Dissertation Volume 2

Literature Review

Empirical Research Project

Reflective Commentary

[redacted]

University College London

Submitted in partial requirement for the Doctorate in Psychotherapy (Child and Adolescent) **DPsychotherapy Child & Adolescent Psych.**

Contents

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Declaration

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

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

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Impact Statement

This study explores how early communication between the therapist and their patient begins. Scant attention has been paid to the real-world context of how therapists act during the opening moments of individual Short-Term Psychoanalytic Psychotherapy (STPP) sessions with adolescents. Examining these moments may enhance our understanding of how therapists work with and engage adolescents in time-limited therapy models.

This study addresses a gap in the clinical and research literature by examining how two psychoanalytic psychotherapists working on two separate cases approach the opening moments of (STPP) sessions with depressed adolescents. It employs a qualitative approach using a Conversation Analysis (CA) method, which allows the capture of social actions.

Findings from the study suggest that the verbal interventions made by the therapist can trace early features of therapeutic alliance activities, such as reconnection with the patient, education of the patient, and establishing and fostering the alliance. Therapists in these samples were vocally proactive from the outset of the session, with therapist silence not a feature of the immediate opening moments. Strikingly, patients'

non-attendance was a dominant topic, with therapists showing different approaches to handling this sensitive area.

This study might help us better understand how therapists offering STPP to adolescents handle the openings of therapy sessions. However, this small-scale study's findings cannot be generalised due to its small sample size. Therefore, it invites further research with larger samples to examine the variations in the opening moments of adolescent STPP.

The current study may help inform clinical practice by considering how therapists engage adolescents and identifying differences between theory and clinical practice. Such understanding may enhance clinical understanding about early engagement of adolescents in treatment alongside how early alliance-building processes take shape. The study findings offer an opportunity to stimulate discussion about how psychoanalytic psychotherapists begin sessions with depressed adolescents, alongside challenging clinical theory to make adaptations for adolescents, and investing in training and supervision of therapist technique in opening moments.

Furthermore, the study findings might promote innovative process research methods and study designs within the discipline of psychoanalytic psychotherapy, which grapples with how therapists might address sensitive clinical issues during the opening moments of therapy.

From an ethical perspective, this study makes a research contribution that may offer opportunities to consider adaptations in clinical practice, particularly for therapists working with the STPP model, to enhance treatment engagement with this clinical population.

Part 1: Literature Review

An exploration of factors for therapists to consider when establishing a therapeutic alliance with adolescents.

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Word Count: 8,408

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Abstract

The therapeutic alliance refers to the collaborative relationship between therapist and patient, yet how therapists build this construct is less well understood.

This review draws on a wide range of theoretical literature and empirical studies to explore therapists' roles in forming and negotiating therapeutic alliances in work with adolescents. It also identifies fragile alliance indicators and/or ruptures in the relationship and notes the relationship between alliance and outcome in this population. Consideration of therapist factors is discussed, which may support alliance building.

Findings highlight variabilities in therapists' attributes and characteristics as discrete factors that may influence alliance-establishing and fostering mechanisms. Findings suggest that therapists identify areas of challenge in their practice through self-reflection and self-development to support modifications of their clinical competencies. Additionally, the review suggests therapists take a thoughtful, robust approach to evaluating safeguarding issues that require mandatory reporting, which may compromise alliances, noting adolescents' responses to interventions alongside sensitive management of competing partnerships to establish and maintain therapeutic alliances.

Research gaps are identified with distinct populations: ethnically diverse communities, sexualised minorities, and young people with disabilities, indicating the need for further research in alliance establishment with these populations. Further

research illustrating closer interactions between participants and tracking therapist factors may support understanding regarding the dynamics involved in alliance establishment phenomena to positively impact adolescent retention in therapy and their treatment outcomes.

Key words: adolescent alliance formation, alliance-outcome relationship, engagement, rupture, repair, therapist factors, competencies

Introduction

Increasing prevalence of adolescent clinical depression worldwide highlights an '*epidemic of depression'* (Jane Costello et al., 2006). A meta-analytic review by Mojtabai et al. (2016) shows significant trends of major depressive episodes between 2005 and 2014 in adolescents and young adults. Their findings correspond with an increased use of specialist mental health providers, prescription medication, and inpatient hospitalisation, specifically within the adolescent cohort. Effective treatment of adolescent depression remains a pressing priority to reduce the potential harmful effects of poor mental health. Poor treatment adherence can lead to a significant risk of relapse, affecting adolescents in debilitating ways, impacting their future life trajectories (Staton, 2010).

The Adolescent Landscape

Adolescence encompasses a pivotal stage of development involving turmoil and uncertainty (Jarvis, 1999). This is underpinned by several changes ranging from internal biological effects on brain development (Music, 2011), pubertal transitions affecting maturation across physical, intellectual, and emotional lines, alongside negotiating the tides of aggression, sexuality, and boundaries (Lanyado, 1999; Jarvis, 1999). Early attachment styles (Ainsworth et al., 1978), and relational experiences within the family, together with those met in social, educational, cultural, and health situations, will shape personality development (Music, 2011) and internal working models (Bowlby, 1969). Kazdin et al. (2006) note distinctions between key dependent relationships that may affect relational capacities across contextual issues: socioeconomic factors, parent psychopathology, stress, and degree of child/adolescent dysfunction. Such strains

compete with adolescents' search for a unique identity, whilst navigating preferences in relationships and choices and expressions regarding their sexuality (Lanyado, 1999; Jarvis, 1999).

Blos (1960) and Waddell (2002) remind us of how the mind's evolving ego capacities and executive functions take shape, encountering and surmounting many emotional, psychological, cognitive, and social growth challenges and tasks. Developmental tasks of individuation, separation (from parental figures), independence of thought, alongside managing relationships with authority structures, will test adolescents' various perceptual capacities and readiness to meet these responsibilities. External factors such as the mediation of risk taking, negotiation of impulses, personal desires, and conflicts require coping with different states of mind, which predominate in this phase (Waddell, 2018). Adolescents' subjective capacities to tolerate these pressures and frustrations will vary, with fluctuating regressions to earlier stages of emotional development. Additionally, psychosocial issues and ways of managing circumstances may perpetuate defensive coping mechanisms, hastening or derailing adolescent developmental tasks (Waddell, 2018). Combining these can mediate their effects through the adolescent's developing cognition, temperament, and personality attributes (Tharpar et al., 2012).

Below, I discuss the various approaches therapists might consider and how modifications in therapist characteristics might be developed to support the developmental needs of adolescents as a therapeutic alliance is established and fostered.

Therapeutic Alliance phenomena

Therapeutic Alliance (TA) has a longstanding history within psychological modalities that is richly and extensively explored amongst adults, with a growing body of empirical studies focused on youth populations. The concept of therapeutic alliance transcends different types of therapy (Kazdin et al., 2006), with differing conceptualisations offering interchangeable terms to define the collaborative bond developed between patient and therapist, e.g., therapeutic alliance (Zetzel, 1956), helping alliance (Luborsky, 1976), and working alliance (Bordin, 1979; Greenson, 1965). Simultaneously, they describe the movement towards shared therapeutic goals, tasks, and the bond (Bordin, 1979).

Therapeutic alliance-outcome relationship with adults views the TA as a main common factor of change across modalities (Anderson et al., 2012; Bedics et al., 2015; Gaston et al., 1998; Martin et al., 2000), the strength of the relationship predicting positive outcomes of symptom change (Fluckiger et al., 2018; Horvarth & Symonds, 1991; Martin et al., 2000). Findings conclude that the relationship between TA and positive outcomes appears reliable regardless of client characteristics, research participant perspectives, i.e., client, therapist, observer, or alliance, and outcome measures used. Meta-analyses of adolescent literature support this consistency, noting that clinician alliance formation and maintenance over the treatment can achieve positive outcomes (Karver et al, 2018; Shirk et al, 2011; Shirk & Karver, 2003). Dimic et al. (2023) highlight that attention towards therapeutic outcomes has received disproportionate attention, with less knowledge cultivated about its specific mechanisms of action. However, perhaps with adult therapies, there is less factorisation of the

developmental fluctuations that apply to adolescent populations, which might impact treatment outcomes with this population.

Anna Freud (1946) emphasised the importance of attachment in the therapeutic relationship and how it is based on the child's experience of the therapist, who helps them with their difficulties and feelings. This collaboration relies on the emergence of a *'proper rapport'* which allies with the patient's ego (Freud, S., 1913), or more specifically, the healthy part of the patient's ego (Bibring, 1937). Klein (1927) challenges such an attachment, particularly through fostering a positive transference (Freud, A.,1946), as unnecessary, because the therapeutic work delivers positive and negative transferences to the therapist, which contain unconscious conflicts that can be interpreted accordingly. Therefore, Klein (1927) favoured relying on the interpretation of play and affect as key factors. Nevertheless, the emergence of 'proper rapport' (Freud, S., 1913) cannot be relied upon as an indicator of continued or future performance of a therapeutic alliance, since its changeability, i.e., fluctuation and turbulence, will impact upon establishing a trusting and collaborative relationship (Bordin, 1979).

Historical understanding of early conceptualisations of the therapist's role has been extensively undertaken with adult patients (Greenson, 1965; Zetzel, 1956). Greenson and Wexler (1969) note that cultivating and nurturing a realistic attachment are fundamental to constructing alliances. To clarify and broaden the therapeutic alliance concept, Greenson (1965), and Meissner (2001), question how components connect different transference variants of the therapist's countertransference and the "real relationship"; since each derive from other motivations, genetic origins, need and demands, requiring flexibility and responsiveness in the therapeutic interaction.

Roughton (1994) links the patients' perspective regarding the therapists' characteristics with the strength and consistency of the unfolding alliance and interpersonal relationship, as aspects that might sustain them.

Lanyado (2004) questions which aspects of the therapist's personality are brought into the room with a young person, and how 'abstractions' of a therapist's personality may shape therapeutic change processes. Therapy interventions, alongside effects of the therapist's presence and prescience through psychoanalytic knowledge (Lanyado, 2004), together with capacities involving quiet and slight incremental changes, bring about developmental shifts (Hurry et al.,1998), essential to the therapeutic relationship.

Tishby and Wiseman (2018) view the relationship variables and technique components as discrete but intertwined aspects of change mechanisms when defining the therapeutic relationship and therapeutic alliance. According to therapist modality, the deployment and timing of techniques may manifest differently with varied client groups (Webb et al., 2010). This suggests that the patient-therapist interpersonal relationship could be supported through a therapist's personal attributes and clinical competency, to apply therapeutic alliance-building variables to individual adolescents' needs. The Therapeutic Alliance and Therapeutic Relationship might thus be seen as distinct phenomena, incorporating different elements of the therapeutic encounter.

Rapport establishment relies on conscious and unconscious variables in the relationship controlled by participants, i.e., the adolescent's participation, sense of autonomy, feelings towards their therapist, or the therapists' interpersonal style of relating, therapeutic attitude and clinical technique, are creatively tailored towards their

adolescent patient (Karver et al., 2017; Midgley et al., 2017). Viewed as distinct agents of change, together with negotiated therapeutic objectives, they co-construct the therapeutic alliance and relationship. However, whether such variables and their effects are modality specific warrants investigation and identification of processes involved (Midgley et al., 2017). Examining the utility of process research to capture and extrapolate the subjective experience of the therapeutic encounter strengthens the efficacy of psychotherapy, linking observations of clinical behaviour through different methodological lenses. This may uncover the mechanisms of interactions, providing a view of psychological concepts in action (Hinshelwood, 2013).

Pioneering the development of alliance instruments has increased recognition of the interactive relationship at the heart of change processes between adult patients and therapists (Luborsky, 1976, 1984, 1996). However, Alongside Luborsky's body of work, Bordin's (1975, 1976, 1979) conceptualisation of the Therapeutic Alliance framework discusses the framework of goals, tasks, and bonds relying on the degree of mutuality, effectiveness, harmony, and joint purpose between participants (Bordin, 1980). A survey of psychological practitioners working with children and adolescents identifies therapeutic alliance as the most critical variable influencing the degree of change and successful outcomes (Kazdin et al., 1990). Several meta-analyses identify the alliance as a predictor of treatment outcomes (Del Re et al., 2012; Flückiger et al., 2012; Martin et al., 2000), regardless of the modality investigated (Orlinsky et al., 1994) or the theoretical approach taken by differing psychotherapeutic schools (Catty, 2004). However, how treatment outcomes are conceptualised and

evidenced amongst psychological therapies with young people is variable (Gillies et al., 2016).

Undertaking a meta-analysis of the alliance-outcome relationship in adolescent studies, Murphy and Hutton (2018) recognise that whilst no causal relationship can be drawn from findings, further research is warranted to support understanding the alliance-relationship and the barriers encountered. Murphy and Hutton (2018) suggest therapists respond to variations in alliance quality through alliance-fostering training programmes. Cirasolla and Midgley 2023 highlight that the influence of therapist characteristics on the relationship and treatment outcome requires further attention. These views indicate that further understanding of the mechanisms and perspectives involved is needed to identify and recognise the impact of therapists' skills and strategies during alliance-building mechanisms.

Williams and Levitt (2007) highlight that few studies focus upon the therapists' factors, i.e., behaviours and attributes, which may be active agents in establishing and sustaining alliance. Therapist-specific behaviours and interpersonal styles during sessions are complex to identify, measure, and interpret (Ryan et al., 2023). Such aspects can significantly affect the alliance and /or outcome, based on child reports or therapist reports of the variables under study. Examining how such effects occur offers opportunities for researcher-clinicians to better understand the nuances unfolding within adolescent interactions, potentially signposting to recommendations on clinical technique and therapist training.

Review aims:

The review considers how therapists handle alliance phenomena and tasks involved in formation, negotiation, rupture-repair events, and alliance maintenance in clinical work with adolescents and presents a variety of therapist factors that support therapeutic alliances and outcomes with adolescents.

Structure of the review:

The focus of the review centres around tasks and competencies within the roles and responsibilities of therapists, to support the therapeutic alliance. A range of studies using various psychodynamic models and methodologies provide approaches and findings that support therapeutic alliance and outcomes with adolescents. These are discussed under the following sections: the formation of a therapeutic relationship, ii) negotiation of the therapeutic alliance factors, iii) rupture recognition, management, and repair, and iv) maintenance of the alliance.

Recommendations are offered and critiqued concerning their applicability across modalities or where contentions in clinical practice might arise due to clinical/theoretical frameworks.

The review concludes by integrating the theory and research findings, offering recommendations, and identifying gaps in the literature and current empirical evidence.

Search strategy

The literature review conducted searches across key databases of: PEP Web, APA PsycINFO, Medline, and UCL Library. Textbooks and published dissertations on therapeutic alliances and outcome relationships were consulted, with secondary references followed up to better understand the subject area. A keyword search

included: therapeutic alliance, therapeutic relationship, adolescent alliance, therapist alliance building, engagement, and youth therapy. Search terms were expanded to consider therapist behaviours, attributes, and competencies in alliance establishment. Adult-therapeutic alliance research is mentioned for its historical contributions, with critiques reflecting where a comparative difference in approach might be required for a developmentally younger clinical population. Inclusion criteria: A range of studies tracing the alliance concept across psychological modalities; these highlight therapist traits, competencies, and forms of personal development, to enhance alliance formation, negotiation, ruptures and repair, and support alliance maintenance. Both psychodynamic and non-psychodynamic studies were reviewed to gain insight into how different modalities view these issues and suggest ways of working with adolescents. Exclusion criteria: studies not written or translated into English.

Section 1: Formation and negotiation of alliance building

This section discusses topics and issues requiring focus and skilful adjustments to the therapeutic invitation that may secure adolescents' engagement in treatment during this tentative phase of alliance building. Topics of engagement and buy-in, therapist competency, goals, and tasks are discussed to bring together the multifaceted aspects involved.

Engagement and Buy-in

Recognising that adolescents have difficulties establishing helping relationships requires therapists to be mindful about balancing different factors in the engagement (Martin et al., 2006). Prochaska and DiClemente (1988) pinpoint a fundamental issue: that referral for child and adolescent psychotherapy is not always initiated by adolescents. This factor may impact adolescents' motivation to participate in therapeutic activities. Supporting adolescents with buying into therapy, i.e., risking investment in treatment, may be a significant task, depending on the patient's developmental age and stage of adolescence. Adolescents may feel pressured to commit, leading to a lack of commitment or resentment. Researchers have offered various hypotheses of potential mediators that, in combination, could be associated with forming and maintaining treatment alliance and outcomes. These include adolescent behaviours with; treatment attendance, punctuality, willingness to participate in treatment, compliance with tasks/homework, lower resistance, or higher motivation to change and exposure to active treatment ingredients (Chu, & Kendal, 2004; Karver et al., 2006; Shirk, 2001; Shirk & Karver, 2006; Shirk & Russell, 1996). Brown et al. (2014)

point out the need for adolescents to own their consent to referral and commence treatment. The journey to obtaining such consent constitutes a type of pre-beginning, opening into a therapy treatment which may affect how the alliance is formed. Handling such pre-therapy conversations and their responses may require further research with this population. Adolescents may also want the right to exercise their autonomy to feel they can withdraw from treatment at any time. Such withdrawal may highlight issues with authority or signal an adolescent's defensive functioning, which may compromise early alliance building and outcome, that may require specific attention by therapists (Brown et al., 2014). Sensitive negotiation of 'buy-in' to treatment requires skilful management and oversight, which can predict positive treatment outcomes amongst youth populations (Karver et al., 2006). Whereas adult patients are self-determining in their buy-in to therapy, modifying how therapy is offered alongside techniques to facilitate co-operation with adolescent behaviours mentioned above, requires further research.

Therapist competency

In their revised theory of general principles of therapeutic alliance, Novick et al. (1998) state that one of the responsibilities of therapists is to initiate the therapeutic alliance, balancing various issues during the initial phase to secure engagement and support positive outcomes. The authors develop a schema outlining specific tasks, resistances, and techniques undertaken by each party (patient, therapist, and parent/significant others), which sensitively proposes an 'evaluation phase' before the 'beginning phase'. Here, the therapist is tasked with initiating transformations of a)

self-help to joint work, b) chaos to order and meaning, c) fantasies to meaning, and d) external complaints to internal conflicts.

Such consideration by the therapist may link with the adolescents' hitherto unknown internal state(s), potentially attuning with the adolescents' unconscious and conscious thoughts and feelings. Novick et al. (1998) place the task of being and feeling with the patient as essential in the beginning phase. This approach of the therapist taking up the role of an emotionally sensitive object, who contains their emotional affect, might aid early alliance construction and enable collaboration whilst addressing resistances or potential/actual ruptures in the relationship early on, indicating that explicit therapist training that supports the adolescent's developmental stage is relevant.

Therapist factors encompassing how therapists relate to their patients, therapists' personal qualities, attributes, and competency level, and adjustment to the adolescents' developmental level may influence how the therapeutic alliance and rapport building with adolescents take shape, suggesting that they are key (Sburlati et al., 2011). Furthermore, handling topics sensitive to sameness, difference, cultural diversity, and disability is a fundamental skill (Sburlati et al.).

Promoting stronger alliances is linked with associations between engagement in therapy, the quality of interaction, and subsequent therapeutic change, i.e., client gains in therapy (Stiles et al.,1998; Kazdin & McWhinney, 2018). However, Kazdin et al. (2006) question whether therapeutic alliance is associated with therapeutic change within these populations or whether other influences confound the relationship. Variables such as inadequate internal working attachment models (Bowlby, 1969) and

histories of poor attachment (Ainsworth et al., 1978) suggest adolescents may be better served by being placed with more experienced therapists (Zack et al., 2015). This recommendation infers that experienced therapists may be better equipped to develop the therapeutic alliance with this population through a) their understanding of attachment theory and b) by drawing on and enhancing their qualities and attributes. However, if the emphasis on therapist attributes is a key variable, these constituents warrant closer examination of their characteristics and how they are employed in early alliance development.

Considering aspects of these relational qualities, Anderson et al. (1999) developed a competency model based on empirically supported cognitive behavioural treatment of child and adolescent anxiety and depressive disorders. Using a constructivist framework underpinned by the therapist's creativity, Anderson et al describe Facilitative Interpersonal Skills (FIS), which define therapist effects, to help therapists build and cultivate the alliance. The therapists' creativity is seen to blend into and across therapists' skills in interpersonal perception, anticipation, experimentation, and reviewing interpersonal hypotheses. These creative skills are seen as potentially encouraging or discouraging towards patients' openness to interpersonal transactions, possibly affecting the development of a positive working alliance, regardless of treatment modality, presenting clinical problems, or level of training experience. However, it is unclear how these creative competencies or approaches realistically translate or unfold within specific modalities in practice, e.g., with psychoanalytic therapists working with adolescents; further research capturing processes between participants could develop understanding across modalities.

Nevertheless, an agreement for therapy does not automatically imply that adolescents will sign up for therapy goals and tasks, which require teasing out with adolescents, as discussed below.

Goals and task assignments

Identifying and negotiating goals requires mutual agreement, which can strengthen the contract between participants (Bordin,1975, 1976, 1979, 1980, 1994; Hawks, 2015). Inevitably, some adolescents may seek greater independence over their relationship investments, whilst others may struggle to voice their views on goals. Such negotiations may require the therapist to delicately balance goal setting and evaluate the adolescent's emotional and cognitive ego capacities at this stage (Hawks, 2015). Balanced with adolescents' increasing need for autonomy, individuation, and confidentiality requires ongoing consultation on treatment goals and tasks (Brown et al., 2014). Additionally, adolescents' wish for self-determination and self-affirmation may compete with potential experiences of mistrust of adult authority, which might lead them to relativise adults' opinions or de-idealise and/or devalue their contribution. These factors could conflict with the opinion or goals of their parent/carer (if involved in the treatment), so a further task is to determine mutually agreed-upon goals for both, whilst working to resolve any differences (Brown et al., 2014). Gatta et al. (2009) argue that establishing a positive alliance with adolescents and caregivers can support therapeutic alliance and continuing engagement in therapy. The study findings also suggest increased adolescent therapeutic compliance when parental partnerships are developed in tandem from the diagnostic stage. This supports the adolescent and parent(s)/caregiver in developing their respective ego strengths and resilience

capacities and relating to the perceived emotional difficulties within themselves and family structures. Therapeutic engagement might then be served by incorporating a systemic approach to adolescents in treatment (Loar, 2001). However, not all adolescents involve their caregivers in therapy. Moreover, therapists need to be mindful in early alliance building of the adolescents' views on parental involvement and goal sharing; these might place undue pressure upon adolescents to share and conform to therapeutic objectives, potentially blurring their sense of the therapist's commitment to them, and risk alliance estrangement.

The second component of task assignment (Bordin, 1979) must be matched to the patient's awareness of their difficulties and willingness to change. Orlowski et al. (2024) suggest explaining the therapeutic model alongside a non-judgmental stance, which fosters an authentic, collaborative bond. Encouraging adolescents to participate actively in therapy activities (Hilsenroth et al., 2012) may support their decision making with therapy tasks (Davidson, 2003). Ensuring tasks are developmentally and cognitively appropriate can promote co-operation towards agreed goals, whilst balancing the therapeutic alliance (Orlowski et al., 2024). As with goals, task negotiation and careful monitoring are required to support the adolescent's developmental bids for separation (Waddell, 2018). Clarification of boundaries around confidentiality, particularly around managing specific mental health risks; management of self-harm, degree of suicidal ideation, and safety planning may require further negotiation (Kafka et al., 2024). Again, the involvement of carers needs sensitive negotiation with adolescents who may struggle to seek help or understanding from their

carers. The bond nurturance section discusses the final component of Bordin's conceptualisation.

Fostering cultural respect and inclusion

Incorporating an appreciation and curiosity regarding culture, diversity, and disability issues significantly contributes to alliance development. Brown et al. (2014) raise the importance of understanding the young person and their family's cultural values and background, which may impact the alliance process and therapy outcome. Aspects of relationship expectations, i.e., degree of formality in the therapeutic relationship, treatment expectations, goals of treatment, and degree of expressed distress (Brown et al., 2014) that can be understood and tolerated throughout therapy, need to be given consideration.

Debating how clinicians think about the faith of Muslim Practitioners in a Child and Adolescent Mental Health setting (CAMHS), Abedi (2021) proposes that an intersubjective process is at work within the perceptions of clinicians, rather than located in their patients, which is essential to uncover. Abedi's study highlights the need for specific cultural awareness training and reflexive practice when working specifically with the Muslim CAMHS population, which might support engaging them in therapy. Whilst the direct impact on therapeutic alliance was not a focus of the study, its relevance as a cultural competency for therapist development, in working with all diverse cultural groups amongst CAMHS populations, might advance therapist alliance training.

Encouraging engagement with cultural humility, Hook et al. (2017) suggest therapists are open, curious, respectful, non-assuming, and authentic in attending to salient aspects of cultural identities. The authors suggest facilitating an open dialogue with adolescents to foster trust and supporting them by feeling their experiences are recognised, fully understood, and appreciated. Such cultural humility requires therapist's to simultaneously develop skills with adolescents presenting from sexual minority populations i.e., Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI). These populations may experience disparities in accessing sensitive treatment (Hook et al., 2017).

Alessi et al. (2019) crucially state the need for safe and supported therapy, given the stigmatisation and discrimination often experienced by this population. Exploring adult clients' perceptions of their therapists, findings suggest that therapeutic alliance and the therapeutic relationship are strengthened when therapists demonstrate culturally competent skills aligned with Affirmative Psychotherapy (Perez, 2007), incorporating therapists' attributes of sensitivity, authenticity, and empathy. The discussion suggests that younger clients with emerging sexual identity labels may be more aware than their therapists, suggesting therapists may need training on the range of sexual identities (Wagaman, 2016). Interestingly, Alessi et al. (2019) indicate that therapists working with this population using Affirmative Therapy might also be prepared to discuss and disclose their orientation (Drescher, 1998), which may help with feeling safe in discussing LGBTQI topics in the relationship. However, current adolescent research with these populations is under-representative.

The range of therapist factors, creativity, and clinical acumen in harnessing adolescent engagement with goals and tasks of therapy can facilitate and influence the alliance relationship, which encompasses a range of equality, diversity, and inclusion issues. The combination of factors discussed may identify additional moderating factors that impact treatment outcomes; however, studies relating to these topics are sparse and require examination of their individual and collective effects in constructing therapeutic alliances. The review considers how ruptures and repair issues are approached to support alliance development and maintenance.

Section 2: Ruptures & repair

This section discusses several issues of adolescent resistance to engagement, compromising factors, adolescents who drop out of treatment, and navigating silences. It also considers how therapists might handle moments of rupture and repair to support the alliance relationship and bring the adolescent to some understanding about their functioning. Similarly, the therapists' awareness of their management during disaffiliation is considered.

Reluctant & resistant engagement

Adolescents with depression are likely to present with low motivation to engage, are less likely to seek therapy, participate, commit to treatment goals and tasks, or may feel under an obligation to attend therapy. They therefore may do so reluctantly, irrespective of a shared decision-making process (Barca et al., 2020). Barca et al. (2020) conducted ten focus group interviews with therapists to explore 1) whether

participants recognised the phenomenon, 2) how participants understood this group of adolescents, and 3) what they did when they worked with adolescents who came into therapy reluctantly. Five themes emerged; i) The hurt and distrustful adolescent, ii) The adolescent lacking hope for the future, iii) The adolescent engulfed in the burden of mental health suffering, iv) the adolescent as something more than a psychiatric patient, v) The adolescent meeting a system with varying flexibility and space for engagement, (Barca, et al., 2020). Striking differences emerged amongst therapist perspectives within/between teams, and amongst individuals depending on the adolescent they had in mind, with how staff understood their responsibilities and the flexibility required to support their adolescent client. Findings also conveyed that adolescent's pressured into treatment demonstrated a greater propensity to drop out. This study offers a critical perspective on how therapists represent and respond to the culture within their healthcare environments, particularly in engaging reluctant adolescents. Further research into how therapists and organisations identify personal and institutional biases and adjust practices to enhance adolescent engagement could support training in alliance engagement and improve patient retention, which may positively impact alliance tasks and treatment outcomes.

Researchers have offered various hypotheses of potential mediators associated with forming and maintaining treatment alliance and outcomes. These include treatment attendance, punctuality, willingness to participate in treatment, compliance with tasks/homework, lower resistance, or higher motivation to change and exposure to active treatment ingredients, (Chu, & Kendal, 2004), (Karver et al., 2006), (Shirk, 2001), (Shirk, & Karver, 2006), (Shirk, & Russell, 1996). Based on the factors

mentioned above, Chu et al. (2014) recognise the dynamic nature of the therapeutic alliance as a fluctuating variable within individual sessions and throughout treatment. Focussing on Cognitive Behaviour Therapy (CBT) with youths, the authors identify that the engagement coping style (characterised by conscious efforts directed towards a stressor i.e., emotional regulation problem solving, cognitive restructuring), of the adolescent before entering therapy, is positively associated with alliance establishment at the start of treatment with sustained alliance growth throughout therapy. Conversely, Chu et al. (2014) found that lower engagement coping, linked with initial alliance growth, then flattened or declined as the CBT progressed during the exposure frame of the intervention. Chu et al. (2014) suggest that teaching engagement coping skills before treatment may support alliance building, particularly in adolescents exhibiting low engagement or high disengagement coping styles. However, such an approach may not favourably align with models such as a traditional psychoanalytic psychotherapy, where pre-teaching emotional regulation skills may be considered counter-intuitive and potentially dilute the navigation system of the transference. Furthermore, Psychoanalytic psychotherapists may not be convinced that coping techniques align with alliance building but view premature reassurance as potential interference with unconscious communications, which might collude with an adolescent's unconscious wish to be pursued. Additionally, such strategies might create unconscious conflicts about whether an adolescent's ambivalent motivations might genuinely be understood. Nevertheless, the findings of Chu et al. (2014) might encourage psychoanalytic therapists to modify aspects of their training and practice to enhance trust, whilst modelling coping techniques to harness adolescent engagement in therapy.

Taking up the issue of resistance in alliance building, Peterson and Shirk (2011), identify differences in resistance from adolescents as passive or active disengagement. Ovenstad et al. (2020) found that rapport-building behaviours were significantly higher with passively engaged youth. These justified therapists focusing on alliance-building strategies during resistance periods to support treatment engagement and continuity (Karver et al., 2018). Identifying and addressing resistance periods with adolescents may require further research to help form alliance-strengthening techniques during these moments, yet these require further investigation and incorporation into training.

Alliance compromising factors

When safeguarding issues arise, therapists pause the therapeutic framework to implement mandatory duties and obligations around safeguarding and mental health risk management (Brown et al., 2014). The mandatory reporting duty from The Independent Inquiry into Child Sexual Abuse (IICSA, 2022) adds a significant dimension to therapeutic practice and has the potential to impact the therapeutic alliance. At such junctures, balancing the immediate risks (legal or protective issues) takes precedence, but also requires therapist skill and diplomacy to advocate for the young person's voice and explain the boundaries of confidentiality (Kafka et al., 2024). Adjusting and stabilising therapeutic alliances for the adolescent and parent/carer are needed to mitigate the potential repercussions, i.e., breakdown of treatment, or the adolescent/parent feeling compromised, which may influence the re-establishment of a stable therapeutic alliance (Brown et al., 2014). This topic requires further research to explore how such issues might impact the therapeutic alliance. Similarly, where risk

regarding significant and/or persistent self-harm is noted, the therapy may become compromised and potentially suspended, impacting the alliance relationship, or result in adolescents who terminate therapy prematurely.

Adolescents who drop out of treatment

Poor engagement and continued resistance increase the propensity to drop out of treatment. Kazdin (1996) reports that 40–60% of young people drop out of therapy, yet this widening trend indicates that between 28- 75% of adolescents drop out of mental health treatment (de Haan, Boon, et al., 2014).

Studies on adolescent dropout from treatment indicate that weaker alliance factors contribute towards the adolescent terminating or failing to return to therapy (Robbins et al., 2006). Garcia and Weisz (2002) found that youth clients expressed failures of the relationship as being the most frequent reason for treatment discontinuation. Additional factors such as non-adherence by the therapist to the intervention protocols, i.e., not following engagement protocols or interventions, or rushing into problem solving with adolescents (Diamond et al., 1999), are attributed to dropout. Poor treatment adherence can lead to a significant risk of relapse. Helping therapists recognise and address these issues through their reflective practice and supervision might improve engagement and encourage them to be curious with adolescents', about their resistance, which may encourage retention in therapy.

Findings by O'Keefe et al. (2017) suggest that poor therapeutic alliance and missed sessions (between sessions two to six) predict dropout, indicating that these may be early warning signs of disengagement in therapy with adolescents.

Identifying and targeting early treatment indicators of fragile alliance formation may allow therapists to adapt their approach, i.e., focus on exploring areas of misalignment during early alliance-building processes. Addressing these aspects might improve adolescent engagement to build trust in the therapeutic alliance, potentially reducing dropout risks.

Disagreements and misunderstandings can create ruptures and impasses in the therapeutic alliance (Safran et al., 2014). Recognising and addressing weaknesses or ruptures in the therapeutic alliance may play a vital role in successful therapy (Safran et al., 2001). Understanding why, how, and when ruptures occur and resolving these instances may improve alliance establishment.

Therapist effects on the rupture-repair alliance cycle are taken up by O'Keeffe et al. (2020). Strikingly, findings highlight that therapists contributed to fifty per cent of the ruptures with adolescents, categorised as ‘dissatisfied dropouts’ within early sessions of the treatment. The contributing themes were the therapist's minimal response, persisting with a therapeutic activity, or focusing on risk. Findings identify that dissatisfied adolescents who drop out have significantly increased numbers of confrontation or withdrawal ruptures and a decrease in Working Alliance Inventory scores between their early and later sessions. The study advocates the importance of further research into rupture resolution-markers that lead to dropout (O’Keefe et al., 2020). Supporting therapists in addressing highlighted topics and interventions might reduce the dropout propensity.

To identify and resolve moments of rupture, Perlman, et al., (2020), discuss the relevance of integrating the Facilitative Interpersonal Skills, (Anderson, et al., 1999), with Alliance Focused Training (AFT), of therapists, (Safran, 2000; Safran & Muran, 2006), which may realign the therapeutic alliance. Drawing on various techniques from relational and cognitive behavioural therapies (mindfulness, interpersonal schemas) allows an adaptable and responsive approach to improve the therapeutic process. A therapist's characteristics might affect how they respond to ruptures in the alliance, requiring self-reflection on their responsive styles.

Psychoanalytic disciplines, where therapists engage in personal psychoanalysis, may implicitly address such reflexiveness. However, such processes are under-researched empirically (Lasvergnas-Garcia, 2020), but sensitive studies could enhance clinical training and have broader implications.

Using the Collaborative Interaction Scale, Coli and Lingardi (2009) pinpoint rupture markers related to the therapist's intervention after the patient's previous utterance, capturing antecedent and successive responses to the moment-by-moment utterances studied. This study offers evidence of micro-processes at work, whereby therapist interventions provoke patient responses (and vice-versa), which capture dynamic yet idiosyncratic interactional patterns.

The Conversational Analysis methodology (Sacks et al., 1974; Schegloff, 2007) is utilised by Muntigl and Horvath (2014) to examine the rupture repair cycle or cycles of affiliation, disaffiliation, and re-affiliation between therapist and client. Disaffiliation moments are relational stress events creating breaches in the therapeutic relationship. Using adolescent therapy research material to examine such moments, the

study holds importance for how therapists might assemble understanding to develop techniques and formulations that subsequently manage moments of disaffiliation or misalignment. Clinically, the study invites further research into verbal, prosodic, and nonverbal communication to help therapists cultivate additional reflective perspectives that might support alliance.

Understanding silences

The impact of moments or periods of silence enacted by participants may indicate the quality of the alliance, such as ambivalence with engagement in therapy or around a specific topic. Therapists' observation and technical management of such occurrences may cultivate or misalign the therapeutic alliance (Mullard, 2015). However, Kurz (1984) and Leira (1995) suggest that silence can aid communication as much, if not more than, speech. Its place amongst the factors that need to be understood and managed technically by therapists is essential. Specifically with adolescents than other clinical populations, exploring the significance of silence might illuminate adolescents' conflicts, in tandem with the therapist's specific modality and ability to understand these silences, i.e., using the therapist's countertransference to aid understanding.

Mullard (2015) considers the treatment of silence by the therapist as a containing phenomenon through considering the patients' experience of the silence and collaboratively making sense of their behaviour and emotional states in these moments. Offering a theoretical matrix where silences are categorised into i)*Generative silences,* which open inner experience and develop ego capacity, or ii) *Destructive silences,* which disrupt the therapeutic alliance with the breakdown of trust and increase

resistance. Mullard (2015) encourages therapists to examine their comfort level or need for silence, to understand and utilise these categories to enhance therapeutic alliance and develop competency.

In a study with adolescents in psychoanalytic psychotherapy, Acheson et al. (2020) recognised that long silences with adolescents may not be helpful. Acheson et al. advocate for therapists to actively explore how their adolescent patients experience silence by offering explicit explanations about understanding and tolerating silences, which may help support their therapy. The authors further suggest actively re-engaging adolescent patients to address alliance ruptures, rather than waiting for them to speak, which might potentially be experienced as abandonment. How adolescents and therapists experience such interventions in these moments warrants further process research. Integrating these research studies proposes that therapists remain alert and active in addressing silences earlier, to facilitate re-engagement and realign the alliance focus. Study findings may support therapists in enhancing their clinical observations, judgements, and adjustments to patients.

Rupture and repair issues require therapists to consistently evaluate the influence and impact of varied alliance relationships with the adolescent, caregivers, and broader network, together with their responses to situations within the therapy or external factors. This includes remaining alert and responsive to safeguarding factors and silences, particularly considering how these may affect tentative alliances with adolescents who are resistant and at risk of dropping out of therapy. Further research identifying such situations, their management, and their impact on alliance formation, negotiation and repair interventions may support therapist training in these areas.

Section 2: Alliance Maintenance

This section links key therapist characteristics to underpin the tasks of bond nurturing, the role of countertransference in assessing and facilitating alliances, and balancing caregiver alliances.

Bond Nurturing

Various aspects of nurturing and supporting the therapeutic relationship rely on the quality of attachment and trust fostered between therapist and patient (Bordin, 1979). Therapists' experiences of these aspects also play a significant role in contributing to the continued bond.

Using interview and survey data from therapists working with children and adolescents, Campbell and Simmonds (2011) applied Bordin's (1979) conceptualisation of goals, tasks, and bond to therapist perspectives. The study collated surveys from fifty-three psychological professionals working with children and adolescents and their caregivers. Five individual therapists undertook a further subset of interviews, analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 2003, 2004; Smith & Eatough, 2006). Findings highlight the importance of emotional connections, which offer trust, warmth, empathy, rapport, and respect that may foster alliance building. Martin et al. (2006) add that collaboration and advocacy are also necessary with adolescents, but interest, reinforcement, and responding to affect across all developmental levels are key. Campbell and Simmonds (2011) further relate theoretical concepts of parental alliance, therapist resources, therapist self-awareness and wellbeing, which interweave with the therapist's characteristics, capabilities, and skills to establish and sustain the

various mechanisms of therapeutic alliance co-construction. Interestingly, one participant said building a working alliance was more essential than just creating a relationship. Perhaps this participant was more keenly aware of the differences between aspects of the alliance development, distinguishing between the bond between therapist and client, balanced alongside the tasks required to achieve therapy goals. For some adolescents, an explicit differentiation between the therapeutic alliance and relationship may help their understanding of relationship dynamics and contribute to alliance establishment.

In their contribution to the topic, Perez-Rojas et al. (2019) discuss the working bond requiring degrees of mutual trust, liking, and respect, alongside a sense of common commitment and shared understanding, facilitating the dyad to work collaboratively through distinct stages of therapy. Attending to the changing qualities in the relationship may alert therapists to shifts in alliance establishment, creating opportunities to address these transferential elements (Meissner, 2001). However, Hanley (1994) challenges views of alliance and transference, distinguishing that the alliance is enhanced by technical modifications, such as utilising non-interpretative communications to sustain and create the therapeutic alliance. This may support the capacity of the adolescent to tolerate later interpretations.

Challenging Bordin's conceptualisation of goals, tasks, and bond as an insufficient traditional formulation of alliance, Lavik et al. (2018) consider the influence of social interactions, particularly the micro-processes occurring between participants, as an aid to progress the alliance-building processes. For adolescents who may benefit from a psychoanalytic developmental approach, targeted towards their ego strength

(Hurry et al.,1998), modifications in technique with a focus on the relationship may be instrumental to; model the intersubjective process, foster containment, and sensitively build their capacity to tolerate reflections, build resilience and maintain the alliance.

Use of countertransference

Techniques such as countertransference - the therapists' response to the emotional material when thinking about their patients- provide additional therapeutic data, which may influence the trajectory of alliance establishment. Arnd-Caddigan (2012) notes that the therapists' reflexive responsiveness, where shifting qualities in the relationship are met with informed interventions, is an important part of understanding and developing therapeutic alliance and treatment direction, as discussed by the Boston Change Process Study Group, with adults (Horowitz, 2010).

Examining this phenomenon through identifying significant associations between the quality of therapeutic alliance and specific therapist reactions, Tanzilli and Gulaco (2020) investigate therapists' responses towards adolescents categorised with Narcissistic-Personality-Disorder (NPD). This clinical population of patients can lack self-awareness and may defensively deny or minimise their psychopathology, whilst projecting complex and contradictory emotions (Klonsky et al., 2002). The study utilises a Therapist Response Questionnaire Measure- Adolescents (TRQ-A) (Satir et al., 2009), which offers a clinician report instrument that evaluates a wide range of thoughts, feelings, and behaviours clinicians express towards their adolescent patients. Findings associate greater levels of collaboration and commitment to therapy with therapists reporting high emotional attunement and positive countertransference. Conversely, weaker levels of alliance were associated with the therapist's intense feelings: anger,

distress, devaluation, incompetence, failure to help, and withdrawal (Hayes et al., 2011; Ronningstam, 2012). The study by Tanzilli et al. (2020) confirms that the clinicians' specific emotional responses and levels of therapeutic alliance are associated with the distinct adolescent NPD subtypes they encounter in treatment. The authors recommend that clinicians' understanding of their countertransference reactions to patients, while simultaneously noting the quality of mutual connection and collaboration, helps make thorough case formulations when embarking on interventions, particularly tailored to narcissistic adolescents' characteristics (Malone & Malberg, 2017). This study highlights how therapists' feelings towards their patients may fluctuate and unduly affect the quality of the therapeutic alliance, potentially impacting the session outcome. Monitoring countertransference nuances, such as noticing with the patient such projections alongside timing interventions, i.e., interpretations of affect, transference may support the alliance maintenance and foster mutual understanding.

Balancing Adolescent and Caregiver Alliances

When young people and their caregivers participate in therapy together or with separate clinicians, therapeutic alliances might compete for attention, rank, and significance of emotional affect and impact; considering such perspectives is important.

A model arranged around strategies and obstacles, differentiated according to the therapeutic alliance audience, is presented by Hawks (2015). For adolescents, strategies for discussing competing interests in therapy and describing confidentiality limits honour their voices. Weighted against barriers where therapists are experienced as authority figures, may create a resistance to therapy, due to perceived

differences in socio-economic status and/or cultural understanding between the therapist and adolescent, requiring therapists to address potential issues mindfully. Hawks (2015) suggests that the complexities in managing vulnerable and challenging dynamics between all participants are highlighted by the obstacle of the therapist's fear of triangulation and balancing caregiver expectations with the adolescents' needs. The model encourages therapists to offer empathy to engage caregivers in an active, collaborative role while establishing clear boundaries. Hawks (2015) advises therapists to remain observant of their positioning concerning parental alliance cultivation and maintenance, which may positively or adversely influence a tentative adolescent alliance. Where a separate therapist undertakes parallel work with parents, the therapeutic team also needs to be mindful of preserving confidentiality whilst considering partisan views of each party's therapy and the adolescents' capacity to tolerate this.

From a multidimensional family therapy perspective with substance abuse adolescents and their families, Robbins et al. (2006) connect poor adolescent and parent alliances as significant factors that affect retention in therapy. Results cite alliance changes between therapist and family members as early as the first two sessions. Given that multiple alliances require cultivation in this modality, the limitation in attending specifically to the adolescent alliance may inadvertently generate a greater propensity towards adolescent dissatisfaction or dropout. A limitation of the study is that the therapist interventions were not recorded and could not be further analysed and reported on.

This section on alliance maintenance has discussed topics of resistance and prematurely ending/dropping out of therapy, which therapists encounter. The literature suggests using techniques such as countertransference to facilitate the therapist's understanding of their adolescent patients' internal conflicts alongside addressing personal reactions and reflections, which warrants further research. Recognising competing alliances within therapeutic relationships and bringing a responsiveness to as many of these areas in a timely fashion may strengthen a fragile partnership with adolescents who are at greater risk of leaving treatment.

Conclusion, limitations, and recommendations

This review explores how therapists hold a key role in building therapeutic alliances, requiring a range of factors that therapists oversee alongside various influences that may coalesce across the tasks of alliance establishment, negotiation, rupture, repair events, and the continued attendance to maintenance of the therapeutic alliance and relationship. A broad range of conceptualisations and methodological approaches across studies have been presented to consider various perspectives about therapeutic alliance factors, which might begin to meet the challenges proposed by Tishby and Wiseman (2009). These studies advocate that therapists evolve their skills to refine their clinical techniques and develop subjective attributes that may enhance alliance building with adolescents, presenting a range of mental health disorders.

Alliance establishment requires identifying compromising factors that can be tolerated to work through negotiations, ruptures, repairs, and relationship maintenance. The emergence of a rapport cannot be regarded as an indicator of the

continued or future performance of the alliance, but as a changeable variable throughout sessions and phases of therapy. This includes the fluctuations and turbulence occurring within and between sessions, affecting the relationship between participants.

Several therapist factors, such as competency and cultural humility (Hook et al., 2017) and experience across a range of diversity issues (Abedi, 2021), disability, sexuality, (Alessi et al., 2019) personal characteristics and use of countertransference (Arnd-Caddigan, 2012) may contribute to the therapeutic relationship and its handling by therapists, which may impact the alliance-outcome relationship.

A recognition of compromising factors and mandatory reporting requirements as dictated by the Independent Inquiry of Child Sexual Abuse (IICSA, 2022) is a significant aspect that may intrude into the therapeutic alliance, derailing or prematurely terminating therapy to safeguard an adolescent. Recommencement of treatment may bring an added dimension of fragility, requiring skilful negotiation to address such ruptures meaningfully and at an appropriate pace, tailoring interventions to suit individuals' developmental stage and contextual needs to repair such events. The literature recommends that therapists carefully evaluate adolescents' responses and be prepared to grapple with arising themes directly and sensitively (Barca et al., 2020).

It is strongly recommended that therapists examine their characteristics, capacities, and competencies and sensitively adapt aspects that befit their modality and personal style, which may support clinical skill enhancements. Technically, it is worthwhile to review whether the delivery, timing, and impact of clinical interventions require adjustments according to how individual adolescents tolerate them.

Personal therapy (Lasvergnas-Garcia, 2020) and clinical supervision can support therapist development. Further research exploring these aspects of clinical technique could inform therapist training.

The literature suggests that therapists remain vigilant as they balance many factors, including any risks or rupture events that may destabilise alliance building. Such incidents offer valuable opportunities for deepening and strengthening the therapeutic alliance through weathering such moments and addressing these events at the earliest opportunity, or when circumstances allow. The evidence suggests that early intervention in compromising factors and ruptures may protect the alliance relationship (O'Keefe et al., 2017, 2020).

Therapists are encouraged to consider how their individual or institutional biases and approaches might foster a culture of intolerance toward adolescents who present as reluctant engagers. Sensitive role responsiveness may improve adolescents' willingness to re-engage with therapeutic tasks (Barca et al., 2020).

Recommendations such as pre-teaching coping strategies, e.g., co-creating a script, or signal words/gestures that indicate discomfort/disagreement with topics adolescents find awkward, might support therapists in personalising the language and timing of clinical interventions. Such adjustments could support alliance engagement and retention in therapy, particularly for vulnerable adolescents. Explicitly embedding research recommendations from the Facilitative Interpersonal skills (Anderson et al., 1999) and Alliance-Focused Training models (Safran, 2000; Safran & Muran, 2006) within therapists' core training may also enhance therapist competencies in building adolescent alliances.

The interface between psychodynamic approaches and distinct schools of psychoanalytic thought, whilst holding different theoretical positions, might consider moving towards an aligned developmentally tailored perspective when considering the adolescent empirical evidence. This may allow for modifications in clinical techniques to support the fluctuating developmental journeys of teenage patients, offering sensitive handling through relational hurdles as the therapeutic alliance takes shape.

Additionally, this literature review recognises that there is a gap within empirical studies that explore adolescent and therapist's experiences in developing therapeutic alliances with young people stemming from a range of cultural backgrounds and engaging with adolescents who identify as LGBTQI sexual/asexual minority statuses (Hook et al., 2017; Wagaman, 2017) ethnically diverse communities, alongside those identifying as having additional needs and/or disabilities. The latter aspect has been a limitation for this review, indicating the gap of adolescent research around therapeutic alliance development and therapist experiences within this population.

Studies showing how therapeutic alliances are built with adolescents are emerging, and innovative methodologies, such as process research, are taking shape across psychotherapy domains.

A gap exists in the adolescent research literature, focusing on studies that capture the therapists' actions in the opening and early moments of sessions. These studies may illustrate how the therapists handle these early interactions. This may offer a window to understanding how therapists engage adolescents or manage issues when the alliance is fragile. Furthermore, capturing naturalistic moment-by-moment

interactions between therapy participants may enhance understanding of how therapists work clinically to engage adolescents in alliance-building components.

Integrating innovative research paradigms with studies that examine therapists' skills with adolescents could develop clinical techniques that support therapists in assisting adolescents psychologically in identifying their inner conflicts, developing their self-reflective capacities, and developing self-advocacy. Moreover, enhancing alliance development training for therapists may positively impact engagement and retention in therapy to hasten recovery, restart developmental progress, and improve adolescent treatment outcomes.

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Part 2: Empirical Research Project

How do Psychoanalytic Psychotherapists open sessions with depressed adolescents in Short-Term Psychoanalytic Psychotherapy (STPP)?

Candidate number KVNT6

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How do Psychoanalytic Psychotherapists open sessions with depressed adolescents in Short-Term Psychoanalytic Psychotherapy (STPP)?

Abstract

The opening moments of therapy sessions have received little attention from theoretical literature or empirical research. However, clinical experience suggests that the influence of this initial interaction may affect how the therapeutic relationship and alliance are formed. This study aims to address this gap in empirical research through an exploratory qualitative study.

No studies have explored how the opening moments of Short-term Psychoanalytic Psychotherapy (STPP) sessions with adolescents unfold. This study examines how sessions get underway between two therapist-adolescent dyads.

Method

Two cases, each with three session samples, were drawn from a randomized control trial of treatments for adolescent depression (IMPACT study). The first three minutes of each sample were transcribed and analysed using Conversation Analysis.

Results

The study identified four main themes occurring across samples that illustrate how the therapist handled the opening interactions to provide support, reconnection, education, establishing the alliance, and fostering an alliance through various linguistic devices that operate to build clinical techniques. Transitional conversations were noted to occur. The therapist's silence was not a feature of openings, non-attendance was a dominant theme, and transitional conversations supported reunion and engagement.

Discussion

Opening moments of therapy sessions are clinically significant transitional spaces for depressed adolescents, requiring a thoughtful handling by therapists to facilitate therapeutic alliance. Therapists were observed to be proactive in these alliance engagement tasks.

This study offers a basis for exploring this under-researched area of clinical practice, understanding this clinically sensitive period, and supporting therapists in developing therapeutic alliances. It offers an initial attempt to meet the gap in current knowledge.

Key words: Opening moments, transitional, Conversation Analysis, adolescence, depression, IMPACT study, short-term psychoanalytic psychotherapy, psychoanalysis.

Introduction

The opening moments of psychoanalytic therapy may be characterized as the time when the therapist and patient re-establish their bond, recalling and engaging with the goals and tasks of their working alliance (Greenson, 1965) whilst fostering their relationship (Bordin, 1979). The first minutes of psychoanalytic sessions have been overlooked, with the focus on therapeutic alliance factors more often concerned with alliance tasks.

Opening moments warrant interest as they hold important contextual information regarding the patient's experiences between sessions and offer an opportunity to revisit and clarify concerns. Little is known about how therapists work with patients to facilitate key techniques such as free association (Freud,1913), which transition into topics concerning the patient's current preoccupations. Furthermore, what emerges between the participants during the handling of these moments may enhance understanding of factors that facilitate alliance establishment or illustrate moments of misalignment, i.e., where therapists and adolescents experience misunderstandings, which may perpetuate fragile alliances or disengagement in therapy (O'Keefe et al., 2020).

Psychoanalytic theory has remained steadfast in adhering to Freud's (1913) directions about the beginning of treatment and the opening of therapy sessions with adults. Freud (1913) directs psychoanalytic therapists to wait in silence, without venturing any comment, to allow the patient time to bring their preoccupations following the free association technique; meanwhile, the therapist offers an evenly suspended attention to the internal preoccupations and topics raised by the patient.

> *"But in any case, the patient must be left to do the talking and be free to choose at what point he shall begin."*
>
> Freud (1913, p. 139)

Later in the same paper, Freud asks.

> *"When are we (therapists) to begin making our communications to the patient?"*
>
> Freud (1913, p. 139)

However, whether this theory remains appropriate when working with adolescents, who fluctuate developmentally in their ego capacities, may require reconsideration. Recent empirical literature examining how adolescents consider the meaning of silences suggests that adolescent patients may experience silences as obstructive, in distinct phases of therapy. Acheson et al. (2020) present how patient silences may convey various meanings, which may affect how such therapeutic communications are interpreted and responded to by therapists. The study focuses on coding silences occurring across individual sessions and phases of therapy, with less emphasis on the presence of silence during the opening moments of a session. Currently, there is limited empirical evidence on whether the therapists' opening silence in psychoanalytic psychotherapy with adolescents occurs, how widespread it is in practice, or if something different is taking place.

The classical view suggested by Freud (1913), using talk as the primary medium in the opening, was considered by Klein (1932) not to be the only medium children and adolescents used. Klein suggested play as a primary mode of communication, which simultaneously brought an unfolding transference; thereby allowing the unconscious anxiety to become known and relieved through interpretation of the positive or negative

transference (Klein, 1932). In contrast, Anna Freud (1946) advises developing a confidence between the patient and therapist to create a positive transference in the analytic play technique. This developmental therapeutic approach considers the ego developmental needs of the patient. However, neither Klein (1932) nor Anna Freud (1946; 2018) challenged Freud's (1913) recommendation on how to open sessions.

Child & Adolescent Psychotherapists (CAPTs)

Within the therapeutic space, it is unclear whether CAPTs strictly adhere to Freud's (1913) method of the therapists' opening silence awaiting the patient's initiation, or if this clinical practice is being inadvertently challenged by therapists, while not captured, openly discussed, or advocated in clinical literature.

The training of CAPTs provides an experience of being a patient, through their clinical training requirement of four times a week (minimum) adult psychoanalysis. Lasvergnas--Garcia (2020) discusses how personal analysis becomes a cornerstone in the development of CAPTs, bringing a direct experience of being an adult patient, held in a traditional Freudian psychoanalytic frame. For psychoanalytic training therapists, the familiarity of not receiving a direct analyst-initiated communication during the opening moments may vary. However, it is implicitly accepted that the traditionally trained psychoanalyst would hold a silence until the patient shares their thoughts. This ingrained and integral experience of CAPT's training may serve as a formative template in their clinical approach with depressed adolescents in therapy. However, these precepts assume that CAPTs remain silent with their adolescent patients. Such

assumptions require exploration, particularly as therapists collect their patients from the waiting room, which may involve transitional conversations that might continue into the session opening. Given the current sparsity of research in this area, how therapists navigate this transition in practice is difficult to know and presents a gap in the research landscape.

Adolescence

Adolescence is a critical developmental stage during which ego capacities are shaped alongside changes in brain neuroplasticity (Music, 2011). This transitional period offers opportunities to improve understanding and attunement by building new templates of social experience, intersubjectivity, and reciprocity (Waddell, 2018).

Adolescents' need for self-determination, including consent over confidentiality, can create uncertainty about an individual's right to informational privacy, across psychological, social, and physiological domains (Barca et al., 2020). It also includes control over one's social interactions, bodily space, and judgment by others; particularly when confidentiality is breached, with the potential repercussions this can bring to patients, parents/carers, the therapist, and the network (Kafka et al., 2024). The Inquiry into Child Sexual Abuse (IICSA, 2022) is transparent on the duties of professionals to prioritize mandatory reporting. Nevertheless, significant situations requiring a breach of confidentiality, i.e., self-harm, suicidality, sexual behaviour, drug taking, can compromise the therapeutic situation and may create varying degrees of rupture within the therapeutic alliance. Kafka et al. (2024) found that young people were uncertain about discussing the importance of confidentiality with professionals. The authors recommend

that the boundaries of confidentiality be frequently discussed together with what information will be protected by it. Whether confidentiality is regularly revisited to reinforce protection and/or elicit trust within the relationship requires further research.

The incidence of major depressive episodes in adolescents and young adults shows a significant increase, with rates rising from 8.7% in 2005 to 11.3 % in 2014 (Mojtabai et al., 2016). This increasing prevalence emphasises a demand for understanding the efficacy and effectiveness of therapeutic processes, alongside effective treatments that can sustain their therapeutic effects (Mojtabai et al., 2016).

Adolescent depression has a multifactorial aetiology involving familial, genetic, and psychosocial factors, including adverse childhood experiences and intergenerational influences. Depression fluctuates in intensity, activity, and symptom severity alongside sways of psychosocial functioning (Dinya et al., 2012). These factors impact adolescents' cognition, temperament, and personality, leading to variability in dysthymic depression episodes, a potential precursor to more severe disorders such as Major Depressive Disorder (MDD) (Thapar et al., 2012). The failure to treat adolescent major depression successfully has potentially profound consequences, including suicide, homicide, severely self-destructive behaviour, or the development of chronic depression with psychosocial deterioration (Staton, 2010).

Therapeutic Alliance

Identifying the types of verbal techniques used by therapists and the way these mechanisms of therapeutic change get underway appears to have been given less attention by researchers (Webb et al., 2010), yet may lead to improving outcomes for

adolescents experiencing depression. In contrast, extensive exploration has been given to the therapists' interpersonal skills and the therapy relationship to search for common factors of therapeutic change mechanisms across different therapy approaches (Lampropoulous, 2000; Luborsky, 1995).

Therapeutic alliance (Greenson, 1965) holds a pan theoretical construct across modalities as a significant agent of therapeutic change, consisting of a working alliance (Luborsky, 1976, 1984, 1996) where specific activities in terms of therapeutic goals, tasks and bond between therapist and patient (Bordin, 1979) are defined and a joint constructive and collaborative process become established and fostered. Several studies use different alliance measures and statistical analysis to focus on various alliance phenomena. These determine how specific interventions affect change, debating reliability, validity, and correlations between instruments (Horvath & Greenberg, 1989; Luborsky et al., 1999). However, these study designs may not easily translate to deconstructing interactional dynamics between participants, which may be more clinically meaningful in understanding the phenomena. Adolescent alliance studies have been under-represented in factors involved in therapeutic change (Wampold, 2015). However, Cirasola and Midgley (2023) note that more attention needs to be paid to the specific characteristics of therapists and the ways this might influence the relationship and outcome with a young person. A closer understanding of these factors might enhance understanding of the ways the alliance relationship unfolds and is fostered. Such information may contribute to updating the outdated theoretical literature on alliance. It may also encourage and enhance therapists' skills, particularly in addressing ruptures as they occur (Cirasola & Midgley, 2023).

The link between therapeutic alliance as a proven factor in symptom improvement (Falkenström et al., 2014; Flückiger et al., 2018) may support assertions that self-esteem may be positively enhanced through a positive alliance relationship (Aafjes-van Doorn et al., 2019). This may redefine self-worth and a sense of self (Ronningstam, 2017). Aafjes-van Doorn et al. (2019) suggest that the corrective relational experience brings about a novel affectively charged experience that secures the relationship enough that challenges of self-perceptions of the interactions with others can be tolerated (Huang et al., 2016). However, such effects might view the use of the therapist as a moderating factor in the alliance, together with the patient's own experiences and Quality of Object Relations (QOR) (Høglend et al., 2011). QORs are defined as the quality of an individual's representation of self and others, and their effects of generating affect, their contribution to stability in interpersonal functioning holds relevance in Object Relations theory, since early influences affect subsequent relationships (Huprich & Greenberg, 2003). This is particularly salient as early imprints of relationships project into the therapeutic relationship, creating a transference first conceptualised by Freud (1888) (Levy & Scala, 2012).

Psychoanalytic Views on Therapist Interventions

Knox and Lepper (2009) highlight that despite the number and variety of scales being developed to identify and quantify processes of intersubjectivity and affect regulation, mentalization and the Reflective Function Scale, these scales do not directly

analyse the turn-by-turn exchange of the interpersonal interaction itself (Schore, 1994; Fonagy et al., 2004; Fonagy et al., 1998).

Bady (1985) argues the curative aspect of talk in psychotherapy, noting how the qualities of the voice through various verbalizations and non-verbal cues can give clues to the therapist about the patients' inner state, (Racker, 1966) and vice versa to the patient about the therapists' inner state (Bady, 1984). Activating various layers of the patients' personality by the modulation of the therapists' voice (Kohut, 1957), in response to the patient's voice tone, among other non-verbal cues, reflects the intrapsychic conflict within the patient, alerting the therapist to opportune times for intervention (Karpf, 1980).

Stone (1961) and Nass (1971) argue the importance of the voice in creating verbal intimacy and forming a psychobiological bridge between therapist and patient, stemming from the primary relationship between mother and child. These reflections link with advances in determining the intersubjective language Stern (1985) describes, where verbal and non-verbal cues and the gaze create the moments of meeting (Schacter, 1992; Squire, 1987). An intersubjective matrix forms a transition space (Schegloff & Sacks, 1973), where conscious verbal and unconscious communications co-occur. Divino and Moore (2010) integrate how neurobiological affective responses can be carefully adapted by the therapist's use of their tone, posture, and gestures to modify feeling states, illustrating Bion's (1962) containing function.

Bucci (1982) formulates how symbolizing processes can be impaired and impacted in their linking to the articulation of feeling states – a specific component of

referential function; a verbal ability based upon an individual's internal lexicon, described as an active process (Bucci & Freedman, 1978).

Deconstructing Therapeutic Interventions

Conversation Analysis (CA) is a valuable tool in psychotherapy research for observing, capturing, and explicating interactional patterns. It complements and enhances insight into how therapists engage dialogue, curiosity, and conversation, bringing new insight among therapy participants (Peräkylä, 2008).

Conversation Analysis (Sacks, 1984) provides a methodology to understand how sequences of talk are constructed, i.e., the relationship between beginnings or openings and endings or closings involves many kinds of single interactions and interactional units (Sacks, 1992; Schegloff, 1996; 2007; 2011). Schegloff (1986) describes further how, at nearly every position in the developing course of these openings, an opportunity arises for one or other participants to pre-empt control of the first topic and shape the rest of the conversation. Topics chart the course of the interaction depending on the contextual nature of the conversation (Schegloff & Sacks, 1973). Heritage (2014) notes that the epistemic stance and status of who holds the relevant topic information and the right to articulate it, marking territory over the information (Kamio, 1997), create epistemic gradients akin to power structures, which may hold specific importance in opening moments of interactions as a therapeutic alliance is built. Yngve (1970) discusses ‘back-channels' as signallers that provide minimal verbal feedback responses *(‘mmm ohh’)* or brief comments, issued by the listener to give information without claiming speakership. Duncan and Fiske (1977) extended the definition to include

sentence completions, clarification requests, and brief statements. Ward and Tsukahara (2000) note their importance as features that do not require acknowledgment of the other and only respond directly to the utterance content. Categories of backchannels include: “continuers” to encourage to continue speaking, “acknowledgement tokens” to signal the listener’s attention, “change of activity tokens” to signal a transition to a new topic, and kinesic activities (laughter, gestural signs, non-verbal movements) (Gardner, 2001; Schegloff, 1982). Newsmakers mark the topic content as newsworthy, and many indicate emotional states as surprise /interjection (Fries, 1952), and markers of dispreference indicate a lack of interest or impatience by the listener in the talk (Levinson, 1983).

Edelsky (1981) defines the operational interaction between participants in the transition space, bringing together terms of *‘turn’* and *‘floor’* to describe the utterances formed in *‘on record speaking’*, alongside the *‘what is going on’* within a psychological time/space, respectively. Hayashi (1996) conceptually defines and extends these dimensions as being formed of both affective and perceptive capacities involving *‘empathy networks*. The relational conversation structure begins to establish a collaboration (either positively or negatively), connecting its interactants in a dynamic cognitive entity, both socially and psychologically. The collaboration is enhanced by the individual interactants’ own *‘meta-knowledge’* which co-construct a *‘meta-floor’* structure based; the storing of what is said, how it is said, its meaning, and/or implication, as well as its capacity to be recalled in current/future interactions (Hayashi, 1996). Labov and Fanshel (1997) argue that the thoughts, feelings, experiences, hopes, and expectations belong to the interactants to know and describe (Heritage, 2011; Sacks, 1984). Points of

transition in the dialogue open Transition Relevance Point (TRP); a point where a second speaker may take up the conversational floor. Where issues of misunderstandings, misalignments, or ruptures occur between participants (Schegloff, 1996), these events open the TRP that allows for a *'repair'* to take place (Sacks, Schegloff, Jefferson, Schegloff, Emanuel, & Jefferson, 1974).

Considering how therapeutic intervention techniques can be understood, Knol et al. (2020) examine conversational actions of reformulating talk and mirroring (Ferrera, 1994) relevant to building sequences of talk and their potential consequences. Antaki (2008) defines reformulating as a reproduction or rephrasing or locally editing the talk by the second speaker of the previous utterance, reflecting their understanding of it, which renegotiates what is held to be important within it. Ferrera (1994) defines mirroring as selecting and repeating a key portion of the client's utterance, which may be modulated by pitch or rhythm changes (Gibbon, 2017). Together, reformulation and mirroring, when undertaken by therapists, may provide insight to patients by reflecting on what has been said and what is relevant to the topic, and offering a new perspective to shift affect (Knol et al., 2020). Depending on the purpose, they are valuable devices for extending or closing down talk (Antaki, 2008). Understanding how CA deconstructs therapeutic actions and redefines their operation may provide evidence of the layering effect of techniques built over successive turns.

This study presents a preliminary attempt to chart and delineate the unfolding interactions in the opening moments of psychoanalytic psychotherapy sessions with adolescents.

Short-Term Psychoanalytic Psychotherapy (STPP)

Short-term psychoanalytic Psychotherapy (STPP) offers a manualized psychotherapy intervention (Cregeen et al., 2017) for adolescents with a diagnosis of moderate to severe depression, using a twenty-eight-session model. A study by Goodyear et al. (2017) compared STPP, Cognitive Behavioural therapy, and a Brief psychosocial intervention and found no statistical difference in effectiveness post-treatment between these therapies. All interventions resulted in symptomatic improvement at post-twelve-month follow-up. The IMPACT study (Goodyer et al., 2017) has yielded relevant data to explore this area.

The STPP manual (Creegen et al., 2017) offers explicit direction on setting up the frame and objectives of assessment, yet is cautious about directing therapists on navigating the opening moments of individual sessions. The STPP manual (Cregeen et al.) describes therapists' general practice techniques. However, the manual does not explain how these techniques are implemented. Additionally, the manual mentions the importance of exploring non-attendance but does not give explicit direction on when to raise this in a session or how to approach this topic.

Studies examining verbal interactions during initial therapy moments are sparse, indicating a gap in current research.

A literature review found no studies focusing on the opening moments of therapy sessions with adolescents, presenting a gap in the current clinical and empirical literature.

The Current Study Aims

This study closely examines the opening moments of therapy sessions to identify the clinical techniques that arise:

a) Exploring the opening three minutes of six therapy sessions from two cases (three from each)

b) Determining the themes that arise when building the Therapeutic Alliance

Rationale for the Study*.*

Examining how therapists manage the opening moments of sessions offers an opportunity to explore the clinical functions, how they are constructed, and how clinical interventions and techniques are developed to establish and foster therapeutic alliance.

Gathering and analysing such clinical data as it unfolds may demonstrate how interventions offered by therapists develop therapeutic alliance; deconstructing these processes through a conversation analysis may support how therapeutic interventions and techniques are actualised.

The study may also help adapt theoretical understanding and encourage the development of therapist training specific to the adolescent population.

Rationale for Sampling:

Two cases comprising three sessions, one good outcome and one poor outcome, were sampled from different stages of the early, middle, and end phases of therapy (where available), and investigated to explore the processes occurring in developing therapeutic alliances in psychoanalytic work across the therapy.

Treatment outcomes were determined by the IMPACT Study findings, based on whether the number of required sessions attended met or fell short of the inclusion criteria of over eleven sessions (Goodyear et al., 2017). One case met the requirements, and the other fell short. The first and final sessions were excluded, since these pivotal sessions hold specific psychoanalytic meaning that might obscure the focus of this study (Cregeen et al., 2017).

Case A involved an adolescent male aged fifteen working with a female therapist. Data from the IMPACT trial study showed that seven sessions had been attended and recorded, even though twenty sessions had been offered. The spread of attendance was erratic. (Sessions: 1, 2, 3, 4, 8, 9, 15) Sessions 2, 8, and 9 were sampled; of the middle session, 8 was available when transcriptions were conducted.

Case B involved a sixteen-year-old adolescent male working with a female therapist. Data from the IMPACT trial study showed that twelve of the fourteen sessions attended were recorded, despite twenty-nine sessions being offered. Attendance was also erratic (Sessions 1, 3, 4, 5, 6, 7, 8, 9, 11, 13, 15, 19, 21). Sessions 3, 11, and 19 were sampled.

The IMPACT study's research design predetermined variables. The researcher was blind to the participants' diversity or disability needs, or whether English was an additional language for the therapists or patients. Additionally, the therapist's experience level, qualification, and theoretical orientation were unknown. Gender pairings were not explicitly selected.

Method

This is a qualitative study using Conversation Analysis methodology. The study focuses on the individual therapists' actions during the opening moments of six sampled sessions. Two separate cases of STPP with different adolescent and therapist dyads were purposively selected.

The data used in this study were obtained from recordings made as part of the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study. The IMPACT study was a randomized controlled trial to compare the effectiveness of STPP with a brief psychosocial intervention and cognitive behavioural therapy (CBT) for adolescents experiencing moderate to severe depression (Goodyear et al., 2017). All three treatment interventions were manualized, and all sessions in the trial were audio-recorded. The study involved young people aged 11-17 with a diagnosis of depression; 465 adolescents were recruited for the trial based in the United Kingdom. The current research focuses on the manualized STPP model described by Cregeen et al. (2017), which comprises 28 therapy sessions.

Conversation Analysis

Conversational Analysis (CA) offers an interdisciplinary approach to studying human social interaction. Deriving from the Ethnomethodological tradition, it encompasses Linguistics, Pragmatics, and Sociology using concepts and tools to analyse the *'here and now'* aspects of interactions, as they occur in their natural settings (Sidnell & Stivers, 2013). CA was chosen as the study method since it allows the structure and process of social interactions to be closely followed. Prosody, which

constitutes the rhythm and melody of speech (Gibbon, 2017), shapes the texture of language.

A transcription notation coding system produced by Jefferson (1985, 2004) supports separating isolated ‘social actions’ that convey social meaning when joined into sequences of utterances. These offer a context of what is being said and inferred between participants, prompting a response, expressed either verbally or nonverbally, as each adds to the topic under discussion. (See Appendix 1).

Procedure

Four peers, each focusing on their area, formed research working group (RWG) with two Research supervisors. The RWG agreed on a standard selection of notation symbols devised by Jefferson (2004). Transcriptions and CA notation of individual session segments were reliability checked for transcription accuracy; any disputes were settled through joint listening by a peer from the RWG.

Data Analysis

All selected session samples were listened to, then separated into three-minute segments and thematically summarised. This provided an overview of dialogue responses between the patient and therapist and captured influencing factors that may have affected the opening of sessions. Identifying information was anonymized in the data excerpts using [NAME] or [LOCATION] to ensure transparency and consistency of the CA transcription application. Extracts followed the usual CA convention; lines numbered T (Therapist) and P (Patient) were used to denote who was speaking.

Extracts start when participants enter the room and end when the topic appears to be settled. This gave the researcher a raw sample based on the interaction within the first three minutes of the recorded sample.

The therapist's verbal utterance was assigned a brief coding acronym of the social action; the action was scored if present, and not on the number of times it occurred. The therapists' and patients' social actions were collated to provide an overview of the CA techniques employed; see Appendix 2.

Therapists' social and institutional actions identified themes across the samples, illustrating the different approaches to reconnecting with the patient, educating the patient, and establishing the alliance. These were observed through how openings were constructed, how topics emerged, their handling, and the building of clinical interventions through successive turns. The researchers' clinical understanding of the combined utterances also gave interaction sequences a psychoanalytic perspective, providing another layer of understanding of emerging themes.

The findings section of the paper presents examples of each theme; these have been selected to illustrate different ways therapists worked to elicit therapeutic communication to support the patient in engagement, education, and fostering the alliance.

Ethics

Ethical approval for the original IMPACT study had been sought from the Cambridge 2 Ethics Committee, Addenbrookes Hospital, Cambridgeshire, UK (Goodyear et al., 2011). Participants had also consented to the data used to support

understanding of research processes in psychotherapy. No further direct contact with research participants was required for this study.

All data was anonymized and held securely on devices. Copies of transcripts and analyses were stored electronically, with password protection. All transcripts were agreed to be deleted following the study's completion.

Findings

Key findings

Through transcription and analysis using CA, the researcher observed and explored vocal processes in the opening 3 minutes of sessions.

The coding of social action across all samples identified forty separate actions (between the two cases) issued by a therapist. A sequential combination of these occurring during a turn or over successive turns by therapists in response to patients' utterances produced a layered effect of therapeutic interventions using specific linguistic devices.

Therapist silence at the opening of sessions did not feature; In five out of six samples, the therapist is heard to offer a vocalisation or verbalization to open the conversational floor.

Analysis showed that Therapists were proactive in engaging their patients to facilitate settling into the session, e.g., checking well-being and comfort levels in the room, using a prompt, vocalisation, or signalling an intention to speak by starting a verbalization. There were occasions when the patient initiated the session.

When the topic of non-attendance emerged, therapists handled the cases notably differently. Illustrated in Theme B (Educating the Patient), in Case A, session 8, the therapist actively pursued the patient's acknowledgment, agreement, and commitment to further sessions. In Case B, sessions 3 and 19, the therapist invited the patient to elaborate on their experiences of missing the sessions and worked to develop their insight by interpreting the material.

No confidentiality statements were noted across these samples.

The vocal interactions between therapists and patients reveal four main themes in the first three minutes of each session: reconnecting, educating, establishing an alliance, and fostering that alliance.

Themes

The analysis showed that session openings were a shared enterprise. Four identified themes emerged from the analysis of the vocal process illustrated in Table 1.

Table 1:

Themes across samples

Theme	Sub theme	Illustrative sample
A - Reconnecting	Topic location Using metaphor & missed session	Case A Session 2 Case B Session 11
B - Educating the patient	Encouraging free association & addressing missed session. Developing unconscious meaning - & missed session	Case A Session 8 Case B Session 3
C - Establishing an alliance	Reframing the patients affect	Case A Session 9
D - Fostering an alliance	Acknowledgement of the challenges faced by the patient, and assistance in enhancing the patient's ability to reflect to promote insight	Case B Session 19

The therapists' clinical techniques were similar across all sessions and merged across themes; see Table 2.

Table 2:

Presents key themes and clinical techniques.

Theme	Therapist behaviours & clinical techniques
Reconnecting with the patient	Welcome and settling into the session, Comfort and wellbeing statements/ questions, Referring to conversation in the transition to the waiting room, Waiting for patients to initiate topics, Acknowledging difficulties in locating topic Developing rapport Redirecting topic choice back to the patient Reassurance Containment, Attunement /reciprocity Acknowledging difficulties in patients experiences Managing momentary silences Encouragement of free association Encouraging elaboration of topics
Educating the patient	**Including above** Giving space for the patients' free association Evading direct questions about the therapist room Reclaiming/returning to a topic Clarifying risk and safety Modelling tonal changes Mirroring tones
Establishing alliance &	**Building on previous two themes** Reframing the patient's affective state Mirroring patients' statements turning them into questions, encourage and /or soothe the patient, Emphasising a point/emotion, Shared humour, Being empathic, Engaging and negotiating goal setting, Negotiating tasks, Gaining buy-in to therapy, Clarifying expectations, Clarifying situations Checking correspondence has been received, Mirroring patients' thoughts feelings to encourage elaboration
Fostering the alliance	**Building on above themes** As above together with: Attunement /reciprocity Developing & modelling) empathy, Inviting elaboration of information, Encouraging free association, Developing interpretations, Linking external reality frustrations to internal affective states, Clarifying risk and safety information Linking information from earlier sessions or inter-session contextual information and sharing it with the patient.

The corresponding sample extract illustrates assigned major themes and describes the conversation analysis between participants. A clinical commentary follows, delineating the unfolding of the clinical techniques.

Reconnecting with the patient

The way the therapists received and made emotional contact with the patient across all samples shared features of welcoming, checking well-being, and rapport building. Two examples are presented here.

The first case, CAS2, shows the patient taking the initiative, with the therapist supporting the patient to settle on a topic. (see Appendix 3 for full transcript analyses)

Table 3.

Excerpt 1: Case A, session 2.

Line	Patient / Therapist	Conversational Analysis
7	**P**	what shall we talk about today↑ (mumbly)
8	**T**	(laughs)↑ I don't know (laughter) what would you like to talk about
9	**P**	shall we follow up my family tree
10	**T**	aah oh↑yes°[you were telling me]°
11	**P**	[from last week]
12	**T**	about your family
13	**P**	= and anything else I need to go over↑ or did I cover all of it↓
14	**T**	(.) you talked about a lot of things didn't you or whatever you'd like to say ↓(.)is it quite hard to know what to say↑

Conversation analysis. In line 7, the patient asks a question with rising intonation. In line 8, the therapist uses a backchannel and laughter to frame their response and names the uncertainty about locating a topic, which bridges the redirection of the question back to the patient to encourage his free association.

In line 9, the patient connects a topic to the previous session. The therapist acknowledges with tokens, locating the topic with intonation. In Line 11, the therapist overlaps with the patient's topic placement from the last session and confirms it. In line 13, the patient takes control, latches onto the therapist, and asks if further information is needed through rising intonation and emphasis together with a question. A further question with lowered intonation follows this as they reach a TRP.

In line 14, the therapist pauses momentarily and then poses a clarifying question, acknowledging the volume of topics previously discussed. She makes a reassuring statement conveyed through a lowered tone that aims to put the patient at ease. Another short pause is followed by a clarifying question, acknowledging the difficulty in finding another topic.

Clinical comment. This early interaction captures several themes of reconnecting with the patient, settling back into the therapeutic space, and educating the patient in free association, thus helping the patient take control and select a topic. The therapist uses back-channels (Yngve, 1970) to facilitate engagement and evade a direct question. The patient initially offers a topic inviting revisiting this. However, the therapist does not immediately take up a recycled topic from a previous session but waits to see whether the patient can bring up a current preoccupation.

The interaction illustrates some of the challenges experienced by the therapist in helping the patient locate a topic and share their affective state. The patient refers to a time and emotional state again in the past that they may concretely identify with. This

offers a route into exploring the patients' thoughts, reconnecting them on a joint topic, and unfolding the patients' experience.

The location and linking up of the topic provide a shared sense of task allocation, topic alignment/agreement, and shared ownership, illustrating a tentative link of the patient having been able to hold onto an aspect of the work from previous sessions.

These different ways of acknowledging what has gone before while bringing the focus back to the present relationship may be another way of supporting the patient in managing the uncertainty together.

The second Case, CBS11, illustrates a session of reconnection facilitated using a metaphor, following the patient's missed session due to significant self-harm. (see Appendix 4 for full transcript analyses)

Table 4.

Excerpt 2: Case B, session 11.

Line	Patient / Therapist	Conversational Analysis
7	**P**	we're back↑
8	**T**	yes ↑we <u>are</u> back ↑after some time↑
9	**P**	oh its been two weeks↑ °aahm ° it's been an <u>interesting</u> couple of °weeks °↓
10	**T**	yes↑ °I must say °↓ I have heard <u>something</u> about it↓ about what's been happening to you↑ <u>but obviously</u> its helpful↓ if you↑ tell me what's been happening about °that°

Conversation analysis. In line 7, the patient gives a newsmaker statement with rising intonation.

In line 8, the Therapist responds using the patient's words, emphasising a point and noting the separation length. In line 9, the patient offers a newsmaker, acknowledging the time elapsed and drawing curiosity.

In line 10, in response to the patient alluding to an 'interesting' time (which creates a TRP), the therapist picks up the cue with an agreement, quietly emphasizes ambiguity about the events, and invites the patient to elaborate.

Clinical comment. In lines 7-8, the repetition of words with emphasis conveys perhaps a sense of uniting themselves back together, realigning themselves to the therapeutic task, after a period of unplanned absence related to the patient's suicide attempt. The therapist offers her knowledge that there had been a significant event, which may symbolize the patient being held in mind. The therapist shows concern and curiosity about the patients' experience whilst showing empathy and letting them know they have a space to share this.

Educating the patient

Across all samples, therapists educate patients about their feelings and help them develop meaning. Addressing issues of missed sessions, acknowledging difficulties, and other techniques are illustrated in Table 2. Two examples are presented here.

The first case, CAS8, explores how the therapist addresses the patient's non-attendance; they work to set expectations and commit to therapy attendance (see Appendix 5 for full transcript analyses).

Table 5.

Excerpt 3: Case A, session 8.

Line	Patient / Therapist	Conversational Analysis
3	**T**	↑Aah so I haven't seen you for ages↑
4	**P**	°Just been busy with stuff ° (.) so I couldn't come last week I was breaking up with my girlfriend↓(.) ↓was really (3s) thinking about it↓
5	**T**	mm before Easter↑
6	**P**	a week before easter↓ I just completely forgot about it
7	**T**	°ok °↓
8	**P**	and then I looked at the post↓ and thought oh↑ I should be there↑
9	**T**	did you get the letters↑
10	**P**	mm
11	**T**	↓yeah? Cos↑ you didn't ring to let us know↓
12	**P**	Just completely forgot↓
13	**T**	°ok ↓ok ° so↑ you decided to come today

Conversation analysis. In line 3, the Therapist initiates entry into the topic of the gap between sessions through a raised intonation and back channels, a token, and a newsmaker to enliven the patient to the topic.

In line 4, the patient issues an initial statement, 'just been busy,' which illustrates a preoccupation that they elaborate on after a short pause. The patient's troubles-telling

is interspersed with another short pause and a longer pause, and the affective intonation after each pause offers a view of the patient's current concern.

In lines 5-6, the therapist issues a token and brief questions about the timing of the incident. At the same time, the patient offered more details about the timing of the break-up, with lowered intonation and an admission about forgetting about the session.

In lines 7-8, the therapist acknowledges the patients' responses, and the patients offer further details regarding their realization of not attending the session.
In line 9, the therapist clarifies the receipt of correspondence through a direct question. In line 10, the patient acknowledges this, as it appeared in their previous turn.

In line 11, the therapist appears uncertain through lowered intonation and provides an ambiguous affirmative acknowledgment. The therapist further seeks to clarify the patient's response by stating the patient's lack of communication or acknowledgment of the letters and missed session. The patient then offers a clarifying statement in line 12 that mirrors the previously given reason.

In line 13, the Therapist makes an interesting intervention: an acknowledgment of acceptance is followed by a lowered intonation and another acknowledgment of the patient’s possible state of mind at the time. Then, the therapist asks a direct question about attendance for this session.

Clinical comment. Initially, it is unclear whether the gap between sessions is a preplanned occurrence or if the patient deliberately missed/avoided engaging with the treatment plan.

The therapists' quiet tone in line 7 may help them respond empathetically to the patient's news and explanations.

The Therapist invites an opportunity to clarify events after the acknowledgement in line 11, followed by the expected social action to educate them. This may confront the patient's ambivalent stance and be perceived as a rupture.

The therapist's double acknowledgment in line 13 may aim to reassure the patient or repair an accusation of non-conformity.

The second example under this theme is Case CBS3, where the therapist facilitates the unconscious meaning of the patient's missed session by developing an interpretation. (See Appendix 6 for full transcript analyses)

Table 6

Excerpt 4: Case B, session 3.

Line	Patient / Therapist	Conversational Analysis
20	T	right (inhale) (.) ehmm (2s) but of course↑, well >thank you< for for telling me↓ ehmm (3s) did you↑ I wrote↑ to you↓ [did you receive my letter]?
21	P	[yeah I got the letter yes]
22	T	(2s) but I↑ ehmm (.) I was kind of >thinking about↓< what you're saying↓ about you know getting on the bus↑ and missing the stop↑, and not getting here↓ and feeling quite lost really↓ WELL [getting lost]
23	P	[Yeah]
24	T	really↓ but I wonder if in a way↓ what you're telling me about is feeling lost?,
25	P	(4s) ↓ °possibly yeah ° I SEE where you're coming from↓ Yeah↓ aah the last couple of days↓ have been horrible for me °anyway° I >split up< with my ((girlfriend))↓, just losing friends and things ↓n stuff

Conversation analysis. In line 20, the therapists' intake of breath may be a response to the foreshadowing of the patient's turn end and lowered intonation, signalling the therapists' readiness to take their turn, followed by the token, short pause, appreciation and clarification statements, and intonation rise. These features together indicate a Transition Relevance Point that prepares and signals the therapist's turn. There is a further elongation of the turn, preceded by a pause. Intonation increases, and emphasis is used to convey an attempt to contact the patient with a direct question, which overlaps with the patient's answer in line 21.

The therapist picks up the information in line 22; the changes in intonation and faster speech signal a wish to bring focus without perhaps interrupting the patient's predicament. Here, the therapist emphasizes the adverb to bring attention to the affective experience before contradicting herself to the patient's experience of finding oneself lost. The patient offers an affirmative back-channel token in line 23.

In line 24, the therapist links the reality of the situation, emphasizes and models some curiosity whilst offering an interpretation, 'feeling lost', simultaneously re-emphasizing the affective connection of the patient's experience. In line 25, the patient gives a long pause indicative of absorbing the therapist's intervention and then offers an agreement token. The patient emphasizes the therapist's interpretation, with an agreement token in lowered intonation. A continuer precedes the newsmaker with lowered intonation and faster speech, conveying the different aspects of the losses experienced.

Clinical comment. The therapist also notes the patients' ongoing real-world experience, which can be gathered to understand an aspect of their internal world conflict. Successive back-channel markers convey her listening, care, and encouragement for the patient to continue, i.e., her *'right'* signals the TRP and allows the therapist to step in and comment on the difficulties experienced by the patient. The pauses appear to be momentary, for reflection (Jefferson, 1989b)

However, it may also feel intrusive to the patient who responds in overlap as if to cut short the enquiry and perhaps avoid lingering on their absence, which may reinforce their embarrassment at becoming lost. The therapist does this in a slow yet sympathetically tailored manner, piecing together the experiences, actions, and affect involved, linking up the symbolic and unconscious meaning for the patient whilst also modelling a way of slowing down, to focus on what is happening in that moment. In this way, the therapist simultaneously educates the patient, making the link between their external and internal experiences explicit. This builds on their alliance relationship.

The patient seems able to take this in, offering an affirmative response and disclosing another topic contributing to their emotional state. The therapist issues a question to encourage further topic coherence.

These actions together signpost the facilitation of early alliance building as the patient brings material that does not initially seem meaningful to them. This material is sensitively pieced together and offered educatively as an interpretation, inviting further elaboration from the patient.

Establishing an alliance with the patient

Across all samples, therapists establish an alliance with the patient by rebuilding trust, developing mutual understanding of difficulties, and demonstrating alternative ways of thinking. In this example, reframing the patient's affect is illustrated. (See Appendix 7 for full transcript analyses.)

Table 7.

Excerpt 5: Case A, session 9.

Line	Patient / Therapist	Conversational Analysis
2	**T**	ohh so how've you been?
3	**P**	I'm okay ↓ I've been okay↓
4	**T**	good↑
5	**P**	(Breathing sounds, sighs) (4s) okayish ↓
6	**T**	okayish↑
7	**P**	[yeah↓]
8	**T**	[better] than last week↑
9	**P**	yeah
10	**T**	right good
11	**P**	like
12	**T**	mm↑

Conversation analysis. In line 2, the therapist opens the conversational floor with a direct question about the patient's well-being. In line 3, the patient responds with a lowered tone after each affirming statement, suggesting a sense of flatness.

The therapist responds with an acknowledgement token 'good' in line 4 with raised intonation. However, the patient's response in line 5 does not take up the rising

intonation cue. Sighs and a long pause of 4 seconds indicate some difficulty shifting from the affective state, which they repeat.

In line 6, the therapist repeats the patient's feelings as a clarifying question, ‘okayish’, using an upward tone to check in and confirm this state. The patient affirms the therapist's statement in line 7 with a lowered intonation.

In line 8, the Therapist overlaps the patient’s response with a clarifying question, asserts an affective scale to determine state, and compares this to the previous week’s session. This intervention may be modelling to the patient that not all states are the same and shifting them from the vagueness of the word chosen by them.

In line 9, the patient issues ‘yeah’ as an agreement token, which the therapist acknowledges and affirms with ‘right good’ in line 10.

In line 11, the patient offers an opening statement that invites the therapist to attend to their free association. The therapist responds with a token ‘mm’ in line 12 and raised intonation, conveying interest and encouraging further dialogue.

Clinical comment. The patient's lowered tone in line 3 suggests a sense of emotional flatness, while the therapist's raised intonation may offer uplifting encouragement. The intervention in line 8 may be modelling (to the patient) that not all emotional states are the same and attempts to shift the patient's perspective by framing a potential improvement in mood.

In lines 9-12, the patient issues an agreement token, while the therapist issues backchannels with raised intonation in line 12 to encourage elaboration. The patient's

news sharing alerts the therapist to the patient's depressive framing of the experience, while the therapist's responses try to get alongside the patient.

Fostering the alliance with the patient

This theme builds on previous themes and suggests familiarity in the relationship. The therapist recognizes the patient's challenges and enhances their ability to reflect and promote insight. In this example, the therapist encourages patient self-reflection. (See Appendix 8 for full transcript analyses.)

Table 8.

Excerpt 6, Case B, session 19.

Line	Patient / Therapist	Conversational Analysis
14	**T**	so really it feels like(.) like you got here after a long time↑
15	**P**	↓mm its been nearly a °month° about three weeks↓
16	**T**	>its four weeks<
17	**P**	it <u>has</u> been long
18	**T**	Yeah
19	**P**	°mmm °
20	**T**	Yes so its been its been quite↑ hard em °coming here °
21	**P**	°mm °
22	**T**	I think
23	**P**	oh I just needed a little break from everything like I didn't go to name last week either↓ so I had like a week off there (.) and so I'm sort of getting back on track with everything now sort of had my little break(.) from(.) all the <u>different people</u> (laugh) getting <u>back</u> back in my routine now
24	**T**	mmm yes (.)↑so yes I remember you mentioned this last time↓ and I and i was I was wondering well(.) emm (5s) what was it that made you feel you↑ needed a break ?(.) because I think its um(.) seems like you're saying(.) ↑you go ahead and I will

Conversation analysis. In line 14, the therapist reclaims the epistemic gradient, offering clarifying and summarising statements that redirect the patients' attention to their affective experience, encapsulating their effort and the sense of lost time.

The patient acknowledges in line 15, placing and adjusting the time frame. The therapist quickly clarifies the correct time to the patient in line 16, which appears to orient the patient to the reality conveyed through their emphasis in line 17. The therapist

offers an agreement token in line 18, asserting the sense of lost time, which the patient acknowledges in line 19 through their quiet vocalisation.

In line 20, the therapist supports acknowledging the gap, linking the struggle with an upward intonation and the effect of it feeling ‘hard’ in returning. The quietness of the end of the statement conveys an attuned response to the patient's difficulties. The patient gives a quiet/muted acknowledgement token in line 21, as if aligning with the therapist's interpretation/observation.

In line 22, the therapist begins to offer a potential reflection; however, the patient regains the epistemic gradient and floor in line 23, explaining that they took a break, emphasising it was from everyone, indicating that this constituted their type of self-prescribed retreat. The patient emphasises they are back in routine and control, too.

In line 24, the therapist makes acknowledgement and agreement tokens with a slight pause after, reflecting and linking it back to previous material. There are repetitions of the therapist's thinking process, a short pause, a back-channel token, and a long pause. This longer pause signifies the therapist considering their subsequent intervention; they offer some starting thoughts and then redirect the floor, inviting the patient to continue.

Clinical comment. In lines 14-15, the sequence of turn-taking illustrates the patient's ongoing sense of internal and external disorientation, which the therapist brings sharply into focus, perhaps reasserting the external reality and impact of time elapsed between their previous face-to-face contact, as shown in lines 16- 19. In line 20, the therapist articulates therapy's practical and emotional hardships.

Lines 22-24 indicate various clinical interventions employed; the therapist regains the epistemic gradient, particularly the patients' way of managing their emotions through their decision to withdraw from support. The therapist asks a direct, open question, then attempts to do the work in answering, elaborating, explaining, and interpreting (we cannot know exactly) before catching it, holding back, and relinquishing the floor to invite the patient to continue.

Discussion and Conclusion.

This study aimed to examine the opening moments of therapy sessions closely to identify the clinical techniques used by therapists during three therapy sessions in each of two cases.

This exploration focuses on the vocal interaction and its implications between a psychoanalytic psychotherapist and a depressed adolescent patient during the opening three minutes of sessions. This study addresses the current literature's deficit about these opening moments with adolescents.

This study used Conversation Analysis to explore the opening minutes of sessions. Findings suggest that therapists used several linguistic techniques to build clinical techniques to form a therapeutic alliance. Four distinct themes are presented: a)

reconnecting with the patient, b) educating the patient, c) establishing an alliance, and d) fostering an alliance.

Therapeutic alliance is a pan-theoretical concept that draws research attention to its efficacy. Exploring the nuances of opening interactions can illustrate how powerfully perceptions between participants can be generated and affect the dynamic interplay that contributes towards building or stalling a collaborative relationship between participants. This study may prompt clinicians to consider the potential importance of the opening moments of individual sessions in building the therapeutic alliance.

It was striking that the recordings did not show an initial silence at the very opening of the interaction. Therapists used vocal phenomena to slide into an opening interaction with patients, suggesting they were doing something different from Freud's (1913) recommendation on clinical technique.

This illustrates a shift in technique and perhaps within social and cultural expectations to accommodate the adolescent's developmental ego stage and vulnerabilities (Waddell, 2018). Theoretical literature does not address such adaptations, suggesting this phenomenon is relatively under-explored. Furthermore, the minimal silences in these samples may represent an anomaly. These therapists may have been experienced at working with adolescents and adapted their techniques to meet the adolescent stage of development. These enabled them to provide back-channel signals (Yngve, 1970) that reduce the propensity towards a '*Destructive*

silence' that might disrupt the therapeutic alliance of trust and increase resistance being generated (Mullard, 2015).

However, further studies may enhance our understanding of whether opening silences differ across sessions or with differing clinical populations of adolescents.

The analysis also showed an episode of transitional conversation between the dyad in the space outside the therapy room. Winnicott (1958, 2016) discusses transitional phenomena as bridging situations that can contain the patient's affect and offer important communication material. These can be analysed and interpreted through both CA and psychoanalytic perspectives.

The conversation in the transitional space between the waiting room and therapy space may also sit alongside A. Freud's (1946/2018) suggestion that developing confidence between the patient and therapist is being prioritised to support engagement and rapport building.

This presents a dilemma to therapists whereby remaining faithful to a psychoanalytic framework could become compromised by the transitional space, providing a spontaneous and early opportunity to hear about the patients' conflicts. Such transitional moments may also expose an adolescent's ego function in its capacity to tolerate anxiety, offering helpful information about their internal state.

The theme of educating the patient highlighted that non-attendance was an important topic. Both therapists were seen to raise this topic surprisingly early in the session. Additionally, preceding session events, e.g., hearing about mental health risk factors increasing, alongside irregular non-attendance, may also influence how these therapists pursued the topic of missed sessions.

The STPP manual suggests that therapists address non-attendance clearly and promptly, to bring into consciousness any unconscious conflicts the adolescent may have been unaware of (Cregeen et al., 2017). This psychoanalytic approach offers an opportunity to consider these issues and link them with other ways of managing conflicts arising in their relationships.

However, it was surprising that this topic was discussed within the opening of the session, which may suggest that therapists are keen to identify and explore this area quickly.

However, given that non-attendance is an indicator of fragile alliance, which can lead to a propensity to drop out of therapy (de Haan et al., 2014; Kazdin, 1996), further studies concerning how therapists handle early non-attendance may enhance understanding and develop clinical techniques specifically for this population.

Themes of reconnection and establishing and fostering the alliance featured across samples, illustrating that progress in these themes is relative to variables such as preceding contextual factors and the therapists' linguistic skills to support the patient. The opening moments provide a glimpse at these processes developing, suggesting that longer sample lengths warrant attention to better identify and understand these vital aspects of therapeutic alliance building.

The therapists' skills were highlighted using clinical techniques in multiple themes, showing cross-theme utilisation. This means that some techniques extend across the different themes and are theme-transcendent. It also supports the likelihood that multiple techniques can serve each theme.

It needs to be examined whether the clinical techniques employed in the initial moments at the opening of individual sessions can contribute towards successful outcomes.

This study may prompt clinicians to consider the potential importance of the opening moments of individual sessions in building the therapeutic alliance.

Whilst endings were not a focus of this study, their importance as a reference to what has occurred in previous sessions may have implications for how the subsequent opening moments of the next session unfold, suggesting further avenues of research.

Therapist training in the opening moments with adolescents may benefit from a specific training focus to enhance therapist skills during this transitionally sensitive time.

There was no discernible difference or similarity in the therapist's handling of the opening across the different phases of therapy or between the good and poor outcome cases, which could be generalised as having a significant impact in these samples. This may be due to the small sample size and the fact that two sessions were concurrent, as these were available when the samples were selected. Factors such as time in treatment offer a contextual view of the patient's treatment history that the therapist might comment on to support alliance building.

Differences in the therapist's style of interaction and management of topics, particularly non-attendance, are subjective, but further studies are required to determine their influence on alliance building.

Limitations.

The small sample design of this study constrains its application and any broader interpretation of its findings. It is limited to the opening minutes of three sessions, each of two cases, which hinders its ability to extrapolate conclusions without relying on generalising the findings. It cannot be assumed that other studies looking at the opening moments will produce similar findings about silence, missed sessions, and transitional conversations. Nor can it promote or endorse assertions such as the opening moments of sessions as transitional periods where several clinical techniques take place to bridge the activities of therapeutic alliance, e.g., reconnecting with the patient, educating the patient, establishing a therapeutic alliance, and fostering an alliance. Therefore, these findings are limited to this study and cannot claim greater significance, nor can they determine whether a different sample of cases and sessions would yield comparable themes.

The multi-step CA process requires streamlining to make such studies practicable. The audio-recorded material does not allow for contextual factors brought to the experience by either participant, such as body language, somatic experiences, clinical ambience, or impingements in the external environment that may impact the interaction, in the opening moments.

The coding used in the Conversation Analysis is narrow in scope due to the first three minutes of the extract used. Larger samples may yield further conversational devices in the utterances. Additionally, a timestamp against each line may better capture the rhythm and speed of the exchange. However, the process of CA

transcription is prolonged and rigorous, and it is, therefore, expensive to perform on larger-scale projects.

The study was based solely on one psychotherapy modality with two psychoanalytic cases. The identified patient was male in both cases, while both therapists were female. Therefore, the findings are limited to this distinct grouping within the approach of this psychoanalytic modality.

This small-scale exploratory study did not have the scope to incorporate further modalities or introduce diverse or different patients and/or therapists. Nor did it consider endings of previous sessions; therefore, its findings are limited to the cases being considered. The therapists' backgrounds, theoretical orientations, and experience levels are unknown, and their bearing has not been factored into this study.

Clinical implications and future research.

This study offers an initial exploration into the opening moments of therapy, an area of clinical practice that has been under-identified as an area for research. The study shows that therapists' handling of openings is a worthwhile area to explore. Further studies into this area of clinical interest may identify other phenomena occurring during this specific interaction window.

Furthermore, how therapists specifically handle the topic of the patient’s non-attendance within the STPP model could enhance understanding regarding any implications on the patient and track how therapists develop their interventions in this area.

This present study hopes to offer an example of research that explores how participants communicate during the openings of sessions, to stimulate clinical discussion, which might support curriculum development in clinical training for therapists in this area.

This research has aided my clinical practice as a child and adolescent therapist in approaching session openings by prioritising the patient's experience of being received into the session, bearing in mind that for some adolescents, coming to therapy can be hugely anxiety-provoking.

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Appendices

Appendix 1 – Transcription Coding symbols – Jefferson Notation

Transcription coding symbols -Jefferson Notation

° ° between degree signs is quiet

Underline - emphasis

LOUD - capitals

↑ raised upward intonation

→ something of interest to the transcriber:

↓ lowered downward intonation – where marked

(.) short- second or under

(−) timed pause write in the number if over a second up to and including 3 seconds i.e.(2s)

( ) if over 3 seconds write in the timing i.e. 5s or 5m s-seconds m – minutes

? question

?, pitch rise

> word word < faster speech if noticeable

< word word > slower if noticeable

[ ] overlapping utterances

((sound)) something not represented in words/sound vocalisation

[[simultaneous utterances

= no interval between adjacent utterances

]] end of simultaneous utterance

(xxxx) inaudible – or what is believed to be heard

Appendix 2 - Meta-categories of Social Actions

Coding Symbols	Criteria	Meta category
APT	Acknowledgement Previous Topic	Verbalisation
AS	Acknowledgement of surprise	Vocalisation
AT	Acknowledgement Token	Verbalisation
AV	Acknowledgement Vocalisation	Vocalisation
SA	Shows Appreciation	Verbalisation
LP	Long Pause	Non-vocal
Q	Quietly spoken	Verbalisation
SP	Short Pause	Non-vocal
TP	Timed Pause	Non-vocal
CQ	Clarifying Question	Verbalisation
CLQ	Closed Question	Verbalisation
DQ	Direct Question	Verbalisation
FQ	Finishes Question	Verbalisation
OQ	Open Question	Verbalisation
RQ	Redirects Question	Verbalisation
SQ	Starts Question	Verbalisation
BE/I	Begins Explanation/interpretation	Verbalisation
CS	Clarifying Statement	Verbalisation
CT	Continues topic	Verbalisation
DA	Direct Answer	Verbalisation
E	Emphasis	Verbalisation
FS	Faster Speech	Verbalisation
H	Humour	Verbalisation
L	Laugh	Vocalisation
I	Interruption	Verbalisation
ITC	Invitation to Continue	Verbalisation
L	Latching	Verbalisation
LT	Lowered Tone	Verbalisation
MT	Mirrored Tone	Verbalisation
NF	Names Feeling	Verbalisation
OCF	Opens Conversational Floor	Verbalisation
OL	Overlap	Verbalisation
OT	Opens Topic	Verbalisation

Coding Symbols	Criteria	Meta category
P	Placation/ed	Verbalisation
RPF	Repeats Patient Feeling	Verbalisation
RPS	Repeats Patients Statement	Verbalisation
RS	Reassuring Statement	Verbalisation
ST	Shifts Topic	Verbalisation
SS	Summarising Statement	Verbalisation
UT	Upward Tone	Verbalisation

Appendix 3 - Extract 1 Case A session 2

Line	Patient / Therapist	Conversational Analysis
1	P	nose blowing sounds (breath) °hello°
2	T	hello (laugh)°have you got a cold°
3	P	yes, mild cold↓ (nose blowing) how are you↑
4	T	°mm°
5	P	how are you
6	T	°↓ok alright° (2s)
7	P	what shall we talk about today↑ (mumbly)
8	T	(laughs)↑ I don't know (laughter) what you would like to talk about
9	P	shall we follow up my family tree
10	T	aah oh↑yes°↓[you were telling me] °
11	P	[from last week]
12	T	about your family
13	P	= and anything else I need to go over↑ or did I cover all of it↓
14	T	(.) you talked about a lot of things didn't you or whatever you'd like to say ↓(.)is it quite hard to know what to say↑
15	P	[yeah xxxxxx]
16	T	[it can be a bit weird at first]
17	P	[yeah]
18	T	=can't it↑ mmmm
19	P	Yeah
20	T	=don't worry↓ there's no right or wrong so
21	P	I'm just really bored↓
22	T	= you're bored
23	P	= from last week↓
24	T	= oh ↓ (3s)
25	P	I started playing Fur Elyse (.) by Mozart↑
26	T	oh↑(.) because you was °bored°↓
27	P	because I was bored↓
28	T	oh ok mmm what (.) what what made everything so boring↑

Conversational analysis - Extract 1 Case A session 2

In response to the patient taking control and asking a question, the therapist responds in line 2 to the patient's greeting and issued a brief question to check the patient's well-being. Utterances in lines 4-6, show that the therapist issued continuers to hand back the floor. In line 7 the patient asks a question with rising intonation. In line 8 the therapist used a backchannel and laughter to frame their response and names the uncertainty about locating a topic, which bridges the redirection of the question back to the patient, to encourage his free association.

Between lines 10–20, the patient connects a topic to the previous session. The therapist acknowledges with tokens, locating the topic with intonation. In Line 11, the therapist overlaps with the patient's topic placement from the last session and confirms it. in line 13 the patient takes control; latches onto the therapist and asked if further information was needed, through rising intonation and emphasis together with a question. This is followed by a further question with lowered intonation as they reach a TRP.

In line 14 the therapist paused momentarily then posed a clarifying question, acknowledging the volume of topics previously discussed. She makes a reassuring statement conveyed through a lowered tone that aims to put the patient at ease. Another short pause is followed by a clarifying question, acknowledging the difficulty in finding where to locate another topic. In line 15 the patient gives an agreement token (followed by something indecipherable on the recording).

In line 16 the therapist overlaps and follows up the previous statement, acknowledging and recognising the strangeness of the experience for the patient, which is verbalised in a clarifying /reassuring statement. The patient in line17 gives an agreement token. In overlap in line18, Therapist latches onto the patient's response and completes the statement, *'can't it mm'* which adds further clarification and reassurance, followed by an elongated acknowledgment vocalisation signalling their attention.

In line 19 the patient gives an agreement token. In line 20 the therapist latches onto this apparent acceptance by the patient of the difficulty and issues a further reassuring statement lowering the intonation (which offers a soothing quality), followed up by a further clarifying statement which appears unfinished.

Clinical comment

This early interaction captures several themes of reconnecting with the patient; settling back into the therapeutic space, and educating the patient in free association; thus, helping the patient to take control and select a topic. The therapist uses back-channels (Yngve 1970) to facilitate the engagement and evades a direct question.

The patient initially offers a topic inviting revisiting this, however the therapist does not immediately take up a recycled topic from a previous session but waits to see whether the patient can bring a current preoccupation.

The interaction illustrates some of the challenges experienced by the therapist in helping the patient to locate a topic and share their affective state.

The patient refers to a time and emotional state again in the past they may concretely identify with. This offers a route into exploring the patients' thoughts, reconnecting them in a joint topic and begins the unfolding of the patients' experience.

The locating and linking up of the topic, provides a shared sense of task allocation, topic alignment/agreement and shared ownership, illustrating a tentative link of the patient having been able to hold onto an aspect of the work from previous sessions. These different ways of acknowledging what has gone before with bringing the focus back to the present relationship may be another way of supporting the patient to manage the uncertainty together.

Overlapping sequences could be viewed as moment of attunement, dyadic reciprocity and containment where the therapist is attending to the anxiety being brought by the patient's struggle in searching and settling on a topic. The therapist functionally offers containment around the projections of uncertainty, capturing the αlpha elements and transforming them into β-elements (Bion 1962).

These moments appear to form a therapeutic holding (Winnicott (1953, 1971), which serves to alleviate the tension and possibly initiate trust building in the therapist, to manage the patients' affective state.

Appendix 4 - Extract 2 Case B session 11

Line	Patient / Therapist	Conversational Analysis
1	**T**	States date and session number
2		Door opens
3		Door closes
4	**T**	°ss °
5	**P**	hahh aah ohh (breathing) mm
6	**T**	pardon?
7	**P**	we're back↑
8	**T**	yes ↑we <u>are</u> back ↑after some time↑
9	**P**	oh its been two weeks↑ °aahm ° it's been an <u>interesting</u> couple of °weeks °↓
10	**T**	yes↑ °I must say °↓ I have heard <u>something</u> about it↓ about what's been happening to you↑ <u>but obviously</u> its helpful↓ if you↑ tell me what's been happening about °that°
11	**P**	well a couple of weeks ago I got put back in hospital↓ for slitting my °wrists ° and o'ding
12	**T**	o'ding?
13	**P**	yes
14	**T**	on what?
15	**P**	co-codamols↓
16	**T**	co-codamols? are <u>those</u> ↑ pain killers?
17	**P**	yeah and then got put in (hospital name) A&E and they got me off to (place name) overnight↓(.) stayed in (place name) for the night↓ got discharged and then (2s) had to see had to come here for umm to see Dr {name} about my medication (.) and just been feeling ↑ I'm feeling a bit better sort of bits and bobs have been going on since <u>but</u> (.)I've been feeling happier since then
18	**T**	so its been a bit of a rollercoaster for[you↑]
19	**P**	[definitely]yeah↓

Conversational analysis - Extract 2: Case B Session 11

The session begins in line 4 with the therapist making an opening quiet token that appears to be an invitation. The patient takes over in line 5 with their own vocalisations, a breathy sound; potential sound of starting something. In line 6 the therapist offers a clarifying statement/question in an upward intonation to help locate the patient in line 7's statement and invites them to continue.

In line 8 the Therapist responds using the patients' words, emphasises a point, noting the separation length. While in line 9 patient offers a newsmaker acknowledging the time elapsed and drawing curiosity.

In line 10 In response to the patient alluding to an 'interesting' time (which creates a TRP), the therapist picks up the cue with an agreement and quietly emphasizes ambiguity about the events and invites the patient to elaborate. Following this the patient in line 11 offers further newsmaker information stating the topic (hospital admission due to a suicide attempt). In line 12, the therapist clarifies the information through repeating the patient's words, which she ends on a quiet note, (foreshadowing the natural TRP), while simultaneously showing concern.

In line14, the therapist asks a factfinding question which is answered by the patient in line 15. while in line 16 the therapist repeats the word and name of the substance. This echoing may serve as a checking function to ensure they heard it correctly. It is followed up with a question regarding their purpose with emphasis.

This invites the patient to share further information in line 17; the Patient's narrative is fast and factual, conveying the events and their affect through intonation changes.

In line18 Therapist makes a simultaneous clarifying and summarising statement using a metaphor that encapsulates an interpretation yet checks in with the patient whether that has indeed been the patient's experience of emotional fluctuation in the intervening gap. It is met (line19) in the final moment by an overlap of agreement which also conveys the patient's affective state in the lowering of intonation.

Clinical comment

In lines 7-8 the repeating of words with emphasis conveys perhaps a sense of uniting themselves back together, realigning themselves to the therapeutic task. after a period of unplanned absence related to the patients' suicide attempt. The therapist offers her knowledge that there had been a significant event, this may symbolize to the patient being held in mind. The therapist shows concern and curiosity about the patients experience whilst showing empathy and letting them know they have a space to share this.

The use of continuers, tokens, newsmakers highlight a use of backchannels (Yngve 1970) create the contextual building of shared understanding of the topic around which to focus. The therapist symbolizes and articulates making conscious using a metaphor to describe the patients fluctuating experience (Bucci 1982; Bucci and Freedman 1978).

This responsiveness signposts an area of continued difficulty in the patient experiences. Attending to this material early in the interaction may indicate the quality of the relationship as open and trustworthy.

Appendix 5 - Extract 3: Case A Session 8

Line	Patient / Therapist	Conversational Analysis
1	T	↑do you mind if I put that on↑
2	P	no reply
3	T	↑Aah so I haven't seen you for ages↑
4	P	°Just been busy with stuff ° (.) so I couldn't come last week I was breaking up with my girlfriend↓(.) ↓was really (3s) thinking about it↓
5	T	mm before Easter↑
6	P	a week before easter↓ I just completely forgot about it
7	T	°ok °↓
8	P	and then I looked at the post↓ and thought oh↑ I should be there↑
9	T	did you get the letters↑
10	P	mm
11	T	↓yeah? Cos↑ you didn't ring to let us know↓
12	P	Just completely forgot↓
13	T	°ok ↓ok ° so↑ you decided to come today
14	P	yes↑
15	T	and you do want to come↑
16	P	Yes↑
17	T	=do you want to come so you want to come from now on↑
18	P	=mmm yes mmm
19	T	Well↑ its Good to see you↑ wasn't sure if you'd make it or not↓ Yes so(.) God↑ lots been going on then?↑
20	P	Suppose↓ (4s) I broke up with my girlfriend on Monday(.) which was depressing↓
21	T	Last week?↓
22	P	Yeah↓
23	T	°Wh at ° happened?↑

Conversational analysis - Extract 3: Case A Session 8

In line 1 the therapist opens the conversational floor with a question (it's unclear what the object is that is asked about), but no verbal response is given.
In line 3 Therapist initiates entry into the topic of the gap between sessions through a raised intonation and back channels-token and newsmaker to enliven the patient to the topic.

In line 4 The patient issues an initial statement '*just been busy*' which functions to illustrate a preoccupation, that they elaborate on after a short pause. The patients' troubles-telling is interspersed with another short pause and a longer pause, and the affective intonation after each pause offers a view of the patient's current concern.

In lines 5-6 the therapist issues a token and brief questions about the timing of the incident while the patient offers more detail about the timing of the break-up, with lowered intonation and an admission about forgetting about the session. In lines 7-8 The therapist acknowledges the patients' responses, and the patient offers further details regarding their realization of not attending the session.

In line 9 the therapist clarifies through a direct question the receipt of correspondence. While in line 10, the patient offers a short acknowledgement of this, as it appeared contained in their previous turn.

In line11 the therapist appears uncertain through lowered intonation and provides an ambiguous affirmative acknowledgment.

The therapist further seeks to clarify the patient's response by stating the patient's lack of communication or acknowledgment of the letters and missed session. The patient then offers a clarifying statement in line 12 that mirrors the previously given reason.

In line 13, the Therapist makes an interesting intervention where an acknowledgment of acceptance is followed by a lowered intonation, and another acknowledgement of the patient's possible state of mind at the time. Then, the therapist asked a direct question about attendance for this session, which the patient give an affirmative token in line 14.

However, in line15, the therapist follows it up with a more straightforward, direct question, emphasising whether the patient is committed to attending therapy with an upward intonation The P again replies in an affirmative agreement token in line 16, where the intonation also appears mirrored.

In line 17 the therapist latches onto the patients answer issuing two back-to-back questions; a direct question and a clarifying question with added emphasis on a commitment to future attendance. The patient mirrors the latching on and gives acknowledgement and agreement tokens in line 18.

Clinical comment

The session begins by the therapist checking the patients' comfort illustrates concern and holding in mind the patient's wellbeing. No verbal response is given.

Initially it is unclear whether the gap between sessions is a preplanned occurrence or that the patient deliberately missed/avoided engaging with the treatment plan.

The therapists' quiet tone in line 7 may serve to align themselves in an empathetic way to the patient's news and explanations. The Therapist invites an opportunity to clarify events after the acknowledgement in line 11, followed by the expected social action to educate them. This may confront the patient's ambivalent stance and be perceived as a rupture.

The therapist's double acknowledgment In line 13 may aim to reassure the patient or repair an accusation of non-conformity. Although the reason remains unclear, it leads to an affirmative response from the patient, indicating agreement with the patient's wish to be present.

This exchange provides potential insights into the challenges of establishing a therapeutic relationship. Missed sessions, poor attendance, and overlooked correspondence may indicate the patient's difficulty in maintaining awareness of the available space for addressing emotional conflicts. Instead, there is a withdrawn attitude toward remaining in contact.

The therapist initially avoids provoking the patient and diligently gains insight from the patient but. The therapist focuses on assessing the patient's commitment level and securing ongoing treatment. This approach may demonstrate to the patient that the therapist is present and able to handle the emotional challenges and actions of the patient. However, this is not explicitly stated at this early stage.

After the absence being raised, pursued and an agreement sought, the therapist moves to a reassurance as if to cajole the patient into a more co-operative stance. This evasive quality of the patient's response here and in previous utterances in the session makes it seem as though the patient is hard to get hold of and this is where the therapist appears to focus much of their energy.

This quality of the therapeutic relationship appears ambivalent or tenuous, with the therapist seeking a commitment to the fundamental task in engaging with a therapeutic treatment before the goals and alliance can be established. It seemed that in comparison to the earlier session where establishing the topic and the therapeutic relationship appeared livelier the start of this session sees the adolescent and therapist dyad as more subdued.

Appendix 6 - Extract 4 Case B Session 3

Line	Patient / Therapist	Conversational Analysis
1	T	states date and session number
2		Door opens
3		Door closes
4	T	ehmm the heaters not working↓so I've (this fan)
5	P	yeah That's fine↓
6	T	if it gets too cold↓ or or If it gets too↑ hot I can switch it off
7	P	yeah that's fine↑
8	T	yeah↓ Oh (.) Ok so you we're telling me↓ um (.) that you got lost↓
9	P	yeah [I decided] to to take the bus
10	T	[last week?]↑
11	P	cos from my school ↑there's a bus that comes right here↑
12	T	mm
13	P	=but↓ it was >they must have took a diversion or something<
14	T	mmm
15	P	>I don't know what<↓ cos I ended up in↓ somewhere completely different↑
16	T	mmm yes
17	P	realised that↑ sort of got on another bus↑ to come back here↓ >and then< I had my headphones in↑ and it just completely missed my stop↓ and I just end up being so late
18	T	so you were coming from school?↑
19	P	yeah↓
20	T	right (inhale) (.) ehmm (2s) but of course↑, well >thank you< for for telling me↓ ehmm (3s) did you↑ I wrote↑ to you↓ [did you receive my letter]?
21	P	[yeah I got the letter yes]
22	T	(2s) but I↑ ehmm (.) I was kind of >thinking about↓< what you're saying↓ about you know getting on the bus↑ and missing the stop↑, and not getting here↓ and feeling quite lost really↓ WELL [getting lost]
23	P	[Yeah]
24	T	really↓ but I wonder if in a way↓ what you're telling me about is feeling lost?,
25	P	(4s) ↓ °possibly yeah ° I SEE where you're coming from↓ Yeah↓ aah the last couple of days↓ have been horrible for me °anyway° I >split up< with my ((girlfriend))↓, just losing friends and things ↓n stuff
26	T	°mmm °
27	P	just hasn't been a good week↓ really↑ anyway↓
28	T	So what happened?↑

Conversational analysis - Extract 4 Case B Session 3

In line 4 the therapist opens the conversational floor using an acknowledgement *'ehmm'* in preparation for sharing information about a fault in the heater not working. This sets up an epistemic gradient where the therapist takes control of the conversation. In line 5 the patient issues back-channel agreement.

In line 6 the therapist lets patient know they can adapt the temperature for comfort, showing she is placing his comfort needs foremost. She uses intonational pitch changes that unconsciously simulate the temperature falling or rising, with added emphasis on the rising intonation of the words, to make her point. In line 7 the patient issues back-channel agreement.

In line 8 the therapist acknowledges the patient's answer, issues an acknowledgement token, followed by a short pause (as she seems to gather herself) and a further token *'Ok' to* return to the topic /theme during the transition to the clinical space. She emphasises the action word *'telling',* which primes the patient to respond to the command to continue to explain.

The lowered intonation after her self-referencing, followed by an acknowledgement token and a second's pause, redirects her back to the patient's experience, which she verbalises, simultaneously reminding him of where they had gotten to in their prior conversation about his troubles.

In line 9 the patient issues an acknowledgement token, sharing their decision, then repeats a word as though hesitating. In line 10 the therapist overlaps the patient with a direct question to confirm the incident time in the previous week. The patient explains by emphasizing where the journey began in line 9, offering the type of transport and directness of the route with rising intonation, simultaneously conveys their intention to attend the session.

In line 12 the therapist issues a token '*mm',* that they accept this explanation and encourage them further. The patient latches the previous token in line 13 and lowers the intonation after the discourse marker *'but'*, then, in faster speech, explains their understanding of the situation.

The therapist offers a longer token *'mmm'* in line 14 and the Patient continues with fast speech, expressing their uncertainty about the situation in line 15, with further lowered intonation and then emphasising their surprise at being somewhere completely different and unexpected.

L16 Therapist makes both the acknowledgement tokens *'mmm yes'*. The Patient continues to explain, adding emphasis '*another bus'* to their added bus journey in line 17. They create further drama through faster speech around the continuer discourse marker, explaining their added difficulty that is signalled through a rise in intonation. The ongoing difficulty and disappointment in this, are seen through the falling intonation and emphasis on the discourse marker *'and then'*, adding weight to the predicaments the patient found themselves in that day.

The therapists only make these small acknowledgement tokens and relinquish the conversational floor over several turns, allowing the patient to offer their explanation. This provides more material to glean the patients' experience finding their way (or not) to their session.

In line18, the therapist poses a clarification question, which conveys their attentiveness to the patients' dilemmas, and the patient confirms this through an acknowledgement token in line 19 but with a falling intonation perhaps to convey a variety of feelings at the situation.

In line 20 The therapists' intake of breath may be a response to the foreshadowing of the patient's turn end and lowered intonation, signalling the therapists' readiness to take their turn, followed by the token, short pause, appreciation and clarification statements, and intonation rise. These features together indicate a Transition Relevance Point that prepares and signals the therapists turn. There is a further elongation of the turn, preceded by a pause. Intonation increases, and emphasis is used to convey an attempt to contact the patient with a direct question, which overlaps with the patient's answer In line 21.

The therapist picks up the information in line 22; the changes in intonation and faster speech signal a wish to bring focus without perhaps interrupting the patient's predicament. Here, the therapist uses emphasis on the adverb to bring attention to the affective experience before contradicting herself to the patient's experience of finding oneself lost. The patient offers an affirmative back-channel token in line 23.

In line 24 the therapist links the reality of the situation, emphasizes and models some curiosity whilst offering an interpretation *'feeling lost'* simultaneously re-emphasizing the affective connection of the patient's experience.

In line 25, the patient gives a long pause indicative of absorbing the therapist's intervention and then offers an agreement token. The patient emphasizes the therapist's interpretation, with an agreement token in lowered intonation. A continuer precedes the newsmaker with lowered intonation and faster speech conveying the different aspects related to the losses experienced.

In line 26 we see an acknowledgement token *'mm'* which appears to convey empathy as the patient can share the difficulties and convey their affect; observed by the consistent lowered intonation after the statements made and quietening before more troubles telling of further disruption and loss occurring in line 27.

In line 28 the therapist picks up the patients' emphasis and pitch changes signifying the TRP and asks a declarative question inviting a response.

Clinical comment

By raising the issue of comfort, the therapist develops a containing environment which could be viewed as a precursory action to building an alliance. The therapist returns to a topic begun transitionally outside the therapy room. This is interesting and we can only speculate who initiated the interaction or topic choice, but the therapist indicates the information was offered up by the patient.

This might be an attempt to explain the missed last session, to pacify the therapist whilst also gaining some control (creating an epistemic power bid).

The reclaiming and returning to the topic, illustrates the therapist holding in mind the patients' various difficulties' in finding their way back to the therapy session. This maybe an important aspect of locating the patients' preoccupations through signalling a topic. It may also be indicative of the patients' familiarity of the therapeutic frame, and of conforming to social courtesy in offering up an explanation and their engagement and attachment to the developing therapeutic relationship.

The therapist also notes the patients' ongoing real- world experience, which can be gathered up to understand an aspect of their internal world conflict. Successive back-channel markers convey her listening and, care and encouragement for the patient to continue, i.e. her *'right'* signals the TRP and allows the therapist to step in and comment on the difficulties experienced by the patient. The pauses appear to be momentary, for reflection (Jefferson 1989b)

However, it may also feel intrusive to the Patient who responds in overlap as if to cut short the enquiry and perhaps avoid lingering on their absence which may reinforce their embarrassment at becoming lost. The therapist does this in a slow yet sympathetically tailored manner, of piecing together the experiences, actions and affect involved, linking up the symbolic and unconscious meaning for the patient whilst also modelling a way of slowing down, to focus on what is happening in that moment.

In this way the therapist simultaneously educates the patient, making explicit the link between their external and internal experiences. This builds on their alliance relationship,

The patient seems able to take this in, offering an affirmative response, and disclosing a further topic that has contributed to their emotional state. The therapist issues a question to encourage further topic coherence.

These actions together signpost facilitation of early alliance building as the patient brings material that does not initially seem meaningful to them, which is sensitively pieced together and offered educatively as an interpretation and invites further elaboration from the patient.

Appendix 7 - Extract 5 Case A session 9

Line	Patient / Therapist	Conversational Analysis
1	T	states Case number date and time
2	T	ohh so how've you been?
3	P	I'm okay ↓ I've been okay↓
4	T	good↑
5	P	(Breathing sounds, sighs) (4s) okayish ↓
6	T	okayish↑
7	P	[yeah↓]
8	T	[better] than last week↑
9	P	yeah
10	T	right good
11	P	like
12	T	mm↑
13	P	ok↑ but not any high↑lights↑
14	T	right↓
15	P	nothing I can say that I wanted to do that [again↓]
16	T	[pardon↑]
17	P	>anything nothing< I wanted to say ↑oh I ↓want to that again↑
18	T	[okay↑]
19	P	[so I] went to (.) I wouldn't call it a party but(.) I went to an outing on Saturday↓
20	T	mm↑ what was that for?↑
21	P	that was supposed to be a party and then it rained↓ so we were under a gazebo↓(.) cos it rained
22	T	[right↓]
23	P	[going] to [LOCATION NAME}↑
24	T	mm ↑↑ and you stood under a gazebo↑ [(laughs)]
25	P	[mm]
26	T	>it was very wet ↑wasn't it<
27	P	[Yeah its cold↓]
28	T	[on Saturday↑]
29	P	right and I was the only one who was warm↓
30	T	Oh↓

31	**P**	Cos I was the only one who prepared↑
32	**T**	ok↓ whose party was it?↑
33	**P**	It was {NAME}↑one of my friends↑
34	**T**	ok↑ uh well that sounds better than >staying in your bedroom not talking to anyone feeling miserable<

Conversational analysis - Extract 5 Case A session 9

Therapist opens the conversational floor in line 2 with a direct question enquiring about the patient's well-being. In line 3 the patient responds with lowered tone after each affirming statement, suggesting a sense of flatness.

The therapist responds with an acknowledgement token *'good'* in line 4 with raised intonation. However, the patient's response in line 5 does not take up the rising intonation cue. Sighs and a long pause of 4 seconds indicate some difficulty shifting from the affective state, which they repeat.

In line 6 the therapist repeats patients' feelings as a clarifying question *'okayish'* using an upward tone to check in and confirm this state. The patient affirms the therapists' statement in line 7 patient with a lowered intonation.

In line 8 Therapist overlaps Patient's response with a clarifying question, asserting an affective scale to determine state, and locating this in comparison to the previous week's session. This intervention may be modelling to the patient that not all states are the same and shifting them from the vagueness of the word chosen by them. The patient issues *'yeah' an* agreement token in line 9. which the therapist acknowledges and affirms with *'right good'* in line 10.

In line 11 the patient offers an opening statement that invites the therapist to attend to their free association. the therapist responds with a token *'mm'* in line 12, and raised intonation, conveying interest and encouraging further dialogue.

The patient finishes their statement in line 13 with another acknowledgement token to describe the experience but shifts the intonation (possibly mirroring the therapists'), which is perhaps mocking. The patient clarifies that the experience did not offer anything extraordinary.

In line 14 the therapist issues a token *'right'* with the opposite intonation to downplay the sarcasm. The patient extends the explanation in line 15 with a negative view of the experience and emphasizes the activity in a lowered tone, which the therapist overlaps. The therapist overlaps using a clarifying token '*pardon'* in line 16 as if acknowledging the information but seeking more information. The patient quickly repeats the essence of their previous statement in line 17 with an opposite intonation to further emphasize their disappointment with the activity.

In line18 the therapist acknowledges the patient's response mirroring intonation. This overlaps with the patient beginning to explain in line 19. Perhaps this acknowledgement signals the patient to offer more information, they pause momentarily as they decide how to describe the event attended, before going on to clarify the nature of that event.

In line 20 the therapist acknowledges vocalisation in upward intonation, followed by a direct question, *'mm what was that for'* to draw the patient into offering more context to their experience. The patient responds to the direct question in line 21 by giving context. Interestingly, there is lowered intonation after the weather description, emphasis with lowered intonation, and a pause as if to punctuate the awfulness of their experience, followed by repeating the weather situation.

In line 22 therapist offers the token *'right'* in lowered intonation, mirroring the disappointment and conveying empathy for the predicament. The patient overlaps in line 23 letting the therapist know where they were heading. In line 24 the therapist issues another token in rising intonation, clarifying what occurred, injecting some humour/laughter into the scenario. Line 25 sees the patient acknowledge vocalisation in overlap but doesn't join in with the therapist's laughter.

In Line 26 using faster speech, the Therapist tempers her previous response by emphasizing the weather conditions with rising intonation and seeking affirmation. In line 27 the patient states the weather situation with a downward intonation, which is overlapped in line 28 by the therapist, who refers to the day with a direct question to check that they are referring to the same day/situation.

The patient further elaborates in line 29 on their predicament and then relates it to being the only one managing to keep physically warm, with a lowered intonation, which conveys some disappointment. In line 30 the therapist follows this up with a surprise acknowledgement mirroring the patient's intonation. The patient reverts to the previous point in line 31, emphasising the unique position they found themselves in due to their foresight. The therapist acknowledges the information with downward intonation in line 32, shifting the topic's focus to the event's purpose.

In line 33 Patient responds by giving the name of the friend, with rising intonation, that has a positive effect on patient. The Therapist acknowledges the reply in line 34 and interprets it as encompassing a reassuring statement and naming a feeling.

Clinical comment

The patients lowered tone in line 3 might suggest a sense of emotional flatness while the raised intonation by the therapist may offer an uplifting encouragement. The intervention in line 8 may be modelling, (to the patient) that not all emotional states are the same; and attempts to shift the patient's perspective through framing a potential improvement in mood. In lines 9-12 the patient issues an agreement token, whilst the therapist issues back-channels with raised intonation in line 12 to encourage elaboration.

The patient's news sharing alerts the therapist of the patients' depressive framing of the experience. While the therapists' responses try to get alongside the patient. Between line 18-26 the therapist again appears to work towards building some shared understanding of the situation and reframing it offering some modelling of how to flip the unfavourable circumstances, using humour to emphasise their situation.

Between lines 27-30 the participants come into contact around the patients' experience. The therapist offers minimal intervention as the patient shares some of the difficulty they experienced, however the therapist does not link to the concrete temperature shifts experienced to any affective state the patient is unconsciously bringing. This could be viewed as a misalignment.

In lines 32-34 the therapist shifts the focus of the topic, reframing the patients experience, focusing on the patients' actions and perhaps bringing the patient's

attention to their own unconscious behaviour to shift their own mood. Reframing allows some remodelling of mentalization processes.

Appendix 8 - Extract 6 Case B session 19

Line	Patient / Therapist	Conversational Analysis
1	**T**	States date & session number
2	**T**	mm
3	**P**	oo waah↑huh
4	**T**	huh↑ (laughs)
5	**P**	huh (laughs) I'm here↑
6	**T**	yes↑ (laughs) I can see↑ yes
7	**P**	↑I was on my way here last week and then I remembered doh=
8	**T**	=↓Oh did [you?]↑
9	**P**	[cos] I completely forgot cos I didn't write it in my calendar to say that it was like >cancelled an I was like oh yeah I got counselling< and then I got half way here an I was like wait no I don't↑
10	**T**	=oh god↑
11	**P**	= it was fine↓ (laughter) I was round my >girlfriends like anyway so it was cool<
12	**T**	Right
13	**P**	Yeah
14	**T**	so really it feels like(.) like you got here after a long time↑
15	**P**	↓mm its been nearly a °month° about three weeks↓
16	**T**	>its four weeks<
17	**P**	it <u>has</u> been long
18	**T**	Yeah
19	**P**	°mmm °
20	**T**	Yes so its been its been quite↑ hard em °coming here °
21	**P**	°mm °
22	**T**	I think

23	**P**	oh I just needed a little break from everything like I didn't go to name last week either↓ so I had like a week off there (.) and so I'm sort of getting back on track with everything now sort of had my little break(.) from(.) all the <u>different people</u> (laugh) getting <u>back</u> back in my routine now
24	**T**	mmm yes (.)↑so yes I remember you mentioned this last time↓ and I and i was I was wondering well(.) emm (5s) what was it that made you feel you↑ needed a break ?(.) because I think its um(.) seems like you're saying(.) ↑you go ahead and I will

Conversational analysis - Extract 6 Case B session 19

In line 2 the therapist opens the interaction with a back-channel token *'mm'* which signals an invitation to the patient who responds with their own vocalisations in line 3, using an upward intonation as if seeking something.

The therapist catches/ mirrors the sound and laughs in response in line 4 which appears to prompt the Patient in Line 5 in a mirroring gesture followed by a newsmaker comment stating his presence.

In line 6 the therapist makes an acknowledgement of this, again laughing which may be a combination of shared humour of the opening moments of apparent awkwardness in reconnecting and mirroring.

As the patient explains the situation in line 7, the therapist latches onto the Patients news-sharing in line 8, perhaps thinking this was the end of the turn. Then in a lowered intonation and expression an *'Oh'* of surprise, and in recognition of the patient's news. This is overlapped by the patient in their next turn line9, as though they (P) hadn't finished the explanation. Here the patient rushes through their explanation highlighting their actions and remembering there was no session with a rising intonation.

In line10 the therapist again latches on with an *'oh god'* backchannel expression of dismay at the Patients' predicament of forgetting and late remembering of the cancelled session.

The patient latches on to the Therapists dismay in line 11, offering a placatory explanation, adding humour into their situation; However, this is said quickly so as to perhaps speed over the embarrassment, (shown as laughter) and information, whilst using a universal token of 'cool' to demonstrate how they managed the dilemma as though it was easily solved.

In line 12 the therapist verbalises an agreement token as though accepting the situation for what it was and the patient's explanation of it which the patient follows up in Line13 with their own agreement token.

In line 14 the therapist retakes the hold of the epistemic gradient, offering both a clarifying and summarising statement that bring the patients' attention back to the affective experience which encapsulates the patients' effort, and the sense lost time.

The Patient issues acknowledgement in line 15, placing and adjusting the time frame. The Therapist quickly clarifies the correct time to the patient in line 16.
In line17 this intervention by the therapist appears to orient the patient to the reality which is conveyed through their emphasis. The therapist offers an agreement token in line 18 which perhaps asserts the sense of lost time, which the patient acknowledges in line 19 through their quiet vocalisation.

In line 20 the therapist moves to support the acknowledgement of the gap, and links it by naming the struggle with an upward intonation and the effect of it feeling *'hard'* in returning.

The quietness of the end of the statement possibly conveys an attuned response to the patient's difficulties. The patient gives a quiet/muted acknowledgement token in line 21, as if aligning with the Therapist interpretation/observation.

In line 22 the therapist begins to offer a potential reflection; however, the patient then regains the epistemic gradient and floor in line 23, giving an explanation advising they took a break emphasising it was from everyone and indicating that this constituted their own type of self-prescribed retreat. The patient emphasizes they are back in routine and control too.

In line 24 the therapist makes both acknowledgement and agreement tokens with a slight pause after, as though reflecting on it and linking it back into previous material. There are repetitions of the therapists thinking process, a short pause, backchannel token, then a long pause. This longer pause offers a moment of the therapist considering their next intervention; they offer some starting thoughts then redirect the floor inviting the patient to continue.

Clinical comment

Reconnection and hearing from the patient help to re-establish the alliance which has had a stop start quality over the therapy span. The therapist offers a range of back-channel devices to encourage the patient's free association and self-refection, alongside acknowledging and naming these in relation to attending therapy.

The sharing of humour in lines 2-6 alongside the mirroring between participants may point to a degree of familiarity and rapport, which eases the transition from outside the room to inside, picking up the thread of the relationship/alliance. In lines 7-12 the use of back-channel devices by the therapist, in response to the patient's situation, offers an empathic responsiveness by the therapist. This aligns the therapist with the predicament and inconveniences caused to the patient by their own confusion. The therapist manages to regain the conversational floor, simultaneously taking over the epistemic gradient.

In line 14-15 the sequence of turn-taking illustrates the patient's ongoing sense of internal and external disorientation, that is brought sharply into focus by the therapist, perhaps reasserting the external reality and impact of time and distance between their previous face to face contact as shown in lines 16- 19. In line 20 the therapist makes an articulates the difficulty of therapy, in practical terms and the emotional hardship.

In lines 22-24 the various clinical interventions being employed here indicate the therapist regains the epistemic gradient; particularly the patients' way of managing their emotions through their decision to withdraw from support. The therapist asks a direct open question then attempts to do the work in answering; elaborating, explaining, interpreting – (we can't know exactly) before catching it, holding back and relinquishing the floor to invite the patient to continue.

Part 3: Reflective Commentary

How do therapists become researchers?

Reflective commentary.

Candidate number: **KVNT6**

Word Count: 3,810

How do therapists become researchers? A reflective commentary.

This paper considers my journey in learning to become a researcher alongside Clinical training to become a child psychotherapist. Since the topics of this doctorate have considered factors about how therapists develop therapeutic alliance, alongside how therapists manage opening moments of therapy, in bringing this journey to a close I would like to explore my how my relationship and alliance with research worked the through Paranoid-schizoid position facing various themes of uncertainty, resistances and ambivalence, with fluctuating depressive position gains that facilitated bringing this project to a close.

Klein (1946) describes how the infantile ego alternates between being integrated and disintegrated, creating emotional states in the mind/body which hold anxiety components of fear and uncertainty that can split the ego and its objects into good and bad fragmented parts. Simultaneously, as these part objects move towards integration and reparation, a depressive position can be found where a relationship to tolerating frustration and persecutory anxieties can evolve into rekindling alliances with those split-off objects.

The structure of this paper adapts subheadings from both my literature review and uses some for the categories from findings in the empirical review.

Personal motivation

My interest in how therapists work during the opening moments of therapy evolved out of my desire to understand how therapists begin to engage and hold adolescents in a meaningful conversation and how therapeutic relationships develop.

The curiosity also appeared out of my work with pre-clinical work with adolescents in school settings, which presented me with trying to understand the puzzling range of interactions of adolescents referred for therapy. This became the subject of my Infant observation master's dissertation, where my direct experience of developing a transference relationship highlighted the struggles some adolescents experienced with how to use a therapeutic object; from coming to sessions to making tentative contact, testing out the object, or breaking off contact or non-attendance. These experiences led me to wonder about a range of questions: How do psychoanalytic practitioners handle the beginning, or more specifically, the opening moments of therapy sessions? How is therapeutic alliance built? What occurs in interactions between participants at the beginning of sessions? Is there a consistent psychoanalytic approach in operation, or are there differences between how therapists work during these opening moments? I was curious about what therapists knew, or had to consider, i.e., the distinctions between learning to build a therapeutic relationship and a therapeutic alliance. In retrospect, as a prospective trainee and then as a child and adolescent psychotherapist in training, I was looking for a concrete manual of what to do and say and a way of structuring and supporting these early moments of our relationship.

Buy in – negotiating early alliances.

My interest in selecting the Independent Psychoanalytic Child & Adolescent Psychotherapy Association's Child training design of the research training was compositely situated alongside the clinical training. I hoped that both the direct clinical experience and research development I would undertake would naturally inform each

other. I slowly understood that they can and do, but there were realities to face, raising further questions; why was I embarking on developing two distinct types of working alliances? i.e., to develop as a researcher with minimal empirical experience, whilst training as a clinician, when I felt uncertain about navigating the latter. Developing an alliance to research required examining my uncertainty about the scope of my chosen topic; you do not know what you do not know. This meant I needed to allow some playful curiosity to appear, whilst bearing with a wish to know and have a clear question to pursue. The struggle, perhaps to balance the uncertainty also held within it, managing some ambivalence; this also stemmed from the scale and formality of the tasks ahead.

Developing a researcher alliance with myself and the literature took time to evolve. I think part of this, in retrospect, was recognising and bearing the overwhelming sense of managing the wealth and richness of theoretical and empirical literature available; how to tackle this search for information and identifying a gap, needing to learn a new language of research terms, including incorporating the Conversation Analysis (CA) methodology. All of these tasks felt enormously daunting and brought apprehension, which was to be expected. Some of this was helpfully debated in various workshops with my year group cohort, some of whom became part of the core research group. Personal analysis, research supervision during clinical training, and the empirical work supported my journey. These structures helped to bind some of my primary anxieties, to enjoy the journey as a potential researcher, allowing for questions to gather, which helped to lessen some of my initial uncertainty and ambivalence.

Part of the research development also required balancing when to suspend the clinical lens to allow my alliance to become a researcher to take shape. This felt like a more difficult side to negotiate, but I recognised that we could consider these issues together with my fellow research trainees, with whom a project group was formed. Our experienced research supervisors who were experienced with the CA method (which was the group's pre-determined process method) would be guiding our studies in using the data supplied by Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study; Goodyer, Reynolds, Barrett, Byford, Dubicka, Hill, Holland, Kelvin, Midgley, Roberts, Senior, Target, Widmer, Wilkinson, & Fonagy, (2017). This took some pressure off the group to decide on methodological approaches, offering a chance to understand why the CA was being adopted and its transferability to psychotherapy research. Still, the CA approach brought a new framework of material to consider with new learning processes.

Balancing working alliances – placement, clinical training, and research.

During my clinical placement, there was also a parallel process of developing clinical learning with research learning. As research demands of listening to IMPACT data material and developing a familiarity with the differing layers of transcription increased, clinical commitments also expanded. I felt there was less time to devote to research tasks, with no time allocation from the clinical placement to support this area of my development. Research tasks needed to fit around the clinical work, preparation for supervisions, and the energies of commuting between the physical and psychic triangulation of these separate areas, which included four times per week in-person

personal psychoanalysis element. However, I was fortunate to have colleagues in my clinical placement who shared my interest in therapeutic alliance and held my research in mind, which helped. As research seminars got underway, there was joint support from my research working group about ideas, reading, and undertaking the literature review areas.

Nurturing research interest

Between considering the direction of my research into the beginnings of sessions and linking this with my early interests, I realized I needed to grapple with different questions and issues that aligned with those I needed to consider in setting up my psychotherapy cases. There are various questions about what was or was not known, how to approach scoping the territory of therapeutic alliances and therapeutic relationships, and why the beginnings or opening of sessions might be a relevant area to focus upon and feel relevant to pursue.

I was also interested in how the interactional process could be captured through close observation using the Conversation Analysis method, which piqued my interest in understanding the technical details, their meaning, and learning about the CA theory. This I later came to realise could be both an asset and a limitation, i.e., knowing when to put in my boundaries of what could be realistically captured and analysed within the time, reporting space, and design of this study. Additionally, periods of feeling disorientated, not knowing how to understand the field of study, caused me to jump into research theory, thereby developing my own selective biases about what I believed would be found, these needed to be restrained to allow the themes from the data to appear naturally and discern their clinical meaningfulness.

Approaching the idea of research design and delivering an empirical project felt quite overwhelming; I came to realise that together with my research peer group, we would be learning to navigate these tasks. This meant having to manage my expectations and ideas and letting go of what my earlier experiences and thoughts of research had been to work in this new way, both as part of a group and as a lone explorer. I came to appreciate a period where sharing our collective hopes, ideas, and anxieties, guided by the experience of supervisors, allowed for some of my thoughts to take shape.

Developing researcher skills and competency.

The phase of developing a question and starting on a literature search felt disconcerting. Mapping what was known, trying to understand studies, search terms, and finding /not finding studies relating to my area of interest, brought the enormity of the task into focus. Not knowing what you do not know led to reading a variety of studies across psychological modalities and methodologies, which helped to gain momentum at times and increased my motivation. At other times, balanced against competing priorities, my attentiveness waned. My confidence in understanding what was and was not present in the literature, discussing these with supervisors, eventually led to refining the question towards considering the therapists' perspectives in the handling of interactions and their intersubjective processes occurring within the material and data, together with my development as a researcher. As I grew more comfortable with listening to the IMPACT recordings, I began to develop my appreciation for closer listening to the nuances; differentiating intonation, pause lengths, types of questions, interruptions, narratives, and sequences of turns as interpretation was developed.

Linking this with the CA brought some rewards as I widened my observation of how people spoke in different situations, across both therapeutic and wider social contexts. Nevertheless, the actual process of research learning to look at sections of turn-taking excerpts was a steep learning curve, although surprisingly I found myself genuinely enjoying being immersed in the data, seeing how themes appeared, developing psychoanalytic perspectives of the sequences, and sharing these insights.

Our research group also fostered a sense of collective research development, but also inevitably raised differences in our experiences as researchers, our motivation for research, and our alliances to our projects. I sometimes struggled to make sense of my research material, develop clarity in my research question, or bring research dilemmas to the group or supervisors, which affected keeping up with the ambitious research expectations; such that my motivation and hence research alliance with goals and tasks fluctuated. Some of these factors were inextricably linked with various personal circumstances. In the latter stages of research findings and writing up, my confidence in my research aims wavered, I felt unsure about my research focus.

Engagement and establishing a research alliance. Across different tasks, distinct parts of this process became uncovered. The literature review offered a more concrete scope of the therapeutic alliance landscape, distilling the range of areas to be explored and illustrating relevant creative research perspectives.

The empirical research required immersion into research processes and consideration of the ‘how?’ aspect of my empirical title to follow, understand, and interpret the evidence. Finding ways to remain focused on the accumulation of the steps

required to refine the data, I was consistently challenged by the clinical workload, which saw my alliance with research wane.

As I grew more comfortable with listening to the IMPACT recordings, I noticed how the parallel research processes fed into my clinical work, providing a lively opportunity to practice applying CA knowledge to modulate my responses to patients. I felt more curious and willing to try out ways of using my voice to create openings in sessions through questions or linguistic devices, which helped soften my anxieties and technique with patients. Such experiences brought to life the authentic, symbiotic, and richly rewarding experience of being both a clinician and a researcher. Nevertheless, the research process of developing research skills continued to be challenging due to factors such as time, motivation, energy, health, family needs, asking for help, and fluctuating confidence in interpreting findings and translating them into the body of work. These factors became other hurdles that I worked to negotiate.

Compromising factors: Losses and gains.

During the initial stages of engaging with empirical research, I experienced two distinct types of losses; the unexpected death of my training analyst was a sudden shock, followed by a temporary physical break of my dominant hand, both within a month of each other. This launched me into on an unwelcome sea of doubt where I felt directionless. The thoughts of needing to keep the research in mind, and in particular the issues of looking at the beginnings of sessions, were something I was rather far removed from. In retrospect, my distancing and disengagement from research prevented me from thinking about how painful my personal experience was. Whilst loss is a lived experience, the truth is that to face loss, you must come back into contact with

the very absence you would prefer to deny – my research became the physical manifestation of resisting this, and I felt adrift for a while. I found myself being dormant to both the loss and at times the research project, although at a deeper level- something was happening; I thought about parts of the project but also found myself in a push-pull relationship, having to bring myself to face the tasks, gain some direction and momentum to bear with the frustration of transcription, listening to voices that became familiar, questioning the relevance of the research, the therapeutic dialogue, all these aspects were painful as well as thought provoking.

These events impeded my focus, practical progress, and engagement with research thinking and tasks. Weighted against continuing clinical commitments, a period of no analysis, then beginning a new analytical relationship, were demands to consider. Nevertheless, trying to handle these issues alongside the various research tasks, meant also trying to establish a different relationship to research. I was also embarking on a new psychoanalytical relationship with an analyst, which supplied a new template for fostering a therapeutic relationship. This also fed into my willingness to grapple with the emotional aspects and barriers I met, alongside tackling the pragmatic research tasks. I felt some confidence return.

Further changes arrived midway in terms of loss of primary supervisor and a transition to a new supervisor, which helpfully brought a shift in research focus, refining questions and areas to explore, and making sense of what had been learnt. Coupled with the earlier difficulties of unexpected losses, the aspects of mourning and melancholia that Freud (1917) describes as being to appropriately let go of the lost object, or sit in denial and rumination, I found myself adrift, fluctuating through stages of

grief, which manifested with a lack of clarity in my empirical research. However, some momentum was generated by discerning a theme, particularly around absence, from my data. Wittenberg (2013) describes how new beginnings and opportunities can follow an ending, despite how painful some endings can be. Negotiating such endings became distracting preoccupations, since simultaneously new alliances needed to be forged whilst working towards clinical qualification, which also became a priority.

With changes in the global situation also occurring as I entered my final year of training, navigating a pandemic, negotiating new ways of working from home, seeking employment post-qualification, holding in mind the research, and interpreting the data and presenting this, felt difficult to keep hold of. Over the middle and latter course of this research, I found that my ambivalence in connecting with the project and communicating this was caught up in uncertainty, lack of clarity, and confidence in my findings, despite having worked through various hurdles and tasks, and a sense of hopelessness and helplessness took up residence.

Nurturing research humility.

The opportunity to attend a Conversational Analysis Conference in Berlin in June 2019 was a pivotal moment for me to work towards. This came at an early stage in research, and I was unsure whether I had any worthwhile offerings, but together with the research group, we produced aspects of our emerging research. Meeting a new community of experienced researcher-clinicians, learning about new research, and some that aligned with my project's aspects, supplied inspiration. This experience encouraged me to return to my research with a newfound enthusiasm to incorporate what I had learnt and steer through my own insecurities with more confidence in my

own belief as a researcher. The call for further CA researchers, and in particular female researchers, was also encouraging from our expert supervisor at the conference. Reflecting on such moments helped to reignite my curiosity to re-engage with the project whilst juggling family health needs.

During my training, I also attended the Association for Child Psychotherapists conferences, which gave me the impetus to show how research was developing within psychotherapy as a field. This perhaps brought a significant spotlight to the generational divide and differing sentiments towards the research discipline. I found the divide sobering, yet interestingly I was surprised by a somewhat persecutory stance towards research which was investigating long esteemed tenets of psychoanalysis, that are perhaps accepted as given therapeutic constructs; here I wondered about how to question constructs I was considering in my project; how much was theoretical, or based on anecdotal reporting, and how could process research support my understanding, whilst examining traditional ways of doing things within psychoanalytical psychotherapy. It felt as worrisome as putting a cat among the pigeons, yet perhaps timely. In this sense, as a trainee, I wondered if the psychoanalytical splitting between the generations was a necessary process that allowed trainees to prove the veracity of psychoanalysis in action, by taking apart the processes and (suspending theory in doing so) to understand them. Perhaps some of the experienced clinicians who appeared less inclined to support the research fervour stood over the growing community of new and experienced researchers, concerned that we were dismantling/vandalising theoretical practices alongside practitioner-assessed and reported healing abilities. As a trainee, I felt in a tug of war with this uncomfortable position, but steadied myself, realising that

whilst the research landscape might be uncertain, it wasn't unnavigable. More pressingly, there was a collective benefit to be gained from engaging with the research, or else risk being left behind as other psychological disciplines raced on, edging us out of our discourse.

As Almond (2006) considers how to tackle the varying cultures from which the poor communication between researchers and clinicians has stemmed from, i.e., historical, economic, educational, and social realities, he answers his question of *"How do we bridge the gap?"* Almond insightfully shares that it can only realistically be future-proofed by current and upcoming researchers and clinicians brokering and formulating a 'bridging language' between the empirical research and psychoanalytical clinical paradigms. This has encouraged me to see how, in a small way, our collective research and my small part could serve to bring these worlds closer together in a less hostile way. Whether I was comfortable or not, I had to endure it as I realised, I needed to make sense of the research discipline. I suspected that, despite doubts and pitfalls, the research part of training was, in fact, shaping my own clinical practice and my own potential as a clinician who needed to learn how to use research in the future.

Reigniting engagement with research.

Reflecting on my fluctuating engagement and relationship to this research task tested my commitment and willingness to bear with uncertainty, face the task, and complete it.

Bordin (1975, 1976, 1979, 1980, 1994) discusses how negotiating the therapeutic relationship's goals, tasks, and bond aspects is vital to establishing a therapeutic alliance. Each aspect requires engagement, and working out tasks at

various stages was a steep learning curve for me to negotiate and attend to. I realised that what I needed and wanted was to make sense of the research experience for my development, such that the value of the struggle shaped me, as opposed to feeling I was mechanically meeting academic requirements, although the value of this was important to me. Perhaps similarly to the adolescents in my empirical project, whose non-attendance to sessions concerned therapists, I too found that my research appetite became withdrawn. I did try to analyse various aspects of these, which also encompassed various competing personal life factors, but underlying this was also a reality of distancing from the project, which fuelled an anxiety about my push-pull relationship to this research task. Inevitably, a fear of getting it wrong also entered the mix. It sat beside a fear of doing a disservice to research, inadvertently showing dissenters of empirical research how untenable dismantling psychoanalysis might be. Nevertheless, I recognised that somewhere between uncertainty and emerging themes, I had not been fully dormant to this project; a preoccupation with the findings and my appetite was being developed, which was exciting and bolstered my efforts.

Letting go.

Inasmuch as bringing this completed thesis to a close has been a much-desired outcome, I also found that in rekindling my alliance to staying with this project, the journey has also brought the challenge of revisiting reflections, resistances, and the collective experiences that have profoundly enriched my learning and personal development. Given that I had at various points seriously considered dropping out of submitting this project, finishing this has been a personal achievement on many levels.

One of my initial questions in pursuing this topic of how to build a therapeutic alliance so that it can become meaningful has come full circle:

From my work as an adolescent therapist, balancing my preoccupations with therapeutic aims, holding space for adolescents to share their preoccupations and reasons for their non-attendance from therapy or silence in sessions, can be allowed to emerge more organically. This has facilitated my clinical curiosity and clinical technique and brought a deeper sensitivity to session openings and the therapeutic encounter.

From my Child and Adolescent trainee and post–qualified positions and completing research positions, staying touch with the various conflicts, anxieties, and fluctuating states of mind, I found the writing-up process moved from feeling overwhelming and intimidating to finding moments of satisfaction through piecing together analysis, findings, and linking the CA with a psychoanalytic perspective. This slow and measured exploration through writing has also brought new insight and a sense of fulfilment.

It is fair to comment that I felt out of my depth throughout the research and writing-up processes, fluctuating between the paranoid-schizoid and depressive positions. Hindsight has offered a perspective of research that offers a developmental object relationship that has felt exposed yet simultaneously built resilience, and with it, the ability to build faith in empirical research processes. Searching for evidence, discerning the methodological approach, summoning the passion and perseverance to stay the course with processes, and seeking guidance have been enormously enriching and worthwhile endeavours. I may now be prepared to consider exploring new areas of interest that I can apply my research thinking towards.

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