

Dissertation Volume: Two

**Exploring Alliance Rupture Resolution Processes
in Psychotherapy with Adolescents**

Literature Review
Empirical Research Project
Reflective Commentary

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Doctorate in Psychotherapy
(Child and Adolescent)

DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

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Impact Statement

This thesis adds to a small but growing body of work exploring in session alliance rupture resolution processes with adolescents in psychotherapy using the Rupture Resolution Rating Scale (3RS). The reviewing of the theoretical and empirical literature shows important differences in how alliance rupture resolution processes might be conceptualised and further studied in work with adolescents from that of adult psychotherapy. Further factors specific to adolescence which are thought to impact on alliance development and how alliance rupture resolution processes are identified, will also be explored. The findings from the empirical study suggest Withdrawal ruptures to be a common feature in psychotherapy with adolescents with depression, with patient confrontation marker behaviours slightly increasing in the middle and later therapy phases. Therapists respond less to Mixed Ruptures in the middle phases of treatment and use more Immediate resolution strategies such as Redirects and Changes Tasks and Goals in early treatment phases. Expressive/ Exploratory resolution strategies exploring the patient therapist relationship are most likely to be used in middle treatment phases and suggest a higher average degree of resolution, despite higher therapist contribution to ruptures. This exploratory study suggests the adolescent field would benefit from further qualitative study of the function of Withdrawal ruptures in adolescent psychotherapy.

Part One: Literature Review

**What is known about Rupture Resolution Processes in the Alliance in
Psychotherapy with Adolescents?**

A Review of the Literature

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Abstract

Emerging evidence has established the significance of alliance rupture resolution processes in contributing to psychotherapy outcomes in work with adults, yet remarkably little is known of these phenomena in the treatment of adolescents. This literature review aims to synthesise and critically evaluate the conceptual origins of alliance rupture resolution processes in adult psychotherapy and critique them for applicability in adolescent treatment. Recent adolescent studies in alliance rupture resolution are explored and summarised, along with identifying further factors considered to impact on alliance development and rupture resolution processes in adolescent treatment. The review suggests that alliance ruptures in psychotherapy are common to both adult and adolescent treatments with a range of treatment, patient and therapist variables impacting on the manifestation of alliance ruptures. It is proposed that distinct developmental processes and socio-ecological factors associated with the adolescent period, need to be considered when utilising the alliance rupture resolution construct in psychotherapy with adolescents. Suggestions are made for how recent re-evaluations of the alliance rupture resolution construct in adult studies might be applied to further studies of alliance ruptures in psychotherapy with adolescents.

Introduction

Over three decades, research into the therapeutic or working alliance has firmly established its relevance as a pantheoretical model for therapy process (Horvath, 2011) and the most robust predictor of psychotherapy outcome across treatments. Moreover, a weak alliance is associated with poor outcome and studies show that 40-50% of patients with weak alliance leave therapy prematurely (Hilsenroth, Cromer, & Ackerman, 2012; Horvath, Bedi, & Norcross, 2002).

Bordin's (1979) tripartite conceptualisation of the alliance, as consisting of collaborative agreement on the goals and tasks of therapy and a strong affective bond, is the most widely used definition. No longer viewed as a static phenomenon, "second generation" alliance research has focused on understanding fluctuations in the quality of the alliance across treatment, with ruptures in the alliance being a common phenomenon in therapy (Safran, Muran, & Eubanks-Carter, 2011). Ruptures have been defined as breakdowns in the collaborative process, fluctuations in the quality of the therapeutic relationship, or problems in establishing an alliance. Several studies have shown that when therapists and patients work through such negative processes and resolve alliance ruptures, patients remain in treatment and have better outcomes (Horvath, 2000; Safran et al., 2011; Stiles et al., 2004). It has been hypothesised that this '*tear and repair*' of the relationship not only strengthens and deepens the alliance but is a key mechanism of change in and of itself (Safran & Kraus, 2014; Safran & Muran, 2006). The American Psychological Association's task force on Empirically Supported Therapy Relationships has acknowledged its relevance as a "promising and probably effective" treatment principle (Norcross & Wampold, 2011).

Given the emerging evidence of the significance of alliance rupture resolution processes in contributing to psychotherapy outcome, it is remarkable how little is known of these phenomena in the treatment of adolescents. Research in the working alliance in youth

treatment trails behind that of adults (DiGiuseppe et al., 1996; Zack et al., 2007), although case reports richly detail the difficulties in engaging, establishing and maintaining alliances with adolescents in psychotherapy (de Haan et al., 2013; A. Freud, 1946a; Meeks, 1971; Wilson, 1999).

Adolescence, defined as a transitional stage between childhood and adulthood rather than a chronological age, is a rapid phase of human development with biological maturity preceding psychosocial maturity (WHO Adolescent Health, 2017). The neurological, hormonal, physical and emotional changes in puberty lead to increased experimentation and risk taking, often characterising this time as a period of turmoil, conflict and interpersonal difficulties. Despite the expected “agitation of inexperience” accompanying this unique period of development, it is “estimated that three-quarters of young adults with mental health disorders will first have met criteria for disorder before the age of 18” (Kim-Cohen et al., 2003). More concerning, a recent meta- analysis (de Haan et al., 2013) of dropout rates in child and adolescent out-patient settings showed 28- 75% of treatments resulted in premature termination. Although reasons for dropout vary, treatment and therapist factors (including weaker therapeutic alliances) were shown to have medium to large effect sizes.

Given the above, this narrative literature review aims to synthesise and critically evaluate what is known about alliance rupture resolution processes in adolescent psychotherapy, with a focus on psychoanalytic approaches, and how this knowledge might enable better engagement and outcomes for young people in psychotherapy. Literature was compiled using advanced database searches on ‘PEP-web’, ‘PsycINFO’ and ‘EMBASE’ and initial search parameters included the following terms: ‘rupture repair’; ‘rupture resolution’; ‘therapeutic or working alliance’; ‘adolescence’; ‘psychoanalytic psychotherapy’. This initial search yielded a small number of studies and theoretical papers. A further search was undertaken using the above search parameters but excluding the term ‘psychoanalytic’,

thereby widening the field of enquiry to all psychotherapies in use with adolescence. This identified a range of empirical studies and theoretical papers which helped to apprehend the conceptualisation and measurement of the working alliance in adolescence, and factors potentially impacting on establishing and maintaining alliances with adolescents. However, the search did not clarify and adequately define the alliance rupture resolution construct, nor offer any detailed exploration of alliance rupture resolution processes, particularly, in session alliance ruptures. A second round of the search terms, ‘rupture repair’; ‘rupture resolution’; ‘therapeutic or working alliance’; and ‘psychotherapy’ was instigated within the adult literature and provided hundreds of empirical and theoretical papers. The following inclusion criteria were then applied; papers detailing concept theoretical origins, development and validity of the alliance rupture resolution construct, methods of measurement, studies investigating the prevalence and pattern of alliance rupture resolutions, and those considering patient, therapist and interactive factors impacting on the alliance ruptures were reviewed. Further emphasis was placed on reviewing papers which considered psychoanalytic practice, or those through comparing and contrasting varying psychotherapy models, highlighting aspects of alliance rupture resolution processes in psychoanalytic psychotherapy.

Given the limited research on alliance rupture resolution in adolescent psychotherapy, and its conceptual origins in adult psychotherapy, the theoretical and empirical literature developed in work with adults is initially discussed and critiqued for applicability in adolescent treatment. This is followed by an exploration of recent adolescent studies in alliance rupture resolution and will conclude by considering further factors impacting on alliance development and rupture resolution processes in adolescent treatment.

From the working alliance to alliance rupture and resolution

The concept of the therapeutic alliance has its roots in Freud’s early writings regarding the dynamics of Transference, where he extended his model of relational dynamics, hitherto

focusing only on the negative aspects of transference, to include the patient's positive "unobjectionable transference" (S. Freud, 1912). Based on the patient's previous relations, the positive transference enabled the patient to see the analyst as "trusted and believed" (Meissner, 2001) thus encouraging collaboration. Freud later argued that "we must ally ourselves with the ego of the patient under treatment" and defined the "analytic situation" as a "pact" (1937; 235). Although grounded in a one-person psychology, the importance of attending to negative processes is viewed in psychoanalysis as essential, and a rupture resolution cycle might be inferred with the oscillation between the patient's negative and positive transference. Freud potentially suggesting a conscious, ego driven process within the patient; however, what contributions the analyst might make towards this process remained unanswered.

Zetzel (1977) and Greenson (1965) took up this question, describing a part of the patient's ego as being an "observing" or "conflict free" ego that is able to ally with the analyst. Greenson delineated the relationship into three components; the transference, the real relationship (i.e. without transference distortions and genuine), and the working alliance, the patient's rational response and "ability to work in the analytic situation". Significantly both authors highlighted the analyst's involvement as a real person who needed to attend to the "basic needs and anxieties" of the patient. Greenson (1967) advocated directly talking with patients about the alliance, and in doing so, prominently considering the two-person interactive nature of therapeutic alliances (Lingiardi & Colli, 2015) and the "reality" and "non-transference" aspects of the relationship.

Bordin (1979b) conceptualized the alliance as "a mutual understanding and agreement about change goals and the necessary tasks to move toward these goals along with the establishment of bonds to maintain the partners' work" (1994, p. 13). For Bordin, every form of therapy presents demands and expectations, and alliance strains are to be expected. Bordin

(1994) highlighted the importance of “tear and repair” processes and thought the tear aspect to be inevitable, since the patient’s pathology creates relationship problems manifesting as disagreements or strains in the affective bond. He proposed that the essence of therapy is the repairing of these tears, and that without them, therapy cannot happen. Bordin was the first to emphasise the potential curative nature of the alliance with it no longer being a “pre-condition for other curative factors such as interpretations” (Lingiardi & Colli, 2015).

This reformulation in conjunction with findings that all psychotherapies produce equivalent results (Smith & Glass, 1977) stimulated a range of empirical studies on alliance and outcomes. Crucially, Bordin provided “not only an alliance definition but a pantheoretical theory of psychotherapy process” (Lingiardi & Colli, 2015).

Influenced by Bordin’s focus on “tear and repair” and drawing from relational psychoanalytic and interpersonal schools, “second generation” alliance researchers Safran and Muran (2000a) focused on alliance rupture and resolution processes. They describe the alliance as “an ongoing process of intersubjective negotiation”, an interactive, dynamic process with contributions from both patient and therapist as they negotiate the needs of agency and relatedness (Safran & Muran, 2000b). Their empirically derived model of rupture resolution is based in a two-person psychology where any “apparent obstruction in the therapeutic process must be understood as a function of the interaction between patient and therapist” (Safran & Muran, 2000b). Therefore, alliance ruptures, resistance or, equally, therapist negative contributions, are understood to be a product (at conscious and unconscious levels) of the interpersonal matrix in which it is produced (Antonello Colli & Lingiardi, 2009). Like Bordin, Safran and colleagues hold that ruptures present key change opportunities; a rupture, addressed with detailed and empathic exploration, can be transformed into meaningful understanding of the patient’s maladaptive interpersonal

processes (Safran et al., 2014).

Ongoing discussion on the conceptual definition of the alliance (2011) suggests a reclassifying of relational constructs, so the question is no longer, is it real, transference or rational, but rather, on what level is the relationship being explored - feelings, relational inferences or relational processes. Colli (2011) supports such a reappraisal, noting the ongoing problematic theoretical differences within the rupture resolution construct – the “restricted rational” versus the “totalistic relational”. The former focuses on *what* the patient communicates, whilst the total relational emphasises *how* the patient communicates and negotiates the affective bond.

More recently Gelso and Kilne (2019) in keeping with Greenson’s model, have cogently argued for a distinction between the “working alliance” and the “real relationship”, noting the varying impact ruptures have on these separate but intimately related “sister concepts”. Ruptures in the “real relationship” are thought to be more detrimental to the therapeutic relationship, whereas those experienced in the ‘working alliance’ less so. They identify a need to narrow the concept of ruptures, differentiating strains from true alliance deteriorations, that is, from those which impact on the ‘real relationship’ and threaten the viability of the overall therapeutic relationship (Gelso and Kilne (2019). Despite these significant and on-going debates, the alliance rupture resolution construct has stimulated a range of clinically relevant research in understanding psychotherapy processual issues. Importantly, the process of negotiation involved in establishing and maintaining alliances in therapy and the many variables which influence this subtle and complex activity.

Alliance Ruptures

Alliance ruptures are in no way a new theoretical construct with overlapping concepts including “empathic failures” (Kohut, 1984) “therapeutic impasses” (Hill et al., 1996) ,

“misunderstanding events” (Rhodes et al., 1994) and “transference- countertransference enactments” (Safran & Muran, 2006). Classical analysis viewed them as an obstacle stemming from the patient’s resistance, needing to be bypassed (Freud, 1923), whilst early ego psychologists understood resistance as a part of the surface ego, requiring exploration (Fenichel, 1947). Kohut (1977) and Fairbairn (1952) regarded ruptures as a patient’s healthy endeavour to protect themselves from re-traumatisation, whilst intersubjectivists conceptualise them as the “intersubjective negotiation” between two different subjectivities (Benjamin, 1990).

Acknowledging the alliance as a “very slippery concept” Safran & Muran (2014) have repeatedly refined their rupture definition, eventually arriving at “problems in the quality of relatedness” or “deteriorations in the communicative process”. Undoubtedly one of their most significant contributions has been the operationalising of ruptures for further observation and empirical study. Through a series of task analytic studies analysing processes involved in producing change (Greenberg, 1986), Safran and colleagues mapped out a theoretical model of the processes underpinning rupture resolutions, arriving at an empirical model of the elements involved in a rupture resolution task (Safran et al., 2011). Over time they distinguished between two categories of ruptures, *Confrontation* and *Withdrawal*.

Withdrawal ruptures occur when patients find it difficult to articulate their concerns and are marked by behaviours by which the patient moves away from the therapist, exhibiting avoidance, or through which they exhibit deference or compliance. Changing topic, long silences, vague, abstract language or a mismatch between affect and narrative content are often indicative of withdrawal ruptures. These impasses are more difficult to detect than their counterpart confrontation ruptures, wherein patients move against the therapist, directly expressing their anger or dissatisfaction. Confrontation ruptures are often marked by verbal criticism of the therapist and appear as hostile or dismissive announcements. Safran &

Muran's operationalising of ruptures draws on a substantial body of theory and research that "emphasises the centrality of the dialectical tension between the need for agency versus the need for self-relatedness" (Aron, 1996; Blatt, 2008a; Safran & Greenberg, 1991; Winnicott, 1965) and the ways in which people navigate this tension. Withdrawal ruptures favour the need for relatedness and can manifest in an individual's submission of their wishes and needs in order to maintain proximity, whilst confrontation ruptures privilege the need for autonomy and can be seen as an individual's attempt to control and dominate within a relationship (Coutinho et al., 2009; Safran & Muran, 2000a). Safran and colleagues note that withdrawal and confrontation ruptures are not mutually exclusive, although they do require different modes of therapist interventions for exploration when working towards resolution (Gelso & Kline, 2019; Safran & Muran, 2000a).

Models of alliance rupture resolution

Baillargeon et al. (2012) established that out of 43 studies on models of alliance rupture resolution only 5 studies included experimental investigation and all 5 were carried out on the same model, Safran, Muran & Samstag's Model 2 (1996). This model consists of four distinct stages;

1. Therapist recognises a rupture marker, attempts to disengage from it and invites patient to explore rupture,
2. Patient and therapist explore their perceptions of rupture experience,
3. Patient and therapist explore any avoidance of communicating about rupture,
4. Therapist and patient work towards clarifying patient's underlying wish or need and attempt to explore interpersonal schema at play.

The process of clarification and exploration in stage 4 is determined by the rupture type. Typical withdrawal rupture processes involve tackling interpersonal fears and internalised

criticisms that diminish a patient's capacity to directly express negative feelings. The therapist then encourages the patient towards increasingly clearer expressions of negative emotions to self-assertion whilst validating the patient's need for agency and autonomy. Confrontation ruptures involve exploring the fears of self-criticism that generate aggressive feelings and can hinder the expression of underlying needs. The therapist encourages the expression of feelings of hurt and disappointment, thereby enabling the patient to make some contact with an underlying vulnerability and need for relatedness.

Resolution strategies may be direct or indirect and can focus on the rational and collaborative aspects or on the relational features of ruptures. As such, interventions can include; repeating the therapeutic rationale, changing tasks or goals, clarifying misunderstandings, linking rupture to common interpersonal patterns between patient and therapist, therapist disclosing internal experience or therapist acknowledging their own contribution to the rupture event (3RS).

Although not subjected to experimental investigation Agnew et al. (1994) developed and tested a psychodynamic interpersonal model for the resolution of confrontation challenges. Agnew et al.'s (ibid) challenge resolution model shares with Safran, Muran & Samstag's (1998) a belief in the significance of the therapist acknowledging and collaboratively exploring ruptures. However, in keeping with psychodynamic practices, places a greater emphasis on developing insight and linking ruptures with past experiences and relationships outside therapy. Both models inevitably reflect their theoretical orientations, and require further investigation to determine whether findings can be replicated and to consider whether certain patient groups might benefit from one model over another.

Detecting and measuring alliance rupture resolution episodes

Ruptures may be characterised by subtle interpersonal interactions sitting below awareness

to full blown alliance breaks resulting in termination. Resolutions can take place within a single session or over a series of sessions and can be found in a single utterance (Colli & Lingiardi, 2009) through sequences of interactions in session (Safran et al., 1994) or noted as fluctuations in alliance scores over sessions (Strauss et al., 2006).

Precisely owing to these varying procedures, Horvath (2011) has cogently argued how methods used in alliance rupture studies often render the “insights uncovered, marooned in a method-determined definition island”, making it difficult to link, generalise and strengthen findings. Nonetheless, each approach contributes to the understanding of rupture resolution episodes, often illuminating the complexities of patient therapist variability within the phenomenon (Safran, 2014; Gumz et al., 2012). Ruptures can be measured through direct and indirect self-report and observer- based methods.

Direct self-report measures such as, the Post Session Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1992) are convenient, reduce data and offer information from patient and therapist perspectives; however these perspectives are often subject to bias owing to poor self- reflection and difficulties with post-session recall (Coutinho et al., 2011). Participant responses are often dependent on a range of factors including emotional state post session and ability or willingness to respond truthfully (Coutinho et al. 2014; Podsakoff et al. 2003). Patient deference to the therapist (Rennie, 1994) and capacity, or lack of capacity, to reveal dissatisfaction with the therapist (Regan & Hill, 1992) have also been shown to impact on ratings and may be a reflection of the defenses used in withdrawal ruptures (Coutinho et al., 2014). Therapists, have been found to rate ruptures more often than clients (Safran et al., 2011).

Indirect self-report alliance measures employ similar methodologies to direct self-report questionnaires. The main distinguishing feature is that they do not explicitly assess the

presence or absence of alliance rupture and resolution. Rather, these are inferred through the tracking of fluctuations in alliance scores across sessions and according to certain criteria established to determine a rupture episode. These measures study alliance ruptures at the “macro-level” through shifts between sessions, and therefore in-session ruptures are likely to go undetected (Lingiardi & Colli, 2015) and may actually be measuring the construct of the alliance as opposed to the construct of ruptures (Coutinho et al., 2014).

The limitation of self-reports has seen the development of observer-based methods such as the *Rupture Resolution Rating System (3RS)* (Eubanks-Carter et al., 2014) and the *Collaborative Interactions Scale (CIS)* (Antonello Colli & Lingiardi, 2009). The 3RS codes for patient markers signifying withdrawal and confrontation ruptures and describes further sub-types for the rupture. The CIS also makes use of the 3RS list of patient rupture markers, however codes these as direct or indirect focusing on the descriptive nature of behavior (Antonello Colli & Lingiardi, 2009). Both the 3RS and the CIS code for positive therapist attempts at resolution, and these are further classified according to intervention. Unlike the 3RS the CIS also codes for therapist negative contributions, thereby emphasising the intersubjective nature of clinical interactions. Both measures have demonstrated good inter-rater reliability and, in keeping with studies employing observer-based methods (Coutinho et al., 2014; Sommerfeld et al., 2008), have shown that observers detail ruptures more frequently than therapists or patients. It is possible that patients may not view moments of withdrawal as a rupture and rate only moments with more intense negative affect; consequently observer-based methods may be over-estimating alliance ruptures (Coutinho et al., 2014).

Observer-based measures examine in-session transactions at a micro-analytic level and relevant studies have provided some fine grained analysis of how rupture resolution

processes affect the therapeutic alliance (Ackerman & Hilsenroth, 2001, 2003). Being identified by both patient and observer, these ruptures are more likely to be explicitly explored, suggesting that patients find therapy more helpful when therapists attend to, and encourage the exploration of ruptures (Sommerfeld et al., 2008) .

Despite the varying ways of defining and measuring them, alliance ruptures in psychotherapy are a common occurrence. A meta-analysis (Safran et al., 2001) of eight studies employing client, therapist or observer reports showed that patients report ruptures in 19% to 42% of sessions, therapists report them in 43% to 56% and external raters observe them in 41% to 100% of sessions.

Prevalence and patterns of rupture resolution episodes

A number of naturalistic studies have attempted to clarify the connection between alliance patterns and treatment outcomes, hypothesising that in addition to stable or linear patterns of alliance development, patterns suggestive of rupture resolution would also yield positive outcomes. Gelso & Carter (1994) operationalised this as a high-low-high or curvilinear pattern of alliance development. Kivlighan & Shaughnessy (2000) attempted to confirm Gelso & Carter's hypothesis and were able to identify three alliance patterns; stable, linear growth and quadratic (U-shaped) growth. The quadratic growth pattern was associated with greater improvement than other alliance patterns with patients reporting significantly less interpersonal problems. Stiles et al. (2004) detected a similar V- shaped pattern with greater treatment gains.

Conscious of the limitations in the different "mathematical methods" used to identify ruptures or 'crises' in previous studies, (Gumz et al., 2012) developed a more refined rupture resolution criterion to take into account the length of rupture crisis and time frame of resolution. They identified five patterns of crisis and resolution describing both gradual and

sudden deteriorations and resolutions; “jump in-jump out” (V-shaped), “jump in-slide out”, “slide in-jump out”, “slide in-slide out” and “complex patterns”. The most frequent pattern was the V-shaped characterised by deteriorations developing in leaps from one session to the next, then resolved in the next session. This detailed study highlights how the number, impact and length of rupture-repair sequences is likely to vary according to the unique unfolding of the individualities of the therapeutic dyad as well as the measures used to assess them.

These studies offer further evidence that ruptures in the working alliance are a common phenomenon and distinct and qualitatively different patterns of alliance development exist. Moreover, patterns of deterioration followed by improvement are associated with positive outcomes and greater treatment gains, in particular with regard to interpersonal functioning (Larsson et al., 2016; Strauss et al., 2006).

It is suggested that treatment type may play a role in the prevalence and pattern of alliance ruptures, with studies highlighting that briefer manualised treatments characterised by CBT (Larsson et al., 2016; Raue, Goldfried, & Barkham, 1997; Stiles et al., 2004) potentially give rise to fewer relational tensions. Whereas, in longer treatments, there is a trend towards a larger number of ruptures (Gumz et al., 2012; Larsson et al., 2016), potentially reflecting additional time for the enactments of interpersonal problems to manifest. Similarly, studies have shown that cognitive-behavioural therapists (CBT) report fewer ruptures than therapists from psychodynamic or interpersonal models (Stiles et al., 2004) potentially impacting on the prevalence and pattern of ruptures.

Therapist, Patient and Interactive Factors Impacting on Rupture Resolution Processes

In what manner ruptures are understood, processed and resolved continues to vary with differences centring around the extent to which therapist contributions are recognised and

relational work prioritised (Hill & Knox, 2009; Lingiardi & Colli, 2015). Quantitative process and outcome studies using the Core Conflictual Relationship Themes method (CCRT) (Luborsky & Crits-Christoph, 1998; Sommerfeld et al., 2008) have found a significant association between the occurrence of ruptures and the presence of dysfunctional relational schemas involving the patient and therapist. Further studies have also found a correlation between therapist negative intervention and disruptive patient rupture markers (Colli & Lingiardi, 2009). These studies importantly acknowledge two relational concepts, “that an alliance rupture is a patient’s vehicle for the expression of core relational problems and is mainly “a patient and therapist co-construction”. Increasingly, it is recognised that patient, therapist, and interactive factors all contribute to alliance rupture resolution processes although therapist contributions have been found to be significant in comparison to patient influences (Hill & Knox, 2009; Safran et al., 2011).

Therapist Factors

Therapist contributions may be separated into two discernible, yet mutually supporting components - relational or personal qualities (warmth, empathy, attunement) and therapist technique (type and focus of intervention, application of technique). Therapists’ techniques or rather misapplication of techniques such as; increased or unyielding transference interpretations (Piper et al., 1993), inflexible adherence to cognitive therapy protocols (Castonguay, Boswell, Zack, et al., 2010), inappropriate use of silence (Eaton et al., 1993), self-disclosure of own emotional conflicts (Price & Jones, 1998) and therapist avoidance of important issues (Marmar et al., 1986) have all been shown to contribute to and intensify existing ruptures. Difficulties in maintaining a focus on the emotional impact of interpersonal problems (Ackerman & Hilsenroth, 2001) and failing to fully attend to the therapeutic relationship and patient experience are further associated with disturbed alliances

(Hilsenroth et al., 2012). Personal attributes influencing difficulties in managing countertransference reactions such as becoming overly involved in patients' maladaptive interpersonal styles (Safran & Muran, 2000a) or unresponsive (Barber et al., 2010), are equally likely to lead to the inappropriate management of ruptures. Additionally, therapists' unresolved conflicts (Hill et al., 1996) self-directed hostility (Nissen-Lie et al., 2013) and a combination of little professional doubt and high positive self-affiliation can also lead to counter-therapeutic interactions (Nissen-Lie et al., 2017). Studies have consistently demonstrated that therapist states, such as: lack of confidence in ability, tiredness, rigidity, being critical, distant, defensive or blaming are present in therapist behaviours related to alliance ruptures. Therapists' personality traits such as; flexibility, honesty, respect, trustworthiness, competence, confidence, empathy and openness (Ackerman & Hilsenroth, 2003) are associated with positive alliances.

The aforementioned personal attributes are likely to influence therapist application of techniques known to positively enhance alliances and resolve ruptures. These include: awareness of reactions to patients; acknowledging problems in the relationship; encouraging and supporting patient expression and exploration of feelings; demonstrating that anger is possible within the context of a caring relationship; promoting a sense of collaboration or wholeness; apologising and taking responsibility for contributions to difficult exchanges; using immediacy, meta-communication, mindfulness, and maintaining a reflective stance (Ackerman & Hilsenroth, 2003; Dalenberg, 2004; Hill & Knox, 2009).

Additionally, therapist attachment styles are thought to impact on alliance rupture resolution processes, interacting with patient attachment dimensions. Rubino et al. (2000) found securely attached therapists were better able to empathise with patients whilst preoccupied therapists were less likely to do so.

Patient Factors

Higher patient reported distress on interpersonal measures and personality pathology, including diagnosis of Borderline Personality Disorder, have consistently demonstrated a higher rate of in session ruptures with greater frequency and intensity of confrontation ruptures and problems establishing an alliance (Coutinho et al., 2011; Larsson et al., 2016; Muran et al., 2009). In addition, patient personality traits such as hostility, defensiveness, excessive control, avoidance and self- directed hostility have been further associated with the manifestation of ruptures (Benjamin & Critchfield, 2010; Diener et al., 2009; Kasper et al., 2008).

A number of studies have shown that patients with secure attachment styles seem more apt to form positive alliances (Eames & Roth, 2000; Mallinckrodt et al., 1995) and patients who have had some experience of positive relationships, past or current, are more likely to establish a bond (Hersoug et al., 2009). Eames and Roth (2000) compared patient and therapist report of rupture and patient and therapist alliance scores to patients' attachment styles and found that a patient's preoccupied attachment style was associated with more frequent therapist reported ruptures, whilst patient dismissing attachment style was associated with fewer therapist reported ruptures. In keeping with earlier studies (Satterfield & Lyddon, 1998) both insecure attachment styles were associated with lower alliance scores when compared to attachment security, and suggested more complicated alliance development over time, whilst also revealing that preoccupied styles were significantly associated with improved alliance ratings over the therapy. The authors hypothesise that, despite high levels of relational anxiety, the preoccupied patient's deep-seated drive for intimacy potentially enables a better alliance to develop as therapy continues.

Summation - To rupture is human, to repair is therapy

The past decade has seen discussion amongst clinicians, theorists and researchers that the alliance rupture resolution construct is at risk of becoming a victim of its own success (Gelso & Kline, 2019; Horvath, 2011, 2018; Lingiardi & Colli, 2015). The ongoing absence of a consensual definition of the alliance along with the diversity of operationalising and measuring alliance phenomena remains problematic. Here, different relationship variables risk being mistaken for one another with different researchers emphasising and prioritising separate relational constructs (Gelso & Kline, 2019) or ‘levels of relating’ (Horvath, 2011). This longstanding difficulty in the conceptualising of the alliance along with the broadening of the definition of ruptures to include ‘subtle tensions’ or ‘minor strains’, risks diluting the alliance rupture resolution construct with meaningful relationships potentially being obscured (Gelso & Kline, 2019). Increasingly, there are calls to revisit these concepts, with a renewed emphasis on the theoretical origins and clinical theory, in order to develop more concise, nuanced definitions and coordinated methods of measuring both the alliance and alliance rupture resolutions (Gelso & Kline, 2019; Horvath, 2018).

Nevertheless, alliance ruptures have been shown to be a common feature in psychotherapy with adults with noticeable and distinct patterns of development potentially influencing outcomes. Empirical studies have further highlighted the multiplicity of therapist, patient and treatment model variables impacting on alliance ruptures and therapist attempts at resolution. This reminding us, that human relationships are messy, and even with the structure provided by the therapy relationship and setting, it is inevitable that interpersonal events will arise and give way to “misunderstandings’ within the therapeutic relationship. There is little doubt that the alliance rupture resolution construct has shifted focus to the dynamic and fluctuating nature of the alliance, bringing into sharp focus the intersubjective experience of ‘helper and helpee’. How therapeutic dyads navigate these “misunderstandings” is widely viewed as the dialectical tension “between the need for agency versus the need for self-relatedness”.

Developed in psychotherapy work with adults, the understanding and applicability of the alliance rupture resolution construct with adolescents is a relatively new area of investigation limited to a small number of studies (Daly et al., 2010b; Gersh et al., 2017; O’Keeffe et al., 2020; Schenk et al., 2019).

Alliance Rupture Resolution Processes – Adolescent Considerations

Conceptual definitions

Conceptualisations of the therapeutic or working alliance in adolescent psychotherapy have largely been “downloaded from the adult literature” (Shirk et al., 2010) along with the controversies around the operationalisation and measurement of alliance-related phenomena. The relevant literature on work with adolescents has yet to coalesce around a single definition of adolescent or youth alliance (Karver et al., 2018b) with its psychoanalytic origins in Anna Freud’s work (1946) and latterly Bordin’s (1979a) pantheoretical model continuing to predominate.

Anna Freud (1946a) emphasised the need for an “affectionate attachment” or “bond” between therapist and child” citing this as a “prerequisite for all later work”. Like her father, she firmly placed the working alliance within transference phenomena and, in keeping with psychoanalytic thinking, saw the “bond” as serving a function - to enable the young child to work collaboratively. This view is held within cognitive behavioural formulations of the alliance (Kendall et al., 2009) and, although differing in treatment tasks, both suggest the association between alliance and outcome is mediated through agreement and involvement in treatment tasks (Shirk & Karver, 2003). In contrast, relational constructs of empathy, genuineness, positive regard, and the child’s experience of the therapist as supportive, attuned and non-judgemental (Axline, 1947; Rogers, 1957) were prioritised within early play therapy and humanistic traditions, emphasising the bond as mediating outcomes. Subsequent research

on alliance in work with young people has continued to contrast these two dimensions, questioning whether it is “attachment or agreement” (Karver et al., 2008) mirroring, similar arguments in the adult literature.

Alliance models emphasising the attachment concept view the therapeutic bond as an important attachment relationship (Shirk & Russell, 1996) built on the adolescents’ experiences of the therapist as a reliable, trustable, responsive person. Studies have shown that therapists’ early responsiveness to adolescent expressions of emotion and attending to the adolescent’s experience, help to both build and strengthen the alliance (Karver et al., 2018b; Russell et al., 2008) with a lack of responsiveness being associated with weaker alliances (Karver et al., 2008). The agreement line of alliance inquiry takes issue with the excessive focus on the bond element, highlighting the importance of the adolescent’s sense of agency in developing agreement on treatment goals. Here the adolescent may have a positive relationship with their therapist, but not a working alliance, with treatment goals potentially aligned with referrers and parents (Karver et al., 2018b). Studies of the adolescent alliance have shown early and explicit discussion around treatment goals as being associated with improved alliances in the third session (DiGiuseppe et al., 1996). It is hypothesised that these two alliance models may be more or less effective with different age groups, with younger ages benefitting from an emphasis on attachment whilst older adolescents privileging agreement on goals (Karver et al., 2018b).

Both alliance formulations draw parallels with Bordin’s pantheoretical model, although this three component model has yet to be fully supported in studies with children and adolescents (Zack et al., 2010; Zack et al., 2007). Most studies have identified single factors; this suggests that alliance features are less distinguished in younger age groups (Faw et al., 2005) or that multiple alliance dimensions exist, but are not differentiated by adolescent patients (Ormhaug et al., 2015; Roest et al., 2016). In addition, diverse

developmental factors are thought to influence the formation of the alliance in youth. For example, cognitive abilities might impact on the adolescent's understanding of therapy tasks (Shirk & Russell, 1996) whereas disagreements on the therapy focus between parents and adolescent might affect the goal dimension (Hawley & Garland, 2008; Hawley & Weisz, 2005), and the therapy bond influenced by the adolescent's perception of the therapist as someone fun to be with, rather than, someone who can help them with their distress (Freud, 1946b; Sandler et al., 1980).

Despite the lack of agreement on alliance definitions, studies have shown that establishing a good working alliance with adolescents in psychotherapy takes longer than in adult treatments (DiGiuseppe et al., 1996; Shirk et al., 2010), a strong alliance early in treatment is essential for engagement, and that attending to multiple alliances with parents and adolescents are important (Cordaro et al., 2012; Zack et al., 2007).

Focusing on the process of alliance development in clinical work with adolescents, researchers have sought to bring together the bond and contractual alliance formulations in a developmentally informed process orientated model (Shirk & Karver, 2006, 2011). This model distinguishes Bordin's alliance dimensions by placing them in a temporal sequence conceptualised as '*engagement, involvement, and alliance*', whilst continuing to recognise their dynamic interdependence. Engagement references therapist behaviours promoting alliance; involvement refers to the adolescent's active participation in therapeutic tasks; the alliance reflects the adolescent's experience and belief in the therapist as a source of help.

With the youth field principally focused on the process of establishing an alliance in therapeutic work with adolescents, ruptures in the alliance, and the alliance rupture resolution construct itself, has only recently been taken up as a line of enquiry. Safran & Muran's alliance rupture resolution model currently serves as the primary model for describing, identifying and resolving ruptures, as described next.

Measures

Alliance ruptures in adolescent treatment, in keeping with adult studies, can be measured through direct and indirect self-reports. In this way ruptures continue to be observed at the “macro-level”, through shifts between sessions (Lingiardi & Colli, 2015) and the question remains whether these studies concern ruptures or the alliance. Likewise, observer-based alliance measures such as, the *Adolescent Therapeutic Alliance Scale* (Faw et al., 2005) developed for use in adolescent work seek to measure various alliance dimensions as opposed to defining and identifying ruptures themselves. A recent meta-analysis (Karver et al., 2018b) revealed there to be seventeen different measures of child and/or adolescent alliance further reflecting the variability of alliance definitions.

Nevertheless, the majority of research uses measures in keeping with the two prominent adolescent alliance models of “attachment or agreement”. Following the agreement line and adapted from the the 36 item *Adult Working Alliance Inventory* (Horvath & Greenberg, 1989), the *Adolescent Working Alliance Inventory – Short Form WAI- S* (Linscott et al., 1993) assesses Bordin’s multi-dimensional alliance through adolescent and therapist report. Notwithstanding the conflicting evidence for Bordin’s multiple alliance dimensions in adolescent work, it remains one the most commonly used measures in youth alliance. Similarly, the *Adolescent Therapeutic Alliance Scale* (Faw et al., 2005) developed for use with adolescents receiving family or individual treatment also relies on Bordin’s (1979) alliance model from an observer perspective.

Shifting away from Bordin’s alliance model, the self-report *Therapeutic Alliance Scale for Adolescents TASA* (Shirk & Karver, 2003), evaluates both the emotional bond and level of collaboration on tasks between the therapist and adolescent, but not necessarily agreement on goals. Relatedly, the *Working Relationship Scale WRS*, also a self-report, aims to tap into the domains of mutuality, the empathic qualities of the relationship, collaboration or working

rapport and a third domain of patient attitude towards treatment (resistance). Using similar alliance domains of Patient Participation, Patient Exploration and Patient Hostility, the *Overall Adolescent Engagement Scale OES* (Jackson- Gilfort, Liddle, Tejada & Dakoff, 2001) is an observer measure developed for use with adolescents which focuses on the formulation of alliance processes.

In-session alliance rupture resolution processes in adolescent psychotherapy

Recently, a handful of studies (Gersh et al., 2017; O’Keeffe et al., 2020; Schenk et al., 2019) have applied Safran & Muran’s observer based Rupture Resolution Rating System 3RS (Eubanks-Carter et al., 2014), in studying alliance rupture resolution processes in psychotherapy with adolescents. These studies found withdrawal ruptures occurring more frequently than confrontation ruptures, yet often therapists responded more to confrontation ruptures, suggesting these are more easily identified (Gersh et al., 2017; Schenk et al., 2019). All three studies identified unresolved and early alliance ruptures as contributory factors to both engagement difficulties and dropout with adolescents in psychotherapy (Gersh et al., 2017; O’Keeffe et al., 2020; Schenk et al., 2019).

When considering rupture typology and rupture resolution processes across beginning, middle and ending treatment phases with adolescents with BPD and depressive symptoms, Schenk (2019) found ruptures increased in the middle phase of treatment, whereas Gersh (2017) showed ruptures increasing throughout phases of therapy with increased confrontation markers observed in the middle and later treatment stages.

Both studies found the degree to which ruptures were resolved by therapists increased as treatment progressed. Therapists working within analytic frameworks had more stages of resolution when addressing ruptures and were more likely to work through negative emotions (Gersh et al., 2017). These relationally focused therapists primarily addressed ruptures by

inviting patients to discuss their thoughts and feelings about therapy and the therapist, through validating the patient's defensive posture and, through illustrating tasks and providing a rationale for treatment. Daly et al. (2010) showed that when Cognitive Analytic Therapists used more rupture stages using a cognitive analytic resolution model there was greater rated success in resolution. On the other hand, therapists have been thought to contribute to ruptures through offering minimal responses, persisting with a therapeutic activity which the adolescent is rejecting, and, perhaps more controversially, focusing on risk-related factors against the adolescent's wishes (O'Keeffe et al., 2020).

These studies offer interesting early insights into alliance rupture resolution processes in adolescent psychotherapy with findings highlighting the importance of early alliance processes with adolescents. Additionally, ruptures appear to increase over treatment with adolescents with BPD and depression, but do not seem to result in treatment breakdown and subsequent dropout. However, the insights gained from these studies also bring with them the existing identified problems with the alliance rupture resolution construct in adult work. These being; a lack of clarity on the relational constructs inferred in the alliance definition, a need to narrow down the definition of a rupture, and to simplify and coordinate methods of measuring alliance ruptures. Further, this direct construct "download" from adult studies risks neglecting what is already "known" about the youth alliance and how it is thought to differ from that of the adult alliance. In particular, that the different components, or alliance dimensions of tasks, goals and bond are less distinguished with younger age groups (Faw et al., 2005). The youth alliance is widely conceptualised, as the affective and collaborative aspects of the client-therapist relationship (Elvins & Green, 2008; Shirk & Saiz, 1992). In addition, there is growing evidence for an emphasis on a process orientated youth alliance model formulated as, 'engagement, involvement, and alliance' (Shirk et al., 2011). Potentially, ruptures in the different phases of this process oriented model, or the different

dimensions of the affective or collaborative may have more or less of an impact on the alliance. Given these differences, alliance ruptures in adolescent psychotherapy might usefully be explored through Gelso and Kilne's (2019) proposed distinction between ruptures in "the real relationship" versus ruptures in "the working alliance". This proposed model narrows down the definition of rupture, clarifying between strains versus ruptures, and distinguishes ruptures which impact on the "bond" or "affect" dimensions (the real relationship) versus ruptures in the "collaborative" or "involved" dimensions (the working alliance). In this way, the alliance rupture resolution construct is more closely aligned to alliance formulations currently in use in adolescent treatment, and might yield further information on the processual alliance model of "engagement, involvement, alliance" developing within the youth field.

Therapist and adolescent experiences of alliance rupture resolution processes

Beyond the above investigations, a small number of qualitative studies (Binder et al. 2008b; Morán et al., 2019; Sagen et al., 2013) have explored therapists' experiences of working through alliance ruptures and have identified that therapists attempt to explore ruptures from the adolescent's point of view. Therapists also routinely understand ruptures in the context of the adolescent's need for autonomy, which is often reflected in the adolescent withdrawing (Binder et al., 2008a) thereby signaling their ambivalence in engaging in therapy. However, there are substantial differences in whether therapists explore and resolve ruptures through focusing on the therapy relationship, or the adolescent's life outside therapy. Therapists have expressed how exploring relational factors expose them to feelings of vulnerability and intense affective experiences, requiring them to carefully attend to their subjective experience to minimize any controlling behaviours on their part (Binder et al., 2011; Binder et al. 2008b; Morán et al., 2019; Sagen et al., 2013).

When interviewed on their experiences of the relational aspects of therapy, and processes involved in establishing and resolving alliance ruptures, adolescents identified a need for, “permitting freedom for individuality and autonomy with a balanced sense of connection through mutuality” (Binder et al., 2011; Sagen et al., 2013). Adolescents readily acknowledge their ambivalence early in therapy and being highly attentive to how their therapists act towards them to determine whether or not to engage. Equally, adolescents expressed concern for vulnerability and dependency, necessitating that their therapists support their autonomy by establishing clear therapeutic boundaries and respecting them as an individual. Adolescents’ reported experiences of the relational aspects of therapy appear to confirm their developmental need to balance autonomy and self-relatedness, thereby signalling potential areas for misunderstandings and alliance ruptures.

Factors impacting on alliance development and rupture resolution processes in adolescent psychotherapy

Socioecological context

The social and organisational contexts wherein adolescents access and receive help present a range of hurdles for engagement and potential early alliance ruptures. Mental health services rarely accept self-referrals necessitating adolescents seek adult support in accessing treatment, often, through professionals who lack training in readily identifying mental health needs. Community services are widely regarded as fragmented and complex, with prolonged waiting times, this, along with continuing stigma around mental health, make establishing an early alliance problematic (de haan et al., 2013; DiGiuseppe et al., 1996;

Adolescents rarely live in isolation and frequently rely on family or social care networks to access therapy, whether through referral, transportation to sessions and/ or payment for treatment (Shirk et al., 2011). Moreover, parents and carers are often involved as, “informants about client functioning, collateral participants, or even as therapeutic

collaborators” (Shirk et al., 2011) bringing their own expectations and identified goals for the adolescent’s treatment. Aligning adolescent, parent and therapist goals is a complicated task with some studies showing that more than 75% of child, parent and therapist triads start treatment without agreement on target problems (Hawley & Weisz, 2005). This has led some in the field to question “whose alliance is it anyway”, suggesting multiple alliances are in operation in youth treatments and, parental or carer engagement is likely to have far reaching implications in establishing an alliance and attending to alliance ruptures (Baldwin et al., 2007; Hawley & Weisz, 2005). The clinical literature has detailed the necessity to develop an alliance and attend to alliance ruptures with both adolescent and parent (King et al., 2014; Novick & Novick, 2005; Schimel, 1974). Within the psychoanalytic tradition Novick & Novick (2005) have developed specific therapeutic alliance models in work with parents with adolescents in individual treatment, addressing areas thought to be touch points for alliance ruptures with adolescents and parents. Importantly, these alliance models address issues around genuine confidentiality, through defining and differentiating between privacy and secrecy, attending to the developmental needs of both parent and adolescent. Despite this, studies evaluating the relation of the alliance with outcomes, rarely consider the alliance between therapist and parents (McLeod, 2011), with alliance ruptures with parents often overlooked or not adequately addressed (Kazdin & Whitley, 2003; Novick & Novick, 2011; Novick & Novick, 2005). It is thought that the minimising of both parental involvement, and parental alliance ruptures in adolescent psychotherapy, has been influenced by early psychoanalytic theory’s modelling of adolescent treatments based on adult analysis. This initiating an emphasis on the intrapsychic nature of the adolescent’s psyche, the impulses, ideas and conflicts which occur in the adolescent’s mind, often to the exclusion of the external world and exploration of family dynamics (Novick & Novick, 2005; Siskind, 1997).

Adolescent Intrapsychic factors

Central to psychoanalytic practice is the role of unconscious communication and this includes work within the transference relationship, the feelings which are attached to the therapist and belonging to prior relationships and the adolescent's intrapsychic life. Here, alliance rupture resolution processes might be viewed in the expression of both the positive and negative transference, and the working through of such transference elements essential to strengthening the overall therapeutic alliance (Long & Trowell, 2001). Whilst recognising the need for a warm and positive attachment, Anna Freud (1946b) also cautioned about the adolescent's capacity to engage in psychoanalytic work. She detailed (1958) how the adolescent task of re-negotiating early Oedipal wishes would result in a regressive pull towards infancy and incestuous relations, with this anxiety then being transferred to the analyst and subsequently all the adolescent's defences being mobilised against the therapy and the therapist. In this way intrapsychic life, and the emergence of a strong negative transference would lead to substantial alliance ruptures. The extent to which therapists attend to intrapsychic and relational factors versus external treatment factors, and when and how such practices might contribute to alliance rupture resolution processes with adolescents remains a pertinent point of clinical discussion (Binder et al., 2008a, 2008b, 2011; Morán et al., 2019; Ricks, 1974; Ulberg et al., 2012). However, research into the practice of transference work with adolescents aged 16- 18 years of age (Ulberg et al., 2021), has shown that when therapists encourage adolescents to explore their positive and negative thoughts and feelings towards the therapist and negotiate the relationship in the here and now (transference work), the young person improved significantly more on symptom measures.

Neurodevelopmental processes in adolescence

Consistent with hormonal, physical and emotional changes, research into the neurobiological changes in adolescence have identified a range of phase-specific challenges

which are likely to impact on therapy processes. Adolescents have been shown to have higher basal stress levels and heightened reactions to stress, social rejection and academic stressors (Masten et al., 2009; Sebastian et al., 2010; Sebastian et al., 2012). In addition, difficulties with social cognition (Gergely et al., 2002; Luyten & Fonagy, 2018) have been identified, indicating that adolescents are more likely to struggle to reflect upon inner states of both self and other, to mentalize, and engage in abstract thinking, as the required structural functions are still under development (Gergely et al., 2002; Luyten & Fonagy, 2018). Such neurodevelopmental dynamics are likely to impact on the manifestation of alliance ruptures as well as resolution processes in psychotherapy with adolescents, influencing practices in both establishing the alliance and in resolving ruptures during this period of development. These neurobiological developments also indicate the plasticity of the human brain within adolescence offering new opportunities for growth and resilience (Luyten et al., 2020).

Conclusion

Empirical knowledge concerning alliance rupture and resolution processes in work with adolescents is in its infancy. Studies to date have shown that Withdrawal and Confrontation ruptures can be reliably identified using adult measures such as the 3RS, however, how these ruptures operate, in service of the therapeutic relationship with adolescents has yet to be understood. The relatively small number of studies directly considering alliance rupture resolution processes in work with adolescents have focused on specific clinical populations, and in particular youth with BPD. Further, these studies were conducted using the 3RS, developed for use with adults and based on Bordin's alliance dimensions of goals, tasks and bond. Yet, the alliance in adolescent work is thought to operate differently to Bordin's multiple alliance dimensions. Although the youth field has yet to coalesce around an alliance definition, there is considerable evidence for the

importance of a process model of alliance development and the significance of early alliance processes, including ruptures. This suggests that there may be distinct phases of development in the youth alliance, which may or may not, at varying times, privilege attachment over agreement or vice-versa. Subsequently, differing therapist behaviours and activities are likely to be required during the varying alliance development phases to facilitate engagement, establish an alliance and attend to alliance ruptures.

Given the early state of research into alliance rupture resolutions processes with youth, the adolescent field might benefit from recent re-evaluations of the alliance rupture resolution construct from within adult work. In particular, those which more closely align with what is known and proposed about the youth alliance. In this way, Horvath's (2011, 2018) reclassifying of relational constructs and the shift away from, is it real, transference or rational, towards, what level of the relationship is being explored - feelings, relational inferences or relational processes could prove useful. Such a focus might address the ongoing dialogue, as to whether or not, or indeed when, therapists address external factors or internal intrapsychic factors in work with adolescents. Similarly, Gelso and Kilne's (2019) distinction between the "working alliance" and the "real relationship", noting the varying impact ruptures have on these separate but intimately related "sister concepts" might prove useful when considering the youth alliance's focus or attachment/ bond versus agreement/ collaboration.

Regardless of the alliance rupture resolution conceptual definition used, future studies must address the diverse developmental factors at play in work with adolescents. Here, acknowledging not only the physical, social and emotional and neurological changes taking place within the adolescent and how these might impact on alliance ruptures but also the external factors influencing the adolescent's capacity to engage. Importantly, that multiple

treatment alliances are likely to exist, requiring therapists to actively attend to ruptures emerging from both adolescent or parent/ carer.

At the heart of the rupture resolution construct is the dialectical tension between the need for agency and autonomy versus the need for self- relatedness. The universality of this theme to human development cannot be denied. However, how it manifests in the clinical encounter with adolescents who are by their nature, in a period of development characterised by these very themes, remains to be seen.

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Part Two: Research Project

**Exploring alliance ruptures and resolution attempts in Short Term
Psychoanalytic Psychotherapy with adolescents with depression**

Empirical Study

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Abstract

Empirical evidence suggests the relevance of alliance rupture resolution processes in contributing to effective psychotherapy outcomes with adults, yet remarkably little is known of these phenomena in the treatment of adolescents. This study aims to explore in-session alliance ruptures and therapist attempts at resolution as they emerge in the different phases of Short Term Psychoanalytic Psychotherapy (STPP), for adolescents with moderate to severe depression. The material for this study comes from a large UK based randomised control trial, IMPACT, Improving Mood with Psychoanalytic and Cognitive Therapies, and purposive sampling was used to identify two treatments indicative of alliance ruptures. Sessions were then selected from early, middle and later phases of the two treatments. Using audio recordings of the selected sessions alliance rupture resolution processes were identified and rated for significance using the observer-based Rupture Resolution Rating Scale (3RS). Descriptive statistics were applied to the categorical data and further statistical analysis between expected and observed frequencies in the categories applied. Results suggest ruptures are a common occurrence and decrease throughout treatment phases with therapists responding less to mixed ruptures in the middle treatment phase. Therapist attempts at resolution using strategies Changes Tasks and Goals and Re-directs Patient decreased in middle and ending phases, whilst resolution attempts Links Between Patient Therapist was found to increase in the middle phase. Future qualitative studies of the content of identified rupture resolution moments will aid understanding of the changing nature of ruptures and resolution attempts.

Introduction

Research into the therapeutic or working alliance, widely viewed as the cooperative/collaborative relationship between patient and therapist, has firmly established its relevance as a pantheoretical model and the most robust predictor of positive psychotherapy outcomes across treatments (Horvath, 2011; Karver et al., 2018). In contemporary approaches, the alliance is thought to be marked with ruptures, i.e. momentary deteriorations in the quality of relatedness between therapist and patient associated with lack of collaboration on the goals and tasks of therapy or strains in the emotional bond (Bordin, 1979; Eubanks-Carter et al., 2015). Two types of alliance rupture have been suggested in the relevant literature, namely Withdrawal and Confrontation ruptures; withdrawal ruptures are characterised by the patient *moving away* from the work of therapy and/ or the therapist, whilst confrontation ruptures are typified by a *moving against*. Therapist attempts at resolving ruptures can involve *Immediate* repair strategies seeking to quickly clarify misunderstandings or adjust expectations, whilst *Exploratory/Expressive* strategies aim to explore core relational themes (Eubanks-Carter et al., 2015). Alliance ruptures are thought to signal to a patient's maladaptive interpersonal processes and the tensions involved in the complexity of balancing the needs of agency and relatedness (Safran & Christopher, 1996; Safran & Muran, 2000a). As such, when worked through collaboratively, alliance ruptures can present key change opportunities - with a moment of rupture having the capacity to be transformed into a meaningful understanding of interpersonal processes (Coutinho et al., 2009; Safran et al., 2014). Empirical studies of alliance rupture resolution processes in adult psychotherapy have established their relevance in treatment engagement and effective psychotherapy outcomes (Coutinho et al., 2009; Larsson et al., 2016; Safran et al., 2005, 2011; Safran & Kraus, 2014), with the American Psychological Association twice

recognising the rupture resolution model as a ‘promising and probably effective’ treatment principle (Safran & Christopher, 1996; Safran & Muran, 2000).

Despite this there remains a paucity of research on alliance rupture resolution processes in adolescent psychotherapy. Yet, there is wide-spread recognition of the difficulties in engaging adolescents in treatment (de Haan et al., 2013; Kazdin, 1996; O’Keeffe et al., 2018). Establishing a good working alliance with adolescents in psychotherapy is known to take longer than in adult treatments (DiGiuseppe et al., 1996; Shirk et al., 2010) and a strong alliance early in treatment is seen to be essential for engagement (Cordaro et al., 2012; Zack et al., 2007). More recently, unresolved and early alliance ruptures have been identified as contributory factors to both engagement difficulties and dropout in psychotherapy with adolescents (Gersh et al., 2017; O’Keeffe et al., 2020; Schenk et al., 2019).

Establishing and maintaining alliances with adolescents

Psychoanalytic theory has long recognised the difficulties in establishing and maintaining the alliance with adolescents and the propensity for alliance ruptures (Bailey, 2006; Blos, 1963; A. Freud, 1958; Meeks, 1971; Wilson, 1987). Notably, the adolescent’s developmental thrust towards separation individuation, and the associated fears of loss of self in the process of identity formation, make it difficult to establish any relative dependency on adults. This may lead adolescents to withdraw, in order to protect their emerging sense of autonomy and self-agency (Blatt, 2008). Further to this, research into neurobiological changes in the adolescent brain have identified phase specific difficulties in social cognition (Blakemore, 2008) and increased sensitivity to external stressors, such as social rejection and academic stress (Masten et al., 2009; Sebastian et al., 2010; Sebastian et al., 2012).

Adolescents, by their very nature, are more likely to struggle to reflect upon inner states of

both self and other and engage in abstract thinking, as the required structural functions within the brain are still under development (Gergely et al., 2002; Luyten & Fonagy, 2018). Such developmental dynamics are likely to impact on the manifestation of alliance rupture as well as resolution processes in psychotherapy with adolescents, influencing practices in both establishing the alliance and in resolving ruptures during this period of development.

Reflecting on the alliance, Anna Freud (A. Freud, 1946) recognised the need for a warm and positive attachment, whilst also cautioning about the adolescent's capacity to engage in psychoanalytic work. She detailed (1958) how the re-negotiation of early Oedipal wishes would result in a regressive pull towards infancy and incestuous relations, with this anxiety then being transferred to the analyst and subsequently all the adolescent's defences being mobilised against the therapy and the therapist. In this way, intrapsychic life, the impulses, ideas and conflicts which occur in the adolescent's mind, might emerge through a strong negative transference, in the here and now relationship with the therapist, leading to substantial alliance ruptures, as the adolescent attempts to protect themselves from distressing thoughts and feelings. The extent to which therapists attend to intrapsychic and therapist-patient relational factors versus external, or life outside therapy factors, and when such practices might contribute to alliance rupture resolution processes with adolescents remains a pertinent point of clinical discussion (Binder et al., 2008; Morán et al., 2019; Ricks, 1974; Ulberg et al., 2012, 2021). Most recently, transference work with adolescents aged 16- 18 years of age, has shown that when therapists encourage adolescents to explore their positive and negative thoughts and feelings towards the therapist and negotiate the relationship in the here and now (transference work), the young person improved significantly more on depressive symptom measures than in treatments without transference-related work (Ulberg et al., 2021).

Therapist and adolescent experiences of alliance rupture resolutions

Qualitative studies (Binder et al., 2008; Morán et al., 2019; Sagen et al., 2013) exploring therapists' experiences of working through alliance ruptures have identified that therapists attempt to explore ruptures from the adolescent's point of view, recognising that a failure to be sensitive to the adolescent's experience would contribute to or exacerbate existing ruptures. Therapists routinely understand ruptures in the context of the adolescent's need for autonomy, which is often reflected in the adolescent withdrawing (Binder et al., 2008) thereby signaling their ambivalence in engaging in therapy. When therapists approach ruptures and 'not wanting therapy', as a rational choice to be made rather than an area for exploration (Binder et al., 2008), the adolescent's withdrawal is considered to be either a positive assertion of the adolescent's mastery of autonomy and/ or an act of self-protection. However, when explored relationally, these ruptures are shown to yield nuanced themes of ambivalence, which can then be validated, enabling adolescents to develop a language to talk about their fluctuating motivation and work through complex and often negative feelings in understanding and managing autonomy and relatedness (Binder et al., 2008). Therapists have expressed how exploring relational factors exposed them to feelings of vulnerability and intense affective experiences, requiring them to carefully attend to their subjective experience to minimize any controlling behaviours on their part (Binder et al., 2011; Binder et al., 2008; Morán et al., 2019; Sagen et al., 2013; Ulberg et al., 2021). Given this, therapist vulnerability might be considered an impediment to exploring relational factors underlying alliance ruptures in work with adolescents, which may warrant further training or supervision.

A few studies have asked adolescents about their experiences and wishes regarding the therapeutic relationship. Adolescents have shown an awareness of their needs in establishing a productive working relationship, and were able to identify a range of preferred

therapist interactions (Binder et al., 2011; Sagen et al., 2013). When interviewed on the relational aspects of therapy and establishing an alliance and resolving ruptures, adolescents' responses identified a theme of 'permitting freedom for individuality and autonomy with a balanced sense of connection through mutuality' as being essential to the process and their engagement. Adolescents readily acknowledge their ambivalence early in therapy and are highly attentive to how their therapists act towards them to decide/determine whether or not to engage, requiring therapists to feel comfortable in their role (Morán et al., 2019; Sagen et al., 2013). Equally, adolescents expressed concern for vulnerability and dependency, necessitating that their therapists support their autonomy by establishing clear therapeutic boundaries and respecting them as an individual. Seeing the person behind the therapist, with limited therapist self-disclosure and some expression of therapist vulnerability, whilst not having to take responsibility for the therapist's wellbeing, was reported to enable the emotional closeness and mutuality that adolescents seek/sought (Binder et al., 2011; Sagen et al., 2013). Importantly, adolescents describe the intensity of their experiences and the need for therapists to help them render their experiences understandable and meaningful, paying attention to the need to balance negative and positive emotional experiencing ((Binder et al., 2011; Sagen et al., 2013).

Alliance ruptures resolution processes with adolescents

The use of observer-based assessments of in-session alliance ruptures with adolescents are limited to three published studies (Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). In keeping with adult investigations (Lingiardi & Colli, 2015) these studies found Withdrawal ruptures occurring more frequently than Confrontation ruptures, with therapists responding more readily to confrontation ruptures, a finding that has been interpreted as suggesting that confrontation may be easier to identify. Additionally, some

studies have found Confrontation ruptures to have a greater impact on the immediate collaboration between adolescents and therapists (Schenk et al., 2019). Early ruptures were found to be more significant barriers to treatment and it is suggested that it is important to address the prevalence of Withdrawal ruptures early in treatment, and support adolescents to express their dissatisfaction more directly (Gersh et al., 2017; O’Keeffe et al., 2020).

Studies on psychotherapy with adults have categorized therapist contributions to alliance ruptures into two categories - relational and technical (Colli et al., 2017). Relationally therapists might contribute to ruptures through exhibiting a lack warmth and respect whilst being critical, defensive and distant (Ackerman & Hilsenroth, 2001), and technical misapplications include use of inappropriate interventions, inflexible adherence to treatment model, inappropriate use of silence and giving uninvited advice to the patient (Ackerman & Hilsenroth, 2001; Lingiardi & Colli, 2015). Similarly, in adolescent psychotherapy, therapists are thought to contribute to ruptures through offering minimal responses when the adolescent expresses difficulties in engaging, persisting with a therapeutic activity which the adolescent is rejecting, and, perhaps more controversially, focusing on risk-related factors against the adolescent’s wishes (O’Keeffe et al., 2020).

When considering rupture typology and rupture resolution processes across treatment phases with adolescents with BPD, Schenk (2019) found ruptures increased in the middle phase of treatment, whereas Gersh (2017) showed ruptures increasing throughout the middle and ending phases of therapy. More specifically, Gersh’s study with adolescents with BPD (2017) saw increased confrontation markers in the middle and later stages of treatment, suggesting that adolescents were getting better at expressing their dissatisfaction directly to their therapist. Interestingly, the degree to which ruptures were resolved was also found to increase as treatment progressed, signifying that increased levels of volatility in the

relationship were accompanied with increased productivity in addressing alliance ruptures. When comparing Befriending with Cognitive Analytical Therapy (CAT), Gersh's study showed CAT therapists had more stages of resolution when addressing ruptures, and were more likely to work through negative emotions, directly address rupture episodes considering relational patterns. In Schenk's study Adolescent Identity Treatment (AIT) therapists primarily addressed ruptures by inviting patients to discuss their thoughts and feelings about therapy and the therapist, through validating the patient's defensive posture and through illustrating tasks and providing a rationale for treatment. As a treatment AIT uses modified elements of Transference Focused Therapy and includes techniques of clarification, confrontation and interpretation alongside psychoeducation (Schenk et al., 2019).

Both the above studies considered rupture resolution processes in treatment phases with adolescents with BPD. O'Keefe's earlier mentioned study (2020b) with adolescents with depression explored ruptures in the context of adolescents identified as "dissatisfied drop outs" from treatment. This group was found to have a higher instance of unresolved ruptures from early in treatment and more frequent Withdrawal ruptures throughout treatment. In keeping with Gersh (2017), O'Keefe supports the view that adolescents may often express their dissatisfaction with therapy indirectly. Although whether or not this is a feature more particular to adolescents with depression is unclear. However, psychoanalytic formulations associate depression with fears about the consequences of aggression, and the conscious or unconscious fear of not being able to manage it appropriately. This resulting in a propensity to turn aggression against the self. In this way, a higher frequency of Withdrawal ruptures in treatment with adolescents with depression might be anticipated, and therapist's active exploration of these ruptures an important feature in treating depression as well as attending to the alliance.

Current Study

Given the scarcity of empirical research into alliance rupture resolution processes in adolescent psychoanalytic psychotherapy and ongoing clinical considerations as to specific treatment type practices during this developmental period, there is a pressing need in establishing both the presence and pattern of rupture phenomena in adolescent treatment and the processes by which ruptures are resolved. The current study aims to explore rupture resolution processes across different phases of treatment with adolescents with depression engaged in Short Term Psychoanalytic Psychotherapy (STPP).

In keeping with Mann's (1973) model of short term psychodynamic psychotherapy, STPP emphasises the need to establish a positive therapeutic alliance early in treatment, establishing a trustworthy and collaborative relationship whilst also exploring the patient's foremost unconscious conflict and setting up the treatment framework. The middle phase focuses on deepening trust and the transference relationship and importantly addressing the negative transference. This might also involve drawing attention to any ruptures happening in the here and now relationship with the therapist. This middle phase is likely to see considerable strains on the alliance with anticipated increases in ruptures with the ending of treatment focusing on feelings associated with loss whilst highlighting progress.

Similar to AIT and CAT, STPP works to identify unhelpful relational patterns and focuses on here and now affects between the patient and therapist using both interpretation and other transference-focused interventions. Central to STPP practice is the role of unconscious communication and this includes work with the negative transference - acknowledging the adolescent's feelings of rage, destructiveness and hostility whether directed towards the self or others, as likely to be a contributing factor to their depression (Catty et al., 2016). Expressions of both positive and negative transference are encouraged

and the working-through of negative transference elements is seen as essential to strengthening the overall therapeutic alliance (Long & Trowell, 2001). In this way, STPP views the evidence of positive outcomes associated with alliance rupture resolution processes as empirically supporting psychoanalytic psychotherapy's emphasis on working relationally in the here and now, with both positive and negative emotions.

The current exploratory study aims to examine and describe the emergence of alliance ruptures in STPP and therapists' attempts to resolve them across treatment phases. More specifically, it aims to explore the types of resolution strategies used by therapists in response to different rupture types over the course of STPP treatment. This study also seeks to further assess the suitability of the 3RS in observing rupture resolution processes in psychotherapy with adolescents.

1. Ruptures - It is anticipated that in the middle phases of STPP there will be an increase in ruptures as patients and therapists focus work on relational patterns alongside increased work in the here and now transference. This middle phase might also see an increase in confrontation ruptures.

2. Responses to ruptures - It is anticipated that when attempting to resolve alliance ruptures therapists will use more direct or "*Immediate*" resolution strategies in the early phases of treatment, focusing on establishing the goals and tasks of treatment. In the middle phases of treatment resolution attempts will involve increased use of "Expressive" or "Exploratory" strategies which aim to explore relational dynamics and address ruptures, in the here and now relationship, with the therapist.

Method

Research Material

The material for this study consisted of 22 sessions, drawn from two STPP treatments which were audio recorded as part of the Improving Mood with Psychoanalytic and Cognitive Behaviour Therapy study or (IMPACT). IMPACT, a large UK based randomised control trial (RCT) compared the effectiveness of three manualised treatments; short-term psychoanalytic psychotherapy (STPP), cognitive behaviour therapy (CBT) and a brief psychosocial intervention in the treatment of adolescents with a diagnosis of moderate to severe depression (Goodyer et al., 2011). The results of the study found no statistically significant differences in either clinical outcome or cost-effectiveness among the three treatments and concluded that all three treatments should be made available to young people with depression, thereby increasing patient choice (Goodyer et al., 2011). The present study focuses on STPP, a manualised 28 – session version of short-term psychoanalytic psychotherapy with a focus on the manifestation of alliance rupture resolution processes in this modality.

Participants

Selection of treatments

Fourteen treatment cases were made available from the IMPACT data and the following inclusion criteria were first applied in order to select appropriate cases for use with the 3RS process measure, and to ensure rupture resolution processes across treatment phases could be observed and detailed. Participants needed to have attended half or more of the 28 or 29 sessions offered with attendance throughout early, middle and later treatment phases ensuring sessions from all treatment phases, were observed for ruptures (see Table 1). Audio recordings of attended sessions needed to be undamaged to enable the adequate use of the selected observer process measure. Importantly, participants also needed to be between the

ages of 15 -18 years as this was felt to be a developmentally appropriate period for use with the selected rupture resolution process measure, which had been developed for work with adults but had previously been trialled in only one published study with adolescents 15 years and above (Gersh, 2017). Following this, 5 cases remained available for use.

Purposive Sampling using a critical case model (Patton, 2014) was then used to identify treatments indicative of self-reported out of session alliance rupture resolution processes based on participants' Working Alliance Inventory scores (see Table 1). The Working Alliance Inventory - Short form (WAI-S), is a patient self-report measure designed to assess the three dimensions of Bordin's (1979b) working alliance concept, namely bond, task and goals. Previous studies have identified alliance ruptures on the "macro level" through examining overall alliance scores on the WAI throughout treatment (Muran et al., 2009; Safran et al., 2014; Strauss et al., 2006). Decreases in alliance scores are suggestive of a weakening or strain in one or more of the alliance dimensions (bond, task, goals) whilst increases suggest a strengthening in alliance and enhanced collaboration between patient and therapist.

Based on overall WAI scores, cases that indicated a V –shaped, or high- low – high pattern which is frequently associated with alliance rupture resolution processes (see Table 1) were selected. This pattern indicates self-reported rupture resolution phenomena at the "macro" or "between session" level, thereby warranting further investigation in order to see and describe what alliance ruptures look like in sessions with adolescents across treatment phases. Of the 5 cases examined for V- shaped WAI scores one case was identified. Given the time limitations and small scale nature of this study, a decision to focus on coding more sessions from selected treatments was made in order to ensure alliance rupture resolution patterns could be identified and any changes throughout treatment phases accurately described. Therefore one further case was randomly selected.

Both participants from the selected treatments were aged 15, male and were considered treatment completers, having attended sessions in the later treatment phase including the final session. Both showed improvement on the IMPACT primary outcome measure, the Mood and Feelings Questionnaire, a self-report measure of depressive symptoms. A five-point change on the MFQ or an improvement of one point, on five of the 33 MFQ items measured, was taken to represent a clinically important difference (Goodyer et al. 2017). At end of treatment and follow-up patient B was no longer reporting symptoms indicative of depression, whilst patient A's scores had dropped more than 5 points from initial baseline assessment (see Table 2).

Table 1

Patient Demographics, Treatment Engagement and Working Alliance Scores

	Gender	Age	Sessions			Working Alliance Inventory Scores		
			offered	attended	recorded	6 wks	12 wks	36 wks
Patient A	male	15	29	29	29	41	48	46
Patient B	male	15	29	14	12	63	49	54

Note: Working Alliance Inventory Scores aggregate overall ratings range from 12 to 84 with higher ratings reflecting a stronger alliance.

Table 2

Patient Outcomes Measures

	Gender	Age	Mood and Feelings Questionnaire Scores Week Administered					
			0	6	12	36	52	86
Patient A	male	15 years	51	45	37	38	49	36
Patient B	male	15 years	50	34	52	18	14	11

Note. MFQ long version scores range from 0 to 66 with higher scores suggesting more severe depressive symptoms, 27 or higher indicates the presence of depression.

Therapists

Therapists delivering the STPP treatment were either qualified child psychotherapists or final-year trainees in Child and Psychotherapy and members of the Association of Child Psychotherapists and trained in the United Kingdom. As part of their participation in the IMPACT study, therapists received fortnightly STPP supervision.

Process Measures

Alliance rupture and resolution processes were identified and coded using the Rupture Resolution Rating System or 3RS (Eubanks et al., 2015). The 3RS is an observer-based coding system for identifying in-session alliance rupture resolution processes. Ruptures are defined as *“a deterioration in the alliance between patient and therapist, manifested by a lack of collaboration on tasks or goals or a strain in the emotional bond”* (C. Eubanks-Carter et al., 2015). The 3RS is based on an array of clinically derived alliance rupture patient marker behaviours originally identified by Harper (1989a, 1989b) and further empirically validated by Safran and Muran (2000b) in work with adult psychotherapy patients. The measure was designed for use by graduate students and in some studies has demonstrated a high inter-rater reliability (ICC = .73–.96) (Coutinho et al., 2014). Its use with adolescents has been limited with a few published studies (Gersh et al., 2017; O’Keeffe et al., 2020; Schenk et al., 2019).

Ruptures are identified through specific client behaviours, considered to be markers of rupture, reflecting lack of collaboration and/ or tension between patient and therapist. If present, observers then decide if a Withdrawal rupture (the patient either moves away from the therapist or toward the therapist in a way that denies an aspect of their experience) or if a Confrontation rupture (the patient moves against the therapist by expressing anger or dissatisfaction) has occurred. For each identified Confrontation or Withdrawal rupture, observers then select a specific rupture subtype, such as for example denial, minimal

response, avoidant storytelling, complains about the progress of therapy, controls or pressures therapist. Alliance ruptures can, and very frequently, present with both withdrawal and confrontation patient marker behaviours and equally, therapists can employ both Immediate and Expressive resolution attempts. The 3RS manual acknowledges that both withdrawal and confrontation patient marker behaviours can occur in the advised 5 minute time points for coding ruptures and is not an altogether uncommon phenomena (Eubanks et al., 2015). Typically Confrontation ruptures appear less frequently than Withdrawal ruptures with this pattern of presentation most often found with adults with depression (Eubanks et al., 2018; Schenkel et al., 2005) and, in the one paper published utilising the 3RS (Gersh et al., 2017) in work with adolescents at the time of the current study taking place. The author's earlier training in the 3RS measure with adolescent cases selected from the IMPACT study, but not part of this study's sample, suggested a high incidence of Withdrawal and Confrontation ruptures occurring contemporaneously. Subsequent conversations with O'Keeffe, who was at the same time investigating ruptures in her own study on adolescent psychotherapy drop out (2020), confirmed a similar presentation along with fewer Confrontation ruptures overall. It seemed important to capture this phenomena as it may speak to a particular way in which ruptures manifest within psychotherapy with adolescents and how the needs of autonomy and relatedness are negotiated within the therapeutic relationship. Further, given that Withdrawal and Confrontation ruptures typically involve different processes of resolution (Eubanks et al., 2015), it would seem important to clarify how therapists approach resolving ruptures when patients are both withdrawing from the therapy and therapist whilst also moving against. Therefore, when both Withdrawal and Confrontation ruptures or Immediate or Expressive resolutions occur in the same measured time point this study adapted the 3RS manual to code these as Mixed Ruptures or Mixed Resolutions thereby capturing something of this phenomena. The 3RS also classifies a range of therapist strategies used to resolve alliance

ruptures defined as either Immediate or Expressive/ Exploratory. Immediate strategies aim to quickly adjust and re-establish collaboration whilst Expressive resolution attempts aim to explore core relational themes potentially underlying a rupture. Expressive *attempts* require the therapist to pay close attention to their own experience and can involve the therapist making transference interpretations. These exploratory resolution attempts involve “*therapeutic metacommunication*” or “*a communicating about the communication process*”.

Following listening to the entire session and coding for ruptures and resolution strategies observers then give a global rating to indicate the overall significance of each type of rupture marker and resolution strategy. A scale of 1 -5 is used with 1 signifying/ equaling no significance or no rupture markers/resolution strategies, or very minor ones that did not seem to affect the alliance and 5 denoting a high significance, with rupture markers/resolution strategies having a striking impact on the alliance.

A further global rating (again using a 5-point scale) is used to indicate the overall extent to which ruptures were resolved in the session. Here, 1 denotes a poor resolution and worsened alliance and 5 signifies a very good overall resolution and improved alliance. The same scale, in reverse, is used to rate the degree to which therapists contributed to or exacerbated existing ruptures.

Procedures

Selection of Sessions

As this study aims to compare alliance rupture resolution processes across STPP treatment phases, sessions were selected from the early, middle and later phases of treatment. Four sessions from each phase were selected. Early treatment sessions included session 3, which previous research has shown to be an important session in alliance development and a strong predictor in treatment outcomes with adolescents in psychotherapy (Karver et al.,

2008; O'Malley et al., 1983) and session 6, the first time point for the WAI -S self-report. Sessions 12, 14, 15 and 16 were considered representative of the middle phase of treatment with sessions 14, 15 and 16 selected as they signified the midway point, marking the beginning period "*in which the time remaining in therapy becomes less than the time already spent in therapy*" defined as the middle phase in STPP. Clinically this period is likely to see both a developing and deepening of the therapeutic relationship alongside a growing awareness of the limitations of the relationship owing to the time limit. Session 12 was selected as this was the second time point in which participants completed the WAI -S self-report. For the later treatment phase sessions 24, 25, 26, and 27 were selected with an aim to capture the late therapy process without including the final therapy session, which would most likely involve more distinctive processes related to a final ending session.

When sessions were missing through non-attendance, poor recording or early termination of treatment the next available session was selected. In this particular data set one treatment ended earlier than scheduled at the request of the adolescent, taking the intended data set from 24 sessions to 22.

Coding and rating of sessions using the 3RS

Each of the 22 audio recorded sessions was segmented into 5-minute time periods. Sessions were marked as having started from when therapist and patient entered the room and ended when the therapist called the session finished. Sessions therefore have 10 time points and a separate code for patient lateness was established. Two coders, both trainees in the Professional Clinical Doctorate in Psychoanalytic Child and Adolescent Psychotherapy, listened to each 5-minute segment and using the 3RS separately identified and categorised the rupture markers and resolution strategies present in the segment. Ruptures were coded as having been responded to when a resolution attempt was made in the same time point or in

the time point immediately following the rupture, provided that a further rupture was not present in this new time point. Resolution attempts made in time points where no rupture was present were included only if a rupture had occurred in the previous time point and no resolution attempt had been made at that previous time point. Once each full therapy session was coded independently, significance ratings were determined for both Withdrawal and Confrontation rupture markers. A further rating for the degree of overall rupture resolution in the session was given as well as a rating of the degree to which the therapist was felt to have caused, and/or exacerbated, ruptures.

Both coders had approximately 20 hours of 3RS self- training and the author took part in an initial online training and consultation session with one of the developers of the 3RS, Catherine Eubanks. Owing to the exploratory nature of the study and the limited use of the 3RS measure with adolescents, consensual agreement was used to determine each code assigned to a five- minute segment. To minimise influencing one another coders did not discuss their coding or rating until each had coded the full session. Where there was disagreement, the coders re-listened to that particular 5-minute segment and discussed it until consensus was achieved. Should consensus not be reached a third external coder (PhD student) would be consulted with; however, there were no instances where consensus was not achieved.

Ethical Considerations

The IMPACT study protocol was approved by Cambridgeshire 2 Research Ethics Committee, Addenbrookes Hospital Cambridge, UK (REC Ref: 09/H0308/137) and local NHS providers. Fully informed written consent was sought from all participants including parental consent for participants under the age of 16 years. Participants were informed of their right to withdraw from the study at any time. To protect confidentiality, all identifiable

details are either disguised or excluded and only relevant patient descriptors of gender and age at the start of the study are employed throughout.

All therapists and young people in the IMPACT study agreed to their sessions being audio recorded for assessing treatment fidelity and examining the process of psychotherapy. Participation in secondary data analysis, as undertaken in this current study, adheres to the IMPACT protocol and permission to use the data for specific projects was obtained from the IMPACT primary researcher. In accordance with this, the author and researcher received additional training in Data Handling and Information Governance Procedures and has signed a Non-disclosure and Confidentiality Agreement.

Results

1. Ruptures - It was hypothesised that in the middle phases of STPP there would be an increase in ruptures as patients and therapists focus work on relational patterns alongside increased work in the here and now transference (c) also, this middle phase might see an increase in confrontation ruptures.

Of the 22 sessions coded, ruptures were present in 79% of the 5-minute time points (see Table 3). Alliance ruptures appeared to be a very common phenomenon occurring at almost 80% of the session time and reduced slightly over the course of treatment. Ruptures did not increase in the middle phase as hypothesised. Equally, therapists contributed to or exacerbated existing ruptures more in the early, rather than later phases of treatment.

Table 3

Percentage of total time with rupture, average therapist contribution to rupture

Therapy Phase	% time in rupture (number of instances)	Therapist contribution
Early	84% (64)	2.9
Middle	79% (56)	2.4
Later	75.5% (45)	2.0
Average	79% (165)	2.4

Note: Therapist contribution to rupture is the mean score of rated sessions from therapy phase on a scale of 1-5 with higher scores indicated more significant contribution to rupture.

Next, the type of rupture across treatment phases was examined along with the average significance given to each rupture type (see Table 4). Pearson's Chi-squared test was used to examine whether the amount of each rupture differed between phases of therapy and was found to be non-significant $\chi^2(4, N = 165) = 5.599, p = 0.18$, Fisher's exact 2 – sided $p = 0.185$. Nonetheless, certain trends were observed, briefly outlined below.

Withdrawal ruptures were the most common rupture type throughout treatment and especially so in the middle phase. However, in this middle phase, Withdrawal rupture impact on the alliance was rated as less significant than in earlier and later treatment phases, yet were 4.5 times more likely to be present. This finding suggests that although adolescents continued to withdraw in the middle phase, this withdrawal had a smaller impact on the alliance, as rated by observers. Pure confrontation ruptures were rare, with the first and only confrontation rupture coded in the later phase of treatment. This later phase saw Mixed Ruptures, which contain a confrontation element, increase to their highest throughout treatment. Correspondingly, average significance ratings for confrontation marker behaviours increased to their highest. These findings suggest that patient confrontation marker behaviours increased over time and were also being rated as having a greater impact on the alliance. Taken together these observations suggest that patients started to move

against the therapist and the therapy as treatment progressed, potentially being more open and direct in expressing their dissatisfaction.

Table 4

Treatment Phase, Presence of Rupture Type, Average Rated Significance on Alliance

Phase	% of Rupture Type (number of instances)			Significance on alliance	
	Withdrawal	Confrontation	Mixed	Withdrawal	Confrontation
Early	76% (47)	0% (0)	24% (17)	4.25	2.5
Middle	82% (47)	0% (0)	18% (9)	3.6	2.0
Later	66% (31)	3% (1)	31% (13)	3.1	2.9
Average	75% (125)	1% (1)	24% (39)	3.7	2.5

Note: Significance on alliance is mean score of rated sessions from therapy phase on a scale of 1-5 with higher scores indicated more significant impact on alliance.

2. Therapists' response to ruptures - It was anticipated that when attempting to resolve alliance ruptures therapists would use more direct or "*Immediate*" resolution strategies in the early phases of treatment, focusing on establishing the goals and tasks of treatment. Further to this, in the middle phases of treatment, resolution attempts will involve an increased use of "Expressive" or "Exploratory" strategies which aim to explore relational dynamics and address ruptures, in the here and now relationship, with the therapist.

Therapists were found to respond with resolution attempts to 63 % of all observed ruptures throughout the whole session time (see Table 5). When we examine the therapists' resolution responses to ruptures at different stages of therapy, the tendency to respond with a resolution attempt dropped as therapy progressed, whilst the average rated effectiveness of resolution increased.

Table 5

Treatment Phase, Therapist Response to Rupture, Average Rather Degree of Resolution, Average Rated Therapist Contribution to Rupture

Phase	% of Ruptures responded to (number of instances)	Average degree of rupture resolution or contribution	
		Resolution	Therapist contribution
Early	75% (47)	2.1	2.9
Middle	64% (37)	2.9	2.4
Later	57% (23)	2.75	2.0
Average	65% (107)	2.6	2.4

Note: Average degree of resolution or therapist contribution to rupture is mean score of rated sessions from therapy phase on a scale of 1-5 with higher scores indicating higher degree, of resolution or more significant therapist contribution to rupture.

Next, therapist response in relation to rupture type across treatment phases was examined to ascertain if particular rupture types were more or less likely to be responded to across treatment (see Table 6). Pearson's Chi-squared test was used to examine therapist response to rupture type across treatment and confirmed that the drop in responses to Mixed Ruptures in the middle treatment phase, from the early treatment phase was statistically significant, $\chi^2 (2, N = 107) = 8.402, p = 0.02$, Fisher's exact 2 – sided $p = 0.012$. Therapists were making considerably less resolution attempts in response to mixed ruptures during this middle phase.

Table 6

Therapist Responses to Rupture Types in Treatment Phase, Average Significance of Rupture Type

Phase	Ruptures responded to			Average significance	
	Withdrawal	Mixed	Confrontation	Withdrawal	Confrontation
Early	70% (33)	82% (14)	Not present	4.25	2.5
Middle	70% (33)	44% (4) ^a	Not present	3.6	2.0

Later	42% (13)	77% (10)	0% (0)	3.1	2.9
Average	61% (79)	68% (28)	0% (0)	3.7	2.5

^a cell count less than 5, Fisher's exact 2 – sided $p = 0.012$.

Next, the type of resolution used in response to ruptures in each phase of treatment was investigated (see Table 7). Pearson's Chi squared test was used to examine the relationship between therapist resolution type and phase of treatment and was found to be non-significant $\chi^2 (4, N 107) = 0.941, p = 0.92$, Fisher's exact 2 – sided $p = 0.917$. Trends showed that Immediate resolution responses were the most used resolution strategies in the whole of treatment and most frequently in the early phase. Expressive/ Exploratory resolution attempts reached their highest use in the middle phase of treatment. Expressive/ Exploratory resolution responses were less likely to be used and when they were employed, these meta strategies tended to be used in conjunction with Immediate resolution responses.

Table 7

Therapist Resolution Type and Treatment Phase

Phase	% of Resolution Response Type (number of instances)		
	Immediate	Expressive	Mixed
Early	46% (22)	19% (9)	35% (17)
Middle	36% (13)	25% (9)	39% (14)
Later	43 % (10)	22% (5)	35% (8)
Average	42% (45)	22% (23)	36% (39)

Following this an exploration of therapist Resolution response type to Rupture type was examined to see whether Withdrawal, Confrontation or Mixed Ruptures were more or less likely to elicit Immediate or Expressive/ Exploratory resolutions. Pearson's CHI squared test was used to examine observed differences between Resolution response types and Rupture types and was found to be non-significant $\chi^2 (4, N= 107) = 4.631, p = 0.11$, Fisher exact 2 – sided $p = 0.087$. This was in keeping with the earlier stated non-significant

statistical analysis of the relationship between treatment phase and therapist Resolution response $\chi^2 (4, N = 107) = 0.941, p = 0.92$, Fisher's exact 2 – sided $p = 0.917$ It would seem that different frequencies of Resolution responses were provided by therapists during different phases of treatment and with regard to different Rupture types.

Table 8

Resolution Response Type to Rupture Type in Treatment Phases

Phase	Rupture Type	% of Resolution Response Type (number of instances)			
		Immediate	Expressive	Mixed	No response
Early	Withdrawal	28% (13)	16% (8)	28% (13)	28% (13)
	Mixed	53% (9)	6% (1)	23% (4)	18% (3)
	Confrontation	None present	None present	None present	None present
Middle	Withdrawal	26% (12)	19% (9)	23% (11)	32% (15)
	Mixed	11% (1)	0% (0)	33% (3)	56% (5)
	Confrontation	None present	None present	None present	None present
Later	Withdrawal	19% (6)	13% (4)	10% (3)	58% (18)
	Mixed	31% (4)	8% (1)	38% (5)	23% (3)
	Confrontation	0% (0)	0% (0)	0% (0)	100% (1)
Total Average	Withdrawal	24% (31)	16% (21)	20% (27)	39% (46)
	Mixed	32% (14)	5% (2)	31% (12)	32% (11)
	Confrontation	0% (0)	0% (0)	0%	100% (1)

Next, a more detailed examination of the specific Resolution sub type strategies contained in Expressive/ Exploratory and Immediate Resolution types and their use across treatment phases was made (see Table 9). Pearson's CHI squared test was used to examine observed differences between the use of resolution subtypes across treatment phases. Findings were statistically significant for particular Immediate resolution strategies Redirects, $\chi^2 (2, N = 61) = 8.000, p = 0.02$, Fisher's exact 2 – sided $p = 0.002$ and Changes Tasks and Goals $\chi^2 (2, N = 15) = 11.200, p = 0.01$, Fisher's exact 2 – sided $p = 0.004$ as well

as Expressive/ Exploratory Resolution strategy, Links between Patient Therapist, $\chi^2 (2, N = 18) = 7.000, p = 0.03$, Fisher's exact Fisher's exact 2 – sided $p = 0.002$.

The reduction in the use of Immediate Resolution strategy Redirects in the later treatment phase suggests that in early and middle treatment phases patients needed more support to stay with, and understand, the tasks and processes of therapy. When moving away from the therapist or therapy, therapists intervened with an immediate response, redirecting the patient to the task, or re-focusing them on the present moment, attempting to quickly re-establish collaboration.

Similarly, the increased use of Immediate resolution strategy Changes Tasks and Goals in the early treatment phase seems logical, in that, therapists and patients are in the process of establishing a shared understanding of the goals of therapy, as well as what tasks the patient is willing and capable of engaging with. Therefore strains in the alliance domain of goals and tasks seem likely. Consequently, therapists might seek to address ruptures in this early phase by changing the task or goal to address the concerns of a patient who is complaining, or engage a patient who is withdrawing, or modify a task in order to make it more acceptable.

Expressive resolution strategy Links between Patient Therapist increased use in the middle phase, suggests therapists were attempting to resolve alliance ruptures in this phase through active exploration of the interpersonal patterns being drawn out and observed in the therapist patient relationship. Within this, it is likely that the bond aspect of Bordin's Working Alliance model was experiencing greater strain from alliance ruptures and therapists were responding accordingly. This is a possible reflection of STPP's psychoanalytic model which emphasises working relationally, and in the transference, in the middle phases of therapy, thereby deepening and exploring the patient therapist relationship more explicitly.

Given the ongoing dialogue regarding the usefulness of drawing attention to relational

dynamics in adolescent psychotherapy the average Therapist Cause of rupture in sessions using resolution strategy *Links Between Patient Therapist* was compared with sessions without its use. Sessions which contained the strategy *Links between patient therapist* were rated as having a higher Therapist Cause of rupture 2.8 than with sessions which did not use the strategy 2.1. However, the average ratings for the degree of Therapist resolution showed less of a difference with sessions containing Links Between Patient averaging 2.7 and 2.6 for sessions without the strategy. Suggesting that therapists actively using the patient therapist relationship to explore and attempt to resolve alliance ruptures were more likely to contribute to the rupture, or exacerbate existing ruptures, however this did not result in ruptures being poorly resolved.

Table 9

Resolution Sub Type Strategies across Treatment Phases

Specific Resolution Strategies	% in Treatment phase (number of instance)			Statistical Analysis
	Early	Middle	Later	
Redirects (I)	33%(29)	32% 21)	25% 11)	$\chi^2(2, N = 61) = 8.000, p = 0.02^a$
Invites thoughts and feelings (E)	23% (20)	27% (18)	36% (16)	$\chi^2(2, N = 54) = 0.444, p = 0.82$
Links between patient therapist (E)	6% (5)	17% (11)	4.5% (2)	$\chi^2(2, N = 18) = 7.000, p = 0.03^b$
Changes tasks and goals (I)	13% (11)	4% (3)	4.5% (1)	$\chi^2(2, N = 15) = 11.200, p = .01^c$
Validates patient's defensive position (I)	9% (8)	3% (2)	7% (3)	$\chi^2(2, N = 13) = 4.769, p = 0.11$
Illustrates tasks or rationale (I)	6% (5)	8% (5)	7% (3)	$\chi^2(2, N = 13) = 0.615, p = 0.83$
Clarifies Misunderstanding (I)	5% (4)	1.5% (1)	4.5% (2)	$\chi^2(2, N = 7) = 2.000, p = 0.52$
Acknowledges contribution (I)	2% (2)	3% (2)	4.5% (2)	$\chi^2(2, N = 6) = 0.000, p = 1.00$
Therapist discl internal experience (E)	2% (2)	1.5% (1)	4.5% (2)	$\chi^2(2, N = 5) = 0.400, p = 1.00$
Links with other relationships (E)	1% (1)	3% (2)	4.5%(2)	$\chi^2(2, N = 5) = 0.400, p = 1.00$

Note. E = Expressive/ Exploratory Resolution, I – Immediate Resolution.

^a Fisher's exact 2 – sided $p = 0.002$. ^b Fisher's exact 2 – sided $p = 0.002$. ^c Fisher's exact 2 – sided $p = 0.004$.

Discussion

This study investigated the occurrence of ruptures and therapist attempts at resolution across treatment phases of STPP with a particular focus on the use of the Expressive/Exploratory resolution strategy, Links Between Patient and Therapist. Given that this is a small scale study aiming to ascertain the applicability of the 3RS with adolescents, and to describe how ruptures emerge across treatment phases and how therapist's respond to these; the generating of standalone findings and the assumption of correlation and generalisability is not intended. However, some tentative conclusions may be drawn from the data analysis which help to describe the emergence of rupture resolution processes, and situate this knowledge within the context of the small but growing number of studies of alliance rupture resolution processes with adolescents.

The results from these two cases support previous findings suggesting alliance ruptures are a frequent occurrence with both adolescents and adults when measured from the perspective of third- party observers (Gersh et al., 2017, Schenk et al., 2019, Eames and Roth, 2000). Ruptures in this study did not increase in the middle phase of treatment as hypothesized and in contrast to Schenk (2019) and Gersh (2017). Rather, ruptures in this study were found to occur most frequently in the early stages of therapy and, although these trends were not statistically significant, ruptures seem to decrease as treatment progressed; a similar trend was observed in the therapists' contributions to ruptures. These observations are in line with the view that stress the significance of early contact and alliance ruptures in therapy with adolescents (Cordaro et al., 2012; Gersh et al., 2017; O'Keeffe et al., 2020). From a psychoanalytic perspective this finding could be conceptualised as reflecting adolescents' ambivalence in engaging in a process evoking vulnerability and dependence during this critical period of emerging autonomy (Binder et al., 2011; Sagen et al., 2013). Further, the adolescents in Gersh and Schenk's studies had a primary diagnosis of BPD whereas this study's participants were experiencing moderate to severe depression.

Therefore, increases in ruptures found in the middle treatment phase with the BPD population may be representative of heightened difficulties in interpersonal relating.

In keeping with earlier studies with adolescents as well as adults with mood disorders (Eubanks et al., 2018; Gersh et al., 2017; Schenkel et al., 2005) Withdrawal Ruptures occurred more frequently than Confrontation Ruptures throughout all treatment phases and were consistently rated as having a more significant impact on the alliance. In this small study minimal clear confrontation ruptures were found, potentially capturing the complexity in adolescents with depression expressing their dissatisfaction and distress directly with the therapist. In keeping with psychoanalytic formulations of depression, this difficulty in directly expressing frustration is a potential reflection of the adolescent's anger turned inwards against the self. Although the relationship between rupture type and phase of treatment was found to be non-significant, the increase in confrontation marker behaviours in this study, bears some resemblance to Gersh's (2017) finding of increased Confrontation markers in the later stages of treatment. Similarly, significance ratings for impact on the alliance reached their lowest for Withdrawal ruptures and their highest for Confrontation markers. This change in rupture type considered most important for the alliance could be seen to suggest that the adolescents in these two cases were somewhat more able to express their dissatisfaction and distress directly in the later phases of treatment. This may be a distinguishing feature of adolescent populations who are recognised as having difficulty engaging in the early therapy phase (Constantino et al., 2010), or may be a feature of depression. Given the cases in this sample showed positive outcomes, this increase in Confrontation could be understood to reflect the constructive effects of treatment and psychoanalytic psychotherapy's understanding of depression as in part, associated with fears about the consequences of aggression and conflict (Bibring, 1953; S. Freud, 1917; Kohut, 1977).

A further notable trend in rupture typology included the increase of Withdrawal ruptures to their highest level in the middle phase of treatment, whilst their rated significance on the alliance decreased, suggesting that, although more frequent, these ruptures created less of a strain or impact on the alliance. The authors of the 3RS and further studies of alliance rupture resolution processes (Lingiardi & Colli, 2015; Safran & Christopher, 1996) have noted that Withdrawal ruptures can also act as patient attempts at resolution. In a wish to protect the relationship with the therapist, the patient withdraws from potentially conflictual situations whilst remaining in treatment. Seen here in the middle phase of treatment this could suggest that these adolescents felt an established bond with their therapists and were actively seeking to safeguard this.

The observed differences in rupture typology across the different phases of therapy are of interest as Confrontation ruptures are typically more noticed and intensely experienced by therapists (Eubanks-Carter et al., 2014) in theory, influencing attempts at resolution. In this sample, therapists routinely responded to all ruptures throughout treatment; however this responsiveness dropped across treatment, alongside decreases in rupture frequency and therapist contribution to ruptures. Whether or not particular Rupture types (Withdrawal, Confrontation or Mixed) were more or less likely to be responded to appears to be partly influenced by the perceived significance of these ruptures on the alliance. When given higher significance ratings responses to ruptures increased. This held true for the middle and ending phases of treatment however in the beginning phase the opposite was observed, with resolution attempts more consistently being made for Mixed Ruptures despite higher significance ratings being given to Withdrawal ruptures. This potentially indicates that in the early treatment phase, therapists appeared more sensitive to the Confrontation aspect of Mixed Ruptures and actively working towards addressing these. Beyond the perceived lower significance ratings given to Mixed Ruptures in this early phase, it is clinically possible

that therapists were considering Withdrawal Ruptures as necessary steps for adolescents to maintain some autonomy (Binder et al., 2008) early in treatment with Confrontation patient marker behaviours being viewed as distinct barriers to establishing an alliance. Whereas in the middle phase therapists may have felt that the already established working alliance could sustain some level of confrontation with patients openly voicing dissatisfaction and this being seen as an important part of treatment for adolescents with depression. Therapists were demonstrably responding less to confrontation patient marker behaviours in this middle phase.

Again, this can be partly understood through the lower significance ratings given to the Confrontation aspect of Mixed Ruptures yet might also reflect the practice and aims of the middle phase of STPP. Here, therapeutic focus is on deepening the transference and working through negative transference elements, enabling adolescents to express their rage, anger and concerns for destruction more openly, thereby strengthening the overall therapeutic alliance (Long & Trowell, 2001). Potentially, therapists were viewing patient Confrontation behaviour markers as necessary steps in the psychoanalytic treatment of adolescents with depression, enabling the adolescent to express their anger outwards as opposed to inwards and against the self, and were focusing efforts on remaining connected to adolescents through this conflictual period by responding to patient Withdrawal Ruptures.

In addition to frequency of resolution response to rupture type, evidence suggests that Confrontation and Withdrawal ruptures are predictably resolved by different means (Safran et al., 1994) suggesting that therapist ways of responding to ruptures might also change across therapy phases. In this sample Expressive/ Exploratory resolution strategies were three times more likely to be associated with Withdrawal Ruptures. Suggesting that as patients moved away from the therapist or therapy, therapists attempted to understand this through observing and commenting on the process and encouraging patients to do the same. Mixed Ruptures

were more likely to evoke Immediate or Mixed Resolution responses, indicating that therapists potentially judged Confrontation patient marker behaviours to require some quick adjustment to re-establish collaboration, in order to facilitate or maintain any Expressive/ Exploratory resolution attempts. As hypothesised, Immediate resolution strategies were most frequently used in early treatment with Expressive/ Exploratory strategies more likely to be used in the middle phase. Immediate resolution subtypes strategies Redirects, and Changes Tasks and Goals were most frequently used in early treatment phases with decreases in their use in middle phases found to be significant, whilst Exploratory/ Expressive resolution subtype Links Between Patient Therapist reached its highest use in the middle phase of treatment and was also found to be significant. This change in Resolution typology is logical in so far as in early treatment, therapists and adolescents regardless of model, are likely to be negotiating the goals of treatment, changing and adjusting expectations with therapists redirecting or focusing the adolescent to the processes and tasks of therapy whilst establishing trust. These results are in keeping with recent studies of interaction structures in adolescent psychotherapy which have shown that when therapists and adolescents have an established strong collaborative working relationship, the therapy process is decidedly more influenced by the therapist's treatment specific techniques (Calderon et al., 2018).

It would appear that therapists felt the alliance to be strong enough in this middle phase to resolve ruptures through focusing on the therapy relationship and supporting adolescents in confronting problematic areas in their interpersonal relating implementing treatment specific techniques to STPP practice. In keeping with the findings of therapies working relationally (Binder et al., 2008; Safran & Kraus, 2014), therapists in this sample appeared to respond to Withdrawal ruptures in the middle phase as signs of ambivalence which needed to be explored within the context of the therapy relationship. They attempted to resolve such ruptures through increased Exploratory/ Expressive strategies attempting to

understand the adolescents experience, drawing particular attention to the rupture happening ‘here and now’ and making links with similar ruptures that have occurred within the therapeutic dyad, through resolution strategy Links Between Patient Therapist. Sessions using this resolution strategy were rated as having a higher therapist contribution to rupture (2.8) when compared with sessions without its use (2.1). However, there was little difference in the rated degree of resolution (2.7 and 2.6) moreover, this middle phase of therapy saw the highest average degree of resolution throughout treatment.

Limitations and Future Research

As already noted, one of the primary limitations of this study is the fact that data came from only two treatments. Although the sample size is the actual ruptures, of which there were 165, the statistical power applies to the number of sessions and patients. The impact of the study’s generalisability was inevitably affected by the restricted sample size; replication with a larger sample size is needed to confirm if there is an effect and further examine this study’s findings. Further, participants in both cases were male and their therapists female and therefore may reflect the particular way in which gender influences alliance rupture resolution processes in psychotherapy with adolescents.

Despite its limited use with adolescents, the 3RS proved effective in identifying rupture resolution processes enabling clear, consistent and easy data management. However, the 3RS does not currently code for therapist negative behaviours influencing ruptures, potentially missing important aspects of the intersubjective process. Equally, it remains unclear if Withdrawal ruptures might also function as patient attempts at resolution. This would be important to discern further capturing the complexity of agency and relatedness in moments of ruptures during a developmental period marked by establishing identity and autonomy.

Although the 3RS provides qualitative descriptions of patient and therapist behaviours attributed to alliance rupture resolution processes, these are coded into pre-determined categories limiting the richness of the descriptions. Further detailed qualitative study of the content of identified rupture moments might aid understanding of the changing nature of rupture and resolution typology and further differentiate the intersubjective process with adolescents in psychotherapy.

Conclusion

Based on these two cases, the results of this study suggest that ruptures are a common occurrence in psychotherapy with male adolescents with depression with an increased presence in the early phases of treatment. Rupture typology changes across treatment phases with adolescents displaying more confrontation marker behaviours as treatment progresses. Therapists were demonstrably responding less to these behaviours in the middle phase of treatment, allowing adolescents to directly express their distress and dissatisfaction; this aspect of clinical work could be conceptualized in relation to depression, in the sense that psychoanalytic practice would view the explicit expression of anger, conflict and dissatisfaction as important in the treatment of depression. During this increased period of conflict and increased frequency of Withdrawal Ruptures, therapists appeared to focus resolution efforts on remaining in contact with adolescents through exploring relational patterns in the patient-therapist relationship. Accordingly, when using resolution attempts actively exploring the patient therapist relationship in the middle phase of STPP, therapists were observed to have a higher average degree of contribution to rupture. Simultaneously, the average degree to which ruptures were considered resolved reached their highest level. From a clinical perspective, this potentially illuminates that despite increased conflict when working relationally with adolescents in moments of rupture, these instants provide an

opportunity to work through complex feelings in understanding and managing autonomy and relatedness, and strengthen the alliance.

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Part Three: Reflective Commentary

*A reflective commentary on the process of undertaking research as part of the clinical
doctorate in psychoanalytic child and adolescent psychotherapy*

Candidate number: PCVP6

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Introduction

As a number of us second year psychotherapy trainees prepared to listen the therapeutic sessions which would ultimately provide the raw data for our individual research studies, I was privy to a conversation which sparked much debate. *“It’ll be good to hear the material, then we’ll be able to see what’s really happening in the session.”* I was struck by the idea implied in this conversation, that there was one reality, one truth, what’s *“really happening”*. This echoing the old battle ground of subjectivity vs. objectivity and which holds the greater truth in clinical work - dispassionate researcher or empathic therapist. As an experienced psychoanalytic arts psychotherapist trained in multiple modalities I had for many years championed the corner of clinical subjectivity. Also a realist, I had come to accept and tentatively understand the importance of outcome and process research in ensuring both effective practice, and accessibility to psychoanalytic therapies within a competitive and resource limited National Health Service. Aside from external pressures to engage in research, my increasing use of routine outcome measures (ROMS) in my clinical work and involvement in service user groups, was slowly dismantling my internal certainty of “clinical wisdom” (Henton & Midgley, 2012). When it came to deciding where to embark on the long held desire to train in intensive psychoanalytic work I knew the training had to involve a robust learning and engagement with research. The integrated doctorate with The Independent Psychoanalytic Child and Adolescent Psychotherapy Association (IPCAPA), The Anna Freud National Centre for Children and Families (AFNCCF) and University College London (UCL) seemed the logical choice, with long established histories of both clinical and research practices. What I did not, and could not know back then, was just how great an impact this mix of study would have on my professional self. Further, how it would reveal to me ongoing tensions within the profession with regard to research, clinical training

and the practice of child psychotherapy, and how intimately intertwined our identities are with these endeavours.

The following reflective commentary aims to examine my developing reflexivity in engaging in psychotherapy research whilst simultaneously training in the practice of psychoanalytic child and adolescent psychotherapy. Organised around key moments or themes, these refrains aim to give a sense of “*my reality*” or “*lived experience*” at different points in time throughout the clinical research journey. This commentary will end with some final thoughts on the relation between the clinical and research elements of the training and the importance of further integrating these essential learning experiences for future generations of child psychotherapists.

Finding the tools

My previous research endeavours had largely followed along traditional psychoanalytic lines of enquiry, clinical case studies, with the possible addition of a routine outcome measure (ROM) or patient rated experience measure (PREM). These, not to be mistaken, as I later learned, for evidence based case studies, with clearly developed research questions and systemically collected data, analysed to examine a hypothesis. In this way, my enthusiasm and curiosity to learn far outweighed any actual experience in engaging with empirical research. I keenly felt this perceived deficit when first meeting my fellow trainees, many of whom had undertaken research projects as part of their post graduate trainings. My response was to somewhat competitively, immerse myself in the first year methodology seminars, feeling both enlivened by the new lenses through which I could examine clinical work, whilst simultaneously alarmed by the idea I needed to learn basic statistical analysis using the Statistical Package for the Social Sciences (SPSS). My long held fear of “the numerical” bore down heavily on my capacity to think, bringing anxiety and a retreat to pretending there was nothing to be gained from any such kind of analysis.

The Journal Club, where first year trainees read a pre-selected empirical paper, then discussed its findings, proved invaluable in helping me to realign these binary positions. Having a thoughtful engaged researcher clinician work through the paper alongside us, helping to translate the language of statistics, and where no question was unwelcomed, created a safe place to explore. I felt I could begin to tentatively evaluate the strengths and limitations of the research methods I was learning about and how empirical findings might constructively influence my clinical practice. Here, young “research heads” and “clinical arms and legs” (Henton & Midgley, 2012) could converse together in an environment which challenged Descartes error, recognising that “rationality requires emotional input” (Damasio, 1994) with both being given equal importance, scrutiny and recognition.

It was just such “emotional input” that fueled my interest, and eventual clinical audit, in understanding the loudly voiced frustrations of CAMHS colleagues and families when accessing appropriate services for children with complex needs. The results of my enquiry into referrals for children with complex needs and neurodiversity was welcomed by the team and led to changes in consultation processes between services. This first year clinical audit was helping me to find the tools required to later undertake the research project whilst also enabling me to actively contribute to the clinical life of the service. Interestingly, I had undertaken clinical audits within my former NHS roles but somehow hadn’t made, or perhaps hadn’t allowed myself to make, the connection, that this was an activity in developing research skills. I felt I was gaining confidence in my ability to engage with the research element of the training believing this would be an important part of my development and identity as a child and adolescent psychotherapist. A conversation with an experienced child psychotherapist at the time somewhat questioned this idea, when she expressed that, “audits are what clinical psychologists do”. Identity or (the conception of who one is) is largely composed of self-descriptions in terms of the defining characteristics of the social groups to

which one belongs, including professional groups (Hogg & Abrams, 1988). Confusingly, I was encountering child psychotherapists with vastly differing self-descriptions equally attributed to the professional group I was training to become a part of. Some of these attributions did not reconcile with my earlier experiences of the profession, nor with my expressed wish for my training - to develop, value and integrate both clinical and research skills into my practice and identity. Interestingly, these differences did not fall upon generational lines, a number of my fellow trainees expressed concerns for the research training component, at times feeling it a burden, something that had to be done, rather than something to be gained from. Encountering these sometimes firmly held and value laden, descriptions of the profession and what constituted the better use of a child psychotherapist's skills and time, was difficult. I was in the process of letting go of, sometimes temporarily as well as permanently, different aspects of my former professional identity, thereby creating in me some vulnerability. I found myself being attentive to not managing this discomfort through reinforcing unhelpful defenses, clinging to perceived clinical wisdom or adhesively identifying with other's descriptions of who child psychotherapists are and what they do. I fought to remain curious and to find my own identity within what I was understanding to be, a changing profession, grappling with issues of loss and identity (Edginton, 2013) and perhaps not yet certain of what was to be gained by integrating research skills into a clinical training.

Unearthing the area of interest

Placed in a peer research group utilising data from the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2011) I had initially been attracted to the suggested topic of silence, as it was a frequent issue in clinical work. Yet, as discussions in my small research supervision group expanded, and I read more

about alliance rupture resolutions and its hypothesised link to outcomes, I was increasingly drawn to the subject. It seemed to resonant with my experiences. I found myself reflecting on my previous clinical work reconceptualising interactions, or perhaps finding a different language to describe these experiences. I recalled quite vividly one of my first and perhaps most challenging, post qualification cases over 15 years ago. Every session felt like a battle with this patient, with considerable time spent avoiding getting into an argument or apologising for some mistake they felt me to have made. My psychoanalytic supervisor's advice at the time was clear, "apologise, take responsibility, step out of the muddle, understand it from their perspective, avoid too much unconscious speak, they're not working at that level" (process notes, 2002). As I read about Safran and Muran's alliance rupture resolution model it was no surprise that this case and my supervisor's clinical thinking at the time should come to my mind, it was in many ways, a precis of their model for resolving ruptures.

I was eager to understand more, sensing this research into alliance rupture resolution processes might benefit my developing clinical practice with adolescents. It was frustrating then to discover the lack of empirical studies with adolescents and how little had be written theoretically and clinically with regard to ruptures in this population. My supervisor rightly cautioned my reviewing too much of the adult literature, knowing there to be thousands of papers, yet I strongly felt it was important to understand how the constructs had been developed in adult treatments and to what extent they could be applied with adolescents.

I soon found myself struggling with the volume of the theoretical, clinical and empirical literature but also the varying conceptualisations of the alliance and multiple ways of measuring alliance ruptures. Interestingly, this confusion seemed mirrored in my clinical practice groups and intensive case supervisions. Here, each tutor or clinical supervisor had their own view on which was more important, working alliance, transference, real

relationship etc. with value judgements, knowingly and unknowingly cast as to which held the greatest importance. Often the therapeutic alliance was spoken of in broad terms with no explicit definition, further reflecting what I was reading in the empirical literature, that the youth field had yet to agree on an alliance definition. It was interesting to notice how closely aligned practice and research were in this struggle, yet frustratingly not quite in conversation with one another, at least not in the clinical seminars on the course. Empirical papers directly studying the clinical practices or specific topics we were studying such as assessments, parent child therapy, transference and indeed the alliance, were noticeably absent.

Nonetheless, I had come to understand there to be an ongoing dialogue about the usefulness of transference focused interpretations and the working alliance and to what extent, and when, psychoanalytic psychotherapists encourage a positive transference whilst equally taking hold of and working with a patient's negative transference. In considering this question, it was hard at times to not attach the aforementioned value judgements, with a tendency to equate work in the transference, as being "the real" work of psychoanalytic psychotherapy. My felt sense in the clinical room, was that establishing and attending to alliance ruptures differed depending both on the stage of therapy, and the adolescent's current state of mind and preoccupations. Horvath's thinking (Horvath, 2006, 2011) on the reclassifying of relational constructs, moving away from - is it real, transference, or rational in favour of - what level is the relationship being explored - feelings, relational inferences or relational processes, spoke to my growing clinical experiences working with children and adolescents.

At that time, a mutual exchange of clinical, theoretical and empirical papers with an experienced child psychotherapist, supervisor and lecturer, who had written on the alliance in work with adolescents, helped me to think about the importance of each of these "levels of relating" when working with adolescents. It was a fruitful exchange which again, seemed to

bring together “research heads” and “clinical arms and legs”. We saw the value of both outcome and process studies on the alliance, and how they might enhance clinical practice, helping us to consider in a more deliberate manner, when and for whom, these different alliances or ways of relating were of benefit.

In a moment of reverie after one of our conversations I found myself recalling my reasons for leaving Jungian archetypal psychotherapy to enter psychoanalysis some years ago. Simply put, I couldn't be angry in my therapist's presence nor did we discuss what was happening in the here and now, with long silences often broken with reference to images which I experienced as outside my awareness and understanding. Despite this, I liked her and enjoyed being with her, it was interesting, but something was missing. It was, as Anna Freud (1946) suggested, a bond but not a working alliance. My later experiences in intensive psychoanalysis could not have been more different.

It seemed that I was unearthing what might be aspects of my unconscious bias within the subject area, particularly those relating to work in the negative transference and the active addressing of ruptures. Researchers and indeed clinicians assume that a bias or skewedness in a study or a clinical encounter is undesirable and likely to unhelpfully shape understanding and outcomes. Malterud (2001) usefully differentiates that “preconceptions are not the same as bias, unless the researcher fails to mention them”. Taking hold of this reverie and acknowledging it, felt an important step in ensuring I didn't unhelpfully shape my understanding and outcomes, allowing me to lightly hold some ideas, pre-conceptions or hypothesis, based on a lived emotional experience, but to bring to this some rationality, a rigour through which I could evaluate these ideas. What might have once been helpful to me, might not be helpful to others. I was reminded again of how much of our personalities and personal stories influence our theoretical orientations and professional identities.

Grand Designs

Debate continued within my small research supervision group on the concept of “reality”, as we grappled with the multiple realities of patient, therapist and observer and how in research terms, triangulation was desirable. Further questions about how to capture phenomena and the strengths and limitations of the plethora of measures and methods available baffled me. Nonetheless, I was feeling creative in my thinking, playing with possibilities in finding my question and designing the study. A combination of naivety and omnipotence led to my struggling to narrow down a research question and subsequent design. My ideas were often too big and unrealistic given the time frame. Yet, it felt difficult to make decisions when I lacked confidence, sometimes I felt as though I wasn’t quite understanding what I was making a decision about. At times I was frustrated and very much wanted my supervisor to tell me what to do. When it came to supporting me to reign in my ideas and focus my question and how I might explore it, her patience matched her extensive experience as she brought me back to basics. I refocused on my initial interest in the area and how little was known of in session ruptures in adolescent psychotherapy, this suggesting the need for an exploratory study. In my clinical work I was undertaking my third STPP case and some of my earlier thoughts around the different levels of relating, and managing of alliance ruptures seemed relevant to the different phases of STPP, with their varying therapeutic foci. This helping me to further narrow down my focus - I would select sessions from each of the phases of STPP and explore and analyse the presence and patterns of alliance ruptures and how therapists attempted to resolve them. The study would also capture something of the ongoing dialogue in working relationally and in the transference, as STPP emphasises this focus in the middle treatment phase.

My review of the measures available confirmed the Rupture Resolution Rating System (3RS), was potentially the most useful and would enable me to work alongside a

PHD student also studying ruptures. This gave me some comfort and reassurance, as I was enjoying working with others in our research groups, a welcomed change from the intimacy of consulting room. I left open, time permitting, the possibility of undertaking some qualitative analysis of identified moments of rupture, but in the main, I was interested in patterns and prevalence, suggesting a quantitative analysis and nomothetic focus. Given my aforementioned fear of the numeric and SPSS, I was challenging myself, in a small but manageable way working within my zone of proximal development (Vygotsky,1978).

Thinking to doing - coding the sessions

The shift from thinking to doing brought great relief. Letting go of the macro view of the study along with its contextual place in the theoretical and empirical literature to focus on the micro tasks, felt like I was emerging from a kind of intellectual paralysis which had taken firm hold whilst trying to design my study. I took comfort in the clarity of the brief: learn the measure; gain inter-rater reliability; code the selected sessions. Following completing the Webinair training with one the developers of the Rupture Resolution Ratings System 3RS, I was confident in my understanding of the tool and what patient/ therapist behaviours might indicate the presence of ruptures and resolution attempts. My research partner and I joined a PHD student to further self- train ourselves in using the measure. We would listen to 10 selected sessions (not to be included in our sample) to gain interrater reliability in using the measure. For the first case we agreed to stop after each minute 5 segment to confer on our coding, discuss any differences and clarify any understandings.

I was then somewhat shocked to discover the degree to which I was struggling with this task. I found it difficult to code what I was hearing and to resist, either trying to find, or make further meaning, in the interactions between therapist and adolescent. My PHD colleague struggled less with this. She was able to filter out the noise, her ideas and assumptions, and other interesting processes which might be occurring in the therapy and

remain focused on the task at hand. In discussing this she explained to me, how she wasn't disregarding her thoughts and feelings or other processes she might have observed, rather she was 'putting a pin in them' sticking them to a metaphorical bulletin board, until such a time it was appropriate to bring these thoughts and feelings to the foreground. In this way she was ensuring the cleanliness of her instruments and her findings. In a small notebook she jotted down thoughts, feelings and associations (her countertransference reactions). This wasn't dispassionate researcher vs. empathic therapist but rather disciplined researcher carefully focusing in on the present moment under investigation, whilst keeping sight of other potential variables potentially impacting on the present moment. As we continued coding our way through the 10 training sessions, my ability to focus in on the present moment and code the patient marker behaviours increased. I also started to make notes on the side. These were often my responses to hearing another therapist conduct STPP and what I might learn from their practice, noting interventions which seemed particularly effective and those which felt at odds with a short term therapy model. I was gaining much from researching a psychotherapy process I was also actively engaged in developing my skills in, and felt myself to be gaining considerable confidence in delivering STPP.

The Not Knowing Stance – Analysing the data and writing up the study

As an MBT practitioner I'd prided myself on my ability to "eschew the need to know", to remain curious and maintain a not knowing stance. Similarly, working psychoanalytically I worked hard in developing my capacity for 'negative capability', tolerating uncertainty and confusion in lieu of sticking with what I and patient, think we know. Sadly, in the research context, if my data were my patients, I think they all would have left the consulting room long ago, possibly slamming the door on the way! There was little eschewing of the need to know, as I slowly entered the raw data into SPSS, premature and over interpretative connections were emerging. I was wrestling with a strong desire "to

know” or rather, to confirm what “I thought I knew” and weaponising my data for this purpose. I was reminded yet again, of how difficult it is to “not know”. I was struggling to be curious, playful, sift through the layers, sit with and digest the findings. Similarly, when writing up the study the need to over emphasise or heavily interpret the data crept in again. Reflecting on this, a number of factors came to mind. I thought my need to overinterpret my data was as in part a defense against my growing awareness, and disappointment, with a flaw in study design. Although I had coded a number of sessions for rupture resolutions, 22 in total, I had not coded enough treatments to be able to generalise the findings, many of my results were non-significant. I had strayed from the nomothetic. Looking back during the early design phase I had considered a qualitative element, potentially listening to the sessions to consider if any ruptures were being worked through or resolved over a series of sessions and what were the content of these ruptures. Time did not permit this to happen and in hindsight, I am not sure how it would have fit with the original question and study design. I think I was also concerned that, a.) I might not find ruptures and b.) I might not capture enough ruptures in each phase of treatment to reliably contrast these phases. An opportunity to change the sample size and make up was then missed. When training myself in the 3RS measure it became clear that ruptures were present in most sessions. At this point in time, I could have decided to code less sessions from each treatment, whilst adding additional treatments. I recall my research partner and I discussing this at the time, however the thought of making this late change unsettled us so stuck with what we knew.

As I had taken a fifth year to complete my research, owing to both family matters and attending to other professional demands throughout the course, I was no longer in regular contact with my supervisor, nor my small research group. I think this left me feeling somewhat alone with my findings. I found it difficult to trust that my study’s findings were interesting enough and useful to others. On my own I had lost sense of the bigger picture of

how my small study was part of a much bigger project in ensuring that the data from the original IMPACT RCT was further used to understand psychotherapy processes. I regret not reaching out earlier to others to think with me and together sift through the findings.

Thinking back on my time spent explicitly learning within the research domain of the doctoral training, one of the most enjoyable elements of this was working with others. There was often a lively sense of collaboration, with considerable creativity and a genuine curiosity to learn and understand more about the practice of child psychotherapy.

Emerging Identity

I entered the integrated doctoral training with an expressed wish to develop my skills in understanding and conducting both research and intensive psychoanalytic psychotherapy. I came convinced of the value of both outcome and process research to clinical practice but lacked the skills to know how to better close the research practice gap. This training has undoubtedly developed my ability and confidence to translate research findings into clinically meaningful information and to apply this information to my everyday practice. Learning how to read an empirical paper, critically evaluate it and the methods used to illuminate its findings was a first step in this process. This remains an integral part of my practice, with Ulberg and colleagues (2021) experimental study of transfer work in teenagers, and Halfon's (2021) recent study in psychodynamic technique and therapeutic alliance my current reading companions.

I was not quite prepared for how each of the stages in conducting my own research would impact on my developing skills in practicing psychoanalytic psychotherapy. From the scoping of the literature, to the narrowing down of the question, designing the study and analysing the findings, each presented me with new challenges in remaining curious, tolerating not knowing and holding my ideas lightly. Equally, I hadn't quite been able to imagine the lively creativeness that would accompany the research process. Researching a

model I was actively learning to practice in was challenging and rewarding, at times exposing me to my lack of knowledge and skill.

Throughout these experiences I was developing a new professional identity within a profession which I experienced, as still in a process of mourning for a training lost. It seemed that at times the wider professional group of child psychotherapists I was encountering, was consciously and unconsciously, self-identifying into sub groups with distinct identities - theoreticians, clinicians and researchers. This left me, as a trainee psychotherapist and fledgling researcher, eager to integrate these multiple realities and identities, struggling to find colleagues who I could identify with.

Reflecting on the integration of research and clinical training elements, the disconnection between “research heads” and “clinical arms and legs” appeared most evident to me in the clinical curriculum and teaching seminars. Here, content and discussion rarely, if ever, included that of empirical studies. Many of which were directly investigating the clinical processes, client populations and models of practice we were learning about. This seems an opportunity lost, perpetuating the split between practice and research, and limiting our ability to be genuinely curious about what we do as child psychotherapists and who this benefits.

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