Attachment and Mentalization in Patients with Co-morbid Narcissistic and Borderline Personality Disorder

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Abstract
This study explored attachment status and capacity for mentalization in a sample of adult female borderline patients with and without co-morbid narcissistic personality disorder. A combined sample of 22 patients diagnosed with NPD/BPD, and 129 BPD patients without NPD was obtained from the participants in two Randomized Clinical Trials. Attachment and Reflective Function (RF), a measure of mentalization with respect to attachment relationships, were assessed with the Adult Attachment Interview (AAI; George, Kaplan & Main, 1985). The results showed that the NPD/BPD group was more likely to be categorized as cannot classify and less likely to be classified as unresolved for loss and abuse using the five-way AAI classification system. Both groups show evidence of attachment disorganization, but in the NPD/BPD group this took the form of oscillation between opposing states of mind with respect to early attachment relationships (most often dismissing and preoccupied), while the BPD/non-NPD group there was focal collapse in the monitoring of reasoning and discourse in response to specific questions about loss and trauma. There were no significant differences between the groups along the other attachment classification systems (three way, secure/ insecure, organized/disorganized) or in the RF score, which was low in both groups as predicted. Notably, NPD/BPD patients were less likely than BPD/non-NPD patients to dropout of psychotherapy over 1-year of treatment in all treatment conditions. The clinical implications of the group differences are discussed with a focus how understanding the diverse attachment representations of NPD/BPD patients helps to illuminate the grandiose and vulnerable manifestations of narcissistic pathology.
Keywords: narcissistic personality disorder, attachment status, mentalization, co-morbidity, borderline personality disorder

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Attachment and narcissism are two divergent concepts that have recently been united by two trends: The first is the identification of insecure and/or disorganized attachment representations and their developmental antecedents that are now recognized as risk factors for personality disorders (Buchheim & George, 2011). The second is the investigation of different phenotypic presentations and/or fluctuating mental states (e.g. grandiose and vulnerable (Cain, Pincus & Ansell, 2008) that characterize narcissistic pathology, and have recently been associated with different attachment states of mind (Meyers & Pilkonis, 2011). In this paper we present findings from a study investigating attachment representations and the capacity for mentalization (e.g. the capacity to understand behavior in terms of diverse and intentional mental states in the context of attachment relationships) of a particular group of narcissistic patients: those with co-morbid borderline and narcissistic personality disorders (NPD/BPD). Individuals with co-morbid NPD/BPD pose the most formidable obstacles to treatment and have the most guarded prognosis of patients in the personality disorder spectrum since they tend to provoke or alienate the therapist through their attempts to direct or devalue the treatment (Clemence, Perry & Plakun 2009; Kernberg, 2007; Ronningstam, 2011; Stone, 1989).

Several studies have shown particularly high rates of co-morbidity of NPD with BPD, with rates ranging from 17% to 80% (see Levy, Reynoso, Wasserman & Clarkin, 2007 for a review). In the recent wave 2 NESARC study the prevalence of NPD was greatest among responders with BPD (37%) with a prevalence rate of 20.2%, among respondents with any other personality disorder (Stinson et al, 2010). In fact, individuals with NPD have been found to have the highest rates of co-morbidity on Axis II of any personality disorders (Widiger, 2011), making it likely that patients with other personality disorders will also have significant narcissistic pathology that may affect their diagnostic and clinical presentation and treatment response. NPD patients have been found to show slower rates of symptom change (Pincus & Roche, 2011), to be among the highest risk for drop out from psychotherapy with the 64% drop out rate for NPD individuals in one study (Hilsenroth et al, 1998), comparable to the 59.2% drop out rate reported for BPD patients treated by experts in the community in non-manualized therapy tailored for BPD (Doering et al, 2010).

Previous research suggests that insecure and/or disorganized internal working models of attachment and deficits in mentalization underlie the difficulties with self-regulation and interpersonal functioning that make individuals with narcissistic and borderline disorders so challenging to treat (Fonagy, Gergely, Jurist & Target, 2002). While BPD has been linked primarily with preoccupied and unresolved (disorganized) attachment status (Bakersman-Kranenburg & van IJzendoorn, 2009; Fonagy et al, 1996, Levy et al, 2006); Patrick, Hobson, Castle, Howard & Maughn, 1994), NPD has been associated primarily with dismissing-avoidant attachment status, and secondarily with preoccupied or secure status (Dickinson & Pincus, 2003; Rosenstein & Horowitz, 1996; Westen, Nakash, Tomas and Bradley, 2006; Smolewska & Dion, 2005).

The focus on the attachment substrate of narcissistic disorders has dovetailed with renewed interest in the diverse clinical presentations, contradictory, complex mental states, and subjective distress of individuals with NPD (Ronningstam, 2010, 2011). Both clinical and empirical investigations have identified different phenotypic presentations of narcissistic pathology including: 1) A grandiose subtype, characterized by self-aggrandizement and self-reliance, overt devaluation and exploitation others, and lack of empathy; and 2) A vulnerable subtype characterized by feelings of inadequacy, rejection sensitivity and emotional dysregulation that are compensated for by grandiose fantasies and covert denigration of others (see Cain et al, 2008 for a review). Although these subtypes have received substantial empirical support in factor and correlational analyses, there are indications that they are two oscillating mental states that characterize narcissistic pathology. A recent study using daily diary cards indicated that pathological narcissism predicted fluctuations within the individual of both shame (vulnerability) and hubris (grandiosity) over eight days (Pincus & Roche, 2011). Nonetheless, those with vulnerable narcissism have been found to be characterized by more experienced distress and affect dysregulation in the face of threat or loss, by more overt psychopathology, and more treatment seeking behavior (Cain et al, 2008). Both the attachment substrate and internal complexity of NPD are absent from current DSM-IV-R criteria that focuses more on symptoms and interpersonal behaviors.

In an effort to further understand the representational world of NPD/BPD individuals compared with BPD/non-NPD individuals, we examined their attachment status and capacity

for mentalization using a sample of borderline patients from two randomized clinical trials. We expected that the NPD/BPD patients would be more likely categorized primarily as cannot classify (characterized by fluctuations between different attachment states of mind) and secondarily as dismissing, while the BPD/non-NPD patients were expected to be more often classified primarily as unresolved for loss and abuse and secondarily as preoccupied on the Adult Attachment Interview (George, Kaplan & Main, 1998). Both groups were expected to show deficits in Reflective Function (RF; Fonagy, Steele, Steele, & Target, 1998), an operationalized measure of the capacity to mentalize in the context of attachment relationships. In addition, in order to investigate whether a co-morbid diagnosis of narcissistic and borderline personality disorder affects treatment response, we examined the drop out rates for the NPD/BPD and BPD/non-NPD groups for both samples.

Method

A full description of the method and findings from the two Randomized Clinical Trials can be found in Clarkin, Levy, Lenzenweger & Kernberg, 2007, Levy et al (2006), and Doering et al (2010). Only the procedures and measures relevant to the current study are described below.

Participants

The current study analyzed the data of 151 patients: 100% women ages 18 - 50 (mean = 27.33; SD = 7.11), who met criteria according to the DSM-IV for Borderline Personality Disorder. Individuals who met criteria for severe Axis I psychopathology or other cognitive disorders, and individuals with current substance abuse and dependency were excluded. Demographics were as follows: 53.8% in a relationship, 24.9% divorced, and 21.3% single, 45.7% of participants were employed, 26.4% were enrolled in school or a training program, and 27.9% had no employment. Of the 151 participants, 22 met criteria for NPD/BPD (14.6% of the sample) while 129 met criteria for BPD/non-NPD.

Measures.

International Personality Disorder Examination. (IPDE). The IPDE is a semi-structured interview based on the DSM-IV criterion for diagnosing personality disorders (Loranger, 1999). The IPDE generates a probable or a sub-threshold diagnosis, and definite diagnosis for each of the DSM-IV Axis II personality disorders. Raters were highly trained clinicians with extensive experience in the diagnosis of severe Axis II pathology trained by A.W. Loranger in administration and scoring of the IPDE. Temporal stability and good to excellent levels of interrater reliability were found for all Axis I and II disorders *(Loranger, Sartorius, Andreoli, & Berger, 1994)*.

SCID II*:* The Structured Clinical Interview for DSM-IV (SCID-I/SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997, Wittchen et al, 1997) is a semi-structured clinical interview administered by trained clinicians and designed to yield psychiatric diagnoses consistent with DSM-IV/DSM-IV-TR (American Psychiatric Association, 2000) diagnostic criteria. The duration of administration ranges between 15 min and 2 h.

Adult Attachment Interview (AAI). The AAI (*George, Kaplan, & Main, 1985)* is a semi-structured clinical interview of 20 questions asked in set order with standard probes, intended to elicit thoughts, feelings, and memories about early attachment experiences. Its scoring system is designed to quantify the individual's current state of mind with respect to childhood attachment relationships. Individuals are asked to choose five adjectives to describe each relationship and to provide specific attachment related memories to support these words. To elicit attachment-related information, they are asked how their parents responded to them when they were in physical or emotional distress, and are asked about prior experience of loss, separation, rejection, and times that they might have felt threatened including, but not limited to, experiences of physical and sexual abuse. The interview also asks subjects to reflect on their parent's style of parenting and how this influenced their development and lives as adults. This allows for numerous opportunities for the interviewee to elaborate on, contradict, or fail to support previous statements.

The AAI was transcribed verbatim. Trained coders scored the transcripts with subscale ratings, with specific patterns used to assign the individual to one of five primary attachment classifications: (secure/autonomous (F), dismissive (Ds), preoccupied (E), unresolved (U), and cannot classify (CC). The first three categories are considered organized because they are characterized by a singular strategy for approaching the interview: The secure by free and autonomous states of mind with respect to attachment and internally consistent and integrated portrayal of relationships; the dismissing by devaluing or idealizing states of mind with respect to attachment with little corroborating evidence; and the preoccupied by oscillations between positive and negative states of mind with respect to attachments figures with whom one remains angrily of passively enmeshed. The two disorganized categories, U and CC, involve discourse dysregulation evident in the case of U either by brief but drastic lapses in the monitoring of discourse and reasoning in response to specific questions about loss and abuse; or in the case of CC in the use of multiple opposing strategies throughout the interview such that the individual oscillates between dismissing and preoccupied, or more rarely between secure and insecure strategies. The two disorganized classifications (U and CC) are always assigned a next best fitting organized classification (Main and Goldwyn, 1998). Previous research has shown remarkable stability and predictive validity of the AAI (see Hesse, 2010 for a review).

Reflective Funtioning Scale (RF). The AAI was also scored by trained coders blind to both time and treatment condition with the Reflective Function (RF, Fonagy, Steele, Steele, & Target, 1998) scale, an 11-point scale that assesses individual differences in the capacity to mentalize in the context of attachment relationships. The RF scale ranges from –1 (negative RF-- interviews are anti-reflective or overly concrete, totally barren of mentalization, or grossly distorting of the mental states of others) to 9 (exceptional RF -- interviews show unusually complex, elaborate, or original reasoning about mental states). A global RF score is given based on questions of the AAI that probe for reflective functioning. Taubner et al (2012) showed good interrater reliability for the global RF score, which is relatively stable across time and is significantly lower in individuals with severe psychopathology.

Procedures

In both studies, participants were assessed by telephone screening and/or individual interviews to determine their suitability and received a diagnosis of borderline personality disorder based on the IPDE (Loranger, 1999) for the U.S-Cornell sample, and on the German version of the SCID-II for the Vienna-Munich sample. All patients were evaluated for pharmacotherapy at entry into the study. In the U.S. Cornell sample, study psychiatrists, blind to psychotherapy assignment, followed a medication algorithm as a basis for pharmacological treatment, while in the Vienna-Munich sample, medication was not standardized but was regulated on an individual basis by psychiatrists in the community.

After the initial assessments, 90 patients in the U.S. Cornell RCT were randomly assigned for one year to one of the three manualized outpatient treatments: Transference-focused psychotherapy (TFP), a twice weekly psychodynamic therapy that focuses on modifying maladaptive representations of self and others through addressing affect laden themes as they emerge in the transference: Dialectical behavior therapy (DBT; Linehan, 1993), a cognitive behavioral treatment with both a weekly group and individual therapy component, which focuses on the learning of emotion regulation skills in the validating environment provided by the therapy; and Supportive psychodynamic therapy (STP) a once weekly noninterpretive psychoanalytic psychotherapy which focuses on promoting the patient's sense of self and agency through the collaborative relationship with the therapist (Appelbaum, 2005). In the Vienna-Munich study 100 participants were assigned to either TFP or therapy by experienced community psychotherapists.

In the current study we included only those participants who received the Adult Attachment Interview (AAI). The combined sample of 151 patients was divided into two groups: One including 129 participants who met criteria for BPD and another that included 22 that met criteria for both BPD and NPD) according to the DSM-IV- based criteria of the International Personality Disorder Exam (IPDE) and the SCID-II. In both studies, the AAI (George et al, 1985) was given at entry into the study and after one year of treatment. For this study only the pre-treatment AAI data was used.

Statistical Procedures

All categorical analyses employed Chi-square tests of association, and Fisher's exact test *p* values were calculated due to the relatively small cell sizes. Cramer's *V* is reported as an estimate of effect size/strength of association (0.10 = small, 0.30 = medium, 0.50 = large). To further breakdown any significant Chi-square analyses conducted, standardized residuals were examined to interpret associations and explore the direction of results. A critical standardized residual value of (+/-) 1.96 indicates that the observed frequency is significantly different from the expected frequency at the $p = .05$ level. We also conducted independent samples *t*-tests to examine mean differences between the NPD/BPD and BPD/non-NPD groups. Cohen's *d* is reported for all t-tests as an estimate of effect size (0.10 = small, 0.30 = medium, 0.50 = large).

Results

All AAI interviews were rated to determine each patient's primary adult attachment classification at pre-treatment. The AAI data was grouped in four different ways. First, each interview was coded to fall into one of five categories [Secure (F), Dismissing (Ds), Preoccupied (E), Unresolved (U), Cannot Classify (CC)]. The overall breakdown of five-way adult attachment classification by group is presented in Table 1. Chi-square analysis revealed a significant overall association between group and five-way attachment classification [χ^2 (4) = 10.65, Fisher's Exact $p = .021$, Cramer's $V = 0.27$]. Examination of the standardized residuals indicated that the NPD/BPD group was more likely to be Cannot Classify (CC) and less likely to be Unresolved for loss and abuse (U).

Second, since the disorganized categories are always assigned a next best fitting organized category, we also classified the interviews according to the three-way classification system [Secure (F), Dismissing (Ds), and Preoccupied (E)]. Chi-square analysis showed no significant overall association between group and three-way attachment classification [χ^2 (2) = 0.16, Fisher's Exact $p = .924$, Cramer's $V = 0.03$]. We further explored attachment in this sample by coding each interview as either secure [Secure (F)] or insecure [Dismissing (Ds), Preoccupied (E), Unresolved (U), and Cannot Classify (CC)]. There was no significant association between group and attachment security [χ^2 (1) = 0.45, Fisher's Exact $p = .620$, Cramer's $V = 0.06$]. Finally, we grouped the AAI interviews as either organized [Secure (F), Dismissing (D), and Preoccupied (E)] or disorganized [Unresolved (U) and Cannot Classify (CC)]. There was no significant association between group and attachment organization [χ^2 (1) = 1.19, Fisher's Exact $p = .357$, Cramer's $V = 0.09$].

We also wanted to investigate differences between the two groups on RF to capture possible differences in mentalization. Mean comparisons of RF score indicated no significant differences between the NPD/BPD and BPD/non-NPD groups ($\mu = 2.52$ and 2.85, respectively) [t (149) = -1.21; p = .228; $d = .26$].

Finally, we examined psychotherapy dropout over 1-year of treatment. Out of 151 patients, 4 NPD/BPD patients and 63 BPD/non-NPD patients dropped out of treatment. Chi-square analysis revealed a significant overall association between group and psychotherapy dropout [χ^2 (1) = 6.14, Fisher's Exact $p = .019$, Cramer's $V = 0.18$]. Examination of the standardized residuals suggests a trend whereby the NPD/BPD group was less likely to dropout of psychotherapy (see Table 1).

Overall, these results showed that the NPD/BPD group was more likely to be categorized as CC and less likely to be classified as U using the five-way AAI classification system. There were no significant differences between the groups along the other attachment classification systems (e.g. three way, insecure/secure, organized/disorganized), or RF score. Notably, NPD/BPD patients were less likely than BPD/non-NPD patients to dropout of psychotherapy over 1-year of treatment.

Discussion

Our results highlight the fruitfulness of the five-way AAI classification system, and particularly the two variants of disorganized attachment, in illuminating the attachment representations of clinical groups and detecting differences between them. As expected the major finding was that NPD/BPD patients were more likely to be categorized as Cannot Classify, with oscillation throughout the interview among two or more opposing attachment strategies (e.g. typically between dismissing and preoccupied states of mind), while the BPD patients without NPD were more likely to be classified as Unresolved for loss and abuse, with focal, but drastic collapse in the monitoring of discourse or reasoning involving the "entrance into peculiar compartmentalized and… dissociated/segregated states of mind" (Main, Hesse & Goldwyn, 2008, p. 61) on specific questions related to childhood loss and abuse.

The preponderance of CC over U classification in the NPD/BPD group suggests that a co-morbid diagnosis of NPD in borderline patients may function as a protective factor that renders these patients more resilient in the face of the past traumatic experiences that have been found to be a ubiquitous feature of their history (Buchheim & George, 2010). The defensive and rigid, if unstable, grandiosity (Kernberg, 1975, 1984; 2007; Ronningstam, 2010, 2011) of NPD/BPD patients has been linked to primitive defense use, particularly devaluation, omnipotence, autistic fantasy and projection (Perry & Perry, 2004). In contrast, the prevalence of U classification in BPD/non-NPD individuals may indicate defensive failure involving the intrusion of normally dissociated memory systems catalyzed by the discussion of traumatic experiences (Main et al, 2008). It is unclear, however, whether the mechanism at work with NPD/BPD individuals is the mobilization of rigid, if working defenses in the face of past trauma, or greater resolution about experiences of loss and abuse that leads participants to discuss them without disorganization in discourse and metacognitive processes. The presence of low RF scores in both groups, evidence of metacognitive deficits involving impairments in the capacity to reflect on mental states, suggests better defense use, rather than the capacity to mentalize in the face of childhood trauma.

It is important to note that built into the Cannot Classify category is the mechanism of the activation of defenses of idealization/devaluation in the context of intense current, preoccupying anger towards attachment figures. Indeed, in order to be rated as CC with dismissing and preoccupied attachment as secondary strategies (the most typical type of CC rating of our participants) the AAI interview must be characterized by both angrily preoccupied speech about attachment figures and high devaluation and/or idealization of them (Main et al, 2008). In dynamic terms the high idealization/devaluation (that defines the dismissing strategy) could be viewed as defenses mobilized against the pervasive, anger that characterizes the preoccupied strategy.

In addition these findings raise the question of whether the NPD/BPD group experienced **less** childhood trauma compared to the BPD group. Previous research with the U.S. Cornell sample only using a self-report measure of abuse (physical and sexual) and neglect (emotional and physical) suggest this may be the case. However, Diamond et al. (2012) found no differences between the two groups in the reported amount of sexual and physical abuse and emotional neglect, and only a trend towards a difference between the groups on physical neglect, suggesting that the two groups may not differ in their retrospective accounts of the amount of trauma experienced, but in the ways that they processed and contained it.

These findings suggest that the pathological grandiose self of the NPD/BPD patient which encompasses ideal and real representations of self and others with negative affects and self representations projected onto others who are then devalued (Diamond et al, 2011) may serve a stabilizing function. That NPD/BPD patients were found to drop out significantly less often than do BPD/non-NPD patients in all treatment modalities speaks to this point. Interestingly enough NPD/BPD individuals were also found in previous studies to have fewer hospitalizations and inpatient days (Hörz et al, 2011) and less self-harming behavior (Diamond et al, 2012)—both of which suggest that narcissistic pathology in the context of BPD may have a stabilizing effect that contributes to holding them in treatment and limiting self destructiveness.

These findings have major therapeutic implications as they offer an attachment-based perspective on the contradictory clinical presentation of NPD/BPD patients. Our primary study finding that NPD/BPD patients were more likely to be rated cannot classify lends support to the clinical observation that fluctuating intraindividual mental states of grandiosity and vulnerability are interrelated aspects of narcissistic disorders for patients with co-morbid borderline and narcissistic pathology. The typical narcissistic resistances and transferences including the inability to depend, pervasive devaluation or brittle idealization of others, arrogant derogation of thinking and feeling itself, and barrenness and/or rigidity of discourse may be understood as dismissing attachment mechanisms in which the focus is "continuously away from past attachment relationships and their influences (Hesse, 2010, p. 556)." Although there were no significant differences between the groups on the organized AAI categories, examination of the data reveals that over 30% of the NPD/BPD patients were rated as Ds, suggesting that dismissing attachment represents a dominant strategy to regulate narcissistic pathology. However, that 22% of NPD/BPD individuals were rated as CC, and 19% E, suggests that preoccupied mechanisms are employed as well where the focus is "persistently although confusedly so strongly oriented towards attachment relationships and experiences (Hesse, 210, p. 556)." In sum, understanding the different representational processes, modes of affect regulation and defense that characterize the diverse, contradictory attachment strategies of NPD/BPD patients helps to illuminate the shifts in mental states from dismissing to preoccupied, from grandiose to vulnerable as the attachment system is activated in the clinical situation.

Limitations. The small sample size and unequal numbers in the two groups of NPD/BPD and BPD/non-NPD patients limits the study's generalizability and power to detect differences. Second, assessment of narcissistic pathology was based on IPDE/SCID-II criteria that are based on the DSM-IV criteria, which is more heavily weighted towards assessing grandiose as opposed to vulnerable NPD (Ronningstam, 2009). Further, there was no assessment of dimensional measures of NPD. Thus, our findings are relevant only to patients with co-morbid narcissistic and borderline disorders and may not be generalizable to higher functioning narcissistic patients.

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Table 1. *Crosstabulation of Five-Way Adult Attachment Classification and Psychotherapy Dropout by Group*

Measure		NPD/BPD (n = 22)		BPD/non-NPD (n = 129)		X^2	*p*	*V*
		Count	%	Count	%			
Five-way AAI Classification						10.65	.021	.27
Secure		2 (.6)	9.1%	7 (-.2)	5.4%			
Dismissing		7 (.7)	31.8%	30 (-.3)	23.3%			
Preoccupied		4 (0)	18.2%	23 (0)	17.8%			
Unresolved		4 (-1.8)	18.2%	61 (.7)	47.3%			
Cannot Classify		5 (2.3)	22.7%	8 (-.9)	6.2%			
Psychotherapy Dropout						6.14	.019	.18
Yes		4 (-1.7)	(18.2)	63 (.7)	(48.8)			
No		18 (1.6)	(81.8)	66 (-.6)	(51.2)			

Notes. df = 4 for five-way AAI classification analysis; *df* = 1 for psychotherapy dropout analysis; *p* = Fisher's exact *p* value; *V* is an estimate of effect size (0.10 = small, 0.30 = medium, 0.50 = large); Standardized residuals appear in parentheses below group counts; AAI = Adult Attachment Interview