

# AAI TIME 1

## NEGATIVE RF

**“How do you think your childhood experiences have affected your adult personality?”**

*“I think that if somebody had been in my room, put me to sleep, and assured me that there was nothing bad going to happen, I think a lot of this stuff would have gone all right...My dad and I, we went to a movie once ...and it was a movie about this woman.... And I was about, maybe 3rd or 4th grade then. It was about this woman– she’s married, and she goes to this party, and her husband doesn’t come with her to the party. And her friend says, well you know, like this guy, he’ll take home... He doesn’t exactly take her home. He rapes her.”*

Speaker gives incoherent, bizarre or inappropriate attributions in response to RF demand questions

# Clinical Implications of Research Findings for NPD/BPD

<b>DISMISSING STATUS</b>	<b>PREOCCUPIED STATUS</b>
<ul style="list-style-type: none"><li>• Focus is continuously away from attachment relationships and their influence</li></ul>	<ul style="list-style-type: none"><li>• Focus is persistently toward attachment relationships and their influences</li></ul>
<ul style="list-style-type: none"><li>• Deactivation of attachment</li></ul>	<ul style="list-style-type: none"><li>• Hyperactivation of attachment</li></ul>
<ul style="list-style-type: none"><li>• Grandiose self states</li></ul>	<ul style="list-style-type: none"><li>• Vulnerable self states</li></ul>

# NPD & Attachment: Defenses and Transferences

## Cannot Classify

oscillates between the two;  
contradictory transferences  
and defenses

### Dismissing Attachment

### Preoccupied Attachment

Therapist relentlessly devalued; inability to depend

Sudden shifts from frail idealization to complete devaluation of therapist

No motivation to reflect on internal world; slot machine attitude to therapy

Excessive rumination on internal states  
disappointment of entitled expectations

Use of therapist as mirror; arrogant dismissal of interpretation

Treats interpretations as oracles from Delphi; but no reflection on them

Rigid, unvarying constricted narratives;  
Deactivation of affect

Uncontained chaotic narratives;  
Hyper-activation of affect

Attitude of superiority; Therapist seen as inferior or included in sense of specialness

Constant sense of inferiority due to failure of self enhancing strategies

# Two Variants of Disorganized Attachment on the AAI for NPD/BPD and BPD Groups

## NPD/BPD CC

- Fluctuating states of mind with respect to attachment throughout the interview
- Oscillation between two or more opposing defensive strategies
- Dismissing and Preoccupied states of mind most typical

## BPD/ U

- Focal, drastic collapse in the monitoring of reasoning and discourse involving “Entrance into peculiar compartmentalized and dissociated/segregated states of mind” (*Main et al, 2008*) on specific questions about childhood loss and abuse

## Example of Lack of Resolution of Loss and Abuse on the AAI in BPD patient

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

Lapses in discourse, irregular speech patterns, psychologically confused statements, and incoherent speech with the intrusion of visual-sensory images)

AQ:1

# Attachment and Mentalization in Female Patients With Comorbid Narcissistic and Borderline Personality Disorder

AQ:2

AQ: au

AQ:3

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- NPD/BPD and BPD patients from two studies N = 151; RCT of TFP vs. DBT vs. STP (Levy et al, 2006; Clarkin et al, 2007) and RCT of TFP vs. ECP (Doering et al, 2010)
- 100% female, Age: M=27.33
- 22 NPD/BPD and 129 BPD patients in TFP
- 1 year TFP treatment
- **Significant Differences in AAI Classification between NPD/BPD and BPD groups**
- **NPD/BPD had significantly more Cannot Classify/Dismissing (55% vs. 30%); BPD more Unresolved/Preoccupied (65% vs. 36%) on the AAI**
- **No differences in RF (low in both groups)**

Diamond, D., Levy, K. N., Clarkin, J. F., Fischer-Kern, M., Cain, N. M., Doering, S., Hörz, S., & Buchheim, A. (2014). Attachment and mentalization in female patients with comorbid narcissistic and borderline personality disorder. *Personality Disorders: Theory, Research, and Treatment*, 5(4), 428–433. doi:10.1037/per0000065

# Summary and Conclusions

***Stabilizing Effect*** of narcissistic pathology in the context of borderline organization; significantly less lack of resolution of loss and trauma (U AAI status) even though comparable self reported trauma (NY–Cornell sample).

***Dismissing and Cannot Classify most prevalent AAI classification for NPD/BPD***; Cannot Classify is high on **both** idealization/devaluation **and** involving anger (subscales); narcissistic defenses help to contain current unresolved anger towards attachment figures.

***Dismissing associated with Narcissistic Defenses*** (devaluation, idealization, omnipotence, projection, autistic fantasy); give the appearance of resilience in the face of childhood trauma (less U status on AAI)

*Clemence et al, 2009; Fonagy et al, 2006; Perry & Perry, 2004)*

## Limitations:

- Assessment of narcissistic pathology only based on IPDE/SCID-II criteria; DSM-IV/5 Criteria; privileges grandiosity
- No dimensional approach to NPD
- No NPD-only comparison group;  
• female sample only
- Small sample size and unequal N's limits the power to detect differences

## Future Studies:

- Effect of co-morbid NPD in context of BPD on treatment process and outcome will be examined next
- Research with higher functioning NPD individuals (NPD only group)
- Do the two groups differ in experience of trauma? Or are NPD/BPD individuals better defended and/or more resilient?

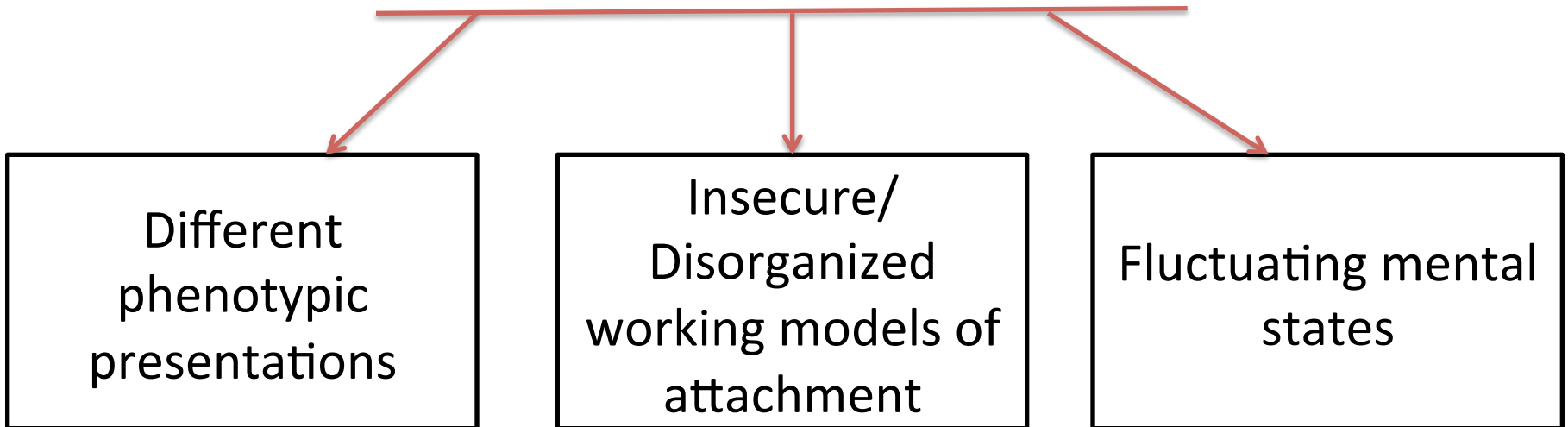


# TFP is an effective treatment for Spectrum of Narcissistic Disorders

- Emphasizes the identification with both self and object poles of the object relational dyads that comprise the internal world.



*TFP Designed to Address:*



# Clinical Illustration NPD/BPD Patient

- AAI Classification: Cannot Classify with Dismissing (devaluing) and Preoccupied (angry, conflicted) states of mind with respect to attachment (CC/D2/E2).
- RF rating: -1, hostile repudiation of RF and bizarre, inappropriate responses to questions designed to elicit reflection on mental states of self and others.
- First 3 months of treatment: Patient dismissed therapist's interventions with contempt and criticized him for being inadequate and doing nothing for her; Talked non-stop and/or interrupted the therapist
- Session 6 months into treatment: Patient came to session after making non-lethal suicide attempt; insisted that behavior had nothing to do with therapist's upcoming vacation.

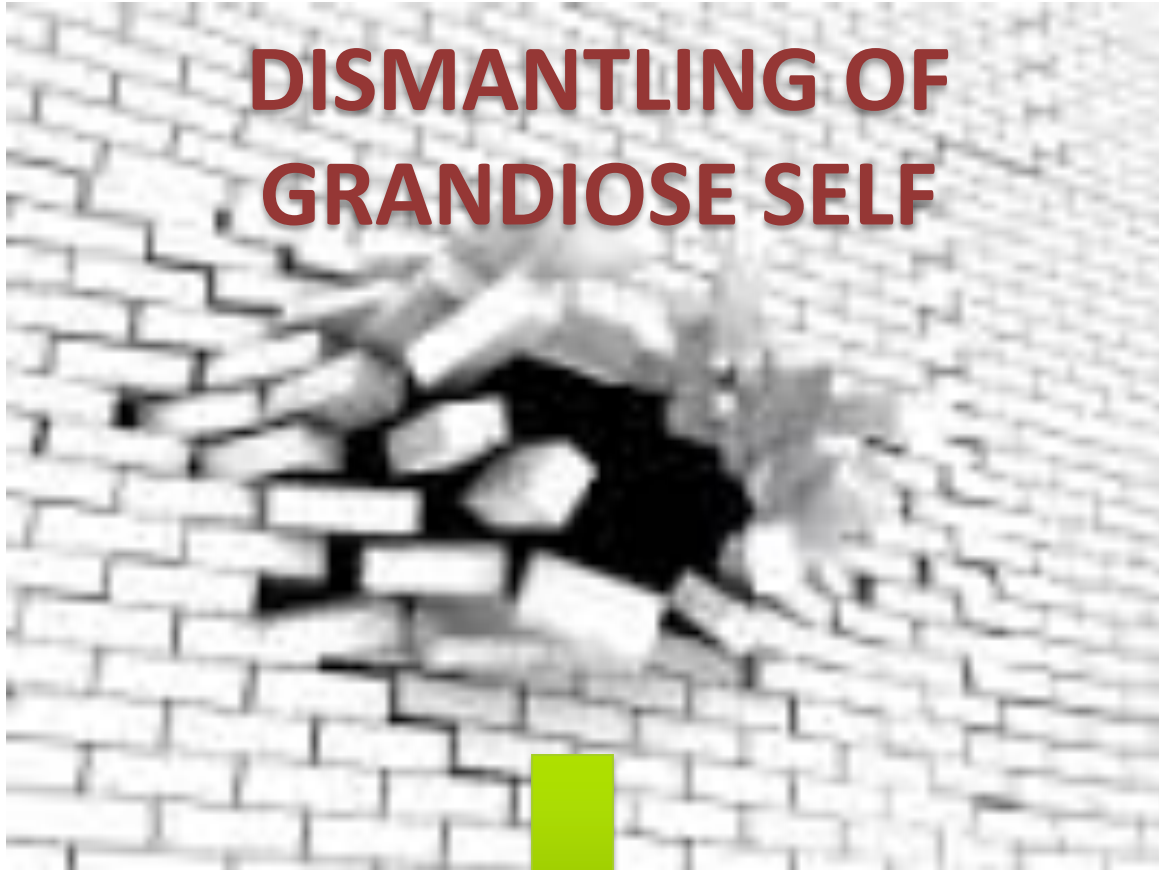
# Clinical Implications

- **Dismissing**: pervasive devaluation of others, dismissal of dependency, reluctance to engage in self-disclosure; contempt for therapist and desire to humiliate him
- **Preoccupied**: immersion in with current involving anger at therapist; oscillation between positive and negative valuation of self and therapist
- **Oscillation between Dismissing AND Preoccupied states of mind (CC): Evident in shift from devaluing statements about the treatment being worthless and ineffective to focus on longing for and dependency on therapist**

# TFP

- **Face to face interaction and emphasis on here and now counterbalances detachment and emotional disengagement** (*Ronningstam, 2014*)
- **Reactivation in the here and now of the therapeutic relationship of the dissociated and/or projected internalized object relations (grandiose and vulnerable)**
- **Activates the attachment system or internal working models of attachment which are likely to be insecure, and/or disorganized (multiple/contradictory)**
- **Technique fosters increased security and coherence of internal working models of attachment** (*Levy et al, 2006*)
- **Explores the subjective suffering and profound anxieties (annihilation) that underlie the grandiose self**
- **“Attends to the patient’s narcissistic defensiveness, underlying aggression, enactment of entitlement, grandiosity, sensitivity to envy, humiliation, shame, inferiority”** (*Ronningstam, 2014*)

# DISMANTLING OF GRANDIOSE SELF



DISSOLUTION OF THE GRANDIOSE SELF  
EMERGENCE FROM RETREAT  
SELF- OBJECT DYADS OR DISPARATE IWM EMERGE  
SUPERIOR SELF--HUMILIATED THERAPIST (DISMISSING)  
DEVALUED SELF--REJECTING THERAPIST (PREOCCUPIED)

## After one year of TFP independent study evaluation showed:

- Improvement in RF score from total repudiation of any reflection on mental states (-1) to clear, explicit capacity to think about her own and other's behavior in terms of intentional mental states (6).
- Shift from disorganized to organized (from Cannot Classify with Dismissing and Preoccupied (CC/D2/E2 to E2) to organized (preoccupied; angry conflicted subtype E2) attachment status on the AAI.
- Improvement in work and interpersonal relations; returned to work and developed a stable relationship

## AAI TIME 2

*“I’ve learned that the world is not as hostile as I thought it was. I’ve learned that people are not two dimensional, they’re three-dimensional and they want to be treated that way the way I want to be treated three dimensionally..... Um, I’ve learned that....people don’t necessarily abandon you...People can be mad with you for a while, but that doesn’t mean that they’re gonna abandon you...it’s possible for people to be mad with you and still like you.”*

## AAI TIME 2: What was impact of your parents' style of parenting on your development?

*"I really didn't live in the real world growing up, I lived in a fantasy world the way I wanted to see the world I really didn't interact with the world, the way my father didn't interact with me...So I don't think I felt any compassion for people."*

- Marked RF evident in capacity to understand and contextualize her behavior and attitudes in terms of intentional mental states and to reflect of their developmental origins.



# TFP

- TFP now has status as an evidence based therapy by the criteria of Division 12 (Clinical Psychology) of the APA (pending further research)

<http://www.div12.org/psychological-treatments/treatments/transference-focused-therapy-for-borderline-personality-disorder>

# Our Findings

## Contribute:

- To understanding the different representational processes, modes of affect regulation and defense that characterize the diverse, contradictory attachment strategies associated with NPD/BPD patients

## Help:

- To illuminate the shifts in mental states between Dismissing and Preoccupied, grandiose and vulnerable as the attachment system is activated in the clinical situation





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***Thank you for your attention!***