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Repairing Alliance Ruptures in Psychodynamic Psychotherapy With Young People: The Development of a Rational–Empirical Model to Support Youth Therapists

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Alliance ruptures in youth psychotherapy can have a significant impact on treatment outcomes. However, there is currently limited guidance on how to effectively repair these ruptures with young people. This study aims to address this gap specifically in the context of psychodynamic psychotherapy with adolescents. The objectives of the study are (a) to understand the therapeutic interventions and attitudes that either facilitate or hinder the resolution of alliance ruptures and (b) to develop a model for repairing these ruptures within this particular treatment approach. To accomplish this, a task analysis of a previously developed rational model of resolving alliance ruptures was conducted using 16 sessions from short-term psychodynamic psychotherapy with depressed adolescents. The analysis supported some stages of the hypothesized rational model while revealing the need for revisions. As a result, the study developed a rational–empirical model that includes flexible strategies that therapists can use to repair alliance ruptures. This model emphasizes the significance of a collaborative, open, and empathetic approach to resolving ruptures. In contrast, rigid, defensive, or invalidating therapist attitudes can hinder the resolution process. The evidence-based model developed from the study can provide valuable guidance to psychodynamic psychotherapists working with young people, offering insights on how to approach ruptures and employ effective strategies to promote their resolution.

Clinical Impact Statement

Question: This study aimed to develop a model to support therapists in resolving relationship issues and ruptures when working psychoanalytically with young people. ***Findings:*** Alongside suggesting the use of a variety of specific reparation strategies, the resulting model emphasizes the importance of therapists being understanding, flexible, and respectful of the young person's feelings when repairing ruptures. ***Meaning:*** To successfully repair ruptures, it is important for therapists to not only consider what strategies they use but also how they use them. ***Next Steps:*** Research on how to repair alliance ruptures should be used to develop guidelines and training to support youth therapists in managing the inevitable strains in the therapeutic relationship.

Keywords: youth psychotherapy, alliance ruptures, rupture repair, task analysis, rational–empirical model

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The therapeutic alliance, encompassing the collaborative aspects of the therapeutic relationship (Bordin, 1979), is a key focus of psychotherapy research. Strong alliances consistently yield positive outcomes in adults (Flückiger et al., 2018) and young people (Karver et al., 2018; Shirk et al., 2011) across diverse treatments. Accordingly, the American Psychological Association acknowledges fostering a strong alliance as integral to evidence-based practice (Norcross, 2011). Recent developments in alliance research have highlighted the frequent occurrence of alliance strains or ruptures, emphasizing the critical role of resolving them for treatment retention and good outcomes (Eubanks et al., 2018). Based on this expanding body of research, the repair of alliance ruptures has been recognized as a promising evidence-based treatment process (Norcross & Wampold, 2018). Consequently, guidelines and training programs have been developed to assist therapists in effectively identifying and resolving alliance ruptures, particularly in adult psychotherapy (Eubanks et al., 2015a).

Alliance ruptures encompass any challenges in collaborating on therapy tasks/goals, deterioration in the therapeutic bond, and breakdown in negotiating client and therapist needs (Muran & Eubanks, 2020; Safran & Muran, 2000). They can be characterized by withdrawal or confrontation markers. In cases of withdrawal rupture markers, either clients or therapists move away from the other and/or the therapeutic process (e.g., minimal response, avoidant storytelling, self-criticism/hopelessness) or move toward the other but in a manner that denies their authentic experience (e.g., denial, content-affect split, deferential behaviors). On the other hand, confrontation rupture markers involve actions where either the client or the therapist displays behaviors against the therapeutic process or the other person involved. This can include behaviors such as complaining, criticizing, pushing back, or attempting to exert control. Ruptures can encompass elements of both withdrawal and confrontation (Muran & Eubanks, 2020; Safran & Muran, 2000).

A rupture is considered repaired or resolved when the client and therapist rebuild a positive affective bond and resume collaborative therapy. Therapists can employ different strategies for rupture repair, which can be categorized into two types: immediate and exploratory approaches (Eubanks et al., 2018). Immediate repair strategies aim to address the rupture promptly, involving the therapist clarifying misunderstandings, renegotiating therapy tasks or goals, providing a rationale for the treatment approach, or helping the client refocus on therapy. Exploratory repair strategies encourage deeper exploration of the rupture experience and uncovering underlying relational themes. These strategies involve inviting the client to share thoughts and feelings about the impasse, providing interpretations of underlying needs/wishes, disclosing the therapist's own experience, and acknowledging possible contributions to relationship difficulties (Eubanks et al., 2018).

Research on alliance ruptures and resolutions has predominantly focused on adults, with limited research conducted in the context of youth psychotherapy. However, available studies in youth psychotherapy have demonstrated similar findings to the adult literature, highlighting a connection between the resolution of ruptures and positive outcomes (Cirasola, Martin, et al., 2022; Daly et al., 2010; Gersh et al., 2017; Schenk et al., 2019). Moreover, unresolved ruptures early in treatment have been linked to treatment dropout among youths (O'Keeffe et al., 2020). Despite these findings, compared to adult psychotherapy, there is a dearth of research and guidance on how to address alliance ruptures in psychotherapy with young people (Cirasola & Midgley, 2023; DiGiuseppe et al., 1996; Nof et al., 2019).

Existing models for resolving ruptures in youth psychotherapy often rely on frameworks developed for adults, neglecting the unique challenges faced by therapists working with adolescents. These challenges encompass factors such as the likelihood of lower motivation resulting from the predominance of external referrals, conflicts stemming from developmental needs of independence and autonomy, and the fact that the alliance in youth therapy also needs to consider the role of parents or carers (Gulliver et al., 2010). Accordingly, building a strong alliance with adolescents has been described as demanding and can lead to frequent ruptures (Binder et al., 2008; Karver et al., 2018). Furthermore, identifying these ruptures might be challenging, especially because the power dynamics in youth therapy can make adolescents hesitant to openly challenge or disagree with their therapists. Indeed, emerging research underscores the prevalence of withdrawal (rather than confrontation) ruptures in adolescent psychotherapy (Cirasola, Midgley, et al., 2022; Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). Withdrawal rupture markers can be subtle and mistakenly interpreted as pseudoalliance, that is a deceptive or false sense of therapeutic alliance, which can hinder genuine progress. Not surprisingly, youth therapists commonly experience vulnerability, caution, and insecurity when dealing with these ruptures and finding the appropriate resolution (Morán et al., 2019). Hence, it is crucial for therapists working with young people to receive training in identifying and addressing even subtle tensions or indications of adolescent withdrawal that may affect therapy.

The issue of identifying subtle indications of withdrawal holds particular relevance for adolescents with internalizing difficulties, as withdrawal ruptures may be more common in compliant and conflict-avoidant individuals (Lipsitz-Odess et al., 2022), such as those with depression. Notably, meta-analyses have consistently shown that the alliance–outcome relationship tends to be stronger for young people with externalizing symptoms compared to those with internalizing symptoms (Karver et al., 2018; McLeod, 2011; Shirk & Karver, 2003). Previous research has shown that adolescents with internalizing disorders may encounter difficulties in openly expressing their anger or dissatisfaction to their therapists and, if unsatisfied, they may be more likely to dropout rather than confront their therapist (O'Keeffe et al., 2020). To better support this vulnerable population, it is crucial to gain a deeper understanding of the unique challenges they face in therapy. By exploring the barriers that hinder their expression of anger or dissatisfaction and identifying alternative coping mechanisms they may utilize, we can develop targeted interventions to improve therapeutic processes and outcomes.

Repairing alliance ruptures may be especially relevant in short-term psychodynamic treatments with adolescents, where empirical evidence has reported frequent alliance ruptures (Cirasola, Martin, et al., 2022; Halfon et al., 2019; Schenk et al., 2019) and lower alliance ratings compared to other treatment types (Cirasola, Midgley, et al., 2022), even in cases with positive outcomes. Alliance ruptures might be frequently observed in youth psychodynamic therapy because this therapeutic approach strives to create a space that allows for the expression of negative emotions through the negative transference (Cregeen et al., 2017). Working with negative transference involves therapists acknowledging and supporting the expression of negative emotions in young people while demonstrating tolerance and

acceptance. This intentional encouragement of negative emotional expression may lead to more evident alliance ruptures and lower ratings on alliance measures. However, effectively resolving these ruptures can play a crucial role in fostering a strong therapeutic alliance and serving as a valuable learning experience for the young person.

Empirical research on the repair of alliance ruptures in short-term psychodynamic therapy is scarce, with only one study exploring this area and proposing a preliminary model for repairing ruptures with adolescents (Cirasola, Martin, et al., 2022). This study provides a comprehensive analysis of the process of establishing and repairing the therapeutic alliance in a successful case of short-term psychodynamic psychotherapy (STPP) with an adolescent diagnosed with depression. The resulting preliminary model for effectively managing alliance ruptures in youth STPP is presented in Figure 1, outlining four distinct stages. The first stage of the model focuses on recognizing and acknowledging the rupture. Therapists can achieve this by (a) using gentle questioning to facilitate the client's expression and clarification of the issue, (b) describing the client's behaviors, and (c) demonstrating empathy, validation, and taking responsibility for their own contribution to the rupture. In the second stage, termed "further exploration of the rupture," the therapist invites the client to express their thoughts and feelings about the rupture.

Depending on the client's response to the initial exploration, the therapist can choose between two subsequent stages to progress toward resolution: Stage 3a & Stage 3b. Stage 3a aims to reestablish collaboration and a positive bond by implementing immediate resolution strategies (e.g., changing topic). This stage is hypothesized to be effective in two scenarios: (a) when a solid alliance has not yet been established, particularly in the early stages of therapy, and (b) when there is excessive tension in the therapeutic relationship and the client does not seem ready for further exploration of the ruptures at that time. On the other hand, Stage 3b focuses on clarifying the underlying wish or need that led to the rupture through exploratory strategies (e.g., working with the transference, including interpretations of negative transference). This Stage is considered effective when (a) an overall positive alliance has been established between the client and therapist, and/or (b) the client demonstrates readiness for further exploration of the rupture. It is important to note that while this model was developed through a combination of theoretical ideas and empirical observations, it was derived from the analysis of a single case. Therefore, replication studies are necessary to establish its applicability and clinical utility.

Given the prevalence of alliance ruptures in youth psychodynamic therapy and the potential impact of resolving these ruptures on positive therapeutic outcomes, it is essential to develop empirically based guidelines for effectively repairing these ruptures, particularly with young individuals experiencing internalizing disorders. This study responds to this need and aims to (a) develop a stage-process model to guide therapists on ways to resolve alliance ruptures when working with young people in psychodynamic therapy, and (b) further understand which therapist behaviors and/or attitudes can facilitate or hinder the resolution of ruptures.

Method

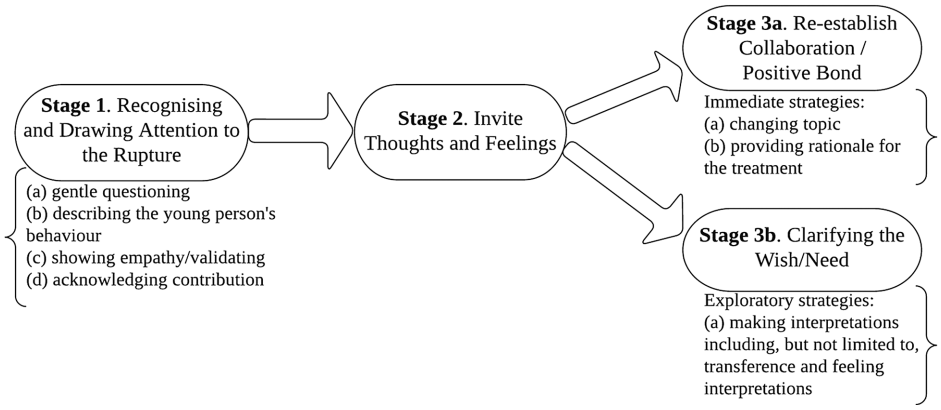
Participant Selection

Four cases were selected from the STPP arm of the Improving Mood with Psychoanalytic and Cognitive Behavioral Therapy (IMPACT) randomized controlled trial. The IMPACT trial aimed to compare the effectiveness of STPP, cognitive behavioral therapy, and a brief psychosocial intervention for treating depressed adolescents (Goodyer et al., 2017). Detailed information on the methodology and procedures of the IMPACT study, including a qualitative substudy involving a subset of participants from the main trial, can be found in the works of Goodyer et al. (2017) and Midgley et al. (2014). In this study, we focus exclusively on the data selection and analysis for this study. Among all available STPP cases who had taken part in the qualitative substudy ($N = 43$) of the IMPACT trial, participants for this study were selected based on the following criteria:

1. The client had attended a minimum of three sessions, as it would be difficult to assess the development and fluctuation in the alliance in fewer sessions.

Figure 1

Preliminary Rational Model of Resolving Ruptures in STPP With Depressed Youth



Note. STPP = short-term psychodynamic psychotherapy.

2. The case had no more than three missing audio recordings of sessions to ensure important information about in-session alliance fluctuations was not overlooked.

3. At least two client or therapist reports of the alliance were available, enabling the selection of cases that exhibited alliance increase or decrease over time.

Following these criteria, a final selection of 10 cases was eligible (refer to Supplemental Flowchart S1). These cases demonstrated similar characteristics to the remaining participants in the STPP arm of the IMPACT study, including demographic information, baseline symptom severity, and treatment outcome at the end of treatment and 1-year follow-up (see Supplemental Tables S1). Out of these 10 cases we selected the two cases that showed the greatest increase in alliance ratings and the two cases that exhibited the greatest decrease, as assessed by either the adolescent or the therapist using the Working Alliance Inventory Short-form (WAI-S). This sampling strategy aimed to capture clinical material representing both successful (improved alliance) and poor (deteriorated alliance) resolution processes, aligning with the task analysis procedure (Pascual-Leone et al., 2009).

Treatment

STPP (Cregeen et al., 2017) is a manualized treatment for depressed youth that spans up to 28 sessions over a 30-week period. Rooted in psychoanalytic principles, STPP conceptualizes behavioral and emotional responses as reflections of early relationship experiences. STPP therapists closely observe the therapeutic relationship and utilize supportive and expressive strategies to address difficulties within the context of adolescent developmental tasks. By working with transference and countertransference dynamics, this approach aims to uncover underlying symptom dynamics. STPP considers the therapeutic relationship as a secure space for exploring and processing emotions and internal working models of relationships, including negative emotions.

Measures

Alliance

The WAI-S (Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) was used to assess the alliance from the adolescent (WAI-S) and therapist (WAI-S-T) perspectives. This was collected at 6-, 12- and 36-weeks post randomization in the IMPACT study. The WAI-S consists of 12 items assessing three dimensions: (a) agreement on goals, (b) agreement on tasks, and (c) the emotional bond between client and therapist. All items are rated on a 7-point Likert-type scale (from 1 = *occasionally* to 7 = *always*). The WAI-S yields scores for each dimension as well as an aggregate summary score (ranging from 12 to 84), with higher ratings reflecting a stronger alliance. The WAI-S has demonstrated good construct validity with other therapeutic alliance measures (ranging between $r = 0.74$ and $r = 0.80$; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) and internal consistency in both adult (Cronbach's $\alpha = .93$; Horvath & Greenberg, 1989) and youth samples (Cronbach's $\alpha = .94$; Capaldi et al., 2016). In the IMPACT sample, the internal consistency was high for both the adolescent (WAI-S) and therapist (WAI-S-T) reported version of the scale (Cronbach's $\alpha = .95$).

Alliance Rupture and Resolutions

Ruptures in the alliance were identified using the observer-based Rupture Resolution Rating System (3RS; Eubanks et al., 2015b, 2019) on audiotapes of the sessions. While listening to a therapy session recording, raters search for a lack of collaboration or the presence of tension between the client and therapist. Ratings are made of 5-minute segments, permitting the microanalytic identification of ruptures and resolution attempts throughout the session. The coding system includes markers of (a) withdrawal ruptures, (b) confrontation ruptures, and (c) resolution strategies. The 3RS defines rupture marker in a way that includes even very subtle withdrawal and confrontation behaviors (see Table 1, for a brief description of the 3RS rupture markers). For each marker, the 3RS yields (a) a frequency score and (b) an impact score, which addresses the extent to which the rupture or resolution markers impact the alliance (rated on a 5-point scale, from 1 = *no impact* to 5 = *significant impact*). Additionally, the 3RS yields an overall impact score of (c) withdrawal, (d) confrontation, and (e) a global resolution score (i.e., the extent to which ruptures were resolved during the session). The latter is rated on a 5-point scale, with higher scores reflecting greater resolution of ruptures (1 = *ruptures were not successfully repaired, and the alliance worsened*, 4 = *ruptures were somewhat repaired*, 5 = *ruptures were repaired a good amount*). The 3RS has demonstrated good to excellent interrater reliability (IRR; intraclass correlation coefficients ranging from .73 to .98, Coutinho et al., 2014; Eubanks et al., 2019). IRR on the 3RS in this study is reported below.

Outcome

In line with the IMPACT study, the outcome was self-reported depression symptoms as measured with the Mood and Feelings Questionnaire (MFQ; Angold et al., 1987). The MFQ includes 33 items, the total score ranging from 0 to 66, with higher scores reflecting higher depression severity. The clinical cutoff for the presence of a major depressive episode is 27 (Wood et al., 1995). Here, we report on the MFQ collected at baseline, end of treatment (36 weeks postrandomization), and 2-year follow-up (82 weeks after randomization). The MFQ has demonstrated good test–retest reliability over a 2- to 3-week period (Pearson's $r = 0.78$), good internal consistency (Cronbach's $\alpha = .82$), and criterion validity ($\alpha = .89$) for detecting an episode of depression in adolescents (Kent et al., 1997; Wood et al., 1995). In the IMPACT sample, the internal consistency was similarly high (Cronbach's $\alpha = .93$).

Data Analysis

This study employed the validation-oriented phase of task analysis to empirically test a previously developed rational model for resolving alliance ruptures in STPP (Figure 1, Cirasola, Martin, et al.'s, 2022, study provides detailed information about this model). Task analysis combines rational and empirical methodologies to develop explanatory models for specific tasks, such as alliance ruptures. It involves creating a structured framework, referred to as a rational model, which outlines the hypothesized sequence of steps based on theoretical and clinical data. The rational model is then subjected to empirical testing to create a rational–empirical model that combines theory and empirical data (Pascual-Leone et al., 2009). In this study, the rational

Table 1
3RS Average Withdrawal and Confrontational in Resolved and Unresolved Sessions

Sessions	Marker description	Resolved sessions		Unresolved sessions	
		M impact	*M* freq	*M* impact	*M* freq
3RS withdrawal markers					
Shuts down	Patient withdraws from the therapist and the work of therapy by being self-critical, denying, going silent, or giving minimal responses to questions or statements that are intended to initiate or continue the discussion.	3.5	6.0	4.0	7.0
Avoids	Patient uses abstract communication, avoidant storytelling, and topic shift to avoid the work of therapy.	2.6	4.1	3.1	2.8
Masks experience	Patient is being deferential/appeasing and withdraws from the therapist or the work of therapy by exhibiting affect that does not match the content of their narrative.	3.3	4.0	3.5	3.7
3RS total withdrawal impact score		4.0	14.1	4.5	13.5
3RS confrontation markers					
Complains	Patient criticizes the therapist, activities, interventions, parameters, and/or progress.	2.5	1.7	2.0	1.0
Pushes back	Patient rejects the therapist's ideas, defends themselves, and/or is being hostile.	2.2	3.7	2.7	3.0
Controls	Patient attempts to control the therapist and/or the session, or the patient puts pressure on the therapist to fix the patient's problems quickly.	2.0	1.4	1.9	1.5
3RS total confrontation impact score		2.8	6.8	2.83	5.5
3RS total resolution		3.4	19.9	1.3	18

Note. 3RS = rupture resolution rating system; Freq = Frequency.

model (Figure 1) was tested using 16 sessions from four cases selected from the STPP arm of the IMPACT trial. In line with the task analytic method, which involves a continuous process of hypothesis-testing and discovery-oriented research, we anticipated confirming certain elements of the preliminary model, but were also open to uncover previously unidentified elements within the research framework.

Case Familiarization and Session Selection

The process of resolving ruptures is complex and occurs both within and across therapy sessions, necessitating a comprehensive understanding of each individual case. As a result, session selection was not randomized but based on a combination of theoretical and purposive sampling methods (Straus & Glaser, 1967). First, all sessions ($n = 73$) for each case underwent assessment using the 3RS by the first author, a qualified clinical psychologist, and the fifth author, a doctoral student in clinical psychology. Subsequently, we selected 16 sessions for the task analysis, with four sessions chosen from each case. The selection was based on two criteria: (a) the overall resolution score of the 3RS and (b) the rater's evaluation of the importance of the rupture and resolution processes in that session, considering the broader context of the overall case history. Our main focus was to develop a model for successful rupture resolution, so we specifically chose 10 sessions that had partially or fully resolved ruptures (rated 3 or above on the 3RS resolution score). In line with the task analysis procedure (Pascual-Leone et al., 2009), we also included six sessions with poorly or unresolved ruptures (rated 2 or below on the 3RS resolution score) to facilitate a comparison between repaired and unrepaired sessions. In each case, we ensured a minimum of two repaired sessions and one poorly repaired session, allowing for both within-case and cross-case comparisons (refer to Supplemental Table S2, for the 3RS overall scores of the 16 selected sessions).

Task Analysis

The same two raters conducted the qualitative analysis on the 16 selected sessions, as part of the task analytic process. This involved reviewing audio recordings and transcripts to identify evidence of each component of the hypothesized rational model (see Figure 1) in the data. The examination of both resolved and unresolved rupture processes within and across cases aimed to evaluate the effectiveness of the specified components of the resolution model in distinguishing between successful and unsuccessful resolution. Additionally, the coders monitored for additional factors that were not initially included in the model but could potentially contribute to or hinder rupture–resolution patterns. Based on the findings, the rational–empirical model for repairing alliance ruptures was developed through multiple revisions until achieving saturation.

Reliability

Both the 3RS ratings and qualitative analyses were performed by two independent raters, ensuring reliability and minimizing potential bias. The first author rated all sessions for three cases, while the fifth author rated all sessions for the fourth case. Both raters received training from the measure developers and achieved reliability in its application. To ensure rating consistency, 30% ($N = 22$) of the sessions were also double rated. IRR for the 3RS was good, with intraclass correlation coefficient values of 0.80 for confrontation rupture impact, 0.78 for withdrawal rupture impact, and 0.84 for resolution of ruptures. For the qualitative analysis, each session was independently analyzed by the same two coders. Additionally, regular meetings were held to discuss findings and reach a consensus, following the task analysis procedure (Greenberg, 2007). The senior authors also conducted an audit of these analyses to ensure precision, consistency, and comprehensiveness.

Ethical Considerations

The IMPACT study was approved by the Cambridgeshire 2 Research Ethics Committee (REC Reference: 09/HO308/137). Informed written consent was obtained for all participants, including written parental consent. All personal details were anonymized.

Results

Descriptive

Participants

Table 2 presents demographic information, self-ratings of the alliance, and outcomes for all participants, categorized based on whether the alliance increased or decreased over time. While the primary focus of this study is therapy process (specifically, the progression toward rupture resolution during sessions), we also provide descriptive information on the outcome of the selected cases. All participants had similar baseline characteristics and experienced a decrease of at least five points in MFQ score between baseline and follow-up, which is considered a minimum clinically significant difference (Goodyer et al., 2011). Notably, the two participants whose alliance deteriorated throughout treatment still met the criteria for clinical depression (MFQ > 27) at the final follow-up, while the two participants with an increasing alliance pattern did not.

The therapists involved in the selected cases were qualified child and adolescent psychotherapists who were registered with the U.K. Association of Child Psychotherapists and had received psychodynamic training. No specific demographic information was collected regarding the therapists. Each selected therapist worked exclusively with one adolescent, indicating that the therapist–dyad combinations were unique and there was no overlap in therapist involvement across the selected cases.

Table 2
Demographic Information, Depression, and Alliance Ratings

Participant characteristics	Increased alliance		Decreased alliance	
	Jade	Alice	Steven	Kim
Baseline age	16.8	16	17	16.6
Gender	Female	Female	Male	Female
Ethnicity	Mixed	White British	White British	Mixed
Client's alliance rating				
WAI-S 6 w	57	38	61	—
WAI-S 12 w	—	54	56	20
WAI-S 36 w	73	70	52	20
Therapist's alliance rating				
WAI-S-T 6 w	50	—	50	61
WAI-S-T 12 w	54	—	42	57
WAI-S-T 36 w	75	—	—	44
Depression				
MFQ baseline	45	44	49	45
MFQ 36 w	16	9	39	14
MFQ 86 w	3	22	42	28

Note. w = Weeks after randomization; — = missing data; WAI-S = Working Alliance Inventory Short-form scale; WAI-S-T = Working Alliance Inventory Short-form scale and therapist; MFQ = Mood and Feelings Questionnaire.

Ruptures

Table 1 provides a detailed description and frequency of each rupture marker. Across all sessions, there were a total of 323 rupture markers, averaging 20 rupture markers per session. Withdrawal rupture markers were more prevalent (68.7%) and had a greater negative impact on the alliance (average impact of 4.2), compared to confrontation rupture markers (31.2%, average impact of 2.81).

Resolution

Resolution attempts were nearly as common as ruptures, with a total of 307 attempts observed across all sessions. This indicates that therapists recognized and made efforts to repair ruptures in most cases, employing an average of 19.2 resolution strategies per session. The frequency of each resolution strategy included in the hypothesized rational model is provided in Table 3, and detailed descriptions of these strategies are discussed in the qualitative results section below.

Testing of the Rational–Empirical Model to Resolve Rupture

First, we present empirical findings which support the existing stages of the rational model. Second, we discuss additional processes, both beneficial and detrimental, not included in the original rational model. Finally, we highlight their contribution to the further development of the rational–empirical model.

Evidence Supporting the Stages of the Rational Model of Alliance Repair

Stage 1: Recognizing and Drawing Attention to the Rupture

As the model had suggested, in the selected sessions, therapists often acknowledged the rupture by pausing and redirecting the young person's attention to the emerging issue using the following strategies.

Description and/or Gentle Questioning. This occurred in 62% of the sessions and involved (a) the therapist describing their perception of the young person's behaviors or feelings without explicitly mentioning the rupture, and/or (b) asking gentle questions to encourage further discussion on the emerging issue. This approach was primarily employed in response to withdrawal ruptures (e.g., "You look very down today. Or perhaps you just wonder where to start?" —Jade, Session 25).

Empathic Stance/Validation. In 75% of the sessions, therapists conveyed empathy and validation to their clients in response to ruptures. They expressed understanding and empathy both verbally and nonverbally (e.g., with the tone of voice), acknowledging the validity of their clients' feelings and difficulties. For instance, when dealing with withdrawal ruptures, therapists often warmly validated the client's struggle to open up: "I realise it's very difficult to start talking to someone you've never met before" (Alice, Session 1). Likewise, in cases of confrontational ruptures, instead of challenging the client's resistance, some therapists chose to ally with and validate it. For instance, when a young person expressed dissatisfaction with the therapist's lack of self-disclosure, one therapist responded

Table 3
Frequency of Each Technique of the Rational Model in the Selected Sessions

Stages	Strategies	Resolved sessions	Unresolved sessions	All sessions
Stage 1	All	100.0%	83.0%	93.7%
	Validation and empathic stance	100.0%	33.3%	75.0%
	Acknowledge contribution	60.0%	33.3%	50.0%
	Description/questioning	50.0%	83.3%	62.5%
Stage 2	Invite thoughts and feelings	100.0%	83.0%	93.8%
Stage 3a	All	80.0%	83.3%	81.3%
	Change topic	40.0%	66.7%	50.0%
	Provide rationale	50.0%	33.3%	43.8%
	Redirect	40.0%	66.7%	50.0%
	Clarify misunderstanding	20.0%	16.7%	18.8%
Stage 3b	All	100.0%	100.0%	100.0%
	Feeling interpretation	90.0%	67.0%	81.2%
	Transference interpretation	80.0%	0.0%	50.0%
	Transference work	90.0%	50.0%	75.0%
	Other interpretations	30.0%	67.0%	43.8%

warmly by saying: "Yes, I suppose that's the weird thing about psychotherapy, it's all about you, not about me, which, I can see it can feel a bit awkward" (Steven, Session 8). Validation played a significant role in both (a) reducing tension between the client and therapist and (b) facilitating exploration of the rupture. Notably, this key resolution strategy was identified in all sessions where ruptures were at least partially resolved, whereas it was observed in only 33% of sessions where ruptures remained unresolved (refer to Table 3).

Acknowledgment of Contribution. Therapists acknowledged their contributions to the ruptures in 50% of sessions, particularly in resolved sessions. Two main types of acknowledgments emerged from the qualitative analysis: "direct" acknowledgment, where the therapist recognized their own contribution to the rupture, and "indirect" acknowledgment, where the therapist suggested that difficult aspects of therapy were related to the rupture. Contrary to the hypothesis in the rational model, acknowledgment of contribution was more commonly observed as a means of exploring and understanding the rupture (i.e., Stage 3b) rather than drawing attention to or pausing on the rupture (i.e., Stage 1).

When therapists directly acknowledged their contribution, resolution was often achieved through nondefensive recognition and apology, regardless of whether the young person expressed direct confrontation or masked their feelings deferentially. For example, in response to confrontational ruptures, like a young person complaining about a perceived wrong interpretation, a therapist responded by saying: "You know, when we're working together, I try to understand you, but I haven't always got it right, and I won't always do, but we are kind of trying to get to understand something together" (Alice, Session 22). Similarly, in response to withdrawal ruptures, therapists openly acknowledged their contribution when they felt that the young person was masking their real experience. For instance, one therapist stated:

> Yes, but there was a mix-up last week, where I actually made a mistake, and you know, of course, you would be cross with me, as that must have been really annoying. And I suppose it is important if you are cross to acknowledge it and for me to say that I am sorry for the mix-up. (Alice, Session 11)

Some therapists also acknowledged their contributions before making challenging interpretations, using warnings such as "this might sound like a criticism" (Steven, Session 9) or "you might not like what I am about to say" (Alice, Session 22). Additionally, they acknowledged the distress they might have caused by expressing statements such as: "Maybe what we have talked about today is really, really scary" (Jade, Session 25).

While direct acknowledgment of therapists' contribution mostly facilitated rupture resolution and received positive responses, when therapists indirectly acknowledged the distress caused by attributing it to some aspects of therapy, such as therapy breaks (e.g., "Perhaps after the break, it might be difficult to get going again"—Kim, Session 10) and/or endings ("There are only a few sessions left and, because of this, it might be difficult to open up"—Kim, Session 22), it led to mixed outcomes. Specifically, when the young person did not express concern about therapy breaks or ending, this intervention did not seem to facilitate rupture resolution, especially if it was repeated. Instead, it shifted the focus away from the immediate relational context of the therapeutic relationship and at times appeared defensive on the therapist's side.

Stage 2: Further Exploration of the Rupture

Therapists consistently encouraged clients to express their thoughts and feelings about emerging issues using open-ended questions in nearly all sessions (94%). For example, in response to a client arriving late and remaining silent and withdrawing, a therapist asked: "I wonder what's happening today. I mean, feeling a bit mixed about coming?" (Jade, Session 7). Inviting further elaboration was also employed during confrontational ruptures to encourage clients to expand on their negative feelings. For example, when a young person complained about the need to attend therapy, a therapist asked: "I wonder what it is that makes you not want to come?" (Jade, Session 18). This strategy was primarily observed as an exploration of the rupture, often accompanied by interpretations, rather than a separate stage as hypothesized. Therefore, this strategy appears to align better with Stage 3b instead of being a separate stage.

Stage 3a: Reestablish Collaboration and a Positive Bond

Therapists employed immediate resolution strategies in 81% of sessions to rebuild collaboration and foster a positive bond

during ruptures. This encompassed (a) changing therapy topic/task, (b) providing a therapeutic rationale, (c) clarifying misunderstandings, and (d) refocusing. For example, the technique of "changing the topic" was employed to address client concerns and complaints during confrontational ruptures. This occurred when the young person rejected the therapist's ideas or avoided discussing a specific topic. It was also employed to engage withdrawn clients who experienced prolonged periods of silence or were emotionally overwhelmed by a particular subject. Notably, changing the topic rather than the task was the primary approach, since in psychodynamic psychotherapy specific tasks are rarely assigned. Only once, a therapist suggested a task change to engage the young person after a prolonged silence: "How would you rate your current feelings on a scale of 1 to 10?" (Alice, Session 1).

The technique of "providing a therapeutic rationale" was also observed as a response to both withdrawal and confrontational ruptures. For instance, with a withdrawing, silent young person, a therapist reassured them by saying: "I have heard from my colleague that you have got some worries and that you would welcome someone to talk to, so that's what this space is for" (Alice, Session 1). Similarly, in a confrontational rupture where a client refused to discuss a relevant issue, a therapist explained the importance of addressing personal aspects in therapy:

> There are things about you that are important for us to talk about, to really get to know you. Therapy is about understanding what is going on in you, inside your mind, what kind of relationships you have, or what you worry about. (Kim, Session 10)

Therapists also attempted to repair ruptures by "clarifying misunderstandings" when they occurred and caused ruptures. For example, a therapist apologized for a mistaken assumption: "Oh! I am so sorry, I wrongly assumed your grandma was no longer alive, my apologies!" (Jade, Session 25). Similarly, therapists employed "refocusing" techniques when clients deviated from therapy tasks, as demonstrated in the following example where the therapist redirected the conversation in response to the client's use of abstract communication (i.e., withdrawal marker):

Client (C): *I'm kind of a laid-back person because I try not to care a lot about things. Like I don't care about climate change [.] (Abstract communication)*

Therapist (T): *I suppose climate change is a bit abstract, whereas your stepfather upsetting you is a bit, it's a bit more/(Refocus)*

C: *Personal to me? T: Yeah. (Steven, Session 3)*

Overall, immediate resolution strategies were less frequently utilized compared to expressive ones and were primarily employed in situations where there was a weak alliance, high tension, or limited scope for further exploration of the rupture.

Stage 3b: Clarify the Wish/Need Underlying the Rupture

All sessions included specific examples of exploratory ways to address ruptures. This was often done by inviting the young person to elaborate on the emerging issue (i.e., Stage 2 described above) and/or by using a variety of interpretations. Interpretations are key elements of STPP and refer to any intervention in which the therapist makes explicit their hypothesis/idea about any latent aspects of the issue presented and/or the young person's thoughts, feelings, and behaviors (Cregeen et al., 2017). Here, we focus solely on the interpretations therapists used in response to ruptures. The purpose of these interventions was to explore and deepen the understanding of the rupture's potential meanings and the underlying wishes, needs, or patterns for the client. As these interpretations encompassed a combination of elements, we found it more valuable to discuss them in a broader sense rather than categorizing them according to the type of interpretation being used. However, we will provide examples of "feeling" and "transference" interpretations (Cregeen et al., 2017, pp. 62–64) since these were the predominant types of interpretation included in the rational model.

Feeling interpretations were frequently employed to address ruptures, particularly in cases of withdrawal. A feeling interpretation involves the therapist explicitly identifying and verbalizing emotions that may have been unconscious or challenging for the client to express. These interpretations were often used to provide reassurance, acknowledging that negative thoughts and feelings are normal, and encouraging their expression as a beneficial and manageable process. For example, when a client appeared to conceal her negative emotions, a therapist stated:

> Mmmm although you feel it's unreasonable, you might also feel rather furious with me (Feeling interpretation). And maybe you wonder, could I understand you having furious feelings? And if you have furious feelings, can we get over that, can we work with that? (Invites thoughts and feelings). (Alice, Session 11)

In response to ruptures, we also noted the implementation of broad transference techniques, commonly known as transference work (Ulberg et al., 2014). These methods aim to explore the young person's emotions and thoughts concerning their therapist and the therapy itself. This encompasses various approaches, including, but not restricted to, "genetic transference interpretations" which aim to clarify and connect the client's experiences of others outside therapy to their relationship with the therapist (Levy & Scala, 2012). In our sample, most interpretations in response to ruptures focused on the client's current thoughts and feelings about the therapist/therapy in the present moment (e.g., "We haven't met for a few weeks, and now it might feel like I'm a stranger to you, and you might not know how to start talking to me again?"—Kim, Session 10). Genetic transference interpretations, although less commonly used (43.8% of sessions), were employed by some therapists. An example of this approach was observed in addressing a client's feelings of helplessness (withdrawal marker) "Today nothing seems to help, you're letting me know about your real helplessness and about the feeling that your mum's not really able to help you, and perhaps that I am not able to help you either" (Jade, Session 7).

Other Observed Helpful Processes Not Found in the Rational Model

We also observed a few noteworthy strategic processes not explicitly defined in the existing rational model that directly or indirectly seemed to facilitate the resolution of ruptures. These included therapists' demonstrating (a) genuine interest and curiosity toward their clients, (b) respect for the young person's idea and individuality/agency, (c) appreciation of their client, as well as (d) therapists' self-disclosure.

Therapists' interest/curiosity was usually demonstrated by (a) allowing the young person to lead the conversation in therapy and being open to discuss any topic, and (b) keeping the young person's ideas and interest in mind between sessions (e.g., by remembering the issues discussed in previous sessions and/or asking for updates). This emerged as an important element of a good alliance and indirectly facilitated the resolution of ruptures when it helped to reestablish a positive interaction between client and therapist.

Demonstrating respect for the young person's ideas and individuality was frequently observed in response to all types of ruptures with positive outcomes. In cases of withdrawal ruptures, this strategy helped convey to the young person that they do not have to please their therapist or hide their negative feelings to be accepted. In cases of confrontational ruptures, this was done either directly, such as acknowledging the validity of the young person's differing opinions and perspectives, or indirectly, by accommodating the young person's position or wish. For instance, in response to a rejected intervention a therapist said: "I think it's very good that you said that you didn't agree with me straight away. And if you don't agree with me sometimes, that's fine because, you know, you have the right to have your own opinion." (Alice, Session 1). Overall, this approach helped to deescalate tension in the therapeutic relationship rather than exacerbating it.

Therapists' showing appreciation for their clients also emerged as important for strengthening the alliance and, in turn, facilitating the resolution of ruptures. For instance, in most sessions where ruptures were resolved, we observed examples of therapists praising the young person for their efforts in therapy (e.g., "I think it is very brave and trusting of you to bring this here because it is the kind of thing you do feel deeply ashamed of afterwards, and you don't even like to admit this to you. So, I do realise and appreciate that it probably cost you a lot to bring this here"—Alice, Session 24).

Therapists sometimes shared their internal experiences in response to ruptures, especially when feeling stuck. This disclosure promoted resolution by demonstrating genuine concern and interest in understanding the client, even if it also showed the therapist's vulnerability. For instance, in a session with a client who withdrew excessively and had poor engagement, a therapist expressed: "I'm worried because you didn't come and I didn't know where you were, um, and I'm worried that that'll happen again, and then if you don't turn up next week, um, how … how we know that you're alright, really?" (Steven, Session 8). In contrast, if self-disclosure conveyed frustration, lack of hope, or a sense of surrender (e.g., "It feels like I can hardly reach you today"—Jade, Session 25) it did not facilitate rupture resolution.

Other Observed Unhelpful Processes

In sessions where rupture episodes were poorly repaired, we observed the following unhelpful therapists' behaviors/attitudes: (a) persisting on a topic/interpretation that the young person rejected, (b) lack of/poor explicit validation of the client's thoughts and feelings, (c) becoming defensive or rigid, (d) using long intellectualized interpretations, and (e) ending the session abruptly while there is tension in the client–therapist relationship. In such cases, therapists appeared to exhibit signs of confrontation (e.g., insisting on a rejected interpretation or topic), or withdrawal (e.g., prolonged silences, difficult interpretations, or abruptly ending sessions). These behaviors often resulted in an unhelpful power struggle between the young person and the therapist or increased distance between them.

Furthermore, in unrepaired sessions, therapists appeared more rigid and/or frustrated with their clients, which seemed to impact their capacity to show empathy and flexibility and, in turn, to successfully repair ruptures. For instance, in one case where the young person arrived late to therapy, missed a few sessions, and complained about the lack of progress, the therapist responded in a frustrated tone:

> So if you're not here, and you were not here last week, and you're very late today, then, of course, it can't do anything. [P: Yeah, I know] So … if you're not coming to something then, of course, it's not gonna be able to help. (Kim, Session 24)

The therapist's intervention in this case was understandable, but it did not provide explicit validation of the client's feelings and difficulties. As a result, the client withdrew further from therapy. In contrast, in repaired ruptures validation often accompanied even challenging interpretations.

Rational–Empirical Synthesis

The empirical analysis of our rational model confirmed most of its components while also prompting some revisions. Figure 2 visually presents the resulting rational–empirical model for repairing ruptures in youth psychodynamic therapy. Although exploratory resolution strategies were favored over immediate ones in the observed sessions, therapists exhibited a flexible approach by frequently shifting between strategies without a predetermined order. Consequently, successful repair of ruptures was linked to therapist flexibility, leading to the depiction of resolution strategies as cyclical rather than linear in the resulting model, as represented by bidirectional arrows in Figure 2. We also made several additions to our model, including a new resolution strategy called validation, which serves as both a primary response to ruptures and a complementary approach to other resolution strategies.

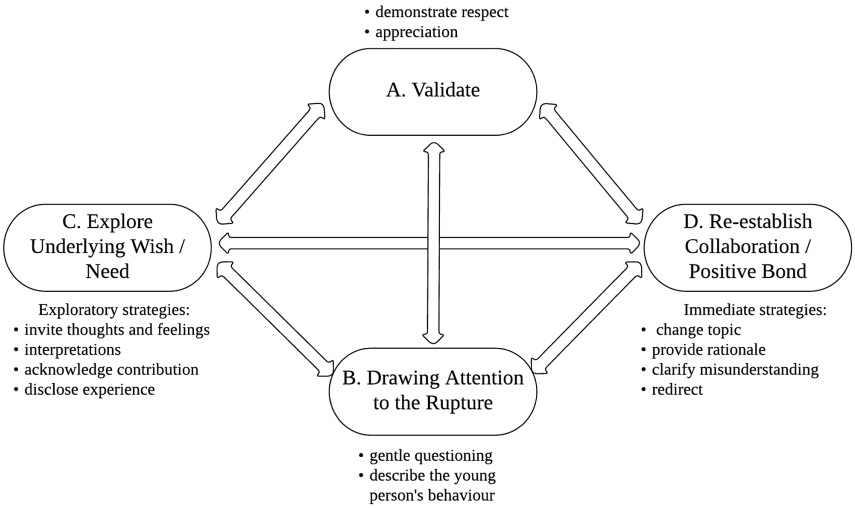
Instead of organizing strategies by stages, we found it more beneficial to categorize them according to their objectives. For instance, Stages 2 and 3b were merged into a broader category encompassing interventions that delve deeper into ruptures and their significance. Ultimately, the repair strategies in our final model were classified into four categories based on their intended objectives: (a) validating the young person's experience and agency, (b) drawing attention to the rupture, (c) further exploring the rupture, and (d) reestablishing collaboration and/or a positive rapport. Each category was expanded to include additional specific strategies identified through qualitative analysis. Importantly, we found that the effectiveness of a resolution strategy depended on both the strategy itself and how it was used. Repairing alliance ruptures is an ongoing process that requires multiple "movements toward" the young person throughout therapy sessions, rather than being a one-time task.

Discussion

The aim of this study was to enhance our understanding of alliance ruptures and repair in psychodynamic therapy with depressed youth and to develop a rational–empirical model to guide therapists in managing these ruptures. Consistent with previous studies (Cirasola, Martin, et al., 2022; Halfon et al., 2019; O'Keeffe et al., 2020; Schenk et al., 2019), our findings revealed a

Figure 2

Revised Rational–Empirical Model of Resolving Ruptures in STPP With Depressed Youth



Note. STPP = short-term psychodynamic psychotherapy.

high prevalence of alliance ruptures in our sample, even in cases where therapists effectively addressed the ruptures and achieved positive treatment outcomes. Most of the observed ruptures were classified as withdrawal type, which can be attributed to our target population comprising depressed adolescents who are more prone to withdrawal (Lipsitz-Odess et al., 2022; Muran & Eubanks, 2020). However, this finding aligns with existing research on adolescents dealing with internalizing and externalizing issues, suggesting a common tendency for withdrawal behaviors among young people (Daly et al., 2010; Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). Therefore, it is crucial for therapists working with adolescents to regularly assess the therapeutic alliance and remain attentive to subtle signs of ruptures, such as minimal responses or denial.

Nevertheless, our findings may also be influenced by the specific challenges associated with developing and maintaining an alliance in STPP, where the exploration of negative feelings within the therapeutic relationship (i.e., negative transference) is a central focus (Cregeen et al., 2017). It can be argued that this aspect of STPP can cause more ruptures and/or make their repair more demanding compared to therapeutic approaches that prioritize agreement and collaboration. Although additional research is necessary to deepen our comprehension of alliance ruptures and resolutions across various therapy types, psychodynamic therapists should be well-equipped to handle the complexities associated with negative transference and possess the essential skills to effectively address ruptures within this therapeutic framework. The model developed in this study is the first step toward achieving this goal.

Our rational–empirical synthesis revealed a diverse range of specific rupture–repair strategies available to psychodynamic therapists working with depressed adolescents. These strategies can be employed in various combinations to achieve successful repair, rather than following a predetermined order. Although the specific strategies may be different, this finding aligns with prior research conducted in cognitive behavioral therapy with adult populations, which suggested that therapists achieve successful rupture resolution through flexible integration of different strategies (Muran et al., 2023). Therefore, regardless of their therapeutic approach, it is potentially more beneficial for therapists to have a broad array of strategies at their disposal and employ them adaptively, guided by their clinical judgment, rather than strictly adhering to a rigid sequential model. Accordingly, in our rational–empirical model, we organized repair strategies into four broad categories without prescribing a specific sequence in which they should be employed.

Category A comprises interventions aimed at validating the young person's feelings and experiences. Validation, which entails conveying to clients that their feelings and perceptions are valid and understandable, even when negative, different, or challenging (Linehan, 2004), emerged as a crucial element in the process of repairing ruptures within our sample. This might be because validation, through active listening and acknowledging young people's experiences, plays a vital role in cultivating trust, fostering deep connection, and establishing a sense of safety within the therapeutic relationship. The significance of validation as a therapeutic process and a mechanism of change is recognized in various therapeutic approaches, including STPP, dialectical behavior therapy, and mentalization-based treatments (Fonagy & Allison, 2014; Fruzzetti & Ruork, 2018; Rossouw et al., 2021). This is not surprising, as being seen and understood by another individual can facilitate the development of epistemic trust, which involves considering information as valid, relevant, and applicable to other situations. Both epistemic trust and trustworthiness are crucial for facilitating change (Fonagy & Allison, 2014). Therefore, maintaining an open channel of social communication, even in the face of ruptures, and generating experiences of recognition that enable genuine learning from the therapist is essential in repairing ruptures and supporting the transformative journey of clients throughout psychotherapy (Fonagy & Allison, 2014).

In addition to the crucial role of validation, Category A encompasses strategies that indirectly contribute to the resolution of ruptures by strengthening the therapeutic alliance such as (a) actively demonstrating respect for the young person's ideas and individuality, and (b) expressing appreciation toward the client.

These strategies are particularly relevant in working with young people, given their developmental stage characterized by a drive toward independence and autonomy (Gulliver et al., 2010). Adolescents often strive to establish their unique identity and assert their individuality, which can influence their reactions to therapeutic interactions and ruptures. By actively respecting and valuing the ideas and individuality of adolescents, therapists acknowledge and honor their need for autonomy and independence, creating a collaborative and partnership-oriented therapeutic environment. Moreover, adolescents are more likely to engage and invest in therapy, especially if difficult, when they feel valued and appreciated for their contributions to the therapeutic process. This result aligns with the notion—again found across a range of treatment modalities—that consistently approaching the client with empathy, validation, and curiosity can be sufficient to repair some ruptures (Muran & Eubanks, 2020).

Category B encompasses strategies aimed at drawing attention to the rupture. In our sample, therapists primarily used implicit strategies such as gentle questions and pauses to address the issue/tension in the relationship without explicitly naming the rupture. This approach may be influenced by the covert nature of withdrawal-type ruptures (Muran et al., 2023). Implicit strategies allow therapists to slow down the young person and gauge the emotional temperature before approaching the ruptures. Employing subtle cues or questions can enhance adolescents' ability to handle and regulate negative emotions, as opposed to directly addressing the issue. While more research is needed on the tropic, therapists should be sensitive to adolescents' emotional reactions when addressing ruptures and adapt their approach accordingly.

Category C encompasses all exploratory efforts to delve into the ruptures and their underlying meaning, patterns, and/or wishes. These interventions, including inviting thoughts and feelings and various forms of interpretations, were the most frequently employed strategies for addressing ruptures in our sample. This preference for exploratory strategies, such as interpretations, aligns with the emphasis on exploring unconscious meaning and motivation within STPP. Interpretations can serve as a vital strategy in deepening the understanding of ruptures and their underlying causes, thereby fostering meaningful insights and the potential for resolution. However, their effective application is contingent upon various factors, including the presence of a strong alliance between the client and therapist, the client's readiness to actively participate in the therapeutic process, and the therapist's use of a validating and collaborative approach. Therefore, creating a safe and supportive environment is crucial to facilitate the reparative role of interpretations; without such a context, there is a risk that interpretations may contribute to, or even cause, further ruptures.

In our sample, therapists used a wide range of interpretive strategies in response to ruptures, including interventions exploring clients' feelings, defenses, as well as engaging in broader transference work (Ulberg et al., 2014). Interestingly, while this study did not directly measure transference work, our findings indicate that when transference work was employed in response to ruptures, it predominantly involved interpretations centered around the client's "present" thoughts and emotions concerning the therapist and the ongoing therapeutic process. These interventions aimed to facilitate the expression of immediate feelings, address treatment-ending issues, and explore the client's reactions and emotions toward therapy (including therapy breaks) and/or the therapist in the present moment, rather than primarily focusing on past relationships. This aligns with previous research highlighting the role of discussing the therapeutic relationship in the here-and-now, known as immediacy. Immediacy has been shown to enhance client engagement, promote open expression of immediate emotions, strengthen the therapeutic bond, and reduce defensiveness (Hill et al., 2008, 2014). Further investigation is required to better understand the role of transference work in addressing ruptures in youth psychodynamic therapy, as this study did not specifically measure its impact.

In addition to interpretations, two extra strategies, namely "self-disclosure" and "acknowledging contribution," were identified and included in Category C. Consistent with Safran and Muran's expressive model of repairing ruptures with adults, therapists employed these strategies to metacommunicate about the rupture and gain deeper insights by sharing their own experiences and perspectives. Particularly in the context of working with adolescents, the strategy of "acknowledging contribution" was found to be relevant and helpful to reduce the inherent power imbalance between the therapist and the young individual. Moreover, our findings revealed that therapist self-disclosure, when expressed with genuine concern, has the potential to enhance intimacy within the therapeutic relationship in STPP. However, caution is necessary, as self-disclosure conveying frustration or pushback can impede the rupture–repair process and create distance between the therapist and the adolescent. Hence, STPP therapists working with young people are encouraged to embrace self-disclosure, even when experiencing challenges, while being mindful of avoiding blame toward the adolescent or conveying a sense of surrender or lack of hope. These recommendations are supported by existing literature on the topic. Although self-disclosure has historically faced criticism in psychoanalytic literature, contemporary perspectives highlight its potential benefits, such as promoting therapist authenticity and assisting clients in overcoming impasses and resistance (Campos, 2020; Malan & Coughlin Della Selva, 2007).

Finally, Category D consists of immediate resolution strategies aimed at quickly reestablishing collaboration. Although these strategies were less frequently used in our sample compared to exploratory approaches, they proved valuable in overcoming therapeutic impasses and creating opportunities to address the ruptures at a later stage. This was particularly beneficial when there was a weak client–therapist alliance, high tension in the therapeutic relationship, or when the client was not yet ready for further exploration. Achieving a delicate balance between exploring ruptures and actively working to swiftly restore collaboration and a positive therapeutic bond is crucial in youth psychodynamic therapy. Immediate resolution strategies are not typically emphasized in the STPP model, potentially explaining their infrequent use. However, pushing for exploration when the young person is not ready may be counterproductive, and analysis of these data suggested that doing so may contribute to further alliance ruptures. Accordingly, therapists should prioritize understanding the client's individual needs, emotions, and readiness for exploration or immediate resolution when attempting to repair ruptures. Therefore, expanding the repertoire of strategies available to STPP therapists, by incorporating often overlooked immediate resolution approaches that are not commonly found in psychodynamic treatment manuals, can be valuable in effectively addressing and repairing ruptures.

Overall, it can be argued that the repair strategies encompassed in Categories A, B, and D are not exclusive to psychodynamic treatment and can be applied across various treatment approaches. In fact, these strategies have been found to be relevant in different adult psychotherapies as well (Muran & Eubanks, 2020). On the other hand, Category C strategies, which involve the use of interpretations, may be more specific to psychodynamic treatments and align with the treatment-specific techniques outlined in the STPP manual. Regardless of the chosen category or sequence of resolution strategies, our study emphasizes the importance of repeated "movements toward" the young person in effectively resolving ruptures in STPP. These movements encompassed recognizing the client's subjective reality, displaying flexibility, and engaging in nondefensive metacommunication about challenges. This observation reinforces the importance of continuous efforts and attunement to the unique needs of the young person, rather than relying solely on a singular strategy.

Our findings underscore the dynamic nature of the rupture repair process, where a good alliance and management of ruptures are supported by repeated experiences of attunement, responsiveness, and fostering a sense of togetherness. This observation aligns with previous literature that highlights the significance of the therapist's "responsiveness" (Stiles & Horvath, 2017) and "skillful tentativeness" in effectively resolving ruptures (Muran et al., 2010), regardless of the treatment modality being used. Not surprisingly, therapeutic attitudes such as genuine interest, curiosity, flexibility, and open-mindedness also emerged as important for enhancing the therapeutic alliance and resolving ruptures. These attitudes have not always been emphasized in STPP treatment manuals (none of these terms are found, e.g., in the index of Cregeen et al., 2017), but they may well be implicit in most therapeutic work, and align clearly with principles underlying mentalization-based treatments (Midgley et al., 2017; Rossouw et al., 2021) as well as humanistic approaches (Axline, 2013; Rogers, 1965).

In contrast, sessions where ruptures remained unrepaired demonstrated instances of movement "away" or "against" the young person. This finding highlights the relational nature of ruptures and resolutions, involving both the client and therapist (Muran et al., 2023). Within our sample, specific therapist behaviors were identified as contributing to or exacerbating ruptures. These behaviors included (a) persisting on rejected topics or interpretations, (b) insufficient explicit validation of the client's thoughts and feelings, (c) defensiveness or rigidity, (d) providing lengthy intellectualized interpretations, and (e) abruptly ending the session. These results confirm previous research conducted with adult samples, linking poor therapeutic alliance and potential ruptures to overstructuring of therapy, inappropriate silence, and perceived therapist rigidity (Ackerman & Hilsenroth, 2001; Roth & Fonagy, 2006). Therefore, in addition to training therapists in rupture resolution, it is crucial to promote self-awareness and assist therapists in recognizing and minimizing any negative contributions they may make to the therapeutic alliance and subsequent ruptures.

Strengths and Limitations

This study presents several strengths including being the first to develop a rational–empirical model of repairing ruptures in youth psychodynamic therapy. Second, it builds on a previous study (Cirasola, Martin, et al., 2022) in line with the iterative process suggested for task analysis (Pascual-Leone et al., 2009). Furthermore, our confidence in the reliability of these analyses was based on the following procedures: (a) the selection of the session was sensitive to the context of therapy but also based on a reliable measure of alliance rupture resolutions (e.g., the 3RS), (b) high level of IRR across raters for the 3RS, (c) the consensus meetings on the qualitative analyses during which the two raters discussed discrepancies and worked toward a consensual assessment, and (d) the senior author conducted an audit of the task analysis.

However, it is important to acknowledge several limitations of this study. First, the sample size consisted of a small number of adolescents with depression, and it is possible that the resolution of ruptures may differ within other populations. Therefore, the generalizability of our findings may be limited, and it is crucial to replicate this study using a larger and more diverse sample of clients and therapists. Second, the assessment of alliance quality for sample selection relied on ratings from either the adolescent or the therapist, lacking a truly dyadic perspective. Considering the convergence of alliance ratings between both participants is vital, as it influences therapist responsiveness (Coyne et al., 2018). Third, the study relied on audiotapes, which lack visual cues such as facial expressions and body postures. These cues are essential for a comprehensive understanding of ruptures and repairs. Finally, our rational–empirical model requires further empirical validation to enhance its reliability and validity in other types of psychodynamic therapy for young people. Additionally, it is unclear if some elements of the model can be applied across different treatment types for young individuals.

Conclusion

The present study expands upon prior research to develop a rupture–resolution model specific to youth psychodynamic psychotherapy. This model holds significant potential as a valuable resource for training youth therapists in cultivating a strong therapeutic alliance and effectively repairing ruptures. The resulting framework provides insights into the objectives of various resolution strategies, without prescribing a specific sequence for their implementation. In addition to identifying effective rupture–repair strategies, the model offers guidance to therapists on their utilization and highlights attitudes and behaviors that can either strengthen or impede the therapeutic alliance. Overall, our findings highlight the significance of considering both the "which" and "how" aspects of employing resolution strategies in STPP with depressed youth. Hence, it is essential to carefully select appropriate strategies, but equally important is the way these strategies are implemented. It is our hope that this study will stimulate further research in the development and evaluation of effective rupture–resolution models for youth psychodynamic psychotherapy and support the ongoing training and professional growth of youth therapists in this domain. Ultimately, these efforts contribute to ensuring that young people receive optimal care and support throughout their therapeutic journeys.

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