It takes two

Ruptures and repairs in the therapeutic relationship with adolescents:

A Hermeneutic Literature Review

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Abstract

The therapeutic relationship is often cited as a key factor in positive treatment outcomes for clients, including with youth and families. This dissertation will look at how psychotherapists approach ruptures and repairs in the relationship with adolescent clients so that more will be known about what promotes or hinders therapeutic work with teenagers. A hermeneutic literature review will be conducted to identify meaningful and practical elements in rupture-repair processes within therapeutic relationships or alliances. The main data will come from existing literature related to psychotherapy with young people and additional data will come from the writer's own reflection of practice.

The findings of the literature review presented that ruptures are inevitable and are understood to be normal in interactions with adolescents given their developmental stage and conflicting needs however if not addressed, ruptures can lead to significant disengagement and early termination of therapy. Repairs (like ruptures) are co-constructed between the client and therapist, and the aim is to have a meaningful, corrective relational experience for better treatment outcomes. There has been growing interest and evidence on rupture-repair processes and strategies with teenagers that link with a range of relevant theories including from developmental, psychodynamic, attachment and neuroscience literatures. These understandings may support other psychotherapists and mental health practitioners in considering rupture resolution as interventions when working with youth. Ideas of further research are discussed at the end.

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in acknowledgements), nor material which, to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Kirsten Wong

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Chapter 1: Introduction

The aim of this dissertation is to know more about how psychotherapists approach ruptures and repairs in the therapeutic relationship with adolescent clients, and by extension why this is important for positive therapeutic outcomes. I intend to explore and learn from the existing literature relating to psychotherapy with some of my own reflections to further develop my practice as a child and adolescent psychotherapist; with the intention of adding to the body of knowledge from a New Zealand-based perspective.

This chapter opens with the initial context for this research. This includes my personal reflections and a preliminary literature review of the theories on the therapeutic relationship and adolescence as a developmental stage which capture my pre-understandings of these topics. I offer definitions of the key terms used and thoughts of the place of this research. Further, I outline an overview of the following chapters in this dissertation.

Personal Reflections

My interest in the therapeutic relationship with teenagers began to take shape from my training in child and adolescent psychotherapy. I spent time learning psychodynamic theories and undertook placements to work with young clients and their families in an outpatient eating disorders service and the university psychotherapy clinic. The significance of the therapeutic relationship was often emphasised however it was one thing to hear and read about, and another to experience it when I formed my own working alliances with clients.

As a beginning therapist I met with many adolescents and struggled with the painful emotions that arose in sessions with them and with their families at a time of high turmoil in their lives. This usually included challenges and distress that have been longstanding. There

were occasions when clients disengaged, and I found several obstacles with my attempts at reconnections. With those cases I sat with worries about their wellbeing and not seeing them again, as well as my own feelings of intense frustration and shame. Through my training, supervision, and own therapy, I was able to reflect regularly on my own journey of becoming a child and adolescent psychotherapist. I was regularly encouraged to practise self-reflection and curiosity of the processes uncovered when working with young people. As Bion (1962) stated, it is worthwhile to learn *from* rather than about this multi-layered experience which is ever shifting. I also had opportunities to reflect on my own adolescence and the unspoken beliefs, emotions and struggles I held around relationships with others.

I am a New Zealand-born Chinese woman who identifies Aotearoa as her home on a deeply personal level. My family on my father's side came to this country in a time of war, trauma, and injustice in China. While being on the receiving end of discrimination and intolerance were common themes in my family's narratives in their immigration journeys, my ancestors came here with the hope of not only surviving but thriving and contributing to a beautiful new land.

The Chinese people have been in New Zealand since the late 19th century and constitute the largest group within the Asian population in this country (Statistics New Zealand, 2019). While I have a strong New Zealand identity, I continue to grapple with my own sense of being Chinese. I often feel inadequate in bringing a Chinese voice forward particularly with being unable to communicate fluently in any Chinese languages. I am still on a path of discovering and learning more about this important part of myself that I hope to bring to my practice.

In Aotearoa, there is a wide range of ethnicities and cultures in a country grounded by a strong bicultural history of European colonisation over the native Māori population. I am

still an "other" in relation to Māori and I believe I sit somewhere outside the longstanding bicultural relationship between Māori and Pākehā. I assume that I represent aspects of "Pākehā-ness" with a New Zealand English accent, upbringing, and education. I also acknowledge that I write this paper from a predominantly western understanding of mental health and working with youth and families, but I try to prompt myself to stay inquisitive and weave in other ways of approaching therapeutic practice.

At the time of writing this dissertation, I have been working at a child and adolescent mental health service (CAMHS) in a public health setting. I work within a multidisciplinary team which has given me great opportunities to learn about and practise different treatment modalities and clinical approaches. At the same time, conducting my own psychotherapy research acts as a useful process to ground myself as a beginning psychotherapist.

In 2020 the COVID-19 pandemic occurred globally, and New Zealand saw an unprecedented move to a nationwide lockdown. Everyone was directed to stay at home for seven consecutive weeks that was initiated on March 25th. Essential workers continued to operate, including myself as a mental health practitioner and I struggled with my own fears of the unknowns of the crisis while being urged to continue onwards with my work and delivering care to those also impacted by similar immense worries.

The Office of the Children's Commissioner (2020) conducted an online survey of young people in New Zealand aged 8 to 18 (n= 1402) and gathered their experiences of this first ever COVID-19 lockdown. 42% of children and teenagers indicated life was about the same as before, with 29% reported it was better or much better and 23% thought it was worse or much worse. The remaining 6% selected something else, that might indicate ambivalent feelings about the situation. The positive factors most identified by participants were the quality time spent with family and hobbies and a slowed down pace of life. Conversely the

negative impacts most reported were missing friends or difficult family dynamics, followed by increased mental health distress.

There were challenges in maintaining relationships with young clients and their families during this and other lockdowns and I moved to solely digital means of communication either by video calls, phone, texts, or emails. For the most part this worked well enough with clients I had already met in person and with whom I established some relationship. Meeting online was also familiar territory for many, if not all the adolescents I was seeing. In fact, they were keen to relate to me at times of government directed isolation and were most helpful in assisting connections for their parents and older caregivers with me. On the other hand, some teenagers who were already dealing with *whakamā*[1] struggled with being seen on camera and declined video calls from the onset and were resistant with contact in other ways. The distance was most challenging for young people I did not know very well prior to the lockdowns or those that I met for the first time online; and saw a few disengaging completely.

As people were able to gradually leave their homes back to their communities, there were opportunities to begin meeting face to face again which was met with mixed feelings. Some were relieved to return to everyday routine and away from feeling trapped with negative thoughts and feelings. Others expressed great comfort in a slowing down of life and were hesitant to re-enter society. This has prompted further wonderings about the internal and external experiences of adolescent clients being thought about and understood in the therapeutic relationship, which might lead to ruptures and repairs.

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[1] *Whakamā* – A Māori term involving feelings of hurt and inadequacy leading to withdrawal or unresponsiveness. This can be experienced individually as well as interpersonally (Metge, 1985).

Background

Therapeutic Relationship

Across human history there has been a recognition and exploration of the important relationships between individuals who are in pain and distress with people that can offer methods of healing (Horvath, 2018). The therapeutic relationship is one of the most researched concepts in psychotherapy and Freud (1912/1958) began to refer to it in his early writings and understood that it was important for treatment success. With the development of child psychotherapy, Anna Freud (1946) noted that an affectionate attachment between the analyst and the child is a requirement for subsequent work in child therapy. She differentiated this relationship from a child's eagerness to form a connection to gratify an interpersonal void in the young person's life, which was noted as a least developmentally mature way of relating. "If no one at home plays games with a child, for example, he might like to come to treatment because there a grown-up pays attention to him" (Freud as cited in Sandler et al., 1980, p. 47).

Anna Freud defined a more mature therapeutic alliance made with children where the positive quality of the relationship facilitated the client to use the therapist in overcoming emotional or interpersonal issues which is based on the child having a sense that "I really need to change, and you are the person to help me to change" (Sandler et al., 1980, p.55). Similarly, a Kleinian approach understands that the therapeutic relationship "is not achieved by acting out the role of an idealized object, but by effective interpretation and being human" (Nuttall, 2000, p. 26).

Bordin (1979) contributed to psychotherapy with his definition of the *working alliance* which involves both an emotional bond and an agreement between therapist and client on the treatment tasks and goals. The first generation of alliance-focused research

sought to clarify the association between a strong alliance and positive treatment outcomes (Nof et al., 2019). Safran and Muran's (2000) conceptualising ruptures and repairs in their work inspired the second generation of this type of research that focused on what makes the alliance itself therapeutic.

Safran and Muran (2000) highlighted the continuous process of an intersubjective to-ing and fro-ing between therapist and client. This involves moments where the quality of the therapeutic relationship increases in tension and/or deteriorates, known as ruptures, and moments where this tension is focused on to be resolved, known as repairs (Eubanks-Carter et al., 2015). Ruptures can appear through disagreement of treatment goals, lack of collaboration on tasks, or strain in the emotional bond (Eubanks et al., 2018). Ruptures in the relationship are common and inevitable events in the therapeutic process and working through them can function as a corrective experience and encourage interpersonal growth (Safran et al., 2011).

There are certain challenges to consider with managing therapeutic relationships with adolescents. A major factor is that the decision for young clients to engage in psychotherapy tends to come externally from caregivers or other adults (Di Giuseppe et al., 1996). This is tricky as a common reason why teenagers seek therapy is because of unmanageable strains in their relationships with their parents (Boldero & Fallon, 1995). On the other hand, Blatt and Behrends (1987) discussed how ruptures are crucial when working with adolescents to allow a process where they can express their needs of identity, separation, and individuation.

In the practice of psychotherapy, any unresolved conflicts between young people with their parents will be evident in the therapy room. How the child perceives and interacts with their primary parental figures can be understood to reoccur in any future relationship, and their ways of relating can be displaced to a person in the present situation (Klein, 1952). If

the client feels accepted by the therapist and feels that they are understood, their trust, openness, and motivation to adopt new perspectives are more likely to develop.

The relationship between a client and therapist are complex and mutually influencing. By nature, it involves connections with other people and experiences in the lives of both individuals. The social, historical, and cultural backgrounds of the client and therapist shapes how each negotiates the relationship between them, usually outside either person's awareness. As such, ruptures and repairs can be understood to be continuously co-constructed between the two in the therapeutic relationship.

Adolescence as Developmental Stage

Adolescence is a time of great developmental changes for children and is often compared with the rapid growth seen in utero. Anna Freud (1958) described this stage in life as "an interruption of peaceful growth which resembles in appearance a variety of other emotional upsets and structural upheavals" (1958, p. 267). Transition into adolescence introduces a certain amount of disruption to family relationships (Chen-Gaddini, 2012).

When young people enter adolescence, a change of environment and expectations are intensified by the shuffling of hierarchies and needs. They also experience bodily changes through puberty which influences fundamental shifts to a sense of self (Waddell, 2002). Often this is experienced as being out of one's control and generates confusion about what is happening to them and the world around them. Elkind (1967) described how young people overemphasise their individuality and immortality as they struggle in response. This provokes what Erikson (1956) termed a *normative crisis* whereby heightened progressive and regressive forces come into conflict. This can evoke defences such as ascetism or risk-taking to eject *phantasies* of physical invulnerabilities, passivity, and regressive wishes (Freud,

1958). These intrapsychic struggles are necessary for movement towards independence and identity.

A reworking of relationships with parents is one of the biggest challenges with adolescents turning more to peer groups for companionship, excitement, a sense of belonging and holding of fragmented feelings. The separation experienced can be dramatic, compared with the parent-child relationship during latency, leading to increased relational clashes. For the child, the degrees of earlier containment and internalisation of parental figures are tested (Freud, 1958). Teenagers are thought to rebel to provoke discipline and punishment from surrounding adult figures. In this process, they are discovering their own boundaries, goals, standards, and connections.

Blos (1967) talked about a *second individuation phase* whereby the adolescent experiences themselves as someone who can pursue new love objects and assume responsibilities for their life choices. How parents support their child in this task allows for the diminishing of powerful parent-child ties, however it comes with an awareness of loss and disillusionment (Gilmore & Meersand, 2014). Ammaniti and Sergi (2003) discussed another concept of *attachment-individuation* with the idea that the adolescent does not need total separation from their parental figures for their development. Parent-adolescent conflicts can then be understood to be universal and function to spur identity-development for young people and to negotiate changes in roles and relationships as they approach adulthood (Branje, 2018).

Risk behaviours are not associated with severe psychopathology and are understood to ease the tensions of aggressive and sexual impulses while lessening internal unconscious guilt (Waddell, 2002). In addition, suicidal behaviours can also be understood as an acting out of internal conflict where there is a developmental bias towards expelling pain (Waddell,

2002). Adolescents at this stage can recognise relative risks and benefits of actions and acknowledge other points of views, which can be protective factors against self-harm and destruction. This can conflict with other influencing factors such as peer pressure and excitement reducing high-level functioning (Steinberg, 2007). Wills et al., (1996) argued that the lack of experimenting can be problematic for development as it is essential for finding new ways of being and preparing to leave the safety of their parents.

Adolescents value self-expression and validation of their individuality from their environment. Waddell (2006) spoke about narcissism being an essential adolescent organisation that holds things together while internal growth continues at a time of many changes. The phantasy of the world being all-giving is important for the omnipotent wish to bypass the pains of necessary losses, relinquishments, inadequacies, and anxieties. Erikson (1964) described this "identity vs. role confusion" task where adolescents are "now primarily concerned with what they appear to be in the eyes of others as compared with what they feel they are, and with the question of how to connect the roles and skills cultivated earlier…" (p. 261).

At the later stage of adolescence, the young person can look back on their childhood with updated perspectives which become incorporated into the emerging self. A sense of personal history deepens connection and meaning with places and things – moulding an experience of a safe and valued external world (Gilmore & Meersand, 2014). A powerful upsurge of sexual interest, fantasy and drive occurs throughout adolescence, with love in earlier phases usually marked by passion and idealisation (Tolman & McClelland, 2011). There is a greater interest in intimacy, commitment, and interdependence which Kernberg (1974) explained involved appropriate feelings of guilt and concern. This adds to meaningful relationships and growth of one's value within a partnership. When entering the first romantic relationship, there is mourning around the separation from past love objects. At the same time

there is a reaffirmation of the internalised good objects which affects one's confidence in giving and receiving love (Kernberg, 1974).

Key terms

The term *therapeutic relationship* has been used synonymously with other terms such as therapeutic alliance, working alliance, and helping alliance (Freud, 1912/1958). Across psychotherapeutic literature, there are also regular references to Bordin's (1979) concept of the working alliance involving the therapeutic tasks, treatment goals and emotional bond shared between the client and therapist. In this dissertation, I will refer to the therapeutic relationship as capturing the working alliance, interpersonal processes and the real relationship that naturally forms from ongoing interactions with another individual (Gelso & Carter, 1994; Greenson, 2016). I acknowledge that it is not something that can be exactly quantified and involves complex perceptions, negotiations and meaning making.

The word *rupture* derives from a medical context, from the Latin word *ruptura* meaning "the breaking (of an arm or leg) or fracture" ("Rupture", n.d.). Safran et al., (1990) termed disruptions in the therapeutic alliance as ruptures and defined them as negative shifts in the quality of the therapeutic relationship or ongoing difficulties in establishing one. This involves the concept of *empathic failure* (Kohut, 1984) however, this does not fully capture the interactional nature of ruptures and repairs.

In the context of a relationship between people, it is understood that every interaction is at risk of moments of frustration, when we suffer a loss of trust in another person as someone with whom we invest our love, and whom we believe can be kind and understanding of our needs. Ruptures are often subtle, and perhaps unremarkable when

observed externally, but can also be more overt in their expression. This dissertation acknowledges ruptures in different stages of therapy as well as ones that relate to endings.

Conversely the word *repair* as a verb means "to mend or put back in order," from the Old French word *reparer* meaning "repair or mend" ("Repair", n.d.). In relationships, repair infers that there is work needed from and between two people to regain each other's trust and restore themselves in the other's mind as someone who is essentially decent and sympathetic and can be a sufficient interpreter of their needs.

The term *adolescents* will generally cover the chronical ages of 10 to 19 which encompass different developmental substages (World Health Organization, 2020). I acknowledge that understandings of adolescence (including needs, roles, identities) have evolved over time and can differ between cultures. The range of people who are grappling with this stage of development may also include people of older ages who are emotionally and mentally younger than their years however, that is outside the scope of this paper.

Place of this Research

> Only the most courageous, perhaps the most foolish therapists are willing
> to treat adolescents, for they are the most difficult group of children with
> whom to work (Spiegel as cited in Blake, 2021, p. 130).

Historically, teenagers have been bestowed the negative reputation of being a problematic population to deal with and this has extended to discourses in mental health. Young people have the right to receiving care for all aspects of health and typically, many mental health difficulties become more prominent during adolescence (The Partnership for Maternal, Newborn and Child Health, 2020). Recent evidence proposed that teenage mental health continues to be neglected while often highlighted as an essential issue (Azzopardi et

al., 2019). There has been growing research on creating and maintaining a working, therapeutic relationship which has positive potential in treatment with youth (Karver et al., 2018) as well as the lack thereof leading to therapy discontinuing (Garcia & Weisz, 2002; Zack et al., 2015)

New Zealand adolescents are a unique group, encompassing multiple cultures and attitudes towards emotional wellbeing and help-seeking. They also have high rates of mental health problems, particularly depression, anxiety, substance use and suicide (Ministry of Health, 2019) with Māori rangatahi among the most affected. Appleby and Phillips (2013) summarised how treatment rates are low as many adolescents with mental health needs do not often connect with a CAMHS in Aotearoa and discussed engagement as an essential aspect of effective treatment. There remains a need in the existing literature for understanding the ruptures and repairs in the therapeutic relationship with young people by mental health practitioners in New Zealand who work in child and adolescent mental health.

Chapter Summary

This chapter has provided an introduction of the context of my dissertation including the inspirations for this research, personal background and pre-understandings that are brought to this study. Key terms as used in this paper and place of this research have also been outlined in this chapter.

Overview of Chapters

In the following chapters, I will discuss the rationale for using my chosen research methodology and method and suggest how they relate to the research question in chapter 2.

Chapter 3 will overview the findings from the literature. The research examining ruptures in therapeutic relationships will be summarised with consideration of those that occur when working with adolescent clients. This includes ruptures leading to dropouts of treatment, therapists' views on ruptures and issues relating to telepsychotherapy. I will discuss what occurs when ruptures are not addressed. How repairs with teenagers are understood will then be explored; overviewing research in this area with repair strategies including telepsychotherapy and considering what happens when ruptures can be resolved. Finally, Chapter 4 is a discussion of the findings and implications that emerged, strengths and limitations of the study and suggestions for future research.

Chapter 2: Methodology and Method

A hermeneutic literature review is conducted for my research question: "How do psychotherapists understand ruptures and repairs in therapeutic relationships with adolescents?". This chapter will outline my use of the hermeneutics methodology that sits within an interpretivist paradigm, and how that relates to the research question as well as how I position myself within this framework. Later I explain my method of searching relevant literature for review including my exclusion criteria, and my step-by-step process of studying and interpreting texts.

Methodology

My chosen research methodology is hermeneutics which acknowledges that reality is not wholly comprehensible. Caputo (1987) related the nature of reality being like a cloud in the sky; an apparent form which can be seen yet it is difficult to grasp as we attempt to understand it. Coming from an interpretive paradigm, it is concerned with understanding what meanings are created around the experience of being human and of life itself (Grant & Giddings, 2002). Psychotherapy is similarly curious about and attentive to the complex ways in which people perceive, comprehend, and make sense of themselves, others, and the world around them.

People and objects do not exist inside a vacuum and everything that we know has come from somewhere. We all have roots elsewhere in time and space or have our own "shadows" as Gadamer (1975) named it. As such reality is enmeshed in its past and we need to remember and recollect historical perspectives and events which interact with the present reality and perceptions. Reality is not a fixed entity but is dependent on the context and viewpoint of the individual that is observing it.

The hermeneutic researcher then seeks to understand this multiplicity of experiences and meanings through a tentative approach. The process builds on previous knowledge and the researcher will delve into places that are unknown and unexpected. There is an ebb and flow movement between different understandings and interpretations in the endeavour, with a gradual enlightening of the phenomenon and simultaneously never fully grasping it. There is no sense of reaching a single truth or gaining a complete knowledge in a linear fashion. Instead, the researcher seeks to broaden the possibilities of their thinking. In establishing a relationship, both therapist and client enter the experiential world of the other who is inevitably different from oneself. They engage in a similar back and forth movement towards meaning making and change. This is a fundamental psychotherapeutic activity regardless of theoretical orientation of the practitioner (Bohart & Greenberg, 1999).

I was drawn to hermeneutics as it requires the researcher to take on a reflective process in their inquiry to think about the intersection of their experiences with the phenomenon of research and the research process itself. "Understanding begins when something addresses us" (Gadamer, 1975, p. 299), so knowledge begins to develop when something affects how people think and feel about themselves and their external world. As a result, they are urged to understand it further. In hermeneutic studies, the objective is to identify the meanings conveyed within images, metaphors, descriptions, and ways of thinking taking into consideration sociocultural contexts. Hermeneutics fits with my research question and my interest to gain understanding of ruptures and repairs in the therapeutic relationship with adolescents through immersing myself in multiple texts and understandings within a particular time and context.

Gadamer (1975) also acknowledged that individuals inevitably perceive things through preconceptions and prejudices and what is known to be true is constrained by the view of the knower. This is not necessarily something to avoid, but in fact forms the basis of

our way of being and how we make meaning from experiences. Through relating with something or someone else, there is potential to expand our horizons. In essence, I hope the hermeneutic methodology will guide me towards looking at a topic and seeing it beyond what I could individually comprehend by engaging with a *fusion of horizons* or the merging of different perspectives and interpretations (Gadamer, 1975). I recognise that a constant tension may be present between my pre-understandings and how I think about the phenomenon with the literature and evolving perspectives I will explore in this research.

Literature Search

A hermeneutic literature review will be conducted as the research method which allows me to review texts that span across time, space, contexts, and cultures. As an important first step to collate relevant literature for my topic, I began with an informal search on the Auckland University of Technology's library webpage to locate online databases that were of relevance to the area of adolescent psychotherapy.

I used the search terms**:** "therapeutic relationship", "repair", "rupture", "psychotherapy" and "adolescents" in databases including Psychoanalytic Electronic Publishing (PEP), American Psychological Association's PsycInfo and PsycArticles. I narrowed my search to literature within the past ten years. Further articles were also found through the reference lists of initial articles that were identified as relevant to my research question through "snowballing and citation analysis" (Boell & Cecez-Kecmanovic, 2010, p. 281). I was also able to find relevant articles, journals and books that were recommended by colleagues and my supervisor, as well as drawing from previous resources used in my training. The result was a compilation of sixteen articles, three book chapters and three books in the disciplines of psychotherapy, counselling, psychology, psychiatry, and social work (see

Table 1). I acknowledge that my selection of texts is inevitably influenced by my own

confirmation bias (Wason, 1960) and through what I deem to be relevant and important.

Table 1

Literature Search

Author(s)	Date	Type	Authors(s)	Date	Type
Atzil-Slonim et al.	2015	Article	Muran & Barber	2010	Book
Baillargeon et al.	2012	Article	Muran & Eubanks	2020a	Chapter
Beebe & Lachmann	2014	Book	Muran & Eubanks	2020b	Chapter
Carpi et al.	2018	Article	Muran et al.	2021	Article
de Haan et al.	2013	Article	Nof et al.	2019	Article
Dolev-Amit et al.	2020	Article	O'Keefe et al.	2020	Article
Eubanks et al.	2018	Article	Safran et al.	2011	Article
Gersh et al.	2017	Article	Straus	2017	Book
Gibson & Cartwright	2013	Article	Tishby & Vered	2011	Article
Gibson et al.	2018	Article	Ulberg et al.	2012	Article
Hartman	2011	Article	Wolpert et al.	2018	Article
Meador & Roger	2014	Chapter	Zack et al.	2015	Article
Morán et al.	2019	Article			

Exclusion Criteria

I excluded texts that examined therapeutic relationships with younger children and

adult clients. I understand that involvement and relationships with the family of adolescents is

paramount in psychotherapeutic work, however I have also excluded literature that

researched the families' perspectives.

Method

My literature review research method is based on Austgard's (2012) steps to develop a research plan for studying and interpreting literature and Boell and Cecez-Kecmanovic's (2010) hermeneutic circle; influenced by the works of Hans-Georg Gadamer.

Step 1: Belonging to tradition

This step involves "acquiring the right horizon of inquiry for the questions evoked by the encounter with tradition" (Gadamer, 1975, p. 302). Austgard (2012) offered questions to reflect on including: 1) What is the background of the hermeneutic question? 2) Is the question relevant? What is its purpose and aim? 3) Does the question have 'openness'? I have provided answers for these questions in Chapter 1. Completing this step and illustrating my "historical horizon" (Austgard, 2008) provided the foundation that impacted on the hermeneutic research process.

Step 2: Hermeneutic preparation, identification of fore understanding

This step requires the researcher to reflect upon their epistemological standpoint including an overview of existing literature relevant to the research question. I have discussed these in Chapters 1 and 2. Boell & Cecez-Kecmanovic (2014) explained that interpretation in the context of literature searches and reviews is grounded in what is known before that makes further knowing possible. This prepared me to enter in a *hermeneutic circle* of exploring and reflecting on an incomplete understanding of a topic. I acknowledged I need to look beyond what I know and have awareness of my own pre-understandings and experiences which is ever evolving.

Step 3: Hermeneutic dialogue with the text and analysis

This step involves repeated reading, reflecting of and writing about the texts chosen for my research. It was no coincidence that the time I was conducting this research, I felt largely unsettled with the multiple disruptions in everyday life by the impact of COVID-19. I had to regularly push to find my way back to engaging and being open to my research, while trying not to lose myself entirely. Understanding and meaning emerges from the reading and writing processes and is seen through the lens of the researcher's perception (both conscious and unconscious) in a constant circular process. Austgard (2008) explained that the interpretations of the researcher can interact with the texts in a dynamic way in a dialogue. My interactions with the hermeneutic circle were also positioned within many numerous hermeneutic circles that represent wider social and collective unconscious processes of understanding life and all its complexities (Boell & Cecez-Kecmanovic, 2010).

Austgard's (2012) steps for developing a research plan and Boell & Cecez-Kecmanovic's (2010) hermeneutic circle framework (Figure 1) provided a structure for me to immerse myself in multiple ways of knowing. I acknowledge that there will often be overlapping perceptions that emerge from a dialogue and I aim to reflect on distinguishing between the authors' perspectives from my own. I compare this similarly with the client-therapist process whereby there is a shared blurring of conscious and unconscious processes that are felt in the relationship; influenced by individual past experiences.

Figure 1

The hermeneutic circle of reviewing literature and techniques associated with different stages

of the hermeneutic circle (Boell & Cecez-Kecmanovic, 2010, p. 134)
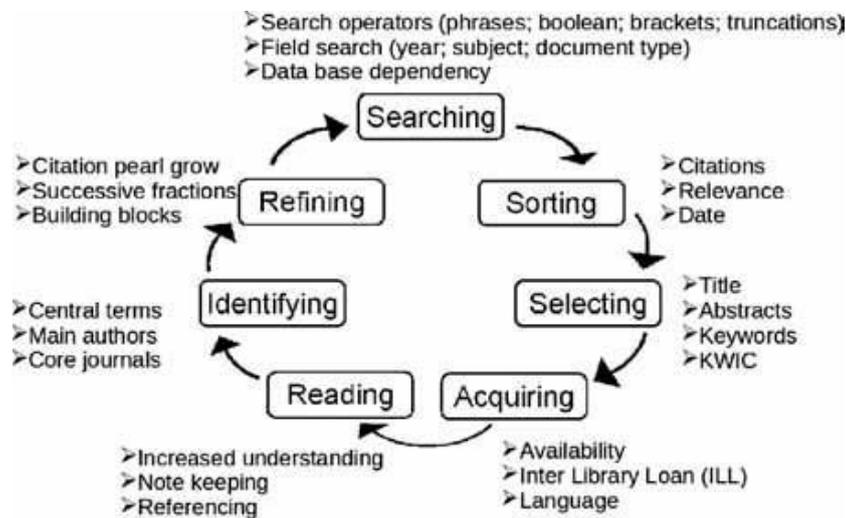
Much like being within a therapeutic relationship, there is a continuous movement in and out of the hermeneutic circle at different stages of the literature review and it is not a straightforward process. I experienced many dualities and internal struggles whilst reading, reflecting, and writing. This involved conflicting urges of stopping and starting, getting lost and finding something, as well as doubting and trusting the process and myself. Much like ruptures and repairs, I came to an acceptance that these seemingly opposing forces are fundamentally part of the other and mutually influencing in the disintegrating and reintegrating of a greater whole.

It can be difficult to know how to come to an end and step away from the hermeneutic circle as the research must arrive at a conclusion. I often found myself led down many lines of thoughts, feelings and images through this experience and it was frequently difficult to hone my focus. Someone once told me that a sufficient ending of any process is much like a good conversation when a silence is reached and there is an experience of something having been fulfilled. This reminds me of the experience in therapy sessions with clients where there

is emotional material that can be tolerated, thought about and processed and a settling pause fills the room, whether within a single session or after some time being with one another in the therapeutic relationship.

I experienced many silences with my research that were anguishing and difficult to sit with which in hindsight, I often acted on urges to distance myself from the process in an avoiding manner. Nearing the deadline, I dedicated some time and space to really sit with myself and the process up to that point. In doing so the tone of the silence shifted to become more tolerable and evoked in me the accepting stance of the work I had accomplished that indicated I had the possibility to step out at the stage of refining to conclude.

Chapter Summary

In this chapter, I explained my approach to this study from a hermeneutic methodological framework relevant for my research question around how psychotherapists understand ruptures and repairs in therapeutic relationships with adolescents. The process of literature review method was outlined, including exclusion criteria, as well as how the data was approached for analysis and synthesis. The next chapter will discuss the findings of the research and what has been written about ruptures and repairs in the therapeutic relationships with adolescents.

Chapter 3: Findings

Part I: Ruptures

This section begins with an overview of the literature examining ruptures in therapeutic relationships, and those that occur when working with adolescent clients. This includes ruptures leading to early termination of treatment, views of ruptures by therapists and ruptures over telepsychotherapy. The experience and psychological processes of ruptures are then explored.

Overview of rupture research

Early psychoanalytic literature talked of *resistance* in the therapeutic process whereby the patient displays or expresses opposition towards the analyst. It was thought about as an unconscious process that could reflect both a changeable state and a characteristic of the patient. Freud (1913/1966) early on talked about eliminating resistances and showing great interest in the patient to encourage an attachment or bond to the analyst. Resistance could be interpreted as an avoidant reaction to painful unconscious content and served to be a barrier for the analytic process (Greenson, 2016). Whilst defined differently, the early thinking about resistance is related to how ruptures in the therapeutic relationships have been theorised by later researchers and practitioners as occurring interpersonally and not just intra-psychically.

Safran and Muran (2000) defined ruptures as moments where the quality of the therapeutic relationship increases in tension and/or deteriorates and can appear through disagreement of treatment goals, lack of collaboration on tasks, or strain in the emotional bond (Eubanks et al., 2018). Ruptures in the relationship are common and inevitable events in the therapeutic process and can vary in frequency, intensity, and duration. Working through them can function as a corrective relational experience and encourage interpersonal growth

(Safran et al., 2011). Although misunderstandings by therapists are common and to some extent inevitable (Bachelor & Horvath, 1999), repeated misunderstandings can rupture the alliance and be detrimental to the therapeutic process (Safran et al., 1990). Pinsof and Catherall (1986) iterated the dynamic nature of the therapeutic alliance that can and does differ depending on who the client is, who the therapist is, the therapeutic orientation(s) being used, and the length and quality of the relationship experienced. How ruptures and repairs occur and are attended to is invariably shaped by the intersection of these factors.

While the research has largely focused on adult populations, there has been increasing evidence of the role of the therapeutic alliance to be significant in facilitating positive therapeutic outcomes for teenagers. It appears to be a more crucial factor for youths than adults (Bhola & Kapur, 2013). This can be understood as ruptures reflecting a developmental need towards separation-individuation and identity formation (Blatt & Behrends, 1987), and a concurrent need for addressing the relational difficulties that arise in the client-therapist relationship. Safran et al., (1990) argued that the presence of ruptures (and subsequent repairs) in the relationship in the treatment process seem to be more effective in terms of treatment outcomes compared with therapies without ruptures. Horvath (2018) also described the alliance with youths compared with adults tends to be more unstable and weaker.

Empirical research has examined a significant positive association between working alliances with overall engagement and outcomes with treatment (de Haan et al., 2013). There have been studies that sought to measure the relationship at a specific point in the therapy (Arnow et al., 2007; Shelef et al., 2005) as well as across whole sessions (Robbins et al., 2006). It is how the therapist identifies and works with the ruptures that will determine how the experience is understood and how a repair process can occur.

Ruptures leading to dropout

O'Keefe et al., (2020) conducted research on whether rupture and repair markers were associated with different types of endings with treatment of depression for adolescents (n= 35) through observational measures. They defined *markers* or signs of ruptures under two categories: confrontation and withdrawal. Confrontation markers appear as direct or hostile anger or dissatisfaction while withdrawal markers appear as verbal or nonverbal expressions of disengagement or avoidance. Muran and Eubanks (2020a, p.69) outlined examples of rupture markers as shown in Table 2.

Table 2

Rupture markers as therapist interpersonal markers

Withdrawal ruptures
Movements *away* from other or self
Efforts towards *isolation* or *appeasement*
Pursuits of *communion* at the expense of *agency*
Examples
- Silences (confusion and mind-wandering)
- Shifts in topics or focus (avoidance)
- Too much or abstract talk (psychobabble)
- Overly protective or accommodating
Confrontation ruptures
Movements *against* other
Efforts towards *aggression* or *control*
Pursuits of *agency* at the expense of *communion*
Examples
- Pathologizing patient (blaming and belittling)
- Coercions to conform to a theory or due to empathic failure
- Microaggressions against cultural identity
- Coercions regarding mutuality versus asymmetry

Research on ruptures in relation to teenagers dropping out of treatment is relatively unexplored compared with studies with adults. Dropout is defined as the termination of treatment involving the client making the unilateral decision of leaving, with the therapist or treatment team perceiving this as premature and ill-advised (Kazdin, 1996). O'Keefe et al., (2020) focused on "dissatisfied dropouts" and "got-what-they-needed dropouts". The former refers to the client voicing that treatment is not helpful, and the latter involves the client expressing not needing to continue therapy when the therapist may not agree. They examined these groups of clients in their study along with "completers" who are those that ended therapy with agreement with their therapist.

Ruptures are unlikely to come up and appear uniformly, and when they were frequently unresolved by the end, this appeared to be linked with dropouts with teenagers. Confrontation ruptures were rarely observed in all three groups which aligns with other research suggesting that teenagers will regularly avoid expressing their negative experiences of therapy to their therapist (Gibson & Cartwright, 2013; Henkelman & Paulson 2006). Dissatisfied dropouts had more confrontation and withdrawal ruptures apparent in late sessions and experiencing more unresolved ruptures from early in treatment compared with the other groups. Ruptures were seen to be usually resolved in sessions with completers and got-what-they-needed dropouts (O'Keefe et al., 2020).

The influence of their therapist's input (or lack thereof) in contributing to the therapeutic relationship breaking down was of interest. Higher proportions of ruptures identified in early sessions were rated as therapists contributing to them for dissatisfied dropouts (50%) compared with completers (14%) and got-what-they needed dropouts (0%). O'Keefe et al., (2020) developed an observational coding system whereby they categorised therapist's contributions to ruptures in three ways: therapist minimal response, persisting with a therapeutic activity and focus on risk.

Therapists being passive and unresponsive was the most common factor identified as impacting the relationship negatively through causing and worsening ruptures experienced by participants. Adolescents who were able to verbalise their worries of feeling uncomfortable and not knowing what to say often responded in a more withdrawing manner when their therapist was silent or passively unreceptive to their concerns. Muran & Barber (2010) suggested looking for withdrawal and indirect dissatisfaction early on and exploring avoidance to make sense of their wish that they are struggling to articulate.

Another way that therapists are perceived to contribute to ruptures is when the therapist persists with focusing on a therapeutic activity at the expense of focusing on what is pertinent for the teenager. This can involve making interpretations that do not fit with the client, focusing on practical goals and issues, or challenging the client's processes. Participants were observed to disengage by withdrawing from or rejecting therapeutic tasks. O'Keefe et al., (2020) discussed how rigid focus on interventions can lead to shutting down the emotional experiences of the client and further ruptures.

Finally, focusing on risk can conflict with the overt wishes of clients in treatment and see strains in the relationship. Adolescents often present with risk concerns. Gibson et al., (2016) conducted a thematic analysis on young people aged 13-18 (n= 63) to highlight what New Zealand youth need to access psychological support. Their findings showed participants voicing need for autonomy and control with engagement, not having parents overly involved, having a relationship different from a friendship, having the experience of being listened to and flexibility of services to meet the lives and needs of young people. They also considered how a focus on risk and confidentiality can contribute to ruptures and dropouts for adolescents. This was presuming that other aspects of major difficulties were missed. Therapists must balance the fine line between keeping the client safe and maintaining

relationship, which can be precarious depending on concerns that are shared. At times, the ruptures are inevitable when there are major risk-taking, care or protection issues.

Therapists' view of ruptures

Morán et al., (2019) conducted semi-structured interviews with eight clinical psychologists that had experience working with teenagers to gather subjective experiences during moments of ruptures in psychotherapy. They used an interpretive phenomenological research methodology to gather thematic findings and arrived at four categories; three of which relate to understandings of ruptures for the individual clients.

The first was the failure to recognise the adolescent's experience whereby participants noted their difficulty to maintain their awareness of their client's experience and applying rigid interventions that felt unconnected. They identified youths being sensitive to the therapeutic context and being drawn to exert their autonomy and respond to any perceived errors by the therapist. This can have the impact of therapists experiencing blame and feeling ineffective for the client who is withdrawing.

The second is the intense affective experience of youth in psychotherapy, namely how it is expressed and felt within the therapeutic relationship. Participants talked about their need to regulate their own internal processes and their vigilance to safeguard the rights of their teenage clients when high distress and safety issues are involved. They found that acting on the urge to respond in a controlling manner can contribute to the rupture which can be experienced as confrontational. This can exacerbate feelings of fear, anguish, and confusion for both client and therapist with a lack of containment.

The third is the therapeutic boundaries as an articulator of the purpose of therapy, with participants discussing their assumptions about the adolescents' understanding of the therapy process. When the therapist's role and purpose are not clarified, and this is mixed

with the client's low motivation, trust, and expectations to engage in psychotherapy, this can lead to a significant barrier to establish a bond.

Morán et al., (2019) suggested a special focus is needed on the occurrence of ruptures. The therapist's role is to consider the relevance of attending to the thoughts, feelings, and intentions of the teenage client to unpack the forming ruptures to understand the deeper, relational nature of these in any therapeutic dyadic situation with adolescents. The absence of doing so can further contribute to ruptures.

Ruptures over telepsychotherapy

Engaging in psychotherapy and recognising ruptures virtually presents with unique challenges and considerations. Withdrawing in the therapeutic process became complicated in 2020 whereby there was a significant shift for therapists to meet with their clients online to ensure safe physical distancing during a global pandemic. Some authors were already looking into the use of technology for clinical use. Hartman (2011) spoke about psychotherapists being unable to ignore the impact of new and evolving technologies on social and interpersonal relations and how that might impact the therapeutic relationship with adolescents.

Therapists might feel isolated and frustrated having to connect through a computer screen and may confuse their own feelings with an actual rupture (Monthuy-Blanc et al., 2013). Dolev-Amit et al. (2020) discussed technical difficulties that challenge the identification of ruptures, such as limited observations of nonverbal language and body cues, unclear facial nuances, inadequate sound quality, or video lags which may mask the length of actual silence. Ruptures may arise that are specific to telepsychotherapy, such as patients withdrawing because of having difficulty maintaining eye contact through the screen or reading text messages popping up on their device. Clients can also avoid the work of therapy

by talking with other people in their surroundings or attending to other distractions during the session.

I found video-calling and texting to be helpful with remaining in contact with my young clients and more importantly, keep them in mind at a time of great ambivalence. Some enjoyed the containment of their familiar bedrooms to allow continuity of sessions. The use technology can offer a different kind of boundary that is represented by the screen that divides the therapist and client and creates a contemporary *transitional space* for the expression of communicating one's internal world. Verheught-Pleiter (2008) discussed how the therapist can facilitate a space between phantasy and reality to make sense of the client's experience and guide a sense of a coherent self for the client.

Technology can also function as a psychic retreat (Steiner & Schafer, 1993) from the external world. There were times when it felt like the relational distance was vast while sitting on separate sides of screens. Carpi Lapi et al. (2018) discussed how technology can be utilised as a defence against mental pain, with a literal and metaphorical barrier between people. Talking behind a screen can avoid the connection of being with someone else and with one's internal objects that the relationship could evoke. I also reflect on what defences are evoked in therapists including myself with the use of devices for therapeutic purposes. Particularly with new clients, it felt that I was able to blame devices or the internet connection when there were difficulties in establishing or addressing a rupture in the therapeutic relationship with the underlying fear of not having a genuine connection at all.

Experience of ruptures

In understanding the experience of ruptures, it is worth noting the immediate challenges in starting and maintaining therapeutic relationships with adolescents. They are

less likely to seek help on their own and are not typically responsible for engaging in treatment (Di Giuseppe et al., 1996). They often enter therapy at the proposition of the adults around them including caregivers, school staff and general practitioners. I have often met with teenagers who can be forthcoming in describing great difficulties with their mental health and simultaneously feel begrudged to attend initial appointments as they feel pressured to meet with one of often many unfamiliar adults.

The beginning atmosphere in which to connect with a teenager client is a tentative one and can be susceptible to breaches in the communication process with a breakdown of intersubjective negotiation (Safran & Muran, 2000). These ruptures in the therapeutic relationship can lead to failures to collaborate on therapeutic tasks, disagreements about the goals of treatment and premature termination of sessions. Muran and Eubanks (2020a) explained that at the heart of ruptures between two individuals, including client-therapist interactions, lies a dialectical tension between the drive to pursue autonomy as well as connection for adolescents who are going through a second individuation phase in their development (Blos, 1967). Ogden (1994) also speaks of this in the therapeutic process of experiencing the dialectic of *oneness* and *twoness*.

Therapy can conflict with one of the central tasks for adolescents during their development; that of shifting towards autonomy (O'Keefe et al., 2020). There is a sense in teenagers expressing wariness of adults, particularly in the therapeutic context, and they can often be reluctant to rely on adult figures for support. An individual's capacity to form a working therapeutic relationship and perceive others as benevolent and cooperative can also be understood as being based on early experiences with affectionate and helping others, or the lack thereof (Frieswyk et al., 1986).

Self schemas and defences

People are made up of multiple selves that exist in a world of interconnected and changeable realities and identities that can be defined and redefined. With the development of humanistic psychotherapies, Rogers spoke about the self being fluid and changing while also being a specific entity at any given moment (Meador & Rogers, 2014). We develop *self schemas* across our lives based on the interpersonal experiences we gather from a young age from which we assess and reassess ourselves and others. These schemas also inform us of how to behave including negotiating needs for self-definition involving feelings of competence, power, and capacity to assert oneself. They also inform behaviours around relatedness involving mutuality and connection. This overlaps with attachment theory and how children form mental representations or *internal working models* of their attachment figures which carries over in future relationships (Bowlby and Bowlby, 2005)

Experiencing ruptures can evoke anxiety and subsequent defensive reactions that can impact how the ruptures themselves can be understood; whether conscious or unconscious. I recall times when exploring difficult emotional material with teenage clients whereby I was met with silent responses in imploring further. When checking in on how they were feeling, I often got responses that it was fine for me to ask questions. Such responses were followed by uncomfortable silences and difficulties making eye contact. I felt withdrawn in those moments and realise in hindsight that there was something happening in the moment that I was not naming, and it felt hard for me to find the words.

Muran & Eubanks (2020a) theorised that when clients display withdrawal-type ruptures the adolescent undergoes self-splitting or psychic movements away from aspects the self as a strategy to appease the therapist. This occurs on an unconscious level due to the associated dread of being in a self-state of pain, and acts to maintain relationship at the

expense of the need to define the self from the other. Distress is often not communicated verbally by young people particularly when there have been past experiences of having their thoughts and feelings dismissed by others overtly or covertly. Safran and Muran (2000) spoke of adolescents engaging in *pseudo-relatedness* when needs are not verbalised and brought forward with the underlying fear of pushing people away or being rejected themselves. Screening out one's own painful affects leads to difficulties to process how one is feeling, leading to dull connections with internal and external objects and events.

I have considered the New Zealand context and how this relates to the concept of whakamā which is not only felt on a personal level but is a shared state between others who might respond in a withdrawing manner as well. Marsden (as cited in Metge, 1985) explained that whakamā is "an outward expression of inward disintegration, an inward unease, because you know you are not what you should be within your group" (p. 77).

Nathanson (1987) talked about shame arising from a perceived violation of what is acceptable and idealised. Adolescents who are in turmoil with their identity-formation can have phantasies of a perfect self. This is influenced by their self schemas the denial of the true self. There is shame for an individual when parts of the self are unintegrated, and the unacceptable aspects become hidden. In addition, the idealising of a perfect therapist and attempts to hold on to being in connection with this phantasy can lead to further issues with differentiating one's sense of self towards autonomy.

On the other hand, there have been times in working with teenagers when frustration and anger has erupted in sessions. I have experienced enormous pressures from adolescents to have their issues and challenges become fixed, influenced by internal and external demands. Clients have often expressed great displeasure with no clear solutions nor relief from their distressing thoughts and emotions. I have often found myself also becoming frustrated within

the therapeutic relationship and noticed myself disengaging with the emotions attached to

confrontation whether it is to be quick to reassure that things will be okay or become

problem/solution focused.

Muran and Eubanks (2020a) explained that confrontation-type ruptures express

movements against the other to uphold their need to assert themselves at the expense of

relatedness in those moments. Menzies (1961) explained how primitive unconscious defences

get stirred up in anxiety-provoking situations such as ruptures in the therapeutic relationship:

> Every individual is at risk that objective or psychic events stimulating
>
> acute anxiety will lead to partial or complete abandonment of the more
>
> mature methods of dealing with anxiety and to regression to the more
>
> primitive methods of defence (p. 109)

Nathanson (1987) talked about the emotion of shame and an individual's use of

excessive *projective identification* to force out feelings of shame and uselessness in to the

other i.e., the therapist. They can then act in anger and rage against these emotions which can

look like dissatisfaction, verbal attacks, laughter, or mockery. This can also be thought about

as the clients' attempts to control and manipulate the other as an object to avoid intolerable

psychic pain attached to parts of the self. I recall seeking supervision about multiple ruptures

I had experienced with a young person whereby I felt useless for them as a therapist. We

reflected upon part of this experience being partially obscured by my own fears of

inadequacy and having a feeling of internal pain. This appeared also connect with pain

coming up from the client's experience of their world being brought into the therapy room.

Anastasopolous (1997) also offered that shame was a developmentally appropriate

affect for teenagers that arises from feelings of vulnerability and loss of a sense of

omnipotence. The experience and expression of it can function to hold on to an ideal self-

image while protecting the fragile psychic self or *ego* from anxieties and intrusions from others in the form of criticism and attention; namely fear of not being good enough. Shame can be understood as inevitable in separation-individuation for young people who are struggling with the pull between dependence and independence.

This links with Waddell's (2006) theorising about how narcissism acts as an adolescent-organising defence to hold things together while internal growth accelerates to keep up with a period of many changes. The phantasy of the world being all-giving is important for the omnipotent wish to bypass the pains of necessary losses, relinquishments, inadequacies, and anxieties. When this phantasy is challenged, it makes sense why youths question the relentless challenges of managing new and changing school demands, relationships, and individual/collective responsibilities. Winnicott (1965) talked about the *adolescent doldrums*; a dilemma of teenagers of having "no way out except to wait and to do this [adolescence] without awareness of what is going on" Winnicott (1965, p. 244). It is unsettling when there is a lack of certainty with one's identity(-ies), way of life or future.

Splitting and projection are used to explore and make sense of the "otherness" of others. By splitting off aspects of the self and locating them in different people, it becomes possible to remain in touch with these parts without having to suffer them too intensely. Narcissism then allows for exploration and experimentation that promote a sense of identity that is distinct from parents, based on good-enough internal relationships and objects, to the point that the individual can feel confident in something called his or her own self, and eventually be comfortable with themselves.

When ruptures are not resolved

Where the quality of the therapeutic relationship becomes ruptured and when misunderstandings and failures to repair persists, this can be detrimental to the therapeutic

process for individuals of all ages (Safran, et al., 1990). Ruptures display experiential

avoiding (Hayes et al. 1996) that results in empathic failure (Kohut, 1984) from the

therapist. Muran and Eubanks (2020a) discussed how *affective misattunements* between

therapist and client contribute to these missteps in communications and negotiations with

reference to mother-infant empirical research. A mother and her infant are often not in states

of attunement or matching emotions; approximately 70% of the time (Beebe & Lachmann

2014; Tronick 2007). Bion (1962) talked about the container/contained relationship and

reverie where the mother can meet her infant's mind with her own and think their thoughts

for them. Conversely, if the mother is not able to provide this function adequately, the baby

can be left to struggle alone with their unprocessed experiences and perceive her and the

world as chaotic and terrifying.

Muran and Eubanks (2020a) also highlighted enactments contributing to ruptures in

therapy which McLaughlin (1991) defined as "events occurring within the dyad that both

parties experience as being the consequence of behaviour in the other" (p. 611). They are

influenced by unconscious, nonverbal ways of interacting within the therapeutic relationship

(Schore, 2003). The behaviours of any individual within an interaction exerts a pull on the

response from another with overt behaviours eliciting similar overt responses and vice versa

(Sullivan, 1953). What can occur is a playing out of maladaptive patterns of communication

and relational behaviours that can lead to increased tensions and deteriorations in the

therapeutic relationship. Lyons-Ruth et al. (1988) referred to this as *enactive relational*

representations which often disguises the original intention or need of the client by acting

out their internal conflictual themes with the therapist.

Therapeutic relationships with adolescents must be understood as forming in the

wider context of societal identities and power dynamics. In any given interaction, we are

always within an interpersonal system that exerts a great influence on our self state, and how

it emerges in any given moment based on our developing self schema over time (Stern 1985). Teenagers beginning a therapeutic process are understandably wary of a new adult on top of the distress they are facing in other aspects of their lives. They can draw the therapist to enacting out withdrawal or confrontation types of interactions that can be experienced as invalidating for clients. Winnicott (1990) explained how adolescents having a "fierce intolerance of the false solution" (p.210), alluding to therapists or caregivers offering responses to what is apparent on the surface regarding perceived difficulties, often in a problem-solving manner. What can feel like intentional accommodating to the client can feel like an experience of misattunement.

Menzies (1961) also explained that the therapist's defences become evoked to avoid disturbing identifications from and excessive emotional investment in the child and family. Subsequently, the therapist can display resistance and unwillingness in the relationship which can further distance the adolescent client. The defences of individual practitioners can reflect the wider systemic defences of mental health services that have enormous pressures to meet the needs of increasing numbers of people presenting with more and more complex issues with short-term interventions. This continues to put pressure on the capacities of therapists to acknowledge and address ruptures in the relationship with teenagers. In New Zealand, there is still unmet need reported for mental health services for young people with some CAMHS reporting times when they are at capacity and cannot see more rangatahi (Malatest International, 2016).

This can lead to many developmental disruptions including inabilities to recognise the self, to distinguish one's own wishes from those of others and to self-regulate (Bion, 1962). When there is an experience of the world as one that does not provide empathic support to how one truly feels (Geist, 1989) the child attempts to self-soothe by attuning themself to the mother and her needs to create the experience of being together when there is an absence of

self-regulation and self-concept. This acts as a defence against the fear of breakdown and leads to strengthening of the false self (Winnicott, 1960; Winnicott, 1974).

Finally, it is worth noting that therapists may have to name that the therapy is not working and there can be potential risks and harm with continuing ineffective treatment (Wolpert et al., 2018). I have met with young people and families through CAMHS who have had several engagements with mental health which were experienced as unhelpful and holding a strong view that seeking help and meeting with practitioners is hopeless. This is detrimental for possibilities of therapeutic change.

Summary

This section provided a brief overview of literature that have examined ruptures in therapeutic relationships including those that relate to adolescents and exploring understandings of how psychotherapists understand the experience of ruptures for themselves and their young clients in different settings, with considerations of psychological processes and internal structures.

Part II: Repairs

This section provides an overview of the literature examining repairs in therapeutic relationships, and those that occur when working with adolescent clients. This includes consideration of attachment histories and repair strategies for therapists as well as how use of transference and countertransference assists with the process. Finally, what occurs psychologically when repairs are established will be discussed.

Overview of repair research

Every relationship is at risk of moments of frustration and mismatch whereby we seek repair to overcome further weakening or breaking of our ties with others. Early mother-infant studies highlighted the natural occurrences of ruptures and repairs in relationships as seen from early life. Most of the time it was observed that the mother and child were not attuned with one another or meeting each other psychically, however approximately 70% of those misattuned periods could be repaired within *two* seconds. These repairs or coming together again is associated with optimal development involving self-efficacy and coping capacity for the child (Beebe & Lachmann 2015; Tronick 2007).

Regarding therapy, there are no consistent guidelines on how practitioners should intervene or work with ruptures in the therapeutic relationship. Safran et al. (1994) developed a preliminary resolution process model with attention on therapists following the behaviours of the client in sessions. When the client expresses negative feelings, the therapist is advised to demonstrate empathy with those feelings and establish focus on the present. The client might then display ambivalence between being self-affirmed and being reliant on the other for assurance whereby the therapist can explore the client's fears of direct communication of their negative affect. The client may speak to this fear, which the therapist can then empathise with them to encourage more communications of their negative feelings and demands. The therapist can validate the experience and what just occurred in the here and now in the therapeutic process.

Baillargeon et al. (2012) conducted a literature review on models of resolving ruptures in the therapeutic alliance such as the one by Safran et al. (1994), as well as those by Safran and Muran (1996) and Inck (1995), to seek which of them underwent experimental investigations. They found that few models were subject to empirical studies except for those

done by Safran and Muran's team; and those studies were limited by low numbers of participants and session numbers which restricts generalisation of the theories.

Muran et al. (2021) offered their most recent overview of the strategies for rupture-repair to recognise the client's needs (Figure 2) overlapping with a stage-process model that occurs between the client and therapist around rupture resolution (Figure 3).

Figure 2

Strategies for rupture–repair (Muran et al., 2021, p. 4; designed by Rachel Small, 2019)
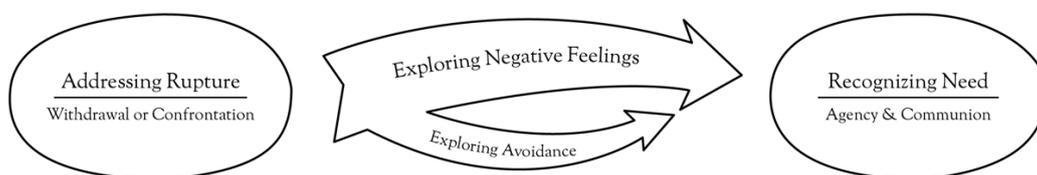
Figure 3

Safran and Muran (1996) stage-process model (Muran et al., 2021, p. 4; designed by Rachel Small, 2019)
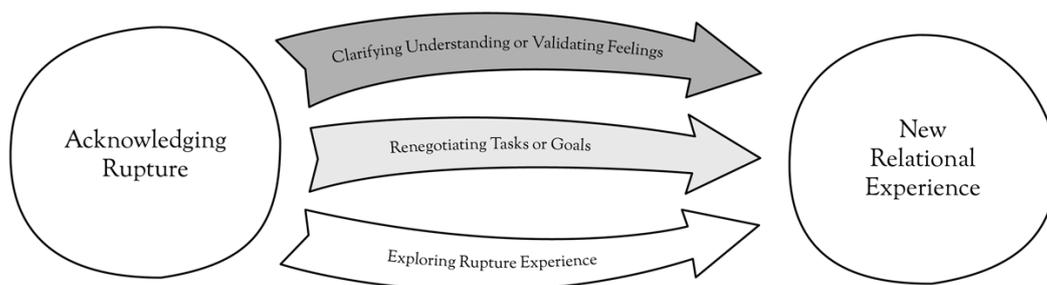
With the latter, they discussed two strategies to attend to the rupture as soon as it is identified to return to the therapeutic process. The first involves alliance building whereby goals and misunderstandings are clarified as well as validating anxious and intolerable feelings, and the second includes renegotiating changing of focus, tasks, or goals. These strategies can promote significant change by the client having new experiences and different

outcomes to their expressed wishes for example shifting negative expectations of the other being withholding, intrusive or not nurturing.

The third strategy of exploring the rupture experience looks at attending to the internal states and behaviours of both the therapist and client that may have contributed to the rupture to highlight the underlying conflicting needs. Often there is an ambivalence between going towards independence and regression to dependence (Winnicott, 1965). The use of this approach to expand awareness of what is occurring around the ruptures makes it possible to exit the vicious circle of enactments and inquiring further to the here and now. Muran et al. (2010) explained that you must be within the rupture dynamics to know how to get out of it. Muran et al. (2021) also suggested thinking with the client "what is happening between us right now?" This *therapeutic meta-communication* is the essential technical principle to guide the approach to ruptures and repairs which has potential for shared emotional regulation and expanding awareness of the subjective experience of the self and other.

Repairs with adolescents

Atzil-Slonim et al. (2015) discussed how research on client–therapist relationships with teenagers lags far behind studies with adult populations. Gersh et al. (2017) investigated the alliance rupture and repair processes in psychotherapy with young people with borderline personality disorder (BPD) and observed any differences between different phases and modalities of treatment. Participants (n= 44) aged between 15-24 received either Cognitive Analytic Therapy (CAT) or a Befriending involving companionship through supportive regular interactions (Mitchell & Pistrang, 2011).

Gersh et al. (2017) refined Bennett et al.'s (2006) model of rupture resolution by using Greenberg's (2007) task analysis of both positive and negative outcomes with cases of six people with BPD (Figure 4). Ruptures and repairs in the therapeutic alliance were

identified using the observer-based Rupture Resolution Rating System (3RS; Eubanks-Carter et al., 2009).

Figure 4

Bennett et al.'s (2006) model of rupture resolution refined by Gersh et al. (2017, p. 87)

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│                 Changes to patterns/aims               │
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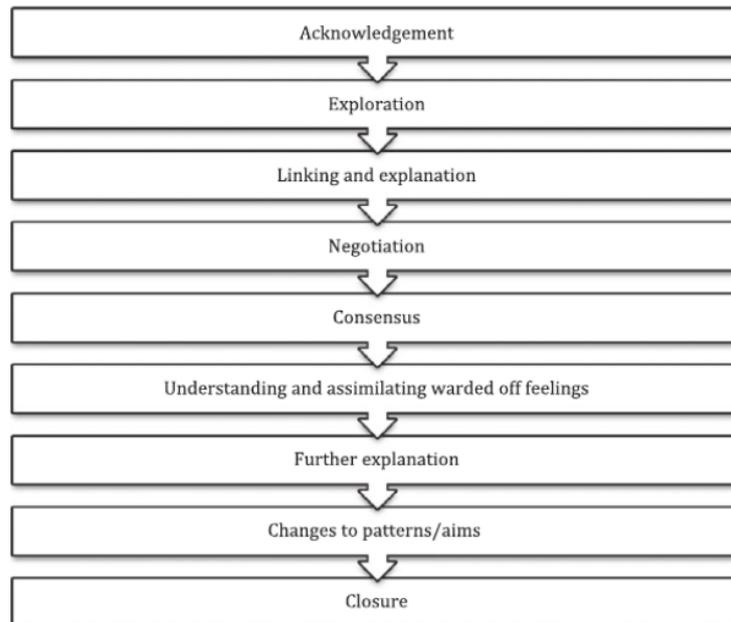
They found that a minimum of one rupture was present in 53% of all sessions, with 61% of CAT sessions having at least one rupture compared with 35% with Befriending sessions. Most sessions with rupture had "little to none" or a "large" amount present indicating a skew in frequency. Ruptures present early on in therapy were associated with poorer outcomes, which contrasts with repairs being made later in sessions with better outcomes. The results showed there were greater numbers of ruptures in the therapeutic relationship, confrontation markers, and repairs with CAT compared with the Befriending approach. This was likely influenced by the explicit focus of CAT to attend to ruptures and linking it with client's patterns (Bennett et al., 2006). Gersh et al. (2017) discussed how therapists could expect more ruptures towards an anticipated ending of treatment and suggested not to focus on blocking them, rather encouraged therapists to actively try to repair

them. Their findings indicated that rupture resolutions later in therapy were associated with change; contrary to other empirical research on adults (Safran et al., 2011).

Eubanks et al. (2018) conducted a study with therapists' experience of alliance ruptures with adolescents and how they responded to it, with peer-nominated experts rating what was effective or not. There were three phases of the research including therapists submitting clinical material describing alliance ruptures (n= 69), therapists then generating responses to the material and strategies underlying the responses (n= 177), and finally peer-nominated experts rated the effectiveness of these clinical strategies (n= 134).

There was some consensus between clinicians and researchers on developing creative techniques and thinking on the topic of approaching ruptures and repairs and there are challenges in putting findings into themes as it can lose details of original strategies. What appeared to be effective regarding clinical techniques was talking about the rupture, validating the client's perspective, focusing on emotional experience, coping strategies, and gathering information. What seemed less effective was interpretation of patterns, cognitive restructuring, problem solving, generating hope, and focusing on interpersonal consequences which can enhance feeling criticised and invalidated, deepening ruptures.

Repairs and attachment

The need for repairs can be understood through attachment theory and people being fundamentally relational from the moment they exist in the world. Central to this theory is the notion that individuals from a young age seek connection with their caregiver or attachment figure. Secure attachment involves experiences of regular and warm availability and responsive care (Bowlby, 1988). When this happens, children learn to use their attachment figure(s) as a *secure base* in that they are willing to turn to them in times of need.

They can be comforted by caregivers in a way that allows them to feel better and to return to other activities and exploration.

Experiences of attachment influences future patterns of relationships in an individual's life, and Bowlby (1988) explained that as infants we develop an *attachment behavioural system* with our caregivers. This system becomes activated when we feel unsafe, whether that be real or perceived. When attachment figures are perceived as not close enough nor responsive enough this can lead to a certain way of being and behaving to maintain relational links.

A part of healthy functioning involves reliance on secure attachment relationships in times of danger, vulnerability, or illness by bolstering us against stress and uncertainty. According to Bowlby (1980, as cited in Wallin, 2007, p.13):

> Intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or a toddler, but throughout his adolescence and his years of maturity as well, and on into old age.

New relationships and life events can shift attachment patterns over time and through each relationship, a child gathers different experiences of themselves. Bowlby and Bowlby (2005) elaborated on how children form mental representations (or *internal working models*) of their caregivers which influence later thoughts and behaviours in future relationships and outlined different forms of insecure attachment - avoidant, anxious-ambivalent and disorganised. This is turn shapes the self and interpersonal schemas. Safran and Muran (2000) explained that the therapeutic relationship functions as an arena for altering maladaptive interpersonal and self schemas.

Zack et al. (2015) examined how the attachment histories of a group of adolescents (n= 100) in residential care in the United States might influence the alliance relationship as a moderator. Ages of participants were between 11 and 25 years and the majority were male (68%) and Caucasian (84%). All youth had a primary substance dependence diagnosis. Attachment histories was assessed by use of the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987). They discussed that those with insecure attachments prior to treatment needed more emphasis on rapport building and rupture resolution while interestingly, those who reported more secure attachments did not appear to be associated with use of the relationships and symptom reduction.

Straus (2017) explained that some attachment strategies that develop from earlier difficulties in relying on others can interfere with developmental tasks for children growing up. With regards to adolescents, aggressive and dismissive behaviours towards others can function as a strategy to be in relationship while maintaining control, distance, and self-reliance. This can involve ignoring their own needs and avoiding negative emotional experiences e.g., attachment-based feelings of fear, anger, disappointment, hurt and loneliness. This can disrupt tasks of developing emotional regulation, adaptive help seeking, information processing, communication, and sense of self (Straus 2017). The role of the therapeutic relationship can then serve to shift internal working models to one of security as well as understanding behaviours that seek relationship with attachment figures.

Lewis (2005) talked about how multiple attachments occurs in a *polytropic social network* which aligns with non-western family configurations as well as contemporary blended families. The concept understands that an individual's network extends beyond the immediate family unit including relatives, friends, teachers, and later romantic partners. A child's system of relationships sits within other networks that can include ethnic tribes, social classes, and religious groups. These networks inevitably mutually influence each other.

Hall (2012) discussed how Māori view of whānau is more horizontal in structure as opposed to the traditional western family hierarchy which dyadic understandings of attachment were based on. This does not overlook central parenting figures as Māori value parental relationships for their important roles in nurturing the growing child, whether it involves biological parents or relatives through *whangai*[2], or both (Metge, 1995). It encapsulates "a bi-lateral arrangement… where physical and emotional care is continuous, consistent and supported by the mutually significant other or others" (Hall, 2012, p.45). Māori view attachment not only through collective interpersonal relationships for the child, but also extra-personal connections including attachment to the land and natural world tied to whakapapa (Mikahere-Hall, 2019).

Bowlby (1988) conceptualised attachment as a guiding framework for clinical practice and implications for conducting and adapting therapy. He suggested that the therapist may become a temporary attachment figure for the client by becoming a reliable and trustworthy person in the patient's exploration of his or her experiences. In the therapeutic relationship, attachment histories of the therapist and client can intersect and might inform different ways of approaching ruptures and repairs.

Repair strategies

Nof et al. (2019) proposed a Child Alliance Focused Approach (CAFA) model of treatment or adjunct to therapy designed for practitioners to identify and repair ruptures in the alliance with young clients aged six to seventeen. This is based on the framework introduced

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[2] *Whangai* – A Māori term meaning "to feed or nourish". It is a practice within Māori society where birth parents give their child to other whānau members to raise. (McRae & Nikora, 2003).

by Safran & Muran (2000) in psychotherapy with adults whereby the aim is to open "an interpersonal space of reflection and negotiation, in which a mutual recognition and relational change can occur" (Nof et al., 2019, p. 46) that can also apply with youths.

It is difficult to resolve ruptures in the therapeutic relationship if they are not identified in the first instance. This can be obscured by strong affect. CAFA's first phase outlines how therapists can attend to the rupture dynamics taking place between them and their young client by first regulating their own emotional responses. Instead of continuing treatment as normal, the therapist must be able to manage their own intense feelings successfully. Not doing so and continuing treatment as normal can lead to further ruptures (Eubanks et al., 2018).

The therapist should make sense of what type of rupture is occurring and reflect internally on the underlying communication of the client. This involves mentalisation skills whereby there is wondering about the thoughts, feelings, and intentions of the young person in the present moment of ruptures. This enables meaning making of the behaviours observed which iscommonly linked with signals of distress and longing around protection and safety (Bowlby, 1998; Harel et al., 2006). Nof et al. (2019) suggested four questions to guide reflection as illustrated in Table 3.

Table 3

RNRN questions to guide therapist's reflection of ruptures with young clients

Reason	What preceded the rupture?
Needs	What did the child need from the therapist?
Reaction	How did the child react to the rupture?
Non-adaptive pattern	Is the rupture part of the general vicious cycle?

With youth, therapists should be wary of going along with the client's tendency of not asserting their needs, withdrawing, and relating to others inauthentically (Safran & Muran, 2000). The deliberate use of pausing should be in response to a noticeable shift in the young client's behaviour or experience in the room observed through the therapist's countertransference. Pausing can also help not only to notice the rupture, but it can also display respect in the therapeutic relationship by showing the young person an earnest attempt to face this in a different, manageable way.

The second phase involves therapists verbally highlighting rupture in the alliance and associated reactions to it. For youths, this would look like simple description of the client's actions around the rupture (e.g., "I can see you tapping your fingers on your leg"). This should be done to focus on what has been done and not what was not done (e.g., "you are not listening to me"). This accurate mirroring helps to build the therapeutic relationship and bolster the client's more adaptive and realistic self schema (Ackerman et al., 2010). Alternatively, therapists can use metaphors as an abstract method of describing the rupture dynamics. This facilitates coherence in the interaction and promote awareness and insight.

 CAFA's third phase focuses on the therapist taking on the responsibility of the rupture in a non-judgemental style. This can aid young clients to assert their emotional needs without overwhelming worry of the relationship falling apart (Safran & Muran, 2000). This should be done by the therapist explaining that their approach or decision was not appropriate for the client and articulating that they made a mistake. Reiterating the rupture as the young person's attempt to signal their distress or discomfort should also be highlighted (e.g., you let me see that this explanation is not helpful for you).

The final phase directs therapists to use meta-communication to ask permission to talk further about sensitive material brought into sessions and be open to this being rejected. Nof

et al. (2019) offer a narrative approach to speaking about the rupture by including content of the young client's interests as well as emotional words and descriptions to capture reactions and the wishes and needs from others. Normalising statements can promote self-acceptance of desires (Misch, 2006), for example voicing to the client that "all young people want to be listened to without expectations for something else". Recapping the therapist's role in containing the unbearable feelings in here, as opposed to outside in the young person's day to day life, is essential in upholding the relationship.

Repairs over telepsychotherapy

Practitioners who have had to switch to telepsychotherapy can assume that technology can interfere with the development of the therapeutic relationship and rupture resolution (Monthuy-Blanc et al., 2013). There can also be a belief that clients are not motivated to engage in therapy remotely (Deen et al., 2013). Empirical studies outlined that clients' ratings of the therapeutic alliance with telepsychotherapy are at least as robust as those formed in traditional face-to-face treatment across a range of diagnostic groups (Backhaus et al., 2012; Germain et al., 2010; Simpson & Reid, 2014). These findings proposed that therapists were also able to develop skills around managing ruptures and repairs virtually.

Dolev-Amit et al. (2020) proposed a four-step model for dealing with withdrawal ruptures (common with adolescents) in telepsychotherapy as they appear more covertly over digital means of communication. Firstly, the therapist should make all the necessary preparations before switching to an online setting through practical setup of technologies used (e.g., equipment, across locations, programmes) and advising the client to be in a quiet, private space without distractions. Secondly, during the first online meeting, the therapist should take time to comment about the change in the usual environment and initiate a conversation about possible difficulties. Therapists should be aware that the setting might

influence how the client is engaging in telepsychotherapy and any ruptures arising, for example if family members are present. Therapists should also be more active and take charge of virtual sessions so that the client can feel their presence more strongly to compensate for lack of the acquainted therapeutic space and reassuring physical presence.

In the third step, the therapist should try to determine whether a rupture occurred. This will be based on cues for example facial expressions, eye contact, acoustic changes, and the therapist's own countertransference feelings. Special attention should be given to acoustic measures such as reduced responsiveness, change in speech rate, unsteady voice quality, or longer silences (Dolev-Amit et al., 2020). Lastly, the therapist can attend to the rupture directly or indirectly; either by assuming responsibility or by revisiting the goals and changing tasks of treatment due to the transition to telepsychotherapy. Alternatively, the therapist can also choose to attempt to fulfil the client's unspoken wish with indirect supportive techniques, such as showing genuine interest in the patient or pointing out the patients' strengths and gains in dealing with their difficulties, especially during stressful times. Therapists are guided to show their clients that they believe in their resilience and to work together with the patient as a team toward better self-understanding (Book, 1998).

Use of transference/countertransference

Themes and patterns of interacting become apparent in some form within the therapeutic relationship. The therapist's awareness, reflection and interpretation of their own internal processes towards the client can be helpful in identifying shifts in the alliance including with ruptures and repairs (Safran & Muran, 2000; Muran et al. 2010). Transference can be defined as "an established pattern of relating and emotional responding that is cued by something in the present, but oftentimes calls up both an affective state and thoughts that may have more to do with past experience than present ones" (Maroda, 2005, p. 134). In a

parallel formulation, neuroscience now documents that the right hemisphere is fundamentally involved in the unconscious processing of emotional stimuli (Mlot, 1998).

The therapist attends to the transference by being in touch with unconscious processes. Stern (2003) explained that "each interpersonal field is defined by both dissociation and imagination, by what it illuminates and what it keeps in the darkness" (p. 155). They also notice the "absences, gaps, contradictions, stereotypes, repetitions, and dead spots in the material" (Stern, 2003, p. 99) which prompts them to be curious and inquire further to fill in the holes in the client's narrative (Levenson, 1982). Rosenbluth (1970) outlined the psychoanalytic technique of unpacking transference which include noticing the shifts in important feelings and behaviours to make sense of the client's internal objects and phantasies that underlie them. The process of transference occurs out of the therapeutic relationship and how it is identified, processed, and understood will impact the outcomes of treatment.

Countertransference can be defined as conscious and unconscious reactions to the client and to the client's transference. It was first described by Freud as the analyst's feelings, attitudes and behaviours that were not objective towards the patient, deriving from their own neurotic conflicts, and should be kept out of therapy (Freud, 1910/1957). Since then, various authors have underlined the relational aspect in the concept of countertransference. For example, Winnicott (1949) described negative feelings for the therapist to be normal when working with young patients who bring negative unprocessed emotions. Sullivan (1953) understood that therapists unconsciously respond to the patient's inviting certain interactions. Even though countertransference originally was described in psychanalytic theory, empirical studies indicate that countertransference is a universal phenomenon, and it is not associated with only one theoretical orientation (Betan et al., 2005; Dahl et al., 2011).

Tishby and Vered (2011) studied countertransference themes with their adolescent clients by interviewing therapists (n=12). They explained how psychotherapy inevitably involves two people continuously perceiving and responding to each other through the frames of their unique interpersonal patterns (Safran & Muran, 2000). The therapeutic relationship is the context where clinical technique is applied and received and where clients explore and learn about themselves in a constant relational movement, or "dance" together. Due to the nature of the developmental stage, adolescents can evoke strong countertransference responses in the therapist (Ghuman & Sarles, 1998).

They used Haye's (2004) model (see Table 4) to define the focus of measuring components of the countertransference. They also used the Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Cristoph, 1998) interview to elicit attachment and relational patterns of the therapist based on meaningful interactions with their caregivers, and two of their patients.

Table 4

Hayes's (2004) operational model of countertransference

Origins	Area of unresolved conflict in the therapist from which countertransference reactions stem
Triggers	Therapy related events that touch on these conflicts e.g. Patient transference, certain content areas as discussed by client, phase of therapy like termination
Manifestations	Affective, cognitive, behavioural and visceral reactions that therapists experiences e.g. Avoidance, over-involvement
Effects	Consequences of these reactions on quality of therapy process and outcome
Management	Ability to deal with and minimise negative impact of countertransference eg. How therapists deal with their anger/anxiety, degree of self-awareness in sessions

Their findings showed that there was a high number of relational themes with therapists' parents being repeated in narratives about their clients across components of CCRT. The most frequent themes that arose were the wishes to be close and loved by parents which reappeared in half of the therapists' narratives about their patients. They discussed how therapists are not neutral in therapeutic relationship and hold their own relational expectations to the encounter. The wish to help clients was common, however it did not appear linked to wishes about parents, which seems to imply that responses are not autonomically replicated for different relationships and may come from learned values about relationship with others.

The disappointed and hurt responses of the self that related to parents were a prevalent theme that also appeared with clients. Vishby and Vered (2011) discussed how negative countertransference appear to dominate in their study which raises issues of the relative impact of positive and negative feelings on countertransference. Hayes et al. (1997) thought about the possibility of therapists experiencing strong negative reactions that lends to a cycle of negativity and the distorted perception of the client being "difficult" and the therapist feeling unable to manage the relationship.

Jones et al. (2020) conducted a thematic analysis study based on interviews with six therapists who were participants from a previous randomised clinical trial examining the effect of transference interventions on adolescents with depression (Ulberg, et al., 2012). The aim was to examine how particular input by therapists might influence response to therapy. They outlined how therapists found working with transference strengthens the therapeutic relationship by shaping what was brought in to talk about in sessions as well as how they talked about it. This includes how repairs become acknowledged and addressed for repair as illustrated from one participant:

We can talk about how what I say affects the patient. If the patient says

"it seems like you did not pay attention" or "you seemed critical," I can

reply that "that sounds like a tough experience and I don't want it to be

that way". And then we ... can take a look at what happened (Jones et al.,

2020, p. 6)

Jones et al. (2020) discussed how the trajectory when exploring a withdrawal marker

involves the mixed expression of negative views towards the therapist and therapy and a

clearer assertion by the client e.g. "I don't find this task helpful". The path when exploring a

confrontation involves the expression of hurt or disappointment about the therapist as well as

vulnerability by the patient e.g. "I don't like it when I see you as not listening". Both these

pathways also often include an exploration of some avoidance by the patient, for example

when a patient becomes anxious about some assertive or vulnerable expression. They might

be afraid of the therapist rejecting them as a response.

Participants reflected on speaking to their feelings that things are not working in

therapy to shape opportunities for repair and expressing their intent to look at ruptures with

their client that arise in session. A part of this is being upfront not to criticise the client while

encouraging them to reflect on their interactions. This includes any repeating relational

patterns playing out that might be a part of the rupture and allow for resolution to occur.

Orange (1995) wrote that in "witnessing, a special form of participation in the intersubjective

field, makes the other's experience real and valid and important to that other" (p. 136). The

therapeutic aim is to foster mindfulness in clients with their experiences with the therapist

bringing to consciousness the details of the experience of the relationship.

Participants brought up the dilemma of building the therapeutic relationship when

there is a known limited timeframe to work within. This can be a difficult reality for young

people who are seeking help where there are anticipated barriers to sufficient therapeutic engagement. I think about this for the cases of young people who are nearing eighteen who would expect to age out of a CAMHS soon and can fall through the cracks between youth and adult mental health services.

Regarding telepsychotherapy, Carpi Lapi et al. (2018) discussed the use of countertransference in the therapeutic relationships with adolescents when meeting virtually. They make a distinction between "digital native" teenagers and "digital immigrant" adults that can approach communication through technology differently. Therapists are warned to confront our prejudices and unconscious feelings around meeting virtually as being artificial and getting in the way of establishing a therapeutic relationship. It is understood that adolescents use the internet as a genuine way of connecting with others. On the other hand, avoiding the real world may lead to teenagers to develop false knowledge of themselves and others whereby interpersonal boundaries and identities become confused (Seligman, 2011).

When repair is established

Schore (1994) in his earlier works investigated infant studies along with research on attachment, developmental psychology, and neuroscience to highlight how the developing relationship between a baby and their primary caregiver(s) is essential in growing the child's capacity to regulate their internal physiological and emotional states. As referenced earlier, ruptures in the mother-infant relationships are regular and frequent and it is through the repair of misattunements or ruptures which nurtures the area of the brain (namely the right hemisphere) that is involved with receiving, expressing, regulating, and communicating emotions. This impacts the sense of the developing self (Schore, 2002).

Schore (2012) has discussed theories for clinical practice and explained that this interactive psychobiological regulation can occur in the therapeutic context under which a

client is empowered to describe and eventually regulate their inner experience with an empathic therapist that provides a safe relational space, rather than just insight alone. A foundation to this is the therapist being able to tolerate negative affect (or countertransference) and be willing to remain in relationship with the client to shape their interactions to approach repair. As Rustin wrote (as cited in Waddell, 2002):

> …the capacity to contain and observe emotionally powerful psychic phenomena is the basis for knowledge of oneself, and for that contact with psychic reality which is at the core of an authentic personality. (p. 249)

Much like the Winnicott's (1987) description of the "good enough parent", a sufficient therapeutic relationship can counter stress reactions, or the fight-flight-freeze response, and "the experience of feeling cared about in a relationship reduces the secretion of stress hormones and shifts the neuroendocrine system toward homeostasis" (Adler, 2002, p. 883). Bromberg (2006) observed that processing in psychotherapy becomes "safer and safer so that the person's tolerance for potential flooding of affect goes up" (p. 79). In other words, the social bonds of attachment embedded in the therapeutic relationship build resiliency towards stress and intolerable affects.

People are relational by nature, and we all need a sense of who we are to connect with others. As Symington summarised, "it is possible to change the emotional facts of our life" (1993, p. 89) and through psychotherapy, there is a possibility to promote a more robust ego to endure external and internal demands with needs to love to remain psychologically healthy (Freud, 1914/1957). Whilst changes are done on an unconscious psychic level, it can be felt as real to the individual.

This can involve displaying one's own self (which is not wholly known) by connecting with others, which can feel terrifying. A fear of the unknown, and by extension of

knowing the self, is a core aspect of narcissism and it becomes an emotional task to overcome it. In working with adolescents, the hope is to understand the function of narcissism in their development and support them in an exploration of the self. This can be met with much resistance from the false self and other defences, and the result can be felt as a demolition of the self.

Winnicott (1960) explained that the false-self develops to hide the true-self. Through that split, the young person becomes extremely restless with a need to focus on impingements from external reality while defending against true feelings. The false-self bolsters a sense of emotional self-sufficiency which prompts a refusal of all help and understanding from others (Winnicott, 1960). Therapists cannot dismiss the shame that clients experience in revealing parts of themselves that feel bad and unacceptable, but that painful confrontation inside can bring about change and the hope is to shift feelings of shame to guilt with movements towards reparations (Anastasopoulos, 1997).

When a therapist gives up his attempts to overanalyse their client and allows himself to know their client through the ongoing intersubjective field they are sharing at that moment, an act of recognition takes place in which words and thoughts come to symbolise the experience instead of being substitutes for it (Bromberg, 2006). In this way, talking through ruptures towards repair in the therapeutic relationship solidifies the moment of both the therapist and the client overcoming a relational hurdle and gaining a sense of being seen and understood. As Jung (1933) expressed, "the meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed" (p. 57).

Summary

      This section covered a brief overview of repairs in therapeutic relationships including those that relate to teenagers and exploring literature in understanding relationships through attachment and repair strategies with youth, and what happens to us internally when repairs are possible. The next chapter will provide a discussion of the findings and implications of the literature, strengths and limitations of this dissertation, and ending with suggestions for future research.

Chapter 4: Discussion

This chapter discusses the findings from the hermeneutic literature review based on the research question: "How do psychotherapists understand ruptures and repairs in therapeutic relationships with adolescents?" The dissertation then considers possible implications of these findings. The strengths and limitations of this study are reflected upon as well as suggestions for future research.

Discussion of Findings

Empirical research has examined a strong positive association between working alliances and therapeutic relationships with overall engagement and outcomes of treatment (de Haan et al., 2013). Research in psychotherapy has historically focused on adult participants and there is regular warning to not extend the findings from adults to teenage clinical populations (Morán et al., 2019). There has been increasing evidence of the role of the alliance as significant in facilitating positive therapeutic outcomes for teenagers and this appearing to be a more crucial factor for youths than adults (Bhola & Kapur, 2013; Safran et al., 2011). The quality of the relationships with youths appears to be more changeable and tentative compared with adults (Horvath, 2018).

Across the literature ruptures in the therapeutic relationship are understood to be inevitable and common, much like misunderstandings in any given interaction. Ruptures and repairs occur regularly; anywhere from 30%-50% of sessions by self-report or 30-100% by the observer (Eubanks et al., 2018; Muran et al., 2021). Ruptures reflect a normative process for teenagers towards separation and individuation that can conflict with the need for relatedness; feeling connected to and recognised by another (Muran & Eubanks, 2020a; Muran et al. 2021).

There are often references to Safran and Muran's (2000) general definition of ruptures as disagreements about the way of working between client and therapist (including in-session tasks, exploring of thoughts and feelings and between-session tasks) and towards goals i.e., increase in self-awareness, developing skills, decrease in distressing symptoms, which is influenced by Bordin's (1979) concept of the working alliance. Ruptures also involves breakdowns in how clients and therapists negotiate their respective needs or wishes (Muran & Eubanks, 2020a).

Research has highlighted that youth are more inclined to display withdrawal than confrontation rupture markers. This suggests that adolescents will regularly avoid expressing their negative experiences of therapy to their therapist (Gibson & Cartwright, 2013; O'Keefe et al., 2019). Withdrawal in the therapeutic relationship can be understood as movements away from another or parts of the self. This acts as way to maintain connection with another at the expense of expressing their need through pseudo-relatedness (Safran & Muran, 2000; Safran & Muran 2020a). Alternatively, confrontation rupture markers are understood as movements against the other involving aggression and control and can be a sign of the adolescent's effort of asserting autonomy at the expense of relatedness (Muran & Eubanks, 2020a).

Empirical studies have looked at dropouts of therapy with adolescents that considered there are different reasons for stopping treatment prematurely (O'Keefe et al., 2019; Swift & Greenberg, 2015). Multiple unresolved ruptures were seen to be related to dropout that supports the idea that repeated misunderstandings can rupture the alliance and be detrimental to the therapeutic process (Safran et al., 1990). There have been considerations on the different contributions to ruptures with research conducted by Morán et al. (2019) who noted that the failure to recognise the adolescent's experience and having difficulties with intense

affect and boundaries within the therapeutic relationship was understood to contribute to ruptures and tensions in the alliance.

Ruptures involve a complex set of maladaptive patterns of communication and increasing tensions in the relationship that occur between the young client and therapist. Experiencing rupture in the therapeutic relationship can evoke anxiety and subsequent defensive reactions (from both parties) that can impact how the rupture itself can be understood; whether conscious or unconscious. There can be a significant experience of misattunement and being caught in maladaptive communication patterns in vicious circles (Muran et al., 2010; Nof et al., 2019; Tronick, 2007). This can lead to the breakdown of the alliance and poorer treatment outcomes. The ruptures experienced in the therapeutic relationship can lead to developmental disruptions of the adolescent's developing self schema; inabilities to recognise the self, to distinguish one's own wishes from those of others' and to self-regulate (Bion, 1962) which can strengthen powerful defences such as the false self (Winnicott, 1974). Wolpert et al., (2018) highlight the worth of naming when therapy is not working to prevent potential risks and harms from unresolved ruptures.

Research into repairs has undergone decades of investigations whereby there is evidence of repairs leading to positive therapeutic outcomes with a new relational or corrective experience for clients (Eubanks et al., 2018; Safran et al., 2011). There is the understanding that therapists need to display a certain set of characteristics in their role when working with clients and particularly teenagers, including humility, compassion, curiosity, and patience (Muran & Eubanks 2020b). Resolving ruptures in the therapeutic relationship holds the aim of challenging expectations or internal working models of others i.e., as being withholding or criticising (Bowlby & Bowlby, 2005).

Various models and strategies of ruptures have been offered in the literature. There has been special attention to recognising the rupture including what preceded it, what rupture marker is it and reactions to the rupture. They therapist can respond immediately to the rupture through clarifying or renegotiating the task, goal, or misunderstanding, acknowledging negative affect, or making space to explore the rupture(s) that have occurred (Gersh et al., 2017; Muran et al. 2021; Nof et al., 2019). Through therapeutic meta-communication, the therapist can promote mindfulness, and dialogue (Safran & Muran, 2000). This can include thinking about how the young client and therapist may have contributed to the rupture, and implicitly suggesting repairing it together. As Muran et al. (2021) put it: "like with ruptures, repairs are co-constructed. It takes two, at least." (p. 363)

It is important for therapists to be clear about not wanting to criticise the young client (Jones et al., 2020) and share states and actions towards understanding better the underlying needs; for adolescents, the wishes to assert and be nurtured (Muran & Eubanks, 2020b). Nof et al. (2019) offered useful ideas for therapists to not go along with the young person's tendency to not assert their needs (with adolescents more often showing withdrawal markers when ruptures occur) and making use of descriptive and metaphorical language that can assist with coherence and narrative of the teenage client's experience.

As seen in the literature, being able to come back together after an experience of misattunement or disconnection from another is essential in psychotherapy. Repairs foster emotion regulation and subjectivity as highlighted in research in attachment, development, and neuroscience (Broomberg, 2006; Schore, 1994; Schore 2002). This also promotes social development in resolving tensions and negotiating needs. This is by no means a straightforward process and we would expect to-ing and fro-ing for adolescents between withdrawal, ambivalence, and aggression along with clearer self- assertion and vulnerable expressions (Muran & Eubanks 2020b).

Given the context of writing during the onset of COVID-19 global crisis, I was also drawn to considerations of rupture and repairs when engaging a client virtually through telepsychotherapy. Using technology can present with more challenges in addressing ruptures and repairs in the therapeutic relationship, however this should not stop practitioners from ignoring the impact of evolving technology on interpersonal relationships and socialising (Hartman, 2011). Authors have offered considerations of challenges and ideas for attending to ruptures through practical setups of the therapeutic virtual space and being more active in communicating as well as theorising what it means for young people to use technology and how it may promote or hinder being in relationship from a distance (Backhaus et al., 2012; Carpi et al., 2018; Dolev-Amit et al., 2020).

Clinical Implications

Rupture-repair and culture

The definitions of rupture markers are naturally based on culturally acceptable vs. unacceptable mannerisms which across the research has been understood from a Western perspective. This makes sense given the origins of psychotherapy. Marsella & Yamada (2010) offered a useful definition of culture to understanding its connection with human thinking and actions:

Culture is shared learned behavior and meanings that are socially

transmitted for purposes of adjustment and adaptation. Culture is

represented externally in artifacts (e.g., food, clothing, music), roles (e.g.,

the social formation), and institutions (e.g., family, government). It is

represented internally (i.e., cognitively, emotionally) by values, attitudes,

beliefs, epistemologies, cosmologies, consciousness patterns, and notions of

personhood. Culture is coded in verbally, imagistically, proprioceptively, viscerally, and emotionally, resulting in different experiential structures and processes. (p. 105)

Different cultures shape how people perceive the world around them. Subsequently this invokes multiple interpretations of how the human mind works and what ways of being and doing are normal or abnormal (Rathod, 2016; Scharff 2013; Sodi & Bojuwoye, 2011). This includes willingness to engage in psychotherapy as well as how assessment information becomes interpreted through the communication skills and sociocultural beliefs between client and therapist (Avasthi, 2011). I have recalled past instances of being misguided by my assumptions of what my clients know or do not know when they access a CAMHS, influenced by my own experiences and perspectives. I find it very useful to start assessment with adolescents by inquiring about their cultural background including beliefs and understanding they have about themselves, others, and the world around them. This often evolves throughout my entire engagement with them and their families.

Marsella (2009) explained that western understandings of mental health and psychological approaches to treatment is driven by ten core factors based off north American and western European cultures of individuality, reductionism, experiment-based empiricism, scientism, quantification/measurement, materialism, male dominance, objectivity, nomothetic laws and rationality. These can and do come into direct conflict with the worldviews of non-Western cultures who account for spiritual dimensions of self and collective societal needs and structures.

In a New Zealand context, Pākehā children are taught to look people in the eye to show that they are interested, attentive and trustworthy. Māori and Samoan individuals often believe that it is rude to look at people directly because it suggests provoking a challenge and

encourages conflict and opposition, so they may fix their gaze elsewhere or even close their eyes. Pākehā in turn may read this as rudeness or shiftiness (Swarbrick, 2013). Māori also commonly display emotions physically with their whole body and speaking words is not needed to capture and release important feelings. Wirihana (2012) identified how forms of traditional oral narrative and performance were used as adaptive ways to express oneself emotionally in Māori communities, such as waiata which has been a long-standing and effective form of conveying and maintaining wellbeing. These understandings help me to expand my thinking about interactions with young people from different cultures that should not be immediately interpreted as ruptures or resistance.

In Chinese culture, compliance towards harmony is favoured over conflict and Chinese individuals are discouraged from expressing their disagreements openly from a young age (Xu, 2016; Zhao et al, 2015). Conflict is often avoided not only for fear of how it reflects on oneself, but also for fear of blaming the family (Chan, 2013). Being assertive with one's needs is not encouraged nor recognised as an important aspect of development. This appeared to not be so evident on clients that have accultured to western culture. As a Chinese woman, I have noticed my own urges to avoid conflict in several therapeutic relationships with past clients which has likely impacted on my ability to name ruptures as they arise. Pan et al. (2011) studied adaptations to working with Asian American clients that emphasise and allow for emotional control and a hierarchical nature of therapeutic relationship saw benefits in the working alliance and cultural process factors. Continuing to practise reflexivity including my own cultural experiences can allow for more opportunities for me as a therapist to become aware and address ruptures and repairs.

Difficulties arise when the therapist fails to understand or explore the cultural context of clients' problems. Sue and Zane (2009) explained that the credibility of the therapist is questioned when she does not have the cultural knowledge necessary "to deal with possible

cultural discrepancies in conceptualising the problem, finding means to resolve problems of the client, and setting goals for treatment" (p. 41). A critical skill for therapists is knowing when to recognise the relevance of cultural values or group characteristics to the client's problems, and when to avoid stereotyping the client. What individuals place value on cannot be simply defined as individualistic or collectivistic.

Regarding understandings of ruptures, some non-Western youths might be labelled as showing signs of withdrawal rather than be understood as displaying respect to the other or complying with norms of maintaining harmony. With repairs, use of body and presence might be more significant than talking through what is happening in the moment. There are many more cultural considerations to make for therapists based in New Zealand in a nation that is comprised of over 200 ethnic groups (NZ Herald, 2013). Practitioners practising psychotherapy need to consider alterations in their understandings of ruptures and repairs that does not necessarily apply to people who identify with other-than-western cultures.

Rupture resolution as intervention

Client behaviours has been a focus of rupture markers in earlier research however the definition has expanded to include the behaviours of therapists. Research highlights the understanding that ruptures and repairs are co-constructed that both clients and therapists contribute to ruptures with movements away from and against the other (Muran & Eubanks, 2020a)

Psychotherapy has always emphasised the use of the therapist self as the instrument, and from psychoanalytic tradition the use of transference and countertransference has been considered in the work with ruptures and repairs. Muran et al. (2021) warns of traditional understandings of countertransference and putting the origin of the rupture solely in the client. As discussed, ruptures and repairs are co-constructed and it is important for the

therapist to use the countertransference to practise mindfulness of shifting of states to have the capacity to choose how to react to them, how to regulate them to approach rupture resolution.

Psychotherapists going through training are encouraged to frequently attend to their own internal experiences as guide to indicate where they sit in relation to client, and this can signify what pertinent feelings are being felt as meaningful markers of any ruptures occurring within the relationship (Muran & Eubanks 2020a). Any strains in the capacity to mentalise, communicate and be reciprocal could affect any use of transference interventions or reflections in the countertransference. I have found my abilities as a child psychotherapist has been greatly challenged with increased distress during the COVID-19 crisis on both a personal level and among clients seeking mental health support. Supervision and emotional support have been essential in my ongoing practice to ensure I am able to be present and attend to the processes that arise from the therapeutic relationship.

Muran et al. (2021) discussed how people go through a process of objectifying others that include putting others in categories to make sense of ambiguity in human relations based on implicit biases and past interpersonal experiences, towards subjectification whereby we develop the capacity to see others as having their own unique perspectives and histories. This extends to psychotherapists as well and it is important to recognise one's own subjectivity or experience. Muran et al. (2021) also express that neither client nor therapist should take full responsibility for rupture or repair and cooperation and responsibility needs to be shared.

It is also worth noting that different population groups require different lenses from which to approach clinical work. It is essential for psychotherapists, as well as other mental health practitioners with young people, to learn about and consider the developmental needs and drives of adolescents as well as how this intersects with other cultural factors including

gender, ethnicity, and societal context. I often consult with cultural advisors when working with young clients and families that have different cultural experiences and identities from my own.

In line with incorporating attachment thinking in the practise of psychotherapy, Straus (2017) highlighted how the therapist's own attachment history influences how the therapist approaches the therapeutic relationship which has been a consideration in the research conducted by Tishby and Vered (2011) and Zack et al. (2015). Straus (2017) offered an adaptation of the adult attachment interview for therapists to use as part of their supervision and reflection of practise. I relate to avoidant attachment experiences and notice my reactions to ruptures with my adolescent clients has stirred urges to also withdraw and avoid thoughts and feelings around guilt and incompetence. It is important to be aware of these patterns to disentangle what is my process as the therapist and what is going on for my adolescent clients.

Muran et al. (2021) suggested alliance-focused training for rupture-repair work for therapists that has encouraging evidence of relevance and effectiveness for therapy for a range of people and presentations (Eubanks-Carter et al. 2015, Muran, 2019). There is focus on understanding rupture definitions, repair pathways and therapeutic meta-communication and fundamental attitudes as well as video reviews and analysis are part of the training. Mindfulness meditation and awareness exercises including roleplay are encouraged for experiential learning of therapist's awareness of own emotions in interactions and to strengthen capacity to regulate affect and face ruptures more effectively.

Strengths and Limitations

Use of a hermeneutics methodology has been a suitable framework from which to examine the ruptures and repairs in the therapeutic relationship with adolescents. There is the understanding that truth and knowledge is dependent on the researcher's position and context from which they are researching. It has allowed appropriate flexibility to think about, choose and interpret the texts around this phenomenon alongside the literature review method to refer to established understandings and promote further thinking about practise from the *fusion of horizons*. Muran (2019) offered some considerations for research that he has learned in his journey that reminds us to think of understanding phenomenon and needing research and reflections from various sources.

Adolescent mental health and therapeutic work with young people are under researched areas (Atzil-Slonim et al., 2015; Azzopardi et al., 2019). I consider that my research will contribute towards extending understanding of the vital process of rupture and repair and its implications for psychotherapy with teenagers. There is originality in considering this topic with evolving therapeutic methods and issues prompted by the impact of a global pandemic.

This dissertation is limited by my own perceptions, interpretations, and process. At times I have felt pinned down by my own horizon and anxiousness in response to the perceived enormity of the topic that I have chosen. There were multiple disruptions in my research and writing process due to the impact of COVID-19 which saw difficulties in being open to the process while not losing myself. At times I have found difficulties with entering and leaving the hermeneutic circle sufficiently and may have impacted the synthesis of these findings.

It is also worth noting again the lack of space for examining literature around the families of adolescents, as acknowledged in the earlier chapter. As Bailey (2006) explained: children "do not exist in isolation, separate and independent…We should add that there is no such thing as a toddler, a child, or an adolescent, as their parents are always present in our work, even if we are mostly working with the child" (p. 180). Psychotherapy with adolescents is often framed and influenced by the family (and wider) context and relationships which shapes experiences of disconnections and reconnections for the young person and how that might play out in the therapeutic relationship.

Considerations for Future Research

Muran et al. (2021) emphasised defining and evaluating the critical principles or mechanisms of change in psychotherapy including rupture-repair processes in the therapeutic relationship. It would be valuable to research how the parents of teenage clients impact ruptures and repairs in therapeutic relationships with adolescents across various presentations of mental health disorders and external contexts. Considerations of parental mental health diagnoses and intergenerational attachment histories would be worthy of investigation. There has not been much empirical study of emotion regulation for therapists in the context of therapy and training (Muran, 2019). This would be a useful area of research in the context of recognising and responding more effectively to ruptures and approaching repairs with clients.

There is a lack of research on non-European ethnic groups in different contexts. Cross-cultural relationships are associated with shorter courses of psychotherapy and poorer outcomes than ethnically matched relationships (Zane et al., 2004). It would be worthwhile conducting empirical research on cultural beliefs of ruptures and repairs in the therapeutic relationships including perspectives from young people. Research on rupture markers across

different ethnic groups whereby social behaviours might take on a different meaning than what is understood in English speaking western societies, as well as investigations of culturally responsive repair strategies.

There are also insufficient studies of rupture and repairs in the therapeutic relationship when telepsychotherapy is utilised and at present, the studies revolve more around adult populations. It is inevitable that modes of communications will further develop, and therapists and researchers must be open to changes in how people, including youths, communicate and make sense of themselves with evolving technologies.

Conclusion

This aim of this dissertation was to understand ruptures and repairs in the therapeutic relationship with adolescent clients in psychotherapy through conducting a hermeneutic literature review. The findings across the literature show that rupture-repair processes in therapy are clinically significant and commonly occur multiple times, including in the work with teenagers. Research has investigated and guided practice in thinking about when there is tension in the therapeutic relationship with youth, what happens internally for both parties, and collaboratively finding a way back into connection through repair.

Engaging with the hermeneutic process of research on this topic has led me to think more about the nuanced ways that ruptures can and do occur regularly with adolescent clients that can be easily dismissed as noncompliance and unreadiness to therapy. Experiences of ruptures can feel highly conflictual which reflects the level of tension between the needs of asserting oneself and being cared for which is appropriate developmentally with teenagers. Ruptures can also arise from therapists not being attuned to their client as well as not being mindful of their own reactions and interactions with the young person. I am curious about how this looks with young people of different cultural backgrounds in relation to me. This research has prompted me to grow my humility, compassion, curiosity, and patience as well as practise speaking about ruptures with working towards repair in future therapeutic relationships I form with young people. Through experiencing rupture resolution, there is a meaningful experience of being able to communicate and be understood in a different way by both the therapist and the client that creates new possibilities in facing relationships and subsequently life itself.

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