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Utilizing Attachment Theory in the Treatment of Interpersonal Dysfunction for Narcissistic Personality Disorder

Meghan Semenick, M.S.

A Doctoral Project Presented to the Graduate School in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology

Eastern Kentucky University

2021

Acknowledgements

I would first like to thank my family and friends for encouraging me to pursue my career in clinical psychology. Your unwavering support has been invaluable throughout this process and provided me with the confidence I needed to reach my goals. I would also like to thank the faculty of the Eastern Kentucky University Psychology Department whose ongoing encouragement and supervision have guided me throughout this doctoral program. A special word of thanks to Dr. Dustin Wygant, Dr. Melinda Moore, and Dr. Michael McClellan for your time and expertise as members of my committee. Lastly, to my cohort, I could not have made it through this program without each and every one of you. I am so proud to stand next to you as we make our way into the world of psychology. I am lucky to be able to call all of you my colleagues and my friends. I hope to keep our friendships strong as we develop our own paths.

Abstract

Narcissistic Personality Disorder (NPD) can be characterized as a pervasive pattern of grandiosity, need for admiration, and lack of empathy beginning by early adulthood and present in a variety of contexts (APA, 2013). A core feature within NPD is interpersonal dysfunction, which in an extreme form, can be physically, emotionally, and sexually abusive. The etiology of this disorder is rooted in the type of parenting received during childhood, which develops into an individual's overall attachment style. For this reason, I propose that by identifying adult attachment styles for individuals with NPD, appropriate attachment-based interventions can be selected to treat interpersonal dysfunction, seen in the use of abusive power and control. Overall, I believe this implementation would not only help the individual but could also prevent others from experiencing interpersonal trauma and abuse.

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Section I: Introduction

The Core of Narcissism

Understanding attachment theory (Bowlby, 1973) is central to unlocking Narcissistic Personality Disorder (NPD). Bowlby's attachment theory emphasizes that mental schemas of the self and others guide interpersonal interactions, expectations in relationships, generate emotional appraisals, and influences informational processing. These concepts are crucial for understanding and conceptualizing NPD, which is a psychological disorder characterized by the DSM-5 (APA, 2013) as, "A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts" (p. 669). This doctoral project is focused on understanding the connections between attachment theory as an etiology of NPD, intertwined with adult interpersonal dysfunction as a core feature of their presentation. This project will include a review of attachment theory, narcissism as a basic psychological construct, and the evolution of narcissism as a psychiatric diagnosis (i.e., NPD).

Specifically, my literature review will examine NPD symptoms, etiology, clinical presentation, and how symptoms pertaining to interpersonal dysfunction can lead to the abuse of others. After reviewing foundational concepts related to narcissism, the next topic of review will be the history of attachment theory, attachment styles as manifested in childhood and adulthood, as well as the assessment for uncovering an individual's attachment style. Then, the relation between NPD and attachment theory will be covered as well as the clinical implications that would be useful in a treatment setting. This project will show the value of understanding the link between attachment style and the development of NPD and further how selecting an attachment-based treatment can untangle learned schemas that contribute to interpersonal dysfunction. This

conclusion aims to improve the understanding of how we apply treatments aimed at attachment theory as the amelioration of NPD.

Definition of the Problem

There are quite a few problems associated with narcissism, as it impacts the individual as well as others in their inner circle, impedes insight to seek treatment, and difficulties with treatment. Specifically, symptoms can deeply affect the client's family, friends, neighbors, coworkers, and community members. This personality disorder can result in many forms of aggression that may become physically, emotionally, or sexually abusive. Heinz Kohut (1972) believed NPD traits to be predictive of physical and psychological violence towards a romantic partner when feeling disrespected or deprived of gratification. Additionally, literature by Babiak and Hare (2006) indicated that narcissism in the workplace can lead to a hostile environment through the use of manipulation, power, and control. Further, effects that narcissism can have on individuals in the workplace, politics, and interpersonal relationships will be discussed in detail to illustrate this impact later in the text.

As explained by Levy (2015), "Personality disorders are highly prevalent, associated with considerable morbidity, and difficult to treat. Intrapersonal and interpersonal difficulties are central to the pathology observed in personality disorders" (p. 197). NPD presents with its own challenges in being unlikely to possess the insight for needing therapy, encountering biases from mental health providers, and a lack of adherence to treatment once intervention is underway. Furthermore, interpersonal devaluation as exhibited in NPD alongside problematic behaviors in seeking power and control over others complicates treatment outcomes. While the prevalence of NPD is lower than other personality disorders, an accurate account is difficult to interpret due to misdiagnoses and a lack of attendance in therapy. In fact, according to Twenge and colleagues

(2009), narcissism as a trait has been on the rise in the United States, as indicated by research with college students, since the early 1980's. These researchers predicted that this may be the start of an epidemic of narcissism within American society. Indeed, it appears cultural studies have suggested that the United States particularly is viewed as a more narcissistic society consequential to the celebration of individualism, professional success, fame, and material wealth (Foster, 2003).

It is also less likely that an individual with NPD will have the insight to identify that they are suffering from a personality disorder, in turn decreasing the overall likelihood that they present for therapy unless as a byproduct of their behavior or as possibly requested by a spouse. In the case that a clinician has a client with NPD presenting for treatment, there are quite a few barriers. For instance, there are certain biases against providing therapy for these individuals due to the risk of experiencing countertransference as a result from feelings of disengagement by the client, being criticized, or mistreated (Tanzilli et al., 2015). A core feature regarding the struggle to form intimate relationships also applies to thwarted trust and feelings of safety with the therapist furthering the obstacle to optimal treatment outcomes.

Statement of Significance and Purpose

The majority of interventions recommended for NPD were originally intended for the treatment of Borderline Personality Disorder and only are adjusted to fit traits of narcissism. NPD is a challenging diagnosis to conceptualize due to the many debated etiological mechanisms. What these competing origins have in common is the idea that this disorder is rooted in the reaction to parenting styles received during childhood. The literature reviewed will show how this variation of maladaptive parenting resulting in narcissism is directly related to attachment theory.

Attachment theory has been modified to create attachment-based interventions that primarily target schemas from childhood related to how the individual understands to the self and others. Within this review, five types of attachment-based interventions will be reviewed as proposed treatments for interpersonal dysfunction seen in NPD. Additionally, supporting information from collaborative therapeutic assessment as well as evidence-based relationships and responsiveness will be reviewed to bolster the claims of this project.

This proposal is significant in the fact that NPD as a psychiatric disorder lacks treatment options that were specifically developed to treat this particular condition. NPD is shown to be problematic for the individual as well as others due to the abusive behaviors that result from the maladaptive thinking patterns. Needless to say, this could be beneficial for many lives involved. By targeting these thoughts and behaviors through attachment-based interventions, this can serve not only as a treatment for the individual but also as a primary prevention for the abuse of others. Therefore, the purpose of this project is to highlight the causal link between attachment theory and the etiology of NPD, explain how this results in defense mechanisms that are abusive toward others, and propose a treatment methodology for the therapist to revolutionize the conceptualization and treatment of the client in a collaborative way.

Section II: Literature Review

Methods for Literature Review

The following literature review outlines the research and theoretical considerations related to topics surrounding NPD, interpersonal dysfunction, current therapies for NPD, and Attachment Theory as related to children and adults. The body of literature contained in this review was obtained from the Eastern Kentucky University library's computerized literature search engine using PsychInfo as the database. Terms used to gather information on this

important topic included, “Narcissistic Personality Disorder,” “Power and control,” “Therapy for NPD,” “Attachment Theory,” “Attachment-Based Therapies,” “Interpersonal Dysfunction,” “Adult Attachment Inventory,” “Attachment-based assessments,” and others.

Literature Review

Symptom Presentation of Narcissistic Personality Disorder

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is an empirically based psychological glossary ultimately used by mental health clinicians in the United States for diagnostic purposes (APA, 2013). Within the DSM-5, NPD can be found as part of the Cluster B personality disorders, predominantly being characterized as overly emotional, dramatic, and erratic. These Cluster B personality disorders include NPD, Antisocial (ASPD), Borderline (BPD), and Histrionic Personality Disorder (HPD). Specifically, the DSM-5 indicates that an individual can be formally diagnosed with NPD through demonstrating a pattern of behavior as indicated by five or more of the following criteria. Those symptoms include a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements), a preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love. They believe that he or she is “special” and unique, only to be understood by, or should associate with, other special or high-status people (or institutions). These individuals require excessive admiration and have a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations.) Those with NPD are interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends) and lack empathy. For example, they are unwilling to recognize or identify with the feelings and needs of others. Lastly, they are often

envious of others or believe that others are envious of him or her and show arrogant behaviors or attitudes.

While problems with entitlement, an excessive need for admiration, and the relative disregard for others leads to the hallmark of clinically significant interpersonal dysregulation, there is another critical aspect in diagnosing NPD. Interestingly, the DSM-5 (APA, 2013) highlights the vulnerable self-esteem aspect of NPD but not until after the listed diagnostic criteria. This vulnerable side of NPD leaves the individual sensitive to psychological “injury” (p. 671) from criticism or subjective defeat. Disapproval from others makes them feel empty and humiliated, possibly resulting in reactions of rage or counterattack. As explained, “Such experiences often lead to social withdrawal or an appearance of humility that may mask and protect the grandiosity” (APA, 2013; p. 671). This narrow emphasis on grandiosity as the main attribute in diagnosing NPD has reportedly led to inconsistent epidemiological studies and misdiagnosis (Cain et al., 2007; Doidge et al., 2017).

The omittance of vulnerability characteristics within the diagnostic criteria has caused clinicians and lay raters to view grandiose features as pathognomonic to the diagnosis of narcissism (Ackerman et al., 2017; Miller et al., 2017; Widiger, 2001;). This could be because the overt aspects of grandiosity encompass attention grabbing symptoms such as arrogance, exhibitionism, and an exploitative nature (Pincus & Lukowitsky, 2010). Another reason the grandiose side may be more optical, is that it is conjoined by a special talent in which the personality is built and revolves. This amplifies the likelihood of receiving the desired admiration as well as the impression of perfection and superiority. Though characteristics of aggressiveness, stubbornness, evasiveness, and impulsivity are widely known as part of the grandiose side of narcissism (Wink, 1991), those diagnosed with NPD experience the self as a

split between the two different personalities.

Alternately, the opposite side to overt grandiosity is vulnerable narcissism, which is experienced as flawed and inferior (Pincus, 2010). The Alternative Model of Personality Disorders (AMPD) within the DSM-5 suggests that there must be at least moderate impairment in two or more personality areas such as identity, self-direction, empathy, and intimacy in order to accurately diagnosed NPD amongst the other personality disorders (Stanton & Zimmerman, 2018). The AMPD suggests that negative affectivity, lability, and difficulties with self-regulation often appear when the individual is feeling vulnerable or when inflated expectations are not being met (Caligor et al., 2015; Ronningstam, 2011a; Wright et al., 2013; Wright, 2016). With this, there is instability in self-esteem accompanied by defensive reactivity, emotion dysregulation, and a range of self-serving behaviors (Ronningstam, 2014). This subjectively incompetent side of NPD is dissociated and avoided at all costs through defense mechanisms that assemble to deny any contact that may elicit a sense of failure. Even minor shortcomings are perceived as a sign of unbearable imperfection that is met with defensiveness, hostility, and rigidity in getting what they want (Wink, 1991).

These overt attitudes and behaviors, however, can differ significantly from the inner experience, where grandiosity conceals an underlying sense of shame and inadequacy. In reaction to such circumstances, the individual may acquire sustained feelings of humiliation fueled by self-criticism and social withdrawal resembling a major depressive disorder. The shifts in self-esteem from grandeur to inferior with fluctuating regulation in self-efficacy demonstrate the subjective turmoil of the dissociative selves. Some researchers refer to the grandiose and vulnerable versions of NPD as thick and thin-skinned narcissism, respectively (Bateman, 1998; Britton, 2003; Rosenfeld, 1987). In some, the presence of introversion acts to conceal the

underlying sense of importance. It is notable that the tenacious ambition and confidence exhibited by individuals with NPD can lead to high achievement, though the avoidance of criticism and fear of possible defeat can prove to be consequential over time (Ronningstam, 2014).

Together, both grandiose and vulnerable sides of narcissism have been linked to reactive aggression when the ego is perceived to be threatened. In this sense, aggression is formed as a defensive response when the grandiose self-view is challenged. This connection was identified in a study after applying provocation through an insult or social rejection to influence a blow to the ego (Gerwirtz-Meydan, 2018). While the splitting of the self (e.g., grandiose vs. vulnerable) has been well documented, Perry (2013) suggested that one is only likely to see this split when the level of self-esteem has been altered, known as a narcissistic injury. This reaction typically follows some form of an ultimatum presented by family members, the court, or an employer. When these individuals or institutions no longer appreciate pursuits of self-serving egocentricity, inner emptiness and inadequacy are recognized, possibly leading to a subjective crisis or psychiatric admission. Ronningstam (2014) expressed that within clinical narcissism, there are periods of proactive and healthy narcissism that are viewed as fluctuating shifts in self-esteem, which are said to be context dependent. While this may be adaptive for the individual, others could describe this outward appearance as seemingly arrogant, abrasive, and hypersensitive (Russ et al., 2008).

These maladaptive behaviors as well as the presence of interpersonal dysfunction have led to a robust overlap of symptomology with other personality disorders, especially Cluster B. The symptoms that drive this overlap include excessive attention-seeking, emotion dysregulation (i.e., impulsive rage), inappropriate sexual behavior, and an unstable view of others (i.e.,

fluctuating between idealizing and devaluing). While the interactive style of individuals diagnosed with a Cluster B personality disorder is described as being flirtatious, callous, and needy, respectively, the most useful feature with differential diagnosis for NPD is within the grandiose characteristic. It should be distinguished that while disorders within Cluster B are known to seek attention from others, those with NPD require that attention to be admiration. To further separate NPD from other Cluster B personality disorders, there are other specific characteristics for each that are useful to identify. The relative stability of self-image, fear of abandonment, and self-destructive behaviors are more congruent with BPD. Excessive pride in achievements, a relative lack of affect, and contempt for others' feelings help distinguish NPD from HPD. Lastly, the presentation of NPD is quite similar to that of ASPD, however a key feature for differentiation is the lack of legal history and conduct issues that are infamous with ASPD (APA, 2013).

In response to this large overlap in symptomology, researchers in this particular area of psychology are moving away from a categorical conceptualization and more toward a dimensional view. For example, it has been suggested that NPD and ASPD could be better understood as indicators of a broad externalizing spectrum with similarities to substance use disorders and other Cluster B personality disorders. Stanton and Zimmerman (2019) researched some of the key differences in ASPD and NPD. Through an analysis, it was found that the two correlated strongly in aspects such as grandiosity, callousness, and disinhibition as well as traits such as deceitfulness, and exploitativeness. Further, lacking empathy appeared especially nonspecific. They did find that individuals with NPD typically perceive themselves as special and of high status, while individuals with ASPD show more traits of outward aggression and unlawful behavior. Furthermore, due to the large symptom overlap in externalization, examining

traits related to vulnerable narcissism are useful when differentiating NPD from ASPD (Pincus, 2010).

Outside of personality disorders, the most common comorbid mental illnesses include depression, dysthymia, anorexia nervosa, and substance abuse disorder, especially Stimulant Use Disorder: Cocaine. These comorbid disorders highlight the distress in the dissociated selves alongside the attempts to cope through controlling their weight or mood as well as their environment. Physical health related comorbidities are also highly prevalent amongst those with Cluster B personality disorders. Research by Kacel (2017) indicated that individuals with NPD are more likely to utilize a variety of health care services in high volume. These studies show that there are significantly higher mortality rates due to cardiovascular disease than those without personality disorders, even after controlling for relevant medical comorbidities. Those with NPD in particular show health problems associated with gastrointestinal conditions.

In comparison to other Cluster B personality disorders, the literature surrounding the symptoms of NPD remain less substantive. The low, as well as varied, rate of epidemiological and community samples show a range of approximately 0 - 6.2% in a community, with 50-75% being male (Kacel, 2017). While NPD is rarely studied, it has become increasingly recognized as a complex pathology associated with significant personal, interpersonal, and occupational consequences (Miller, 2007; Penny & Spector, 2002; Ronningstam & Maltsberger, 1998; Volkan & Fowler, 2009).

Etiology of Narcissistic Personality Disorder

As with most psychiatric disorders, etiology relies upon both biological and environmental factors. Narcissism appears to have a heritable component, though research primarily relies upon environmental factors through psychodynamic and learning theories. With

the many competing ideologies behind the origin of NPD, the most prominent theories by Kohut, Kernberg, and Reich will be chiefly elaborated upon, accompanied by other relevant information. Overall, the common theme amongst scholars is the presence of faulty parenting and disturbed object relations (Imbesi, 1999). Lastly, research examining the utility of these theories alongside therapeutic implications are explored.

Starting with a brief introduction of biological influences, Torgersen (2008) examined the genetic basis for Cluster B personality disorders in Norwegian twins between the ages of 19 to 35 years old. Results indicated a 24% heritability rate with NPD, 38% for ASPD, 31% for BPD, and 31% for HPD. In another study, there was a significant correlation for NPD between fathers and their daughters, but zero correlations for the other parent-offspring dyad. The authors interpreted that this could be the result of a genetic basis including X chromosome involvement for NPD traits with contributions from the style of parenting as well (Miles, 2014). More research needs to be conducted before definitively making these assumptions.

Diving into the environmental factors related to the development of NPD, Otto Kernberg (1984) proposed the Object Relations approach emphasizing the role of conflict, aggression, and envy of others. In this “conflict model,” Kernberg postulates that early childhood experiences of cold, indifferent, or aggressive caregivers push the child to forge feelings of specialness as a sense of refuge from negative emotions. It was proposed that these feelings evolve into pathological grandiosity with a self-structure defending against rage alongside an inability to internalize good objects. He believed that emphasized special qualities appear to attract the attention of others and serve as a haven for feeling unloved by parental figures. When care is able to be obtained from others through these means, the child does not feel love for himself but rather for performing special talents or wishes imposed by the parents. As this cycle of reaching

for unattainable love continues, the child becomes more anxious and angrier. This presumably results in classic narcissistic tendencies as well as being preoccupied with intense urges for control over their environment. In other instances, a narcissistic mother's extortion of the child prompts perceived uniqueness and fosters a quest for admiration and greatness while also reinforcing pathological defenses such as the devaluation of others (Imbesi, 1999).

Kernberg understood typical defense mechanisms seen in NPD as idealization, defamation, and splitting as dominate, while the capacity for sadness, guilt, and mourning is deficient. This impacts feelings of shame, envy, and aggression. These clients tend to devalue others as a defense against the fear of being considered to be lesser than or ordinary. Experiencing negative feelings are thought to be connected to problems with dependency and envy, a significant factor in NPD (Perry, 2013). Another common feature is splitting; individuals with NPD split the world dichotomously as the rich, famous, and successful against the worthless and mediocre. Such clients have a fear of being excluded from the former group and being viewed as part of the lower half. These individuals desperately evade feelings of inferiority and vulnerability through efforts at omnipotent control and aforementioned defense mechanisms. Personal failures and disapproval received from others are denied, covered up, or misattributed to other people (Perry, 2013).

Kohut (1971), similarly, offered the “deficit model” asserting that pathological narcissism originates as a result of the parents’ failure to empathize with the child in the form of a cold, indifferent disposition (Kernberg, 1975). During formative years, typical developing children require admiration and need to have their self-importance mirrored by their parents. When the egotistic needs are appropriately fulfilled alongside a degree of appropriate frustration, this enables healthy internalization, and the grandiose behaviors recede. For individuals with

emerging NPD, the normal integration of the 'grandiose self' and 'idealized parental image' is missing. It was posed that grandiose omnipotence emerges as a defense against fragmentation of the self. Kohut did not consider feelings of inferiority and imperfection as a key characteristic of pathological narcissism, though he recognized that they are prone to experiencing feelings of emptiness and depression as a response to narcissistic injury.

Reich (1953) viewed NPD through the lens of the Freudian Oedipus complex. He believed that pathological narcissism stems from early trauma elaborating that bodily threat during a time when the ego is not sufficiently developed brings about "magical restitution." This is meant to ward off the perceived castration threat and rebuild a feeling of power through denial of vulnerability. This institutes compensatory actions resulting in an inflated self-image. Interestingly, he discussed the belief that exaggerated self-esteem in men and infantile megalomania in women manifest through the choice of a life partner. It was indicated that these women seek to compensate for feelings of inferiority through courting men with a high social status, believed to be representative of their own grandiose ego ideal. Reich alleged that these women wished to blend with seemingly elite men to acquire a greater sense of self-worth. Later, Reich (1960) focused on narcissistic-phallic men who, notwithstanding their success, would constantly strive to demonstrate their talents and superiority over others in an attempt to compensate for their feelings of low standing that is rooted in childhood (Afek, 2018).

While these aforementioned theorists led the field in this area of study, others have presented significant theories regarding NPD. In Theodore Millon's (1981) social learning perspective, children learn about themselves and others through parental modeling. Individuals with NPD hold beliefs surrounding their own perceived uniqueness and entitlement that are thought to stem from early parental overindulgence. Beck and Freeman (1990) described

dysfunctional core beliefs or schemas stemming from early experiences of adverse parenting. This would lead the growing child to become self-indulgent, demanding, and aggressive while also presenting symptoms of depression.

In a study conducted by Imbesi and colleagues (1999), results unveiled common personality characteristics conducive to the development of narcissism in “welfare” children (p. 41). Imbesi (1999) postulated that the specific fault lied in the failure to provide optimal frustration experiences that are necessary for children to develop realistic self-images. In his study, he described seeing approximately 100 patients that did not have a significant history of trauma. He described that the primary caregivers were unable to set appropriate limits for the children; in turn, this led to those children taking control of the household. These caregivers felt helpless and victimized while parenting in a fearful and overindulgent manner. In fact, the consistent feature among these parents was the “Tendency to feel guilt-laden masochistic submissiveness to their children” (p. 44). He believed that those with NPD acted out as children in a deliberate manner increasing the maladaptive behaviors when rules were attempted to be forced upon them. Imbesi (1999) voiced that all of the children in his study expressed fantasies of invincibility while consistently denying their own limitations. In retrospect, as adults those with NPD disclosed that they viewed their caregivers as disappointing, but ultimately ‘there’ for them.

Problems Leading to Clinically Significant Distress

The diagnosis of NPD is typically a moderately impairing condition when compared to other DSM-5 diagnoses. This is because the disorder is oftentimes accompanied by specific capabilities and a high level of functioning (Ronningstam, 2014). Cognitive, affective, interpersonal, and behavioral symptoms of NPD such as impulsivity, volatility, attention-

seeking, low self-esteem, and unstable relationships result in the pervasive pattern of significant interpersonal, occupational, and psychosocial distress (Kacel, 2017). Collectively, these symptoms increase a broad spectrum of challenges that lead to suffering and an enhanced risk for suicide (Ronningstam, 1996). In fact, the presence of NPD is a significant predictor for multiple suicide attempts, the use of lethal means in those attempts, and doing so in proximity to experiencing domestic, financial, or health related problems or subsequent to being terminated from a job. Kacel (2017) explained these increased rates as a biproduct of the high frequency of risk factors for suicide such as shame, helplessness, self-directed anger, and impulsivity. Additionally, Stinson and colleagues (2008) found high 12-month prevalence rates of substance abuse (40.6%), mood (28.6%), and anxiety disorders (40%) among participants with the diagnosis of NPD further placing the individual at risk for suicide.

Intrapersonally, they do not experience a difference between the actual self and their ideal self (Yeomans, 2012). Interpersonally, the individual demonstrates "an orientation toward seeking out self-enhancement experiences from the social environment to satiate needs for admiration and recognition" (Roche et al., 2013; p. 237). Continuing on the idea of building an identity around a certain talent or career, the sudden loss of control or competence connected to performance or achievement can be devastating. This type of loss threatens the sense of stability and wellbeing, often leaving the individual feeling overwhelmed (Maldonado, 2006). For this reason, the grandiose self fails to successfully process failure, rejection, or abandonment and further exaggerates negative feelings (Gerzi, 2005). Ronningstam (2014) considers this to be a unique narcissistic trauma, which involves humiliation and shatters self-esteem. While this does not meet a Criterion A description of PTSD, this "trauma" can be entirely emotional and internal. This is accompanied by compromised hope, self-worth, and the internal sense of control. Simon

(2002) described these as Trauma Associated Narcissistic Symptoms (TANS) elaborating that they are inherent in vulnerability, disrupting emotional regulation and adaptive self-esteem. Others have referred to TANS as a narcissistic injury. This subjective experience occurring at a young age may be deeply internalized and contribute to a seemingly armor-like character function with denial and omnipotence organized to protect the narcissistic fantasies. This is intended to overshadow the split reality of experienced shame and fear within the vulnerable side of NPD (Ronningstam, 2014).

To ward against TANS, defense mechanisms are a readily available feature for NPD with the oscillating grandiose and vulnerable aspects of the disorder. These grandiose defenses act as a shield to protect against typical negative experiences, including feelings of inferiority, envy, hatred, and rejection. This is seen as a “refuge or retreat into omnipotence which makes contact with the real world very threatening—even simple contact with you the therapist, is a challenge to their defensive system.” (Yeomans, 2012, p. 2) In order to salvage superiority, these dysphoric occurrences are displaced on to others through recurrent criticisms, such as viewing the therapist as incompetent (Kernberg, 2012). Due to these maladaptive behaviors, hostile and distrustful projections make it challenging to obtain social acceptance. This can result in a “narcissistic paradox” (Morf & Rhodewalt, 2001, p. 179). An example of this concept can be explained as exhausting friends or family members with incessant requests for affirmation to the point of damaging the relationship on which they are dependent (Hinrichs, 2016). This abrasive behavior can be broadly described as contempt, argumentativeness, verbal, and physical confrontation leading to relationship dissatisfaction, infidelity, and a general dislike from others. To cope, these individuals may choose to use drugs or alcohol, likely perpetuating the presence of depression, anxiety, and suicidality (Hinrichs, 2016).

Suicidal ideation, the presence of TANS, or comorbidities are various reasons that an individual with NPD may seek treatment. A common theme amongst presentations is the complaint of life and relationships not living up to their elevated expectations. Due to the lack of insight, they often externalize their problems or project onto others alongside complaints of victimhood. This is typically seen as blaming others for mistreating them or criticizing others' faults while denying any of their own (Yakeley, 2018). This general lack of insight and treatment resistant tendencies can steer the client away from seeking treatment, however these individuals are likely to request services from primary care providers with a variety of complaints. The problem lies within misdiagnosis. Mental health professionals may encounter these individuals in a subjective experiential crisis (e.g., TANS) with complaints of interpersonal difficulties or supposedly unacceptable legal sanctions. It is also likely that these individuals request therapy due to comorbid issues as discussed above or difficulties including isolation, sexual dysfunction, irritability, or aggression with an increasing reliance on substances to elevate their mood. Some may also report feelings of emptiness, despair, or dysphoria alongside experiencing shame, humiliation, and worthlessness that originate from a career or relationship loss (Yakeley, 2018).

Treatment may also be sought due to the anxiety that follows harmful defense mechanisms (APA, 1994). Personality disorders show a series of characteristics involving low inference such as impulsivity, self-mutilation, feelings of emptiness, or a grandiose sense of self-importance. While these traits are viewed as ultimately maladaptive, they are difficult to replace with more effective coping skills due to fixed patterns of problem-solving. Avoidance is a key defense mechanism that aids in maintaining a lack of awareness to stress and conflict. This is largely what prevents the client from understanding their role within aversive life experiences and inhibits "suppressive effects of punishment or the competing effects of new operant

learning." (Perry, 2013; p. 33) Any gratification from this technique only reinforces the behavior. For example, Perry (2013; p.33) explained this as, "the pleasure obtained when passive aggression discomforts one's oppressor or superior." Other attempts at self-protection used by those diagnosed with NPD include sublimation, intellectualization, dissociation, projection, and acting out. NPD has been found to be negatively associated with repression.

Presenting Concern: Interpersonal Dysfunction and Abusive Behaviors

Individuals with NPD are more likely to exhibit physical, emotional, or sexually abusive behaviors. The following studies amplify this understanding in contexts including aggression in romantic and interpersonal relationships, within the vocational setting, sexual offenders, and correctional facilities. Overarching themes show a lack of empathy and struggle for power and control over their internal and external environment.

Campbell (2005) compared relationships with individuals with NPD to eating chocolate cake; initially, they are enjoyable but would become unpleasant and have consequences in large quantities over time. These individuals generally are adept at making a positive first impression through being viewed as agreeable, charismatic, and confident (Paulhus, 1998). Over time, personality pathology interferes with healthy relationships including vengefulness, domineering behavior, and interpersonal aggression (Brown, 2004; Ogrodniczuk, 2009). More research needs to be conducted to examine the impact in more diverse environments and heterogeneous samples.

As stated above within symptomology, these clients show deficits in cognitive, behavioral, and interpersonal facets of functioning. Cognitively, they perseverate on fantasies of unlimited power, superiority, perfection, and adulation. By attracting the attention of others, the craving for admiration is satisfied, however this charm fades quickly, further preventing lasting support

systems. Their overt grandiosity is typically expressed through exploitative acts, intense envy, aggression, exhibitionism, and lacking empathy (Pincus et al., 2009; Pincus et al., 2014; Wink, 1991). Those with NPD are willing to assert and defend their competence by publicly exclaiming their superior skills while diminishing the success of others (Campbell et al., 2002). They can outwardly exhibit relatively mild hostility and aggression (Bushman et al., 1998) while also having explosive tendencies toward extreme aggression and violence (Reidy et al., 2008).

In viewing domestic relationships, individuals with NPD are under the impression that they have better alternatives for romantic partners ensuing lower levels of commitment and higher rates of infidelity (Campbell et al., 2002; Campbell & Foster, 2002). Relationships appear to last longer when partnered with someone who feeds their grandiosity with flattery or if the relationship increases their social status (Gerwirtz-Meydan, 2018). Indeed, people with NPD as well as many other personality disorders, have a greater likelihood of being generally unhappy in their marriage (South et al., 2008). More importantly, "They may fail to recognize that the source of their unhappiness lies in their own way of processing and interacting with the world, as they tend to interpret actions by their spouse in a threatening or negative manner" (Gerwirtz-Meydan, 2018, p. 298). Supporting this literature, Gerwirtz-Meydan and colleagues (2018) conducted a study examining the mediating effect of psychological aggression between narcissism and relationship satisfaction among 128 nonclinical heterosexual couples. Results revealed two mediation paths affecting men's relationship satisfaction, "The higher men's narcissism, the higher their perpetration of psychological aggression, which, in turn, was negatively linked with their own relationship satisfaction and the higher women's narcissism, the higher their perpetration of psychological aggression, which, in turn, was negatively linked with their male partner's relationship satisfaction" (p. 296).

Domestic relationships with an individual who suffers from NPD can also be very dangerous. Acts of abuse appear to stem from the interplay between the grandiose and vulnerable selves, when narcissistic vulnerability involves a plethora of negative emotions linked with either social avoidance or overt aggression when threatened with feelings of shame (Konrath et al., 2006). This aggression can be physical, psychological, or sexual in nature. Psychological aggression can be described as a specific behavioral category of interpersonal violence (Winstok & Sowan-Basheer, 2015) and is defined as behaviors aimed to harm the partner's emotional well-being (Yoon & Lawrence, 2013). As explained by Gerwirtz-Maydan (2018, p. 300), "Common psychologically aggressive tactics include frightening, humiliating, ridiculing, controlling, silent treatments or purposeful ignoring, degrading, threatening to abandon or harm, or damaging personal property." The literature indicates that both grandiose and vulnerable narcissism share a preoccupation with satisfying their own needs at the expense of others (Ronningstam, 2014). Narcissistic rage ensues when feeling disrespected or deprived of gratification. This aggression reacts as a means to defend against experiencing the subjectively incompetent self (Kohut, 1972). Keiller (2010; p. 531) explained that heterosexual women are usually the victims of this rage because, "they have unparalleled potential for gratifying, or frustrating, heterosexual men's narcissism." This grandiose sense of entitlement, lack of empathy, and conviction that they are in the right may explain reasoning behind sexual offenses with sexual partners, as their rage can become an obsessive drive to dominate their partners and sexual conquests (Dudeck et al., 2007; Kernberg, 1998; Livesley, 2001).

Fossati (2007) believed that trait aggression in NPD is more connected to emotionality, such as irritability and anger, rather than physical aggression. However, comorbidity with another personality disorder, such as ASPD or BPD, increases the risk for violence, especially

murder (Warren, 2002). Keulen de Vos (2014) takes a schema-focused approach in understanding aggression as an overcompensation of externalizing behavior that is a response to a violated sense of entitlement. The impaired ability to take another's perspective may exacerbate anger arousal enhancing the risk of impulsivity and reckless violence (Day, 2012). Further, substance abuse and emotion dysregulation are also factors found in NPD that are associated with violence and aggression (Pluck, 2014).

Outside of romantic relationships, interpersonal dysfunction can be seen with acts of white-collar crime or with people in powerful positions within the workplace. Freud coined the term "megalomania" in reference to an obsession with the exercise of power and domination of others (Afek, 2018). It was argued that feelings of inferiority and shame play a key role in NPD and, in line with Freud as well as with Jacobson (1964), it was noted that these feelings arise when a person fails to meet the expectations of his ideal self. In the book *Snakes in Suits*, Babiak and Hare (2006) report, "Narcissistic managers, in particular, tend to rise to management positions in organizations in disproportionately large numbers." (p. 131) This makes sense, as Rovelli and Curnis (2020) identified key personality traits that lead to positions of leadership being over-confidence, extroversion, dominance, self-esteem, and authoritarianism, many of which are in line with that of grandiose narcissism. In fact, Rovelli and Curnis (2020) completed a study with 172 Italian CEOs indicating that an individual with NPD has a 29% higher likelihood of becoming a CEO with quicker rates of progression within the field, regardless of the type of firm. Moreover, even elevated levels of narcissism, two standard deviations above the mean using the NPI, revealed an increased likelihood of becoming a CEO. The authors postulated that these individuals seek out positions of power with higher ambitions and greater levels of confidence.

This is concerning for these corporations because those with high instances of power with NPD are more likely to procure negative outcomes such as financial crime, tax avoidance, and generate less collaborative work environments. Overall, employees were found to be less happy and communication was diminished. It was explained that being self-absorbed can lead to the abuse of subordinates compounded by playing up to their superiors to assure their own success. It was reported that those with NPD are far less likely to ask for assistance, guidance, or even feedback from others on projects until it is too late. In these moments, they are more likely to diffuse blame to others in order to maintain a positive appearance (Babiak & Hare, 2006).

Similarly, in the book *The Anatomy of Human Destructiveness* (Fromm, 1973), it was postulated that narcissism amongst political leaders is frequent. The author states, “If the leader is convinced of his extraordinary gifts and of his mission, it will be easier to convince the large audiences who are attracted by men who appear to be absolutely certain. But the narcissistic leader does not use his narcissistic charisma only as a means for political success; he needs success and applause for the sake of his own mental equilibrium” (p.229). The author surmises that in fighting for their fame and their means they are truly fighting for their sanity, les they become depressed. The book also covers group narcissism, which illustrates similar reactions of certainty in their cause and rage to any real or imaginary attack. Interestingly, the violation of a group symbol, such as a flag or president, it met with intense fury and aggression by the group members, as they are willing to support the leaders in a policy of war (p. 231).

Reviewing aggression in female inmates, Warren et al. (2002) found a powerful relationship between Cluster B personality traits and predicted self-reported institutional violence as well as, more specifically, NPD and violent behavior. These results demonstrated that those with NPD were eight times more likely to have a current conviction for a violent offense, such as

homicide. Later, Warren and South (2009) used a similar sample to show that the presence of antisocial, borderline, and narcissistic traits all correlated positively with the use of threats and physical assault in the prison environment. Specifically, those with comorbid narcissistic personality traits and less distinct antisocial personality traits were correlated with behavioral indices of threatening behavior and violence. These individuals displayed elevated levels of aggression, anger, exaggerated but fragile self-esteem, and a pervasive lack of remorse. Ulrich (2014) added that NPD traits with grandiose delusions and reported anger show an increased risk for serious violence.

Lastly examined is NPD as it relates to sexual violence. Due to the deleterious consequences for victims, it is vital to focus on risk factors for sexual offenses, NPD being one of them. Again, referring to diagnostic criteria, those with NPD have inflated views of themselves, possibly leading to the belief that they are more sexually desirable. They possess a need for admiration, likely wanting to be viewed as sexually desirable. They are highly responsive to negative experiences, such as can an overreaction to rejection. These common symptoms compounded by low empathy, high hostility, and high exploitativeness can ultimately lead to sexual coercion or rape (Zeigler-Hill et al., 2013). Researchers (Dudeck et al., 2007) compared 19 sexual offenders to 32 non-sexual offenders in a maximum-security forensic hospital. Within this study, NPD was found to be significantly more frequent amongst sexual offenders (36.8%) than the comparison group (9.4%). Moreover, exposure to childhood sexual abuse was present in 40% of those with NPD, significantly more than those without NPD (5%). The authors hypothesized that, “Early traumatic experiences can be reproduced with a reversal of roles: the former victim becomes the perpetrator” (Dudeck et al., 2007, p. 502). Moving forward with these findings in mind, it was suggested that individuals similar to this could benefit from

an intervention that uses trauma-informed care alongside victim-specific, empathy-enhancing approaches (Marshall et al., 1998; Marshall et al., 2005; Webster et al., 2005).

Current Treatments for Narcissistic Personality Disorder

Overall, due to the chronic and persistent nature of personality disorders, there are no wholistic cures for NPD. At this point, the main treatments available aim to manage symptoms through a psychoanalytic/psychodynamic or cognitive–behavioral approach, many of which were originally intended for the treatment of BPD. Livesley (2012) indicated that there is an increasing amount of support for a more integrated approach for treating personality disorders. This recognizes that different modalities and techniques can be used harmoniously in a stepwise manner for the different presentations and developmental stages of NPD. Workgroups for the DSM-5 Section III proposed that there should be a focus on problems with identity (regulation of self and emotions), self-direction (self-agency), empathy, and intimacy (interpersonal relatedness) (Ronningstam, 2014). In most of the therapeutic modalities described below, the treatment is intended for individual intervention; although, group therapy may be effective in challenging difficulties related to shame, dependency, self-sufficiency, as well as contempt for or envy of others. Conversely, highly narcissistic individuals may dominate or disrupt groups and compete with the therapist to be the group leader (Yakeley, 2018).

The Psychoanalytic/Psychodynamic perspective primarily relies on Transference-focused psychotherapy (TFP), which is a manualized intervention used in individual therapy intended to be delivered two to three times a week. Randomized control trials have shown that this can be utilized to improve symptomatic and reflective functioning in BPD (Clarkin, 2007). This treatment is also seen as effective for individuals with NPD, though a less interpretative and more supportive technique is recommended. TFP is the most prominent psychodynamic

psychotherapy that was developed by Kernberg and his collaborators (Clarkin, 2006). TFP is based on object relations theory aiming to explore the patient's aggression, envy, grandiosity, and defensiveness. The goals are to uncover negative transferences, challenge pathological grandiose defenses, and explore the deeply rooted sensitivity to shame and humiliation. This process uses the therapist's countertransference as a tool to aid in understanding the patient's projection of unacceptable aspects of themselves. Additionally, a systematic review found studies of moderate effects that demonstrated a positive impact of short-term psychodynamic psychotherapy (Kacel, 2017).

Cognitive-Behavioral approaches include Schema-focused therapy (SFT; Young, 2003), Dialectical Behavioral Therapy (DBT; Linehan, 1993), and Meta-Cognitive Interpersonal Therapy (MCIT; Dimaggio, 2012). With a cognitive-behavioral base, these interventions rely on examining the individual's maladaptive thoughts, how they impact emotions, and behaviors in the present. The majority of these treatments were initially aimed at treating BPD and only suggest the possibility of effectiveness with NPD.

Schema-focused therapy applies an integrative approach through incorporating elements of object relations, psychodynamic, and gestalt therapeutic models. SFT was originally developed by Jeffrey Young and colleagues in the Netherlands (Young, 2003) to treat BPD. Research identified mixed results for its effectiveness. A study by Doyle and colleagues (2016) revealed no significant effects for treating impulsivity, anger regulation, interpersonal style, or schemata. SFT focuses on challenging early maladaptive schemas and coping skills that were formed as a response when childhood needs were not being met. These established schemas produced intense emotions that disrupted emotional functioning and interpersonal relationships. SFT was designed to lower the intensity of the emotional memories and change cognitive coping

patterns that result in avoidance, surrender, and counterattack (Doyle, 2016; Lunding, 2016). The therapist uses a process of ‘re-parenting’ to encourage the patient to better regulate narcissistic tendencies in emotional reactivity. This is also intended to enhance empathy and intimacy with others.

Dialectical Behavioral Therapy (DBT) is a manualized treatment developed by Marsha Linehan (1993) for the treatment of BPD. DBT shows evidence of efficacy in randomized controlled trials for treating symptoms of BPD. It pulls aspects of acceptance and mindfulness that originates from Buddhist philosophy to be implemented in a combination of individual and group sessions. Group therapy allows for skills-training to promote modules of mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. For patients with NPD, validation is a key technique to reduce the feelings of shame and self-criticism (Reed-Knight, 2011).

Meta-Cognitive Interpersonal Therapy (MCIT) is a manualized step-by-step treatment developed by Giancarlo Dimaggio and colleagues (2012). MCIT contains a focus on treating aspects of perfectionism through disrupting typical narcissistic processes. MCIT gains a shared understanding of the patient’s problems in their autobiographical context. This assists in recognizing maladaptive schemas and problematic interpersonal functioning. Change is sought through identifying grandiose thoughts, distancing from old behaviors, and utilizing perspective-taking to build more healthy schemas (Yakeley, 2018).

Thus far, there is no evidence that suggests any specific psychopharmacological treatment is effective for NPD, though comorbid disorders such as anxiety, depression and bipolar disorder likely respond more positively to medication. Unfortunately, these clients may

report being particularly sensitive to side-effects, particularly those that impact sexual function or intellectual capacity. It is also possible that they may resent the idea of becoming dependent on psychotropic medications. Such factors may reduce their adherence to a medication regime.

The literature is consistent in that many therapists find individuals with NPD to be difficult to engage impeding the therapeutic alliance (Yakeley, 2018). This factor alongside slow progress in behavioral change and premature discontinuation by the client are features associated with NPD that can lead to a poor prognosis in therapy (Kacel, 2017). When treating NPD, ruptures are to be expected. These issues can be exasperated if the client misattributes clinical interventions, feels criticized, or treated unfairly, even when this is not the therapist's intention. Due to the nature of therapy, where the therapist acts as the expert to provide a service, the client may also resent the perception of lost power and control satiating the rejection of treatment (Yakeley, 2018). Individuals with Cluster B personality disorders, in general, are more likely to have a criminal conviction, spent time in prison, a history of interpersonal violence, caused pain or suffering to others, and evidenced overall impairment in social roles. Additionally, the cross-contextual interpersonal dysfunction with interactions seen as dramatic, emotional, and erratic can also pose for problems within therapy (Kacel, 2017).

With these compounding treatment obstacles, it is certain that this disorder comes with many challenges for both the client and the therapist. It is the author's hypothesis that it may be better to target a main factor of the disorder, such as interpersonal dysfunction, rather than treating the branching symptoms. This next section will reveal the history and philosophy behind attachment as a developmental theory within psychology. Following will be an explanation of how attachment theory can hold the key to treating the root of NPD.

History of Attachment Theory

John Bowlby revolutionized the conceptualization behind how we understand the bond between an infant and its primary caregiver, typically described as the mother, and what happens in response to separation, deprivation, or bereavement. Bowlby (1951; p. 53) explained that the mother serves as the child's ego and superego, "She orients him in space and time, provides his environment, permits the satisfaction of some impulses, restricts others. Gradually he learns these arts himself, and as he does, the skilled parent transfers the roles to him." To obtain long term mental health, Bowlby asserted that the child must experience a warm, intimate, and continuous relationship with the primary caregiver (Bretherton, 1992). This postulation called for a theoretical explanation.

Bowlby's primary research built off the work conducted by Harlow (1965) regarding the effects of maternal deprivation in rhesus monkeys. In this experiment, it showed that newborn baby monkeys preferred a created cloth "mother" that provided tactile comfort over the other simulated mother made of wire that supplied food. This suggested that infants possess an innate need for touch and cling for emotional support. This research identified three phases of responses to separation: protest (separation anxiety), despair (grief and mourning), and denial or detachment (defense mechanisms). Lastly, Bowlby ascertained that separation anxiety can be present as low or even absent giving an inaccurate impression of stoicism that is truly a form of defense. He opined that if a child is loved, they are likely to protest separation from their parents at a young age but will later develop self-reliance (Bretherton, 1992). This was the original layout for Attachment Theory.

Attachment is developed in infancy when babies identify if their caregivers are available to provide the support and resources needed to feel soothed. If the infant's needs are met and

they feel emotionally cared for, they will develop an understanding that others can be reliable and supportive. Conversely, if ignored or mistreated, the child may grow to view others as inaccessible and uncaring, resulting in an insecure attachment style as an adult. Attachment insecurity is associated with feelings of distress, impaired interpersonal functioning, and an increased likelihood for developing psychopathology, possibly leading to the development of a personality disorder (Crowell et al., 1999; Mikulincer & Shaver, 2007). While about 50% of adults have a secure attachment, there are three forms of insecure attachment: Preoccupied, Dismissing, and Disorganized (Levy et al., 2015).

To better explain this theory, Bowlby later coined the term, Internal Working Model (Benneth, 2006). This comes from the relational, subjective experience when the primary caregiver is able to read the child's cues, validate, and reflect back their perceived uniqueness (Cortina, 2003). Through this interaction, attachment is built within the first two years of life by the affective experiences involved in seeking and receiving emotional care. This represents the relationship of the self, the attachment figure, and the external world reflecting conceptualization of being worthy of affection and protection. The ability to elicit attention and comfort when needed is suggestive to the internal working model of the self. Thoughts, memories, and feelings are organized with the attachment figure as the guide to set expectations for all future relationships (Buchheim, 2003). Later experiences will become interpreted through this lens so that the continuity in one's sense of self is experienced. Parenting styles that are seen as unresponsive, rejecting, and insensitive foster the development of an insecurity in thought processing (Rosenstein, 1996). For example, when attachment behaviors, such as crying, persistently fails to regain recognition, the child develops defense strategies that exclude this painful information from the conscious (Buchheim, 2003).

As stated previously, attachment patterns begin during the first months of life, when brain development is efficient, forming motivational schemas to drive behavior (Badenoch, 2008). Grawe (2007) used a behavioral lens to combine knowledge from attachment theory and neuropsychology to propose what he termed as, consistency theory. He explained that early attachment experiences shape behavior as trying to either gain or protect basic psychological needs. This behavior derives from the internal working model suggesting that we all have implicit motivational schemas to fulfil needs such as attachment, control and orientation, pleasure maximization/pain avoidance, and the enhancement of self-esteem. These necessities are met through either approach (cortical processes) or avoidance driven (limbic processes) schemata. An individual with a secure attachment will have an approach schema that is oriented toward interpersonal interaction. Conversely, insecurely attached individuals develop environmentally avoidant schemas manifested as anxious and avoidant behavior (Spielberg et al., 2011). Someone with an established neural propensity for avoidance is more likely to avoid perceived threats rather than show goal-oriented behavior. This can lead to the limbic system dominating behavior, which results in anxiety, negative emotions, and an increased likelihood for mental illness (Grawe, 2007).

Attachment theory is an eclectic approach combining aspects from evolutionary, developmental, and neuropsychological domains. This provides an explanatory framework for understanding the development, maintenance, and treatment of personality pathology. While the brunt of the available research between attachment theory and personality disorders is focused on BPD, there is proof of linkage for other personality disorders, such as NPD and Avoidant Personality Disorder (Levy, 2015).

Childhood Attachment Styles

Bowlby's colleague, Mary Ainsworth, famously executed a study known as the Strange Situation (Ainsworth et al., 1978). In this experiment, a mother briefly acclimates her baby to a playroom, leaves the approximately one-year-old in the room with an unfamiliar woman briefly, then returns. The infants' reaction to their mother's departure and return identified four forms of childhood attachment. These were grouped broadly as either secure or insecure. In line with Bowlby's theory, a securely attached child (65%) would protest the mother leaving and run to the attachment figure for comfort upon return. Within insecure attachment styles, there are avoidant, ambivalent or anxious, and disorganized. In the study, a child that was seen as ambivalent (10%) often became distressed at the disappearance of the parent and maintained anger and resistance upon their return; it is believed that this is due to the parent's chronic inconsistency with meeting the child's needs at home. Avoidant children (20%) outwardly appear unphased, choosing to engage with toys over the caregiver upon return (Levy, 2015). Interestingly, research shows that while these children may appear indifferent, there are heart rate changes that continue at an elevated rate even when the parent reappears (Sroufe & Waters, 1977). Lastly, disorganized children (5-10%) exhibit cognitive dissonance. The child begins by engaging the parent, but their behavior is followed by a frozen reaction. This is likely due to past abuse that results in an internal conflict of wanting to be comforted while knowing that this individual may be dangerous (Shaffer, 2010).

Beyond the experiment, it was discovered that a child with a history of a secure attachment pattern will develop a model of the self as being worthy of care and will establish an expectation of intimate relationships as being dependable and responsive. A child with a history of an avoidant attachment typically has parents who chronically ignored or dismissed emotional

needs (Benneth, 2006). This child will likely view themselves as unworthy of care and view significant others as rejecting and unresponsive resulting in a lack of comfortability with intimacy. Those with a history of ambivalent or anxious attachment have experienced inconsistent or intrusive care. For this reason, they view themselves as being weak or needy. Others in their life are thought of as unpredictable and intrusive. Lastly, the child with a disorganized attachment style likely has caregivers that were abusive and/or unresolved about their own losses or trauma. This leaves the child with an unsound approach using avoidance of conflict that leaves them ambivalent in fear of their caregivers while also yearning for their physical and emotional comfort (Soloman & George, 1999).

Beginning in lower elementary school, those with a secure attachment demonstrate complex and creative symbolic play while exhibiting more positive emotions as a whole. This is seen as more suitable for friendships with other children, possibly being described as sensitive. Those with insecure attachment styles often show poor peer relations and fewer close friends in general. They are more likely to demonstrate deviant behaviors. Relationships may be colored with trepidation that their partner will unexpectedly leave them. Some relationship problems may be attributable to attracting the same “type” of individual that matches their internal working model, as the significant other is treating the individual the way they think they should be treated. It is of note that avoidant children, in particular, engage in defensive behaviors to gain distance from internal distress, downregulate negative affect, and negate the importance of emotionally relevant information. This alleviation is ultimately short lived and longitudinally ineffective. As adults, those identified as avoidant show “increased electrodermal activity when queried about potential abandonment or rejection in past attachment relationships” (Levy, 2015; p. 200).

Adult Attachment Styles

Given the relative stability of internal working models, adults proceed with similar attachment styles, though they are referenced differently in the literature. A secure attachment style for adults maintains the label as secure, while insecure attachment styles are referred to as Preoccupied, Dismissing, and Avoidant. Fortunately, the internal working model can be modified through correcting unhealthy views of the self and others, fostering adaptive interpersonal interactions; however, insecure attachment can remain maladaptive in adulthood if the individual remains unable to emotionally connect or find support in others (Levy, 2015).

Adult attachment styles are examined through an individual's level of avoidance and anxiety as they relate to attachment figures such as the primary caregivers, significant other, and closest friendship. Those who show low levels of anxiety and avoidance within their relationships in general generate a secure attachment style. Those who are not likely to avoid relationships, though show high anxiety with these relationships, have a Preoccupied attachment style. A Dismissing attachment is characterized as having low anxiety while reporting high avoidance. Lastly, a Fearful-Avoidant attachment is created through having high anxiety and high avoidance within aforementioned relationships (Brogaard, 2015).

Through examining results from the Strange Situation task and later research with adult attachment styles, children with Avoidant attachment styles show similarities to adults who are classified with a Dismissing attachment style. It is believed that repeated rejection results in defensive behaviors that distances themselves in social situations. Over time, others are viewed as irrelevant because of perceived past failings to provide comfort (Meyer & Pilkonis, 2011). The data by Diamond and colleagues (2006) implicated that individuals with a Dismissing attachment are challenged by intense negative emotions as they relate to significant others,

despite reported disinterest. These adults, similar to their childhood selves, experience increased electrodermal activity in response to attachment-related stressors (Diamond et al., 2006). Those with preoccupied attachments do not exhibit such a response and Fearful-Avoidant individuals may not show the same physiological response patterns, however there is evidence that these groups show a divergence between self-reported and physiological activity. This may indicate that defensive strategies utilized by individuals with insecure attachment styles may help to regulate behavioral responses while also being ineffective in reducing physiological arousal. The data suggests that vulnerable narcissism is strongly linked with Preoccupied attachment in which they show attachment anxiety with low interpersonal avoidance. Grandiose narcissism is related to Dismissing attachment in which they report little attachment anxiety and high defensive avoidance of intimacy (Meyer & Pilkonis, 2011).

In 2013, Canterberry and Gillath identified that those who were identified as anxiously attached exhibited greater activation in areas of the brain that are associated with experiencing and regulating emotions when primed with secure attachment words, such as “comfort” compared with insecure words such as “abandon.” These patterns of activation are consistent with the idea that Preoccupied adults show heightened emotional arousal to secure primes while consecutively revealing difficulties with downregulating intense affect. The authors also discovered increased activation in brain regions devoted to memory among Avoidant individuals. This involves repeated memory retrieval attempts due to a lack of easily accessible secure representations. Activation also increased within areas, such as the amygdala, when associated with processing salient or aversive emotional stimuli. These findings reveal that insecurely attached individuals exhibit behavioral dysregulation as well as show hypersensitivity to emotional cues and difficulties with emotion regulation on a neural level.

When preparing for treatment, Vogel and Wei (2005) explained that attachment avoidance is associated with a reluctance to seek medical care as well as reported low levels of distress. The authors reported that individuals with personality disorders that are anxiously attached may present to treatment as engaged and interested in pursuing treatment. Preoccupied individuals may appear more likely to seek care and disclose personal difficulties, although they do not show overt compliance in therapy. Those with Dismissing attachment also demonstrate nonadherence to treatment beyond that of other attachment classifications and poor alliance with the therapist (Mallinckrodt et al., 2005). Specifically, Dismissing adults see themselves as strong and independent, valuing possessions, facts, and activities over typical relations with others. They are likely to idealize the attachment figure; however typically criticize or forget the parenting they received during childhood. This is inconsistent with their current state of mind, though this discrepancy goes unnoticed. As infants, they are usually rated as Avoidant (Jellema, 2000).

Clients rated as Preoccupied are opposite to Dismissing showing intense emotional enmeshment with their primary caregiver. Preoccupied adults lack the personal identity and autonomy needed to appropriately detach from the parent. These individuals appear confused, angry, or fearful when requiring comfort. Interviews are often long, vague, and rambling. As infants, they are likely rated as Ambivalent (Jellema, 2000).

Assessment of Adult Attachment Styles

Research indicates that the gold standard for assessing attachment styles for adults is through using the Adult Attachment Interview (AAI; George et al., 1996; Main et al., 1985). This is an extensive one-hour, semi-structured interview used to determine an individual's attachment style as it relates to primary attachment figures spanning from the past up until the present. This

conceptualizes the individual in role relationships as opposed to personality traits. The AAI reveals self-protective interpersonal strategies, possible unresolved traumatic experiences that distort behavior, and patterns of information processing. Caregiver patterns perceived by the AAI are correlated with attachment styles discerned from infants in the Strange Situation study (Ainsworth et al., 1978; Benneth, 2006). The AAI has been found to have up to 80% predictability of how the child of an adult interviewee would be attached to their parent. Individuals are classified as Secure, Dismissing of attachment, Preoccupied with past attachments, Cannot Classify within this system, or Unresolved/Disorganized with respect to loss or abuse (Jellema, 2000). There are other tools available for clinicians to obtain an understanding of an individual's attachment style as an adult, such as the self-report measures including the Attachment Styles Questionnaire (Feeney et al., 1994). However, the AAI is considered to be the best assessment tool due to the amount of research that deems this particular tool valid and reliable with interviewer effects being insignificant. A limitation is that the training needed to administer the AAI is sophisticated, often requiring approximately two weeks of professional training. Further, the interview is extensively transcribed, which can be time consuming.

Causal Links between Attachment and NPD

The connection between the etiology of NPD and the basis of attachment theory is the crux of this doctoral project. In this section, the author will discuss specifically how these concepts relate on theoretical and functional levels. More specifically, the relation between Dismissing attachment with grandiose narcissism as well as the connection between Preoccupied and vulnerable narcissism will be highlighted.

Beginning with the etiology of NPD, as mentioned previously, there are contradictions in the way that this disorder's origin is conceptualized. Some believe the growing narcissist was

formed through excessive parental admiration and overindulgence where the child develops an egotistical view of the world. Others hold an opposite view, where the child must have been chronically rejected and neglected (Meyer & Pilkonis, 2011). Both of these trajectories are plausible through an attachment lens. As explained by Meyer and Pilkonis (2011; p. 435), "Consistent overindulgence may lead to impoverished mental models of others as the narcissist does not learn that attention of others need to be contingent upon his behavior. By definition, consistent overindulgence means that attention and praise are indiscriminate, so others may be viewed as autonomous agents with whom reciprocal interactions are possible."

Through the understanding of Dismissing attachment, the self is adored while others are viewed either benignly as providers of attention or angrily as withholding attention. Conversely, experiences of neglect suggest that one is unworthy of affection. This could elicit defensive narcissism to protect from thoughts of deserving callous parenting or *fully* internalizing the belief of being unworthy. These attachment styles are considered to lead to an Avoidant attachment pattern. Vulnerable forms of narcissism may progress when attention and nurturance by the attachment figure is inconsistently available. In this case, the threat of abandonment increases the child's need for proximity and may appear as more Preoccupied. To counter this, they demand the attention they feel they deserve. Inconsistent responding can lead to chronic disappointment and negative affect. The consequentially developed internal working model guides further behaviors and attachments. Research by Otway and Vognoles (2006) is consistent with Meyer and Pilkonis' (2011) findings. In their study, Otway and Vognoles found that many individuals with NPD recalled their parents as either cold or overestimating. There was an overt connection between this overvaluation and grandiose narcissism suggesting that this phenotype may be from childhood expectations of superiority. Negligent parents that provided indiscriminate praise

resulted in similar behavioral adaptations. The authors conclusions supported the idea of NPD displaying an Avoidant pattern of attachment.

As confirmed by the many aforementioned theorists, difficulties with attachment and traumatic parenting are at the heart of pathological narcissism. Proposed instrumental parenting qualities include inappropriate generational boundaries, using shame or humiliation, rejecting dependency, or failing to provide a gradual level of frustration in the child's early environment (Benneth, 2006; Imbessi, 1999). Attachment theory aids in the conceptualization of the etiology of NPD as it relates to developmental connections with interpersonal interpretive capacities. In fact, research by Jellema (2000) strongly suggested a link between Dismissing attachment and NPD; while a Preoccupied attachment is a possibility for vulnerable NPD, though it was more likely seen in BPD (Jellema, 2000).

While it is possible for those with NPD to have any of these attachment styles, a Dismissing attachment is seen predominantly. Within a Dismissing attachment, relational avoidance potentially contributes to distrust in others and distancing behaviors result in the suppression of emotions. Typical defenses and transferences include the pervasive devaluation of attachment related experiences and feelings, fragile idealization of others, and the perception of omnipotence. This appears to be related to the inability to empathize or value reciprocal relationships in a more typical fashion. Generally, adults with a Preoccupied attachment appear overwhelmed by anxiety and negative emotions related to their relationships. Adults with a Dismissing attachment distance themselves from close relationships in attempts to internally defending against painful feelings of rejection or disapproval (Bowlby, 1977).

In 1973, Bowlby paired specific personality disorders to certain insecure attachment styles. He believed that those with an overall anxious attachment could be linked to dependent

and hysterical personalities and that the more avoidant attachments had a connection to NPD and psychopathic personalities. (Levy, 2015) Diamond, Hicks, and Otter-Henderson (2006) reviewed interviews and self-report studies that conveyed connections between a Preoccupied attachment style with HPD, Dependent Personality Disorder, and Avoidant Personality Disorder. Additionally, they found a linkage between dismissing attachment and paranoid personality disorder, NPD, ASPD, and Schizoid Personality Disorder. For Fearful attachment, they found associations with Schizotypal, Paranoid, Avoidant, and Obsessive-Compulsive Personality Disorder alongside BPD and NPD.

Early attachment-related research utilized the AAI to show that disturbances between the child and the primary caregiver led to the development of narcissism (Fossati, 2014). Through this research, the authors unveiled the association of narcissism with both Dismissing and Preoccupied attachment styles as adults. These contradictory attachment styles are thought to be reflective of a differing mental status that coincides with grandiosity and vulnerability found in NPD (Meyer & Pilkonis, 2011). A robust number of empirical studies support a psychodynamic approach in concluding that dysfunctional parenting styles are significantly associated with the development of NPD in adulthood (Horton, 2011). Many indicate that parental indulgence can lead to both grandiose and vulnerable narcissism, while others show that parental coldness and emotional control are more likely to exclusively lead to vulnerable narcissism. Drawing to a large extent on Kernberg, as well as on attachment theory, Diamond and Meehan (2013) believed that the defensive role of grandiosity is used as protection against feelings of inferiority and the threat of imperfection. Similarly, Dickinson and Pincus (2003) identified that both pathological and clinical narcissism is anchored in a Dismissing attachment style or an Avoidant style surrounding defensive self-sufficiency. It was described that the individuals reported disliking

connection with others, though invested in interpersonal space and self-agency. Additionally, it was again stated that vulnerable narcissism was associated with a Preoccupied attachment style (Ronningstam, 2014).

Imaging studies examined attachment constructs as they relate to NPD in the brain. Neurological regions associated with the ability to empathize highlighted functional and structural abnormalities within those who are diagnosed with NPD. Compared to healthy controls, those with NPD have, "smaller gray matter volumes in the left anterior insula, rostral and medial cingulate cortex, and dorsolateral and medial prefrontal cortex, areas implicated in the ability to empathize" (Schulze et al., 2013; p. 1363). Comparatively, those with high levels of narcissistic traits exhibit decreased activation in the right anterior insula during a task requiring the use of empathy (Fan et al., 2011). It was concluded, "Given the importance of empathy in fostering interpersonal relationships, attachment patterns may therefore be disrupted in patients with NPD" (Levy, 2015; p. 201).

Collaborative Therapeutic Assessment

The process of an assessment involves disclosing intimate and sometimes shameful information while tolerating feelings of vulnerability and trusting an unfamiliar professional. It is expected that the client accepts the diagnosis and will follow treatment recommendations in order to have the best possible outcome. Those with NPD view these clinical experiences as quite challenging. Stemming from an insecure attachment, it is likely that the client with NPD will demonstrate denial, minimize minor shortcomings, devalue therapeutic attempts, resist the alliance, and terminate therapy prematurely (Campbell & Miller, 2011; Hewitt et al., 2003; Hilsenroth et al., 1998; Ronningstam, 2011a).

Preparing an assessment for an individual who may have NPD can be quite challenging

due to many of the face-valid questions that the patient is likely unwilling to endorse. The evaluation should include an in-depth clinical interview that seeks interpersonal patterns and how flaws are conceptualized, a personality assessment such as the MMPI-2-RF (Ben-Porath & Tellegen, 2008), PAI (Morey, 1991), or MCMI-III (Millon, 1997), and a Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD; First et al., 2016) or the Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979). Within testing, it is likely that individuals with NPD will show low Agreeableness, low Neuroticism, and a variety of negative social behaviors (Cain et al., 2008). The limited ability to recognize their own contribution to their problems or how their behaviors impact others may impede this process. Collateral information is preferred in aiding an objective diagnosis. What is notable are observations of hypersensitivity and defensive reactions to testing items alongside the limited ability at self-disclosure, self-reflection, and empathy (Ronningstam, 2014). Upon assessment feedback, clients often reject the diagnosis of NPD, as it challenges their idealized self and accentuates feelings of shame (Yakeley, 2018).

There is a growing empirical support for the effectiveness of utilizing a Collaborative/Therapeutic Assessment (C/TA) approach with clients and patients in treatment settings. C/TA utilizes the collaborative exploration of assessment results to generate new ways for the client to conceptualize their own psychological experiences (Finn & Tonsager, 1997). Research validates that patients are more likely to incorporate more information from a feedback session when the findings are explained in a way that is in accordance with their current view of themselves and when they are actively involved in the interpretation process (Schroeder et al., 1993). C/TA is associated with greater engagement from the patient, increases motivation for treatment, and produces a stronger alliance with the subsequent therapists (Ackerman et al.,

2000). For these reasons, the benefits from C/TA appear well-suited for client's with NPD in order to strengthen the alliance by enhancing engagement. Hinrichs (2016; p. 2) explained that this could "deter the expected denial of difficulty, scaffold a vacillating self-esteem intolerant of vulnerability, encourage a successful internalization of assessment results rather than a devaluing reaction to feedback, and hopefully prevent premature termination."

Hinrichs (2016) utilized the C/TA approach within the framework of assessing and treating a client with NPD. It was explained that the fluctuating levels of self-esteem found in narcissism made attempts at organizing a conceptualization challenging. With this heterogeneity in mind, three subtypes of NPD were proposed. The first was high functioning and exhibitionistic. The second was characterized as arrogant and entitled, likely showing overt and grandiose narcissism. The third entailed the depressed and depleted which was defined as behaving in a hypervigilant, shy, and fragile manner. Individuals with personality disorders combined with an insecure attachment style have a variable presentation in therapeutic settings. Those with a Preoccupied style are more likely to seek care and disclose personal distress, but do not show greater adherence to treatment in comparison to other attachment styles. Attachment avoidance has been associated with a reluctance to seek medical care as well as lower levels of reported distress (Vogel & Wei, 2005). Those with a Dismissing attachment also show treatment noncompliance beyond that of other attachment classifications as well as a poor alliance with the therapist (Mallinckrodt et al., 2005).

Evidence-Based Relationships and Responsiveness

As stated above, there are many barriers in treating individuals with narcissistic traits or NPD. Therefore, a carefully constructed therapeutic process should be created in order to benefit not only the client but also the clinician. Evidence-based relationships and responsiveness

involves adapting therapy to fit the individual client. Broadly, this technique has been a universally recognized approach since the beginning of modern psychotherapy. In 1919, Freud introduced psychoanalytic psychotherapy as an alternative based on the recognition that many patients required differing levels of psychoeducation. As stated by the father of modern medicine, Sir William Osler (1906), "It is much more important to know what sort of a patient has a disease than what sort of disease a patient has."

Norcross and Wampold (2018) designed a study that demonstrated increases in therapeutic effectiveness through the use of evidence-based relationships and responsiveness. In the study, they summarized the meta-analytic results and clinical practices on the adaptations of psychotherapy to multiple transdiagnostic characteristics, such as attachment style, culture, gender identity, sexual orientation, religiosity, coping style, therapy preference, reactance level, and stages of change. This further demonstrates the effectiveness of tailoring the intervention to the person as a whole. Norcross and Wampold (2018) suggested a series of "when…then" statements. For example, when the client presents with X feature, or perhaps when they express Y value or belief, then consider implementing Z (a relevant intervention or therapy). They emphasized that this could aid the clinician to treat the entire person instead of relying merely on conforming to the diagnosis. Fitting the client's culture, spiritual identity, and treatment preferences are described to markedly improve treatment outcomes. In reaction, the client's coping style, reactance level, and stages of change are likely to improve. The authors concluded that correlational research relating patient attachment security to their psychotherapy outcome was promising.

Attachment Based Interventions

In 1977, Bowlby hypothesized that attachment theory can be effectively utilized in psychotherapy. He inferred that by having the therapist provide a secure base, past and present relationships could be explored. This aids in the understanding of how social interactions contribute to the individuals current internal working model as well as other presenting difficulties. Through such exploration, patients can adjust the lens of how they view themselves and others while developing more prosocial behaviors. Research concurs that therapeutic methods today have increasingly called for a reliance on attachment theory, especially when treating clients with a personality disorder. The contributions of attachment constructs as they apply to treatment progression and outcomes are also of interest to research being done to enhance psychotherapy. Thus far, there are five well-known different types of therapies that utilize constructs from attachment theory as part of the intervention. Those therapies include Cognitive Analytic Therapy, Cognitive Behavioral Analysis System, Object Relations Therapy, Mentalization-Based Treatment, and Attachment-Based Family Therapy.

Cognitive Analytic Therapy (CAT; Ryle, 1990) is a 16-session individual therapy created for neurotic and personality disordered outpatients that uses reciprocal roles to identify and target interpersonal dysfunction. Within CAT, personality disorders are viewed as disorders of interpersonal relatedness and specifically show promise with treating Dismissing and Preoccupied attachment styles (Jellema, 2000). This treatment acknowledges the dissociation of NPD and proposes contesting role reversals of admired and admiring as well as contemptuous and contemptable, all four being relevant to a Dismissing attachment. This challenges the narcissistic tendencies to rely on cognitions over emotions. Jellema (2000) wrote that in session, Dismissing clients often present with depression or ‘workaholic’ tendencies with a grandiose

narcissistic structure. As the treatment progresses, these individuals appear more Preoccupied showing an emergence of anger or emotional neediness with their partners or social outlets. Studies concluded that there is evidence for integration at the end of therapy with a positive outcome at a three-month follow-up.

Cognitive Behavioral Analysis System of Psychotherapy (CBAST; McCullough, 2000) was originally developed for chronic depression in adolescents and adults. This therapy focuses on discussing the individual's attachment figures and key learning experiences from the past that constructed their current internal working model. Clients in this type of therapy typically reveal attachment figures that were neglectful, insulting, and abusive. This parenting style likely led to distorted cognitions of chronic interpersonal punishment. The therapist forms a transference hypothesis from these highlighted experiences to evaluate interactions that may have included an unconscious aspect, such as implicit expectations from early learning experiences. These schemas are examined in treatment using the therapist to model a healthy therapeutic relationship. Through these sessions, the individual is treated based on the underlying pathology making the internal working model more flexible. This particular intervention may be better suited for vulnerable narcissism with a Preoccupied attachment.

Object Relations Therapy (OTR; Diamond, 2020) uses the individual's attachment style and the internal working model as the primary aspects of therapy. Object relations theory proposes that through gradual unveiling of interpersonal conflict, the aspect of impulse as well as defense mechanisms can be explored through the understanding of early learned interactions and expectations. This can be used as a couples, individual, or family therapy. ORT provides the perspective of the individual with NPD to explore the defense mechanisms that are used, why they are used, and how to adjust the behavior to be healthy and adaptive. Receptivity to the

individuals needs as well as an understanding of early object relations can maximize engagement in therapy and effectiveness of the therapeutic process (Scharff & Bagnini, 2006). Additionally, operating out of the object relations theory is Transference-Focused Psychotherapy for NPD. This includes a contracting phase and interpretive process to locate and modify maladaptive internal working models. The primary focus is on problematic interpersonal patterns through using the therapeutic relationship as a vehicle to impact enduring changes in personality organization and relationships with others (Diamond & Hersh, 2020).

Mentalization-Based Treatment (MBT; Cherrier, 2013) is an intervention that fosters the ability to mentalize and revert harmful effects of attachment insecurity as they relate to personality development. Mentalization is the ability to reflect on one's own as well as others' mindset when conceptualizing thoughts and behaviors. This was originally intended to be a treatment for BPD, as research suggests its efficacy on symptoms such as suicidal ideation, self-harming behaviors, and interpersonal dysfunction (Levy, 2015). MBT has proven to be useful in the treatment of other mental disorders for group or individual therapy (Bateman, 2012). In addition to utilizing aspects of attachment theory, MBT integrates psychodynamic, cognitive, and relational components. While MBT has not been extensively studied in relation to NPD, there are a few reports within the literature of MBT programs that are said to be better designed to treat NPD (Cherrier, 2013; Lee, 2013). The use of MBT or mentalization techniques with patients with narcissistic traits (Seligman, 2007; Rossouw, 2015) are promising because both transference-focused psychotherapy and MBT draw from attachment research in their conceptualizations of the psychopathology behind NPD.

Attachment-Based Family Therapy (ABFT; Diamond, 2002) is a manualized, empirically supported model that is designed to target familial and individual processes associated with

adolescent suicide and depression. ABFT is grounded in interpersonal theory suggesting that adolescent suicidality and pervasive depression can be exacerbated or resilient by the quality of relationships within the family. This intervention is trust-based and emotion-focused aiming to repair interpersonal ruptures and rebuild an emotionally protective, secure-based, parent–child relationship. ABFT acknowledges that family conflict, detachment, criticism, or intergenerational trauma can cause or maintain depression in adolescents. The impact from abuse and neglect by family members can be a sign of insecure attachment and become exacerbated when the parents fail to comfort or support the adolescent. Conversely, when parents are perceived as caring, protective and autonomy-granting, a secure base is formed helping the adolescent to withstand and grow from distress. While the diagnosis of NPD is meant for adults due to the need for pervasive personality features to meet full criteria, adolescents can be determined to have certain traits relevant to NPD.

ABFT aims to repair ruptures in the attachment relationship and establish or resuscitate the secure base to nurture adolescent development. Repairing attachment occurs by helping family members to remember the desire for closer relationships and instill the hope for rebuilding trust. In individual sessions, adolescents are assisted in identifying and articulating their perceived experiences of attachment failures and are supported in discussing these experiences with their parents. Parents are encouraged to acknowledge how their own intergenerational histories impact their parenting style, leading to greater empathy for their child's experiences. The family discusses the adolescent's thoughts, feelings, and memories while receiving acknowledgement and empathy from the therapist. The parents are reinforced in becoming more willing to consider their own contributions to the overall conflict. This opportunity for mutual respect and emotionally laden dialogue serves as a corrective attachment

experience that can set in motion a renewed sense of trust and commitment. As tension and conflict diffuse at home, therapists encourage adolescents to pursue pro-social activities outside the home that will promote competency and autonomy. Parents are taught to serve as the secure base from which adolescents seek advice, comfort, and encouragement in exploring these new opportunities.

Section 3: Contributions to Research

Overview

Attachment theory postulates that early life experiences show an enduring impact on development and personality organization. As explained by Bowlby (1988), this effect is mediated by the internal working model as the individual either negatively or positively understands the self and others. Parenting styles set the stage and secure an attachment style, which can be directly related to an individual's experienced interpersonal dysfunction or the diagnosis of a personality disorder. NPD likewise is rooted in the received parenting style during childhood. The complex development of grandiose and vulnerable narcissism is intertwined with insecure attachment styles, such as Preoccupied and Dismissing, as they relate to interpersonal dysfunction. In NPD, this need for admiration, power, and control can become physically, emotionally, or sexually abusive in interpersonal relationships. This behavior, complaints of life and relationships neglecting to meet high expectations, or comorbid psychological problems can lead to seeking a therapist, all without the general insight to their own narcissistic tendencies.

With the understanding that insecure attachment contributes to the dissociated selves of NPD (i.e., grandiose and vulnerable), it is understandable that treatment can be challenging in acknowledging the client's current symptomology all while targeting the underlying etiology. It is promising that the AAI can assist in this foundational knowledge of the individual's

attachment style and internal working model. These dissociative selves appear to coincide with the opposing split of Preoccupied and Dismissive attachments, each requiring a special strategy to treat adequately. With the AAI being utilized as a C/TA, the therapist can collaborate with interpreting these results with the client and provide the needed secure base required to understand more healthy interactions without fear of rejection or abandonment. The AAI additionally depletes barriers through better conceptualizing countertransference with perceived arrogance as exhibited by the client, improves rapport, and collaborates to decrease the likelihood of early termination. Through a greater conceptualization of these behaviors as defense mechanisms, the therapist can modify the intervention in order to potentially decrease maladaptive interpersonal interactions. Further, this enhanced conceptualization of the off-putting personality features as part of the symptomology that is the target of treatment should help decrease countertransference and increase empathy for the client.

The utilization of attachment theory in session is flexible for therapists who work from a psychodynamic or cognitive-behavioral base. Attachment theory shows an expectancy of those with a Dismissing attachment to fear exhibiting the vulnerable side of their personality due to the implicit belief that weakness is met with rejection. The therapist in this case should reward vulnerable acts with praise and support. Further, the client could benefit from exploring perceived cold or rejecting early experiences and the consequences which followed. Vulnerable narcissists showing a Preoccupied style may reveal the desire for closeness and nurturance as well as the anticipation of disappointment with the therapist. The clinician can be effective by encouraging acts of openness and vulnerability while also discussing potential disappointment reactions (Meyer & Pilkonis, 2011).

Given the vast amount of research discussed, it appears that through utilizing the AAI as a form of C/TA, an appropriate attachment-based intervention can be selected to treat interpersonal dysfunction, thus enhancing evidence-based relationships and responsiveness in therapy. The attachment-based interventions that were mentioned above are empirically based with the flexibility needed to treat an individual client's personal needs as they apply to interpersonal relationships and their internal working model. This intervention has the potential to be very helpful for treating interpersonal dysfunction in NPD as well as serve as a primary preventative strategy for friends, family, and colleagues in that individual's life.

Conclusions

There are three main points to be emphasized throughout this discussion. The first is that the etiology of NPD being rooted in traumatic parenting is synonymous with the aspects of attachment theory. This proves to be true systemically as this connection is seen in both childhood (e.g., Avoidant) and adult attachment styles (e.g., Dismissing and Preoccupied) relate heavily to the dissociative selves of NPD (e.g., grandiose and vulnerable). The second point is that NPD deserves appropriate intervention. While the exact epidemiology is uncertain, it is likely that each individual with clinically severe narcissism will likely have a negative, if not abusive, impact on many lives. This interpersonal dysfunction is the core to NPD and therefore should be the primary emphasis of treatment. The last discussion topic is that attachment theory is a well-known aspect of developmental psychology that is easily applicable to many therapeutic styles. Clinicians would benefit in more readily adopting these validated attachment-based interventions, especially for NPD and likely for other personality disorders.

The next steps that should be addressed in the following research should focus on how to enhance diagnostic practices beyond that provided in the DSM-5 for NPD. Clearly, there needs

to be a more inclusive focus on vulnerable and dissociative related symptoms. Research regarding studies on abusive behaviors needs to expand to more heterogeneous samples, as the majority of the literature appeared to focus on heterosexual couples. This attachment literature could be built upon to see if attachment-based interventions are also indicated for other personality disorders, Cluster B in particular. Further, it would be interesting to see study how the dissociative grandiose and vulnerable sides of narcissism may present within forensic evaluations.

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Appendix A: Adult Attachment Interview Protocol

George, C., Kaplan, N., & Main, M. (1985). The Adult Attachment Interview. Unpublished manuscript, University of California at Berkeley.

(Note: This document is for illustration only. Contact the authors for information about training and the most current version of the interview protocol.)

This material is not a substitute for training in AAI administration procedure. It is provided because it is important for consumers of AAI research to have easy access to the interview questions. Without them, it is difficult to evaluate published research. Seeing the full interview protocol can also help consumers of AAI based research appreciate the level of interview information and detail underlying AAI scores. It can also help them make important decisions about the adequacy of procedures in various reports they may encounter.

The authors of the AAI make the scoring manual available only in conjunction with their training courses. Researchers interested in understanding more about the logic of scoring the AAI can however see the scoring manual for Crowell & Owens' Current Relationship Interview (CRI) which is available in full on this site. The logic and procedures for scoring the CRI closely parallel those for the AAI. The primary difference is that the AAI focuses on relationships to parents and the CRI on relationships to adult attachment figures. At present this is the only detailed source of insights into the criteria for scoring the AAI available to those who do not take the training course. Do not reproduce this material without permission of the author.

Introduction

I'm going to be interviewing you about your childhood experiences, and how those experiences may have affected your adult personality. So, I'd like to ask you about your early relationship with your family, and what you think about the way it might have affected you. We'll focus mainly on your childhood, but later we'll get on to your adolescence and then to what's going on right now. This interview often takes about an hour, but it could be anywhere between 45 minutes and an hour and a half.

1. **Could you start by helping me get oriented to your early family situation, and where you lived and so on? If you could tell me where you were born, whether you moved around much, what your family did at various times for a living?**

This question is used for orientation to the family constellation, and for warm-up purposes. The research participant must not be allowed to begin discussing the quality of relationships here, so the "atmosphere" set by the interviewer is that a brief list of "who, when" is being sought, and no more than two or three minutes at most should be used for this question. The atmosphere is one of briefly collecting demographics.

In the case of participants raised by several persons, and not necessarily raised by the biological or adoptive parents (frequent in high-risk samples), the opening question above may be "Who would you say raised you?": The interviewer will use this to help determine who should be considered the primary attachment figure (s) on whom the interview will focus.

Did you see much of your grandparents when you were little? If the participant indicates that the grandparents died during his or her own lifetime, ask the participant's age at the time of each loss. If there were grandparents whom she or he never met, ask whether this (these) grandparents) had died before she was born. If yes, continue as follows: *Your mother's father died before you were born? How old was she at the time, do you know?* In a casual and spontaneous way, inviting only a very brief reply, the interviewer then asks, *Did she tell you much about this grandfather?*

Did you have brothers and sisters living in the house, or anybody besides your parents? Are they living nearby now, or do they live elsewhere? –

2. **I'd like you to try to describe your relationship with your parents as a young child if you could start from as far back as you can remember?**

Encourage participants to try to begin by remembering very early. Many say they cannot remember early childhood, but you should shape the questions such that they focus at first around age five or earlier, and gently remind the research participant from time to time that if possible, you would like her to think back to this age period.

Admittedly, this is leaping right into it, and the participant may stumble. If necessary, indicate in some way that experiencing some difficulty in initially attempting to respond to this question is natural, but indicate by some silence that you would nonetheless like the participant to attempt a general description.

3. **Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother starting from as far back as you can remember in early childhood--as early as you can go, but say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give them to me**.

Not all participants will be able to think of five adjectives right away. Be sure to make the word relationship clear enough to be heard in this sentence. Some participants do use "relationship" adjectives to describe the parent, but some just describe the parent herself --e.g., "pretty"... "efficient manager"--as though they had only been asked to "pick adjectives to describe your mother." These individual differences are of interest only if the participant has heard the phrase, "that reflect your childhood relationship" with your mother. The word should be spoken clearly, but with only slight stress or emphasis.

Some participants will not know what you mean by the term adjectives, which is why we phrase the question as "adjectives or words." If the participant has further questions, you can explain,

"Just words or phrases that would describe or tell me about your relationship with your (mother) during childhood".

The probes provided below are intended to follow the entire set of adjectives, and the interviewer must not begin to probe until the full set of adjectives has been given. Be patient in waiting for the participant to arrive at five adjectives and be encouraging. This task has proven very helpful both in starting an interview, and in later interview analysis. It helps some participants to continue to focus upon the relationship when otherwise they would not be able to come up with spontaneous comments.

If for some reason a subject does not understand what a memory is, you might suggest they think of it like an image they have in their mind similar to a videotape of something which happened when they were young. Make certain that the subject really does not understand the question first, however. The great majority who may seem not to understand it are simply unable to provide a memory or incident.

The participant's ability (or inability) to provide both an overview of the relationship and specific memories supporting that overview forms one of the most critical bases of interview analysis. For this reason, it is important for the interviewer to press enough in the effort to obtain the five "overview" adjectives that if a full set is not provided, she or he is reasonably certain that they truly cannot be given.

The interviewer's manner should indicate that waiting as long as a minute is not unusual, and that trying to come up with these words can be difficult. Often, participants indicate by their non-verbal behavior that they are actively thinking through or refining their choices. In this case an interested silence is warranted. Don't, however, repeatedly leave the participant in embarrassing silences for very long periods. Some research participants may tell you that this is a hard job, and you can readily acknowledge this. If the participant has extreme difficulty coming up with more than one or two words or adjectives, after a period of two to three minutes of supported attempts ("Mm... I know it can be hard ...this is a pretty tough question... Just take a little more time"), 3 then say something like "Well, that's fine. Thank you, we'll just go with the ones you've already given me." The interviewer's tone here should make it clear that the participant's response is perfectly acceptable and not uncommon.

Okay, now let me go through some more questions about your description of your childhood relationship with your mother. You say your relationships with her was (you used the phrase) Are there any memories or incidents that come to mind with respect to (word)

The same questions will be asked separately for each adjective in series. Having gone through the probes which follow upon this question (below), the interviewer moves on to seek illustration for each of the succeeding adjectives in turn:

You described your childhood relationship with your mother as (or) your second adjective was," or "the second word you used was"). Can you think of a memory or an incident that would illustrate why you chose to describe the relationship?

The interviewer continues, as naturally as possible, through each phrase or adjective chosen by the participant, until all five adjectives or phrases are covered. A specific supportive memory or expansion and illustration is requested for each of the adjectives, separately. In terms of time to answer, this is usually the longest question. Obviously, some adjectives chosen may be almost identical, e.g., "loving ... caring." Nonetheless, if they have been given to you as separate descriptors, you must treat each separately, and ask for memories for each.

While participants sometimes readily provide a well-elaborated incident for a particular word they have chosen, at other times they may fall silent; or "illustrate" one adjective with another ("loving ...um, because she was generous"); or describe what usually happened--i.e., offer a "scripted" memory--rather than describing specific incidents. There are a set series of responses available for these contingencies, and it is vital to memorize them.

If the participant is silent, the interviewer waits an appropriate length of time. If the participant indicates nonverbally that she or he is actively thinking, remembering or simply attempting to come up with a particularly telling illustration, the interviewer maintains an interested silence. If the silence continues and seems to indicate that the participant is feeling stumped, the interviewer says something like, "well, just take another minute and see if anything comes to mind." If following another waiting period, the participant still cannot respond to the question, treat this in a casual, matter of fact manner and say "well, that's fine, let's take the next one, then." Most participants do come up with a response eventually, however, and the nature of the response then determines which of the follow-up probes are utilized.

If the participant re-defines an affective with a second adjective as, "Loving ---she was generous," the interviewer probes by repeating the original adjective (loving) rather than permitting the participant to lead them to use the second one (generous). In other words, the interviewer in this case will say, "Well, can you think of a specific memory that would illustrate how your relationship was loving?" The interviewer should be careful, however, not to be too explicit in their intention to lead the participant back to their original word usage. If the speaker continues to discuss "generous" after having been probed about loving once more, this violation of the discourse task is meaningful and must be allowed. As above, the nature of the participant's response determines which follow-up probes are utilized.

If a specific and well-elaborated incident is given, the participant has responded satisfactorily to the task, and the interviewer should indicate that she or he understands that. However, the interviewer should briefly show continuing interest by asking whether the participant can think of a second incident.

- If one specific but poorly elaborated incident is given, the interviewer probes for a second. Again, the interviewer does this in a manner emphasizing his or her own interest.
- If as a first response the participant gives a "scripted" or "general" memory, as "Loving. She always took us to the park and on picnics. She was really good on holidays" or "Loving. He taught me to ride a bike"--the interviewer says, "Well, that's a good general description, but I'm wondering if there was a particular time that happened, that made you think about it as loving?"
- If the participant does now offer a specific memory, briefly seek a second memory, as above. If another scripted memory is offered instead, or if the participant responds, "I just think that was

a loving thing to do," the interviewer should be accepting, and go on to the next adjective. Here as elsewhere the interviewer's behavior indicates that the participant's response is satisfactory.

4. **Now I'd like to ask you to choose five adjectives or words that reflect your childhood relationship with your father, again starting from as far back as you can remember in early childhood--as early as you can go, but again say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think again for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give them to me. (Interviewer repeats with probes as above).**

5. **Now I wonder if you could tell me, to which parent did you feel the closest, and why? Why isn't there this feeling with the other parent?**

By the time you are through with the above set of questions, the answer to this one may be obvious, and you may want to remark on that ("You've already discussed this a bit, but I'd like to ask about it briefly anyway..."). Furthermore, while the answer to this question may indeed be obvious for many participants, some--particularly those who describe both parents as loving--may be able to use it to reflect further on the difference in these two relationships.

6. **When you were upset as a child, what would you do**?

This is a critical question in the interview, and variations in the interpretation of this question are important. Consequently, the participant is first encouraged to think up her own interpretations of "upset," with the interviewer pausing quietly to indicate that the question is completed, and that an answer is requested.

Once the participant has completed her own interpretation of the question, giving a first answer, begin on the following probes. Be sure to get expansions of every answer. If the participant states, for example, "I withdrew," probe to understand what this research participant means by "withdrew." For example, you might say, "And what would you do when you withdrew?"

The interviewer now goes on to ask the specific follow-up questions below. These questions may appear similar, but they vary in critical ways, so the interviewer must make sure that the participant thinks through each question separately. This is done by placing vocal stress on the changing contexts (as we have indicated by underlining).

-----**When you were Upset emotionally when you were little, what would you do?** (Wait for participant's reply). **Can you think of a specific time that happened?**

-----**Can you remember what would happen when you were hurt physically?** (Wait for participant's reply). **Again, do any specific incidents (or, do any other incidents) come to mind?**

-----**Were you ever held when you were little?** (Wait for participant's reply). **Do you remember what would happen?**

When the participant describes going to a parent, see first what details they can give you spontaneously. Try to get a sense of how the parent or parents responded, and then when and if it seems appropriate you can briefly ask one or two clarifying questions.

Be sure to get expansions of every answer. Again, if the participant says, "I withdrew," for example, probe to see what the participant means by this, i.e., what exactly she or he did, or how exactly they felt, and if they can elaborate on the topic.

If the participant has not spontaneously mentioned being held by the parent in response to any of the above questions, the interviewer can ask casually at the conclusion to the series**, "I was just wondering, do you remember being held by either of your parents at any of these times--I mean, when you were upset, or hurt, or ill?"**

In earlier editions of these guidelines, we suggested that if the participant answers primarily in terms of responses by one of the parents, the interviewer should go through the above queries again with respect to the remaining parent. This can take a long time and distract from the recommended pacing of the interview. Consequently, it is no longer required.

What is the first time you remember being separated from your parents?
- - -How did you respond? Do you remember how your parents responded?
- - -Are there any other separations that stand out in your mind?

Here research participants often describe first going off to nursery school, or to primary school, or going camping.

In this context, participants sometimes spontaneously compare their own responses to those of other children. This provides important information regarding the participant's own overall attitude towards attachment, so be careful not to cut any such descriptions or comparisons short.

7. **Did you ever feel rejected as a young child? Of course, looking back on it now, you may realize it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having been rejected in childhood.**

-----How old were you when you first felt this way, and what did you do?
----Why do you think your parent did those things--do you think he/she realized he/she was rejecting you?

Interviewer may want to add a probe by refraining the question here, especially if no examples are forthcoming. The probe we suggest here is, "*Did you ever feel pushed away or ignored?"* Many participants tend to avoid this in terms of a positive answer. "*So, were you ever frightened or worried as a child?"*

Let the research participant respond "freely" to this question, defining the meaning for themselves. They may ask you what the question means, and if so, simply respond by saying "It's just a more general question". Do not probe heavily here. If the research participant has had traumatic experiences which they elect not to describe, or which they have difficulty

remembering or thinking about, you should not insist upon hearing about them. They will have a second, brief opportunity to discuss such topics later.

8. **Were your parents ever threatening with you in any way - maybe for discipline, or even jokingly?**

-----Some people have told us for example that their parents would threaten to leave them or send them away from home.
-----(Note to researchers). In particular communities, some specific kind of punishment not generally 6 considered fully abusive is common, such as "the silent treatment", or "shaming", etc. One question regarding this one selected specific form of punishment can be inserted here, as for example, 'Some people have told us that their parents would use the silent treatment---did this ever happen with your parents?': The question should then be treated exactly as threatening to send away from home, i.e., the participant is free to answer and expand on the topic if she or he wishes, but there are no specific probes. The researcher should not ask about more than one such specific (community) form of punishment, since queries regarding more than one common type will lead the topic away from its more general intent (below).

Some people have memories of threats or of some kind of behavior that was abusive.
-----Did anything like this ever happen to you, or in your family?
-----How old were you at the time? Did it happen frequently?
-----Do you feel this experience affects you now as an adult?
-----Does it influence your approach to your own child?
-----Did you have any such experiences involving people outside your family?

If the participant indicates that something like this did happen outside the family, take the participant through the same probes (age? frequency? affects you now as an adult? Influences your approach to your own child?). Be careful with this question, however, as it is clinically sensitive, and by now you may have been asking the participant difficult questions for an extended period of time.

Many participants simply answer "no" to these questions. Some, however, describe abuse and may some suffer distress in the memory. When the participant is willing to discuss experiences of this kind, the interviewer must be ready to maintain a respectful silence, or to offer active sympathy, or to do whatever may be required to recognize and insofar as possible to help alleviate the distress arising with such memories.

If the interviewer suspects that abuse or other traumatic experiences occurred, it is important to attempt to ascertain the specific details of these events insofar as possible. In the coding and classification system which accompanies this interview, *distressing experiences cannot be scored for Unresolved /disorganized responses* <u>*unless*</u> *the researcher is able to establish that abuse (as opposed to just heavy spanking, or light hitting with a spoon that was not frightening) occurred.*

Where the nature of a potentially physically abusive (belting, whipping, or hitting) experience is ambiguous, then, the interviewer should try to establish the nature of the experience in a light,

matter-of-fact manner, without excessive prodding. If, for example, the participant says, "I got the belt" and stops, the interviewer asks, "And what did getting the belt mean?" After encouraging as much spontaneous expansion as possible, the interviewer may still need to ask, again in a matter-of-fact tone, how the participant responded or felt at the time. "Getting the belt" in itself will not qualify as abuse within the adult attachment scoring and classification systems, since in some households and communities this is a common, systematically but not harshly imposed experience. Being belted heavily enough to overwhelmingly frighten the child for her physical welfare at the time, being belted heavily enough to cause lingering pain, and/or being belted heavily enough to leave welts or bruises will qualify.

In the case of sexual abuse as opposed to battering, the interviewer will seldom need to press for details, and should be very careful to follow the participant's lead. Whereas on most occasions in which a participant describes themselves as sexually abused the interviewer and transcript judge will have little need to probe further, occasionally a remark is ambiguous enough to require at least mild elaboration. If, for example, the participant states `and I just thought he could be pretty sexually abusive', the interviewer will ideally follow-up with a 7 query such as, ` well, could you tell me a little about what was happening to make you see him as sexually abusive?'. Should the participant reply that the parent repeatedly told off-color jokes in her company, or made untoward remarks about her attractiveness, the parent's behavior, though insensitive, will not qualify as sexually abusive within the accompanying coding system. Before seeking elaboration of any kind, however, the interviewer should endeavor to determine whether the participant seems comfortable in discussing the incident or incidents.

All querying regarding abuse incidents must be conducted in a matter of fact, professional manner. The interviewer must use good judgment in deciding whether to bring querying to a close if the participant is becoming uncomfortable. At the same time, the interviewer must not avoid the topic or give the participant the impression that discussion of such experiences is unusual. Interviewers sometimes involuntarily close the topic of abuse experiences and their effects, in part as a well-intentioned and protective response towards participants who in point of fact would have found the discussion welcome.

Participants who seem to be either thinking about or revealing abuse experiences for the first time-- "No, nothing ....no... well, 1, I haven't thought, remembered this for, oh, years, but ...maybe they used to... tie me...."-- must be handled with special care, and should *not* be probed unless they clearly and actively seem to want to discuss the topic. If you sense that the participant has told you things they have not previously discussed or remembered, special care must be taken at the end of the interview to ensure that the participant does not still suffer distress and feels able to contact the interviewer or project director should feelings of distress arise in the future.

In such cases the participant's welfare must be placed above that of the researcher. While matter of fact, professional and tactful handling of abuse-related questions usually makes it possible to obtain sufficient information for scoring, the interviewer must be alert to indications of marked distress, and ready to tactfully abandon this line of questioning where necessary. Where the complete sequence of probes must be abandoned, the interviewer should move gracefully and smoothly to the next question, as though the participant had in fact answered fully.

9. **In general, how do you think your overall experiences with your parents have affected your adult personality?**

The interviewer should pause to indicate she or he expects the participant to be thoughtful regarding this question and is aware that answering may require some time.

Are there any aspects to your early experiences that you feel were a set-back in your development?

In some cases, the participant will already have discussed this question. Indicate, as usual, that you would just like some verbal response again anyway, "for the record."

It is quite important to know whether or not a participant sees their experiences as having had a negative effect on them, so the interviewer will follow-up with one of the two probes provided directly below. The interviewer must stay alert to the participant's exact response to the question, since the phrasing of the probe differs according to the participant's original response.

If the participant has named one or two setbacks, the follow-up probe used is:

---Are there any other aspects of your early experiences, that you think might have held your development back, or had a negative effect on the way you turned out?

If the participant has understood the question, but has not considered anything about early experiences a setback, the follow-up probe used is:

---Is there <u>anything</u> about your early experiences that you think might have held your development back, or had a negative effect on the way you turned out?

Although the word **anything** receives some vocal stress, the interviewer must be careful not to seem to be expressing impatience with the participant's previous answer. The stress simply implies that the participant is being given another chance to think of something else she or he might have forgotten a moment ago.

RE: PARTICIPANTS WHO DON'T SEEM TO UNDERSTAND THE TERM, SETBACK. A few participants aren't familiar with the term, **set-back**. If after a considerable wait for the participant to reflect, the participant seems simply puzzled by the question, the interviewer says,

Well, not everybody uses terms like set-back for what I mean here. I mean, was there anything about your early experiences, or any parts of your early experiences, that you think might have held your development back, or had a negative effect on the way you turned out?" In this case, this becomes the main question, and the probe becomes -Is there anything else about your early experiences that you think might have held your development back, or had a negative effect on the way you turned out?

10. **Why do you think your parents behaved as they did during your childhood?**

This question is relevant even if the participant feels childhood experiences were entirely positive. For participants reporting negative experiences, this question is particularly important.

11. **Were there any other adults with whom you were close, like parents, as a child?**
--- Or any other adults who were especially important to you, even though not parental?

Give the participant time to reflect on this question. This is the point at which some participants will mention housekeepers, au pairs, or nannies, and some will mention other family members, teachers, or neighbors.

Be sure to find out ages at which these persons were close with the participant, whether they had lived with the family, and whether they had had any caregiving responsibilities. In general, attempt to determine the significance and nature of the relationship.

12. **Did you experience the loss of a parent or other close loved one while you were a young child--for example, a sibling, or a close family member?**

(A few participants understand the term "loss" to cover brief or long-term separations from living persons, as, "I lost my mom when she moved South to stay with her mother". If necessary, clarify that you are referring to death only, i.e., specifically to loved ones who had died).

-----*Could you tell me about the circumstances, and how old you were at the time?*
-----*How did you respond at the time?*
-----*Was this death sudden or was it expected?*
-----*Can you recall your feelings at that time?*
-----*Have your feelings regarding this death changed much over time?*
If not volunteered earlier. *Did you attend the funeral, and what was this like for you?*
If loss of a parent or sibling. *What would you say was the effect on your (other parent) and on your household, and how did this change over the years?*
-----*Would you say this loss has had an effect on your adult personality?*
-----Were relevant How does it affect your approach to your own child?

13a. Did you lose any other important persons during your childhood?
(Same queries--again, this refers to people who have died rather than separation experiences).

13b. Have you lost other close persons, in adult years? (Same queries).

Be sure that the response to these questions covers loss of any siblings, whether older or younger, loss of grandparents, and loss of any person who seemed a "substitute parent" or who lived with the family for a time. Some individuals will have been deeply affected by.

Probe any loss which seems important to the participant, including loss of friends, distant relatives, and neighbors or neighbor's children. Rarely, the research participant will seem distressed by the death of someone who they did not personally know (often, a person in the family, but sometimes someone as removed as the friend of a friend).

If a participant brings up the suicide of a friend of a friend and seems distressed by it, the loss should be fully probed. The interviewer should be aware, then, that speakers may be assigned to the unresolved/disorganized adult attachment classification as readily for lapses in monitoring occurring during the discussion of the death of a neighbor's child experienced during the adult years as for loss of a parent in childhood.

Interviewing research participants regarding loss obviously requires good clinical judgment. At maximum, only four to five losses are usually fully probed. In the case of older research participants or those with traumatic histories, there may be many losses, and the interviewer will have to decide on the spot which losses to probe. No hard and fast rules can be laid out for determining which losses to skip, and the interviewer must use best of his or her ability to determine which losses--if there are many--are in fact of personal significance to the participant. Roughly, in the case of a participant who has lost both parents, spouse, and many other friends and relatives by the time of the interview, the interviewer might elect to probe the loss of the parents, the spouse, and "any other loss which you feel may have been especially important to you". If, however, these queries seem to be becoming wearying or distressing for the participant, the interviewer should acknowledge the excessive length of the querying and offer to cut it short.

14. **Other than any difficult experiences you've already described, have you had any other experiences which you should regard as potentially traumatic?**

Let the participant free-associate to this question, then clarify if necessary, with a phrase such as, **I mean, any experience which was overwhelmingly and immediately terrifying.**

This question is a recent addition to the interview. It permits participants to bring up experiences which may otherwise be missed, such as scenes of violence which they have observed, war experiences, violent separation, or rape.

Some researchers may elect not to use this question, since it is new to the 1996 protocol. If you do elect to use it, it must of course be used with all subjects in a given study.

The advantage of adding this question is that it may reveal lapses in reasoning or discourse specific to traumatic experiences other than loss or abuse.

Be very careful, however, not to permit this question to open up the interview to all stressful, sad, lonely or upsetting experiences which may have occurred in the subject's lifetime, or the purpose of the interview and of the question may be diverted. It will help if your tone indicates that these are rare experiences.

Follow up on such experiences with probes only where the participant seems at relative ease in discussing the event, and/or seems clearly to have discussed and thought about it before.

Answers to this question will be varied. Consequently, exact follow-up probes cannot be given in advance, although the probes succeeding the abuse and loss questions may serve as a partial guide. In general, the same cautions should be taken with respect to this question as with respect

to queries regarding frightening or worrisome incidents in childhood, and experiences of physical or sexual abuse. Many researchers may elect to treat this question lightly, since the interview is coming to a close and it is not desirable to leave the participant reviewing too many difficult experiences just prior to leave taking.

15. Now I'd like to ask you a few more questions about your relationship with your pants. Were there many changes in your relationship with your parents (or remaining parent) after childhood? We'll get to the present in a moment, but right now I mean changes occurring roughly between your childhood and your adulthood?

Here we are in part trying to find out, indirectly (1) whether there has been a period of rebellion from the parents, and (2) also indirectly, whether the participant may have rethought early unfortunate relationships and "forgiven" the parents. Do not ask anything about forgiveness directly, however--this will need to come up spontaneously. This question also gives the participant the chance to describe any changes in the parent's behavior, favorable or unfavorable, which occurred at that time.

16. Now I'd like to ask you, what is your relationship with your parents (or remaining parent) like for you now as an adult? Here I am asking about your current relationship.

----*Do you have much contact with your parents at present?*
----*What would you say the relationship with your parents is like currently?*
---*Could you tell me about any (or any other) sources of dissatisfaction in your current relationship with your parents? any special (or any other) sources of special satisfaction?*

This has become a critical question within the Adult Attachment Interview, since a few participants who had taken a positive stance towards their parents earlier suddenly take a negative stance when asked to describe current relationships. As always, the interviewer should express a genuine interest in the participant's response to this question, with sufficient pause to indicate that a reflective response is welcome.

17. I'd like to move now to a different sort of question--it's not about your relationship with your parents, instead it's about an aspect of your current relationship with (specific child of special interest to the researcher, or all the participant's children considered together). How do you respond now, in terms of feelings, when you separate from your child / children? (For adolescents or individuals without children, see below).

Ask this question exactly as it is, without elaboration, and be sure to give the participant enough time to respond. Participants may respond in terms of leaving child at school, leaving child for vacations, etc., and this is encouraged. What we want here are the participant's feelings about the separation. This question has been very helpful in interview analysis, for two reasons. In some cases, it highlights a kind of role-reversal between parents and child, i.e., the participant may in fact respond as though it were the child who was leaving the parent alone, as though the parent was the child. In other cases, the research participant may speak of a fear of loss of the child, or a

fear of death in general. When you are certain you have given enough time (or repeated or clarified the question enough) for the participant's natural occurring response, then (and only then) add the following probe:

-----Do you ever feel worried about (child)?

For individuals without children, you will pose this question as a hypothetical one, and continue through the remaining questions in the same manner. For example, you can say, now I'd like you to imagine that you have a one-year-old child, and I wonder how you think you might respond, in terms of feelings, if you had to separate from this child?" Do you think you would ever feel worried about this child?"

18. ***If you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child I'll give you a minute or two to think about this one.***

This question is primarily intended to help the participant begin to look to the future, and to lift any negative mood which previous questions may have imposed.

For individuals without children, you again pose this question in hypothetical terms. For example, you can say, "Now I'd like you to continue to imagine that you have a one-year-old child for just another minute. This time, I'd like to ask, if you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your imagined child I'll give you a minute or two to think about this one":

19. ***Is there any particular thing which you feel you learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood you had.***

Give the participant plenty of time to respond to this question. Like the previous and succeeding questions, it is intended to help integrate whatever untoward events or feelings he or she has experienced or remembered within this interview, and to bring the interview down to a light close.

20. ***We've been focusing a lot on the past in this interview, but I'd like to end up looking quite a ways into the future. We've just talked about what you think you may have learned from your own childhood experiences. I'd like to end by asking you what would you hope your child (or, your imagined child) might have learned from his/her experiences of being parented by you?***

The interviewer now begins helping the participant to turn his or her attention to other topics and tasks. Participants are given a contact number for the interviewer and/or project director, and encouraged to feel free to call if they have any questions.