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The Alliance With Young People: Where Have We Been, Where Are We Going?

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The therapeutic alliance is considered an important mechanism of change in youth psychotherapy. Accordingly, it has become one of the most investigated psychotherapy variables. Yet, the theoretical and empirical literature on the alliance with young people is complex and has received criticism. This article aims to (a) critically review the existing knowledge on the alliance in youth psychotherapy from its definition to the existing research and (b) discuss some of the implications of this knowledge for clinical practice ad future research. This review highlights that the alliance in youth psychotherapy, as commonly measured, has a significant, although small, impact on outcomes; and that the alliance–outcome association may be influenced by the young person and the therapist's characteristics, as well as therapy types. This points to the importance of finding tailored ways of fostering a strong alliance when working with young people and questions the assumption of the alliance as a generic aspect of all types of youth psychological treatments. Attention to repairing alliance ruptures also emerged as key, especially to preventing early dropout in adolescent therapy. It is argued that despite its limitations, alliance research in youth psychotherapy can have important clinical implications to improve youth psychotherapy. A resumption of a conversation between the clinical and research field on the alliance is needed to better understand the nature and role of this important variable when working with young people and to use this knowledge to inform and improve clinical practice and therapeutic training.

Clinical Impact Statement

Question: This article aims to summarize the current theoretical and research knowledge on the alliance in youth psychotherapy and its challenges. ***Findings:*** Despite its limitations, current research points to the importance of a strong alliance with young people for the success of treatment, but attention must be paid to monitoring and repairing alliance ruptures. ***Meaning:*** Existing knowledge on the alliance can have important clinical implications and should be used to inform both future research agenda and clinical practice. ***Next Steps:*** The understanding of the alliance should be updated in light of existing research and developmental theories. Alliance research and clinical practice should be integrated so that research can be used to develop evidence-based clinical guidelines and clinical ideas can guide future research.

Keywords: alliance, literature review, rupture and repair, youth psychotherapy, clinical implications

The importance of the quality of the relationship between client and therapist in talking therapies has long been recognized, and strenuous efforts have been made to conceptualize and measure this crucial element of psychological treatments. The most studied aspect of this relationship is the alliance, which refers to the quality of the bond and collaboration between client and therapist in the therapeutic process (Bordin, 1979). Different terms have been chosen to describe this important, yet complex, component of psychotherapy. Terms such as therapeutic alliance (Zetzel, 1956), treatment alliance (Freud, 1946; Shirk & Saiz, 1992), working alliance (Bordin, 1979; Greenson, 1965), and helping alliance (Luborsky, 1976) have all been used to refer to one or more specific aspects of the alliance. Because the use of these labels has not been consistent, the term alliance is mostly used in this review.

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The construct of the alliance has roots in the psychoanalytic literature and can be traced back to the work of Freud, who recognized the need to "make the patient into a collaborator" for the success of treatment (Breuer & Freud, 1895, p. 282). Following Freud, other psychoanalytic thinkers further developed the alliance concept (e.g., Greenson, 1965; Sterba, 1940; Zetzel, 1956), and from the 1950s onwards the alliance was adopted as a core concept in a range of psychotherapies, including humanistic, cognitive, and behavioral approaches (Hayes et al., 2007; Leahy, 2008; Raue et al., 1997; Rogers, 1965). As such, the alliance has now come to be considered a "trans-theoretical" concept, especially thanks to Bordin's (1979) contribution, who developed what has become the most widely used pan-theoretical definition of the alliance to date. According to him, the alliance refers to "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" (Bordin, 1994, p. 13).

As a trans-theoretical concept which has lent itself to measurement, no other therapy process has received as much attention in empirical research. While the literature on the alliance in adult psychotherapy is vast and complex, youth psychotherapy research, despite its recent growth, presents several limitations. To make progress in the field it is necessary to take stock of the current knowledge and use it to inform both clinical practice and future research agenda. This review responds to this need and aims to provide a broad theoretical and empirical overview of the alliance and its role in youth psychotherapy. It summarizes the challenges facing the definition, measurement, and research on the topic and points out some of the implications of the current knowledge for clinical practice ad future research.

What Do We Mean by the Alliance in Youth Psychotherapy?

Similar to the adult literature, the theorization of the alliance with young people started in the psychoanalytic tradition with Freud's (1946) work. She considered the alliance as the more mature and rational part of the therapeutic relationship based on the young person's wish for help with internal difficulties (Freud, 1946). According to her, the alliance with young people "involves an acceptance of the need to deal with internal problems and do analytic work in the face of internal resistance or external resistance, as from the family" (Sandler et al., 1980, p. 45). In contrast to Klein (1952), who believed that there was no "conflict-free" element of the patient's ego that could relate to the therapist outside of the transference, Freud (1946) attempted to disentangle the alliance from the transferential components of the therapeutic relationship. However, she also recognized that elements of transference might inevitably influence the alliance: "a solid alliance … is not the same as positive transference even though positive transference may assist the alliance" (Sandler, et al., 1980, p. 47). Building on this psychodynamic understanding of the alliance and drawing on Bordin's (1979) influential work, Shirk and Saiz (1992) described the alliance as a two-dimension phenomenon, including an affective and a collaborative component (Shirk & Saiz, 1992).

In youth, psychotherapy more has been written about the affective/relational component than any other alliance component. Such emphasis is based on the assumption that a positive bond is an essential prerequisite to foster young people's participation in the therapeutic work, especially because their motivation to engage and collaborate in treatment might be different to adults (DiGiuseppe et al., 1996; Gulliver et al., 2010). First, young people tend to be referred to treatment by others (parents, family, and/or school) and rarely seek therapy themselves. Second, younger children in particular might have limited self-evaluation of their own emotional and behavioral problems, hence, might not understand or agree with the need for therapy (Freud, 1946; Rickwood et al., 2005). While this is usually not the case for older children or adolescents, a positive motivation to seek therapeutic help may still be lacking since attending mental health services may conflict with adolescents' developmental needs for social acceptance by peers and autonomy from parents, as well as with their high reliance on self to resolve problems (Gulliver et al., 2010).

Some have, however, criticized an exclusive emphasis on the bond component of the alliance, especially with adolescents (DiGiuseppe et al., 1996; Sandler et al., 1980). For instance, in the psychodynamic literature it has been argued that while for a young child the bond might constitute "the main basis for the therapeutic work" (p. 47), an older child or adolescent is expected to develop "a proportionally greater awareness of [their] problems and greater wish to work towards their solutions" (Sandler, et al., 1980, p. 45). Similarly, the cognitive perspective has emphasized the importance of reaching a collaboration on therapy goals and tasks for a solid alliance and positive outcomes (DiGiuseppe et al., 1996; Leahy, 2008). Furthermore, some young people do express a need for help, especially when older and/or experiencing anxieties or obsessional problems. This is even more relevant nowadays in most western societies where attitudes to mental health and seeking mental health support have started to change, especially since internet-based information and interventions have increasingly been used to engage young people (Gulliver et al., 2010).

Important developmental considerations should be considered about the collaborative component of the alliance too. First, developing an agreement on goals may be particularly challenging if the young person has been referred to treatment by others and/or lacks self-awareness of their problems (Gulliver et al., 2010; Kazdin, 2003). Second, a variety of cognitive skills are necessary to formulate long-term therapeutic goals and to elaborate the link between such broad, sometimes abstract, goals, and the specific tasks of therapy (Shirk, 2013; Zack et al., 2007). Such judgments may exceed the cognitive capacities of some young people, who may also have little knowledge or understanding of the activities expected in therapy (DiGiuseppe et al., 1996; Gulliver et al., 2010). While adolescents have more sophisticated cognitive capacity, for them, independence and self-determination may be important developmental issues, which could complicate reaching an agreement on therapy goals and tasks (Karver et al., 2018; Meeks & Bernet, 2001).

Furthermore, while the alliance with adults is based on a single, dyadic relationship between client and therapist, the alliance in youth psychotherapy often includes an alliance with caregivers. Caregivers tend to be involved in their children's therapy in various ways. They are often the referral source and might contribute to the initial assessment or some of the sessions. Even when not directly involved with their children's treatment, caregivers are often responsible for bringing them to therapy and/or for its financial cost. Consequently, youth therapists need to also negotiate an alliance with their client's caregiver(s) and perhaps manage various sets of goals, since the goals of parents and youths might diverge.

Importantly, the degree of parental involvement can change based on the client's developmental stage and their culture. For instance, in most western society, where adolescence has often been framed in terms of a process of separation and individuation from parents, less direct involvement of caregivers in therapy might be considered more appropriate to develop an alliance with the young person and foster trust and respect for their independence and confidentiality. In contrast, with younger clients having the caregivers more involved might be more beneficial for the alliance, due to children's greater dependence on their caregivers. However, in cultures which emphasize more of a relational self, and where less emphasis is placed on adolescence as a period of separation from parents, it could be that parental involvement is crucial to develop an alliance with adolescents too. Overall, existing research shows that social support and encouragement from caregivers can be helpful to engage young people in therapy (Cirasola, Martin, et al., 2022; Gulliver et al., 2010), yet it offers little clinical guidance, especially when it comes to working with adolescents from non-Western cultures.

Young people are developmentally distinct from adults, and these differences inevitably influence the alliance and its development. Accordingly, it might be that various alliance components and their role differs in prominence across developmental phases and perhaps also across phases and types of therapies. However, these assumptions have been neglected when defining, measuring and conducting research on the alliance. There has been little elaboration on the meaning of the alliance with young people since Bordin's (1979) and Shirk and Saiz's (1992) definitions were developed, and starting from the mid-1970s, there has been a direct move into the empirical measurement and research on the alliance (Horvath, 2018). Hence, even if the alliance definitions were developed over 30 years ago and might not be developmentally sensitive enough, they are still the most used to date (Bose et al., 2022; Karver et al., 2018). Perhaps attempts to research the role of the alliance may have blurred important considerations on its definition in favor of a uniform and more measurable concept, with a consequent loss of precision and, perhaps, clinical meaning. Not surprisingly, in the last decade these alliance definitions have been criticized for being vague and not so clinically meaningful (Cirasola, Midgley, et al., 2022; Horvath, 2018; Safran & Muran, 2006).

To be more developmentally appropriate and clinically relevant some have argued that alliance definition(s) (and measures) should describe this key therapy variable according to what young clients and therapists report as being important to them (Bedi, 2006; Horvath, 2011). Some recent attempts to qualitatively explore young people's experience of the therapeutic relationship point to the importance of developing trust and emotional closeness for the development of a good alliance (Cirasola, Martin, et al., 2022; Mortimer et al., 2022). Furthermore, especially with adolescents, respect for their individuality, agency, and confidentiality have been found to be key aspects of a strong alliance (Gulliver et al., 2010; Wilmots et al., 2020). Even if current definitions and measures do not explicitly highlight these aspects, youth therapists should take a developmental approach when fostering an alliance with young people and aim to nurture the above-mentioned aspects with their young clients (and their caregivers). Our understanding of both child development and psychotherapy process has evolved over the last decades, but these changes have not been integrated with the existing alliance definitions and measurers yet. This is an issue that ought to be addressed.

Why Does the Alliance Matter in Youth Psychotherapy?

From a clinical and theoretical perspective, the literature on the role of the alliance in the treatment of young people is mixed and varies according to therapy types. In the psychoanalytic tradition, in contrast with earlier thinkers, who considered the alliance a necessary precondition for the therapeutic work, (Freud, 1912, 1946; Sterba, 1934), Anna Freud (1946) highlighted that the therapist could act as a new and understanding object, providing the young person with a different experience. This implies that a positive alliance (or therapeutic relationship more broadly) could produce change, suggesting that the alliance can be a mechanism for change in and of itself. Such a view has also been highlighted by play therapists (Axline, 1947; Landreth, 1993). In this tradition, the young person's experience of the therapist as supportive, attuned, and nonjudgmental is considered central for therapeutic change (Axline, 2013). In cognitive behavioral therapy (CBT), relationship factors were initially given less attention or only considered as a way to facilitate the young person's involvement in the tasks of therapy (Kendall et al., 2009). However, with the second wave of CBT, the alliance started to be seen as directly beneficial and a vehicle for promoting therapeutic learning and change in this tradition too (Tee & Kazantzis, 2011).

From an empirical perspective, the most common aspect of alliance research concerns the study of the relationship between alliance and therapy outcomes. Similar to the adult literature, youth alliance research has consistently demonstrated the existence of a relationship between strong alliance and good outcomes (Bose et al., 2022; Karver et al., 2006, 2018; McLeod, 2011; Murphy & Hutton, 2018; Shirk & Karver, 2003; Shirk et al., 2011). However, compared to the adult literature this association was found to be smaller (ranging from $r = .14$ to .29) and influenced by several variables including clients' characteristics and type of treatment. Caution is needed when interpreting these findings. Most studies on the alliance–outcome association in youth psychotherapy have not systematically measured the alliance in the early stages of treatment or across its duration, but assessed it at one time point, often toward the end of treatment (McLeod, 2011; Simpson, et al., 2013). Although this design highlights covariation of alliance and outcome, it complicates the assessment of the direction of the relationship between alliance and outcomes, that is, whether the alliance drives symptom improvement and it is not a product of it.

In the last decades, researchers have attempted to better determine the temporal precedence of the alliance and symptom change using more sophisticated designs and analyses (Falkenström et al., 2013; Zilcha-Mano et al., 2014). In youth psychotherapy, a few studies found a significant association between early alliance and later symptom severity while controlling for initial severity (Chiu et al., 2009; Labouliere et al., 2017; Marker et al., 2013). One study controlled for both pretreatment symptom severity and prior symptom change and found that adolescent and therapist average alliance ratings early in therapy had a weak but significant association with subsequent symptom change even using this strict design (Cirasola et al., 2021). These findings provide some support to the idea that a strong alliance early in therapy can produce subsequent positive change in outcomes rather than being a product of earlier improvements.

Overall, despite its limitations, youth alliance research seems to support the idea that a strong alliance can produce subsequent

positive change in outcomes. This seems to be the case both in face to face and online therapy. In recent years, since internet-based interventions have shown promising results for adolescents (Christ et al., 2020; Grist et al., 2019; Midgley et al., 2021), a small body of research has begun to examine associations between alliance and outcome in online therapy too (Anderson et al., 2012; Hanley, 2012; Henson et al., 2019; Mortimer et al., 2022). Despite the small number of studies, research has thus far supported the existence of an association between alliance and outcome in internet-based therapy for adolescents (Anderson et al., 2012; Mortimer et al., 2022). Since most western adolescents live within sophisticated online worlds internet-based therapy might be an effective option for them (Pagnotta et al., 2018), and fostering an alliance remotely might need to be a clinical priority.

Since the alliance has emerged as a key ingredient of successful youth psychological therapies, clinicians should prompt their attention to fostering a positive alliance from the onset of treatment. To do so, it is crucial to learn more about how to build a good alliance when working with young people, especially in internet-based therapy, since many of the techniques used in face-to-face therapy, such as body language, cannot be relied upon online (Wood et al., 2021). A qualitative study exploring the role of the alliance in text-based psychodynamic psychotherapy for adolescents identified the "supportive" techniques of praise, warmth, and creating a sense of hope as being important for building a strong alliance (Mortimer et al., 2022). Therapists working remotely with young people might, thus, need to be even more explicit in demonstrating their support and positive regard verbally to form a good alliance, compared to those working face to face, where alliance-building may depend more on nonverbal cues. Qualitative studies in face-to-face therapy have indicated that a positive alliance (and therapeutic relationship more generally) was fostered with therapists who offered experiences of emotional closeness and genuine interest, while respecting the young person autonomy (Binder, Holgersen, Høstmark Nielsen, 2008; Gulliver et al., 2010; Wilmots et al., 2020). This seems to be achievable by balancing the dual roles of being "friendly" with being a "professional expert" thereby embodying a collaborative and egalitarian approach (Wilmots et al., 2020). This is essential information for providing useful evidence-based clinical guidance on what aspects of the alliance therapists should focus on to foster and maintain an alliance with young people.

Does the Alliance Matter More for Some Young People Than Others?

Another important finding of the alliance literature in youth psychotherapy is that, unlike the adult literature, the alliance–outcome relationship was found to be moderated by a variety of factors; in other words, having a good alliance may matter more for certain groups of clients than others. Some studies have found that being female and younger were associated with a stronger alliance–outcome relationship (McLeod, 2011; Shirk et al., 2011). However, other studies failed to confirm this relationship (Cirasola et al., 2021; Karver et al., 2018). Similarly, the alliance–outcome association was found to be stronger for externalizing samples than for internalizing samples in some but not all meta-analyses (Shirk & Karver, 2003; Karver, et al., 2018; McLeod, 2011; Shirk et al, 2011). It may be that, because of the greater challenge in engaging oppositional and disruptive youths, the alliance might have a more important role in promoting change with this population compared to youth with more internalizing problems. It is also possible that the alliance role changes for different clients based on the stage of therapy. For instance, since young people with depressive disorders might have lower initial motivation to complete therapy tasks, developing an alliance with them might be key at the onset of treatment to foster their engagement. In contrast, young clients with anxiety disorders may have greater initial motivation for treatment as they might find their symptoms more disturbing, so less emphasis might be needed on the alliance early in treatment (Bose et al., 2022). These are all important clinical considerations but need empirical support.

It may also be that the above-mentioned research findings might be due to the methodological limitations of the studies. One recent study, which assessed possible moderators of the alliance–outcome association while controlling for prior symptom change and baseline symptom severity, found that adolescents (a) age, (b) gender, (c) baseline symptom severity, and (c) level of conduct problems did not have a statistically significant effect on the alliance–outcome association (Cirasola et al., 2021). It might be that when using more sophisticated research design, the early alliance–outcome association is no longer influenced by young people's baseline characteristics, in line with the evidence in the adult literature (Flückiger et al., 2018).

Although the literature on the topic is still mixed, current research suggests that the relationship matters when working with most (perhaps all) young people, even if it may be more important to establish a good, early alliance with some young clients than others, due to their preexisting characteristics (e.g., gender, age, background, attachment style etc.)

Is the Alliance the Same Across Various Therapy Types?

Another important finding of existing youth alliance research concerns the relationship between alliance and treatment type. In contrast with the adult literature, treatment type has emerged as a possible moderator of the alliance–outcome association, with stronger associations in youth behavioral versus nonbehavioral therapies (Cirasola et al., 2021; Karver et al., 2018; Shirk et al., 2011). A few studies also found differences in the alliance strengths across various treatment types (Cirasola, Midgley, et al., 2022; Hogue et al., 2006; Mcleod et al., 2016). Overall, these findings suggest that the role of the alliance might differ across youth therapy types, and may play more significant in role for outcomes in approaches such as CBTs. This may be because in youth CBT the alliance might be essential to encourage active participation and engagement on the part of the young person, especially in more emotionally challenging tasks like exposure. In contrast, in nonbehavioral therapies, like the psychodynamic approach, where there is sometimes less explicit emphasis on reaching an agreement on therapy tasks and goals, it might be that good outcome depends less on establishing an alliance (or at least the elements of the alliance which are captured by the measures most commonly used in existing studies). Yet, psychodynamic therapies, as the research suggests, may be effective (or ineffective) regardless of whether the young person and the therapist have established this type of collaborative agreement (Cirasola et al., 2021), and other alliance aspects might be more important.

As hinted at above, these results might reflect genuine differences in the alliance strength and its relationship with outcome across treatment types, but they may also be related to the issues of the current conceptualization and measurement of the alliance. The alliance construct has been operationalized as a general psychotherapy variable, and alliance measures have been written in a general rather than a therapy-specific manner. We would, thus, argue that most alliance definitions and measures might be more suitable for some types of therapy than others. For example, given the emphasis on collaboration on tasks and goals of therapy in CBT, Bordin's alliance definition and related measures might better capture alliance aspects that are in line with the way the alliance is conceptualized and used in CBT, where explicit collaboration is an essential part of how technical aspects of the therapy are delivered. By contrast, a measure of alliance which focused more on the relational bond, including establishing a level of trust that would allow the therapist to offer challenge and bring more unacceptable emotions into view, could be of more relevance to psychodynamic approaches, where tasks and goals are not necessarily explicitly discussed during sessions (e.g., Cregeen et al., 2017). Consequently, reaching a collaboration on therapy tasks and goals might be a less instrumental aspect in this treatment type, explaining the lower association between alliance and outcome found in this treatment type when measures based on Bordin's alliance definition, such as the Working Alliance Inventory (Horvath & Greenberg, 1989), are used.

Overall, the notion of the alliance as a common factor acting independently of specific therapeutic approaches might be flawed, and it may be more beneficial to think of the alliance as a complex variable that can change across types and stages of therapy. Considering these issues, youth therapists should reflect on how therapy-specific interventions might facilitate or hinder certain aspects of the alliance. Furthermore, alliance measures assessing the degree of collaboration on therapy tasks and goals may be more appropriately used in CBT than other nonbehavioral therapy types such as psychodynamic therapy, and therapists should be mindful of this if/when using these scales to monitor the alliance with their young clients.

Is the Alliance a Static Variable of Therapy or an Ongoing Negotiation Characterized by Ruptures and Resolutions?

It is our view that global assessments of "the alliance" may have less relevance to clinical practice than approaches that focus more on the on-going negotiation and renegotiation of the therapeutic relationship, as a process that continues across the course of therapy. Starting from 2000, there was a shift in the alliance research toward understanding what makes the alliance therapeutic. This led to what has been called the "second generation" of alliance research (Safran et al., 2011), which focused on the alliance fluctuations over the course of therapy, including the processes of alliance ruptures and resolutions. Building on Bordin's (1979, 1994) ideas, Safran and Muran (2000) redefined the alliance as a continuous, dynamic process of intersubjective negotiation between client and therapist, characterized by moments of deterioration in its quality (ruptures) and moments in which such tensions are resolved (resolutions/repair). Like the alliance concept itself, alliance rupture "is a very slippery concept" (Safran & Muran, 2006, p. 288), and it is not easy to distinguish the term from other elements of impasse in psychotherapy. Alliance fluctuations have been conceptualized using various terms, such as strains in the alliance (Bordin, 1994), weakening and repairs of the alliance (Lansford, 1986), impasses in the therapeutic relationship (Kohut, 1972), misattunement (Stern, 1985), and alliance ruptures and repairs/resolutions (Colli & Lingiardi, 2009; Safran & Muran, 2000). Although the term rupture might be controversial, what makes Safran and Muran's work influential and a milestone in the alliance literature is that they supported their theory with rigorous clinical and empirical investigation (Eubanks et al., 2018, 2019; Safran, et al., 2011).

The second generation of alliance research in adult psychotherapy has demonstrated that the alliance commonly undergoes periods of strains or ruptures, and that working through these relational impasses can be beneficial for treatment retention and outcomes (Eubanks et al., 2018; Safran, et al., 2011). In particular, lower rupture intensity and higher rupture resolutions have been found to predict better ratings of the alliance, session quality, and good outcomes. In contrast, unresolved alliance ruptures predicted poor outcomes and treatment dropouts (Eubanks et al., 2018). Although most research on alliance ruptures and resolutions consists of studies with adults and may not necessarily transfer to youth psychotherapy, the few available studies on the topic have found a relationship between the resolution of ruptures and good outcomes in youth psychotherapy too (Cirasola, Martin, et al., 2022; Daly et al., 2010; Gersh et al., 2017; Schenk et al., 2019).

Research on alliance ruptures with young people also found a predominance of withdrawal over confrontation ruptures (Cirasola, Martin, et al., 2022; Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). This may be because adolescents, due to the power dynamics involved in working with an (adult) therapist, tend to hide their disagreement or even claim to agree with the therapist in a deferential way. Withdrawal ruptures, such as minimal response or being deferential, are more subtle than confrontation (e.g., complaints about the therapist and/or the tasks of therapy) and can be confused with pseudoalliance (Muran & Eubanks, 2020). This seems to point to the importance of training youth therapists in how to recognize and address even minor tensions or signs of adolescents' withdrawal, especially given the power dynamics inherent in a therapy between an adult and a young person. Identifying and exploring these ruptures from the very early stages of treatment might be a way to prevent the young person's withdrawal from dictating the course of therapy.

Research also suggests that unresolved ruptures are associated with premature dropout from therapy with adolescents (Eubanks et al., 2018; O'Keeffe et al., 2020). While more should be learnt on this, the following therapists' behaviors have been identified as associated with alliance ruptures and poor resolution: (a) therapists failing to recognize the young person's emotional experience in psychotherapy, (b) therapists being passive, unresponsive, or silent for long periods of time, (c) therapists persisting with a therapeutic activity, which the young person had rejected or not engaging in, and (d) therapists focusing on risk issues and a potential need to break confidentiality (Morán et al., 2019; O'Keeffe et al., 2020). These findings show how the knowledge of what helps and what hinders the alliance is relevant to clinical practice since it can guide therapists' interventions. It may be that therapists need particular training, for example, in how to raise safeguarding issues in a way that recognizes this may cause alliance ruptures, but helps these to be addressed.

Yet, to date, there are only two models on how to address alliance ruptures with young people and in both cases these involved a downward extension of models developed for adult clients, which might not adequately take into account the additional challenges youth therapists might face. Daly et al. (2010) validated for use with adolescents Bennett et al. (2006) model of repairing rupture with adults in cognitive analytic therapy. More recently, Nof et al. (2019) adapted Safran and Muran's (2000) original rupture–repair model for child and adolescent psychotherapy and developed the "child alliance focused approach," which has not been empirically validated yet. Given the lack of guidance on how to handle ruptures with young people, it is not surprising that a few qualitative studies have found that youth therapists often feel vulnerable, even wary in relation to ruptures (Binder, Holgersen, Høstmark Nielsen, 2008; Binder, Holgersen, Nielsen, 2008; Morán et al., 2019). Ruptures pose great emotional and interpersonal challenges to the therapeutic work and cause pressure on therapists, who need to be able to withstand such pressure while managing to repair them and continue the work of therapy (Muran & Eubanks, 2020). Research is, therefore, essential to learn more about the process of repairing rupture with young people and develop evidence-based guidance for both clinical practice and therapists' training.

Discussion

Despite the popularity of the alliance concept, defining and measuring this complex construct has involved several conceptual and methodological challenges, and the construct and its measurements have attracted criticism (Elvins & Green, 2008; Horvath, 2011). From a broad, historical perspective an essential issue of the alliance definition concerns its link with the search for common factors. But it might be that this research on common factors and a common language to define them led to a loss of precision and somehow clinical meaning regarding the alliance (Horvath, 2011). As a result, the current literature relies on alliance conceptualizations for youths who are too general and not developmentally complex enough. As Horvath (2018) said: "Science progresses by making distinctions; homogenizing differences does not serve the enterprise" (p. 509). Furthermore, the current alliance definitions are a bit "outdated" since they do not take into account the accumulated knowledge on child development and psychotherapy process, both face to face and online. Inevitably, issues in the alliance definition are linked with the above-mentioned issues on the existing alliance measures and research.

Although the alliance is considered an trans-theoretical aspect of all therapies, existing research in youth psychotherapy seems to suggest that treatment type can influence not only the average alliance strength across time, but also the alliance–outcome relationship, with stronger associations between alliance and outcome in behavioral versus nonbehavioral therapies (Cirasola et al., 2021; Karver et al., 2018; Shirk et al., 2011). While these findings might be a result of the issues of the current measures, they question the idea that the alliance is a trans-theoretical factor that has the same meaning and role across youth therapy types. Perhaps agreement on goals and tasks matters more in behavioral treatments because this is central to the therapeutic model. In contrast, in nonbehavioral therapies, it may be that attention to the relational component, and in particular how it is repaired when there are ruptures, has a greater impact on the effectiveness of treatment. These issues are part of the larger debate on whether the alliance is a common ingredient of all therapies acting independently of technique or whether its clinical function—and perhaps meaning—is specific to each therapy type.

A revision of both the definition and measurement of the youth alliance is needed, but we do not need to start from scratch. Current research suggests that essential elements underpinning the alliance with young people are not only the development of trust and a genuine sense of "togetherness" between client and therapist, but also an acknowledgement and respect of the separateness of minds and perspectives (Binder, Holgersen, Nielsen, 2008; Cirasola, Martin, et al., 2022). This is not to say that the relationship cannot have difficulties or misunderstandings. Almost any human conversation and/or relationship involves a constant and ongoing process of correction and clarification, and so does the alliance. Accordingly, research has shown that disagreement and relationship issues should be considered as integral parts of the alliance with young people (Cirasola, Martin, et al., 2022; O'Keeffe et al., 2020; Schenk et al., 2019). This might be even more relevant in online therapy when misunderstanding can happen more easily due to the lack of access to some nonverbal clues. Hence, the alliance should not be understood as a form of idealized alignment or agreement but rather as an ongoing process of reaching a sense of being and working together, even (or especially) when things go wrong.

Youth therapists should, thus, pay close attention to fostering and maintaining an alliance (especially the development of trust) and be alert to, but not alarmed by, alliance stains and ruptures. Accordingly, it might be essential to encourage youth therapists to adopt an open and nondefensive approach to the development of the alliance so that alongside fostering a strong alliance that could survive eventual strains, they also openly acknowledge that, even with their best intentions, they can get something wrong. This might have a positive effect for various reasons. First, it can help balance the power difference between young people and adult therapists, an aspect especially appreciated by adolescents. Second, it would convey the message that a perfect agreement/understanding is not realistic, which might help even the more withdrawn young person to be more assertive and let their therapists know when they do not agree with them, rather than mask their dissatisfaction in a deferential manner.

The experience of being together despite some relational challenges can not only form the basis for cooperation and commitment to shared goals, but also promote the development of trust and trustworthiness (Fonagy & Allison, 2014). This is in line with the second generation of alliance research (Muran & Eubanks, 2020) as well as the literature on the importance of mentalizing (including attention to mentalizing breakdowns) and building epistemic trust in the therapeutic relationship (Fonagy & Allison, 2014). Accordingly, we believe that when (re)defining the alliance, its components, and its role across various types of youth psychotherapy, it is important to also take into account learning from attachment theory, infant research, neuroscience, mentalization theory, and psychotherapy process research.

More attention should also be paid to the "fit" between client and therapist characteristics and how sociocultural similarities and/or differences between client and therapist, and how these can influence the alliance (Bose et al., 2022). Most literature on youth alliance is from Western countries, and the populations included in existing research are not inclusive of young people and therapists from a range of cultural and ethnic backgrounds. Knowledge of for whom and in what circumstances the alliance contributes to

outcomes is essential since it can help tailor interventions for young people, in line with recent calls for precision in mental health (DeRubeis, 2019). In the adult literature, recent research highlighted the need to distinguish between trait-like (between-individuals variance, i.e., clients' preexisting characteristics that influence their capacity to form and benefit from an alliance) and state-like (within-individual variance, i.e., the alliance fluctuations throughout treatments) alliance components (Zilcha-Mano & Fisher, 2022). Disentangling baseline trait-like alliance factors (e.g. attachment security, interpersonal style, reflective functioning) from genuine changes in state-like components that influence the alliance over treatment can be helpful to provide further insight into the characteristics and role of the alliance in youth psychotherapy too.

Despite these limitations, there are real opportunities for therapists working with young people to draw on what we have learned from research to date, especially when looking at the more recent literature on alliance rupture and repair. One issue the research highlights is that therapists' feelings of vulnerability in response to alliance ruptures could hinder their capacity to successfully work through them and use ruptures as critical opportunities for exploration and therapeutic change (Muran & Eubanks, 2020). To address this issue, methods of recognizing alliance ruptures and working to repair them should be regarded as a fundamental aspect of therapy manuals and clinical training in youth psychotherapy. We also advocate the importance of creating a shared culture in which mistakes and interpersonal difficulties in the therapeutic relationship are tolerated and accepted. If therapists are prepared for the occurrence of ruptures when working with young people, they might be less intimidated by them and even be more willing to approach ruptures as opportunities to better understand the young person and create a more authentic sense of we-ness and shared exploration.

Limitations of This Review

Limitations of this review include a lack of attention to the alliance in specific types of therapy, including group and family therapy, which might involve different alliance dimensions and dynamics. Another limitation concerns the issues of culture, similarities, and diversity. Most of the literature reviewed consisted of studies from Western countries and might not be inclusive of young people and therapists from a range of sociocultural and ethnic backgrounds; hence, most of the claims made might not be generalizable to clients and therapists from different cultures.

Conclusion

Overall, this review highlights the importance of the alliance construct in youth therapy, but also its complexity. We hope to have demonstrated that alliance research has the potential to bring the clinical and research fields closer together, by providing both fertile grounds for dialog between research and clinical practice. What seems to be needed is a renewal of the conversation between the clinical/theoretical and the research fields so that current research findings can inform theoretical and clinical developments on the alliance, and clinical ideas can guide future research. Insight into the mechanisms of change, like the alliance and the process of repairing alliance ruptures, is of direct relevance to improving psychotherapy for young people, as well as making mental health services more productive and cost-effective.

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