# Alliance challenges in the treatment of a narcissistic patient: the case of Alex

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## ABSTRACT

People with pathological narcissism, with their conflicted sense of grandiosity and vulnerability, often pose a variety of therapeutic challenges, which may impede these patients' ability to benefit from psychotherapy. To offer a case illustration and provide insight into the intrinsic difficulties of working with this patient group, we examined the treatment of a fictional character, Alex, from the TV series In Treatment. Based on the Shedler-Westen Assessment Procedure-200 we diagnosed Alex with pathological narcissism, and evaluated the treatment process (seven sessions) by reporting on measurements of session-by-session change in explicit working alliance, implicit language alliance, and ruptures and repairs. Over the course of treatment, the working alliance (Working Alliance Inventory-Observer scale) fluctuated with a particularly low bond at session five, identified as a rupture (Rupture Resolution Rating System). Language analysis (Linguistic Inquiry and Word Count) showed that the unconscious aspects of the alliance started to deteriorate just before the rupture occurred. The results illustrate how therapists might be pulled to collude with narcissistic patients' grandiosity, with the risk of neglecting their vulnerability. This fictional portrayal of a treatment with a narcissistic patient may be widely shared with researchers, students and therapists alike, offering a common locus of scholarly attention, and an innovative tool for teaching. Given the lack of empirical treatments for pathological narcissism and the great therapeutic challenges narcissistic patients present, further research and development of clinical guidelines are warranted.

**Key words:** Narcissism; Alliance; Rupture; *In Treatment*.

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## Introduction

Patients with pathological narcissism – narcissistic traits that interfere with their well-being but that do not meet criteria for narcissistic personality disorder (NPD; American Psychiatric Association, 2013) – can present great challenges in therapy (Pincus, Cain, & Wright, 2014). Pathological narcissism may be diagnosed by various measures, including the Shedler-Westen Assessment Procedure-200 (SWAP-200; Westen & Shedler, 1999a; Westen & Shedler, 1999b; Westen, Shedler, & Lingiardi, 2003). Exact prevalence rates of pathological narcissism are unknown but estimated as higher than those of NPD which range from 0% to 6.2% in the general population (Cain, Pincus, & Ansell, 2008). High levels of narcissistic symptoms are a significant risk factor for suicidal behavior, identified in 4.7%-23% of patients who commit suicide (Pincus, Roche, & Good, 2015).Pathological narcissism encompasses two main themes of dysfunction: narcissistic grandiosity and narcissistic vulnerability (Cain et al., 2008). Narcissistic grandiosity might present as entitled attitudes, inflated self-image, and engaging in fantasies of unlimited power, superiority, and perfection (Pincus et al., 2015). A pathological grandiose self is formed by the accumulation of all the positive and idealized characteristics of the self and others, which guards the person against an enraged and empty self that is long-

ing for acknowledgment (Pincus et al., 2015). People with pathological narcissism tend to maintain their self-esteem by controlling others, denying any form of dependency on others, and devaluing those who threaten their sense of superiority. Consequentially, their interpersonal relationships are typically characterized by exploitation and distrust of others, everlasting rivalry, and cold and emotionally detached behavior (Kohut, 1984; Miller, Campbell, & Pilkonis, 2007). When narcissistic individuals interact with others who do not recognize their unrealistic needs to be admired, their vulnerability is triggered, causing them emotional pain, and a lowered shaky self-esteem (Pincus et al., 2015). This narcissistic vulnerability may result in conscious experiences of helplessness, emptiness, low self-esteem, and shame (Pincus et al., 2015). Among the two main themes of dysfunction, the grandiose part seems to be the one that elicits strong emotional reactions within therapists (Gabbard, 2013). This pattern might be the reason that therapists tend to pay more attention to their patients' grandiosity than to their vulnerability (Pincus et al., 2015), sometimes to the extent of neglecting the vulnerable part.

## Therapeutic challenges

Therapists who work with narcissistic patients may face several challenges due to the complex nature of the intra and interpersonal processes, and the lack of empirical research to guide the therapist (Magnavita, 2018). At the start of treatment, narcissistic patients are often reluctant or lack motivation to participate, and they may not want to collaborate with their therapist (Ronningstam, 2012). Even when narcissistic patients continue the treatment, their narcissistic traits, such as grandiosity, low self-esteem, and emotion dysregulation, pose a burden on the formation of a therapeutic alliance (Ronningstam, 2017). First, any slight injury of the fragile self may create an explosive situation, with impending risk of premature termination of the treatment (Gabbard, 2013). Second, narcissistic patients are more likely to test limits by trying to provoke and control the therapist rather than to express appreciation for their therapist who tries to help them (Ronningstam, 2012). Patients with pathological narcissism also tend to evoke strong reactions within therapists, which may further challenge the therapeutic alliance (Gabbard, 2013). For example, therapists might feel useless as their narcissistic patients tend to talk *at them* and not *to them*. Further, therapeutic challenges may also arise when narcissistic patients treat their therapists as if they were an extension of themselves. As such, they do much to prevent separation, by not allowing therapists to make comments that challenge such fusion, and they may erupt in a narcissistic rage when therapists do not comply with expectations (Gabbard, 2013). Because of these multiple challenges in the treatment of patients with pathological narcissism, it seems important to consider aspects of the therapeutic alliance in more detail.

The importance of the therapeutic relationship in the psychotherapy process is illustrated by the vast number of clinical writings on alliance. Further, a recent meta-analysis found that the relation between alliance and treatment outcome is positive and robust, regardless of the researchers' clinical orientation, alliance and outcome measures, treatment modalities, location, and patient characteristics (Flückiger, Del Re, Wampold, & Horvath, 2018). Given that narcissistic patients may be less inclined to share their vulnerability and admit their need for other people, it might be relevant to not only focus on the explicit aspects but also examine more implicit aspects of the alliance, not captured by traditional observer-rated measures. Understanding the unconscious alliance – *i.e.*, the extent to which the therapist and the patient are implicitly relationally-congruent, may thus provide a deeper understanding of the quality of their relationship (Lord, Sheng, Imel, Baer, & Atkins, 2015). Moreover, deteriorations in the alliance between the therapist and the patient, defined as alliance ruptures, may also be particularly relevant to patients with pathological narcissism. Alliance ruptures are evidenced in decreased collaboration on goals or tasks, or a strain in the emotional bond (Eubanks, Muran, & Safran, 2018). According to Safran and Muran (2000), ruptures can range from subtle tension (*e.g.*, patient passively accepting interpretation) to a more explicit tension (*e.g.*, patient rejecting the necessity of a given task). Ruptures may be repaired through a resolution process, such as changing tasks or disclosure of the therapist's internal experience, which enables therapists and patients to renew or support their emotional bond, and collaborate on the tasks and goals of therapy. Successful rupture-repair is associated with good outcome in therapy (Eubanks et al., 2018).

## Aims

In order to illustrate a clinical phenomenon that might be unique to the treatment process with patients with pathological narcissism, we aimed to provide a detailed description of the treatment process of the fictional case of Alex from the TV Series *In Treatment*. We chose this case description to illustrate the challenges inherent to narcissistic psychopathology, specifically therapists' gravitation toward addressing patients' grandiosity at the expense of neglecting their vulnerability. We believed that the immense grandiosity of narcissistic patients draws therapists' attention, making them unavailable to address other issues emerge in the therapeutic dyad. Although the fictional-seven-treatment sessions of Alex could have been explored through many lenses, we focused on three aspects of the therapeutic alliance that might be particularly relevant to patients with pathological narcissism: the explicit observed working alliance, the implicit alliance communications, and the alliance ruptures and subsequent repairs. We hypothesized that the therapeutic alliance (both explicit and implicit) and the level of ruptures and repairs at the start of treatment would be relatively neutral

as the therapist and patient are cautiously getting to know each other. Given the intra and inter personal difficulties in patients with pathological narcissism, we then expected the patient's grandiosity to surface and evoke the therapist's countertransference, leading to a deterioration of the (explicit and implicit) alliance and an increase in ruptures and incomplete repairs over the course of therapy.

## Methods

### Clinical case

In the TV series *In Treatment* (a TV production by Garcia, 2008), we meet the character of Alex, an African-American male, married with two children, a seven-year-old boy and a nine-year-old girl. Alex served as a combat pilot in the US Navy and was involved in a failed operation in Iraq, when he dropped a bomb on a madrasa in Baghdad that killed 16 civilians. Since this incident Alex became known in the Arabic media as *The Madrasa Murderer* and is wanted by a local armed group. Alex is traumatized by this mission that went wrong and arrives in therapy to discuss his stated wish to return to the bombing site despite his family and friends' objections. All we know about Alex is taken from the description of the TV series, as well as from watching the seven episodes on the treatment of Alex; no previous papers have been published specifically on the treatment of Alex.

Alex' therapist, Dr. Paul Weston, is portrayed as a white male psychologist in his early 50's. He is married but currently in the process of divorcing his wife. They have two children, who complain about his alienation and aloofness from the family (Garcia, 2008). We learn from Greenberg's (2011) examination of the therapies conducted by Dr. Paul Weston in the TV series, that this fictional therapist likely received psychoanalytic education and used a classic analytic-Rogerian therapy approach. In the TV series, it appears that the therapist works at the Washington-Baltimore Psychoanalytic Institute, and sees patients for fifty-minute sessions, on a weekly basis, at his private practice on the ground floor of his home. He uses psychodynamic elements, including exploring the here and now, and makes transference interpretations, and also incorporates elements of Rogerian therapy such as being supportive and person-centered. Frequently he responds to questions with questions, makes interpretations, and shows variable alterations in temperament. The therapist appears as a healer who strives to help others while experiencing many personal issues. At some point, he seeks help from his previous supervisor as he is *losing patience with patients*. He presents several professional deficits as countertransference behaviors and ethical failures (Greenberg, 2011).

### Alex's treatment

Alex appears to seek therapy because he plans to return to the bombing site and wants to hear from a therapist that his wish to return to the bombing site is not insane. Although the deadly accident was caused by faulty military intelligence, Alex appears to deal with intense feelings of guilt that he is unable to rationalize away. He is drawn to therapy with therapist *Paul* because of his reputation as *the best*. During the treatment, Alex examines his ruthless desire to excel and to never disappoint others, his futile relationship with his wife, his painful relationship with his father, and his enigmatic relationship with his son. Over the course of his treatment, Alex develops an intense relationship, full of ruptures, with his therapist. At some point in session 5, during one of the ruptures, Alex harshly demeans the therapist, and the therapist goes so far as to physically attack Alex. A session later they discuss the violent incident, and in session 7, Alex terminates the therapy because he wants to return to full service in the navy, despite the therapist's warning that he is still not ready. Alex and his therapist agree that when Alex feels the need for more therapy in the future, the therapist will see him. The last episode indicates that soon after Alex terminated his treatment, Alex lost his life during a flight training exercise. Although it is not clear whether or not Alex committed suicide, there are a number of general hints, including the possibility that he unconsciously chose to return to active duty before he was ready to fly again.

### Measures

#### *Shedler-Westen Assessment Procedure-200*

Alex's personality style was assessed using the SWAP-200 (Westen & Shedler, 1999a; Westen & Shedler ,1999b; Westen et al., 2003), an assessment instrument designed to bridge the gap between the clinical and empirical traditions in personality assessment. The SWAP-200 is a Q-sort instrument that includes 200 descriptive statements describing both pathological and health aspects of personality. The statements are sorted into eight categories, ranging from 0 (irrelevant to the patient) to 7 (highly descriptive of the patient). SWAP-200 statements are written in a manner close to the data (*e.g.*, *Tends to be passive and unassertive* or *Living arrangements are chaotic and unstable*) and items that require inference about internal processes are written in clear and unambiguous language (*e.g.*, *Is unable to describe important others in a way that conveys a sense of who they are as people; descriptions lack fullness and color* with *Tends to blame others for own failures or shortcomings; tends to believe his or her problems are caused by external factors*). Reliable descriptions with the SWAP-200 have been obtained from clinicians from a variety of theoretical orientations (Westen & Shedler, 1999a; Westen & Shedler, 1999b; Westen et al., 2003). Clinician ratings are converted to T scores (M=50; SD=10) for each of the DSM–4 PDs, and for an alternative set of empirically-based personality syndrome scales. The scales can be used categorically and/or dimensionally, with T scores from 55 to 59 indicating PD features or clinically significant features, whereas a T score of 60 or above warrant a full PD or personality

syndrome diagnosis, depending on the set of scales employed. The SWAP-200 also produces a trait dimension profile, which gives scores for 12 personality factors or trait dimensions. The SWAP-200 scales have good internal consistency (Westen & Shedler, 1999a; Westen & Shedler, 1999b), interrater reliability (Marin-Avellan, McGauley, Campbell, & Fonagy, 2005), and convergent/discriminant validity (Marin-Avellan et al., 2005).

***Working Alliance Inventory-Observer Scale***

The Working-Alliance Inventory (WAI; Horvath & Greenberg, 1989) is one of the most frequently used instruments in the therapeutic alliance literature (Horvath & Bedi, 2002). It is based on Bordin's (1979) conceptualization of the working alliance, consisting of three subscales: affective bond, agreement on tasks, and agreement on goals. The subscales provide separate scores for each of the three domains they measure and a global score of the working alliance. Items are rated on a Likert scale ranging from 1 (*never*) to 7 (*always*) with 2 (*rarely*), 3 (*occasionally*), 4 (*sometimes*), 5 (*often*), and 6 (*very often*) between the two extremes. The observer version is adapted from the client and therapist forms by altering the pronouns to fit an observer perspective (Tichenor & Hill, 1989). Various studies of the Working Alliance Inventory-Observer scale (WAI-O; Tichenor & Hill, 1989) have demonstrated high internal consistency (α=.93; Horvath & Greenberg, 1989), predictive validity, and interrater reliability (*e.g.*, an intraclass correlation coefficient of .92 in Tichenor & Hill, 1989). Observers are to assume a good alliance and therefore subtract from the rating when negative evidence is present and add to the rating when positive evidence is present. This means that ratings for all items start at 4 (*sometimes*), the middle point of the scale that means *no evidence* (Horvath & Greenberg, 1989).

***Language Style Matching***

The Language Style Matching (LSM; Ireland & Pennebaker, 2010) is a synchrony index that calculates the degree to which two or more participants are producing similar rates of function words (*e.g.*, pronouns, prepositions, and conjunctions) in their dialogue. The calculations of the LSM metric (Gonzales, Hancock, & Pennebaker, 2010) for each dyad are based on the number of words in each category of function words that are identified in the transcribed session for the two people separately. High LSM suggests that the people in the dyad pay attention to one another, are engaged or involved with each other (Pennebaker, 2011), and subtly influence one another, implying a heightened level of an unconscious alliance. The range of LSM scores within psychotherapy training on standardized patients is .42-.52 (Lord et al., 2015), and in sessions of a twelve-session-manualized treatment for substance dependent mothers is .88-.89 (Borelli et al., 2019). There is consistent evidence that LSM increases as two individuals interact over time (Borelli et al., 2019), and that it is related to qualities of the relationship, *e.g.*, Lord et al. (2015) found that higher LSM was related to more empathy in therapists. These two preliminary applications of LSM to 122 Motivational Interviewing training sessions and 84 sessions of manualized short-term psychodynamic therapy suggest that more empathetic therapists have higher levels of LSM and that LSM reflects a relationship quality in psychotherapy, that is important for post treatment symptom reduction.

***Rupture Resolution Rating System***

The Rupture Resolution Rating System (3RS; Eubanks, Muran, & Safran, 2015) is an observer-based coding system of alliance ruptures and resolution strategies. The 3RS includes codes for markers of two categories of ruptures: confrontation ruptures, in which the patient moves against the therapist or the work of therapy (*e.g.*, complaining about the therapist or attempting to control the therapist); and withdrawal ruptures, in which the patient moves away from the therapist or the work of therapy (*e.g.*, by changing the topic or speaking in an overly abstract, intellectualized manner). Resolution strategies are therapists' attempts to repair the rupture, and include both immediate efforts to renew collaboration (*e.g.*, changing a task the patient finds objectionable) and efforts to explore the rupture (*e.g.*, inviting the patient to share his or her thoughts and feelings about the rupture, and acknowledging the therapist's contribution to the impasse). After rating the occurrence of rupture markers and resolution strategies, the coders rate the clinical impact of rupture markers and resolution strategies on the therapeutic relationship using a Likert-type scale, ranging from 1 (No Significance, indicating that no rupture markers or resolution strategies, or only very minor ones, appeared and did not impact the alliance) to 5 (Very High Significance, indicating that rupture markers or resolution strategies occurred and had a noteworthy impact on the alliance). Between these two extremes (1-5) there are the scores of 2 (Possible but Unclear Significance, indicating that rupture markers or resolution strategies might have occurred and have possible impact), 3 (Moderate Significance, indicating that rupture markers or resolution strategies occurred), and 4 (High Significance, indicating that significant rupture markers or resolution strategies occurred and had a substantial impact on the alliance). In this paper, the authors calculated the weighted frequency of rupture markers and resolution strategies at each of the sessions by multiplying the occurrence of rupture markers and resolution strategies by their impact rating. After watching an entire session, coders also made overall ratings of the extent to which ruptures in the session were resolved, and the extent to which the therapist contributed to ruptures in the session, using 5-point Likert-type scales. The 3RS has demonstrated good to excellent interrater reliability using graduate student coders (inter-class correlation coefficients ranging from .73 to .99) for the frequency of

rupture markers and resolution strategies, rating as well as the ratings of clinical impact (Eubanks, Lubitz, Muran, & Safran, 2019).

### Procedures

All seven sessions of the treatment of Alex were viewed by all authors. After viewing all seven sessions, the first author completed a personality assessment (SWAP-200) to assess the narcissistic personality traits of Alex. Then, two quantitative process measurements were applied based on the videos (WAI-O and 3RS). The first and second author completed an observer rating of the therapeutic alliance for each session, resulting in an average score per session (interrater reliability ICC=.92). Also, a team of four trained research assistants, together with the third author (one of the developers of the 3RS measure) coded the frequency and nature of the ruptures and repairs that occurred in these sessions; final codes were based on consensus. Subsequently, the seven treatment sessions were transcribed (LSM) by the first author according to the psychotherapy transcription standards outlined by Mergenthaler and Stinson (1992). To calculate the function word usage within the therapeutic dyad, the transcripts were segmented by speaker, separating therapist utterances from patient utterances into separate documents. Then, the two text files of each verbatim transcript per session were manually edited according to the guidelines put forth by Pennebaker, Boyd, Jordan, and Blackburn (2015) in the Linguistic Inquiry and Word Count (LIWC) coding manual. For example, *filler* words (*e.g.*, *like*) and *nonfluencies* (*e.g.*, *um*) were marked so that they would be treated as fillers rather than as content words. The second author then analyzed the edited patient and therapist texts for each session with the computerized text analysis program LIWC (Pennebaker et al., 2015). LIWC calculates the percentage of total words in a text that fall into function word categories. The total LSM score for each of the seven sessions for each patient-therapist dyad was then calculated as the absolute value of the difference between proportions for a patient and a therapist (|(Function Word Patient – Function Word Therapist)|) for each function word category. This value was then divided by the combined function word category proportion (Function Word Patient + Function Word Therapist) for the dyad. Finally, this value was subtracted from 1, following the equation: LSM word category = 1 – [(Function Word Patient − Function Word Therapist)/(Function Word Patient + Function Word Therapist)]. This calculation was repeated for the other eight function word categories for each dyad at each of the seven therapy sessions. The nine category-level LSM scores were then averaged to yield a composite LSM score bounded by 0 and 1, where higher numbers represent greater stylistic similarity between the patient and therapist, following the equation: LSM Total = (LSM word category 1 + LSM word category 2 + ⋯ + LSM word category 9).

## Results

### Alex's personality assessment

Alex's Overall Personality Health Score (60.3) indicates a high level of overall functioning. Individuals scoring in this range typically possess substantial ego strength, *e.g.*, the ability to use their own talents productively and effectively, and their interpersonal resources and capacities are evident across multiple life domains, *e.g.*, the ability to assert themselves appropriately when necessary.

Furthermore, the SWAP-200 showed elevated scores on the DSM personality disorder scale for NPD (57.3), indicating narcissistic features, as well as on the SWAP Personality Syndrome scale (68.1), indicating narcissistic personality. This diagnosis of pathological narcissism was characterized by various depictions, including *appears to feel privileged and entitled*, *expects preferential treatment*, *has an exaggerated sense of self-importance*, *has fantasies of unlimited success, power, beauty, talent, brilliance*, *etc.*, *tends to be arrogant, haughty, or dismissive*, *expects self to be 'perfect,'* and *tends to get into power struggles*.

### Alliance

On the WAI-O, Alex and his therapist demonstrated an overall neutral working alliance, around the score of 4 (M=4.02 SD=.33, ranging from 3.44 to 4.50) that indicates neither positive elements nor negative elements in the alliance (Figure 1). Alex and his therapist showed relatively low levels of agreement on tasks (M=3.86 SD=.26, ranging from 3.58 to 4.33), low levels of bond development (M=3.88 SD=.72, ranging from 2.75 to 4.67), and high levels of agreement on goals (M=4.33 SD=.24, ranging from 4.00 to 4.67). It appears that, over the course of treatment, the bond development subscale showed the most variability and reached its lowest score at session 5 (2.75).

### Language Style Matching

The average unconscious language style matching between Alex and his therapist throughout the treatment was .87 (SD=.03), similar to matchings between patients and therapist in the other studies that have employed this measure (.88-.89). This average matching ranges from the lowest score of .83 (a score characterizing communications between acquintances) at session 6 to the highest score of .91 (a score characterizing communications in romantic relationships) at session 4 (Figure 2).

To illustrate the unconscious verbal matching we chose to focus on sessions 4 and 6. In these sessions the unconscious verbal matching was the highest and the lowest, respectively. In session 4 the unconscious verbal matching was 0.9, as evidenced in higher attunement, *e.g.*, when the therapist empathized with Alex, *Must have been very complex experience for you being with another woman after all this time*, and Alex accepted his thera-

pist's comfort, *Complex. Right. I gave a shitty performance...I started thinking about my first date with my wife Michaela about fifteen years ago. Jesus...* In session 6 the unconscious verbal matching was 0.83, as evidenced in less attuned moments, *e.g.*, when the therapist tried to explore Alex's self-perceptions, *So, do you think that there is something about you, something obvious that people see?* and Alex responded in a way that indicates that he was in another place, deeply preoccupied with his negative feelings towards the therapist, *You probably wanted to strangle me the first time…you finally got a chance to show your hatred for people like me.*

### Ruptures and repairs

On average, in each treatment session, the weighted frequency of rupture markers was 20.14 rupture markers (SD=4.40), ranging from 15.5 at session 7 to 29 at session 1, and the weighted frequency of resolution strategies was 11.42 (SD=4.80), ranging from 5.5 at session 7 to 18 at session 5. As such, the rupture markers were more frequent than the resolution strategies (Figure 3). A recent validation study of the 3RS, which analyzed 42 cases of cognitive behavior therapy, found that, on average, 12.68 rupture markers and 5.05 resolution strategies were identified per session (Eubanks et al., 2019).

The degree to which ruptures were resolved over the course of the treatment was rated as being below that of a *typical* therapy (M=2.14, SD=.69, Figure 4). Also, it appeared that the therapist caused or exacerbated ruptures in the treatment to some extent (M=2.71; SD=1.38), with scores indicating that the therapist had most of the responsibility for the ruptures during session 5 (score of 5, *Very High Significance*) in which he physically attacked Alex (Figure 4).

In session 1, there were mainly rupture markers of confrontation (19.5). The ones with the highest clinical impact ratings (5, *Very High Significance*) were rejection of the therapist intervention (*e.g.*, when Alex rejected his therapist's interpretation: *No, no, that's not - How much longer do we have?*), complaints about the therapist (*e.g.*, when Alex criticized him: *you have no patience. I was told you're a good listener,*) and efforts to control the therapist (*e.g.*, when the therapist asked Alex's opinion, and Alex responded with: *I'll come to that in a minute*) The



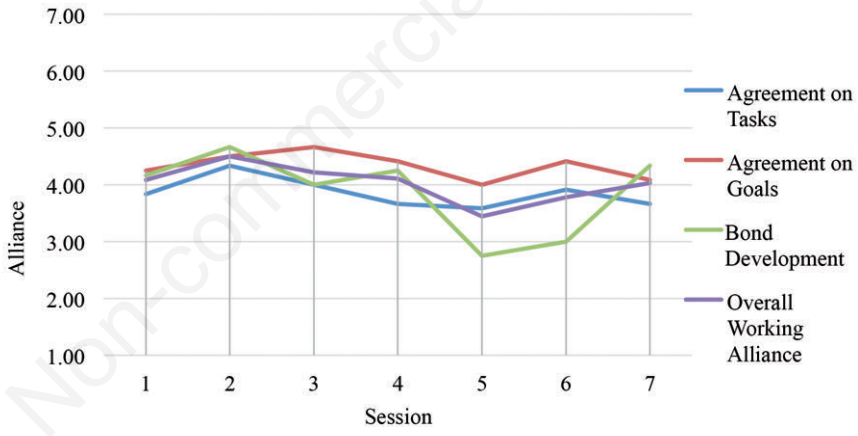


**Figure 1. Changes in the observer-rated alliance throughout the therapy.**

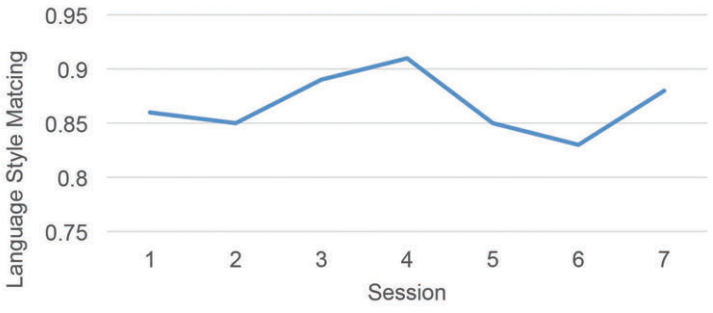


**Figure 2. Changes in the level of average language style matching between Alex and his therapist throughout the treatment.**

resolution strategy with the highest clinical impact (4, *High Significance*) in this session was the therapist's invitation to discuss Alex's thoughts about the therapy (*e.g.*, *you think it is too soon?*) Overall, in this session a *below average* degree of rupture resolution was achieved.

Also in session 2, there were mainly confrontational rupture markers (11.5), and the ones with the highest clinical impact ratings (4, *High Significance*) were complaints about the therapist (*e.g.*, when Alex remarked: *I do not get what you are telling me. Feelings are not a philosophy. You feel or you do not. You cannot bullshit about it*) and efforts to control the therapist (*e.g.*, when Alex was disappointed in what the therapist told him: *You are supposed to be smarter than me*), The resolution strategy with the highest clinical impact (5, *Very High Significance*) in this session was the therapist's disclosure of his internal experience of the interaction with Alex (*e.g.*, *so we are competing to see who is the smartest?*). Also in this session, there was a *below average* degree of rupture resolution.

Similarly, in session 3 rupture markers were mostly confrontational (13), and the ones with the highest clinical impact ratings (5, *Very High Significance*) were complaints about the therapist (*e.g.*, when Alex asked his therapist: *Are you making fun of me?* in response to the therapist's attempt to challenge Alex's perception of his son), and efforts to control the therapy (*e.g.*, when Alex took a call in the midst of the therapy). Also, in this session, the most significant resolution strategy (4, *High Significance*) was the therapist's disclosure of his internal experience of his interaction with Alex (*e.g.*, when the therapist told Alex: *OK. I think we have started therapy, Alex,* as Alex just acknowledged that he is in therapy after several implied comments that denied his need of help). In this session, a *below average* degree of rupture resolution was achieved.

In session 4 the dominant rupture markers were also mainly confrontational (13.5) and the ones which the highest clinical impact ratings (5, *Very High Significance*) were complaints about the therapist and efforts to control the therapy. However, this time Alex's attempts to defend himself against the therapist was also significant (4, *High Significance*) (*e.g.*, when Alex discussed with his therapist the



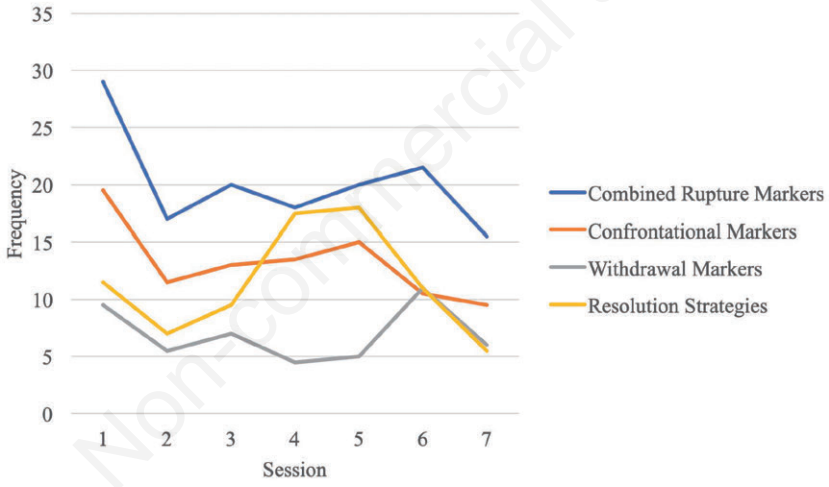


**Figure 3. Changes in the occurrence of rupture markers and resolution strategies throughout the treatment.**

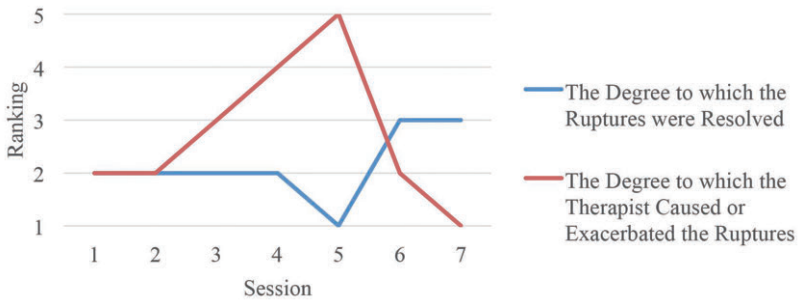


**Figure 4. Changes in the degree of resolution and in the degree of the therapist's responsibility over the course of the treatment.**

night he had spent with the other patient for whom the therapist has erotic feelings, Alex tried to show that the woman used him – *you don't think she belittles me* – while the therapist tried to defend her behavior.) In this session, the most significant (5, *Very High Significance*) resolution strategy was a change of the task as the therapist allowed a break. Also here the degree to which the ruptures were resolved over the course of the session was *below average*.

In session 5, there was a very significant deterioration in the alliance between Alex and his therapist. Although the ruptures were of the same type and sort, their magnitude seemed to be higher (15 confrontational markers), culminating in patient and therapist engaging in a physical altercation and a harsh verbal exchange. Alex accused his therapist of wanting his patients to think that he is flawless, and then started to insult him and to expose the therapist's personal issues. When Alex raised the issue of the erotic feelings that the therapist had for one of his patients, the therapist lost his temper and attacked Alex: *How fucking dare you? You prick.* In this session, the most significant (5, *Very High Significance*) resolution strategies were the therapist's disclosure of his experience of the interaction with Alex (*e.g.*, when the therapist confessed that his work with Alex is challenging for him: *Do you really think not judging you is easy, Alex?*) as well as linking the current rupture to larger interpersonal patterns between others and Alex (*e.g.*, when the therapist connected Alex's experience in therapy to the way he reacts to his father: *but that's still a reaction to him*). As expected, the degree to which the ruptures were resolved over the course of this session was poor.

In session 6, the most prevalent rupture markers were withdrawal (11), and the most significant one (5, *Very High Significance*) was shifting the topic of discussion (*e.g.*, when Alex was discussing his experiences with a gay friend, and suddenly changed the topic: *He told me once, 'I didn't know the meaning of life until I got fucked in the ass.' I once read that, psychologically, water symbolizes emotions*). Also in this session, the most significant (5, *Very High Significance*) resolution strategy was the therapist's disclosure of his internal experience of his interaction with Alex (*e.g.*, when the therapist explained why he behaved disrespectfully to Alex: *I felt offended, hurt, cruelty*). However, the degree to which ruptures were resolved over the course of this session was average.

Lastly, in session 7, the rupture markers were mostly confrontational (9.5), and the ones with the highest clinical impact ratings (5, *Very High Significance*) were around issues of control (*e.g.*, when Alex urged the therapist to cooperate with his plan to return to fly, *Paul, don't fuck me up with this navy shrink. Please. Don't take my world away from me*). The most significant (4, *High Significance*) resolution strategy was again the therapist's disclosure of his experience with Alex (*e.g.*, *It makes me feel like you're asking me to share responsibility for another major decision in your life*). Over the course of this session, the ruptures were moderately resolved.

## Discussion

Within clinical practice, patients who present with narcissistic personality traits pose a variety of therapeutic challenges that may impede the patient's ability to benefit from psychotherapy. To illustrate these clinical difficulties, we examined the alliance in a seven-session treatment of a fictional character, Alex, a helicopter pilot from the TV series *In Treatment*. A personality assessment indicated that Alex displayed pathological narcissism. The observer rated-alliance scores revealed that Alex and his therapist had an overall lukewarm working alliance, with a relatively higher agreement on goals than agreement on tasks or levels of bond development. Over the course of the treatment, their working alliance seemed to fluctuate somewhat; they experienced unstable unconscious alliance, illustrated by a reduction in language style matching between Alex and his therapist. Rupture and resolution analysis suggested a similar pattern as they experienced several ruptures, that were exacerbated over the course of the treatment to the extent that they had a physical altercation in session 5.

Based on observing the patterns of the three alliance measures (WAI-O, LSM, and 3RS), the treatment can be divided into three main phases: The initial period (sessions 1-3); the middle period (sessions 4-5), and the termination period (sessions 6-7) (It should be noted that the WAI-O may not completely capture withdrawal ruptures (Dolev et al., 2018), and therefore some discrepancies between the 3RS and the WAI-O may be expected with the 3RS finding more ruptures). Each phase appeared to have its own alliance characteristics reflected by the quality of the observed working alliance, the unconscious matching between patient and therapist language style, and the observed ruptures and repairs.

In the initial phase of the treatment (sessions 1-3), it seems that Alex and the therapist started off with a neutral working alliance (overall working alliance scores of 4.08, 4.50 and 4.22, respectively). This fairly neutral level of alliance at the beginning of treatment was also reflected in the level of language style matching (0.85-0.89), which was similar to the scores reported in the other two psychotherapy studies (Borelli et al., 2019; Lord et al., 2015) and falls between LSM scores for more distant communications with strangers (.75) and conversations in romantic relationships (.95). The working alliance was relatively neutral despite the high rate of rupture markers (29, 17, and 20, respectively) at the start of treatment. The ruptures were most significantly manifested in Alex's rejections of the therapist's interventions (significance of 5), *e.g.*, at session 1 when Alex rejected his therapist's interpretation: *Excuse me? Don't you think you're exaggerating a little? I explained something simple…what's that got to do with Daniel?* and in Alex's attempts to control the therapy (significance of 5), *e.g.*, at session 1 when Alex explicitly tells his therapist to keep at his pace: *Don't try to get ahead of*

*me*. In response to Alex's seemingly resistant stance, the therapist uses a sarcastic statement at session 1: *in my profession, we say that the customer is always wrong*, which could indicate the therapist's initial negative countertransference feelings towards Alex's attitude in therapy. The alliance in this phase was strongest with regards to the agreement on goals (4.25, 4.50, and 4.67, respectively), which might be reflected by Alex's possible positive expectations of therapy, and excitement and curiosity about this new intellectual challenge. Maybe Alex started in a state of idealization, *e.g.*, when Alex told his therapist: *I was told you were the best, a man in tune with everything around him*. This could also be interpreted as pressuring the therapist that he better be good because Alex will only associate with the best, preferring to ignore possible sources of disharmony that appeared present in the relatively lower score of bond development (4.17, 4.67, and 4.00, respectively) and agreement on tasks (3.83, 4.33, and 4.00, respectively). It might also be that the attention the therapist paid to Alex's time in Baghdad, a trip that his friends and family all objected to, confirmed his sense of grandiosity.

Over the following two sessions (4-5), we get the impression that there is a deterioration in the alliance between Alex and his therapist. Possibly during this phase, idealization, high expectations and curiosity might have faded, with Alex more likely to reveal more of his *true colors*, and the therapist becoming less able to tolerate Alex's grandiosity and treat his vulnerability. This possible pattern of deterioration in alliance might be indicated by the decrease in the overall quality of the working alliance (4.11 and 3.44, respectively). Also the level of language style matching in session 4, which is the highest of all the sessions in Alex's therapy, may indicate a deterioration during this phase. As language style matching indicates the extent to which two sides are engaged in reciprocal verbal exchange, such a high rate may suggest a high engagement in the ruptures that Alex and the therapist had. The elevated frequency of ruptures in these two sessions (18 and 20, respectively) points to a deterioration in the alliance. The ruptures during these sessions appeared to occur among various themes related to narcissistic traits, *e.g.*, in session 5, Alex and his therapist had a rupture related to attempts to control the therapist (significance of 5): *That's another brilliant theory there, Doc., but how about you, Paul? ...I even read a book...about how everything that goes on in here should be reciprocal. So it made me think- you sit here, you listen to me and you pretend to solve all my problems. But you don't have a fucking clue about yourself. So, I figured: Hey, I got a choice: Either I accept your superiority as if you're some kind of god, or I use my intelligence and do a little investigating, just to make sure that this god is not some kind of Dr. Ruth who, uh, tells everybody how to fuck while she's still a virgin…* Comparing his therapist to Dr. Ruth might put the therapist in a negative light, which is likely to improve Alex's position relative to the therapist. Alex may have felt the need to put the therapist down because he was having difficulty tolerating the therapeutic situation, in which he was not in control. It seems that at this mid-stage of treatment Alex was very vulnerable, and at the same time, the therapist was pulled into a negative countertransference response towards him. It is possible that the negative countertransference was evoked in response to Alex's accusations of his therapist being a hypocrite and the personal attack Alex made by highlighting the therapist's inability to manage his personal life (from session 5): *I found a hell of a god in my investigations. A god whose life is falling apart. Whose wife is sleeping around behind his back. Whose daughter is fucking junkies. Whose father, yeah, whose father is rotting away in some geriatric hospital...And you, you fall in love with that crazy slut*. This rupture (significance of 5) seems to have triggered so much anger in the therapist, that the therapist physically attacked Alex. He pushed Alex against a bookshelf and poured a glass of water on him, saying that he would never tolerate insults against his patients. During these moments, we see the therapist missing Alex's vulnerability. As much as Alex is pushing his therapist and hitting him in his own vulnerable spots, the therapist is becoming too enraged to see where the patient is vulnerable and what has led him to act so maliciously. The therapist did nothing to explore what had led Alex to do research about his life and become so hostile toward him. Perhaps such exploration could have exposed Alex's vulnerability and enable the therapist to address it.

During the termination phase of the treatment (sessions 6-7), the alliance between Alex and his therapist appeared to re-establish itself, as was identified by the increase in the scores of the overall working alliance (3.78 and 4.03, respectively) and the unconscious matching of language style (.83-.88) towards the initial level. The relatively high rupture score in session 6 (21.5) may not appear to reflect new experiences of ruptures, but might be explained by the fact that during this session, Alex and his therapist discussed the physical altercation that occurred during session 5, *e.g.*, when Alex explained to his therapist why he had decided to return: *It's a survival tactic… I've been trying to understand- why you're all so afraid of me.* In the very last session, the number of rupture markers reached its lowest level (15.5) and this was also the only session in which the therapist was not observed to cause or exacerbate any ruptures. In both of these two last sessions, the degree to which ruptures were resolved was higher than in the previous sessions (score of 3). This improvement in alliance and increase in rupture resolutions might be explained by them trying to undo the harm caused in session 5, given their mutual disclosure of vulnerability and/or by fear of the looming termination of treatment. This might be illustrated by the therapist's self-disclosure (significance 5 of a resolution strategy) in session 6 when they discussed the violent in-

cident in the previous session: *You're right. You're absolutely right. I apologize. It should not have happened. But I felt very offended by what you said*. Despite the optimistic note with which Alex and the therapist conducted theses two sessions, there were no attempts by the therapist to address Alex's vulnerability. Even when the two discussed their actions and reflected upon their appropriateness, the therapist missed this crucial aspect of Alex's personality as if he intentionally ignored it.

This challenging treatment process illuminates the way therapists of narcissistic patients might be drawn into friction with the grandiosity of their patients while neglecting their vulnerability, which, in fact, may lead to catastrophic consequences. It appears that, throughout the treatment, the therapist was drawn again and again to ruptures that have evolved from Alex's grandiosity. At the same time, it seems that the therapist has not dedicated enough resources to analyze and treat Alex's vulnerable sides, including his weak self-image and the source of his over-striving to achieve power throughout his life. This pattern of alliance challenges, as indicated by the three different measures of the therapeutic process, appears to suggest that Alex's relationship with his therapist was negatively impacted by Alex's narcissistic tendencies all along. From the very beginning of therapy, when Alex displayed a narcissistic expectation of receiving special treatment from his therapist, a tension in the therapeutic relationship was observed as the therapist felt the need to clarify himself and how therapy works. At this point the therapist also had to overcome a rupture that occurred because he did not recognize Alex and was not smart enough to accurately grasp one of Alex's thoughts, according to Alex. Throughout the treatment, Alex's repeated demonstrations of his grandiosity (*e.g.*, emphasis of his own skills in various domains, including his performance in the military, his sexual abilities with women, and his general knowledge) triggered many quarrels; many times possibly because the therapist could not handle well the strong emotions that Alex might have evoked within him. A clear instance of this pattern might be Alex's discussion of the therapist having sex with another patient, evoked by unmanaged erotic countertransference. Also, Alex's great difficulty empathizing with his therapist (another narcissistic trait) seemed to affect the way the therapist related to Alex, *e.g.*, when Alex did not understand that overpayment is inappropriate and insults the therapist, the therapist was irritable with Alex, responding to Alex impatiently. Also Alex's narcissistic vulnerability appeared to affect the way the therapist treated him as the therapist made numerous harsh interpretations of this tendency that seemed to be very painful to Alex and constantly cut the treatment's smooth flow. Perhaps if the therapist were not drawn to counter the grandiose side of Alex, he could be more open to treat the significant themes that Alex had brought to the treatment room and particularly treat his vulnerable side. Further, it seems reasonable to assume that if the most severe ruptures were avoided, and the less severe ruptures more effectively repaired as ruptures can never be entirely avoided, the therapist could have had a stronger alliance with Alex and maybe convince him to stay in therapy. Given these observations, we believe that this fictional case example of Alex accurately illustrates some of the difficulties experienced in the therapeutic alliance with narcissistic patients and how their therapist may be responding to such pathology ineffectively.

This case illustration, although highlighting the importance of the topic, is limited in several ways. First, this case study reflects a fictional therapeutic process rather than a real-life patient-therapist dyad. Arguably, Alex was presented as a neat and well-formed patient and sensationalized aspects of the treatment unfolded in dramatic fashion in response to the therapist, a shoot-from-the-hip protagonist. This also means that the three measures of alliance reported in this paper are not based on speech from two actual, separate people, but reflect the screenwriter's words. However, in our view, the basic human experiences that the screenwriter infuses in this character of Alex (with the help of licensed psychologists; Baht, 2010) poignantly capture narcissistic psychopathology and crystalize the ways in which subtle, and not so subtle, interactions between the therapist and the narcissistic patient challenge the building of a therapeutic alliance.

Second, this case study includes only process ratings, and lacks information about outcome measurements during and after therapy, or at follow-up. If this case were real, it would be important to include such measures and to relate specific alliance changes with outcome. Although the process research measures we applied (WAI-O, 3RS, and LMS) are clinically valuable in that they give the reader an insight into the dynamics between the therapist and Alex throughout the process of the treatment, interpretations based on these quantitative data are limited due to the lack of normative data and cutoffs scores. Also, this process analysis was limited by the availability of only seven treatment sessions, and therefore only provides a snapshot of a normally much longer treatment process. Moreover, given the post-hoc nature of the process analyses only observer-rated and computerized measures of alliance could be applied. This means that the perspectives of the therapist and the patient himself were missing from this case illustration.

Despite its obvious limitations, this study is innovative in two ways. First, it applies a new computerized measure of text-analysis, possibly operationalizing the unconscious alliance reflected by the matching of function word use between therapist and patients. This perspective of language style matching complements the two other more frequently reported measures of the therapeutic alliance process (WAI-O and 3RS) and allows for triangulation of the collected alliance data. Second, the use of widely available streaming videos from a TV series in order to illustrate the psychotherapy process is unique and possibly very appealing to therapists in training world-wide. In

order to build our understanding of this case further, future researchers and clinicians may freely examine the exact same videos and transcripts and complement the reported process analyses with other observer measures of therapeutic process. Given the current lack of clinical and empirical guidelines around working with narcissistic patients, this case illustration might offer a useful teaching tool in graduate training programs in psychotherapy. The fact that this imperfect therapy process is conducted by fictional characters might allow students to question and criticize the therapeutic interactions more freely.

Future studies based on *real* therapy cases should include process and outcome measures that are patient and therapist rated and that include detailed diagnostic assessments and symptom measurements to create a more comprehensive picture of processes and outcomes of treatment of pathological narcissism. Also, if this were a *real* patient, a task analysis interview post treatment might have shed more light on the patient's experience of the process. Moreover, the use of patient self-report measures of alliance, attunement and affect experiencing would have offered an interesting addition to the observers' perspectives on the termination process reported in this paper. Rather than completing instruments after the event in an ad hoc manner, it might be possible in training clinics to standardize these assessment, process and outcome measures as part of training practice and in support of the treatment process. It should also be noted that the computerized linguistic methods used in this study rely on a dictionary approach. It would be interesting to investigate contextual meaning captured by methods such as n-gram models (statistical prediction of natural language sequences taking groups of words into consideration) or topic models (statistical modelling of the themes present in text based on the combinations of words present) in future research.

## Conclusions

In sum, Alex's narcissistic personality traits and the struggle in maintaining a good alliance with his therapist over the course of treatment are representative of therapeutic treatments with narcissistic patients. The triangulation of alliance measurements applied to this case example, including observer rated alliance, ruptures and resolutions, and unconscious matching of language style, shows the overall pattern of alliance building, deterioration and repair during the course of treatment. Given the fictional nature of these interactions between Alex and his therapist, this treatment video in conjunction with this paper, widely accessible to psychotherapy students and the lay public, might provide a helpful case illustration of the complexity of a therapeutic process with a narcissistic patient. Within limitations of observer-rated measures and a case study design, the results illustrate how therapists might be pulled to collude with narcissistic patients' grandiosity, with the risk of neglecting their vulnerability. Given the current lack of clinical and empirical guidance on the therapeutic process with narcissistic patients, further examinations of the unique complexities in treatment of this population are warranted. Questions remain about what therapeutic techniques are best suited to manage cycles of re-traumatization brought on by the unavoidable ruptures and challenges in psychotherapy treatment. How can therapists be supported, trained and supervised to help them support their patients through these therapeutic challenges? While patients might choose to defend against these internal and interpersonal conflicts to protect their vulnerable sense of self, therapists who are more aware of their patients' vulnerable personality might be less blinded by their presentation of a grandiose sense of self and able to learn and reflect on its meaning.

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