"*Maybe you don't know what answers I want*": unresolved alliance ruptures preceding dropout in short-term psychoanalytic psychotherapy with depressed adolescents

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ABSTRACT

The therapeutic alliance is a predictor of therapy outcome across treatments with adolescents, with ruptures and unresolved ruptures in the alliance being associated with treatment dropout. This study investigated the psychotherapeutic process in short-term psychoanalytic psychotherapy (STPP) with five adolescents with moderate/severe depression who had dropped out of STPP in a large randomized controlled trial and reported dissatisfaction with treatment. In each case, sessions were rated as featuring unresolved ruptures with the therapist. This study aimed to explore the processes characterising ruptures preceding dropout using the Adolescent Psychotherapy Q-set (APQ). Data were analysed using descriptive statistics of the APQ coding; a qualitative reading of the transcripts and clinical vignettes was used to illustrate how the APQ findings manifested in practice. Results revealed a weak alliance preceding the adolescent dropping out of therapy, with a mismatch between self-reliant and disengaged adolescents presenting with strong negative affects and therapists seeking to maintain an active exploration of the adolescents' difficulties. Research and clinical implications are discussed.

Key words: Adolescent Psychotherapy Q-set, therapeutic alliance, rupture-repair, adolescence, depression, dropout, psychoanalytic psychotherapy.

Introduction

Depression, which is associated with self-injuries (McManus *et al.*, 2014) and suicidal risk, is the third leading cause of death in 15-19-year-olds (Mars *et al.*, 2019; WHO, 2017). However, there are a number of psychological therapies that have demonstrated their effectiveness for this clinical population, including cognitive behavioural therapy (CBT), interpersonal therapy (IPT), and family therapy (NICE, 2019).

One talking therapy included in the NICE guidelines as an

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evidence-based treatment for moderate-severe depression in adolescents is short-term psychoanalytic psychotherapy (STPP) (NICE, 2019). STPP consists of 28 sessions (alongside parent work of up to 7 sessions) and aims to help young individuals process uncomfortable thoughts, feelings, and behaviours that are contributing to their depression (Cregeen, 2017). By paying particular attention to the client's relating to the therapist, the therapist can help them identify and understand past dynamics and feelings that can unknowingly be enacted within the therapeutic relationship (Sandler *et al.*, 1980). This shared effort helps the client recognise and process conflicts, defenses, and anxieties within the therapeutic relationship, which, in turn, supports symptom improvement (Midgley *et al.*, 2021). Psychodynamic psychotherapy research identifies that 75% of depressed adolescents show symptom reduction on successful termination of treatment (Horn *et al.*, 2005; Target & Fonagy, 1994).

A key element of STPP, which is shared with other types of talking therapy, is the establishment of a therapeutic alliance (TA). TA is broadly described as a relationship where the client and therapist share an emotional bond, collaborate on tasks, and negotiate goals (Bordin, 1979). TA has been shown to be a moderator of symptom improvements (Falkenström *et al.*, 2016) across treatments (Lambert & Ogles, 2004; Norcross, 2011). Better alliance quality early in therapy is associated with lowered depressive symptoms in adolescents (Midgley *et al.*, 2021). However, the IMPACT study, a randomised controlled trial (Goodyer *et al.*, 2011; Goodyer *et al.*, 2017), found that adolescents in STPP had lower mean self-reported alliance ratings when compared with a brief psychological intervention (BPI) and CBT, despite all treatments proving equally effective (Goodyer *et al.*, 2017). The reasons for this difference are not immediately clear. The STPP manual prioritises work on alliance formation in the early stages of the therapy, which later facilitates interpretative work (Cregeen, 2017). However, it may be that STPP, which is less structured than some other types of talking therapy, leaves some adolescents feeling unsure about the tasks of therapy and without clear agreement on goals. In some cases, such uncertainty may be associated with an increased risk of treatment dropout.

Dropout can be defined as the client's unilateral, non-mutually negotiated treatment termination (Warnick *et al.*, 2012). Using this definition, approximately 45% of young people can be considered as having dropped out across a range of psychological therapies (de Haan *et al.*, 2013). In the IMPACT study (Goodyer *et al.*, 2017), 37% of young people dropped out of treatment across all three treatment arms (O'Keeffe *et al.*, 2018). Secondary analyses identified that treatment dissatisfaction was associated with difficult therapist-adolescent interactional patterns and treatment dropout (O'Keeffe *et al.*, 2019). In particular, it appeared that unresolved ruptures in the therapeutic alliance preceded the decision to stop going to therapy among some adolescents who were considered to be 'dissatisfied dropouts' (O'Keeffe *et al.*, 2020).

Therapeutic alliance ruptures are defined as deteriorations, tensions, or breakdowns and refer to a broad range of alliance strains, from minor tensions to major rifts, in the client-therapist's understanding, collaboration, or communication (Safran *et al.*, 2011). A rupture is generally deemed 'repaired' when the emotional bond and the collaborative working relationship are restored (Eubanks *et al.*, 2018). The literature describes that repairs with adults can be immediate when they are aimed to accommodate the patient's request and restore the relationship. These might involve clarifying a misunderstanding, renegotiating tasks/goals, or providing a rationale for the treatment approach. Repairs can also be explorative of the rupture and of its underlying communication of needs, concerns, or wishes (Eubanks *et al.*, 2018; Safran & Muran, 1996; 2000). Resolving ruptures has been associated with better treatment outcomes compared to therapies where no ruptures occurred in studies with adults (Norcross, 2011). Resolving ruptures may, therefore, contribute to good therapy outcomes, especially in the early treatment stage (Henriksen, 2017), and support symptom reduction in the long term.

The literature identifies confrontation ruptures, expressing a client's movement *against* the therapist (client's active feelings of anger or resentment), and *withdrawal* ruptures. The withdrawal ruptures are of two subtypes: *move-away* and *move-toward* ruptures. Move-away ruptures feature young people's avoidance and emotional disengagement from the therapist (for example, long silences, minimal responses, changing the subject, abstract/intellectual talk), whilst move-toward ruptures feature excessive compliance, deference, or submission to the therapist at the cost of denying the rupture experience (Safran & Muran, 2000).

Research with depressed adolescents has found evidence of an alliance-outcome association across different treatment modalities (Cirasola *et al.*, 2021). Additionally, this research has found a pattern of greater unresolved ruptures in those who dropped out of therapy due to dissatisfaction compared to those who completed therapy (O'Keeffe *et al.*, 2020). Research with youth affected by borderline personality disorder (BPD) shows that ruptures that occur and that are repaired later in psychodynamic treatments are associated with positive outcomes (Gersh *et al.*, 2017). Therefore, the resolution of ruptures may lead to better engagement and clinical outcomes for adolescents.

Youth and adult psychotherapy research has looked at therapists' behaviour and investigated how this contributes to ruptures (Lingiardi & Colli, 2015; O'Keeffe *et al.*, 2020). Some therapist personality traits, such as flexibility and confidence or trustworthiness, are associated with and contribute positively to building a good TA (Ackerman & Hilsenroth, 2001). These include awareness of reactions to the client, acknowledging problems within the relationship, encouraging exploration of feelings, acceptance of anger within the therapy relationship, and promoting collaboration and metacommunication, reflection, and making immediate repairs (Ackerman & Hilsenroth, 2001). In contrast, rigidity, defensiveness, or allocating blame are features of therapist behaviour linked to ruptures. High levels of transference interpretations (Piper *et al.*, 1993), inappropriate use of silence (Eaton *et al.*, 1993), persisting with an activity that the young person has rejected, or adopting a rigid approach to treatment can also exacerbate ruptures (O'Keeffe *et al.*, 2020). Studies on adults (Safran & Muran, 1996) suggest that exploring avoidance can further increase a patient's defensiveness; similarly, with adolescents, the literature endorses acknowledging a rupture when this manifests (Binder *et al.*, 2008), as failure to do so and to acknowledge its associated experiences can cause rifts in the therapeutic alliance (Nof *et al.*, 2019). The literature explicates that some rupture-resolution processes may pertain to the here and now of the therapy relationship, whilst higher-order rupture-resolution processes attempt to export the learning from the rupture experience to other significant ruptures in the client's life. It is noticed that repairs that might work with adults might not work with young people at a stage where the TA has not been formed (Cirasola *et al.*, 2022) and that, in the early stages, more traditionally psychoanalytic interpretative therapeutic behaviours may need to give way to a client's therapeutic engagement, for example, through other CBT techniques (Samstag & Norlander, 2019). Exploratory repairs can be used with young people, although emerging adolescent litera-

ture advocates for a cautious approach. Generally, therapists might choose an immediate over an exploratory strategy depending on the strength of the TA (Eubanks *et al.*, 2018) or on the young person's emotional and cognitive maturity, tolerance for interpretations, and anxiety (Cirasola *et al.*, 2022; Nof *et al.*, 2019). Considering the young person's maturational levels and their pull towards independence may be significant, especially when dealing, respectively, with their ambivalence towards treatment and with the young person's non-attendance (Binder *et al.*, 2008).

Recognising ruptures is a precondition to repairing them, motivating the exploration of factors contributing to alliance weakening, especially with adolescents at risk of disengagement. Given the dearth of research on rupture resolutions with young people at risk of dropout and its impact on process and outcome, an in-depth exploration of therapeutic treatment that resulted in its premature termination would address the identified gap.

This study, therefore, aimed to investigate the psychotherapeutic processes in STPP sessions featuring unresolved ruptures with adolescents with moderate to severe depression who dropped out of treatment due to dissatisfaction. It aimed to explore the psychodynamic processes that characterise those rupture interactions preceding dropout and to identify and illustrate common features.

Methods

Design

This was a mixed-methods, cross-sectional, retrospective, and exploratory study. It explored the characteristics of the therapists' and clients' behaviours and the client-therapist interactions by looking holistically at sessions with unresolved ruptures.

Setting

This study used a subset of data from the IMPACT trial that compared three interventions for adolescent depression (Goodyer *et al.*, 2017). Adolescents with moderate/severe depression were recruited following their referral to their local Child and Adolescent Mental Health Service (CAMHS) in three UK regions. Eligible participants were randomly assigned to one of the three treatment arms: STPP, cognitive behavioural therapy (CBT), or a brief psychosocial intervention (BPI) (see Goodyer *et al.*, 2011; 2017 for full details).

Data selection

The sessions for the current study were purposively selected from the North London arm of the IMPACT trial. An additional qualitative and longitudinal study on the North London region of the IMPACT trial, called IMPACT-ME (IMPACT-My Experience; Calderon *et al.*, 2014), explored therapists' and young people's expectations and experiences of therapy. Based on the IMPACT-ME post-session interviews, O'Keeffe *et al.* (2019) constructed a typology of treatment dropout, which included a group of adolescents who were classified as 'dissatisfied' with treatment, having reported stopping therapy because they did not find it helpful.

Of 32 young people who had dropped out across STPP, BPI, and CBT, 18 of them were identified as 'dissatisfied' (O'Keeffe *et al.*, 2019). Of those 'dissatisfied' 18, nine had been allocated to STPP and had available audio recordings (for more details, see *Supplementary Figure 1*). Therefore, to explore the rupture dynamics preceding dropout in this study, the authors purposively selected two sessions for each of the nine young people who had dropped out from STPP as 'dissatisfied': the second session and the last available therapy session before dropout.

Taking the second session allowed for a deeper therapeutic interaction to unfold, as research highlights that first sessions tend to be introductory and may not reflect a typical session (O'Keeffe *et al.*, 2020). Furthermore, psychotherapy research on adults suggests that when psychodynamic therapists attempted to repair early treatment ruptures, they were not successful, causing later treatment disruptions (Muran *et al.*, 2009). Hence, where available, the two sessions were taken cross-sectionally, from early therapy and from the time of dropout.

The present study aimed to further understand the dynamics that are characteristic of unresolved ruptures exacerbated by the therapist with young people who dropped out; therefore, a key factor in choosing these specific session pairs (the second session and the last session before dropout) was that they had previously been rated, as detailed in O'Keeffe *et al.* (2020), using an observer-rated tool known as the Rupture Resolution Rating System (3RS). This can systematically identify the lack of client-therapist collaboration during each therapeutic interaction (Eubanks *et al.*, 2018). More specifically, the 3RS detects rupture types and frequencies throughout the session and produces a '*resolution index*' (1=poor; 2=below average; 3=average; 4=good, above average; 5=very good), providing information on the extent to which a rupture is resolved. Most importantly, the 3RS quantifies the '*therapist's contribution*' (*or exacerbation*) to a rupture (1=no; 2=maybe; 3=yes, somewhat, 4=yes, moderately; 5=yes, mostly), but it is limited and cannot illustrate how this unfolds (Eubanks *et al.*, 2018). This current study aimed to address this gap.

Therefore, the following inclusion criteria were applied: i) sessions of adolescents affected by depression (Moods and Feelings Questionnaire [MFQ]≥27) that belonged to the 'dissatisfied' drop-out group of STPP; ii) the 3RS '*resolution index*' for those sessions was lower than or equal to two (≤2); iii) the levels of '*therapists' contribution*' to the rupture for such sessions were greater than or equal to three (≥3) (for further details, see O'Keeffe *et al.*, 2020).-

Therefore, the final sample was purposively selected and consisted of eight audio-recorded STPP sessions of five therapy dyads (between three therapists and five dissatisfied young people) in two phases of treatment preceding dropout. These sessions were analysed using observer-rated methods and qualitative reading of the transcripts.

Participants and sessions

Of the five young participants, two were male and three were female, with an average age of 16.85 at the start of treatment (min=14.38; max=17.82; standard deviation [SD]=1.4). Details about ethnicity were not available. The three therapists, one male and two female, had UK doctoral-level professional training in Child & Adolescent Psychoanalytic Psychotherapy.

Five early sessions and three late sessions were included in this study (Table 1). For three young people, the third session was rated as the second one had not been recorded as not available. The STPP audio recordings lasted 48.82 minutes on average (min=38.45; max=56.32; SD=5.16).

Moods and Feelings Questionnaire

The primary outcome in the IMPACT study was the Moods and Feelings Questionnaire (MFQ), a 33-item self-reported meas-

ure for depression scored on a 4-point Likert scale (from always=3 to never=0 [Angold *et al.*, 1987]). The MFQ was completed by young people prior to randomisation and at 12, 36, 52, and 86 weeks after randomisation. A score of 27 is the cutoff for clinical depression.

The MFQ scores after treatment illustrate two relapses at follow-up (Table 2), while two of the young people maintained improvements.

As shown in Table 2, the mean MFQ score dropped from 49.2 (T0: SD=9.8) to 21.2 (T2: SD=12.6). MFQ scores dropped in a non-clinical range (≤27) for two young participants at T1 (Maria=16; Eva=25) and for three participants at T2 (Tommaso=9; Eva=14; Maria=15). However, there was heterogeneity at TFU (time follow-up): two young people maintained improvements (Eva=18; Maria=14); two young people relapsed (Tommaso=41; Melina=31) more than one year after treatment. Overall, young people attended an average of 8.6 sessions (SD=1.1).

The Adolescent Psychotherapy Q-Set

The Adolescent Psychotherapy Q-Set (APQ) (Calderon *et al.*, 2017) for young people aged 12-18 years describes the therapy process by capturing events of importance in a session. It comprises 100 items, each of which represents a feature of the therapeutic process that describes one of the three following aspects: the young person's feelings, behaviours, and thoughts; the therapist's actions and attitudes; and the quality of the relationship. The APQ items are a-theoretical and can be found on a continuum from most uncharacteristic to most characteristic therapy processes in a session across treatment modalities. Raters observe a session, review the 100 items, and sort them into nine piles according to a fixed normal distribution (Calderon *et al.*, 2017) (*Supplementary Table 1*). The APQ has a coding manual to ensure reliability.

Data analysis

The APQ rater was a psychoanalytic psychotherapist in doctoral training. She was trained in the use of the APQ, achieving reliability (ICC=0.71). Two other APQ-trained doctoral students rated one more session each to evaluate interrater reliability, which was achieved (ICC=0.842) for the reported sessions.

The APQ data analysis comprised two stages. In stage one, the rater coded the eight sessions in random order to prevent cognitive biases and ran descriptive statistics (means and SD) on overall sessions' ratings. The overall means and SD of the APQ ratings' sample were calculated in Excel. The SD identifies the amount of variation of a set of values. A low SD (absolute value of ≤2) indicates that the item received a similar pattern of ratings across the eight sessions; a high SD identified a larger variation of ratings per item. These statistics identified the thirteen most 'characteristic' and fifteen most 'uncharacteristic' APQ items across all eight sessions. Then, the identified items were grouped in a narrative cluster that described the behaviours and interactions shared by the five dyads and narratively integrated the most 'characteristic' and most 'uncharacteristic' features (Calderon *et al.*, 2017).

The results of the first descriptive analysis guided a qualitative reading of the eight sessions' transcripts to identify clinical vignettes to illustrate how the therapeutic processes identified with the APQ manifested in real-world settings. Based on the qualitative reading of the transcripts, four additional APQ items illustrating the therapist's behaviour were included in the results. Although their means ranged between 4.3 and 4.6 on the APQ and exceeded the manual's guidance for uncharacteristic items

Table 1. Participants' early sessions, drop-out sessions, and therapists.

YP	Early session	Last session before dropout	Therapists
Tommaso	3	11*	Federica
Melina	3	15*	Angela
Eva	2	15	Luca
Maria	2	12	Luca
Mattia	3	18	Federica

*Sessions that do not meet inclusion criteria and are not included in the study. Pseudonyms are used for young people (YP) and their therapists.

Table 2. Mood and Feelings Questionnaires' scores, means, SD, and number of sessions attended *vs.* offered.

YP	T0 (0w)	T1 (closest to dropout)	T2 (52w)	TFU (86w)	Sessions attended	Sessions offered	Sessions attended (%)
Tommaso	48	51	9	41	8	16	50
Melina	58	29	28	31	7	19	37
Eva	37	25	14	18	9	20	45
Maria	60	16*	15	14	10	28	36
Mattia	43	52	40	n/a	9	29	31
Mean	49.2	34.6	21.2	26	8.6	22.4	39.8
SD	9.8	16.1	12.6	12.4	1.1	5.8	7.6

YP, young person; T0, time of randomisation; T1, closest to dropout; T2, one year after randomisation; TFU, follow-up at 86w from randomization; n/a, not available, not completed; SD, standard deviation; *MFQ completed at 6w although dropout at 12w. Pseudonyms are used.

(as their average ratings were M≥4), these items received similar patterns of ratings across the sample and were meaningful in the study of rupture dynamics.

Ethical considerations

Ethical approval was granted by the Cambridgeshire 2 Research Ethics Committee (reference 09/H0308/137). Written informed consent was obtained from young people and their parents (Goodyer *et al.*, 2011; 2017). All audio recordings and transcriptions were encrypted and securely stored. No identifying data were accessed. Pseudonyms are used to protect young people's confidentiality; potentially identity-conferring material has been changed or omitted.

Results

The APQ findings and their cluster illustrate the most and least common features of the therapy process across the five dyads (Table 3). Qualitative data extracts illustrate how these identified features manifest in practice.

Characteristic therapeutic processes of the sessions

The descriptive statistics on the APQ ratings identified 28 items as either characteristic or uncharacteristic across the sample (Table 3). Most characteristic items received a mean APQ rating between 6 and 7.6, deeming them 'characteristic' ($\bar{x}\geq6$). Uncharacteristic ($\bar{x}\leq4$) items' means ranged between 2.6 and 4. Characteristic and uncharacteristic items had a SD equal to or lower than 2, receiving similar patterns of ratings across sessions.

Therapists' and young people's interactions preceding dropout

The interaction between therapists and young people was generally characterised by a weak working relationship between disengaged young people who experience strong negative affects, show autonomy, and do not feel helped by the therapy, and therapists who seek active exploration and encourage reflection on the young people's difficulties by searching for meaning even when the adolescents did not respond to this approach.

Table 3. Most characteristic and most uncharacteristic APQ items in the APQ cluster – means and standard deviations.

Item	Item description	M	SD
91	YP discusses behaviours causing concern	7.6	1.6
84	YP expresses angry/aggressive feelings towards others	7.3	1.8
31	T asks for information/elaboration	7.1	1.6
10	YP conveys irritability	6.8	1.4
9	T & YP try to make sense of experience	6.5	1.1
55	YP feels unfairly treated	6.4	1.5
29	YP conveys sense of autonomy	6.4	1.8
1	YP expresses negative feelings towards T	6.3	1.5
98	Therapeutic relationship is a focus	6.3	2
37	T is thoughtful when faced with strong affects	6.1	1.6
2	T draws attention on YP non-verbal behaviour	6.1	1.9
62	T Identifies a pattern or a theme in the YP's behaviour	6.0	1.7
96	T attends to the YP's current emotional state	6.0	2
47	T accommodates when therapeutic relationship is difficult*	4.6	1.7
93	T refrains from taking position in relation to YP thoughts/behaviour*	4.5	2
57	T explains rationale behind technique*	4.5	1.9
66	T is directly reassuring*	4.3	1.7
33	T adopts a psychoeducational stance	4	1.5
3	T uses remarks to convey that they are listening	3.9	1.5
25	YP speaks with compassion/concern	3.9	1.5
51	YP attributes own characteristics to the T	3.9	1.7
11	YP discusses sexual feelings	3.8	1.4
32	YP achieves a new understanding	3.6	1.7
52	YP has difficulty ending the session	3.6	1.9
22	YP speaks with feelings of remorse	3.3	0.9
86	T encourages reflection on feelings and thoughts of others	3.1	0.6
69	T explores the impact of the YP's behaviour on others	3.1	1.1
95	YP feels helped by the therapy	2.6	2

APQ, Adolescent Psychotherapy Q-set; M, mean; SD, standard deviation; YP, young person; T, therapist; *APQ items with mean APQ ratings included between six and four ($6<\bar{x}<4$; SD≤2).

Specifically, the young people discuss behaviours and thoughts that cause concern for the therapist (item 91: mean score 7.6). These behaviours and concerns relate to both young people and their friends or families. The young people convey resentment, hatred, and anger towards others (84: 7.3); specifically, they convey feeling unfairly treated by significant others in their life, such as friends, parents, or their partners (55: 6.4). The adolescents do not tend to show remorse (22: 3.3) nor compassion (25: 3.9), often arguing that some wrongdoing was done to them. They do not explicitly attribute their own characteristics or feelings to the therapist (51: 3.9) but rather to other people in their lives. Although the adolescent may hint at their sexual feelings during sessions, they generally avoid exploring their meaning therapeutically (11: 3.8).

The therapists do not explore with the adolescent the impact of the young people's behavior on others (69: 3.1), nor do they focus the therapeutic work on reflecting on others' thoughts and feelings (86: 3.1). The therapists tend not to reassure the young people (66: 4.3) about these feelings or offer psychoeducation, but, when the opportunity manifests, they rather tend to adopt an exploratory stance (33: 4), trying to understand their meaning with the adolescent. When possible, during sessions, the therapists encourage active reflection and try to explore and make sense of the young people's experience (9: 6.5). To do so, they request information and elaboration regarding such experiences (31: 7.1); however, they endeavor to remain contemplative (37: 6.1) in response to the intense emotions of the youth. The therapists do not use remarks to indicate that they are listening but leave the young people to speak freely (3: 3.9). In most sessions, the therapists attend to the adolescent's emotional state in the therapy room (96: 6), sometimes pointing out some of the young people's non-verbal behaviour (2: 6.1). The therapists are actively trying to find meaning in the young people's experiences by identifying a theme or a pattern (62: 6).

Meaning is often found and discussed by the therapist in the context of the client-therapist interactions, with the therapy relationship becoming a focus (98: 6.3). The sessions seem to mostly go over familiar ground (32: 3.6), with the adolescents not showing a new understanding. The adolescents convey irritability (10: 6.8). Sometimes, they express mild negative feelings towards the therapists (1: 6.3).

In some sessions, the therapists are seen taking a position on the young people's behaviour, either verbally or non-verbally, whilst they seemed more neutral in other sessions (93: 4.5). The therapists tend not to change their approach when the therapeutic interaction becomes difficult (47: 4.6). The young people do not always express confusion about how the treatment works, but during sessions, when they seem confused, the therapists are consistent in their approach and do not tend to explain the rationale behind their technique (57: 4.5). The young people express feelings of autonomy (29: 6.4) and convey that they do not feel helped by the therapy (95: 2.6). Ultimately, the young people do not seem affected when the session's time is up (52: 3.6).

Illustrations of the interactions preceding patients' dropout

The selected vignettes aim to enrich the findings shown above by illustrating how a weak alliance, alongside the behaviours and interactions manifested in practice, played out across the five dyads.

Vignette 1: the therapist's authority threatens the young person's autonomy

The therapist is trying to adopt an exploratory approach while the young person (Eva, a pseudonym) is describing situations that are a cause of concern. Although thoughtfully, the therapist is diligently fulfilling his duty of care by engaging in a therapeutic activity that addresses the concerning behavior while prioritizing Eva's safety. The young person's sense of autonomy is threatened by the therapist exercising his duty of care.

T: My priority is to keep you safe; it does not sound like things are 100% safe. There are different ways of helping you be safe at home.

[...]

Eva: Yes, but what if [people] get angry that I told you, then what?

T: Well, then we need to think about ways to keep you safe still. It is a very difficult decision, and one I am not gonna rush into, and I am not gonna do anything about it without talking to you first. Ok?

[...]

Eva: But, to be honest, I don't want Social Services involved, as it is bad enough that I have got lots of trouble already, and I am just gonna get more angry.

T: Who are you worried that you are gonna get angry with?

[...]

Eva: No, I will get angry with everything. I'll run away. I can promise it now. Nobody won't see me. If I find out that they are gonna get involved, […] it's gonna get worse.

T: So, what do you think about me having a conversation with (other colleague) [to see if we may try other ways to keep you safe]?

Eva: I don't mind, as long as Social Services are not involved.

T: Well, I can't guarantee that, at the moment.

Eva: Mm…

T: Well sometimes adults have to take control of the situation. I am not sure that we need to do that [now], so I want to check it with someone else and I will phone you whatever happens.

Eva: Fine.

T: Ok, So I will call you by the end of tomorrow at the very latest, is that ok? We'll talk more about what we may do to help you.

[Silence]

T: Yeah? What are you thinking?

Eva: I want to be out, far [inaudible].

[YP chuckles nervously]

(Eva, session 15)

Vignette 2: the therapist pursues a therapeutic activity that the young person is not responding to

While trying to make sense of the young person's experience in therapy, initially, the young person (Tommaso, a pseudonym) is accepting of the therapist's attempts at identifying a pattern. However, ruptures occur when the therapist offers interpretations that the young person does not share, withdrawing from the interaction.

T: I wonder, you maybe think this is bizarre, but maybe there are two versions of [you]; one who tags along [and one that says] you are rubbish, you can't join, a kind of saboteur.

Tommaso: Yeah.

T: So, again, there's kind of a pattern here, isn't there? So, the thing that stopped you from joining in an ordinary way was feeling that it's all gonna go wrong, so you rather not risk it in the first place.

Tommaso: Yeah, pretty much.

T: It's a kind of sabotage, isn't it? Of the bit of you that would like to go and see what happens.

Tommaso: Yeah.

T: […] I was thinking, actually, your t-shirt… with [the Incredible Hulk]…

Tommaso: The reason why I got this t-shirt is from the film […]

T: Yes, but […] is he the character that spoils things?

[…]

T: …Yeah, so there's something about this [t-shirt] that spoke to you really, that you can relate to…?

Tommaso: Not really, I don't see myself in [Hulk], really.

T: Mm…

[silence]

T: But it does seem like it's a bit what we are talking about? That there is a saboteur […]

Tommaso: Yeah, I guess so… in a way…

[…]

Tommaso: The main reason I chose this t-shirt is that I thought that it was kinda cool from the film.

T: Well, actually, you know, I am not saying it is not true. There might be something else to it that you never thought of.

Tommaso: Yeah… I suppose… [laughter]

T: Might be worth, interesting, thinking about and speculate about, yeah?

Tommaso: [laughter]

T: Anyway… that may sound a bit bizarre to you as well.

Tommaso: [laughter]

T: Yeah…Mm…

[Silence]

(Tommaso, session 3)

Vignette 3: the therapy tasks are not clear to the young person

Although the therapist is keeping an emotionally attuned approach and is keeping a reflective stance in response to the questions asked by the young person (Maria, a pseudonym), she is struggling with silence and with understanding the greater task of therapy.

[Silence]

Maria: I just don't know what to say, argh!

[Silence]

Maria: this is scary now, come on. What am I gonna do?!

T: Sounds like this silence... we should fill it quickly.

Maria: Yeah, I hate silences. Not a big fan.

T: What should I do? It makes you feel quite helpless?

Maria: I think I don't know much about this and so...

T: Do you think that's what I am doing?

Maria: Yeah

[…]

T: I suppose that it may feel like you may think I am a bit cruel for leaving you in a position of being helpless.

Maria: I don't knooow!

T: What kind of therapist have I got… that does not make you feel comfortable or relaxed…

Maria: No, sometimes I feel comfortable talking to you but sometimes it feels like I am waiting for answers so maybe you don't know what answers I want […]. I suppose, I don't know what you want.

T: Exactly; you just don't know, but sometimes some feelings are just difficult to have.

Maria: It is just difficult…

(Maria, session 2)

Vignette 4: the therapist maintains an interpretative stance and tries to encourage reflection in his quest for meaning

The therapist and the young person (Maria, a pseudonym) discuss an unexpected therapy break initiated by Maria going on holiday, which the therapist takes as a communication of Maria's resistance towards treatment. Maria expresses dissatisfaction about a therapy that does not match her expectations and expresses irritability. The therapist acknowledges this but does not reassure her when the therapeutic relationship becomes difficult.

T: I don't know but you may not have given much thought to your therapy.

Maria: I don't know… I guess I had lots of things that I wanted to do […] and I am adamant that I am gonna do them.

[…]

T: I mean, I am just thinking… that's hard talking about the break, and I think your response is to think about your break […]. I suppose I was thinking, in that context, you would not have any curiosity about what I would be doing. So, I was thinking, maybe you would like… to keep a bit of a distance between the two of us.

Maria: I don't know. I just thought that this is the way that it should, has to be… coz before I asked you questions, you would just be there… sat there…

T: Maybe you've had lots of questions, and it is hard to come to therapy […] you may have lots of questions, and maybe I won't answer them. I am sort of saying it is not unusual that you have questions, and having this sort of relationship is unusual and this is something that you find hard.

Maria: I think that a lot of open questions that I struggle with, and I have to answer myself… It would be a lot easier if you could just answer them.

T: So maybe, I suppose, what you are saying is why do you do this, [therapist], and why do you respond in that way, coz it is really annoying; but I suppose what I would say is that I am interested in what you are thinking and what your thoughts are… in a way that we think about you… and that's not always comfortable, not always easy.

[Maria withdraws from this topic and gets distracted in the room]

(Maria, session 12)

Discussion

This study explored the therapy process with adolescents who dropped out from STPP because they reported that they were dissatisfied with some aspect of therapy. It focused on unresolved alliance ruptures exacerbated by therapists based on an analysis of sessions identified in an earlier study (O'Keeffe *et al.*, 2020). Adolescent research has been looking at how to enhance treatment engagement to reduce adolescent mental health risks and relapses (Costantino *et al.*, 2010; Mars *et al.*, 2019). This is because failure to engage young people in treatment can predict treatment discontinuation (Garcia & Weisz, 2002; Zack *et al.*, 2007). Hence, understanding treatment impasses would enable clinicians to address them (de Haan *et al.*, 2013). In keeping with research on improving knowledge of the TA with adolescents, the results of this study were observed within the therapeutic relationship, from the behaviours and attitudes that were characteristic of each agent in the dyad. They showed that the sessions prior to the young person dropping out were characterised by a weak working relationship between disengaged and self-reliant young people who did not feel helped by the therapy and therapists who made it their priority to find meaning in the young people's difficulties; even though in general the young people could not tolerate this approach. Where the young people were caught up in negative affects and brought up some concern for the therapist, the therapists tended to maintain a reflective and meaning-making approach, which did not appear to facilitate repair of any ruptures to the therapeutic alliance. In fact, young people reacted with mockery and confrontation and dropped out as the ultimate withdrawal from the therapy. Nonetheless, the outcome data show heterogeneous findings across the cases included, with two relapses and two improvements at 86 weeks follow-up after randomisation. However, the focus on the therapeutic interactions and each single agent in the dyad helped to further differentiate the psychodynamic processes occurring in those rupture dynamics, which are discussed by themes in the following paragraphs.

Exploring risk

During sessions, the young people in this study brought up situations that were concerning for the therapists, including feelings of hopelessness and engagement in unsafe behaviours. Ratings of the APQ revealed that therapists actively explored their concerns. Thereafter, the therapist actively attempted to engage the young person despite the presence of a weak alliance. They attended to the young person's safety as clinically recommended (Cregeen, 2017; NICE, 2019). However, these attempts appeared to be associated with unresolved ruptures (O'Keeffe *et al.*, 2020), as the findings showed that adolescents reacted with concern, frustration, or anger to these discussions around safety and safeguarding, ultimately withdrawing from the therapy. Risk exploration involves aspects of safety planning and risk management procedures (Cregeen, 2017), which can result in breaching confidentiality to protect the young person's safety. However, seeking meaning in symptoms, including risk-related behaviours, is a core therapeutic task in psychoanalytic treatments. Psychoanalytically, each risk-taking behaviour can reveal the behavioural components of the adolescent's unconscious anxieties, defenses, or conflicts (Cregeen, 2017). Therefore, discussing risk behaviours in therapy could bring up the young people's anxieties that they are trying to defend against by acting out their behaviours, which would thus require therapeutic attention. This therapeutic intervention can be overridden by the urgency of dealing with the risk issue in more practical terms.

In vignette 1, for example, Eva's fear of getting angry and of losing her family due to social care involvement seemed uncontainable as well as impossible to explore, despite the therapist emphasising that he aimed to ensure her safety. She seemed anxious that the therapist could compromise her family relationships and get them to be angry with her. In turn, she threatened to get "angry at everything […] and disappear". Meaning-making around the risk behaviour, in this case, might have been challenging for the therapist, as he had to ensure Eva's safety, which was precarious. Following this session, Eva dropped out of the therapy. Therefore, breaking confidentiality may have been experienced by the young person as breaking the therapeutic 'contract' and, with it, the safety of the setting, especially at a stage when the therapeutic alliance was not strong.

Furthermore, an intergenerational conflict seemed to taint this rupture: when Eva conveyed her negative emotions and agency by threatening to disappear, the therapist introduced an adult parental boundary into the relationship. Although the therapist tried to involve Eva in the safeguarding process, Eva was sensitive to the unresolved rupture and terminated the treatment. This finding suggests the importance of paying attention to the adolescents' developmental task of seeking autonomy (Binder *et al.*, 2008; Blos, 1967), fostering agency even when discussing issues of risks. One way of thinking about this in a psychoanalytic style could perhaps involve the therapist wondering aloud about how the young person may be trying to tackle their difficult dilemma by exerting their own autonomy in an attempt to escape a situation that puts them in danger and which they do not have any control over.

Managing non-attendance

The young people in this study attended an average of 8.6 sessions of the 28 available before dropping out. There was also a pattern of missed sessions prior to dropout. Unresolved ruptures were sometimes observed in the context of discussions around breaks and missed sessions when the therapists' comments attempting to make meaning out of the missed sessions did not match the young people's treatment expectations (*e.g.*, vignette 4).

Based on studies with adults in therapy, a strong TA is forged on the ability of the therapist to recognise the patient's two opposing wishes: the wish to move on and overcome their difficulties and explore their symptoms and the wish to remain the same and not to change (Tatarsky & Kellogg, 2010). Therefore, it is possible that the young people's missed sessions may have signaled a defense or an unconscious resistance to change and to explore their symptoms.

During ruptures that occurred during discussions about planned/unplanned breaks (*e.g.*, vignette 4), Maria struggled with dissatisfaction with a therapy that did not match her expectations around breaks. The therapists strived to remain thoughtful and reflective, attending to the young people's experience while still trying to focus on the negative feelings (or negative transference) of the young person towards the therapeutic space when missing those sessions. However, Maria appeared frustrated that the therapist could not accept to accommodate her needs; alongside, the audio recordings rated with the APQ revealed that therapists conveyed some judgement about the young people's non-attendance. Although, generally, the therapists' interpretative stance aimed to help the young people find meaning in their symptoms, including

noticing the young people's resistance to explore their symptoms when missing therapeutic sessions, the therapists seemed not to sufficiently notice that their subtle disapproval might have contributed to the rupture remaining unresolved.

Psychoanalytically, the therapist's subtle disapproval might indicate a counter-transferential response to a young person's transference communication of criticism, and equally, the therapist's personal frustration about feeling unvalidated and not valued, likely evidenced by the young people's treatment non-attendance. With the young people in this study, the therapists may have conveyed judgement about their non-attendance but not paid sufficient attention to their wish to overcome their difficulties, which in turn may have discouraged discussions around conflict towards change.

Although further interpretative efforts were made to try and respond to the young people's dissatisfaction (*e.g.*, vignettes 3 and 4), these did not seem to yield the desired effect of overcoming the alliance rupture, leaving the rupture unresolved and possibly contributing to the young people's withdrawal from the therapy. Young people may be particularly sensitive to the therapist's conscious and/or unconscious communications and judgement around non-attendance, suggesting that therapists will need to carefully monitor their own counter-transference responses and find ways to respond to non-attendance that recognise the adolescent's wish for autonomy as well as fears of dependency.

Therapeutic technique: holding neutrality

This study's findings support previous literature suggesting that young people may avoid expressing treatment dissatisfaction directly (Below & Werbart, 2012; Gersh *et al.*, 2017). Sometimes, treatment dissatisfaction was communicated through clients' questions as an indication of strong feelings (Yadlin *et al.*, 2022) or through mockery (*e.g.*, vignette 2). However, young people did voice direct confrontations around risk issues (*e.g.*, vignette 1) or silences that were perceived to be unhelpful (*e.g.*, vignette 3). Clients' dissatisfaction and perception of not feeling helped seemed to occur when adolescents appeared unclear about how therapy would work and when they struggled to understand some of its tasks (Cirasola *et al.*, 2022; O'Keeffe *et al.*, 2020). For example, Tommaso (vignette 2) subtly disagrees with the therapist's attempts at interpreting his behaviour; it is possible that he may have been left confused about the tasks of the therapy and how this may work.

In these regards, the analysis of APQ ratings revealed that in response to the young people expressing uncertainty about the goals and tasks of therapy causing alliance ruptures, therapists did not attempt immediate repairs by clarifying the tasks of the therapy; instead, they maintained an interpretative stance and had a tendency not to offer an explicit explanation of their technique nor offer direct reassurance. Hence, they maintained some 'analytic neutrality' (Leider, 1983), which the young people generally responded to with some discomfort. The STPP treatment manual underscores, especially initially, the importance of conveying to young people how therapy works by referring to the setting of the sessions (including the missed sessions and the resistance to attend) in order to make connections between depressive symptoms and conscious and unconscious thoughts and feelings (Cregeen, 2017). The findings of this study suggest that in cases that led to a dissatisfied dropout, therapists maintained a reflective stance and tended to encourage the young person to explore their feelings rather than directly respond to the young person's questions or doubts about how therapy works. The therapists mostly responded to such doubts by encouraging the young people to think about their struggles with the therapy, although it appears that these young people were not in a position to accept such interventions.

The findings offer support to the hypothesis that a rigid approach to therapy can contribute to ruptures (Ackerman & Hilsenroth, 2001), especially in the presence of low mentalising capacity on the part of the young person (Cirasola *et al.*, 2022; Nof *et al.*, 2019), as well as low frustration-tolerance or ego-strength. The APQ ratings revealed that the young people in this study showed traits, or rather symptoms reactive to their depression, of heightened self-reliance, expressed little concern or remorse, showed negative feelings towards others, and tended to attribute their own feelings to other people; this potentially evidences defensive processes to protect themselves from deep-seated rejection (Glasser, 1979), weak ego-strength and/or low frustration-tolerance (Hurry & Sandler, 1971).

It might, therefore, be hypothesized that when an adolescent experiences dissatisfaction about the process of therapy, the therapist can be experienced as 'withholding' or 'unfair', even when they make conscious efforts to help the adolescents think about and understand their difficulties. In this study, the young people generally rejected the therapists' interpretative attempts, which may have been experienced as persistent by young people and which may have contributed to leaving ruptures unresolved, especially when these interpretations did not make sense for the young people (O'Keeffe *et al.*, 2018) (*e.g.*, vignette 3: the young person did not understand silences; vignette 2: the therapist commented on the young person's non-verbal behaviour). Therefore, it may be that some therapists' interventions were not aligned with the young people's developmental stage or their needs regarding the therapeutic treatment at that stage, thus creating a rupture. This may, in turn, have contributed to the perceived sense of helplessness expressed by some young people, following which they stopped attending. This finding suggests that unresolved ruptures seem to characterise therapy dyads in which the therapists tended to invite further reflection from young people who had already demonstrated a lack of interest (or lack of readiness) in exploring their feelings, especially those related to feelings of dependency on others. Therefore, this study's results are tentative but may suggest that, with young people who show treatment dissatisfaction, further clinical adaptations are needed; for example, while meaning-making approaches still hold importance towards symptoms' improvement, these may come after employing immediate repair strategies (for example, clarifying a misunderstanding or providing further rationale for the therapeutic technique). This could have a twofold aim in reducing both the therapist's and the young person's anxieties linked to the treatment framework, as well as reinforcing the therapeutic alliance with this cohort of young people who are harder at trusting professionals and who present with a higher risk of treatment disengagement.

This study has the potential to enrich our understanding of interactions between adolescents and therapists during unresolved ruptures in STPP. The systematic analysis of different therapy dyads highlighted clinical challenges that therapists face when treating this high-risk, dissatisfied group who ultimately dropped out of therapy. Furthermore, this study's findings indicate that the relapses of certain adolescents at follow-up within this dissatisfied high-risk group necessitate further investigation into the reasons these individuals discontinue therapy.

Blinding of sessions and double coding ensured reliable APQ ratings, although there may have been some susceptibility to cognitive bias since data had been purposively sampled (O'Keeffe *et al.*, 2020); moreover, the sample was small, and it was

limited to the initial and latter sessions, respectively, with limited generalisability.

Finally, this study did not explore the role of other personal characteristics (*e.g.*, age differences, ethnicity, or the young people's attachment style) in the occurrence of said unresolved rupture dynamics within the therapeutic dyads and how these impacted leaving ruptures unresolved due to lack of information on the full sample or trajectory of the therapy. It is hoped that future research will evaluate how these factors may intersect with one another and impact the therapeutic process. While this limits generalisability, these findings highlight the fine-grained TA processes preceding dropout and elicit thinking around technique with this high-risk group.

Conclusions

This study suggests that, in STPP sessions with depressed adolescents who go on to drop out of therapy due to dissatisfaction, alliance ruptures occur frequently, especially during the task of exploring risk and responding to non-attendance. Alliance ruptures were especially likely to remain unresolved if therapists responded by maintaining therapeutic neutrality, *i.e.*, not directly providing clarification of confusion or addressing specific points of dissatisfaction but rather offering interpretations of the young person's behaviour and/or continuing to invite the young people to explore and reflect on their own feelings. Important inferences can be derived from this small-scale research, including that some young people might struggle with some aspects of the interpretative therapy process in STPP, such as therapists focusing on what was happening in the therapy room at the expense of clarifying the rationale behind the technique, and similarly, adolescents struggled with non-directive therapists and silences (Acheson *et al.*, 2020; O'Keeffe *et al.*, 2020). The study contextualises these struggles within the adolescents' development and capabilities, indicating a potential for ruptures when such emotional needs are not attended to. Hence, unresolved ruptures may indicate adolescents' underlying relational difficulties, which require adaptive therapeutic techniques (*e.g.*, validation, mirroring, managing silences flexibly, or greater containment) that account for their developmental stage, emotional needs, and the nature of their defenses. These alternative techniques may contribute to strengthening the emotional bond of the alliance and the therapist's admission of owning their own therapeutic misattunements.

This study may equip therapists with new opportunities for reflection on how to work with ruptures in this high-risk adolescent group. The findings also illustrate the importance of clinical supervision to understand the impact of ruptures on both agents in the relationship. Further, it provides evidence of the interactional nature of rupture-repairs through the APQ's versatility in capturing co-constructed aspects of the alliance (Lingiardi & Colli, 2015). Although other factors, such as lack of insight or ambivalence towards change, are equally important TA factors with young people, the therapist's role remains pivotal in facilitating the therapeutic work in their constant quest to achieve balance when addressing positive and negative feelings with sensitivity.

This study's findings also advocate for reviewing the model of TA with adolescents. For example, with young people who struggle to own their difficulties and have been referred to treatment by others, therapists could sit alongside them and help them identify goals as the therapy progresses. When adolescents encounter difficulties comprehending the objectives of treatment, these can be conceptualised, and the adolescents can be assisted by a therapist who elucidates the therapy's expectations and clarifies its mechanisms. In the presence of high levels of defensiveness and emotional difficulties, for example, the therapist should assess the young people's emotional maturity and developmental stage to respond to ruptures with immediate or expressive repairs in a timely manner. The therapist's quest to assess the young people's emotional and developmental needs may facilitate the therapist's role in the therapeutic process. In this regard, the therapist may consider prioritising the formation of an emotional bond over and above goal or task-setting in the presence of low ego strength and low reflective functioning levels. These observations reinforce the importance of clinical supervision and clinical training, supporting therapists to disentangle and understand their role in countertransference reactions and rupture dynamics. It is recommended that further clinical understanding be offered to such rupture dynamics, especially when these may contribute to the termination of the therapy process. Investigating such aspects further could boost therapists' flexibility, their ability to guide intervention, and improve treatment retention with young people; it would support therapists in discerning which empirically-based treatment may suit the adolescent's needs to produce lasting positive change (Odhammar *et al.*, 2019).

Therefore, clinical supervision and the further longitudinal study of rupture-repairs with adolescents could improve therapists' understanding of their communicative value so that they are able to respond accordingly.

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Online supplementary material:

Supplementary Figure 1. Flowchart to show IMPACT sampling strategy.

Supplementary Table 1. APQ cards' distribution in each category.