Dissertation Volume Two

Exploring ruptures in the therapeutic alliance in Short-Term Psychoanalytic Psychotherapy with adolescents with depression

Literature Review

Empirical Research Project

Reflective Commentary

Candidate Number: VDPQ4

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Doctorate in Psychotherapy

(Child and Adolescent)

DECLARATION

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

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Impact Statement

Despite the wealth of research on the therapeutic alliance in adult psychotherapy, this literature is limited for adolescents. This study contributes to a growing body of research on the therapeutic alliance with adolescents; more specifically, it provides information of alliance ruptures in Short-Term Psychoanalytic Psychotherapy with depressed adolescents. The literature review conceptualizes the therapeutic alliance with adolescents, by exploring the history of the therapeutic alliance concept and reviewing its definition, measures and association with treatment outcome in adolescent psychotherapy. The literature review shows the lack of clarity and consensus on the concept of the therapeutic alliance with adolescents, on its methods and measures. Finally, it addresses some of the gaps in the literature. The empirical paper analyses the emergence of ruptures in two cases using mixed methods. It is one of the few studies utilizing the Rupture Resolution Rating System (3RS). The study offers insight on the patterns of ruptures that may emerge with depressed adolescents. Furthermore, this study sheds light on the patients' and therapists' experiences of the therapeutic relationship, and how these experiences might explain the emergence of alliance ruptures. Although there are limits to the generalizability of the study due to the small sample size, this study contributes to theoretical information of how alliance ruptures emerge in psychotherapy with depressed adolescents; this information should be further studied and validated with larger sample sizes.

Additionally, this study informs the clinical practice in adolescent psychotherapy, addressing the relevance of alliance ruptures. Engaging adolescents in psychotherapy tends to be challenging, due to several developmental factors. Alliance ruptures play an important role in therapeutic change, therapy dropout, and disengagement, depending on how these ruptures are addressed and acknowledged. Through the analysis of two cases of adolescents with depression, the study offers a clinical picture of the emergence of ruptures and nuances in the

therapeutic relationship. Findings show that withdrawal ruptures were a frequent phenomenon in the alliance of the analysed cases. Moreover, patients' ambivalence was a strong feature in these two therapies, with patients finding some helpful aspects of therapy, but also struggling with silences and transference interpretations. This study emphasizes the need to address alliance ruptures and adolescent ambivalence when treating depressed adolescents. This information might help improve clinical practice with adolescents, prevent therapy dropout, and help engaging adolescents in therapy. Finally, the reflective commentary shows the strains and rewards of doing research as part of a clinical doctorate program. This information could potentially show the benefits of doing research for clinical practice, and testimony the enriching gains, both professionally and personally, when doing research.

Part One: Literature Review

Conceptualizing the therapeutic alliance in psychotherapy with adolescents: A theoretical and empirical framework

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Abstract

The therapeutic alliance in adult psychotherapy is a widely researched field; however, this is not the case in child and adolescent psychotherapy. There are several reasons for expanding and furthering research on the therapeutic alliance with adolescents, especially considering their developmental stage, reasons for attending psychotherapy and difficulties with engagement. This literature review presents theoretical and research literature on the therapeutic alliance with adolescents. Initially, the conceptual origins of the therapeutic alliance in adult psychotherapy are presented followed by the most significant contributions of research on the alliance with adults; later the review focuses on the alliance with adolescents and its definition, measures and association with treatment outcomes, providing information about the research done in the field of alliance with adolescents. Findings show the lack of clarity and consensus on the concept, methods and measures used to assess the therapeutic alliance with adolescents, and the varied approaches that exist in conceptualizing the alliance with adolescents. Additionally, it is shown how research on the alliance-outcome association with adolescents suggests a similar effect than with adults. Finally, gaps in the literature are described and suggestions for further research made.

Introduction

Research has paid attention to psychological services offered to children and adolescents, considering the prevalence, persistence and recurrence of mental health disorders (Schmidt & Schimmelmann, 2013). Mental health disorders are a main public health concern around the world (World Health Organization, 2017), with a prevalence of up to 20% in children and adolescents worldwide (Belfer, 2008; Kieling et al., 2011). These disorders present increasing impairments in children and adolescents' lives and development and pose a high risk for this population (Erskine et al., 2017; Fryers & Brugha, 2013; Kieling et al., 2011; Slomski, 2012). Moreover, prognosis tends to be poor, with the likelihood of

symptoms reappearing or the development of other disorders in adult life (Flisher, Hatherill, & Dhansay, 2010). The Department of Health (2015) estimates that half of mental health disorders in adults start during adolescence.

Within this alarming context, research has focused on the effectiveness of treatments for children and adolescents, with authors providing different evidence-based treatment options for a variety of mental health disorders (Fonagy et al., 2015; Steele, Elkin, & Roberts, Michael, 2008). In addition to studying the effectiveness of different types of therapy, it is also necessary to understand the change mechanisms that occur within a therapy. In recent years, change-process research (research focusing on the factors that promote or prevent individual change) has gained popularity because its insights can help further develop and improve treatments, informing the clinical practice on the elements that promote change in treatment (Falkenström et al., 2017; Mechler et al., 2021). Moreover, understanding the mechanisms of change underlying different types of therapy is relevant for clinicians, as it informs on the elements that promote change in treatment and helps endorse treatment adherence and good outcomes (Baier, Kline, & Feeny, 2020); additionally, this understanding contributes to the development of manualized treatments (Fonagy & Bateman, 2006).

A large body of psychotherapy research focuses on the therapeutic alliance as a mechanism of change, emphasizing its importance in psychotherapy with children and adolescents. The concept of the therapeutic alliance with children and adolescents has been developed drawing upon the concept as originated in work with adults (Shirk, Caporino, & Karver, 2010). The same authors emphasize the need of understanding the therapeutic alliance in adolescent treatments and suggest that this concept can be viewed as a collaborative bond between the adolescent and therapist (Shirk et al., 2010).

The alliance with adults has been widely studied; however, this is not the case with adolescents. There are gaps in the literature and there is still lack of agreement on the concept, measures, and methods.

The development and preservation of the therapeutic alliance is considered a crucial factor in the treatment with adolescents. It has been suggested that this may be even more crucial than in work with adults, as more difficulties can appear in the relationship (Mishne, 1996). It might be difficult for an adolescent and their family to engage and participate in a therapeutic process. Dropout rates are high with this population (Kazdin, 1996; Nock & Ferriter, 2005) and this is a significant difficulty in psychotherapy (De Haan, Boon, De Jong, Hoeve, & Vermeiren, 2013; Kazdin, 1996; O'Keeffe et al., 2018; O'Keeffe, Martin, & Midgley, 2020), generating concerns for mental health services (Nock & Kazdin, 2001). In order for therapy to continue, it is essential that adolescent patients see the helpfulness of treatment and to address the patient's lack of trust in therapy (Constantino, Castonguay, Zack, & Degeorge, 2010).

Some developmental tasks of adolescence – although these tasks might be culture specific – might bring complications with therapists, such as difficulties with an adult authority, conflicts around dependency and concerns around confidentiality. At the same time, this stage of development, can be a big opportunity for change, considering the cognitive development that occurs in adolescence (Bhola & Kapur, 2013). Usually, adolescents have low motivation for therapy, as they are referred by others, whose opinion regarding the need or goals of treatment is often different to that of the adolescent. For DiGiuseppe et al. (1996) there are two main obstacles in engaging children and adolescents in a therapeutic treatment: first, children and adolescents are not self-referred; second, they generally begin therapy with resistance.

In addition, clinical work with adolescents might trigger responses in therapists in a unique way; this must be recognised and monitored in the treatment with this population (Mishne, 1996). It is very important for adolescent services to be seen as a source of help, to encourage the adolescent to attend appointments, and to give them a space where they feel comfortable to disclose their feelings and behaviours (Freake, Barley, & Kent, 2007). Furthermore, it is necessary to train therapists on engagement strategies and to help adolescents and their parents have realistic expectations about the treatment process (King, Currie, & Petersen, 2014).

Considering the difficulties in engagement for this age group, their developmental tasks and the risks to which adolescents might be exposed, working on the therapeutic alliance in treatment with adolescents becomes crucial. For Shirk and Karver (2011), therapists should constantly monitor the alliance over the course of a treatment with adolescents.

Given the relative lack of theoretical and research literature on the therapeutic alliance with adolescents, this literature review aims to analyse this concept and discuss the controversies concerning the components of the alliance in therapy with adolescents. Initially, the concept of the therapeutic alliance with adults will be described, including a brief history of the concept, information about the measures that have been used to assess the alliance with adults, its relation to outcomes; this literature can enrich the limited research about the alliance with adolescents. Next, the literature on the therapeutic alliance in adolescent psychotherapy will be reviewed and discussed, focusing on conceptual and methodological issues; then, alliance measures used with adolescents and the findings on the alliance-outcome association with adolescents will be discussed.

Search strategy

Literature for this review was collected by advanced searches on PsychINFO, PEP-Web and APA PsycInfo databases, and on UCL library. Keywords used to find relevant papers were: “therapeutic alliance”, “working alliance”, “helping alliance”, “adolescent psychotherapy”, “therapeutic alliance with adolescents”; given that few studies appeared under these keywords, the researcher expanded the list of keywords, including: “adolescent engagement psychotherapy”, “adolescent alliance psychotherapy”, “alliance factors adolescent psychotherapy”, and “alliance measures psychotherapy”. Inclusion criteria for this review were: studies that traced back the therapeutic alliance concept and its origins, papers investigating alliance patterns and their association with therapy outcome, studies on the alliance with children and adolescents, and studies that assess the validity and generalizability of alliance measures. The literature included was not limited to psychodynamic psychotherapy, given that the therapeutic alliance is a widely used concept across therapies. Exclusion criteria for this review were: studies that were not written or translated to English.

Therapeutic Alliance

Over the last two decades a paradigm shift in psychotherapy research highlights the relevance of relational factors in the therapeutic process (Safran & Muran, 2006). Currently, the concept of the therapeutic alliance is widely used in research and in clinical practice across different psychological therapies.

Contemporary conceptualizations of the therapeutic alliance draw upon Bordin’s model. Bordin (1979) defines the therapeutic alliance as a *collaborative construct* formed by three factors: a bond between patient and therapist, agreement on the therapeutic tasks of treatment, and agreement on the therapeutic goals of treatment. Although this author analyses the therapeutic alliance, or working alliance, from a psychoanalytic perspective, he mentions that it can be applied universally and in different relationships, not only in psychotherapy or

in the analytic situation, such as between teacher and student. This definition has been applied across therapy types. For the author, every treatment has specific goals and tasks, agreed by therapist and patient. Moreover, the bond between therapist and patient is linked to these goals and tasks, and requires trust to develop. Bordin gives examples of how different types of therapy, even focusing on different aspects of the patient, need these elements to work.

The therapeutic alliance is a very important component in psychotherapy and one of the key factors in the process of change (Bordin, 1979). Current research has emphasized the therapeutic alliance as a significant variable in psychotherapeutic processes (Ackerman & Hilsenroth, 2003). Different authors have discussed the importance of patients' involvement or engagement with the therapy for sustaining the process of therapy and avoiding break-down (Chu et al., 2010; Constantino et al., 2010). Indeed, as discussed later in the review, the therapeutic alliance has consistently been shown to be related to therapy outcome.

History of the Concept

The therapeutic alliance has been studied for a long time in psychoanalysis and it has been used by other psychological disciplines. It is possible to look at its origins in Freud´s (1955) work, when he already addressed the importance of making the patient a collaborator. Freud (1940) emphasized how analyst and patient ally with external reality, forming a pact to master the patient´s ego against the forces of the id and the superego. Although the therapeutic alliance concept was not yet formalized, it is possible to see how Freud already had the idea of the importance of bonding and allying with the patient. At this stage, the concept was not differentiated from the transference (Freud, 1912a, 1912b, 1913) and this created confusion between the two concepts among analysts (Sandler et al., 1992). Recognizing the difference between the treatment alliance and transference can benefit the

analytic process; for example, a patient who has strong affectionate feelings towards his analyst has not necessarily established a strong therapeutic alliance (Sandler et al., 1992).

After Freud, other psychoanalytic theorists have written about the therapeutic relationship, with different theoretical views, based on object relations theory and the ego psychological tradition (Safran & Muran, 2000; Sandler et al., 1992). These different perspectives created huge debate amongst psychoanalysts and still have important implications on technique and on the conceptualization of the therapeutic alliance (Safran & Muran, 2000; Sandler et al., 1992). From the point of view of object relations theory, the therapeutic alliance is, as other aspects of the psychoanalytical treatment, part of the transference (Safran & Muran, 2000). This point of view comes from Ferenczi´s (1932) idea of the importance of patients reliving their past in the therapeutic relationship. On the other hand, the ego psychological tradition focuses on the reality-oriented part of the ego to build the therapeutic relationship; these theorists developed the idea of the working or therapeutic alliance (Safran & Muran, 2000).

Richard Sterba´s work is very important in distinguishing the therapeutic alliance from the transference. According to Safran and Muran (2000), Sterba´s (1934) idea of a *therapeutic split in the ego* is the base for the development of the concept of the therapeutic alliance. This author explains how transference works in a dualistic way, bringing conflict and contradictory feelings, which might create resistance to the analysis. Then he describes a *dissociation within the ego* that can help the analysis; a part of the ego has the capacity for self-observation, it allies and identifies with the analyst, bringing the opportunity to work on the resistance and to generate change through the analytic work. A crucial author in the development of the concept of the therapeutic alliance is Elizabeth Zetzel (1956), who argued that the prerequisite for forming a strong therapeutic alliance are the patient´s mature ego functions that allow the patient to deal with transference interpretations. In addition, she

suggested that the analyst should interpret and understand the identification based on the therapeutic alliance, not only on the transference. After Zetzel, Greenson (1971) addressed the importance of differentiating the *real relationship* that occurs between patient and analyst from the transference aspects of this relationship. These views have been criticised due to the danger of leaving some aspects of the transference without analysis or interpretation because of a confusion between them and the therapeutic alliance (Brenner, 1979).

Bordin (1979) pondered these previous ideas and conceptualized the therapeutic alliance as a key factor in any psychotherapeutic process and suggested that the alliance has three components: agreement on tasks of therapy, agreement on goals of therapy, and a strong emotional bond. For Safran and Muran (2000, 2006), Bordin´s contributions to the concept of the therapeutic alliance have significant implications for the following reasons: this model emphasizes the interdependence between relation and technique, it offers a context where the therapist's interventions can be more flexible, it permits the therapist to understand the patient´s organizing principles and internal object relations through the ruptures that occur in the therapeutic alliance, and it stresses the importance of the negotiation of tasks and goals between therapist and patient. They show how dynamic Bordin´s model is, as it allows to understand the patient´s dilemmas and desires in the relationship with the therapist.

Currently, there is debate about whether the therapeutic alliance is a change mechanism in psychotherapy (Baier et al., 2020). Some authors claim that the alliance is a prerequisite for any psychotherapy to be successful (Hatcher & Barends, 2006; Raykos et al., 2014; Weck, Grikscheit, Jakob, Höfling, & Stangier, 2015). Others contend that the alliance fosters change by itself in some types of therapy more than in others, being the alliance a change predictor in specific types of therapy, such as in relational therapy more than in CBT, as some therapies focus more on relational aspects in the sessions, (Siev, Huppert, & Chambless, 2009), and others argue that it is a change factor across therapies (Falkenström,

Ekeblad, & Holmqvist, 2016; Falkenström, Granström, & Holmqvist, 2013; D. N. Klein et al., 2003). For Baier et al. (2020) the alliance is likely to drive change in psychotherapy, although it is still unclear how and to what extent it does so. It is possible that the alliance contributes to change increasing treatment adherence and patients' engagement (Barber, 2009; DeRubeis, Brotman, & Gibbons, 2005; DeRubeis & Feeley, 1990; O'Keeffe et al., 2018, 2020; Puschner, Wolf, & Kraft, 2008), and enabling a collaborative relationship, as patient and therapist mutually engage in therapeutic joint work (Hatcher & Barends, 2006); in addition, it has been suggested that the alliance can predict symptom changes by the following session (Falkenström et al., 2016; Feeley, DeRubeis, & Gelf, 1999; Strunk, Cooper, Ryan, Derubeis, & Hollon, 2012; Wampold & Imel, 2015; Xu & Tracey, 2015; Zilcha-Mano, 2017; Zilcha-mano et al., 2016). However, other authors contend that the alliance is not a change factor by itself, but that symptomatic change in early sessions predict a good alliance (Barber, 2009; DeRubeis et al., 2005; DeRubeis & Feeley, 1990; Puschner et al., 2008), fostering good outcomes later. Within these conflicting ideas, the association between alliance and outcomes has been a theme that generated interest among researchers in the field.

Alliance-outcome association

Research has shown a *moderate yet robust* association between alliance and treatment outcomes across therapies (Flückiger et al., 2018; Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

Research on the relation between the therapeutic alliance and treatment outcome has a central focus in the literature and is extensive. Different findings have been shown in the literature, with a heated debate that has gone on for decades and no agreement around this topic (Flückiger et al., 2012; Zilcha-Mano, 2017). Hatcher & Barends (2006) claim that this debate is due to a broadened and unclear concept of the therapeutic alliance and lack of

clarity of its relation to technique, relationship and outcomes. Zilcha-Mano (2017) argues that a possible contribution to the different results found in the literature is treating the alliance as static and not dynamic, without measuring alliance changes in treatment, or focusing only on patients' perspective of the alliance.

Within this debate, some authors contend that the alliance is an important outcome predictor. Bordin (1979) emphasizes that therapy outcomes depend much more on the strength of the therapeutic alliance than on the type of therapy. For him, this strength depends, amongst other things, on personal characteristics of the therapist and the patient, such as the patient´s enduring dispositions, hopes, attachment style, and dependency; or the personality of the therapist, their working style and different capacity to respond to the patient´s needs and alliance. Additionally, there is an argument that the alliance is an important component to achieve good outcomes, irrespective of the type of therapy (Hatcher & Barends, 2006; Horvath & Greenberg, 1994; Horvath & Luborsky, 1993); although other authors argue that the alliance is not relevant in all types of therapy, but it is a necessary technique in specific types of therapy, such as relational therapy (Siev et al., 2009).

Supporting Bordin's (1979) claim, some authors emphasize the alliance role in good therapy outcomes, suggesting that a strong alliance is a predictor of good treatment outcome independent of the type of therapy and that session-to-session changes in the alliance predict session-to-session symptom changes (Ardito & Rabellino, 2011; Crits-Christoph et al., 2011; Flückiger et al., 2018; Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Karver et al., 2018; Martin et al., 2000).

On the other hand, some authors argue that there is no relation between alliance and outcome (Feeley, DeRubeis, & Gelf, 1999; Gaston et al., 1991) or that only one aspect of the alliance, "patient commitment" could be associated with treatment outcomes (Marmar et al., 1989). Others claim that the alliance-outcome association is the other way around, in the

sense that early symptomatic change predicts a good alliance (Barber, 2009; DeRubeis et al., 2005; DeRubeis & Feeley, 1990; Puschner et al., 2008); although this has been contested by results showing that the alliance strength can be predicted by alliance in the early sessions, but not by early symptom change (Zilcha-Mano et al., 2014). In addition, there are authors who suggest that patients' traits are decisive on developing a strong alliance and good outcomes, but the alliance itself does not foster good outcomes (DeRubeis et al., 2005).

In response to the aforementioned debate, Zilcha-Mano (2017) suggests a new model to understand and examine the alliance role on treatment outcomes. In her view, the alliance has *trait-like and state-like components.* The former refers to the patients' capacity to form a meaningful relationship with their therapists, and the latter refers to changes in the alliance that can predict treatment outcomes, being the alliance sufficient to foster change. Her proposed two-part model focuses on both components of the alliance, trying to disentangle them for statistical and conceptual reasons. Other authors have considered the dynamic nature of the alliance, suggesting that session-by-session alliance fluctuations may predict symptom change (Falkenström et al., 2016; Feeley et al., 1999; Strunk et al., 2012; Wampold & Imel, 2015; Xu & Tracey, 2015; Zilcha-Mano, 2017; Zilcha-Mano et al., 2016).

Finally, the "second generation" alliance research has greatly contributed to research in this area with the notion of *alliance ruptures*, which are defined as a problem or deterioration in the quality of the relationship between patient and therapist (Safran & Muran, 2006) or momentary deteriorations of their collaboration (Eubanks, Muran, & Safran, 2015), with disagreements on tasks or goals of therapy, or with strains in the bond between patient and therapist (Safran & Muran, 2000). These authors highlight the idea of negotiation, indicating that the therapeutic alliance is not static and shifts over the course of a treatment, i.e. that during a treatment, the therapeutic alliance is constantly negotiated (Safran & Muran, 2000). Currently, ruptures are seen as an opportunity in psychotherapy as, when properly

resolved, ruptures can promote change through working on the patients' relational patterns (Safran & Kraus, 2014) and, therefore, impact on therapy outcomes. There are important contributions to the literature on alliance-outcome association, showing that outcomes not only depend on a high-alliance, but also on the repairs made after alliance ruptures (Eubanks, Muran, & Safran, 2018). Additionally, it has been shown that changes in the alliance from one session to another can predict session-to-session changes in symptoms (Crits-Christoph et al., 2011).

It is also important to consider what measures are used in alliance research and how these measures contribute to a better understanding of the alliance. The next section describes the current measures used in alliance research with adults.

Therapeutic alliance measures

There is a varied development of alliance measures in the adult psychotherapy literature, which might indicate the extent to which the alliance with adults has been studied. Table 1 will present some of the tools that have been used to measure the alliance with adults. The range of measures used to evaluate and understand the therapeutic alliance and its components is wide. Some measures as the WAI (Horvath & Greenberg, 1989) have been further used and there seems to be an agreement on their validity and usefulness for research; however, research on the therapeutic alliance is growing and there are new measures that could be implemented and that might improve research in this area. Findings differ depending on how the alliance is operationalized and measured, i.e. there are important differences between patients' therapists' and observers' perspectives.

Table 1. Adult alliance measures

Measure	**Assesses**	**Reports from**	**Other versions**
Pennsylvania Scales (Alexander & Luborsky, 1986)	Alliance in sessions	Patients, therapists, and observers	
Vanderbilt Scales (O'Malley, Suh, & Strupp, 1983)	Interaction between patient and therapist	Observers	
Toronto Scales (Marziali, Marmar, & Krupnick, 1981)	Patients' and therapists' contributions to alliance	Patients and therapists	
Working Alliance Inventory – WAI – (Horvath & Greenberg, 1989)	Alliance strength	Patients, therapists, and observers	WAI-S (Hatcher & Gillaspy, 2007; Tracey & Kokotovic, 1989).
California Scales (Gaston & Marmar, 1994; Marmar, Weiss, & Gaston, 1989)	Alliance strength	Patients, therapists, and observers	
Therapeutic Bond Scales (Saunders, Howard, & Orlinsky, 1989)	Therapeutic relationship and bond	Patients, therapists, and observers	
Therapeutic Collaboration Coding System, TCCS (A. P. Ribeiro et al., 2014; E. Ribeiro et al., 2013)	Patients' collaboration with therapists	Observers	
Rupture Resolution Rating System, 3RS (Eubanks et al., 2015)	Alliance ruptures and repair attempts	Observers	

Therapeutic alliance in adolescent psychotherapy

As discussed above, the therapeutic alliance with adults is a widely researched area. However, this is not the case in child and adolescent psychotherapy. Although interest in the field seems to be growing, there is still scarce literature or agreements on the topic, its concepts and measures, compared with the literature on the alliance with adults (Shirk et al., 2010). It is important to consider that therapeutic processes in childhood and adolescence differ from those in adulthood. Therefore, the formation, strength and patterns of the therapeutic alliance with adolescents differ from the alliance with children or adults for diverse developmental factors (Shirk et al., 2011). However, research on the therapeutic alliance in children and adolescent therapy has made use of adult conceptualizations in the field (Shirk, Caporino, & Karver, 2010). Moreover, many studies are focused on children and adolescents together, despite the different developmental milestones these age groups present and differences that take place in their therapeutic processes. Although most of the literature around the alliance in adolescence has made use of the concepts and measures used with adults, this seems to be gradually changing. The concept of the therapeutic alliance with adolescents has been in construction over the last decades (Shirk et al., 2010).

The growing interest in the field could explain the diversity on the themes that appear in research related to the therapeutic alliance with adolescents. When looking for literature, a wide variety of research that assesses the therapeutic alliance with adolescents appeared. Some of the themes that appear when looking for alliance with adolescents are the following: The most studied issue concerned the alliance-outcome association in adolescent psychotherapy, with some meta-analyses and other important contributions up to date (Bhola & Kapur, 2013; Cirasola et al., 2021; Cummings et al., 2013; Karver et al., 2018; Karver et al., 2006; Labouliere et al., 2017; Mattos et al., 2017; McLeod, 2011; Shirk & Karver, 2003; Shirk et al., 2011). Findings of these studies will be explained in another section. Following

this topic, other authors have studied the alliance in relation to the diagnosis or type of problems (Afolabi & Adebayo, 2015; Cummings et al., 2013; Gersh et al., 2017; Labouliere et al., 2017; L. Levin, Henderson, & Ehrenreich-May, 2012; Lotempio et al., 2013). Other studies present the alliance with adolescents in relation to type of treatment (Cummings et al., 2013; Diamond, Liddle, Hogue, & Dakof, 1999; Karver et al., 2008; Lotempio et al., 2013). Other themes that appear in the literature are related to therapists' and patients' perspectives about the alliance in adolescent psychotherapy (Campbell & Simmonds, 2011; Hawks, 2015; Hawley & Garland, 2008; Ormhaug, Shirk, & Wentzel-Larsen, 2015), or patients' predictors of early alliance (L. B. Levin, 2011; Lotempio et al., 2013). Finally, other studies have focused on rupture-resolution processes with adolescents (Binder, Holgersen, & Nielsen, 2008; Daly, Llewelyn, Mcdougall, & Chanen, 2010; DiGiuseppe et al., 1996; O'Keeffe et al., 2020; Schenk et al., 2019); this seems to be a growing field of interest and looks promising in its contributions to understand adolescent psychotherapy. The results of these studies in different themes are varied and show the lack of agreement on the concept, measures and methods to understand the alliance in adolescents' treatment. In the following sections, it will be shown how the therapeutic alliance with adolescents is understood, and the literature around it will be described.

Definition of Therapeutic Alliance with adolescents

Anna Freud (1946) talked about the therapeutic bond formed in children´s psychotherapeutic treatment. For her, this bond is grounded on the child´s experience of the therapist as a person who can help with different problems or feelings. In addition, research on the therapeutic alliance with children and adolescents has made use of Bordin´s (1979) definition of the alliance with adults (Shirk et al., 2010). The therapeutic alliance with children and adolescents is defined as:

> A contractual, accepting, respectful and warm relationship between a child/adolescent and a therapist for the mutual exploration of, or agreement on, ways that the child/adolescent may change his or her social emotional or behavioural functioning for the better and the mutual exploration of, or agreement on procedures or tasks that can accomplish such changes (DiGiuseppe, Linscott, & Jilton, 1996, p.87)

There are two main lines of thought around the therapeutic alliance with adolescents. The first emphasizes the importance of adolescents' experiences in the relationship with the therapist as a reliable, trustworthy, and responsive person (Shirk et al., 2008; Shirk & Russell, 1996; Shirk & Saiz, 1992). This approach is based on Bowlby's (1988) attachment theory; it equates the therapeutic bond to an attachment relationship, and emphasizes this bond as a change process by itself (Shirk et al., 2010; Shirk & Russell, 1996). According to this line of thought, an important strategy to build alliance with adolescents is the therapist's responsiveness to the patient's emotional expressions (Shirk et al., 2010). In line with this conceptualization, the lack of response to the adolescent´s emotional expressions has been found to be related to a weaker alliance (Karver et al., 2008). In another study, attending the young person's experiences and bringing them to the treatment was shown to strength the alliance (Russell, Shirk, & Jungbluth, 2008).

The second line of thought criticizes the former for focusing excessively in the bond and not taking in consideration the agreement on goals that, for these authors, is the major component of the alliance with adolescents (DiGiuseppe et al., 1996). This approach suggests that in order to strengthen the alliance it is important to make explicit treatment goals, based on a study that found that the alliance was improved at the third session when the goals were made explicit since the beginning of the treatment (Diamond et al., 1999).

There is lack of agreement on what components of the therapeutic alliance with adolescents are the mechanisms that allow engagement and change. Similar debates regarding which aspects of the alliance are mostly associated with good outcomes have been carried out in the adult literature (Zilcha-Mano, 2017). This shows the diversity of approaches present in the literature on the therapeutic alliance with adolescents and the need for continuing research that provides understanding on how the alliance works with adolescents.

Shirk et al. (2010), have made an important attempt to bring agreement on this topic. For them, both components of the alliance, the bond and agreement on goals, are important in adolescents' treatment. Even more, Shirk and Karver (2006) suggested a model to integrate these two components of the alliance. This model brings Bordin's (1979) notion about the alliance with adults, that refers to the dynamic interdependence between bond, tasks and goals. In this model, they offer three constructs for the therapeutic alliance with adolescents: *engagement, involvement* and *alliance.* The first highlights the therapist's strategies used to strengthen the alliance, involvement and treatment adherence. The second refers to the adolescent's participation in the treatment. Finally, the third is defined as the young person's experience of the therapist as someone reliable who can help. As can be seen, this model includes the bond, as well as the agreement on goals and tasks, taking in consideration both views around the alliance with adolescents, and Anna Freud´s (1946) initial idea of the bond with the patient. Moreover, this model contributes with a new perspective about the alliance with adolescents, which for Shirk et al. (2010) places the alliance in the centre of the model, as a consequence of the engagement process and patient's involvement. However, this model could also bring some problems and confusion in the definition and differentiation of the concept of therapeutic alliance with the concepts of engagement and involvement.

Two different alliances in adolescent treatment: one with the adolescent and one with the carers

There is limited literature around the alliance with adolescents and with their parents or caregivers, which is a complex area for clinical practice (Hawks, 2015). For Novick and Novick (2013) involving parents in adolescent treatment has advantages for the work, such as working on the parents' necessary development to allow adolescents grow, helping the parents with their own anxieties around the patients' difficulties, giving the parents strategies as they are an important part of the patients' life. Therefore, it is not only important to establish and develop a therapeutic alliance with the patient; it is also crucial to develop a relationship and working alliance with the parents (Schimel, 1974). Some studies suggest that a strong alliance with adolescents and with their caregivers are indicative of better treatment outcomes and might prevent dropout (Gatta et al., 2009; Robbins et al., 2006). However, this might become particularly difficult considering the problems in agreement between the adolescent and the parents. For Hawley & Weisz (2003), finding agreement on the goals of the treatment is a very difficult task for clinicians, especially for those who work with children and adolescents; in this case, the concerns of the child or adolescent as well as those of the parents are legitimate and need consideration from the therapist. In the treatment of children and adolescents, there needs to exist mutual trust and respect between the therapist and the parents; there should also be regular contact between them, allowing the patient to know that the confidentiality will not be broken (Schimel, 1974). However, it is difficult to keep a balance on how much and when to share information with caregivers (Novick & Novick, 2013).

It is important to note that studies that evaluate the relation of the alliance with outcomes, rarely consider the alliance between therapist and parents (McLeod, 2011); studying this type of alliance as well as the alliance between therapist and adolescent might bring important

findings in the understanding of therapeutic processes with adolescents. Considering the importance of the therapeutic alliance with the adolescent, and the need of parental engagement in the treatment, research in this topic needs more exploration, as it might have important implications in the practice with this population (Hawks, 2015).

Relation between the therapeutic alliance with adolescents and treatment outcomes

Literature on the alliance-outcome association with adolescents is more limited than the literature on adults, although developing. The results on this association are varied and suggest the need to continue researching on this area. Although some studies found a strong association (Bhola & Kapur, 2013; Cummings et al., 2013; Labouliere et al., 2017; Mattos et al., 2017), other authors suggest that the alliance-outcome association in adolescent psychotherapy has a small to medium effect size, which they find consistent with the adult literature (Karver et al., 2018; Shirk & Karver, 2003). Different studies analysed the alliance-outcome association with varied adolescent populations and across a range of treatments (Karver et al., 2018, 2006; McLeod, 2011; Shirk & Karver, 2003; Shirk et al., 2011).

According to a meta-analysis that examined the association between alliance and outcomes using 23 studies, the alliance-outcome association is modest, as the one with adults, and can be influenced by the type of problems, and by the methods used by the researchers to understand this association; however, it is not influenced by the type of treatment or by the age of the participants (Shirk & Karver, 2003).

In their meta-analysis about the associations between the alliance and outcomes, Shirk et al. (2011) found that there is consistency with the findings from the literature around alliance-outcome association with adults; however, this meta-analysis included studies with children, and the authors indicated that the association was stronger with children than with adolescents. There are other studies with adolescents that suggest a strong association

between alliance and outcomes (Bhola & Kapur, 2013; Labouliere et al., 2017; Mattos et al., 2017).

In another meta-analysis with children and adolescents (McLeod, 2011), 38 studies were analysed. These studies were completed between 1992 and 2009, with the majority being completed after 2003. Most participants in the studies received treatment in an outpatient setting, other settings differed between community/ home services, school, inpatient, residential or jail settings; however, nine studies did not mention the setting. The studies researched on 45 different treatments, of which the average of sessions number was 16.38. This meta-analysis found that the variety of measures used to assess the alliance was wide. 60.5% of these studies used alliance measures to assess the relationship, 55% used them to assess the adolescent's alliance in therapy, and 5% focused on the alliance between parents and therapist. The authors found that a stronger alliance is related with positive outcomes; they also found that parents' reports about the therapeutic alliance were more strongly linked with the outcomes. Additionally, this meta-analysis indicates that the way of measuring the alliance influenced the association between alliance and outcomes. Finally, the authors showed that the alliance has a stronger association with outcomes when it is measured from one informant instead of more. These results are an important contribution because they indicate how the association between therapeutic alliance and outcomes is influenced by other factors.

As in alliance research with adults, when analysing the alliance-outcome association, there are additional factors that might influence the results; therefore, some studies have taken these moderators in account on their findings (Cirasola et al., 2021; Karver et al., 2018). When analysing these factors, it was found that age did not mark any differences, although gender was an important factor affecting alliance ratings, with males reporting better perceptions of alliance (Afolabi & Adebayo, 2015). In addition a significant

association between the alliance and outcomes reported by parents was found (Hawley & Garland, 2008). Karver et al. (2018) found that diagnosis, treatment type and settings, or method used to understand the mentioned correlation were moderators of results presented on the alliance-outcome association with adolescents. Similarly, Cirasola et al. (2021) found a varying effect of alliance and outcome, depending on treatment type, with a stronger association between alliance and outcomes in CBT than in STPP when treating adolescents with depression. Even more, for Cirasola et al. (2021) some meta-analysis on the alliance-outcome association present the following methodological limitations: a limited number of studies included; not taking in consideration other variables besides the alliance, like treatment involvement or therapists' responsiveness; not differentiating between types of therapy; or measuring the alliance early in therapy.

In sum, recent findings show that there is a small to medium effect between alliance and treatment outcomes in adolescent psychotherapy, which is consistent with the adult literature. However, research on this area is still developing and requires improvement in its methodology, especially considering how other variables might influence the results. Additionally, when studying the alliance-outcome association with adolescents, seems important to not only differentiate between treatment types, diagnosis, or settings, but also separate adolescents from children, as they are in different developmental stages and this could impact the results. Finally, research on the association between alliance with adolescents' carers and outcome still requires further development.

As in the adult literature, the measures used in research with adolescents are an important factor on the findings and on the debate. Variability in measurement is problematic (Cirasola et al., 2021) and a contributor to the heterogenous findings in the field. This could partly explain the debate and lack of agreements in the association between adolescent

alliance and outcomes. For this reason, the following section will give an account of the measures used to assess the alliance with adolescents.

Therapeutic alliance measures with adolescents

Some of the measures applied to study the therapeutic alliance with adolescents have been modified from the measures used with adults. There are also some measures developed for adolescents that have been designed or used in specific studies or in limited number of studies, without necessarily having proved yet their psychometric properties (Shirk et al., 2010). Table 2 shows the measures that have been created or modified to assess the alliance in adolescent psychotherapy. However, there are other measures developed for adults that have also been used with adolescents, such as the WAI for adults (Dennis, Ives, White, & Muck, 2008; Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000; Linscott, DiGiuseppe, & Jilton, 1993; Tetzlaff et al., 2005), the Pennsylvania Scales (Alexander & Luborsky, 1986; Eltz, Shirk, & Sarlin, 1995; Zaitsoff, Doyle, Hoste, & Le Grange, 2008), the Vanderbilt Scales (Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006; O'Malley, Suh, & Strupp, 1983; Shirk et al., 2010) and, to the time of writing this review, only three studies have used the 3RS (Eubanks et al., 2015) to understand alliance rupture-resolution processes with depressed or BPD adolescents (Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019), suggesting that withdrawal ruptures are more frequent and need to be addressed from early on in treatment, that confrontation ruptures have a greater impact on the alliance, and that alliance ruptures might predict dropout in adolescent psychotherapy.

Table 2. Adolescent alliance measures

Measure	**Assesses**	**Reports from**	**Other versions**
Adolescent WAI (Linscott, DiGiuseppe, & Jilton, 1993)	Alliance strength	Patients, therapists and observers	
Therapeutic Alliance Scale for Adolescents (Shirk, 2003)	Emotional bond and collaboration on tasks	Patients and therapists	
The Working Relationship Scale (Doucette, 2004)	Alliance strenght	Patients and therapists	The Working Relationship Scale (Bickman et al., 2004)
The Overall Adolescent Engagement Scale (Jackson-Gilfort et al., 2001)	Involvemente in treatment	Observers	
The Adolescent Therapeutic Alliance Scale (Faw et al., 2005)	Alliance strength	Observers	
The Alliance Observation Coding System (Karver et al., 2003)	Patient feelings around progress and towards therapist	Observers	

As it can be seen from the variety of measures used, interest in the field of alliance with adolescents seems to be growing. It is important to continue researching in this field and to find consensus about valid measures that can help researchers understand the therapeutic alliance processes with adolescents.

Conclusions

The therapeutic alliance is a widely studied topic, principally in the research literature of psychotherapy with adults. Research on the alliance with adolescents is still limited, but it has grown over the last years. The conceptualization of the therapeutic alliance with adolescents has developed from the concept of therapeutic alliance with adults and, even though there are some further contributions, research on alliance with adolescents has not yet developed its own methods and concepts. Even more, the measures used to assess the alliance with young people are varied and still lack consensus on their use and validity.

There is an ongoing debate on the components of the alliance with adolescents. One approach emphasizes the bond in the alliance, and the other argues on the importance of agreement on goals of therapy element. Research on both approaches show the relevance of these two components. Important contributions have been made to bridge this gap, with some authors putting together these two elements of the alliance. Furthermore, the concept of the alliance with adolescents has been connected to the concepts of engagement and involvement.

Regarding the alliance-outcome association, as in the adult literature, there is debate around the alliance being a change factor in psychotherapy. From the existing literature, it is possible to conclude that the therapeutic alliance with adolescents is a predictor of treatment outcomes, and that the results in this area are similar to those with adults. Even more, there is a variety of measures and methods used to understand this association, and there are

methodological limitations in the literature on alliance-outcome association with adolescents; these limitations might explain the varied results on the topic and show the need to continue researching this area.

Another finding of the review shows that the existing literature about the alliance with adolescents is very diverse and heterogenous. The most studied topic is the association between alliance and outcomes in adolescent treatment. This finding shows the growing interest in understanding the therapeutic alliance in adolescent psychotherapy; but, again, shows the lack of clarity and consensus on the concept.

There is still research to be done on the alliance with adolescents. Its clinical relevance and the research interest on this area demand further studies in the field. This will inform clinicians and researchers and improve the treatment and services offered to adolescents. Given that this area of research is quite new, it has some gaps and requires further research. Some of these gaps are:

- Lack of agreement on conceptual considerations about the therapeutic alliance with adolescents, such as its components and which factors are necessary to form an alliance in the treatment with adolescents.
- Lack of agreement on the measures applied for studying the therapeutic alliance with adolescents.
- The alliance with adolescents has been conceptualized from the literature on adults. Although this literature can offer important contributions for this conceptualization, it is important to consider that adolescents are in a very different developmental stage than adults, and that there is need of a theoretical and empirical framework that can provide an understanding of the therapeutic alliance with this specific population.
- Debate around the strength of the alliance-outcome association with adolescents, and the factors that could potentially influence this association.

- Little research on alliance rupture-resolution processes with adolescents. Being this a widely researched field with adults and a key change feature of therapy in the literature, it seems important to further research these phenomenon with adolescents.

This literature review shows the relevance of the therapeutic alliance in psychotherapy with adolescents. There is need for further research in the alliance with adolescents. Theory has not expanded the topic of the alliance with adolescents, and might benefit from having a more homogeneous agreement on the concept. Additionally, the clinical practice requires an in-depth understanding on how the therapeutic alliance might be fostered when treating adolescents, particularly thinking about the difficulties in engaging them in therapy. Research on this area could potentially inform and improve adolescent treatment.

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Part Two: Empirical Research Project

Exploring ruptures in the therapeutic alliance in Short-Term Psychoanalytic Psychotherapy with adolescents with depression

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Abstract

Despite the wealth of literature on the therapeutic alliance in adult psychotherapy, research on this area is limited for adolescents. Alliance ruptures are considered an important aspect of therapy; when properly resolved, ruptures are thought to pose an opportunity to foster change. However, rupture-repair processes have not been widely studied with adolescents. This exploratory, mixed methods two-case study aimed to describe the patterns of alliance ruptures through treatment phases with depressed adolescents. Observers', patients' and therapists' views were used to describe the emergence of alliance ruptures in two Short Term Psychoanalytic Psychotherapy cases, drawn from the London branch of the IMPACT study. The audio-recordings of 22 sessions from the beginning, middle and end phases of therapy were examined using the Rupture Resolution Rating System (3RS) in order to identify therapeutic alliance ruptures. Alliance ruptures were found in all sessions, and these were analysed using descriptive statistics. Additionally, six post-therapy interviews, two for each patient and one for each therapist, were thematically analysed to inform analysis of rupture patterns through the sessions. Ruptures emerged in all sessions, withdrawal ruptures being significantly more frequent than confrontation ruptures. The frequency and types of ruptures varied between patients and between treatment phases. The impact ruptures had on the alliance was stronger for withdrawal ruptures and varied through the treatment phases. Therapists' contribution to ruptures decreased from beginning to ending therapy. Patients reported strong ambivalence in the therapeutic relationship; they found difficult to begin and end therapy. In addition, silences and transference interpretations were experienced as difficult to tolerate. Both patients addressed their discomfort with therapy, but felt therapy had some helpful aspects too. Therapists reflected on the importance of engaging adolescent patients in treatment, and on the need to address anger and ambivalence. The current study informs clinical practice, considering the importance of addressing alliance ruptures and ambivalence in psychotherapy

with depressed adolescents, the opportunity ruptures pose to work on adolescents' relational schemas, and the need to adapt technique to engage adolescents in therapy.

Introduction

Research on the therapeutic alliance with adolescents is scarce and lacks agreements on concepts and measures, despite a large number of studies on alliance with adults (Shirk et al., 2010). However, the literature emphasizes the relevance of the alliance when working with adolescents, given that a strong alliance is related to patient´s involvement in therapy and can increase treatment adherence (Chu & Kendall, 2004; Shirk & Karver, 2006b), while a poor initial alliance has shown to be a drop-out predictor (O'Keeffe et al., 2018, 2020). Therapists often report finding work with adolescents challenging and dropout rates with this population are high (Kazdin, 1996). Given that difficulties to engage young people in therapy is a considerable problem (De Haan et al., 2013; Kazdin, 1996; O'Keeffe et al., 2018, 2020), developing a strong alliance is an important issue for psychotherapy process research .

Most of what has been researched in the alliance with adolescents has been drawn from adult studies (Shirk et al., 2010), where it is generally considered that the alliance is an important change mechanism in psychotherapy (Baier et al., 2020). The alliance is usually defined in terms of the collaborative relationship between patient and therapist, with three characteristics: a positive emotional bond between them, agreement on goals of therapy, and agreement on tasks of therapy (Bordin, 1979). The association between alliance and outcomes across therapies has been emphasized by different authors (Ardito & Rabellino, 2011; Cirasola et al., 2021; Crits-Christoph et al., 2011; Flückiger et al., 2018; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Karver et al., 2018; Martin et al., 2000). Additionally, research shows that session-by-session changes in the alliance predict symptom changes for the next session (Falkenström et al., 2016; Feeley et al., 1999; Strunk et al., 2012; Wampold & Imel, 2015; Xu & Tracey, 2015; Zilcha-Mano, 2017; Zilcha-mano et al., 2016).

Furthermore, the "second generation" research on the alliance points at alliance rupture-repair processes as an important aspect of therapy, emphasizing the need to understand and address ruptures (Eubanks et al., 2018; Safran, Muran, Samstag, & Stevens, 2002). Ruptures are defined as moments of tension between patient and therapist (Safran & Kraus, 2014), or momentary deterioration in their collaboration (Eubanks et al., 2015) with either disagreements on tasks or goals, or difficulties in the bond (Safran & Muran, 2000). The concept of ruptures is similar to other concepts such as the empathic failure (H Kohut, 1984), therapy impasses, or a misunderstanding event (Rhodes, Hill, Thompson, & Elliott, 1994) and can be traced back to the initial psychoanalytic concept of resistance.

More recently, alliance ruptures have been described as a trans-theoretical phenomena, due to their relevance across treatment types (Safran & Kraus, 2014). Alliance ruptures are inevitable in psychotherapy and a key factor to understand change processes (Eubanks et al., 2018; Safran & Kraus, 2014; Safran, Muran, & Eubanks-Carter, 2011; Safran et al., 2002). Even more, ruptures are understood not only as manifestations of the patient's inner world, but also as patient's reactions to the therapist's conscious or unconscious attitudes or interventions; this means that ruptures need to be understood both intrapsychically and interpersonally (Colli & Lingiardi, 2009; Safran & Muran, 2000).

Alliance ruptures differ in intensity, from minor strains, sometimes unnoticeable for patient and therapist, to major events that impact the collaboration between them (Eubanks et al., 2018; Safran, Crocker, McMain, & Murray, 1990; Safran et al., 2011; Safran & Kraus, 2014), and have been differentiated between withdrawal and confrontation ruptures (Harper, 1989a, 1989b). The former happen when the patient moves away from the therapist or the work of therapy, while the latter occur when the patient moves against the therapist (Eubanks et al., 2015, 2018; Safran & Muran, 2006). Research on alliance ruptures is rather limited, but there is some evidence that withdrawal ruptures occur more frequently than confrontation ruptures,

happening in almost every therapy session (Lingiardi & Colli, 2015) and are more subtle, passing sometimes unnoticed by patient or therapist (Boritz, Barnhart, Eubanks, & McMain, 2018).

For Safran and Kraus (2014), resolved ruptures are an opportunity to foster change through working on patients' relational patterns. Safran and Muran (2000, pp. 14) claim ruptures are "the royal road to understanding the patient's core organizing principles". These authors emphasize the depth of rupture-repair processes, as an acceptance of oneself and the other´s subjectivity, and a negotiation between the patient and the therapist's desires and between the need for relatedness and for agency (Safran & Muran, 2000, pp. 15). Ruptures are thought to help understand the patient's core relational schemas and to restructure them, given the therapist is able to offer a different relational pattern (Safran & Muran, 2000). It has been argued that properly resolved ruptures are the main vehicle for change, given the interpersonal process that takes place in psychotherapy (Coutinho, Ribeiro, & Safran, 2009). Some studies suggest that the association between rupture-repair processes and therapy outcome is significant, regardless of type of therapy (Eubanks et al., 2018; Larsson, Falkenström, Andersson, & Holmqvist, 2018; Safran et al., 2011). On the other hand, unresolved ruptures may generate difficulties in therapy and even predict dropout (Eubanks, Lubitz, Muran, & Safran, 2019; O'Keeffe et al., 2020), which indicates the importance of tracking the strength of the therapeutic alliance and to address alliance ruptures.

Developing a strong alliance with adolescents is different than with adults, due to unique developmental factors that take place in adolescence (Shirk et al., 2011). Blos (1967) has emphasized the need of adolescents' separation from important adult figures; for this author, adolescents go through a second individuation process, in which they seek closeness and intimacy, but at the same time want to establish their identity through a sense of agency. Adolescents struggle with feelings of defiance and dependence at the same time (Donald Wood

Winnicott, 1961). This process might bring strains in the relationship with the therapist. Anna Freud (1946) emphasized the importance of the therapeutic relationship with adolescents, stating that it is the base for later work. When working with adolescents, there are additional aspects of the therapeutic relationship that need consideration. In a time of "personal discovery" (Winnicott, 1961, pp. 188), the tasks of adolescence and a need to move away from adult figures are additional challenges when trying to develop a therapeutic alliance (Shirk et al., 2010), making the alliance harder both to establish and maintain with adolescents (Bailey, 2006; Blos, 1963; DiGiuseppe et al., 1996; A. Freud, 1958; Meeks, 1971; Shirk et al., 2010, 2011; Shirk & Karver, 2003; Wilson, 1987). Additionally, adolescents with depression might present difficulties with expressing their anger or ambivalence in therapy, as has been presented in adult psychoanalytic literature (Abraham, 1924; Bleichmar, 1996; S. Freud, 1917; Jacobson, 1972; M. Klein, 1935; Heinz Kohut, 1977; Rado, 1928). It is important to consider that claims made about adolescents development might differ from one culture to another.

Owing to these developmental and relational aspects of adolescence, it is crucial to embrace the challenges in the therapeutic relationship and to develop a strong alliance (Shirk & Karver, 2011; Wilmots, Midgley, Thackeray, Reynolds, & Loades, 2019; Wilson, 1987, 2009). It has been argued that treatment participation depends on a strong alliance when working with depressed adolescents (Brent et al., 1998) and that the alliance is a predictor of treatment outcomes in youth psychotherapy, regardless of treatment type (Shirk & Karver, 2011).

In relation to the difficulties in engaging adolescents and developing a strong alliance, some authors address the need of adaptation of technique with this particular group (A. Freud, 1958; Wilson, 1987). For example, Binder, Moltu, Hummelsund, Sagen, and Holgersen (2011) reported aspects that adolescents consider important in the therapeutic relationship; additionally they described adolescents feeling vulnerable and ambivalent during the beginning

phase of therapy. Along similar lines, Shirk and Karver (2011) addressed the importance to provide a framework that helps adolescents understand the work that will be carried, to scaffold the patient´s emotional disclosures, to show the collaboration in the patient-therapist relationship, and to acknowledge the patient's feelings.

As the literature on adults shows, the alliance is dynamic and might change both between and within sessions (Horvath & Luborsky, 1993; Safran & Muran, 2000). Alliance ruptures in the treatment of adolescents are important; however, the literature on this area is limited (DiGiuseppe et al., 1996). The idea of difficulties in therapy process was already stated by Anna Freud (1958, pp. 261), who described adolescents' psychoanalysis as: "a hazardous venture from beginning to end, a venture in which the analyst has to meet resistances of unusual strength and variety". Daly, Llewelyn, Mcdougall, and Chanen (2010) suggest that alliance ruptures and resolutions might be a key change factor related to good outcomes in treatment of BPD adolescents. Schenk et al. (2019) argue that confrontation ruptures had a greater impact on the alliance than withdrawal ruptures with this population. O'Keeffe et al. (2020) examined the relationship between ruptures and dropout with depressed adolescents, with three groups of depressed adolescents: completers, got-what-they-needed dropouts and dissatisfied dropouts. They found that a poor alliance and unresolved ruptures are indicators of a dissatisfied dropout. Additionally, they suggested that confrontation ruptures occurred rarely in all groups and that there was a slight increase of confrontation ruptures by the end of treatment in the third group, while the other two presented little change through treatment phases. This study, in line with other studies trying to understand drop-out in adolescents' psychotherapy (O'Keeffe et al., 2018; O'Keeffe, Martin, Target, & Midgley, 2019), highlights the importance of addressing and understanding alliance ruptures with adolescents. Binder, Holgersen, and Nielsen (2008), focusing on how therapists understand ruptures in psychotherapy with adolescents, reported that therapists saw ruptures in line with the

adolescents' independence seeking, and considered missed sessions a way of withdrawal rupture. These authors, as well as Morán, Díaz, Martínez, Varas, and Parra Sepúlveda (2019) emphasize the importance of addressing and validating adolescents' ambivalence in the process.

Current study

Given that the literature on alliance ruptures with adolescents is limited, the current study hopes to contribute to this body of research. This is an exploratory, mixed methods two-case study intending to understand the emergence of ruptures in two Short-Term Psychoanalytic Psychotherapy (STPP) treatments (Cregeen, Hughes, Midgley, Rhode, & Rustin, 2017) with depressed adolescents.

STPP is a psychodynamic manualised time-limited treatment model for adolescents diagnosed with moderate to severe depression, where the young person receives 28 sessions with a Child Psychotherapist; in addition, seven sessions with carers are carried out by another therapist. STPP focuses on relational factors, transference, countertransference, and feelings of loss, allowing to work with complex difficulties that underly the patient's depression. The treatment is divided in three phases: beginning, middle and ending. The first phase focuses on stablishing the therapy setting, assessing the appropriateness of treatment, and developing a strong alliance. The middle phase looks to deepen into the transference and patient-therapist relationship. In the latter phase, therapists focus on patients' feelings of loss, review the progress, and consider the need of further treatment in the future (Cregeen et al., 2017).

This study aims to shed light on:

a) The emergence of ruptures in adolescent STPP, examining more specifically the frequency and significance of each type of rupture across treatment phases.

b) Thematically analyse participant interviews to deepen our understanding of their experience of the therapeutic relationship.

The researcher expected more withdrawal than confrontation ruptures to emerge in all treatment phases, considering that the participants were depressed adolescents and the possible difficulties they might experience expressing discomfort in therapy. Additionally, it was expected to find more ruptures in the middle phase of treatment, taking in account that STPP focuses on transference and on relational aspects of therapy in this phase of treatment.

The quantitative and qualitative analyses of the research material will be combined, to provide a fuller picture regarding the emergence of alliance ruptures in STPP therapy with adolescents with depression.

Method

Design

This exploratory, mixed methods two-case Study (Fishman, Messer, Edwards, & Dattilio, 2017), explores the emergence of alliance ruptures through treatment phases in two STPP cases and aims to gain in-depth understanding of ruptures processes with depressed adolescents throughout therapy. This study obtained corroboration (Midgley, 2006) incorporating views from the two patients and therapists, besides the observers' perspective of the clinical material.

Case-study research is a clinically-meaningful way of gaining in-depth understanding of the mechanisms that take place in therapy (Midgley, 2006) such as alliance ruptures processes. Moreover, in psychotherapy research, besides analysing effectiveness, it is important to understand the therapeutic process or how psychotherapy works (Midgley, 2009). Therefore, case-studies have an important role as a method in psychotherapy research when the aim is to develop new ideas or to gain an in-depth understanding of therapy process

(Midgley, 2006). Considering the lack of research in alliance ruptures processes with adolescents, plus some authors' claim that there is need to offer a more nuanced description of alliance rupture processes that illustrate its fluctuations (Falkenström & Larsson, 2017; Stevens, Muran, Safran, Gorman, & Winston, 2007), it was thought that an in-depth case-study design could enlighten clinical practice, showing session-by-session ruptures, as well as patients' and therapists' views of the therapeutic relationship and the strains in it. Additionally, considering all the measures that have been used to assess the alliance with adults and adolescents, and that there are few studies using the 3RS (Eubanks et al., 2015) with adolescents, it was thought that a mixed-methods case-study could enlighten how this measure can be used with adolescents and add information about alliance ruptures with adolescents to the field.

Data was drawn from the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2011), a large RCT that compared treatment outcomes of depressed adolescents receiving a brief psychosocial intervention, CBT or STPP in different CAMHS across the UK. Data for the patients' and therapists' views was obtained from the IMPACT-My Experience (IMPACT-ME) study (Midgley, Ansaldo, & Target, 2014) that added qualitative analysis to the previously mentioned RCT. Patients had one interview before therapy started (T1) and two after-therapy interviews (T2 at the end of treatment, and T3 one year after treatment finished) and therapists had one interview at the end of treatment. Patients' T2 and T3 interviews and therapists' interviews were used in the current study.

Participants

Two therapies were selected for this study, out of 14 available cases from the IMPACT trial (Goodyer et al., 2011). The cases were selected based on the following inclusion criteria: patients who met depression criteria based on the MFQ, had received STPP treatment, completed it, and had a good outcome, defined as cases who dropped 5 or more points in the

MFQ (this will be further detailed in the measures section). The reason for selecting cases with a good outcome was that it was thought that patients with a good outcome would present a rupture-repair pattern in therapy. Furthermore, patients aged between 15-18 were selected, in order to ensure that language would be their main way of working in therapy; outcome measures completed and all interviews for the IMPACT-Me study (Midgley et al., 2014) also needed to be have been completed. Sessions from the beginning, middle and end phases of treatment needed to be clearly audio-recorded for each case. After examining all available cases, two participants met these inclusion criteria. There were no additional cases meeting these criteria; therefore, the author decided to work with these two participants. Information of their demographics is detailed in Table 1. It is important to note that the researcher did not have access to the full demographics of the two patients involved in the study and their therapists, such as their ethnicity or the therapists' age.

Table 1. Participants' demographics

	Given name	Gender	Age	Outcome	No. sessions offered	No. sessions attended	No. sessions recorded
Participant 1	Paul	Male	15	Good	29	29	29
Participant 2	Ben	Male	15	Good	29	14	12

Note: For clarity reasons, the author decided to name each participant. All names in this study are false.

Paul

Paul, a 15-year-old boy, presented with severe depression symptoms and suicidal ideation. Before the appearance of his depressive symptoms, Paul had an injury that stopped him from playing sports; additionally, he had stopped playing music and withdrawn from social activities. He was offered 29 sessions with a female Child and Adolescent psychotherapist, and attended all of them; nonetheless, his treatment was characterised by long periods of silences and withdrawal. Furthermore, he struggled expressing and managing anger in treatment, but he talked about violent dreams that evoked fear in him. Throughout treatment sessions, Paul

described the continued presence of depressive symptoms but being better able to manage these so they had less of an impact on his life. Towards the middle and end phases of treatment, Paul reported increased social activity, interest in peer relationships and being more involved and engaged in his academic and social life.

Ben

Ben started STPP at 15-years-old, with a female Child and Adolescent psychotherapist. He presented with severe depressive symptoms, suicidal ideation and self-harm. Ben reported conflicts in his relationships, finding it difficult to manage his anger. Although he completed therapy, his treatment was characterised by poor attendance and late arrivals to his sessions, with 14 attended sessions of 29 offered. However, when he attended, he engaged and made use of his sessions. By the end of treatment, Ben reported feeling better and being more engaged in social interaction, he also described being better able to manage his anger.

Research Material

The material consisted of 22 audio-recorded sessions, 12 from Paul's therapy and 10 from Ben's, drawn from the IMPACT study (Goodyer et al., 2011). Sessions were selected using the following criteria: two to four consecutive sessions were used from each phase of therapy, with an aim to study in-session and between sessions ruptures, following Schenk et al.'s (2019) suggestion to analyse successive sessions due to variability between sessions. Given that session 3 has been characterised as important in establishing a strong alliance and predictive of outcomes (Karver et al., 2008; O'Malley et al., 1983), it was decided to include this session. Sessions 6 and 12 were also included, as these were the timepoints when the MFQ and WAI-S were taken. It was agreed not to use sessions 1, 2 or the final session, as the therapeutic relationship in these sessions could be manifested in very particular ways. Considering these criteria, the following sessions were used for the beginning: 3, 4, 5, 6;

middle: 12, 13, 14, 15; and ending: 24, 25, 26, 27. If one of these sessions was missed or unclearly recorded, the following session was used. Detail of what sessions were used for each case is shown in Table 2.

Table 2. Coded sessions

	Beginning	**Middle**	**Ending**
Paul	3, 4, 5, 6	12, 14, 15, 16	24, 25, 26, 27
Ben	3, 4, 5, 6	7, 8, 9, 10	11, 12

Additionally, relevant segments of the "Experience of therapy interviews" from the same patients drawn from the IMPACT-ME study (Midgley et al., 2014) were used; these were semi-structured interviews aiming to understand the therapeutic process from the patients' and therapists' perspectives. It was decided to select the patients' T2 and T3 interviews and the therapists' interviews because these addressed the therapeutic relationship, while the patients' T1 interview focused on the young persons' experiences of depression. The interviews had been previously transcribed for the IMPACT-ME study.

Measures

Rupture Resolution Rating System (3RS)

The 3RS (Eubanks et al., 2015) is a validated, observer-based coding system used to identify and classify in-session alliance ruptures and resolution strategies by the therapist. Additionally, raters code the impact of ruptures on the alliance (ruptures significance), the degree to which therapists contribute to ruptures, and the degree to which ruptures are resolved in the session. The 3RS has been mainly used with adult patients; however, there is a small number of studies that used it for research with adolescents (Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). The system is based on Bordin's (1979) conceptualization of the

therapeutic alliance and uses the differentiation of Withdrawal and Confrontation ruptures from Harper (1989a, 1989b).

The 3RS manual advises to divide video-recorded sessions in 5-minutes segments and to mark the presence of Withdrawal or Confrontation ruptures, as well as the therapist's resolution strategies in each segment. There are seven patient behaviours or markers for each type of rupture, such as "minimal response" or "denial" for withdrawal ruptures; and "rejects intervention" or "complains about the activities" for confrontation ruptures. The significance of each type of rupture, the therapist's contribution to ruptures and the extent to which ruptures were resolved are then rated using 5-point scales.

Mood and Feelings Questionnaire (MFQ)

The MFQ (Angold et al., 1995) is a validated self-report questionnaire used to screen depression in children and adolescents aged 6-17. Its long version was used in the IMPACT study as the principal outcome measure at baseline, 6, 12, 36, 52 and 86 weeks after initiating treatment (Goodyer et al., 2011). The MFQ has 33 items with scores ranging between 0 and 66; higher scores indicate more depressive symptoms. The cut-off for depression is 27. For Goodyer et al. (2011) a decrease of 5 points in the MFQ denotes clinically significant change; the same criteria for a good outcome was used in this study.

Working Alliance Inventory – Short-form (WAI-S)

The WAI-S (Tracey & Kokotovic, 1989) is a validated self-report tool that measures the alliance from the patient's perspective. It consists of 12 items that evaluate the strength of the alliance based on Bordin's (1979) three dimensions, with higher scores indicating a stronger alliance. This measure was used in the IMPACT study at 6, 12 and 36 weeks into treatment (Goodyer et al., 2011).

Procedure

The author and another doctoral student coded all 22 sessions. Both coders shared this data for their doctoral theses. Previously, coders had 20 hours of self-training in the 3RS, in which randomly selected STPP or CBT sessions from the IMPACT project were coded with other two PhD students and, a part of them, with two supervisors. After self-training on the 3RS, it was agreed to do consensual coding for all the sampled sessions of this study, given the subjective nature of the material, the lack of research using this measure with adolescents, and the coders' lack of experience using this system. As suggested in the manual, sessions were divided in 5-minutes segments, beginning when the patient entered the room and ending when the therapist said it was time to close. Coding was checked and discussed after each session was completed; disagreement was discussed by relistening to the session segment. It was agreed to consult a third coder if consensus was not attained; however, external consultation was not needed. The emergence of ruptures in the clinical material was analysed using descriptive statistics; types of ruptures were compared with T-tests and ruptures through treatment phases were compared with linear regressions.

In addition, the relevant segments from the "Experience of Therapy" interviews were analysed using thematic analysis. The researcher listened to the six whole interviews and read the transcripts at the same time, in order to select all interview extracts where the participants talked about the therapeutic relationship. These segments were analysed systematically, using guidance from supervision and following Braun and Clarke's (2006) data analysis phases. To triangulate the analysis, 33.3% of the interview extracts were consensual coded (Hill et al., 2005) with other two doctorate students, who were not involved in the 3RS coding; in this process, any disagreements were discussed until consensus of the codes and themes in each extract was reached. If consensus was not obtained, a supervisor would be consulted, although this was not needed.

Ethical considerations

The IMPACT study obtained ethical approval from Cambridgeshire 2 Research Ethics Committee, in Addenbrookes Hospital Cambridge, UK (Goodyer et al., 2011). All participants in the study were informed of the procedures and gave consent for the sessions to be audio-recorded. All data was anonymised, and patients' and therapists' information was not shared. Additionally, the author had NHS training on Data Security Awareness and signed a non-disclosure agreement, adhering to the IMPACT study ethical protocols. All sessions and interviews were accessed remotely and for a specific period of time.

Results

Findings are presented for each of the two cases in two sections; the first concerns a description of the emergence of alliance ruptures throughout the treatment; this is followed by an exploration of their possible meanings for participants, based on the thematic analysis of the interviews. Due to space constraints, only the more dominant themes that concern ruptures are presented. An outline of all the themes is presented in Appendix 1.

Paul

MFQ and WAI-S

Paul showed clinically significant change (more than 5 points drop in the MFQ) (Goodyer et al., 2011); however, his scores at the end of therapy were still above the cut-off point for depression. The decrease in his MFQ scores was reflected in Paul becoming more interested in social activities, resuming school and reengaged in playing music. Paul WAI-S scores indicate a strong initial alliance with a linear increase at 12 weeks and a slight decrease at 36 weeks, although it was still higher than at 6 weeks, first timepoint when this measure was taken, showing that the strong alliance was maintained through treatment (Table 3).

Table 3. MFQ and WAI-S scores

	Paul MFQ	Paul WAI-S	Ben MFQ	Ben WAI-S
Baseline	51		50	
6 weeks	45	41	34	63
12 weeks	37	48	52	49
36 weeks	38	46	18	54
52 weeks	49		14	
86 weeks	36		11	

Note: MFQ scores of 27 or more are indicative of depression.

Ruptures in the alliance

Alliance ruptures appeared in all 12 sessions examined. Over the course of therapy, the percentage of 5-minute segments with ruptures decreased, as shown in Table 4. Paul's treatment contained significantly more withdrawal than confrontation ruptures (t=2.20; p=0.00), as illustrated in Figure 1. Moreover, all instances of patient confrontation rupture markers occurred in conjunction with a withdrawal marker; this could reflect Paul's difficulty to express frustration and dissatisfaction directly. Overall, the impact of withdrawal ruptures on the alliance was significantly higher than for confrontation ruptures (t=2.20; p=0.00). Finally, the therapist's contribution to ruptures also decreased as therapy progressed, as shown in Table 4.

Figure 1. Number of 5-minute segments with ruptures in sessions - Paul

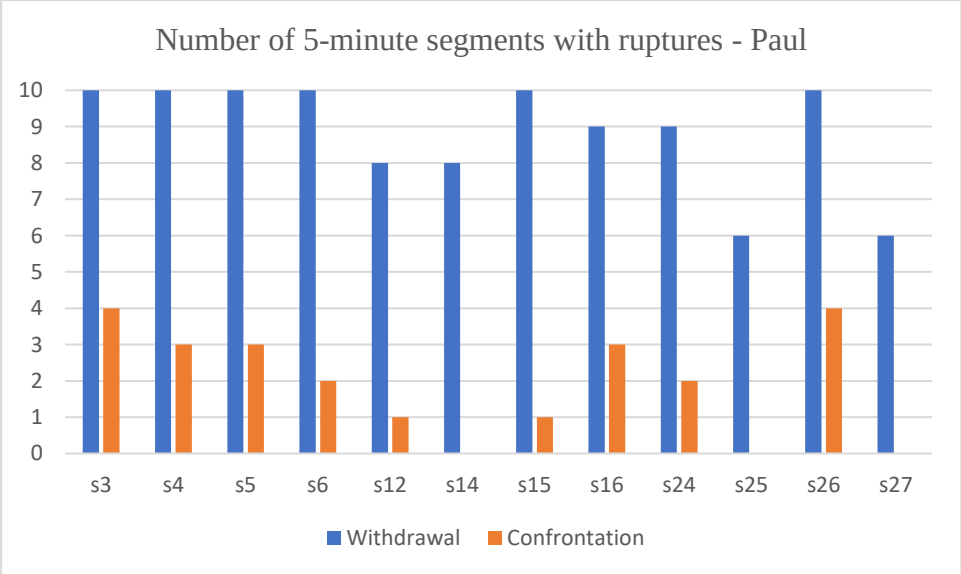
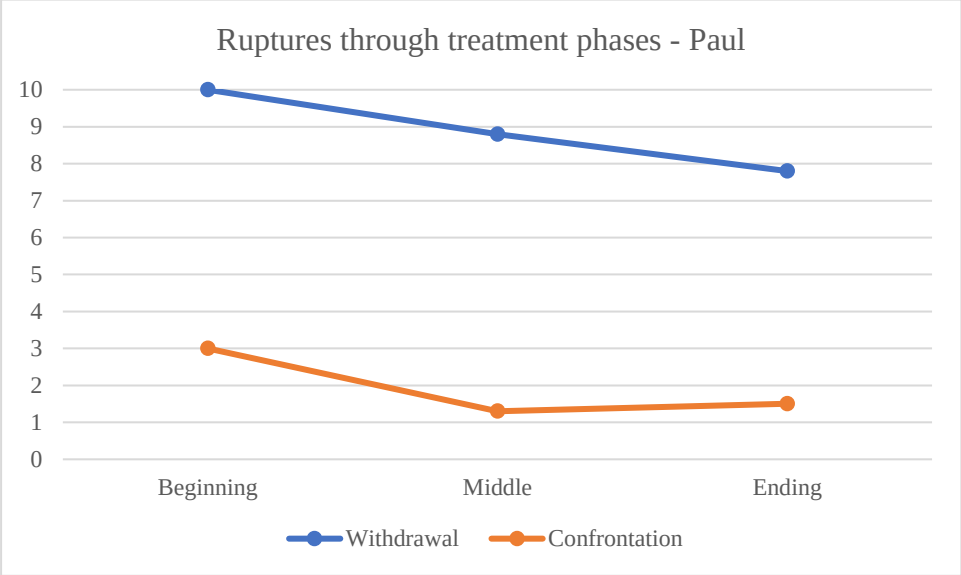


Table 4. Ruptures' significance and Therapist's contribution - Paul

Phase	Withdrawal Significance	Confrontation Significance	Therapist´s contribution
Early	5	3.5	3
Middle	3.5	3	2.25
End	3.25	1.25	1.5
Average	3.9	2.6	2.6

Furthermore, withdrawal ruptures presented a linear decrease across treatment phases. Confrontation ruptures occurred more frequently at the beginning of treatment as compared to the middle and end phases, as shown in Figure 2. Appendix 2 shows the results of the linear regression that compared the number of ruptures across the three phases.

Figure 2: Ruptures through treatment phases - Paul



To summarize, ruptures in the therapeutic alliance were a common phenomenon throughout this therapy, despite Paul's high WAI-S scores. Withdrawal ruptures were both

more frequent and had a more significant impact on the alliance than confrontation ruptures. Indeed, the few confrontation markers in the sessions co-occurred with signs of withdrawal. The therapist was shown to contribute a fair amount initially to the ruptures, but her contribution reduced as therapy progressed. Similarly, the occurrence and significance of alliance ruptures decreased through therapy, with withdrawal and confrontation markers showing a different trajectory.

Experience of ruptures

In both interviews, Paul expressed conflicting views regarding what the therapeutic relationship meant to him. However, his views about therapy changed from T2 to T3, being Paul better able to integrate his conflicting feelings and ambivalence around therapy at T3.

A central theme in Paul's interviews concerned his sense that therapy was unhelpful. He described finding the initial sessions "boring, monotonous and strange" (T3), which made it difficult for him to relate to his therapist and to engage in the process. He also described feeling obliged to attend sessions, despite feeling that therapy was "a waste of time" (T2).

An important issue for Paul related to silences in the sessions; he expected the therapist to ask him questions rather than him talking about whatever came to mind and reported feeling uncomfortable and worried about the frequent silences. In addition, he described not needing someone to talk to and finding it difficult to share his feelings; he also felt his thoughts were not important enough to bring to the sessions, as shown in the extract below.

> Like a lot of the time it felt like some things weren't worth bringing up (.)because (.)erm (.)all (.)most of the time I-I didn´t feel like that, coz it was just like (.)you know (.)it was just things that didn´t (.)that didn´t feel significant, like reading a

> book or something, I just didn´t feel there was a point bringing that up, coz it wouldn´t really help (T2).

Paul also reported feeling irritated when the therapist suggested links between the content of sessions and his relationships with others or the transference. He seemed to experience interpretations as an imposition and felt his therapist laid too much importance on therapy, which did not make sense to him. In addition, Paul acknowledged that he avoided therapy, in an attempt to avoid inner conflict. Drawing upon this analysis, the dominance of withdrawal ruptures, especially in the beginning of therapy, seems to reflect Paul's experience of feeling obliged to attend sessions, his experience of therapy not being helpful, his need to defend against inner conflict, and his sense that his thoughts and feelings are not sufficiently important.

According to the therapist, their relationship was generally collaborative, although she was also aware of Paul's ambivalence. She reported Paul presenting "two styles of communication", being at times very articulate and at others extremely silent, presenting as "wooden or frozen", 'withholding' and 'difficult to draw out'. In her view, giving space to these different aspects was an important part of the therapeutic work. She interpreted Paul's withdrawal as an expression of his way to relating to the world and a manifestation of anger; she reported finding this difficult to work with. Additionally, she wondered whether Paul may have felt desperate for help but did not believe therapy could help, which led him to withdraw. Finally, the therapist questioned whether a time-limited treatment was appropriate for Paul and believed that the time constraints did not allow them to address his anger sufficiently.

Although the unhelpful aspects of therapy were a dominant theme in Paul's interviews, he also mentioned that over time he "got used to therapy […] understood this way

of working" (T3), could talk more freely about what was on his mind, and wondered if therapy did indeed help; he ended therapy with a wish of having used it more.

As mentioned before, at T3, Paul seemed to be better able to articulate his ambivalence about therapy, having integrated his split views, as illustrated below:

> I sort of like (.)have two-sides of it [therapy] in my mind (.)like erm (.)sort of you know some part of – a part of me didn't like it at all, but a part of me (.)felt that it was helpful and felt that it was ok, like good in some ways. Well, I guess you know like in relation to therapy they're both really strong sides, I guess (.)like conflicting I suppose […] I get that sort of conflict of yeah it's good and it's bad, but I don't really know.

The shift in Paul' perceptions of therapy is in line with the observed decrease in both the frequency and the significance of ruptures over time. The therapist also described that, as therapy progressed, Paul became more vocal, bringing dreams, stories and music to describe his emotional state, allowing his 'colourful' internal world to be seen and explored. This is also reflected on his improvement and clinical change showed in the MFQ.

The observation that the number of ruptures significantly decreased from phase to phase could be an indication that ruptures were addressed and resolved. At the same time, ruptures were still frequent in the ending phase, an observation that could be associated with Paul's ambivalence around ending therapy, an issue also expressed by the therapist.

Ben

Ben's MFQ scores showed a decrease in depressive symptoms, with scores under the cut-off from 36 weeks; however, at 12 weeks there was an important increase, reaching a peak on the scores. The WAI-S scores were indicative of a V-shaped alliance pattern, with a strong initial alliance, a decrease at 12 weeks and an increase at 36 weeks. It is worth noting that the

decrease in the alliance coincides with the increase in the MFQ scores, as well as his improvement coincides with the increase in the WAI-S, as shown in Table 3. In the lead up to 12 weeks, when the alliance was poorer, Ben reported self-harm and session 10 was missed owing to an overnight stay at hospital for an overdose and harming through cutting. Additionally, he missed sessions 15 to 20, stating that he needed a break from therapy; Ben did not attend his final sessions reporting these crashed with school times.

Ruptures in the alliance

All 10 sessions coded had 5-minute segments entailing ruptures. Ben's treatment had significantly more withdrawal than confrontation ruptures (t=6.18; p=0.00), as shown in Figure 3. Only on one occasion a confrontation rupture occurred without a withdrawal rupture in the same 5-minute segment. The impact of withdrawal ruptures on the alliance was significantly higher than for confrontation ruptures in therapy as a whole (t=3.07; p=0.01). Finally, the therapist's contribution to ruptures was similar along treatment phases, as shown in Table 5.

Figure 3. Number of 5-minute segments with ruptures in sessions - Ben

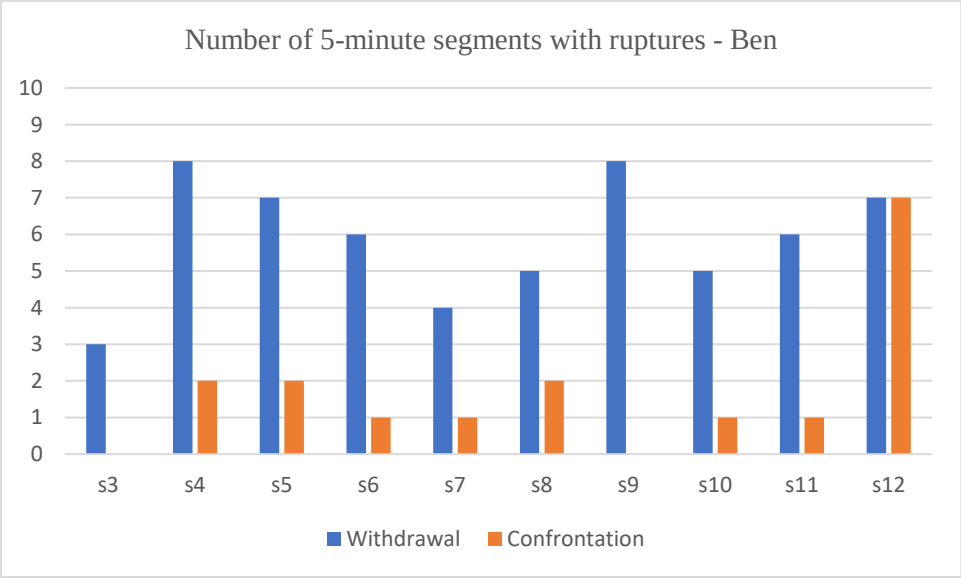
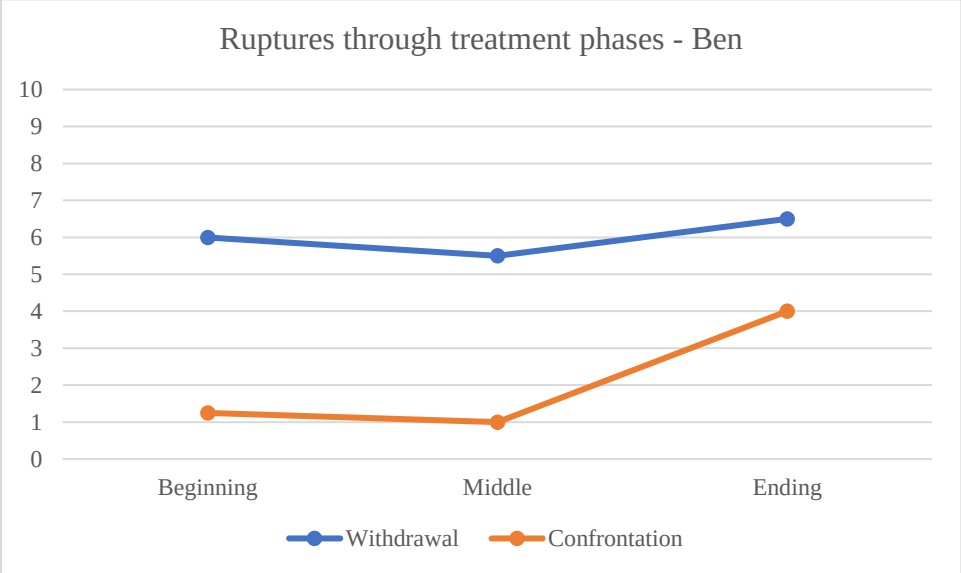


Table 5. Ruptures' significance and Therapist's contribution - Ben

Phase	Withdrawal Significance	Confrontation Significance	Therapist´s contribution
Early	3.5	1.5	2.75
Middle	3.75	2	2.5
End	3	4	2.5
Average	3.4	2.5	2.6

Additionally, withdrawal and confrontation ruptures decreased by mid-treatment, and increased, reaching a peak, by the end of therapy. There were significant differences between all three treatment phases for withdrawal ruptures, and a significant increase for confrontation ruptures by the end of treatment, as presented in figure 4. The results of the linear regression that compared ruptures across treatment phases are shown in Appendix 2.

Figure 4: Ruptures through treatment phases - Ben



Summarizing, ruptures occurred in all therapy sessions. By the time Ben had the lower scores in the WAI-S, there were less ruptures. Withdrawal ruptures were more frequent and had a higher impact on the alliance. Only one confrontation marker occurred alone in all coded sessions, with all other confrontation ruptures happening alongside withdrawal ruptures. The therapist's contribution to ruptures did not change through time and was not high on average. Withdrawal and confrontation ruptures were higher at the end of treatment, following a similar trajectory, although this increase was particularly pronounced for confrontation ruptures.

Experience of ruptures

In both interviews, Ben evidenced ambivalence around the therapeutic relationship. He reflected on his difficulties attending the sessions and his concerns about therapy; however, he also noticed how important therapy became for him and the changes he made.

Ben reported finding starting therapy difficult. He explained he felt "awkward and uncomfortable" (T2) during the first sessions. He added not knowing what to talk about, and silences became very difficult to tolerate. He wondered why he was there, which led him to "admittedly miss sessions" (T2); he "found it a nightmare to go" (T3), partly because it felt difficult to talk and think about his difficulties. Additionally, Ben felt worried that his therapist would judge him, although with time, he noticed that was not the case. Ben's feelings and concerns during this stage could explain the initial amount of withdrawal ruptures.

When thinking about the end of treatment, Ben reported therapy clashed with school and he could not have his final few sessions; this felt difficult for him: "It kindda just ended. There wasn't really a goodbye or anything. […] I didn't really get a goodbye" (T3). Even though Ben seemed to feel the loss of the end of therapy and to protest about not having had a

goodbye, the researcher wonders if there were unresolved ruptures that led Ben to end treatment earlier, especially considering the increase in confrontation ruptures by the ending phase.

Despite the difficulties in beginning and ending therapy, Ben reported some helpful aspects of therapy too. He said he felt more "relaxed" (T2) with his therapist as he got to know her, finding there was "less tension in the room" (T2). With time, he felt it was easier to talk and was more engaged in the process, feeling it was useful to have someone who understood and helped him "learn to connect the dots" (T2) and make sense of his behaviours; this might explain the decrease of ruptures during the middle phase of treatment. Additionally, Ben felt he "liked her [his therapist]" (T2, T3), which seemed to enhance their collaboration and strengthen their bond. Ben talked about feeling he was "in safe hands" (T3).

Similarly, Ben's therapist addressed his ambivalence in therapy. According to her, he presented as affective towards her, and perceived her as "friendly". However, she considered that he expected her to "collude with his defences" and to repeat his patterns of interaction; when he noticed these expectations were not fulfilled, he felt anxious about their relationship. Additionally, Ben's therapist thought he might have felt pressured by her when she tried to think about his difficulties.

Furthermore, Ben's therapist reported finding it difficult to engage him in therapy. She said she tried to address the work they had to do and to help Ben to get in touch with how he was misusing therapy. Regardless of her attempts, she considered she "failed to engage him". Finally, she reflected on how Ben seemed to expect something different from therapy, as illustrated in the following quote:

> I think he saw me as someone who maybe would give him strategy or something like that, so probably he was expecting something different (.)something that (.)um focused more (.)let's say problem solving or something more um (.)practical or tangible.

This quote could indicate the lack of agreement on the goals of therapy, although from Ben's interviews, there seemed to be agreement on this aspect. Possibly, this lack of agreement impacted negatively on the collaboration between Ben and his therapist, leading to unresolved ruptures that may have been associated with a premature ending of his therapy.

Discussion

This study aimed to describe the emergence of alliance ruptures with two depressed adolescents and to explore their experiences of the therapeutic relationship. This study could inform the clinical practice with adolescents by laying importance on the need to track ruptures and to work on them in psychotherapy with adolescents.

Findings of the study showed that the emergence of alliance ruptures was a frequent phenomenon in these two adolescents' psychotherapy. All coded sessions had 5-minutes segments of ruptures, although the frequency of these segments varied between patients and between treatment phases. Both cases were considered to have a good outcome, possibly alliance ruptures and repairs were part of their change process.

In both cases, withdrawal ruptures were more frequent than confrontation ruptures in all phases. This finding is in line with research on alliance ruptures in therapy with adults (Lingiardi & Colli, 2015). In addition, withdrawal ruptures were very frequent at the beginning of both treatments. Patients reported feeling uncomfortable at this stage of therapy, as in Binder et al.'s (2011) study. Patients also felt they did not understand the work of therapy, which might show a lack of collaboration with their therapists, possibly fostered by not agreeing on the tasks

of therapy (Eubanks et al., 2015; Safran & Muran, 2000). This could explain the initial amount of withdrawal ruptures. Additionally, it is possible that Paul and Ben's worries about silences and transference interpretations, especially during this phase of treatment, also enhanced lack of collaboration. This finding might show the need for therapists to actively try to engage adolescent patients in therapy and to address ruptures from initial sessions, helping adolescents to be aware of the tasks of therapy and to understand their rationale, as claimed by Shirk and Karver (2011).

Despite therapists aim to deepen their work on the transference and patient's relational patterns during the middle phase of STPP treatments (Cregeen et al., 2017), which could increase ruptures in this phase, both patients presented a decrease of alliance ruptures during this stage of treatment, contrary to what would be expected. It might be that Paul and Ben's feelings that they "got used to this way of working" increased collaboration with their therapists. Another factor that could explain the decrease of ruptures in this treatment phase is the development of trust in the therapists (Cregeen et al., 2017; Safran & Muran, 2000), as Paul and Ben reported finding it helpful to talk, to feel understood, and Ben mentioned realising that his therapist was not judging him and that he was "in safe hands".

Based on the interviews, ambivalence and anger were strong features in both treatments. This finding indicates the need to address anger, hostility and ambivalence with depressed adolescents, as has been greatly studied in psychoanalytic literature of adults (Abraham, 1924; Bleichmar, 1996; S. Freud, 1917; Jacobson, 1972; M. Klein, 1935; Heinz Kohut, 1977; Rado, 1928). Furthermore, the results support other studies claiming that ambivalence has to be addressed in psychotherapy with adolescents (Binder et al., 2008; Morán et al., 2019). It is also possible that in experiencing ambivalent feelings, both patients were working on their conflict between their need for relatedness and for autonomy, a common

conflict in adolescence (Blos, 1967) and in psychotherapy more broadly (Safran & Muran, 2000).

How patients delt with anger and strong ambivalent feelings varied. Even though Paul attended all his sessions, he withdrew from the therapeutic work, especially with long silences. His therapist was aware of the need to work on hostility and ambivalence, considering that his withdrawal was a manifestation of anger and of his way of relating to others. Her understanding of Paul's ambivalence, anger and withdrawal could be aligned with the idea of ruptures as an opportunity to work on the patient's relational schemas (Safran & Muran, 2000). On the other hand, Ben missed many sessions and had late arrivals to most of the attended sessions which, in accordance with Binder et al. (2008) study, could be understood as a withdrawal rupture. The author wonders if Ben's missed sessions during the middle phase of treatment was a withdrawal rupture that could not be captured by the 3RS. This would be in line with the decrease in Ben´s WAI-S scores at 12 weeks. Furthermore, his therapist talked at length about the difficulties in engaging Ben, and felt she "failed to engage him", in accordance with other studies (De Haan et al., 2013; Kazdin, 1996; O'Keeffe et al., 2018, 2020).

Possibly, the high frequency of withdrawal ruptures shows how difficult it is for depressed adolescents to express hostile and ambivalent feelings. Considering adolescence conflict (Blos, 1967; A. Freud, 1958), and the theoretical assumption that depressed adolescents tend to direct aggression towards themselves (Cregeen et al., 2017), it was expected to find more withdrawal ruptures in the cases. Additionally, in both cases withdrawal ruptures had a higher impact on the alliance overall; this result contradicts Schenk et al.'s (2019) finding where confrontation ruptures had a greater impact. This could be explained by the differences of working with depressed and BPD adolescents, as it is possible that the cases analysed in the current study presented a disguised hostility, as has been mentioned by the therapists, leading

to withdrawal ruptures to have a higher impact on the alliance. This contradiction might also be a result of the small sample of the current study.

Both patients presented a clear pattern of the therapeutic alliance in the WAI-S. Paul's pattern was in line with a linear increase, although at the last time-point there was a slight drop in the score. His alliance pattern seems to agree with the 3RS coding. On the other hand, Ben presented a V-shaped alliance pattern. His ruptures pattern from the 3RS coding was not clear and was not in line with the WAI-S pattern. This is something to further examine. The ruptures patterns from the 3RS coding in both cases were different.

Moreover, it might be that ruptures helped to understand the patient's relational schemas, in correspondence with other studies (Kohut, 1971, 1977; Kris, 1951; Reich, 1949; Safran & Muran, 2000; Sandler, Dare, Holder, & Dreher, 1992; Schafer, 1992). An example of a change in the relational schemas worked through ruptures could be Ben's realisation that his therapist was not judging him, or Paul's therapist offering a space for his silences to be understood and explored. Considering that both patients presented clinically significant change, the author wonders if their strong alliance is associated with their outcomes (Shirk & Karver, 2011) and if the work on their relational schemas through the emergence of ruptures was one of the therapies' features that promoted clinical change, as in other studies (Coutinho et al., 2009; Larsson et al., 2018; Safran & Muran, 2000). In Paul's case, it was necessary -and arguably inevitable (Safran & Kraus, 2014; Safran et al., 2011, 2002)- to allow withdrawal ruptures to happen in order to understand his "way of relating to the world", while it seems like Ben's therapist showed him a different pattern of interaction (Coutinho et al., 2009; Safran & Kraus, 2014; Safran & Muran, 2000) where a meaningful adult did not judge him.

In accordance with O'Keeffe et al. (2020), withdrawal ruptures happened more frequently than confrontation ruptures. However, in O'Keeffe et al.'s (2020) study,

confrontation ruptures only increased by the end of treatment in the dissatisfied dropout group; this result was different in Ben's case, where there was a significant increase in confrontation ruptures by the end of treatment. This contradiction could be explained if Ben was seen as a dissatisfied dropout case; despite he was considered a completer, he missed his final sessions and the increase in confrontation ruptures was striking. It could also be that by the end of treatment, he felt enough trust to show his dissatisfaction, or that an increase in confrontation ruptures with depressed adolescents could be associated with a better capacity to show anger instead of directing it towards oneself; this should be further studied in future research. Again, the small sample size and Ben's few available ending sessions do not allow to understand this phenomenon further.

Ending therapy possibly had an impact on the alliance in both cases. Patients reported ambivalent feelings about ending therapy, and confrontation ruptures increased in both treatments during this stage. Both therapists had in mind the losses of this stage of therapy, and one of them considered she needed more time to work on the patient's anger. It is important to note that therapists' contribution to ruptures during this stage was lower in both cases, which might show that they were working on the loss of the end of therapy (Cregeen et al., 2017) and not addressing other relational factors.

Another finding indicates the approach therapists had when thinking about ruptures. Paul's therapist seemed to understand his withdrawal as an expression of his way to relate with others; however, she did not wonder about her contribution to ruptures or about intersubjective factors that had an impact on the alliance, as suggested by Eubanks et al. (2015), and Safran and Muran (2000). On the other hand, Ben's therapist wondered about her contribution to Ben's lack of engagement, perhaps showing that she had in mind a two-person psychology (Safran & Muran, 2000) when thinking about Ben.

There are some limitations to this study. The small sample size does not permit to generalize the findings. Even though generalization was not the purpose of this study, it is important to further research rupture-resolution processes with adolescents, and it would be helpful to have a detailed study of ruptures in adolescents' psychotherapy with a larger sample size, helping to understand which findings are transferable to other cases and which are not, as suggested by Midgley (2006). The rating system has been shown to be reliably used and to be a helpful tool in capturing rupture-resolution processes in psychotherapy; however, video-recordings of sessions was not available; working with audio-recorded sessions might not have allowed coders to fully capture some of the patients' or therapists' attitudes that might have added information. In addition, this study might have been impacted by the researcher's expectations about the type and frequency of ruptures to emerge in each treatment phase; although consensus coding might have decreased bias in this aspect. Although the researcher did not have access to the therapists' demographics, when listening to the sessions, the researcher could make her own assumptions about these demographics, which might have influenced the coding; again, this bias could have been reduced by consensus coding. Another limitation regards to only having analysed good outcome cases; it is possible that comparing good and poor outcome cases, might have added important information to this study. Finally, it emerged in one of the therapist's interviews that the WAI-S did not fully fit a psychodynamic approach; it is possible that the WAI-S scores might show a different picture of the alliance in these cases sessions, considering that both had STPP treatment.

In conclusion, this study found that ruptures were a common phenomenon in the two analysed cases. Withdrawal ruptures were more frequent and had a greater impact on the alliance. Ruptures' frequency and significance changed through treatment phases in both cases. Patients found difficult to start therapy and gradually felt they understood this way of working, although anger and ambivalence were important features in these two therapies. Silences and

transference interpretations were difficult to tolerate for both patients. Therapists felt important to work on patients' anger, to find a way to engage them in treatment, and to understand and work on their relational aspects. It is possible that the patients' relational schema was worked in therapy, and that some aspects of it were understood through the emergence and resolution of ruptures.

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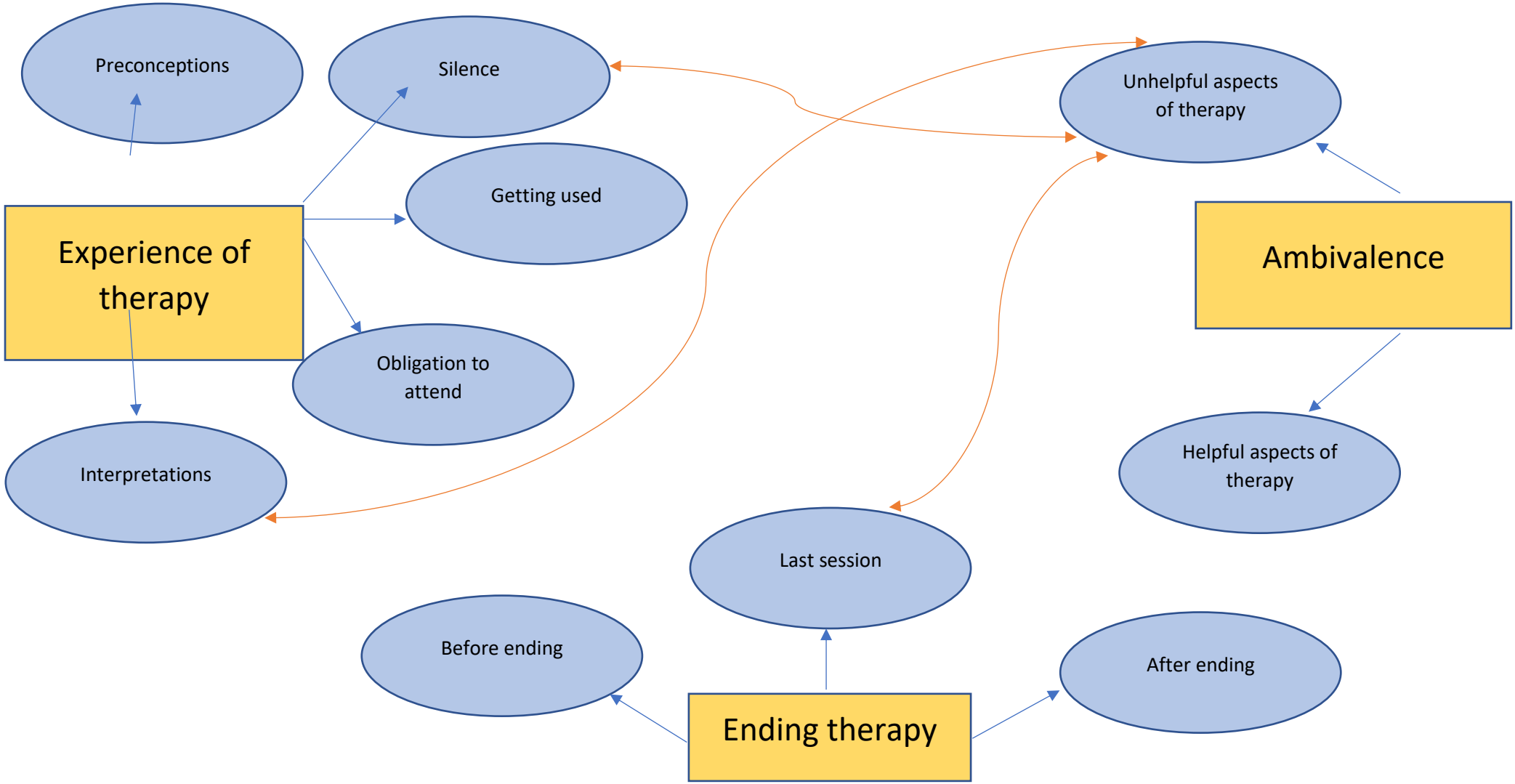
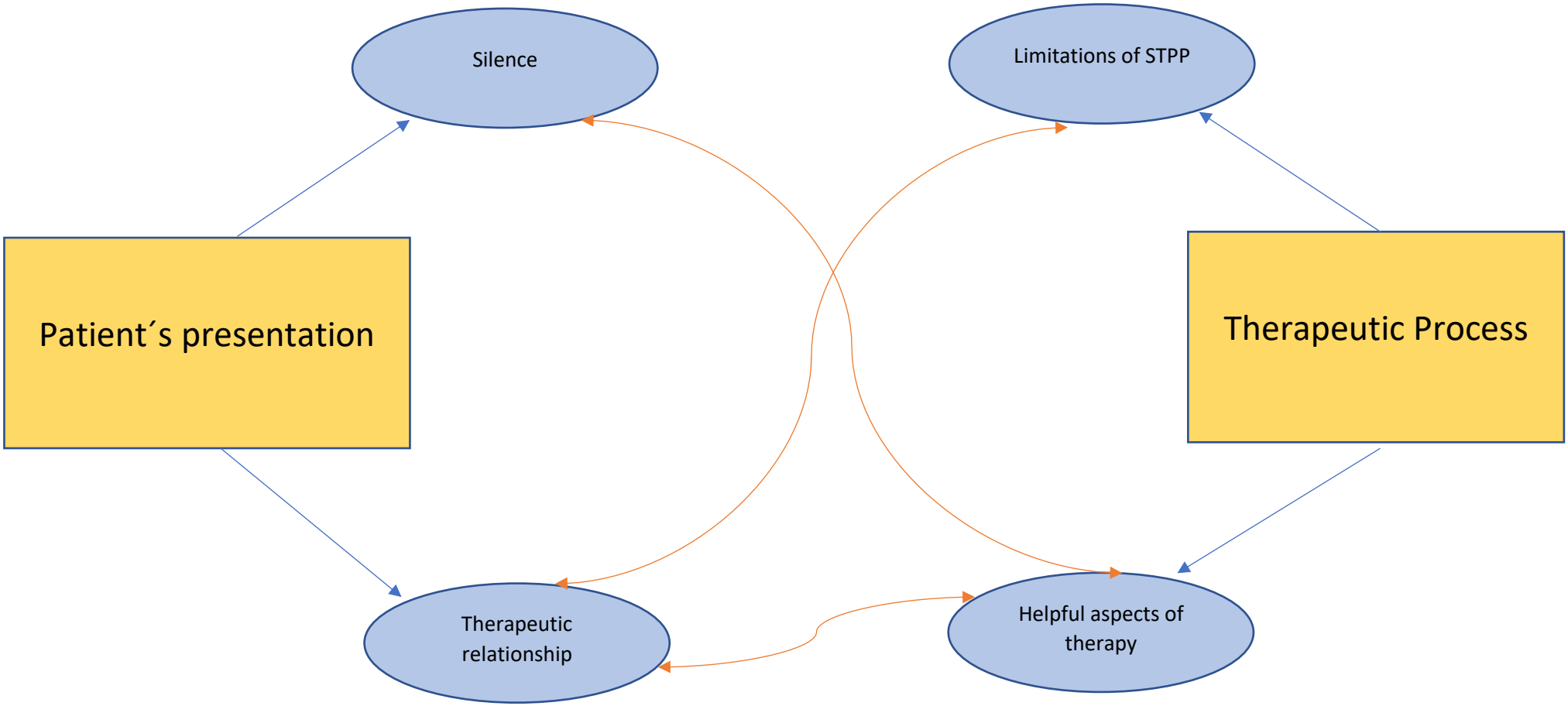
Appendix 1: Themes outline

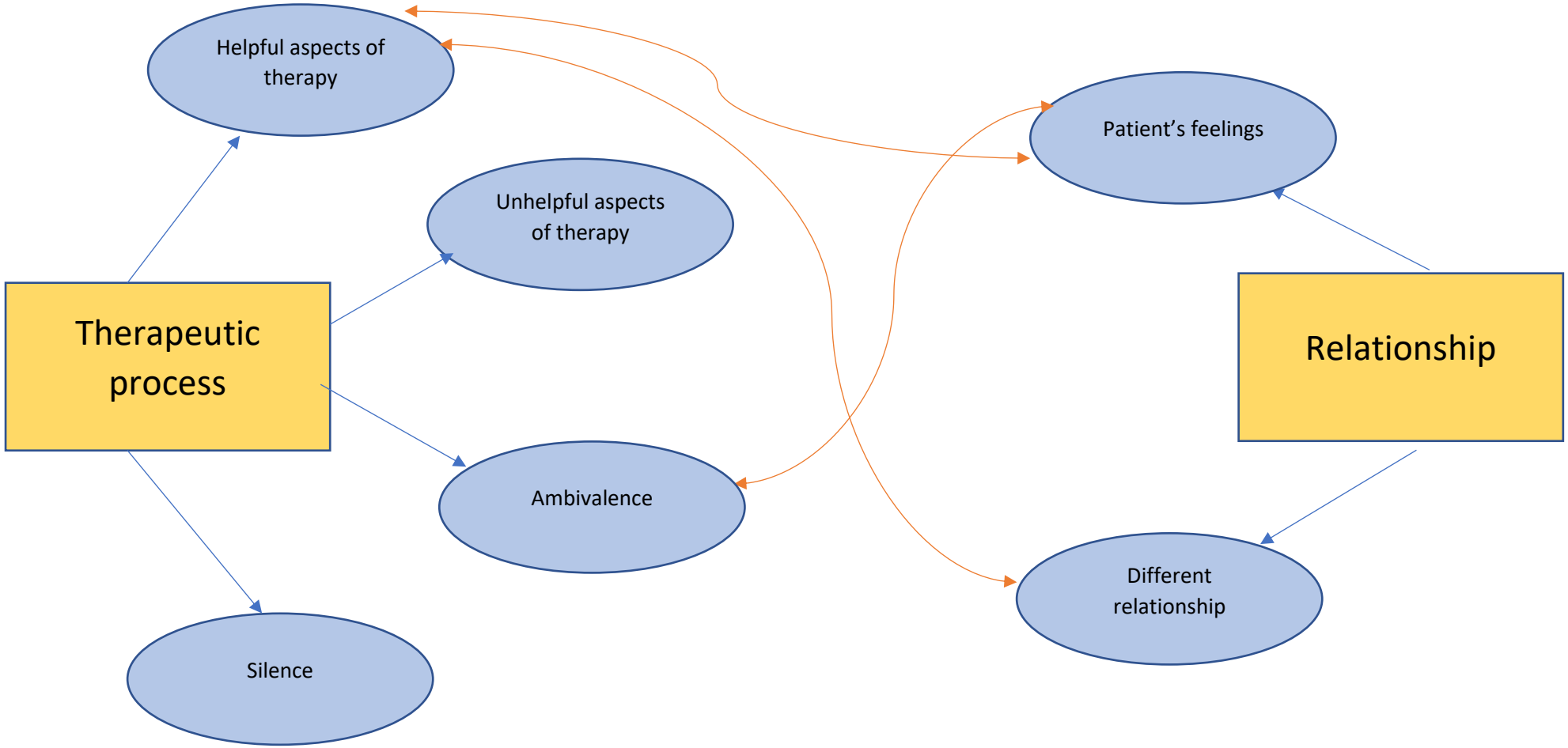
Experience of the therapeutic relationship – Paul



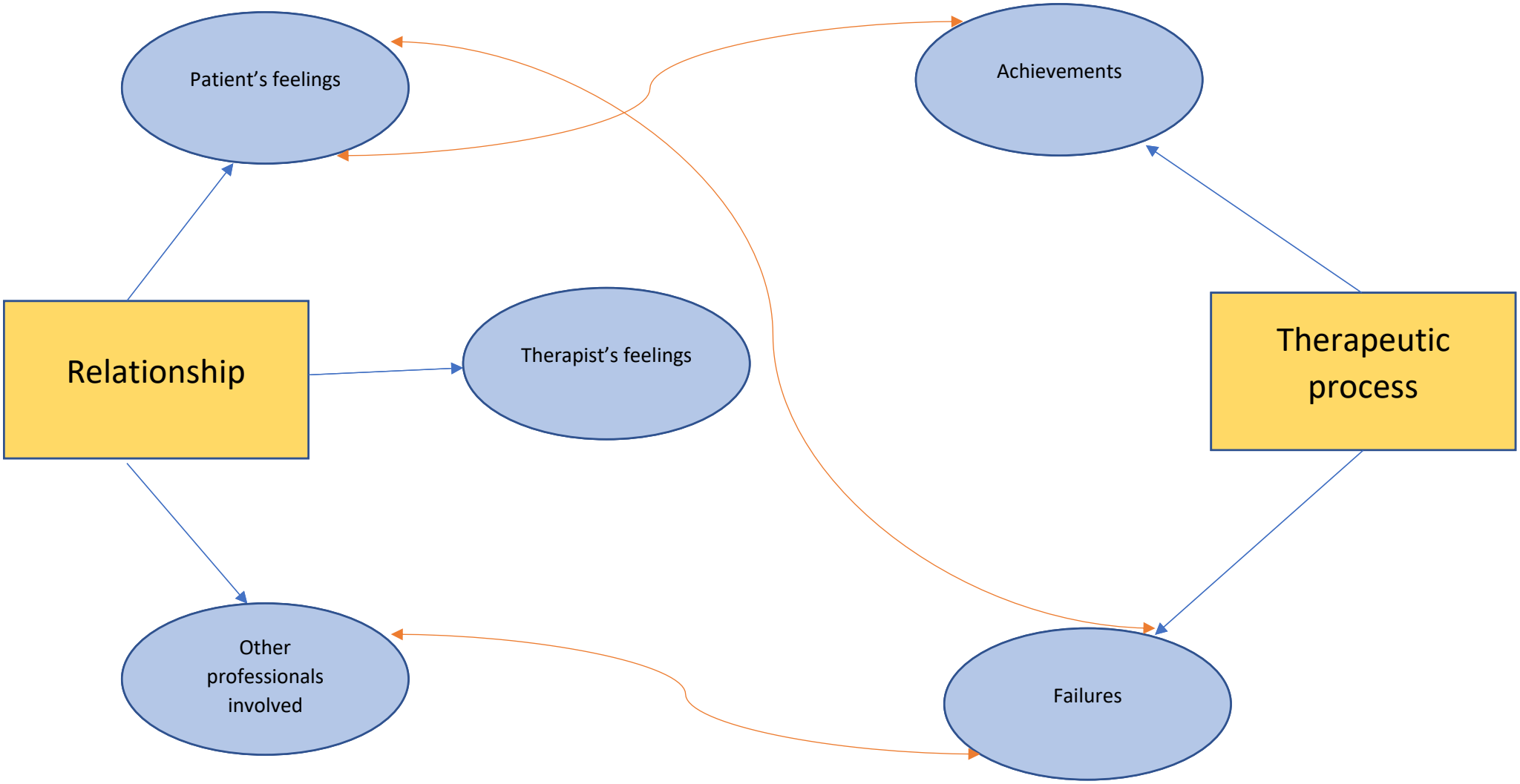
Experience of the therapeutic relationship – Paul's therapist



Experience of the therapeutic relationship – Ben



Experience of the therapeutic relationship – Ben's therapist



Appendix 2: Thematic analysis summary

Experience of therapeutic relationship - Paul

Themes	Subthemes	Example Quote
Experience of therapy	Preconceptions	*It was just, sort of (.) you know, like I might as well (.) I didn´t think it was going to help [...]* *I thought I might give it a go to see if it would (.) make a difference (T2)*
	Silences	*I just remember (.) just sitting in silence really (.) just not saying anything, just sort of uncomfortable* (T2) *I feel like a lot of the time I didn´t say anything because I didn´t think it was worth bringing up* (T3)
	Getting used	*I mean (.) over time I sort of got used to it [therapy] and (.) and it was a bit easier* (T3)
	Obligation to attend	*I just (.) sort of felt it [therapy] was something I had to do* (T2)
	Interpretations	*[...] like she linked a lot of things to go into therapy (.) and sometimes it just didn't feel like that al all* (T2)
Ambivalence	Unhelpful aspects of therapy	*[...] it felt a bit (.) like (.) not necessarily pointless, but like erm (.) I wanna say ill-fated I guess* (T3)
	Helpful aspects of therapy	*I would have felt like everything was just gonna stay the same but (.) in that sort of feeling it just gradually changed to the way it is now* (T3)
Ending therapy		*[...] just something that was once there has gone and, and I just have to deal with it* (T2)

Experience of therapeutic relationship – Paul's therapist

Themes	Subthemes	Example Quote
Patient's presentation	Silence	*The silence was like the withdrawal that was going on (.) in the rest of the world with him and how he was relating in life [...] to be able to have that in the room and think about it and work with felt helpful*
	Therapeutic relationship	*I think it became an important relationship (.) to him (.) it was collaborative [...] but I think he also (.) there's a bit of him that's quick to wipe out (.) things*
Therapeutic process	Limitations of STPP	*[...] maybe we never got to (.) sometimes the level of hostiligy or aggression towards me in the room erm (.) that maybe in a longer treatment, maybe (.) would have got to*
	Helpful aspects of therapy	*I think having a sapce (.) away from his parents [...] where he could really explore what is going on in his mind (.) and have it sort of (.) thought about by somebody else*

Experience of therapeutic relationship – Ben

Themes	Subthemes	Example Quote
Therapeutic Process	Helpful aspects of therapy	*To understand, that was the main thing that I came away from it [therapy]. One think I learnt was how to understand certain emotions and ways and undertando how things affected me in certain ways* (T3)
	Unhelpful aspects of therapy	*I found it a nighmare to go [...] I was always talking about things I didn't want to talk about*
	Ambivalence	*You sit there, you don´t want to talk about certain things [...] and there's some parts you don't want to understand, but you do at the same time* (T3)
	Silences	*I was sort of sittin there in like awkward silence and just like 'Oh God (.) erm (.) why am I here?'* (T2)
Relationship	Patient's feelings	*Like the relationship was (.) I didn't feel uncomfortable with her. I felt very safe, in safe hands* (T3)
	Different relationship	*She was the person who sort of (.) no matter what you say, she wasn´t emotionally involved and stuff* (T3)

Experience of therapeutic relationship – Ben's therapist

Themes	Subthemes	Example Quote
P-T Relationship	Patient's feelings	*I think he probably, at times, felt quite anxious (.) erm (.) about me not exerting or not colluding in this idea that things were fine, even though he was ending up in hospital and things like that*
	Therapist's feelings	*I really was very concerned for him and I remember feeling quite inept because I thought I had recently qualified and I did think if only he had a more experienced therapist who could get (.) a more skilled one*
	Other professionals involved	*He shared the intensity of the feeling that patients bring to therapy, I think it was spread out to other professionals, so I think it was confusing and I think it also got in the way of him investing in the therapy*
Therapeutic process	Achievements	*I would like to think that it was helpful to have someone trying to understand why he needed to be so charming all the time [...] that at some level this has contributed in some way*
	Failures	*I remember feeling that I had failed him and that I had failed to engage him*

Appendix 3: Comparison of means of ruptures across treatment phases

Paul

Dependent variable	Number of withdrawal ruptures	Number of confrontation ruptures
Beginning	10	3
	(0.00)	(0.00)
Middle	8.75	1.25
	(0.00)	(0.11)
Ending	7.75	1.5
	(0.00)	(0.06)
R^2	0.87	0.57
n	12	12

Note: P-values are in parenthesis. These findings are descriptive, given that this analysis was conducted on multiple observations of the sessions within one case to compare ruptures in the three stages of therapy, going against typical assumptions for regressions.

Ben

Dependent variable	Number of withdrawal ruptures	Number of confrontation ruptures
Beginning	6	1.25
	(0.00)	(0.21)
Middle	5.5	1
	(0.00)	(0.30)
Ending	6.5	4
	(0.00)	(0.02)
R^2	0.77	0.41
n	10	10

Note: P-values are in parenthesis. These findings are descriptive, given that this analysis was conducted on multiple observations of the sessions within one case to compare ruptures in the three stages of therapy, going against typical assumptions for regressions.

Part Three: Reflective Commentary

Ambivalence on the way: An attempt to integrate conflicting feelings present in my research journey, as part of the clinical doctorate in Child and Adolescent Psychotherapy

Candidate number: VDPQ4

Word Count: 3915

"Ambivalence is quite generally a prerequisite of cultural progress"

(Eissler, 1971, pp. 50).

Introduction

In my Empirical Paper, I noted how ambivalence was such a strong feature in the two cases I studied. Now, I realise how ambivalence has also marked my research journey, as an important component of my clinical doctorate. Therefore, I decided to write this Reflective Commentary based on an attempt to give sense and integrate opposing feelings evoked by the research process.

Doing research as part of the clinical doctorate in Child and Adolescent Psychotherapy was a challenging and rewarding process, full of learning opportunities, but also great deals of frustration. It certainly was a developing path, professionally and personally. It enriched my clinical work and knowledge, helped me develop research skills, and led me to accept some of my own limitations. Frustration and anger were an inherent part of this process, but also learning, gratitude and joy. Looking back in these years of doing research, I can see my ambivalence and conflict manifested along the way. Opposing feelings were present in different forms, and might have helped me thrive and, later on, create. Overall, now I feel grateful for this opportunity, although I did not complete my research without strains on the way. In this Reflective Commentary, I will first reflect on some of the difficulties I experienced alongside this journey, to then think about the rewards and satisfactions of doing research. Finally, I will talk about how I came to integrate these feelings and give sense to the research process as a whole.

Strains and difficulties

As generally happens in our program, I started my research project on my second year as a Child and Adolescent Psychotherapist Trainee. In addition, due to personal circumstances, I could not start clinical work on my first year, which meant that I was immersing myself in the research project at the same time that I was beginning work with my patients. Beginning clinical work on my second year also implicated that I had to complete the clinical requirements in less time and added time constrains to an already limited space to do research.

When I first started to think about the topic of my research and what questions would lead my review on the literature and my empirical paper, I felt unmotivated. Looking back, I think part of this lack of motivation was that I had to do too many things at the same time, and it was unrealistic to fully dedicate time to read and deeply understand my research topic. For me, lack of understanding was translated into lack of motivation.

Additionally, I felt I had demands everywhere. The CAMHS where I worked was a lively and vibrant place, where I could learn from other clinicians, but it also felt as a space where I had to keep up to date with many things and could not be behind. The demands I put on myself regarding the clinical and multidisciplinary work were very high, and that took a great deal of my interest and energy. I also had other personal and family demands to which I wanted to attend and that were a source of joy in the midst of a very stressful time in my life. I felt I did not want to give up my family life and dedicated as much time as possible to it. Plus, my own analysis was a process that required time and dedication, and that evoked strong feelings in me. In general, I felt I was juggling with so many crystal balls, and I did not want to drop any of them.

The time constrains to do research were a real limitation to it. I felt very angry at not being able to dedicate the time this 'task' required. I felt pressured by myself to do readings, to understand concepts I was just beginning to grasp, and to have a plan of how I would do my research. I also felt I was behind my research group, which was shameful and, again, increased my lack of motivation.

Moreover, I felt inadequate and unable to do this work. I read research papers and wondered how I was going to complete my own research. Although I had previously done research for my Masters and for work, it felt this project was huge for me, and I doubted my skills to complete it. In addition, as a non-native speaker, reading and writing in English was a challenge for me, which increased the time I had to dedicate to my research project.

Somehow, I felt I was not a researcher and I was completing one of my program's requirements. Not identifying as a researcher made me feel alienated from this requirement; this was probably increased by my interest and inclination to do clinical work. At this moment, I could not see how a clinician could also be a researcher, and devoted most of my work-time to the clinical work.

Perhaps a defence I used to deal with all these feelings was to avoid my research project. I always found something more urgent I had to do, and of course this was based on reality, but now I wonder if I was also psychically trying to look at other things that required my attention and leaving my research project behind.

Our first Winter School, where we defined our projects, shook me. I noticed I was not fully understanding the topic of the therapeutic alliance, and now I think I could only see it in a superficial way, without being able to look at its clinical and theoretical implications. Although reading about it was interesting, I could not fully immerse myself on comprehending the concepts and elaborating a research plan.

The next step was to do the literature review. Again, this did not come easily for me. Even though I used some of my time at the clinic to look for papers and read them, writing a literature review implies a more systematic way of analysing and displaying the information, which I was not able to follow until later. I used my second-year summer to organise the information I had and to finish writing the literature review; this felt exhausting. I managed to complete a decent work, that still required a lot of changes.

Part of the clinical requirements of my doctorate, was that I had to have three intensive cases: children and adolescents I saw three times per week, with a minimum treatment length of one year for two of them and two years for the other one. Again, because I started clinical work later, and due to some particularities of my patients and the clinic, I could only start work with two of my three intensive cases in my third year of training. The work with the third intensive case started in my fourth year, when I was also working with the other two intensive patients. When my work with intensive cases started, I had moved on to work on my empirical paper. One more time, it felt that my patients' demands, especially from the intensive cases, and the work at the clinic were taking all my energy and time to dedicate to research.

During my third year, my research partner and I trained on the 3RS (Eubanks et al., 2015) and coded the sessions. This process felt more lively and rewarding, although challenging too. We managed to get time from work and used some weekends to code the sessions. Listening to the sessions awoke the clinician in me and was a hook that helped me keep on track with my research. My research partner's tenacity and constancy were also helpful in this time when I had all these other demands at the clinic. By the time we finished coding the sessions and had to analyse the data, I felt more interested in the emerging results and also felt more capable of doing this work. Also, my supervisor's support and her

guidance assisted me to define a plan and research questions that helped me remain steady when working on this part of my research.

However, time constrains were still a big obstacle and I felt I was doing my research by bits, which did not allow me to fully see the picture of my empirical paper. I felt I had too much information that I did not know how to put together and I had not yet started the thematic analysis of the interviews. By the end of my third year, I was not able to complete my empirical paper and decided to wait until the end of the summer to resume it.

At the beginning of my fourth year, I thought about all the amount of work I had with three intensive cases going on at the same time, besides work with other patients I saw once weekly and the clinical papers I had to write to obtain my clinical qualification on time. I had the pressure to complete all the clinical requirements, as this was the last year I would receive an stipend from a scholarship, and I would not be able to continue working on an honorary basis at the clinic without that economic support. Doing all these things at the same time proved unmanageable; it felt urgent to prioritize and give some order to my various activities. I had to accept and tolerate my own limitations. After reflecting on the time restrictions and considering how it felt so difficult to complete the research by bits, I had a discussion with my supervisor and my progress advisor. We decided it was best to pause my research project during that year and resume it after I had completed my clinical requirements. As my supervisor wisely put it, I needed longer chunks of time to do the thematic analysis, and I did not have that space at that moment. It felt difficult and painful to stop the research at that moment. Partly because I had a strong desire to finish all the doctorate requirements on time, and had recently engaged with my research project, beginning to enjoy it. Additionally, I did not know if I was going to remain in London after finishing my work at the clinic, and the uncertainty of what would happen with my life, also brought hesitations about being able to complete the research. Moreover, I continued attending the research seminars over that year,

and I saw how my research group moved on with their projects, which again made me feel I was behind and my insecurities on my research skills increased. Pausing my research project at that moment felt as a big, but necessary, loss. However, I also felt great relief that I could wait to complete my research in a more thoughtful and dedicated way. Overall, I think it was a wise decision, even though I did not expect further strains that came with the pandemic.

After completing my clinical requirements, I was able to devote enough time to fully analyse the participants interviews. By the time I was completing the thematic analysis, I moved countries and a few weeks later the well-known worldwide lockdown occurred, which brought additional strains to my life, that interfered with my studies. Again, I had to wait longer to resume working on my research project, having urgent family situations that I had to attend to.

During the whole process, I had to deal with feelings of inadequacy, with my own insecurities and anxieties about doing research, and I had to accept the frustration that came along with having to postpone my research project more than once, and 'dragging it' without being able to allocate the time it required and to complete it. Fortunately, after giving some order to my new life in the midst of the pandemic, I managed to adjust my daily routine; this allowed me to devote time and to develop a mindset to re-engage with my research project, which also had enjoyable sides.

Rewards

Despite all the difficulties faced in this journey, my research experience overall feels very enriching. I feel thankful for this learning experience and to have had this opportunity. Now, I acknowledge the importance of the research component as a part of our program, which I could not always do. Working on my research project did not only give me some

research skills and taught me about the importance and the need of research for clinical practice, but it also enhanced perseverance, reflexivity, creativity, and critical thinking in me.

I felt grateful for the opportunity to use data from the IMPACT (Goodyer et al., 2011) and IMPACT-ME (Midgley et al., 2014) studies. When I knew I was in the research group that was analysing data from these studies, I felt excited and thought about how promising this research sounded. I had heard about these studies when I did my Masters degree, and was aware of how important and huge they were. Being able to use some of their data and to, perhaps, contribute to them in a small way felt gratifying.

I surely enjoyed reading about the therapeutic alliance and ruptures in the alliance. As mentioned before, at the beginning I could barely see the depth of alliance rupture and resolution processes, and only through immersing in the reading I could understand its theoretical and clinical relevance. Given that the literature on alliance and rupture-resolution processes with adults is so vast, at times I felt lost in it; one paper took me to a new one, and I had difficulties stopping myself and refocusing. There were plenty of times that I had to go back to my research scope, this required to develop some skills that otherwise I might not have been able to. Also, learning from this extensive literature was very stimulating and I still feel I want to continue reading on this topic after completing my doctorate.

Not only reading fostered my learning. Training on the 3RS (Eubanks et al., 2015) was a great opportunity for me as a researcher and as a clinician. Learning to identify subtle, and sometimes imperceptible, attitudes from patient and therapist and to differentiate when these attitudes were collaborative or when these were an indicator of ruptures has proved invaluable to me. Additionally, even though my research did not focus on repair processes, I learned a great deal on resolution techniques from coding the sessions, and from the discussions my research partner and I had at the time of coding and later. Other discussions

with the PhD students who were also training on this coding system and with our supervisors were enriching and expanded my learning.

In addition, I had the opportunity to listen to therapy sessions. At the time I listened to the sessions, I did not have much experience working with adolescents, and being able to fully listen to STPP (Cregeen et al., 2017) sessions throughout the whole treatment was very helpful for my clinical practice. Listening to other psychodynamic psychotherapists' interventions was a luxury that, I am aware, not every Child and Adolescent Psychotherapist Trainee has. I was able, not only to identify ruptures and reparation attempts, but also to have the picture of a whole STPP treatment and of the way two psychotherapists worked with very different 15-year old depressed boys. By listening to the sessions, I could see their attempts to engage the patients in therapy, how they included transference interpretations in the treatment, their active work on trying to understand and give meaning to what the patient said, and the work on the ending of therapy undertaken by one of these therapists. Even more, when training on the 3RS, I also had the opportunity to listen to other STPP and CBT sessions, which was also very enriching in terms of my learning experience.

Additionally, I learned a lot from doing the interviews' thematic analysis. I enjoyed listening and reading the interviews; coding the meaning units to then group the codes by themes was also very interesting to me. Hearing what the patients and therapists thought about each therapy was revealing, as from an observer's perspective, who was also training in psychodynamic psychotherapy, I imagined they could have different ideas about therapy. It allowed to open a space in my mind with the possibility of adolescents not always finding therapy helpful. Although it was painful to hear that, the patients' and therapists' words still resonate, and I think help, in my current work with adolescents. Moreover, part of the thematic analysis process implied making decisions on what parts of the analysis were relevant to understand the ruptures pattern and leaving behind what was not. Midgley (2006)

warns us about the risks of getting lost in the detail of the data; when doing the thematic analysis, I felt every mention of the therapeutic relationship was relevant, and I still think what they said was important, but I had to decide what was related to my research topic and what could explain the emergence of ruptures in these two therapies. My supervisor was very helpful in redirecting me to my research path. Accepting to lose parts of the thematic analysis was a painful process that kept me focused. That itself was an important learning experience.

I also learned from my peer group. Very interesting discussions emerged when my research partner and I coded the sessions, and when I did the thematic analysis of some interviews with other doctoral students. Even more, my research group, though not all of them working on the therapeutic alliance, had important contributions and comments about my research and their own; the conversations in my research group felt alive, thoughtful and informative, provoking self-reflections and analysis about my research project.

In addition, I was able to understand and value the importance of research for clinical practice. Before starting this journey, I was convinced that clinicians learned from theory and from working with patients. Important as these aspects are, now I can say that research is another meaningful way of learning and should not be left only for academy. Dialogue between researchers and clinicians is crucial if we want to make contributions on our patients' lives. Research has something to say about how to improve clinical practice, in the same way as clinicians can contribute to research by offering a crucial view on what happens in therapy and what is needed to understand or to further develop.

Finally, I feel I gained great insight on alliance rupture-repair processes. Besides learning from the theory on the therapeutic alliance, my clinical practice has been profoundly informed by research on this area. Now I am more inclined to notice ruptures and to make attempts to repair them when working with adolescents, but also when working with children

and parents. I also think about what I could have done differently to repair ruptures with some former patients and their parents, which might have changed the path their therapies took. Understanding the profound implications that rupture-repair processes have in psychotherapy and their role in patients symptomatic change has opened my eyes in a different way as a Child and Adolescent Psychotherapist, and became a core learning for my practice.

Integrating conflicting feelings

Understanding that doing research was not straightforward and would not go the exact way I expected was a process that drove me through painful and enriching paths. At the beginning, it was hard to deal with anger and frustration, and I avoided being in touch with my research project and with the researcher in me. Accepting that these feelings were part of this process possibly helped me deal with them and use them in a creative way.

Thinking back, I identify with an adolescent in therapy. Starting my research was very tough, and I felt I had no idea of how to do it. Gradually, I felt more interested and engaged with the work I had to do; I enjoyed learning, reading and understanding the theory, listening and coding the sessions, coding and analysing the interviews, looking at the data and trying to give sense to it. Now I value the whole research process. However, I do not identify with the loss adolescents might experience at the end of therapy; as I am aware that research does not end here, there is always something else to understand and learn. I hope I can continue walking on this path that I started with my doctoral studies. If I do, I know I might as well experience anger, loss, frustration, and I am sure I will also find joy and rewards in learning through research.

Some gratifications in the research pathway helped shape and give sense to the initial anger and frustration. Seeing it in perspective, I understand why I felt this way at the

beginning, and I think this was a necessary part of the process. However, I no longer protest on having to complete a 'task' that felt imposed. I think I was able to embrace this process and to obtain important gains from it. Conflicting ideas and feelings came along the whole process, but I managed to overcome the initial limitations, some of them part of my way of dealing with anxieties and insecurities. Understanding and moving further from these initial limitations helped me find interest in what I was doing and invest energy and time on my research.

Winnicott (1971, pp. 65) describes creativity as the "colouring of the whole attitude to external reality". Without joy and interest, I am not sure I would have been able to continue with my research or to find a creative way of completing this 'task'. I found joy in this project because of my clinical interest in working with patients and in what happens in therapy that can promote change, by my supervisor's support and guidance, and by the enriching conversations with my peers. I also think that a part of me allied with the admiration I feel for other researchers and helped me create this piece of work.

After thinking back on the whole process and the feelings it evoked, besides learning, I mostly find in myself gratitude towards the people who were part of this path and who helped me overcome my initial feelings and self-limitations. This was not an easy journey, but maybe that is part of what made it so rewarding and especial. Now I cherish this process, with its ups and downs.

Conclusion

Doing research requires tenacity, perseverance and a strong will. There are obstacles in the way and sometimes we need to take a different path and accept it. In this process, I had to embrace my frustrations and accept its difficulties. I think I defended from the anxiety research provoked in me by avoiding it; even more, it was generally easy to avoid working on

my research due to additional personal and professional circumstances that interfered with this project. When doing research, I had to face time restrictions, language limitations, and strong feelings that were not easy to tolerate.

Despite its struggles, I found great joy and rewards in this process. This was an enriching experience that allowed me to learn and grow in different professional and personal ways and I feel grateful for this experience and for the support I received alongside the whole process. Now I can see that strains and struggles are necessary to grow and to develop. I was able to get involved in this journey in a creative way and used my ambivalent feelings to potentiate this creativity.

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