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EMPIRICAL PAPER

Alliance ruptures and resolutions in short-term psychoanalytic psychotherapy for adolescent depression: An empirical case study

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ABSTRACT

Most research on alliance rupture-repair processes in psychotherapy has been carried out with adults and little is known about the alliance dynamics with adolescents, especially in psychodynamic treatments.

Objective: This study aimed to better understand the process of alliance rupture–resolution and its role in a good-outcome case of a depressed adolescent treated with short-term psychoanalytic-psychotherapy (STPP).

Method: A longitudinal, mixed-methods empirical single-case approach was employed. Multiple sources of information (questionnaires, interviews, sessions recordings) from various perspectives (adolescent, therapist, observer) were assembled and analysed.

Results: The different sources of evidence converged and showed that, despite the presence of frequent alliance ruptures, patient and therapist managed to resolve these and develop a good and collaborative relationship. Both patient and therapist regarded the evolution in their relationship as the treatment factor mainly responsible for the positive changes experienced by the adolescent. Based on both theoretical and empirical data, a preliminary model of how to explore and repair alliance ruptures in STPP is presented.

Conclusion: This study illustrates one way of applying an empirical, mixed-method approach to a single case. Its finding supports the idea that the process of repairing ruptures is an important mechanism of change. Strengths, limitations, and possible implications are discussed.

Keywords: alliance; alliance ruptures; rupture resolutions; short-term psychoanalytic psychotherapy; adolescent depression; single case

Clinical or methodological significance of this article: This paper illustrated a way to apply a systematic, mixed-methods approach to the empirical study of a single case. The use of different sources of information, including self-report, session recordings, and post-therapy interviews, offers subtle insights and evocative descriptions of what happens in the therapeutic room. The findings of this study provide some support to the assumption that the process of repairing alliance ruptures can be an important mechanism of change in short-term psychoanalytic psychotherapy for adolescent depression. Hence, training and supporting therapists in recognizing and exploring alliance ruptures with young people might be an important clinical and research endeavour.

Introduction

Over the last decades, researchers have increasingly recognized that, alongside assessing the effectiveness of various types of treatments for young people, it is crucial to understand what factors contribute to outcomes. Among possible factors, the therapeutic

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alliance has been identified as a promising one (Karver et al., 2018). The growing literature on the alliance highlights the importance of building a strong working relationship for the success of treatment (Flückiger et al., 2018; Karver et al., 2018). The second generation of alliance research, focusing on the fluctuations of the alliance within and across therapy, has highlighted that the alliance commonly undergoes periods of strains or ruptures and that working through these relational impasses is crucial for treatment retention and outcomes (Eubanks et al., 2018). Based on available empirical evidence, the repair of alliance ruptures seems to be a promising line of investigation to gain further insight into psychotherapy process and outcome in young people, but to date most of the research has focused on the treatment of adults.

Alliance ruptures, defined as moments of lack of collaboration about the tasks and goals of therapy and/or tension in the relational bond between therapist and patient (Safran & Muran, 2000), are common during adult therapy, including in cases with successful outcomes (Zilcha-Mano et al., 2018). While in the common language the word rupture may imply a major conflict or breakdown, in the alliance literature the term is used to refer to a broad range of alliance strains, from minor tensions to major rifts (Safran & Muran, 2000). Two main types of ruptures have been identified: withdrawal and confrontation. In withdrawal ruptures patients avoid or resist the therapists. In confrontation ruptures patients express their anger/dissatisfaction in a direct, frequently hostile, manner. The process by which alliance ruptures are repaired is usually referred to as alliance resolutions or repair (Safran & Muran, 2000).

The resolution of rupture with adults requires patient's and therapist's willingness and collaboration in working through the emergent issue(s). Therapists can attempt to repair ruptures in various ways. Muran and colleagues (Eubanks et al., 2018; Muran & Eubanks, 2020) identified two main categories of resolution strategies: immediate and exploratory. Immediate repair strategies include the therapist's efforts to promptly address a rupture and get treatment back on track. These might involve the therapist's attempts to (a) clarify misunderstanding, (b) renegotiate therapy tasks or goals, and/or (c) provide a rationale for the treatment approach. Exploratory repair strategies involve a deeper exploration of the rupture experience and aim to uncover the core relational themes potentially underlying the rupture. To do so, the therapist could (a) invite the patient to share their thoughts and feelings about the impasse, (b) disclose their own experience of the therapeutic relationship, (c) and/or acknowledge their possible contribution to the difficulties they are facing in the relationship. Therapists might choose an immediate over an exploratory strategy if it is early in treatment and they do not feel the bond is strong enough, and/or if they feel the patient is not yet ready for further exploration of a rupture (Eubanks et al., 2018).

In adult psychotherapy, Safran and Muran (Safran & Muran, 1996, 2000) developed the first and most influential stage process model of how ruptures could be successfully repaired across various therapy types. According to this model successful resolution or productive exploration of ruptures is expected to involve one or more of the following: (a) the therapist recognizes the rupture and addresses it by drawing the patient's attention to it, (b) the therapist invites the patient to explore the rupture and the negative feelings associated with it, (c) patient and therapist explore the patient's potential avoidance manoeuvres, (d) therapist and patient focus on clarifying the patient's core relational need/wish that underlies the initial rupture (Lipner et al., 2019; Safran & Muran, 2000). This model has been updated over the years based on empirical data and its elements can be applied to any treatment type (Lipner et al., 2019). Building on Safran and Muran's (2000) work, other researchers developed rupture–resolution models in various adult therapy types, while less research is available on the topic in the treatment of young people.

It is unclear to what degree the findings from existing literature on rupture–resolution processes in psychotherapy with adults may transfer to therapy with adolescents. To date, there are only two models of how to repair ruptures in youth psychotherapy. Daly et al. (2010) validated Bennett et al.'s (2006) model of repairing rupture with adults in cognitive analytic therapy (CAT) for use with young people. Nof et al. (2019) adapted Safran and Muran's (2000) original rupture-repair model for child psychotherapy and developed the child alliance focused approach (CAFA). However, CAFA has not been empirically validated yet. Furthermore, with emotionally and cognitively mature young people, aged 12–16 and above, the authors recommend the use of Safran and Muran's original rupture model. More research is needed on the alliance rupture-repair processes with young people. This is especially relevant in psychodynamic psychotherapy since the few studies available on the topic have so far shown that, in this therapeutic approach, the alliance tends to falter in some moments of treatment and might be characterized by frequent alliance ruptures (Cirasola et al., 2021; Halfon et al., 2019; Schenk et al., 2019). Halfon et al. (2019) investigated the trajectory of the alliance in psychoanalytic therapy with young people with

internalizing and externalizing problems. They found a quadratic trend (high–low–high) in the alliance throughout therapy, which predicted positive outcomes. This might suggest that alliance ruptures occurred in the middle phase of therapy and were subsequently resolved, since the alliance increased in the final phase of treatment. Similar results were found by Schenk et al. (2019), who assessed alliance ruptures and resolutions in a sample of ten adolescents with borderline personality symptoms undertaking psychodynamic treatment. Their findings indicated that alliance ruptures occurred frequently and showed a U shape pattern (i.e., more alliance ruptures in the middle phases of treatments), which was associated with a significant reduction in psychopathology. However, the authors reported on the frequency of resolution attempts and not on whether alliance ruptures were resolved; hence, it's not possible to draw conclusions about the relationship between the resolution of ruptures and outcomes. Likewise, in a relatively large randomized controlled study, the average strength of the alliance with adolescents was found to be lower in short-term psychoanalytic psychotherapy (STPP) compared with both brief psychological intervention (BPI) and especially cognitive–behavioural therapy (CBT), although the treatments were found to be equally effective. However, in the STPP group, the alliance increased more over time compared to both BPI and CBT (Cirasola et al., 2021). The lower alliance ratings in STPP might suggest that this treatment type is characterized by more alliance ruptures than BPI and CBT, without this impacting outcome. This might be because the alliance improved in the later phases of treatments, which could suggest that ruptures were repaired. Furthermore, in the same sample, the early alliance-subsequent outcome association was found to be weaker in STPP compared to CBT (Cirasola et al., 2021). This result might raise questions about the strength of the relationship between alliance and outcome in STPP and warrant further investigation.

Systematic Case Study Approach

Ever since the earliest case study published by Freud (1905), careful analysis of the process and outcome of single cases have been used as a vehicle for developing and articulating evidence-based clinical theory. However, the early clinical case reports have been criticized for failing to meet the burden of proof demanded by the modern medical-scientific community (McLeod, 2013). To address these issues, researchers have begun to apply systematic research methods to single case studies (Lingiardi et al., 2010; McLeod, 2013; Midgley, 2006). The use of session transcripts and the development of empirical instruments for the assessment of different dimensions of patient functioning and therapeutic process have facilitated this task. A combination of qualitative and quantitative methodologies has also been considered valuable to evaluate the process and outcome of psychotherapy (Lingiardi et al., 2010; McLeod, 2013). Hence, if systematically conducted, case study methods can be effective in the study of psychotherapy variables that involve complex interactions between different factors and in the early stages of the investigation of a topic (McLeod, 2013). Since the alliance likely varies based on unique patients' and therapists' characteristics, the therapeutic approach, as well as the interaction between these variables, a case-study approach is an appropriate research method.

The Current Study

The goal of this study was to gain further insight into the dynamics and role of the alliance in good outcome Short-Term Psychoanalytic Psychotherapy (STPP, Cregeen et al., 2016) for adolescent depression. Accordingly, it has the following three specific aims: (1) to describe the alliance and its dynamics, including the type and frequency of alliance ruptures and resolutions, in a case of STPP with good outcome, as assessed by a standard quantified measure of depression, (2) to explore and understand how alliance rupture and resolution events are managed in the context of a good-outcome STPP, and (3) to investigate patient's and therapist's views on the role of their relationships and its dynamics on the change process.

Method

This research employed a longitudinal, mixed-methods empirical approach to an STPP case from the IMPACT-ME study (Midgley et al., 2014), the qualitative arm of the IMPACT clinical trial (Goodyer et al., 2017). Full details of the method and procedure of these studies are reported in Goodyer et al., 2017 and Midgley et al., 2014.

Ethical Considerations

The study protocol was approved by 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,

and some information has been changed to preserve anonymity but clinical details have not been altered.

Case Selection Criteria

Amongst all available STPP cases within the IMPACT-ME sample ($N = 27$), a case was selected based on the following criteria:

(a) Indication of a "good" outcome to assess whether there was any relationship between the positive change and the alliance dynamics. This was measured by (1) a shift from the clinical range (27 or above) to the non-clinical range on the primary outcome measure of the IMPACT trial, the Moods and Feelings Questionnaire (MFQ), (2) a decline of at least five points in MFQ score between baseline and follow-up, which has been considered as a minimum clinically significant difference (Goodyer et al., 2011).
(b) Fluctuations in adolescent's self-reported rating of the alliance, as measured by the Working Alliance Inventory Short-form (WAI-S) at 6-, 12-, and 36-weeks post-randomization, from low to high. This alliance pattern was selected because (a) it might indicate the presence of rupture-repair processes, (b) it was found to be frequent in an earlier investigation of STPP drawing on data from the same study (Cirasola et al., 2021).
(c) Presence of audio recordings of therapy sessions enabling the in-depth assessment of the alliance fluctuation within and across sessions.
(d) Presence of semi-structured interviews with adolescent and therapist, separately, at the end of treatment to explore their perspectives on their relationship, therapy process, and outcome.

Of the 37 STPP cases included in the IMPACT-ME sample, 27 adolescents had both adolescents' and therapists' post-therapy interviews. Amongst these, only 9 had ratings of the alliance (WAI-S) at all time points (3-, 6-, 12 weeks after randomization). Of these 9 adolescents, 3 had a complete set of audiotapes of therapy sessions, but only 1 showed indication of a "good" outcome, as described above. Hence, only one case met all the above inclusion criteria. This was mainly due to technical reasons as this case required a high level of completed research data (e.g., self-report of both alliance and outcomes at all time points, audio-recordings of all therapy sessions, as well as post-therapy interviews) and less so to the alliance pattern. In fact, the selected alliance pattern (from low to high) was not a unique, specific characteristic of the selected case but was found to be frequent in an earlier investigation of the alliance trajectory in STPP (Cirasola et al., 2021).

Participants

Some details about the backgrounds of the patient and therapist have not been reported or changed to preserve anonymity, although important and relevant information about the alliance and its dynamics have not been altered.

Patient. The selected case was assigned the pseudonym "Lewis." Lewis was 14 years old at the start of treatment and his ethnicity was described as White British. He had an MFQ score of 41, suggesting high levels of depression. He was the youngest of a large and loving family, who had recently gone through a traumatic event affecting one of Lewis's family members, to whom he was close. Following this traumatic event, Lewis started experiencing low mood and his school performance deteriorated. Firstly, he was referred to community-based counselling, which he attended on a drop-in basis for about 5–6 months until he was referred to a Child and Adolescent Mental Health Service (CAMHS) where he consented to take part in the IMPACT trial and was randomized to STPP.

Therapist. The therapist (pseudonym: Tim) was a male, qualified child and adolescent psychoanalytic psychotherapist accredited by the Association of Child Psychotherapists. No other demographic information, such as ethnicity or years of experience, was collected about the therapists involved with the study.

Treatment

Short-Term Psychoanalytic Psychotherapy (STPP) (Cregeen et al., 2016) aims to promote better self-understanding of feelings and difficulties and to address the underlying dynamics of the symptoms, not only the symptoms per se. STPP focused on a close observation of the therapeutic relationship and used supportive and expressive strategies to address difficulties in the context of the developmental tasks of adolescence. It included 28 weekly sessions over 30 weeks. Parents were also offered up to 7 parent work sessions with a different clinician (for more details, see Cregeen et al., 2016 and Midgley et al., 2011).

Case Study Data

A rich case record, including multiple sources of evidence from various perspectives was assembled and

analysed. The different data sources are outlined below.

Self-report measures. *Outcome*. In line with the IMPACT study, the primary outcome was self-reported depression symptoms as measured with the MFQ (Angold et al., 1987). The MFQ includes 33-items and the total score ranges from 0 to 66, with higher scores reflecting higher depression severity. It has demonstrated good test–retest reliability over a two- to three-week period (Pearson's $r = 0.78$), good internal consistency (Cronbach's $\alpha = 0.82$) and criterion validity ($\alpha = 0.89$) for detecting an episode of depression in adolescents (Kent et al., 1997; Wood et al., 1995). The clinical cut-off for the presence of a major depressive episode is 27 (Wood et al., 1995). The MFQ was collected at baseline and after randomization at the following time points: 6 and 12 weeks (during treatment), at 36 weeks (completed treatment), as well as at 52 and 86 weeks (after treatment follow-ups).

Alliance. The WAI-S (Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989) was used to assess the alliance from the adolescent perspective at 6- (after the 4th session), 12- (after the 7th session) and 36-weeks (after the last session) post-randomization in the IMPACT study. The WAI-S consists of 12 items grouped in three 4-item subscales assessing: (a) agreement on Goals, (b) agreement on Tasks and (c) the emotional Bond between patient and therapist. All items are rated on a 7-point Likert-type scale (from 1 = Occasionally to 7 = Always) and yield scores for each subscale 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 $\alpha = 0.93$) (Horvath & Greenberg, 1989) and youth samples (Cronbach's $\alpha = 0.94$) (Capaldi et al., 2016).

Observer Rated Measures Applied on Session Recordings

The following measures were applied to the audio-recordings of therapy sessions. Although therapy comprised 25 sessions, due to technical errors the recording of the last session included only the first 12 min and was, therefore, excluded from the analysis.

Alliance. The observer version of the WAI-S, the WAI-O-S (Tichenor & Hill, 1989), was used to assess the alliance in each session. The WAI-O-S provides a global assessment of the alliance across the whole session. It is composed of 12 items analogous to the therapist and self-rated scales. Responses are rated on a seven-point scale from "very strong evidence against" to "very strong evidence for." The WAI-O-S has similar characteristic to the WAI-S and has been shown to have good reliability ($r = 0.81$; Andrusyna et al., 2001).

Alliance rupture and resolutions. Ruptures in the alliance were identified using the observer-based Rupture-Resolution Rating System (3RS) (Eubanks et al., 2015, 2019). While listening to a therapy session recording, raters watch for a lack of collaboration or presence of tension between patient and therapist. Ratings are made of 5-minute segments, permitting the micro-analytic identification of ruptures (both confrontation and withdrawal) and resolution attempts across the course of a session. The coding system includes seven markers of withdrawal ruptures, seven markers of confrontation ruptures, and ten markers of resolution strategies. Tables III,IV,V display a brief description of the 3RS rupture and resolution markers. For each marker, the 3RS yields (1) a frequency score and (2) a significance score. The 3RS significance score 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), therefore we will refer to it as 'impact' score. Additionally, the 3RS yields an overall impact score of (3) withdrawal and (4) confrontation markers as two separate groups (rated on a 5-point scale, from 1 = no impact on the alliance to 5 = significant impact), and (5) a global resolution score assessing the extent to which ruptures were resolved during the session. The resolution score is rated on a 5-point scale with higher scores reflecting greater resolution of ruptures. A resolution score of 3 is used in both (a) sessions that are at least partially addressed and resolved, (b) sessions with minor ruptures that have no significant impact on the work of therapy. The 3RS has demonstrated good to excellent interrater reliability (intraclass correlation coefficients (ICCs) ranging from .73 to .98) for both the frequency ratings and the summary ratings (Coutinho et al., 2014; Eubanks et al., 2019).

Raters and interrater reliability. The first author rated all sessions in chronological order using the 3RS first and then the WAI-S-O. Aproportion of the session (33.3%, $n = 8$) was also rated using the same measures by an independent researcher, who was blind to therapy outcome and self-rating of the alliance. Both raters were doctoral students who had been trained on the 3RS by the measure developers and became reliable in the use of the measure.

Good reliability between the two raters was established on the WAI-O-S (intraclass correlation ICC = 0.81) and on the 3RS for confrontation rupture frequency (ICC = 0.76), confrontation rupture impact (ICC = 0.81), withdrawal rupture frequency (ICC = 0.75), withdrawal rupture impact (ICC = 0.76), resolution attempts frequency (ICC = 0.80) and resolution of ruptures (ICC = 0.86).

Post-Therapy Interviews

Semi-structured interviews were carried out by an independent research psychologist with the adolescent and his therapist, separately, after therapy had ended using the Experience of Therapy Interview (Midgley et al., 2011). This interview schedule focused on the following main areas: (1) the young person's difficulties and how they made sense of them, (2) any changes they might have experienced in their symptoms and/or feelings, (3) the story of their therapy, including the quality of the relationship with their therapist, (4) their evaluation of therapy, (5) the experience of taking part in the IMPACT study. The therapist version of the interview schedule mirrored that of the adolescent and aimed to explore the story of therapy from the therapist's perspective.

Data Analysis

Firstly, each therapy session was scored using the 3RS and the WAI-O-S by the first author and an independent researcher. Once the ratings of the sessions were completed, the transcripts of the post-therapy interviews were analysed by the first author using framework analysis (Parkinson et al., 2016) to assess patient and therapist's views on the quality of their relationship and its impact on the change process. Framework analysis is a qualitative way of analysing data in which a priori research question and emergent data-driven themes guide the development of an analytic framework. The developed framework (see Table S1 in the Supplementary material) is then used to select data, which is thematically analysed and interpreted. To avoid confirmation bias, i.e. to avoid that the ratings of the sessions were influenced by what patient and therapist reported about therapy and their relationship, raters did not have access to the post-session interviews until the ratings of the sessions were completed. Furthermore, to ensure that the qualitative analyses were conducted in a precise, consistent, and exhaustive manner and to verify the trustworthiness of the findings, the second and last authors conducted a detailed inquiry audit of these analyses.

Finally, to develop a model of repairing ruptures in STPP based on both empirical and theoretical data, a selection of rupture and resolution episodes were identified and analysed using some elements of the discovery-oriented phase of task analysis (Greenberg, 2007; Pascual-Leone et al., 2009). Task analysis is a research method to describe the steps in the successful completion of a task, such as repairing alliance ruptures. Its discovery-oriented phase involves the construction and description of an initial model based on the consistency and differences between some theoretical ideas on the phenomenon object of research and the evaluation of multiple empirical observations of the phenomenon. A total of about 9–12 events of interest have been suggested as being sufficient for the first phase of task analysis (Greenberg, 2007; Pascual-Leone et al., 2009). For this study, 10 rupture and resolution episodes were selected using a combination of theoretical and purposive sampling (Straus & Glaser, 1967). Specifically, ruptures were selected from sessions that contained moments mentioned by patient and therapist as difficult in the post-therapy interviews, and that were also identified as rupture events by the 3RS raters. These were transcribed and evaluated in relation to Safran and Muran's (2000) model of repairing ruptures by the first author and discussed in detail with the whole author team. Based on this analysis an initial model of repairing ruptures in STPP was developed and described. Finally, the evidence provided by each of the abovementioned sources of information, alongside the quantitative data on the alliance and outcome, were integrated to fully address each of the aims of this study.

Results

This section firstly provides an overview of the case based on both the session recordings and the post-therapy interviews, then it presents the results organized by study aims. Every effort has been made to preserve the participants' confidentiality while leaving undisguised information that is directly related to the dynamics of the case and in particular the topic of alliance ruptures and resolutions.

Overview of the Case

Lewis was referred to CAMHS by his counsellor due to his low moods, difficulties in sleeping and concentrating, suicidal ideation, and episodes of self-harm. However, he had developed a positive and helpful

relationship with a counsellor he had seen previously and was reluctant to end that work to engage in a new therapy. As such, when at their first meeting Tim suggested that if Lewis was to engage in STPP it would be better to end counselling, this created great tension in their relationship. Despite his initial resistance, Lewis stopped seeing his counsellor and, over time, became committed to his new treatment with Tim. He attended 25 of the 28 sessions offered. STPP took place weekly over a period of 35 weeks with 8 breaks. Two therapy breaks were due to the adolescent not being available and six were initiated by the therapist. Of the six breaks due to the therapist's absence, two were sudden and not communicated in advance to the adolescent. Breaks revealed important moments with respect to alliance ruptures.

Aim 1: The Alliance Dynamics, Including its Rupture and Resolutions

To describe the alliance dynamics in this case, data from different perspectives were analysed. These included (1) Lewis's alliance ratings at 3 time points (WAI-S), (2) session by session observer ratings of the alliance (WAI-O-S); (3) session by session observer ratings of alliance ruptures and resolutions (3RS); (4) the patient's and therapist's descriptions of their relationship in the post-therapy interviews. The findings from each of these data sources are reported below and integrated.

The alliance dynamics. Lewis's self-report of the alliance, using the WAI-S, showed a linear increase over time (see Table VI) from very low (WAI-S = 38) in the early phase of therapy (after the first 4 sessions) to quite high at the end of therapy (WAI-S = 70 after his final session). In the overall IMPACT sample the average alliance at 6 weeks in the STPP arm was slightly higher (WAI-S average score was 48.3) and there was a smaller increase over time (the WAI-S average score at 12 and 36 weeks was 47.8 and 53.9 respectively) compared to Lewis's WAI-S scores (Cirasola et al., 2021).

As shown in Table I, session by session observer ratings of the alliance, using the WAI-O-S, also reflected an overall increase in the alliance over time, despite showing some fluctuations through treatment. The major fluctuations in the alliance happened in the first part of the treatment (within the first 8 sessions) when the majority ($n = 5$) of breaks occurred. In the middle and especially the final stage of therapy most therapy sessions were characterized by a sense of warmth and mutual collaboration, reflected by a steadier and relatively high alliance (see Table I). The lowest ratings of the alliance were found at session 1 and session 8. Session 1 is the session in which Tim suggested ending the community-based counselling, something Lewis was not happy about. Session 8 followed a two-week unplanned break when, due to a misunderstanding about the session date, the therapist missed a session. Both sessions were mentioned in the post-therapy interviews as difficult and more details about these are reported below. According to the WAI-O-S ratings, the alliance improved after both strains. Yet, small fluctuations in the alliance were observed even in the final phase of therapy (especially at session 21), although they were in the context of an overall high alliance.

Frequency and type of alliance ruptures and resolutions. Across the 24 sessions used in the analyses, 274 ruptures were identified. Of the overall number of ruptures, 83.2% ($n = 228$) were withdrawal ruptures and 16.8% ($N = 46$) were confrontation ruptures. Withdrawal rupture markers were present at least once in all sessions. Confrontation rupture markers were present in 62.5% of sessions ($n = 15$). The total average frequency and impact ratings for confrontation and withdrawal ruptures, as well as for resolution markers, are shown in Table II and described in more detail below.

Table I displays the overall frequency and impact of rupture and resolution markers for each session. The sessions that showed the highest frequency and impact of ruptures were sessions 1, 8, and 21. While ruptures were poorly repaired in session 1, they were at least partially repaired in session 8 and generally resolved well in session 21. This was also reflected in the WAI-O-S scoring, where session 1 and 8 showed the lowest alliance scores while session 21 showed a minor decrease but an overall good alliance.

Withdrawal ruptures. Over treatment, withdrawal ruptures were more frequent and showed an average higher impact on the alliance than confrontation ruptures (see Table II). As shown in Table I, Lewis's level of withdrawal and its impact on the alliance fluctuated over time. According to the 3RS impact score, in the initial phase of treatment there were more withdrawal ruptures with higher impact on the alliance (especially sessions 1 and 8), compared to the middle and final phase of therapy. The description, average frequency, and average impact of each withdrawal rupture marker per session are displayed in descending order of average frequency in Table III.

Confrontation ruptures. Confrontation ruptures were less frequent than withdrawal ruptures, but overall followed a similar pattern (see Table I). This lower frequency might be because Lewis

Table I. WAI-O and 3RS session ratings.

Sessions	Alliance strength WAI-S-O	3RS Withdrawal markers		3RS Confrontation markers		3RS Resolution markers	
		Freq.	Impact[a]	Freq.	Impact[a]	Freq.	Overall Resolut.[b]
1	42	16	5	3	2	13	2
2	54	12	4	0	1	9	3
3	59	12	4	1	1	8	2
Break 1 due to adolescent's unavailability							
4	63	11	4	1	2	12	3
Break 2 planned							
5	55	13	4	6	3	16	2
Break 3 planned							
6	58	7	3	2	2	8	2
Break 4 due to adolescent's unavailability							
7	55	10	4	4	3	11	3
Break 5 unplanned							
8	40	21	5	6	3	20	3
9	64	4	2	0	1	3	3
10	65	9	2	0	1	7	3
11	69	9	3	2	2	10	4
Break 6 planned							
12	71	7	3	2	1	6	3
Break 7 unplanned							
13	67	6	2	1	1	7	3
14	68	7	2	0	1	7	3
15	71	9	3	3	2	8	3
16	66	8	3	0	1	4	4
17	67	5	2	0	1	8	3
18	65	9	3	0	1	8	3
Break 8 planned							
19	63	8	3	3	2	10	4
20	66	10	3	3	2	11	3
21	62	15	4	8	3	16	4
22	69	9	2	0	1	6	3
23	72	2	2	0	1	1	4
24	72	9	3	1	1	9	4

[a]Impact refers to the 3RS significance rating, e.g., the impact of the rupture/resolution marker on the alliance.
[b]The overall resolution rating is a global assessment of the extent to which resolution occurred across all the ruptures in the session.

seemed to struggle to directly express his negative feelings about the therapist. For instance, he frequently expressed his complaints/concerns in a subtle, polite way often in conjunction with a withdrawal rupture (e.g., concern expressed with an apology). As a group, confrontation ruptures had on average minor or some impact on the alliance as rated on the 3RS impact score (see Table II). This may be because the few instances in which Lewis contradicted and/or disagreed with the therapist were seen by the therapist as positive, rather than a threat to the alliance, and encouraged by the therapist. The description, average frequency, and average impact of each withdrawal rupture marker per session are displayed in descending order of average frequency in Table IV.

Table II. 3RS average frequency and impact ratings of overall withdrawal and confrontation ruptures, and overall rupture resolution across all sessions.

3RS scores		Mean	SD	Median	Mode
Withdrawal Ruptures	Freq.	9.50	4.04	9.5	9
	Impact	3.13	0.94	3	3
Confrontation Ruptures	Freq.	1.91	2.24	1.5	0
	Impact	1.63	0.77	1	1
Resolution Attempts	Freq.	9.08	4.16	9	8
	Overall resolut.	3.08	0.65	3	3

Resolution. Resolution attempts happened almost as regularly as ruptures themselves, mostly leading to successful resolution of ruptures (see Table I). In 83.3% of sessions ($n = 20$) ruptures were at least partially addressed and resolved (scored 3 or above on the 3RS overall resolution scale). As shown in

Table III. Overall Frequency, average impact, and percentage of sessions in which each withdrawal marker appeared.

Withdrawal markers		Mean Freq.	SD	Mean impact.	Session %
Minimal Response	Patient withdraws from the therapist and/or the work of therapy by going silent or by giving minimal responses to questions or statements that are intended to initiate or continue discussion.	2.29	1.65	3.3	87.5
Deferential and appeasing	Patient withdraws from the therapist and/or the work of therapy by being overly compliant and submitting to the therapist in a deferential manner	2.04	1.54	3.18	91.6
Content/Affect Split	Patient withdraws from the therapist and/or the work of therapy by exhibiting affect that does not match the content of his/her narrative	1.42	1.17	2.8	75
Abstract Communication	Patient avoids the work of therapy by using vague or abstract language.	1.29	0.69	2.57	79.2
Denial	Patient withdraws from the therapist and/or work of therapy by denying a feeling state that is manifestly evident or denying the importance of interpersonal relationships or events that seem important and relevant to the work of therapy.	1.25	0.98	2.7	70.8
Avoidant Story/Shift topic	Patient tells stories and/or shifts the topic in a manner that functions to avoid the work of therapy	0.63	0.82	2.55	62.5

Table IV. Overall frequency, average, impact, and percentage of sessions in which each confrontation marker appeared.

Confrontation markers		Mean Freq.	SD	Mean impact	Session %
Reject intervention	Patient rejects or dismisses the therapist's intervention	0.92	0.92	2.69	58.3
Defend self	Patient defends his/her thoughts, feelings, or behaviour against what he/she perceives to be the therapist's criticism or judgment of the patient	0.83	1.16	2.3	50
Complaints about therapist	Patient expresses negative feelings about the therapist	0.04	0.204	3	4.2
Complaints about progress	Patient expresses complaints, concerns, or doubts about the progress that can be made or has been made in therapy	0.04	0.204	3	4.2
Control/pressure therapist	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	0.04	0.204	3	4.2
Complaints about activity	Patient expresses dissatisfaction, discomfort, or disagreement with specific tasks or activities of therapy	0.04	0.204	3	4.2

Table V. Overall frequency, average, impact, and percentage of sessions in which each resolution marker appeared.

Resolution markers		Mean Freq.	SD	Mean impact	Session %
Invite thoughts and feelings	The therapist invites the patient to discuss thoughts or feelings with respect to the therapist or some aspect of therapy	2.38	1.27	3.58	95.8
Link to other relationship	Therapist links the rupture to larger interpersonal patterns in the patient's other relationships	1.92	1.1	3.45	91.6
Validate defence	Therapist responds to a rupture by validating the patient's defensive posture	1.79	1.02	3.17	91.6
Change task/goals	Therapist responds to a rupture by changing tasks or goals	0.88	1.16	3.08	54.2
Acknowledge contribution	Therapist acknowledges his/her contribution to a rupture	0.83	0.96	3.02	54.2
Disclose internal experience	The therapist discloses his/her internal experience of the patient-therapist interaction	0.42	0.58	2.76	37.5

Table I, while at the beginning of treatment the rupture–resolution score tended to be at the low end of the scale, it increased over time and became stable in the middle and final phases of treatment, when most ruptures had minor impact on the alliance and/or were at least partially resolved (resolution rating = 3). The description, average frequency, and average impact of each resolution strategy the therapist used are displayed in descending order of average frequency in Table V.

Table VI. Depression severity and alliance scores at all time-points.

	Assessment time-point					
	Baseline	6 weeks	12 weeks	36 weeks	52 weeks	86 weeks
Depression severity (MFQ)	41.00	40.00	37.13	9.00	26.00	23.00
Alliance self-rating (WAI-S)		38.00	54.00	70.00		

Adolescent and therapist's perspective on their relationship. The specific themes that emerged on the therapeutic relationship and its evolution from the qualitative analysis of the post-therapy interviews are reported below.

"*I didn't like him … but then I started to trust him … and it all changed.*" Both Lewis and Tim talked about a difficult start in their relationship and linked it with Lewis's initial reluctance to end counselling, as recommended by Tim, and engage in the new treatment. Further, Lewis's initial impression of Tim was negative: "*my first thought was that I'm never going to get comfortable talking to him [..] but then yeah it all changed.*" Despite his initial negative feelings and thanks to his parents' encouragement towards attending therapy, Lewis gave this new therapy a go until he felt differently about it: "*it must have been about after 5 weeks, like, I was finally like getting used to going to seeing him [Tim] and I don't know […] I think I began to trust him and […] some of the things he said were really helpful.*" According to Lewis, what facilitated this positive shift in their relationship was the development of a certain level of trust towards the therapist, which was based on (a) the therapist's statements that were experienced as helpful, (b) the therapist's clarity about the confidentiality of treatment, (c) and a sense that the therapist "*genuinely cared" and "wouldn't judge.*"

Similarly, Tim explained that his relationship with Lewis was not straightforward but that there was ongoing work on it over the course of therapy. He seemed to be aware of Lewis's initial negative feelings towards him: "*I do remember that he was quite ambivalent, really, about engaging in the work […] he wasn't sure about me at all.*" According to Tim, the positive change in their relationship "*unfolded over time"* and was paralleled by a more general shift in Lewis, which enabled them to develop an "*authentic*" and positive relationship and to work collaboratively. More details about how, according to Tim, working on their relationship led to positive changes in their relationship and in Lewis are reported below.

Even once they had developed a more positive relationship, both Lewis and Tim reported experiencing and overcoming a few more difficult moments and misunderstandings.

"*It wasn't like he did this just because he didn't want to see me."* Both Lewis and Tim reported feeling that therapy breaks were not easy. Specifically, Lewis referred to an unplanned break as one of the most difficult misunderstandings in his therapy. This refers to the break between sessions 7 and 8, when the therapist missed a session mistakenly thinking that Lewis would be away that week. Talking about this event, Lewis reported feeling not only disappointed and angry, but also rejected. He explained that he was eventually able to overcome these feelings because Tim called him as soon as he realized his mistake and made an effort to apologize and reassure Lewis that his absence was due to a genuine mistake, rather than suggesting that Tim did not want to see him: "*I would have had angry feelings for ages, but, I don't know, just that he'd called me to like explain that, like, it wasn't like he did this just because he didn't want to see me. I don't know, I think it just made everything better, yeah*." This misunderstanding was discussed at length in the following session (session 8) in which Lewis was able to express his angry feelings, as shown by the low WAI-O-S rating and high number of ruptures that took place in this session, which by the end of the session were at least partially addressed and resolved and the alliance increased after this session (see Table I).

While the therapist did not refer to this specific episode in the interview, he acknowledged that throughout the whole duration of treatment he had to be mindful of breaks and reassure Lewis that he would keep him in mind between sessions. This was because Lewis "*was in constant fear that people would dessert him, or not stick with him, or abandon him, um … and [he felt] that that was what he deserved. So when it came to holidays there was a lot of grist to the mill … really, um. Was he too much for me? Is that why I was having a holiday? [..] and would I, you know, want to see him again kind of thing?*"

"*It kind of hurt*." Lewis reported that even if ultimately helpful, some of the things Tim told him over the course of therapy were not easy to acknowledge at first: "*it kind of hurt, because it was kind of … it was the truth, but I didn't wanna accept that[..] like in a way I felt like he was telling me off*." However, over time Lewis had learnt to trust Tim not only as someone professional and knowledgeable, but also as

someone genuinely caring for him and helpful. This, over time, enabled him to make use of what Tim said, even if painful: *"Tim is a professional, like, he knows what he's talking about, and I realised that he's only there to help me, like, he's not there to make me upset or hurt me, but he's there for my benefit .[…] and so after that I began to get, to like understanding what he was saying and accepting that*."

Similarly, the therapist explained that allowing negative feelings to enter the relationship created some tensions because Lewis was not always ready or willing to recognize "*something of his negative and manipulative points*." Nonetheless, they worked on this in their relationship and over time Lewis become "*able to acknowledge some of his less than perfect characteristics, and for it be OK*."

Aim 2: How Alliance Ruptures-Resolution Events Were Managed in This Case

The alliance rupture-repair model that emerged from the assessment of the selected rupture events in relation to Safran and Muran's (2000) rupture-repair model is presented below. The resolution of ruptures in this case was found to involve one or more of the following steps. In the supplementary material are reported three illustrative rupture–resolution interactions taken from different stages of therapy (early, middle, and late) and from the sessions with the highest number of ruptures (sessions 1, 8 and 21).

- *Recognizing and drawing attention to the rupture*. The therapist recognized some indication of a rupture, paused on it, and attempted to draw the patient's attention to it. To do so, he would (a) describe the patient behaviours (e.g., "*it looks like you are rolling your sleeves a lot"*), (b) use gentle questioning to help the patient elaborate what he is saying and/or to clarify aspects of the emerging issue (e.g., "*can you say what makes you feel this way?"*).
- *Empathic stance*. The therapist showed empathy and validation of the patient's difficulty and might also acknowledge his contribution to the rupture (e.g., "*I realise it's very difficult to start talking to someone you have never met before"; "You might have furious feelings with me sometimes, especially when I was not here last week.. because that must have been very annoying"*).
- *Initial exploration of the rupture*. The therapist explored the meaning of the rupture. This was often done by inviting the patient to express thoughts and feelings about the rupture (e.g., "*if you were to give me a completely straight answer, what you might feel?")*.
- *Further exploration of the rupture*. Based on the adolescent's response to the initial exploration of the rupture, the therapist would:

  (a) *Re-establish collaboration and a positive bond.* To do so the therapist would use immediate resolution strategies such as change topic and/or provide a rationale for the treatment (*e.g., "psychotherapy kind of goes into things in a bit more depth"*). This was usually the case when (a) patient and therapist had not yet established a solid alliance (e.g., in the early stage of therapy); (b) there was too much tension in the therapeutic relationship and the patient did not appear to be ready for any further exploration of the ruptures at that time (e.g., when past attempts to explore the rupture had been rejected and/or resulted in the patient becoming more withdrawn and/or confrontational).

  (b) *Clarify the wish/need underlying the rupture*. To do so the therapist would use exploratory strategies such as interpretations. This was usually the case when patient and therapist had established an overall good alliance and the patient seemed to be able to handle further exploration of the rupture. Interpretations often included transference interpretation and feeling interpretations. Transference interpretations were done in different ways: from interpretations that linked current issues in the therapy to events in the patient's history, through those that linked events in the patient's external world to his phantasies about the therapist or the treatment (e.g., "*I wonder whether your parents are getting a bit something that belongs to me here really. Because I am kind of a therapist parent, am I?"*). Feeling interpretations made explicit and named a feeling that may have been unconscious and/or difficult to acknowledge for the patient (e.g. "*I wonder whether, in a way, I mean correct me if I am wrong, possibly you actually might feel like being a bit cross with them")*.

Importantly, this model does not represent a fixed, linear ordering of resolution stages, but it is assumed that cycling between and within stages will occur in and between sessions. This model was developed based on a combination of both theoretical and observational data, and research is needed to empirically validate and further develop it.

Aim 3: Patient's and Therapist's Views on the Role of Their Relationships and Its Dynamics on the Change Process

The exploration of the impact of the patient-therapist relationship and its dynamics on the change process was mainly assessed using the post-therapy interviews. This was integrated with data from the MFQ and WAI-S.

Evidence of positive change. Both patient and therapist reported feeling that Lewis's mood had substantially improved by the end of treatment and that he was no longer depressed. Specifically, Tim reported that "*some deep changes were made in him [Lewis]*" over the course of the treatment. This was supported by Lewis, who said: "*I don't feel suicidal anymore, um, and like to me I think that is the greatest improvement […] now my grades have got better, I can concentrate, […] and I just generally feel like happier within myself […] like I go out with friends […]and, I don't know, I'm not sad anymore.*" Lewis also talked about the possible long-term benefits of his therapy with Tim, as he felt that he learned something from him that could support him in the future: "*if something goes wrong, I'll always remember him [therapist] and the stuff he said to me about how to cope with it*." The evidence that Lewis did experience improvements in his depression over time was also supported by a decrease in symptoms below the clinical cut-off at both end of treatment and follow-ups, which was paralleled by an increase in the alliance (see Table VI). Thus, there is converging evidence about Lewis's improvement and recovery from depression by the end of treatment and follow-up.

The alliance dynamics and the change process. In the post-therapy interviews, patient and therapist both attributed Lewis's positive changes mostly to the treatment and specifically referred to the importance of their evolving relationship. From Lewis's perspective, the following three aspects of the therapeutic relationship were, directly or indirectly, responsible for change: (a) trust, (b) their affective bond or, as Lewis said, his feeling that Tim genuinely cared and was interested in him, and (c) a feeling of being understood. Tim mainly attributed change to (a) the work they did on the transference and (b) Lewis's tolerance of conflicts and his suitability to treatment.

"*I started trusting him*." Trust emerged as a particularly relevant factor in Lewis's treatment from the start. As reported above, according to Lewis, only once he started trusting his therapist was he able to use the treatment: "*when I started trusting him [Tim] … I was talking like a lot more … there wasn't like any awkward silences or anything like that … everything was just flowing really well*." Lewis also explained that trust in Tim helped them resolve misunderstandings and enabled him to learn from Tim even when things were difficult to acknowledge at first. Hence, even if not directly related to change, trust seemed to have been crucial for Lewis to use therapy.

"*He cared about me*." Lewis reported having benefitted from the affective bond he developed with his therapist. He particularly valued the experience of having someone to rely upon "*who is constantly there for you at the same time, the same place*." The experience of a caring therapist made Lewis *"feel kind of special",* empowering him to feel better about himself: "*because back then I felt like nobody cared about me and I think it made me feel good within myself because it was just, it's kind of what I needed to feel*." This seemed to have also had a positive effect on Lewis's expectations of relationships outside therapy: "*he proved to me that he does care about me, and that I had to accept the fact that people do care about me, um, it just felt really good to know*."

"*He understood me*." Lewis also explained that the experience of being understood by his therapist helped him to feel less confused and more positive about himself: "*I was so confused about everything, like, he [therapist] helped me like understand what I wanted um and, like, it basically felt like I didn't understand myself but he [therapist] understood me and he'd help me to understand myself and I don't know, like, I think that was really, really helpful*."

"*Working with the transference*." Tim felt that the work they did in their relationship in the here and now of the sessions was responsible to a large extent for the positive changes achieved by Lewis over the course of treatment. Specifically, he mentioned the importance of what he referred to as "*working with the transference*." With this, he referred to his attempts to acknowledge and facilitate the emotional expression of Lewis's negative feelings towards him, and to be able to tolerate them: "*It was important for me to take up his negative feelings towards me and um … There was a lot of exploration of them, like, could we … if we disagreed about something, could we express that disagreement openly? And get through it? And um … find a way forward?*". According to Tim working with the transference played an important role in enabling Lewis to make the kind of psychological developments (less self-critical, more accepting of imperfection, less all-or-nothing) that led to a reduction of depression and improvement in his interpersonal relationships. This seems to be supported by the 3RS ratings, as one of the most frequent and impactful strategies used by the therapist to resolve ruptures was to link the rupture to larger interpersonal patterns in the patient's

other relationships (see Table V), a strategy that encompasses transference interpretations.

Specifically, the therapist thought that Lewis's depression was in part due to his unrealistic expectations about how he should be: "*I think he felt he had to be good, good, good, or he was just such a failure, but also he wasn't good, good, good [laughs] because he had lots of ordinary human, angry and aggressive feelings towards others … which he couldn't acknowledge.*" In response to this, Tim not only acknowledged but also accepted Lewis's negative side without rejecting him. This experience was felt to have allowed Lewis to become more forgiving of and comfortable with his own and other people's ordinary imperfections and human feelings, enabling him to develop "*a more rounded view of himself … and of the things surrounding him*." Similarly, Tim felt that Lewis's interpersonal difficulties were due to his unrealistic wish to have "*such a perfect closeness*" with all the important people in his life and his expectation that "*if something went wrong in these idealised and over-close relationships, it would all be ruined.*" In this regard, according to Tim, the experience of a different, imperfect but genuine relationship with the therapist helped Lewis to change his idealized view of relationships and of himself in relation to others: "*I think, at some level, he couldn't believe that if anybody saw the more nasty side of him, that they would really stick with him*." Overall, the survival of their relationship, despite the tensions they experienced, was felt to lead to improvement not only in the patient-therapist relationship but also in Lewis' relationship outside therapy: "*I think there was a great shift in his relationship with his parents too*." Thinking about their relationship with hindsight, Tim could see how the difficulty they experienced from the start, despite its risks, turned out to be ultimately beneficial as allowed them to work on resolving it from the start.

Lewis's "tolerance for a certain amount of conflicts." Tim also attributed Lewis's positive changes to his "*tolerance for a certain amount of conflicts*" and his suitability for this type of therapy. He valued Lewis' "*capacity to engage*" and "*persevere*" despite some conflicts and difficulties. As the therapist said: "*although some of it was tough, you know, facing aspects of himself that were not that great, that he didn't really want to know about. He was willing to go on that journey with me*." This highlights the importance of a mutual collaboration between them in the process of overcoming difficulties.

Integration of data. Overall, what emerged from the interviews corresponded well with, and provided further insight into the self-report of the alliance and outcome, as well as the coding of the session recordings. Neither Lewis nor Tim used terms such as 'alliance', 'ruptures' and 'resolutions', yet their description of the difficulties they experienced and how they overcame them bear a resemblance to these concepts and matched well with the results of the WAI-S-O and the 3RS. Both Tim and Lewis attributed to a large extent the positive changes experienced by Lewis to the evolution and dynamics of their relationship. This was also supported by the self-report ratings on both alliance and outcomes which showed a negative relationship between them, with the alliance increasing over treatment and depression severity decreasing over treatment and at follow-up. Importantly, when asked what else besides therapy might have contributed to his improvements, Lewis mentioned the importance of the support he received from his family and the self-help he experienced from listening to inspiring music. Tim also recognized the importance of the meetings with a parent worker that Lewis's parents also received and the parents' encouragement of Lewis's engagement in his own treatment.

Discussion

This study aimed to better understand the process of alliance rupture–resolution and its role in a good-outcome case of a depressed adolescent treated with STPP. Although this treatment started with an important alliance rupture in its very first session, which caused great tension in the patient-therapist relationship and poor early alliance, there was converging evidence that such tension was resolved and the alliance improved over the course of therapy. Yet, this was not a straightforward process and there were alliance fluctuations and frequent ruptures throughout therapy. Importantly, the therapist seemed to be aware of most ruptures and actively attempted to repair them. In the majority of the sessions, ruptures were at least partially resolved, with only a few sessions in the early phase of therapy showing a low level of resolution. The post-therapy interviews provided important information about what factors both patient and therapist saw as contributing to the positive shift in their relationship and the resolution of ruptures. A turning point in their relationship seemed to have been the development of trust and of a genuine bond between them. This supports the idea set out in the STPP treatment manual that "*psychoanalytic work [..] is only possible if the psychotherapist has established a relationship of trust*" with the adolescent (and their caregivers) (Cregeen et al., 2016). Increased trust in the therapist and a feeling that the therapist genuinely cared

seemed to have also enhanced the patient's capacity to bear frustrating aspects of the treatment. As Busch et al. (2004) put it: "*only in the context of a trusting relationship can a patient feel truly comfortable exposing areas of shame and vulnerability in order to do the necessary therapeutic work*" (p. 44).

The alliance ruptures profile that emerged from this case was characterized by a high presence of withdrawal ruptures, especially in the form of minimal response and submissive behaviours. Confrontation ruptures occurred less frequently, had a lower impact on the alliance, and were usually accompanied by withdrawal ruptures. While the overall rate of ruptures found in this case was higher than the average rate reported by other studies with adolescents (O'Keeffe et al., 2020; Schenk et al., 2019), the predominance of withdrawal over confrontation ruptures is consistent with previous research in youth psychotherapy (Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). It might be that withdrawal ruptures are particularly characteristic of youth populations, who might have some difficulty engaging in therapy and tend to be more prone to withdrawal (Constantino et al., 2010; Johnson et al., 2009). As such, youth therapists should be alert to even subtle signs of withdrawal to be able to actively work to repair them and/or use them for therapeutic purposes.

Nevertheless, the frequency and type of ruptures found in this study could be due to the specific characteristics of this case including treatment type and/or patient's and therapist's characteristics. For instance, the large number of withdrawal ruptures may reflect the diagnostic profile of the selected case, which featured a patient with depressive disorders, who may be more prone to interpersonal withdrawal and have a tendency to hide (consciously or unconsciously) their disagreement or even claim to agree with the therapist in a deferential manner (Muran et al., 2010). Similarly, the selected case was a treatment (and research) completer, which might also reflect a propensity to compliance.

The frequency and type of ruptures found in this study might also be due to the therapeutic approach of this case. It might be that some elements of psychoanalytic psychotherapy led to the occurrence of frequent ruptures. This could be the case because this way of working gives considerable attention to allowing negative feelings to enter the relationship and focuses on tolerating rather than avoiding them. Working through painful and hostile feelings, even if eventually helpful, could be difficult and frustrating for young people and might cause alliance ruptures. As the patient of this case explained, some aspects of therapy "hurt" even if discussions of these aspects ultimately revealed to be beneficial.

The few studies available on alliance rupture-resolution in youth psychodynamic treatments have also shown that the alliance is often characterized by strains and ruptures throughout treatment, even in cases that turn out to have a good outcome (Halfon et al., 2019; Schenk et al., 2019). Hence, the results of this study seem to add the available evidence suggesting that ruptures per se might not be synonymous of poor alliance and/or outcome as long as the therapist and patient manage to explore and resolve them (Eubanks et al., 2018).

How Alliance Ruptures were Managed

Based on both observational data and existing theory, a preliminary model of the rupture–resolution process in STPP was developed. This model does not differ greatly from Safran and Muran's model of resolving rupture with adults, but it is specifically characterized by the comparatively common use of interpretations, especially transference interpretations. As in Safran and Muran's model essential steps towards the successful resolution of ruptures are the therapist's awareness of the ruptures and their openness to (a) be the subject of the patient's negative feelings, (b) acknowledge their own responsibility in the rupture process, and (c) maintain a curious, non-judgmental and empathic stance, which might include the validation of the patient's feelings (Lipner et al., 2019). Validation is an intervention that conveys to the patient that their feelings have been understood and have worth, and it is considered important in various therapeutic approaches, including STPP and Dialectical behavioural therapy (Fruzzetti & Ruork, 2018).

However, differently from Safran and Muran's model which focused more on the exploration of the rupture in the here and now of the therapeutic relationship, the model developed from this case was specifically characterized by the frequent use of transference interpretation and feelings interpretations. Transference interpretation involved making links between the rupture and a situation outside of therapy and/or in the patient's history and vice versa; hence not necessarily bringing the focus to the here and now. As transference interpretations are a core element of the STPP, the use of this strategy might have been influenced by the therapeutic approach of the selected therapist, while Safran and Muran's model is not specific to any type of therapy. On the one hand, this result might suggest that this specific STPP technique can be a helpful way of addressing ruptures in this treatment type. On the other hand, as transference work was not

the a priori focus of this study but emerged from the analysis of the data, we did not specifically assess whether its use was associated with resolution and/or outcomes. Therefore, it is not possible to draw conclusions of the specific role played by transference interpretations in the resolution of ruptures based on these results. Furthermore, as the therapist of this single case acknowledged, working on the transference might be effective only for young people who can tolerate the frustration that often accompanies this treatment technique. Notably, transference interpretations also appeared to be beneficial in another study of STPP for depressed teens, which found that transference work in some respects amplified the positive effects of STPP compared to young people undertaking STPP that did not include transference work (Ulberg et al., 2021). However, precisely what it is about transference work that makes it effective and whether this is the case for some specifc groups of young people (e.g. those with high levels of frustration tolerance) will require further examination.

Feeling interpretations are also not specifically mentioned in Safran and Muran's model but are a recognized intervention in STPP (Cregeen et al., 2016). Alongside being related to the STPP approach, the focus on emotion might be also related to developmental considerations as Safran and Muran's model was developed for adult patients and not for adolescents. Due to the developmentally-appropriate levels of adolescent emotional turmoil, young people tend to experience more frequent high-intensity emotions, greater emotional intensity and instability, and might struggle more to recognize and voice their strong feelings than adults (Bailen et al., 2019). This might also explain the high presence of withdrawal ruptures such as content/affect split, denial, abstract communication, which all seem to suggest an underlying difficulty to express and manage emotions. Both therapy specific and developmental considerations need to be considered when developing models to repair rupture with adolescents within and across therapeutic approaches.

Other resolution strategies used by the therapist of this case were less in line with the STPP manual. For instance, Tim also attempted to repair ruptures by changing the topic/task of therapy. This intervention aims to overcome tension by making the topic more acceptable. In doing so, the therapist might be moving away from difficult feelings rather than exploring them further, as proposed in the treatment manual (Cregeen et al., 2016), although this could also be seen as a way of being responsive to the patient's needs in that moment. Likewise, in response to ruptures Tim also often acknowledged his contribution and/or disclosed his internal experience. These interventions are all part of Safran and Muran's model of repairing ruptures, but are not strictly part of the STPP technique (Cregeen et al., 2016); although they are part of other psychodynamic approaches for children and young people (e.g. Midgley et al., 2017). Therefore, Tim's attempts to repair ruptures went beyond rigidly adhering to the STPP manual. This adds to the available literature suggesting that in response to strains in the therapeutic relationship the techniques used by therapists of different theoretical orientations become more similar with the aim of (re)engaging the young person in the therapeutic work (Calderon et al., 2019). This also points to the importance of therapist's responsiveness, e.g. therapist's ability to achieve optimal benefit for the client by adjusting responses to the current state of the client and the interaction (Stiles et al., 1998)

Importantly, the model of repairing ruptures outlined in this study has not been empirically validated beyond the current case and future research is needed to empirically test it and further elaborate on the ways alliance ruptures can be successfully addressed in STPP with young people.

Alliance Rupture–Resolution and the Change Process

In this case study, both patient and therapist regarded the evolution in their relationship as the treatment variable mainly responsible for the positive changes experienced by the patient, although they underlined different elements of their relationship: Lewis emphasizes the experience of their relationship, Tim emphasizes theexploration of their relationship.. Overall, this suggests that therapeutic change was not only due to the development of new skills or new insights, but rather to the capacity of the therapeutic relationship to create a feeling of being understood, accepted, and thought about. Importantly, what both patient and therapist described as resolving difficulties in their relationship (including working on the negative transference) bears a resemblance to the process of exploration and resolution of ruptures described in Saran and Muran's theory (2000). Therefore, the attribution of the success of therapy to the work on the therapeutic relationship can be seen as consistent with the results of existing research showing an association between the resolution of ruptures and good outcomes (Eubanks et al., 2018; Safran et al., 2011). It is also important to notice that parental encouragement and support of therapy were felt to be beneficial for the establishment of an alliance in this case. Caregivers can be directly or indirectly involved in youth

psychotherapy, therefore, alongside developing an alliance with their young patients, youth therapists need to negotiate an alliance with their patient's caregiver(s). Future research should also pay attention to the parental contributions to the alliance in the treatment of young people.

Strengths and Limitations

This study presents several limitations. Firstly, as it included only one case, its findings cannot be immediately generalized beyond the specific patient and therapist dyad and/or treatment type. Secondly, due to the absence of a control condition, causal conclusions about the relationship between alliance rupture resolutions and outcomes cannot be made. Other variables, such as the adolescent maturing and/or intervening life events, might have also influenced outcome. Another limitation of this study was that the same judge rated the alliance rupture-resolution events and the post-therapy interviews, albeit at different times so that the coder was blind to the patient's and therapist's accounts of their relationship and therapy when rating the sessions. This can be a source of bias as raters are subject to confirmatory and other biases. However, inter-rater reliability with an independent researcher was assessed and obtained on a proportion of the sessions for the observer-based measures used and an inquiry audit was conducted to determine the trustworthiness of the findings of the qualitative analyses. Further, the post-therapy interviews were conducted by an external researcher blind to the aims of this study and did not include any specific questions about the alliance and/or its rupture and resolution. Hence, what emerged about the therapeutic relationship was spontaneously reported by the participants. Finally, another limitation of this study might be related to its strict inclusion criteria. To benefit from a rich, longitudinal and multi-perspective database, a case with an almost full database was selected, which reflects a high level of compliance with the IMPACT study research protocol. While certain characteristics of the selected adolescent might be a result of this, the alliance pattern found in this case was typical of most adolescents in the STPP arm of the IMPACT study (Cirasola et al., 2021). Furthermore, despite the possibility of a certain level of compliance, both patient and therapist were not aware of the aims of this study and therefore could not be affected by them when completing the measures.

A major strength of this single case study was the use of various sources of information at different time points and from different perspectives (e.g., adolescent, therapist, observers). While none of these sources could provide direct access to the reality of the alliance and its dynamics, each piece of information provided important data, and when taken together, the various perspectives can provide a fuller picture of the phenomenon. The complete observation of alliance ruptures and resolutions on a session-by-session basis was another strength of this study. This observation enabled a holistic assessment of alliance rupture-repair processes over time. Another strength of this study was that the researcher who collected the data, the second rater of the observer-based measures, and the participants were all unaware of the aims of this research, hence could not be influenced by them. Since the different perspectives that were considered converged to a large extent, the findings are highly suggestive and, although cannot be generalized, therapists may find them informative in working with similar adolescents.

Conclusion

This study supports the idea that the resolution of alliance ruptures, despite being a challenging and uncomfortable process for both therapist and patient, if managed successfully can ultimately foster deeper exploration of relational patterns, strengthen the patient-therapist relationship, and foster positive therapeutic change (Muran & Eubanks, 2020). This study also illustrates one way in which empirical methods can be applied to clinical material and how combining various sources of information using a mixed-methods approach can lead to a deeper and more precise understanding of the alliance and its role. Studying in-session transactions through a microanalytic investigation of the way patient and therapist construct their alliance has the potential to increase our knowledge of how alliance ruptures and resolutions affect process and outcome in youth psychotherapy, informing clinical practice and therapeutic trainings. The empirical study of a single case seems to be a particularly useful research strategy to better understand psychotherapy process and bridge the gap between science and practice (Lingiardi et al., 2010).

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