Transference Focused Psychotherapy For Patients With Co-Morbid Narcissistic And Borderline Personality Disorder

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Abstract

Clinical experience involving the treatment of patients with co-morbid borderline and narcissistic personality disorders suggests that this patient population is among the more difficult to treat within the personality disorder spectrum. In this paper, we present modifications of Transference-Focused Psychotherapy (TFP) based on our clinical experience with and research data on patients with co-morbid BPD/NPD. We will briefly review object relations formulations of severe narcissistic pathology, as well as recent research in attachment and the allied concept of mentalization, which have provided a new lens through which to view narcissistic disorders. The research findings from three studies demonstrating the efficacy and effectiveness of TFP are presented, which allowed for the study of the characteristics of the subgroup of borderline personality disorder patients who have co-morbid narcissistic personality disorder (NPD/BPD). Findings on co-morbidity, attachment status, capacity for mentalization, and level of personality organization of borderline patients with co-morbid NPD/BPD compared with borderline patients without co-morbid narcissistic pathology are presented. Clinical implications of the observed group differences are discussed, with a focus on modifications in the technique of Transference-Focused Psychotherapy (TFP). Clinical case material is presented to illustrate the specific challenges posed by narcissistic patients to carrying out TFP in each phase of treatment.

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

Recently we have turned our attention to the applications of TFP to patients with narcissistic pathology, particularly those with co-morbid narcissistic and borderline

personality disorders (NPD/BPD). Based on our own research and clinical investigations at the PDI, we have found that patients with more severe forms of narcissistic pathology are particularly difficult to treat and may have a more guarded prognosis than all other personality disorders functioning on the borderline level (Clarkin et al., 2006; Kernberg, 2007; Diamond and Yeomans, 2008, 2010), a finding that has been confirmed by a number of other clinical investigators (Stone, 1989; 1990; Clemence, Perry and Plakun, 2009). Previous research has found the co-occurrence of narcissistic and borderline personality disorders with rates of co-morbidity ranging from 10% (Barone, 2003) to 17% (Clarkin et al., 2007) to 80% (Pfohl, Coryell, Zimmerman, and Stangl, 1986; see Levy, Reynoso, Wasserman, and Clarkin, 2007 for a review). Indeed, previous studies have shown a high degree of co-occurrence of NPD with other Axis II disorders, especially those in cluster B, i.e., borderline, anti-social, and histrionic personality disorders (Fossati, Beauchaine, Grazioli, Carretta, Corinovis and Maffei, 2005; Zimmerman, Rothschild and Chelminski, 2005). Although the co-occurrence of narcissistic and borderline pathology has been shown to be a complicating factor for both accurate diagnosis and for psychotherapy (Kernberg, 1984; Stone, 1990; Diamond et al., 2008, 2010), there has been surprisingly little empirical research investigating the characteristics of these patients, how they may differ in their clinical presentation from personality disordered patients without narcissistic pathology, and how these co-occurring personality features might pose particular treatment challenges with respect to treatment course and outcome.

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

Transference Focused Psychotherapy

TFP is a twice-weekly psychoanalytic psychotherapy grounded in a psychoanalytic object relations theory of the structural organization of personality (Kernberg, 1984, 2007). TFP has also been increasingly informed by neurocognitive and attachment research with personality disordered populations (Levy, Yeomans, Clarkin, Scott, Wasserman and Kernberg, 2006). The theoretical model informing TFP posits a dynamic interaction of temperament (individual differences in affect activation and regulation and motor reactivity), environmental factors such as abuse or neglect, an insecure working model of attachment, deficits in mentalization, low effortful control, and other neurocognitive deficits that that predispose BPD individuals to affective dysregulation, particularly in interpersonal situations (Posner, Rothbart, Vizueta, Levy, Thomas, and Clarkin, 2002; Adolphs, 2003; Depue and Lenzenweger, 2005; Clarkin et al., 2006; Gabbard, Miller, and Martinez, 2006; Silbersweig, Clarkin, Goldstein, Kernberg, and Tuescher, 2007; Fertuck, Lenzenweger, Clarkin, Hoermann, and Stanley, 2009; Zaki and Ochsner, in press). Although our understanding of patients with severe personality disorders is informed by these multiple perspectives, our theory posits that such disorders, including BPD, are characterized at root by identity diffusion, i.e., the lack of a coherent, integrated sense of self and others. The work of TFP is to facilitate the reactivation, under controlled circumstances, of the dissociated internalized object relations in the transference relationship in order to observe the nature of the patient's split polarized internal representations, and then, through a multi-step interpretive process, work to integrate them into a fuller, richer, and more nuanced identity (Caligor, Diamond, Yeomans and Kernberg, 2009).

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

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

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

Model of NPD: The contributions of Object Relations and Attachment Theory

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

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

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

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

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

Such deterioration is particularly severe in individuals characterized by the syndrome of malignant narcissism, a more severely pathological form of NPD that is marked by 1) prominent narcissistic features, 2) ego-syntonic aggression, 3) intense paranoia, and 4)

antisocial traits (Kernberg, 1984). For such individuals, the grandiose self is not only infiltrated with aggression, but also is sustained through identification with a punitive, primitive and powerful introject which provides the illusion of triumph over pain, death and limitations through relentless attacks on the self. This pathological form of narcissism includes a particularly intense level of envy that can lead to the need to triumph over others as the principle source of gratification, causing negative therapeutic reactions in which the patient may engage in self-destructive actions, even suicide, as a means of defeating the therapist (Kernberg, 1984).

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

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

The Contributions of Attachment Theory and Research to Understanding Narcissistic Personality Disorders

From an attachment point of view the manifestations of pathological narcissism devolve from insecure internal working models of attachment, particularly dismissing avoidant states of mind with respect to attachment figures who were experienced as consistently rejecting and or emotionally unavailable (Bowlby, 1988). Bowlby (1988) hypothesized that attachment theory and research would contribute to our understanding and treatment of severe personality disorders. He wrote that those with avoidant-dismissing internal working models of attachment might "attempt to live his life without the love and support of others, and that such individuals might later be diagnosed "narcissistic" (1988, pp. 124-125). In fact, narcissistic disorders have been associated with dismissing-avoidant attachment status in both

clinical and empirical investigations (Levy, 1993; Rosenstein and Horowitz, 1996; Westen, Nakash, Tomas and Bradley, 2006; Westen and Shedler, 2006), using different methodologies including the Adult Attachment Interview (AAI), self report measures of attachment including the Experience of Close Relationships Questionnaire, (ECR, Brennan, Clark, and Shaver, 1998), and Relationship Questionnaire, (RQ, Bartholomew and Horowitz, 1991) as well as clinician ratings. Individuals with dismissing internal working models of attachment may describe attachment figures with contemptuous derogation and/or brittle idealization that is not substantiated by specific or episodic memories of childhood experiences, or alternately, may show loss of memory of childhood experiences altogether.

Although dismissing mechanisms are often primary for such patients, our investigations along with previous research in both clinical (Hamilton, 1987; Bender, 2001; Barone, 2003; Levy et al., 2006; Diamond et al., 2010, 2011) and nonclinical populations (Dickinson and Pincus, 2003; Smolewska and Dion, 2005, Otway and Vignoes, 2006), suggest that narcissistic patients may also be characterized by preoccupied attachment status, in which the individual alternates between idealization and denigration of attachment figures with whom he or she remains angrily or passively enmeshed. Investigations of the relationship between subtypes of narcissism and attachment dimensions of anxiety and avoidance indicate that covert (vulnerable) narcissism was significantly associated with attachment anxiety (Smolewska and Dion, 2005). Another study indicated that those with covert (vulnerable) narcissism showed high self report ratings of fearful-avoidant attachment, while those with grandiose narcissism endorsed a secure attachment style, or secondarily a dismissing attachment style (Dickinson and Pincus, 2003). In our research (Diamond et al., 2010), individuals with NPD/BPD have been found to be characterized by both dismissing and preoccupied attachment, or have been assessed as cannot classify attachment, a disorganized attachment category in which individuals oscillate between different attachment states of mind (e.g. dismissing, preoccupied, and secure) without being able to mobilize any consistent attachment strategy on the AAI. Thus individuals with NPD/BPD may exhibit multiple, unintegrated attachment representations, leading to contradictory transferences and resistances which make these patients particularly challenging to treat.

Deficits in Mentalization in NPD/BPD

The mechanisms of insecure dismissing and preoccupied attachment that are associated with severe narcissistic pathology may also truncate the narcissistic individual's capacity for mentalization, i.e., the capacity to make sense of and interpret the behavior of self and others in terms of intentional mental states. We concur with Fonagy (2002) and his colleagues, believing that deficits in mentalization for patients with severe narcissistic pathology may pose formidable impediments to treatment. Conversely, as our research investigations indicate, improvements in mentalization may be a key mechanism of change in psychodynamic psychotherapy with patients with severe personality disorders (Bateman and Fonagy, 2004; Levy et al., 2006; Kernberg et al., 2008). Fonagy and his colleagues have suggested that mentalization is "intrinsically linked to the development of the self, to its gradually elaborated inner organization, and to its participation in ….a network of human relationships with other beings who share this unique capacity" (Fonagy et al., 2002, p. 3). For the patient with severe narcissistic pathology, the rigid organization around the pathological grandiose self may distort and erase awareness of their own minds and the mind of others, and even of thinking itself, (Bion, 1967), posing major impediments to the development of mentalization.

In our view, the severe deficits in mentalization observed in narcissistic patients organized at a borderline level may be seen as the distortion of their internal world of object relations—which is the focus of our treatment. We believe it is sometimes difficult for them to comprehend that the grandiose self is a mental state among other mental states that

characterize the self. Furthermore, the grandiose self serves a defensive function in terms of protecting the individual from understanding the mental states of the self and the other, who historically may have been experienced as cold, exploitative, shaming or overindulgent in ways that may have compromised the development of the individual.

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

Research Findings

The research endeavors on the effectiveness of TFP have been based on a well delineated model of treatment development (Kazdin, 2004). We will comment on three studies conducted by the Personality Disorders Institute and by the Vienna-Munich TFP group, to investigate the impact of one year of TFP upon symptomatology, social adjustment, utilization of psychiatric and medical services, attachment organization, neurocognitive functioning, and mechanisms of change in all of these dimensions in patients with borderline personality disorder and borderline personality organization. These studies have been described in detail in previous publications (Clarkin et al., 2001a; Clarkin et al., 2007; Doering et al., 2010) and hence will be summarized briefly here.

Despite the high rates of comorbidity of NPD/BPD and the plethora of theories about its etiology and treatment, there have been few empirical studies that might help illuminate the etiology, course and treatment response of NPD/ BPD patients. Data from the studies noted above (Clarkin et al., 2001a; Clarkin et al., 2007; Doering et al., 2010) allowed for the delineation of the characteristics and clinical differences of the subgroup of patients with combined and borderline personality disorders (NPD/BPD), compared to BPD patients without NPD.

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

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

In order to assess improvement in TFP as compared with other manualized treatments, the next step was to conduct a randomized clinical trial (Clarkin, Levy, et al., 2004; Levy, Meehan, et al., 2006; Clarkin, Levy, et al., 2007) in which 90 patients (84 women and 6 men) were randomly assigned to one of three year-long outpatient treatments : TFP; Dialectic Behavioral Therapy (DBT), an empirically supported cognitive behavioral therapy; and a manualized supportive psychodynamic therapy (SPT), which although psychodynamically based did not use transference interpretation (Appelbaum, 2005). This study combined aspects of effectiveness and efficacy studies in that patient assessment and recruitment were done in a standardized way in a hospital setting and therapists were trained and carried out manualized treatments; however, the treatments were carried out by clinicians in the community and there were few exclusion criteria for therapists (Levy et al., 2006; Kernberg et al., 2008; Levy, Meehan, and Yeomans, 2012).

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

We also hypothesized that Reflective Functioning (RF) (Fonagy et al, 1997) may be the primary mechanism by which patients with personality disorders improve, and that because of the nature of the treatment, RF would improve in TFP but not in DBT or supportive psychotherapy. Our results supported this view, with only patients in the TFP group evidencing a shift in RF, moving from low RF, in which reflection on mental states of self and other was naïve and simplistic, to an adequate RF (Levy et al., 2006). For patients in TFP, but not DBT or supportive therapy, there was also a significant increase in the AAI subscale of narrative coherence, the best predictor of attachment security (Waters et al., 2001). After 12 months there was also a significant (three-fold) increase in the number of patients classified with secure attachment in TFP, but not for the other two treatments.

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

The third study, conducted by the Vienna-Munich TFP group (S.Doering, P.I) involved a randomized clinical trial of 104 female BPD patients randomized to TFP or to treatment by community psychotherapists with experience treating BPD (ECP; Doering et al., 2010). This study found TFP to be superior to treatment by ECP, with TFP patients evidencing significantly fewer suicide attempts, higher BPD remission rates according to DSM-IV SCID-II criteria, greater improvements in psychosocial functioning and personality organization, and fewer psychiatric inpatient admissions (AAI and RF data have yet to be analyzed).

Data from the three studies described above, two conducted at the PDI (Clarkin et al., 2001a, 2007) and one conducted by the Vienna-Munich TFP group (Doering et al., 2010), also allowed for the study of the characteristics and clinical differences of the subgroup of patients with combined narcissistic and borderline personality disorders (NPD/BPD), compared to borderline patients without NPD. Our goal was to investigate the nature of co-morbid narcissistic and borderline pathology by reexamining data from all three studies (Clarkin et al., 2007, Clarkin et al., 2001a, Doering et al., 2010) on a number of dimensions. The three studies yielded a combined sample of 198 patients, 32 of who met criteria for NPD with BPD, and 166 for BPD without NPD. In the first study 70% (N=7) of patients had co-morbid NPD/BPD; in the second, 18 % (N=15), and in the third (the Vienna Munich RCT), 10 % (N=10). The patients were predominantly women between 18-50, although the PDI RCT included some male participants. In the three studies, all patients met criteria for BPD (Borderline Personality Disorder) and in the Vienna-Munich RCT for BPO (Borderline Personality Organization). Note that all patients in these three studies were treated for a minimum of one year in private offices by experienced therapists with advanced postdoctoral or psychoanalytic training who were in supervision with expert TFP therapists regularly.

With the new subset from the pooled samples of NPD/BPD patients compared to BPD-only patients, we chose to examine Axis I symptoms; Axis II symptoms; self-harming and suicidal behaviors; global function (GAF); level of personality organization; attachment status, and RF. Measures of these dimensions were given at admission and after one year of TFP. Our goals were to 1) to compare Axis I and Axis II comorbidity, general functioning, self-harming behavior, mental health service use and personality organization in patients with NPD/BPD compared to patients with BPD without NPD at baseline; 2) to investigate attachment classification and mentalization (RF) for these two patient groups at the beginning of treatment and after one year.

Our preliminary findings indicate that compared to the BPD-only group, the NPD/BPD group had significantly less Axis I psychopathology and more co-morbid Axis II personality disorder criteria; specifically, more fulfilled diagnostic criteria for histrionic PD, antisocial PD (both Cluster B), paranoid PD, schizotypal PD (both Cluster A), and fulfilled diagnoses for histrionic PD and paranoid personality disorder compared to the BPD without NPD group. Although the BPD with NPD group showed comparable amounts of self-directed aggression (self-harming behavior and suicide attempts), there were significantly fewer hospitalizations in the NPD/BPD group compared to the BPD without NPD group. Finally, although the BPD with NPD group showed comparable levels of personality organization, they exhibited higher levels of Primitive Defenses assessed both on Structured Interview of Personality Organization and Inventory of Personality Organization (Hörz, Diamond, Clarkin, Levy, Fischer-Kern, Rentrop, Cain and Doering, 2011).

In sum, the higher levels of Axis II co-morbidity in the context of significantly less Axis I pathology noted in the NPD/BPD group may indicate the stabilizing aspects of the grandiose self discussed earlier (Ronningstam and Gunderson 1991). The rigid organization of the grandiose self may protect NPD/BPD patients to some degree from experiencing overt Axis I symptoms of anxiety or depression. That the rigid organization of the grandiose self that underlies NPD is to some extent a protective factor may also be seen in the fact that the NPD/BPD group has fewer hospitalizations, and a trend (in the Munich-Vienna study only) towards less self-harming behavior. In addition, the NPD/BPD group exhibits higher levels of Primitive Defenses. These patients are not only better defended but their defenses are more ego syntonic: higher levels of defense use are indicated on self report (IPO, Clarkin et al., 2001b) as well as interview (STIPO, Clarkin et al., 2004) measures.

Furthermore, in the context of BPD, NPD may co-occur with more malignant features: paranoia, antisocial personality features and behaviors, distortions of reality or variable reality testing (schizoptyal features). The triad of paranoid and anti-social features along with more distorted reality testing that characterized our NPD/BPD patients provides one of the first empirical confirmations of Kernberg's conceptualization of malignant narcissism as a subgroup of NPD diagnosis (Kernberg, 1984, 1997, 2007).

Although analyses of attachment and RF for the combined samples have yet to be completed, preliminary analyses involving the PDI RCT are ongoing. Despite small and unequal sample sizes (12 in NPD/BPD group and 69 in the BPD group) that did not permit systematic statistical analyses, some trends in the data are noteworthy. Compared to the BPD only group, the NPD/BPD group was more likely to show dismissive and cannot classify attachment status on the AAI at time 1 (CC being a mixture of dismissing and preoccupied attachment). In addition, no differences in levels of RF and coherence were noted between the two groups at the beginning of treatment, and both were in the low range. In the TFP group, for the BPD/NPD group, RF improved, but there were no significant group differences between the NPD/BPD group compared to the BPD without NPD group in all three treatment groups (e.g. TFP, DBT and supportive treatment cells). Thus, as was the case with the larger study (total sample), the group of patients with co-morbid NPD/BPD were more likely to show significant improvement in RF only in TFP (but not DBT and Supportive therapy) after one year of TFP treatment (Levy et al., 2006; Diamond, Yeomans, Levy, Meehan, Clarkin and Carrasco, 2011).

These preliminary findings suggest that there is change in RF for NPD/BPD patients in the TFP group, although the ratings of narrative coherence changed minimally for these patients in all three treatment groups. The result that RF changes more than coherence for NPD/BPD patients in TFP suggests that the capacity to think in terms of intentional mental states in attachment relationships may be a precursor to attachment security, and that reflective function may be a mechanism of change. Since clinically we have noted that narcissistic patients tend to have difficulty considering the grandiose self as one among many self- states, with the concomitant difficulty viewing others with any complexity, the improvement in RF that we see in our patients after one year of TFP is encouraging. While it may be generally true in exploratory therapy that RF changes before coherence, it may be more true in narcissistic patients whose narrative is dominated by the defensive functioning of the grandiose self. In fact, our research findings that patients with co-morbid narcissistic and borderline pathology show higher levels of primitive defense use than do BPD patients without NPD both on self report instruments (IPO, Clarkin et al., 2001b) and interviewer ratings (STIPO, Clarkin et al., 2004), indicates how ego-syntonic these defenses may be.

Considerations related to Clinical Technique

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

Treatment Contract

The essence of TFP is to create a treatment frame through the treatment contract that allows the patient's internal representations to unfold in the relationship with the therapist (Clarkin et al., 2006). With the narcissistic patient, contract setting is more difficult because the setting of responsibilities confronts (poses limits to) the grandiose self and hence is often initially rejected or tested in ways that may threaten the continuance of treatment. The contract and frame are particularly important in cases in which the patient's grandiosity has

kept him from functioning in the real world. Such patients often receive significant secondary gain from the disorder in the form of assistance from family or the social service system (Diamond et al., 2008; Diamond, Yeomans and Levy, 2011; Stern, Diamond, Yeomans and Kernberg, in press).

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

Defining the Dominant Object Relations

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

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

engage in counter-transference enactments, struggling to tolerate the patient's devaluation and understanding it as an aspect of the patient's internal world of self and object representations and associated affects.

Working in the transference

Interpretation of role reversal in the transference, a phenomenon characteristic of BPD patients without comorbid NPD, is complicated with narcissistic patients because of the rigid defensive nature of the grandiose self, which makes the expected oscillation of grandiose and deprecatory self states less prevalent in certain cases, although one can see oscillation between grandiose and deprecatory self states, particularly in the case of covert narcissism. With BPD patients without severe narcissistic pathology, the dominant object relations are usually readily activated with the patient oscillating between identification with the self or object poles of the dyad in rapid succession in both the extra-transferential and transference relationship.

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

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

The following case example will indicate how the co-occurring personality features might pose particular clinical challenges and affect the course and outcome of TFP treatment.

Case Illustration

Marta, a single, unemployed Latin-American woman, was referred for TFP at age 33 after many years in other treatments. Her condition had worsened to the point where she spent the 6 months prior to beginning TFP isolated in her apartment, lying in bed with chronic suicidal ideation, binge eating and only rarely bathing. She was the middle of three siblings in an upper middle-class family that immigrated to the U.S. so that her father could pursue advanced professional training. She described her mother as extremely controlling, "pushing us to the limit." She felt chronically rejected by her mother who was often depressed, suicidal and unable to care for her children. She felt that mother gave her "mixed signals," at times clinging to her when she was lonely and in states of depression, but at other times shutting her out, locking her in a car alone on one occasion and frequently sending her to room for punishment. She stated that she often felt that she did not really have a mother and that "I just remember being disciplined, I don't remember comfort." Marta described her father as emotionally absent and preoccupied with his legal career, but she also experienced him as obsessed with his children's educational performance to the point of abusing them verbally and sometimes physically if they did not perform up to expectations. She felt that she "lost" her father when she was not doing well in school. When she was upset or distressed or when she was being punished she would go to her room where she would "play, pretending to be teaching, and living in this fantasy world."

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

In the research evaluation, she met criteria for not only borderline personality disorder, but also narcissistic and avoidant personality disorders on the International Personality Disorders Examination (IPDE, Loranger, 2000), and she met SCID-I (First et al., 1996) criteria for current dysthymia. Finally on the (IPO) Inventory of Personality Organization (Clarkin et al., 2001b), a self report inventory designed to assess level of personality organization, she scored very high on identity diffusion and primitive defenses, and evidenced compromised reality testing and elevated aggression scores.

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

From the earliest sessions, Marta's interactions with her therapist were characterized by a non-stop monologue through which she entirely blocked his participation in the therapy and eliminated any possibility of dialogue or reflection. Marta's stream of discourse consisted mainly of vociferous complaints about how others treated her with aggression and disrespect. She interrupted and talked over her therapist if he tried to speak. While on a

superficial level Marta seemed to seek validation of her narrative from the therapist, her treatment consisted in fact of haranguing him while dismissing and criticizing him as doing nothing for her. When the therapist attempted to draw her attention to this behavior, Marta became more forceful in her efforts to control him, becoming increasingly aggressive, agitated, and, at times, overtly abusive. Her haughty, derogatory, or withdrawn attitude seemed to empty out the therapeutic relationship of any meaningful human contact, leaving the therapist feeling in the countertransference alternately controlled, shut out, mistreated, helpless and/or infuriated.

The therapist's initial response was to tolerate the confusion and frustration that such a stance engendered in him as he was effectively silenced by her grandiosity, aloofness and arrogance. After some time, the therapist chose to tactfully address Marta's style of communication. Focusing on the nature of their interaction and on her experience of him, as well as his of her, he pointed out that Marta's barrage of words and rejection of anything he offered might function to control him, immobilize him, and keep him at a distance. In addition, he commented on the apparent discrepancy between this and Marta's regular and punctual attendance at her sessions. With time, Marta became more aware of her own behavior and, the therapist was able to raise the question of what might motivate her to interact this way.

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

In the initial sessions, the omnipotent object relation of the controller and the controlled buttressed the patient's self-esteem, but at the expense of any genuine investment with the therapist who might offer help, and also functioned to protect her from envy directed towards the therapist—the potentially good object (Rosenfeld, 1964/1965). Her dismissing devaluation of the therapist was punctuated by envious attacks on him. She periodically referred to the therapist's accomplishments and publications which she looked up on the internet, but then would interject comments such as: "You're supposed to be an expert! You don't do anything!" As these primitive object relations began to emerge, her experience of the transference was concrete, highly affectively charged and confusing and anxiety provoking for therapist and the patient. In addition, the patient accused her therapist of being interested in her only because he was gaining something for himself—scientific knowledge from a research participant—and that there was no possibility for an authentic human relationship based on trust and reciprocity.

The therapist's efforts to identify an object relation was experienced as shameful and humiliating because it evoked a relationship that she could only imagine would be harmful and exploitative. However, his interpretation of the patient's representation of herself as "a guinea pig" and her therapist as an exploitative experimenter focused on the affect embedded in this dyad, namely the distress of the neglected, discounted child who is longing for caring, with the idea that the affects related to this dyad (longing, fear of neglect, criticism, and

abandonment) might underpin the predominance of the controlling/controlled dyad. Focusing on the internal working model characterized by neglect and exploitation that came through in her comment about feeling like a guinea pig, the therapist said: "We might have the answer to why you behave with me the way you do right here in your last comment. You may be convinced that I'm not interested in you, that I don't care, and that I have a negative opinion of you. You feel that you're always doomed to neglect. Someone who believes that might want to control the interaction for fear that if she weren't in control, she'd be mistreated by the other person or lose him altogether." Marta burst into tears and replied: "Of course if I don't control you, I'd lose you – like everybody else. Even my parents weren't interested in me, so why should you be?"

Her therapist's comprehension of the affects and anxieties that underlay her grandiose controlling behaviors momentarily broke through her conviction that he was indifferent, neglectful, and critical. Thus, in the early stages the therapist made use of his countertransference in conjunction with Marta's verbal and non-verbal communications to organize her experience in the transference in his own mind and then to put it into words. When Marta confirmed that this was, indeed, how she experienced him, the therapist added that viewing him in this way understandably left her feeling upset and angry, Thus in the early stages we see the example of therapist-centered interpretation (Steiner, 1993) which focuses on elaborating what the patient is experiencing towards the therapist in the moment and only gradually expanding awareness of that to an object representation that was part of the patient's self.

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

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

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

she attributed to him, and then to recognize that she could behave in the way she had attributed to him.

The patient's recognition of alternating between identification with the self and object poles of a particular dyad infused with a particular affect led to an expanded capacity to think in mental state terms, in that it enabled her to recognize that her mind is representational in nature; that is, that her experience of self and others was shaped in part by myriad mental models of self in relation to others. Interpretation of Marta's attempt to control the supposed rejecting other led to an awareness of rejecting and critical elements in herself and of the identification with both poles of the dyad, enabling her to take back the projection Her recognition of this pattern cleared the way for a more libidinally charged gratifying experience of the self in relation to the therapist to emerge, setting the stage for the integration of her disparate experiences of self and object. This stage also poses challenges for the patient with severe narcissistic pathology in that it involves the dismantling of the grandiose self into its component aspects of ideal self and ideal other, triggering awareness of dependent wishes with the therapist and others. Inevitably narcissistic defenses of envy and devaluation are activated in order to protect against the humiliation experienced in a genuine need of and connection to another, as the patient decenters from the rigid identification with a hostile but stabilizing introject.

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

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

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

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

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

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

In this session we see several major developments in the treatment: First her need to control the other as a means of controlling a critical rejecting object representation—here through the suicide gesture—alternates with an opposite object relation of a self longing for affection from a loved other. Here the therapist, moving into the more advanced stages of interpretive process, begins to link the dissociated positive and negative transferences, leading to an integration of the mutually split-off idealized and persecutory segments of experience. As Marta shifted from her discussion of wanting to kill herself to what she was feeling toward her therapist – something she could do only after he named the split-off libidinal dyad, she moved from the dyad imbued with negative affect that served defensive

purposes (the harsh critical object rejecting the helpless unworthy self) to the one imbued with positive affect (the longing self and loving object). The therapeutic work focused on clarifying which part of her experience belonged to the other person and which part to her self. Marta felt rejected and humiliated by the therapist's planned absence, while presenting with rejecting behavior. As the session progressed, Marta described a fantasy she had had of humiliating her therapist in the waiting room.

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

The above material, by necessity highly condensed, also shows the beginning of the dissolution of the grandiose self, which is devolving into object relations that were internalized but not integrated. The splitting between idealized and persecutory object relations in the transference (e.g. he is the longed for but unattainable fantasy figure and also the person who is indifferent to her, who treats her like "one on an assembly line"), functions as a regression on the way to integration (La Farge, 2006; Kernberg, 2007). Such paranoid micro regressions or even suicidal tendencies in patients with severe narcissistic pathology can occur in the context of the deepening of the transference as the patient begins to experience real dependency, gratitude, and fears of losing the therapist. These affects replace the earlier deadening omnipotent control, emotional vacuousness and envious devaluation of the relationship that correspond to the grandiose self. In this session, the therapist noted role reversals in the transference, whereby the patient identified with both aspects of the object relationship: the abandoner or humiliator and the abandoned and humiliated. Marta was able to acknowledge the significance of the therapeutic relationship that such role reversals entail, moving beyond her fixed attitude of grandiose superiority, that devolved from her identification with a hostile introject and served as a retreat from a range of object relations, internal and external.

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

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

strengthening her capacity for increased mutuality and trust. In the course of treatment, she started a relationship with and eventually married an appropriate partner.

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

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

Summary and Conclusion

Our research and clinical findings suggest that patients with narcissistic personality disorders functioning on an overt borderline level show a specific configuration of personality disorder comorbidity, psychopathology, and of attachment patterns, when compared to patients with borderline personality disorder. We found some empirical confirmation of the stabilizing effect of the grandiose self as well as the predominance of ego-syntonic defenses in these individuals, emphasizing the need to specifically focus on these aspects of the self-representation in the clinical work.

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

Future studies need to examine in larger samples the characteristics of this complex patient population, study how they further differ in their clinical presentation as well as neurocognitive characteristics from BPD patients without NPD, and test in longitudinal designs how these co-occurring personality features might affect the course and outcome of treatment.

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