treatment, which shifted to an organized, if still insecure, state of mind after one year of TFP. However, at time 1, Sara, the NPD/BPD patient, showed constant shifts between two opposing attachment representational states, vacillating throughout the interview between dismissing devaluation and angry preoccupation vis-à-vis attachment figures, whereas Helena, the BPD/non NPD patient, showed breakdown in discourse and reasoning in response to questions about childhood loss and abuse, as well as preoccupying anger and periodic collapse into dissociative states of mind throughout the interview, as memories of early trauma were activated.

Thus, although both patients showed lack of integration among multiple disorganized and insecure working models of attachment on the AAI, there were substantial differences in the nature of underlying structural disorganization, and associated modes of defense and affect regulation, evident in both the content and the discourse characteristics of the AAI. Sara's alteration between dismissing and preoccupied attachment states of mind illustrates the diverse attachment representations of NPD/BPD patients, which have been linked to the fluctuating grandiose and vulnerable manifestations of narcissistic pathology (Meyer & Pilkonis, 2011). That the NPD/BPD patients were more likely to be rated cannot classify than were the BPD patients, lends support to the clinical observation

that fluctuating mental states of grandiosity (dismissing) and vulnerability (preoccupied) are interrelated aspects of narcissistic disorders for patients with comorbid borderline and narcissistic pathology. In addition, in Sara's case there is evidence that the mechanisms of devaluation/idealization, characteristic of dismissing attachment states of mind, function to contain the current, overpowering anger typical of preoccupied states of mind. Also evident in Sara's AAI is her tendency to cope with attachment trauma and stress through withdrawal into autistic fantasy, or what Fonagy and colleagues (2002) would refer to as the "pretend mode," in which fearful experiences may be contained in an encapsulated world of fantasy and play, but divorced from reality (Clemence et al., 2009). By contrast, for Helena, primitive mechanisms of dissociation and splitting predominated, the former in the sudden intrusion of traumatic material accompanied by breakdowns in logic and discourse, and the latter in sweeping condemnation of parental figures alternating with covering idealizations (particularly of mother).

It is interesting that, as was the case in the Cornell-N.Y. RCT, both patients report considerable histories of trauma, including much evidence of abuse and neglect, on the AAI. Sara's father was alternately overstimulating and rejecting, and emotionally abusive in his extreme pressure to achieve, whereas her mother, who was depressed and at times suicidal, often neglected her emotional needs, although she was also periodically overprotective and overinvolved. By contrast, Helena's father slept in her room and abused her sexually, and she recollects extreme physical abuse, such as being thrown down the stairs by father. In addition, her mother neglected her emotional and physical needs, often leaving Helena to fend for herself while she worked long hours, and failed to protect her from, or even acknowledge, the abuse she endured at the hands of her father. Helena's report of extreme physical neglect was not characteristic of Sara's interview, which stressed that her parents provided basic food and shelter, despite the emotional and physical abuse she endured. The retrospective reports of abuse and neglect on the AAI of the two patients are consistent with previous findings (Diamond et al., 2012) of no significant differences in the reported frequency of sexual and physical abuse and emotional neglect, but a trend towards a difference between the groups on physical neglect. Thus, there are indications that the two patients did not differ significantly in their retrospective accounts of the frequency or type of trauma experienced, but in the ways that they experienced and coped with it.

It is interesting that, after one year of TFP, both patients showed a shift to organized/insecure attachment, notably preoccupied (angry, conflicted subtype), although Helena continued to show lack of resolution of loss and trauma (U status) as a secondary AAI classification. This shift in primary attachment status from disorganized to organized after one year is consistent with recent research findings on change in AAI classification from insecure to secure, and from disorganized to organized after one year of psychodynamic treatment (Diamond et al., 2003; Gerber, 2004; Buchheim et al., 2012). In one study, for example, Gerber (2004) used the AAI to track the shifts in attachment representations over the course of treatment of 25 young adults with severe personality disorders, who were sequentially assigned to psychoanalysis or psychodynamic psychotherapy at the Anna Freud Center. Gerber found that for those who were classified as secure or dismissing on the AAI at admission, there was a shift towards preoccupied attachment representational states in the mid phases of therapy, with another shift towards secure attachment states of mind towards the end of treatment. Thus, several studies have indicated that the AAI is a useful measure to track changes in representational states with respect to attachment, shifts that may occur in the course of treatment and that may accompany progression and regression in the transference, which is characteristic of psychoanalytic therapy.

In both cases it is clear that anger, anxiety, and sadness about past attachment traumas, losses, and disappointments, previously defended against either through devaluation (Sara) or dissociative mechanisms (Helena), were activated in the treatment and expressed, after one year, in a more organized fashion. However, for Sara this shift was accompanied by a substantial improvement in both RF [(from repudiation (-1) to marked (6) RF)] and coherence [(from very low (1.5) to near average (4)], whereas for Helena RF and coherence remained low (3 or below) after one year. It should be noted that the coherence subscale of the AAI, a nine-point subscale that measures organization, clarity and credibility of discourse, provides a continuous, as opposed to a categorical measure, of secure attachment states of mind. It is significant that coherence is the subscale most highly correlated with overall attachment security (Waters, Merrick, Treboux, Crowell, & Albersheim, 2001), and hence has been used in previous research to track movement towards security (Waters, Treboux, et al., 2001).

Although improvement in RF and coherence in Sara's case is consistent with the overall study findings described earlier, the stasis in Helena's RF and coherence ratings was not consistent with the significant improvement in these ratings seen for the majority of patients in TFP in the overall study (Levy et al., 2006). However, it should be noted that previous research has not only established a link between childhood abuse and neglect and BPD (Zanarini, 2000), but also between disorganized (unresolved) AAI status and severity of BPD symptoms, lower global psychosocial functioning, and lower levels of personality organization (Buchheim et al., 2012). Hence, although the shift from unresolved/disorganized to organized/insecure on the AAI after one year illustrates the efficacy of TFP to effect change in internal working models of attachment for both NPD/BPD and BPD/non-NPD patients, it is possible that in individuals with severe trauma histories this shift may be more gradual. That this shift for Sara, the NPD/BPD patient, was accompanied by substantial improvement in both narrative coherence and reflective functioning, illustrates the efficacy of TFP for improving mentalization and attachment security for NPD/BPD patients. This case also suggests that narcissistic pathology in the context of BPD potentially may serve a protective or stabilizing factor, perhaps stemming from buttressing identifications with powerful, and intermittently protective or encouraging, if punitive parental figures. In sum, both cases illustrate the usefulness of the AAI to assess the representational world of patients with borderline and narcissistic personality disorders, as well as to track the subtle interplay of changes in RF and attachment security over the course of TFP.

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