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When Is Transference Work Useful in Psychodynamic Psychotherapy? Main Results of the First Experimental Study of Transference Work (FEST)

Abstract. This article presents the main results of the First Experimental Study of Transference (FEST). The background of the study, as well as the aims, main hypotheses, and methods are described. The participants were 100 patients who were randomized to psychodynamic psychotherapy of one year's duration, with transference work or without transference work. The analyses of the effects of psychodynamic psychotherapy with transference work versus psychodynamic psychotherapy without transference work are presented. The two treatments were equally effective, but analyses of moderators revealed differential effects. Patients with low quality of object relations (QOR) and/or presence of personality disorder showed specific positive effects of transference work. Female patients responded better than men. Further analyses included mechanisms of change and three-way interactions among factors, with an impact on outcome. We also found that (1) insight was a mediator of change, and (2) that the specific effects of transference work were influenced by interaction of object relations and alliance, but in the direct opposite direction of what is generally maintained in mainstream clinical theory. For patients with more mature object relations and high alliance, a negative effect of transference work was observed.

Keywords: transference work, psychodynamic, alliance, personality disorder, insight, quality of object relations

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Background

FEST is a recent, large-scale study that was specifically designed to investigate the long-term effects of transference work in dynamic psychotherapy (Høglend et al., 2006, 2008). Transference work (analysis of the patient-therapist interaction) was assumed to have specific long-term effects on the two primary outcome measures (Psychodynamic Functioning Scales and the Inventory of Interpersonal Problems). Transference interpretations are subcomponents of transference work. In the FEST study, 3,200 therapy sessions were audiotaped and provided unique material for process studies.

Although thousands of studies have documented that psychotherapy works, we need to know more about how and why it works. The technical use of transference interpretations in psychoanalysis and psychodynamic psychotherapy have been debated extensively over a period of one hundred years. More than 8,000 papers and book chapters have discussed the concept of transference. Up to year 2000, 10 studies of brief dynamic psychotherapy had explored the association between dosage levels of transference interpretations and therapy outcome. Malan (1976) initially reported a positive correlation between frequency of transference interpretations and outcome, but subsequently four studies have reported negative correlations (Piper, Azim, Joyce, & McCallum, 1991; Høglend, 1993; Connolly et al., 1999; Ogrodniczuk, & Piper, 1999). All of the studies were naturalistic and lacked experimental control. FEST is a dismantling randomized clinical trial specifically designed to study long-term effects of transference work experimentally. The study is described in more detail in the main outcome articles (Høglend et al., 2006, 2008).

Aims of the Study

The main aim of FEST was to explore the effect of transference work on long-term improvement of dynamic, adaptive, and interpersonal functioning.

1. The a priori hypothesis was that patients treated with transference work would improve more than patients treated without transference work.
2. Based on mainstream clinical thinking (Malan, 1976; Gabbard, 1992; Sifneos, 1992; Høglend, 1993; Gabbard et al., 1994), it was assumed that highly suitable patients—that is, patients with a history

of more mature object relations and/or without personality disorders (PD)—might do particularly well with transference work.
3. Long-term changes in interpersonal functioning would be mediated through increased insight gained during therapy.

It was an important methodological aspect of the study that the patients were not told about the main hypothesis, i.e., they did not know that they were randomized to two different treatments. They were told that that the aim of the study was to explore long-term effects of dynamic psychotherapy. All patients were followed up one and three years after treatment termination. Another unique aspect of FEST was that all 100 patients were clinically evaluated at three years post-treatment follow-up.

Outcome Measures

1. The Psychodynamic Functioning Scales (PFS; Høglend et al., 2000) was the primary outcome measure in this study. The PFS has six scales, with the same format as the Global Assessment of Functioning. Three of the scales measure the quality of relationships: Quality of Family Relationships, Quality of Friendships, and Quality of Romantic/Sexual Relationships. The other three measure intrapersonal functioning: Tolerance for Affects, Insight, and Problem Solving Capacity. The rating of PFS was based on a two-hour clinical interview. The ratings were made by independent clinicians, blind to treatment group, four times over the study period.
2. Inventory of Interpersonal Problems (IIP; Alden, Wiggins, & Pincus, 1990), which was used to assess patients' self-reported interpersonal problems at pre-treatment, mid-treatment, post-treatment, one-year follow-up, and three-year follow-up. The total mean score of IIP was used in the study.

Insight, which was assumed to be a mediator of long-term changes, is defined as cognitive and emotional understanding of the main dynamics of inner conflicts, the related interpersonal patterns and repetitive behaviors, and connections to past experiences. An ability to understand and describe one's own vulnerabilities and strengths is also part of this dimension.

Furthermore, personality pathology (PD) was evaluated before treatment as the sum of fulfilled personality disorder criteria on the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID II). At all evaluations, patients also rated 24 life events on a scale from -3 (extremely negative) to +3 (extremely positive). Furthermore, additional treatments, such as contact with mental health professionals, psychotherapy, psychopharmacological treatment, and sick leave, were recorded. The Working Alliance Inventory (Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) was rated in Session 7.

Moderators of Treatment Effects

Psychotherapy researchers are constantly confronted with questions concerning how individuals differ in their response to treatment. For what types of patients or for what patient characteristics and aptitudes are treatments maximally or minimally effective? Two patient characteristics were chosen a priori as possible moderators of treatment effects: the Quality of Object Relations Scale (QOR), and the presence versus absence of PD. The QOR measures the patient's life-long tendency to establish certain kinds of relationships with others, from mature to primitive, using three eight-point scales. The predetermined cut-off score for differentiating high versus low QOR scores was 5.00. QOR scores above the cut-off means that recent relationships may be difficult, but there is evidence for at least one mature relationship in the patient's history. QOR scores at or below the cut-off means a history of less gratifying relationships, characterized by less emotional investment, less stability, and need for dependency or overcontrol.

Participants

The patients from general practice, private specialist practices, and psychiatric outpatient departments were referred to the study therapists and assessed for eligibility. Inclusion criteria were liberal. One hundred patients were randomized to dynamic psychotherapy of one year's duration with transference interpretation or therapy without such interventions. The clinicians evaluating outcome were blind to treatment groups. The randomization procedure was successful. No significant differences were detected between the two groups with regard to baseline characteristics.

The mean GAF score before treatment was 61.2 (SD = 6.1) in the transference group and 60.4 (SD = 7.2) in the comparison group. The main diagnoses were: depression (56% in the transference group and 60% in the comparison group), and anxiety disorders (37% in the transference group and 31% in the comparison group).

Therapists and Treatments

The therapists were specifically trained to provide treatment with a moderate level of transference work (an average of two transference interpretations per session) and treatment without such interventions, with equal ease and mastery.

Both treatments were based on general psychodynamic principles. One treatment avoided an interpretive focus on the ongoing patient–therapist interaction (comparison group). The other treatment used material from the patient–therapist interaction as an important vehicle for clarifications, confrontations, and interpretations (transference group). The design of the study is a so-called constructive or dismantling design, in which a single component (analysis of transference) is added (or subtracted) to an existent treatment package. Thus, the causal efficiency of a specific technique can be identified.

Treatment fidelity or treatment integrity was extensively documented using ratings of 4–5 full sessions from each treatment by two raters, blind to treatment group (sessions n = 452). Treatment integrity was excellent. Only use of transference interventions was significantly different between the two treatments. Use of extratransference interventions were made more often in the comparison group; however, even in the transference group extratransference interventions were made more often than transference interventions (Høglend et al., 2006, 2008). The skill of delivering therapist interventions was high and equal in both groups. The use of supportive interventions was low and equal in both groups.

The specific techniques used for transference work is shown in the following list. Categories 1–3 are preparatory interventions, and categories 4 and 5 are transference interpretations in a stricter sense. In the comparison group, the therapists consistently used material about interpersonal relationships outside of therapy as the basis for similar interventions (extratransference interpretations), without any links to the patient–therapist relationship.

1. Therapist addresses transactions in the patient–therapist relationship.
2. Therapist encourages exploration of thoughts and feelings about the therapy and the therapist.
3. The therapist encourages the patient to discuss how the therapist might feel or think about the patient.
4. The therapist explicitly includes himself in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to the transference.
5. The therapist interprets repetitive interpersonal patterns, including genetic interpretations, and links to transference.

Examples of the Different Categories of the Transference Techniques

Category 1

Example 1

P: I didn't understand what you meant.
T: Yeah, it was silly of me in a way, because what I said was unclear.

Example 2

P: No, I don't agree with you on that.
T: All right. That's fine, because now you're perfectly clear when you're saying you don't agree with me. It might just be that I have misunderstood and that I've been barking up the wrong tree.

Category 2

Example 1

T: You say you're annoyed by me being too quiet.
P: Yes. Suddenly I don't know what to say or do. And then it might become kind of a struggle to find something to talk about.
T: And then maybe you come up with things to say, such as "now I quit."
P: Well, come up with? I have been thinking about it for a long time. Wanting to scale down. Move on, in a way. But I wonder if despite that, I might still come to the appointments, continue in the same pattern. Sit here until the end of the year, without telling.

T: So even if it's not ok to come here and you perceive me as an inhumane robot as you said, you would maybe still continue to come, even if you don't get anything out of it?

Example 2

T: What can I tell you that would help you?

Example 3

T: You have had a tendency of at least indirectly asking me what you should do and a desire to check what I think; for example, my views on whether your article was good enough. What do you think about that?

Example 4

T: We have talked about the image you have of me in a joking manner. Has that image changed? I mean, might it be that I, too, am a person who you can miss from time to time?

Category 3

Example 1

P: Towards other people I've had a polished facade and strongest is my barrier against being sad and helpless so people can't see it. But here I have indeed revealed my sadness and helplessness so there is not so very much more to embellish here.
T: How do I look at you then?

Example 2

T: You're saying it as if you're asking me if I think that this is too demanding for you.

Example 3

P: When I sit there with others then I feel that they think that I'm silly and stupid.
T: Yes, and that I also think so?
P: Yes, perhaps not so much, but the feeling itself is the same.

Category 4

Example 1

T: You become annoyed when those closest to you say things like that, but you aren't able to mobilize that amount of annoyance towards me, because you think that this is what psychiatrists should say.

Example 2

P: It has struck me a couple of times lately that people have shown me genuine care and that I have reacted by feeling sad. I don't know if it evokes a longing or that there's something frightening in it. I have a kind of fear of disappointment. I don't like dependent relationships because I was so dependent on my mother and I became so disappointed.
T: Are you afraid of this in relation to me; that you will connect yourself too strongly emotionally to me and become disappointed?
P: No, but the thought about the therapy being over makes me anxious. How will I manage on my own?

Example 3

T: It's like you're rejecting having a personal opinion on how we can facilitate the therapy in practice.
P: Yes.
T: Just like you initially turned away from, that there was nothing more to get from mother?
P: Yes. I'm thinking about how damaged my sister and I are. I have had little contact with her, but she used to be with me on Christmas Eve. One year I was mad at her and didn't invite her, but last year she was there. She has been going to therapy for years. I called her recently and invited her for Christmas.

Category 5

Example 1

P: He says he's very fond of me and could very well have a relationship with me.
T: But you're afraid of being let down, that he loses interest in you or something like that?
P: Mm hmm.

T: You did think that I, too, didn't have any interest in you.
P: Yeah, I know that logically speaking you care, but I felt something else. I didn't know what. It's sort of just a feeling I get.
T: This fear that people that mean something to you won't care; have you always had it or has it appeared later?
P: I think I have had it for a long time, but I have actually never thought about it before.

Example 2

P: My mother called this morning. I immediately interrupted her and told her that if it wasn't very important, I had no time to talk now. I hung up and even though I had lots to do, I got a terribly bad conscience.
T: You told about your difficulties saying no at work and taking care of yourself. You couldn't "hang up," either when talking with colleagues, your mother, or your father, because you were anxious about being rejected or punished. However, here you managed to tell me that our next session had to be changed because of your meetings at school and work.

Results

Transference Work—Different Effects for Subgroups

The results indicated that the treatment effect was equal in the two treatment arms, as reported in Høglend et al. (2006). Further analyses of subgroups revealed different effects for different patients. A surprising finding was that those patients with a long-term pattern of difficult interpersonal relationships benefited most from therapists' use of transference interventions. This finding challenged the myth that only the patients with most resources benefit from psychoanalytically oriented therapy. On the contrary, those patients who are most in need of therapy benefit more from therapy with transference interpretation than without. Thus, although different types of psychotherapy generally are equally effective, specific techniques may have different effects for subgroups of patients.

Transference Work Has a Long-Term Impact

In the subsample of patients with low QOR scores who received transference work, outcome was significantly more favorable than therapy without these interventions. In the high QOR subsample, outcome was equal in the two treatments. The effects were not due to life events, additional

treatment in the follow-up period, or attrition from the follow-up assessments. On the contrary, the patients in the control group received four times as much additional treatment in specialist care as the transference group, and all patients participated in the follow-up assessments (100%) three years after termination of treatment. After psychotherapy with transference work, we also observed that the patients sought 60% less psychiatric treatment at their general practitioners, and that sick leaves were 75% reduced.

The findings in FEST seem to be partly consistent with a previous quasi-experimental study by Høglend (1993). That study reported a negative effect of a high frequency of transference interpretations (on average six per session) to high QOR patients, versus a positive effect of a low frequency of transference interpretation (one per session) to low QOR patients. This study compared high and low frequency of transference interpretation, but there was no comparison group without transference interpretation in that study. Clarkin, Levy, Lenzenweger, and Kernberg (2007) and Levy et al. (2006) showed that one year of transference-focused psychotherapy for borderline patients was highly superior to the well-established dialectical behavioral therapy, or in some areas superior to dialectical behavior therapy, which supports that transference work has an effect.

Mechanisms of Change

The results indicated that for low QOR patients, insight during one year of dynamic psychotherapy improved twice as much for patients who received transference interventions compared to patients in the comparison group, both groups having been treated by the same therapists. Insight gained during therapy fulfilled all the statistical criteria for mediation (Baron & Kenny, 1986) plus temporal precedence. Of the 26 patients in the transference group with low scores on the QOR Scale, 18 (69%) changed more (faster) on the Insight Scale than on the Interpersonal Scales during the one-year treatment period. During the one-year after treatment, only eight (32%) of the same patients changed more on the Insight Scale than on the Interpersonal Scales. On average, insight did not increase after treatment termination, but interpersonal functioning continued to improve over the three-year follow-up period after treatment termination. In the comparison group, interpersonal functioning and insight changed in closely parallel lines. Insight may also have an important

impact on interpersonal functioning in the other subgroups of patients, but it wasn't possible to determine what came first in these groups.

Improved insight may increase one's understanding of others, thereby improving interpersonal relationships over time. The results supported the notion that long-term changes in interpersonal functioning are mediated through increased insight (the mechanism of change). The results indicate a causal association between transference work, insight, and outcome.

A large proportion (60%) of the long-term effects of transference work was explained by more insight gained during treatment. FEST is the first study to provide evidence that insight, a theory-based mediator, can explain so much of the long-term effect of transference interpretations, in line with Freud's speculations more than 100 years ago.

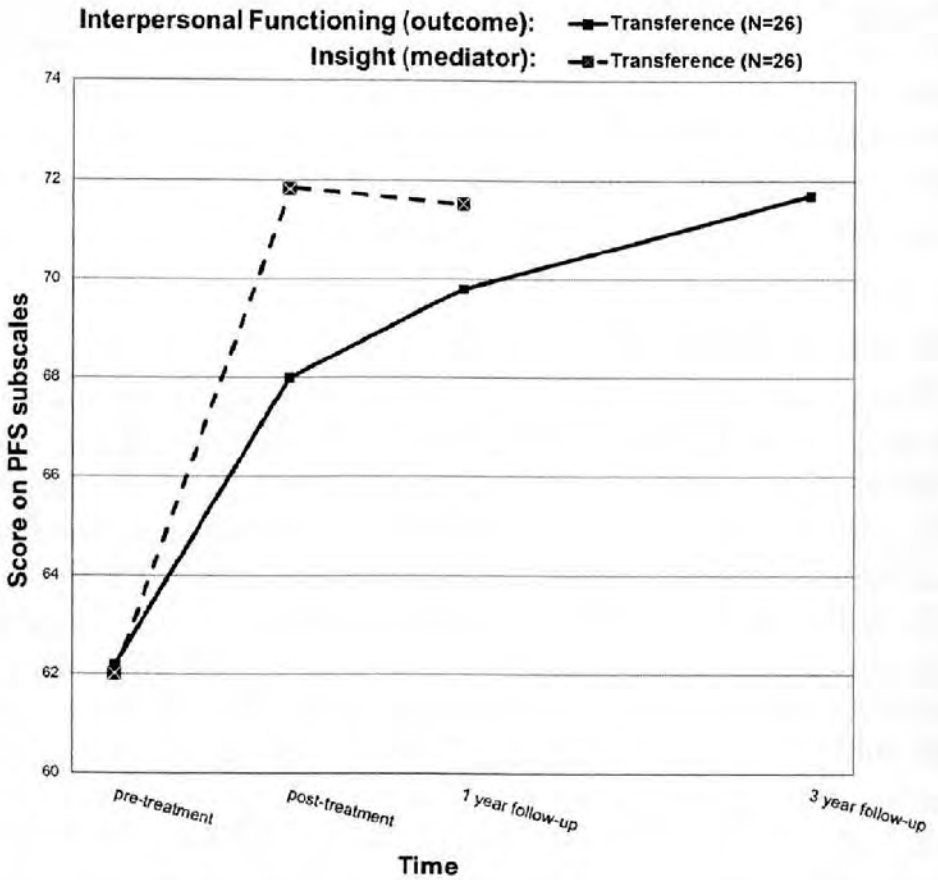

Figure 1. Change over time of Insight and Interpersonal Functioning for patients with low Quality of Object Relations receiving transference interventions.

Figure 1 illustrates that, in the subsample of patients with low QOR scale scores who received transference interpretation (n = 26), insight improved substantially during treatment, whereas interpersonal functioning continued to improve over the three-year follow-up period after treatment termination.

The Impact of Therapeutic Alliance

Common factors versus specific factors. The therapeutic alliance is regarded as the factor that most consistently explains the variance in the effect of psychotherapy. Whether psychotherapy has an effect through common, nonspecific factors like the therapeutic alliance, or through specific techniques, such as transference interpretation, has been a focus of debate in psychotherapy research. Yet, few studies have explored the interaction between common factors and specific factors. A three-way interaction analysis between quality of object relations, transference work, and alliance revealed that the therapeutic alliance had a significantly different impact on the effects of transference work, depending on the level of QOR (Høglend, Hersoug, et al., 2011). For patients with a lifelong pattern of conflictual relationships, loneliness, and more pathological interpersonal functioning, the effect of transference work was positive, independent of the quality of the alliance. Within the context of a low therapeutic alliance, the transference work was positive for the majority of the patients. When both the quality of alliance and QOR were high, we observed a negative effect of transference work, i.e., therapy without such interventions had a better effect. The findings were in the direct opposite direction of what has generally been maintained in mainstream clinical theory—that more mature relationships, as well as a strong therapeutic alliance, may be prerequisites for successful transference work.

These results indicate that transference work seems to be most important for patients with a history of poorer object relations and difficult, less satisfactory interpersonal relationships. These patients seem to benefit most from transference work within the context of low alliance. One possible explanation of the negative effect of transference work is that for those patients with better interpersonal functioning and good collaboration with the therapist, transference work may be experienced as disturbing and irrelevant.

Did patient characteristics and alliance have a predictive effect on long-term dynamic and interpersonal functioning after therapy, across the two therapies? Based on the well established association between

early alliance and psychotherapy outcome, the associations between the therapeutic alliance and long-term outcome three years after treatment termination were investigated. The alliance alone had a significant impact on long-term outcome of the predetermined primary outcome variables of the study: Psychodynamic Functioning Scales (PFS) and Inventory of Interpersonal Problems (IIP; Hersoug, Høglend, Gabbard, & Lorentzen, 2013). When, in addition to the early alliance, both expectancies and pretreatment patient characteristics that were significantly related to early alliance were included in the statistical analyses, more personality disorder pathology was the strongest predictor of favorable outcome, over and above the effect of the alliance, which was no longer significant, i.e., patient characteristics outperformed alliance as predictors of long-term outcome across treatments. The findings indicate that longer psychodynamic treatment is beneficial, especially for patients with PD.

Associations between alliance, expectancy and outcome. Johansen et al. (2010) and Johansen, Høglend, and Hersoug (2011) analyzed patients' pretreatment target expectancies and global expectancy. The results indicated that Global Optimism was significantly associated with the PFS and GAF. The expectancy–alliance–outcome mediational chain seems to be a general phenomenon, not limited to subgroups of patients or modes of treatment. None of the six putative moderators had a significant effect. Expectancies seem to be one of the common factors across different kinds of treatment. Negotiating realistic expectancy for psychotherapy may be important, whether the patient has unrealistically high expectancy or unrealistically low expectancy. In both situations, educating the patient about what can be expected from therapy can go a long way to forge a solid therapeutic alliance and favorable outcome.

Transference Work and Gender Differences at Posttreatment

In FEST, women and men responded equally to both treatments in the whole sample (n = 99), consistent with earlier research findings. However, the patients' gender was a moderator of effects of transference work. Women responded significantly better than men to therapy with transference intervention, and men responded significantly better than women to therapy without transference intervention. There was an interaction between patient gender and QOR: a strong positive effect of transference work among female patients with low QOR scale scores appeared, versus a negative effect of transference work for male patients with high

QOR scale scores. The subgroup of women with poor interpersonal functioning had a particularly strong effect of dynamic psychotherapy with transference work (Ulberg, Johansson, Marble, & Høglend, 2009; Ulberg, Høglend, Marble, & Johansson, 2012).

Long-term effects. A positive long-term effect of dynamic psychotherapy with transference interventions, compared to therapy without transference interventions, was found among women with average functioning, in interpersonal relationships. Men did not differ in long-term response to the two treatment modes.

The Impact of Personality Pathology

We explored the subgroup of patients with mainly cluster C PD (n = 46, i.e., avoidant, dependent, obsessive-compulsive PD), with regard to the effects of treatment. The outcome measures were remission from PD, improvement in interpersonal functioning, and use of mental health resources in the three-year period after treatment termination. After therapy with transference work, PD patients improved significantly more in core psychopathology and interpersonal functioning; the drop-out rate was reduced to zero; and use of health services was reduced 75%, compared to therapy without this ingredient. Three years after treatment termination, 73% no longer met diagnostic criteria for any PD in the transference group, compared to 44% in the comparison group. Long-term psychotherapy that includes transference work seems to be an effective treatment for cluster C PD and milder cluster B PD, i.e., borderline, narcissistic, histrionic, and antisocial PD (Høglend, Dahl, Hersoug, Lorentzen, & Perry, 2011).

Clinical implications. Patients with more personality pathology responded more favorably than patients with less personality pathology, and can be successfully treated with psychotherapy with transference interpretation. In the long-term perspective, this patient characteristic had the strongest effect on outcome, which is a reminder of the importance of focusing on dysfunctional interpersonal problems because they appear both in the transference and in patients' day to day lives outside therapy. The therapeutic task is to balance a forthright discussion of recurrent patterns of interpersonal difficulty with an empathic appreciation that these patterns are hard to change because of their longstanding entrenched nature.

The Interfaces between Research and Clinical Practice: FEST Experiences

Is there still an inherent tension between clinical judgment, creativity, and innovation on the one hand and clinical guidelines based on research findings on the other? Bridging the gap between researchers and clinicians is a challenge: Clinicians tend to consider psychotherapy research as overly simplistic or irrelevant for their clinical practice.

The results from the FEST study indicated that the clinicians were very good at precise evaluations, e.g. when using PFS or Insight (Høglend, 2003). How were the results obtained? The therapists were initially interested in their own patients and eager to develop their own clinical skills. In the study period, the group of therapists met regularly for discussions of their experiences. The therapists learned good operationalizations of theoretical concepts. All of them found that this was a valuable and important addition to clinical experience, which inspired and helped their clinical reflections and thinking.

The FEST therapists were also clinical raters and investigators, i.e., the therapists had repeated contact with all the patients. Patients reported that this contributed positively to the effect of the therapeutic process. Long-term follow-up evaluations several years after termination of treatment also seemed to be a particularly valuable learning experience for the therapists.

The research tools were perceived by the therapists as congruent with their clinical aims. All of them valued their research-based clinical training as superior to their prior extensive training at different teaching institutions, which consisted mainly of theoretical seminars and instrumental case supervision. Although some maintain that clinical supervision based on manualized therapeutic procedures may inhibit clinical judgment, the impression in this study was that manualized techniques did not impair clinical flexibility and creativity, and that therapists did not compromise their personal style. With extensive training, therapist use of specific techniques can be measured and monitored according to treatment manuals.

Summary

The first a priori hypothesis in this study was that transference work would have specific long-term effects, at least for patients with more mature relationships, more psychological resources, and less psychopathology. However, contrary to conventional clinical wisdom, the results

indicated that the subsample of patients with low quality of object relations benefited significantly more from therapy with transference work than without, whereas patients with mature interpersonal relationships benefited equally well from both treatments. Despite the fact that patients in the comparison group received more than twice as much additional treatment, compared to the transference group, the effect of transference work was sustained over a three-year follow-up period for low QOR patients.

Because the patients had different problems and symptoms—depression, anxiety, and PD—the results cannot indicate precisely what the effects are for homogenous diagnostic groups. On the other hand, the variety of diagnoses increases the generalizability to outpatients seeking psychotherapy. Experimental control of a specific psychotherapeutic technique may yield different results from clinical practice, where the therapist tries to adjust his or her technique to the individual patient. But such control is the only way to study causal relationships.

Healthier patients may present more subtle transference cues, thus forcing therapists to base transference work more on inference than concrete evidence. In contrast, the early "spontaneous" transference enactments of less healthy patients, such as fear of rejection, dependency/counterdependency, or idealization/devaluation, may take on a "dependent" or "pathological" form that is more suitable to transference work.

Conclusion

The overview of results in the FEST study indicates that:

- Moderate emphasis on transference work may be particularly useful when treating patients with personality disorder pathology and more severe and chronic difficulties in establishing stable and fulfilling relationships.
- A moderate use of transference work has specific positive effects on long-term functioning for low QOR patients, mediated by an increase in insight during therapy.
- FEST may have contributed to the development of methods to study some of the techniques in psychoanalysis—why, for whom, and how they are effective.

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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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