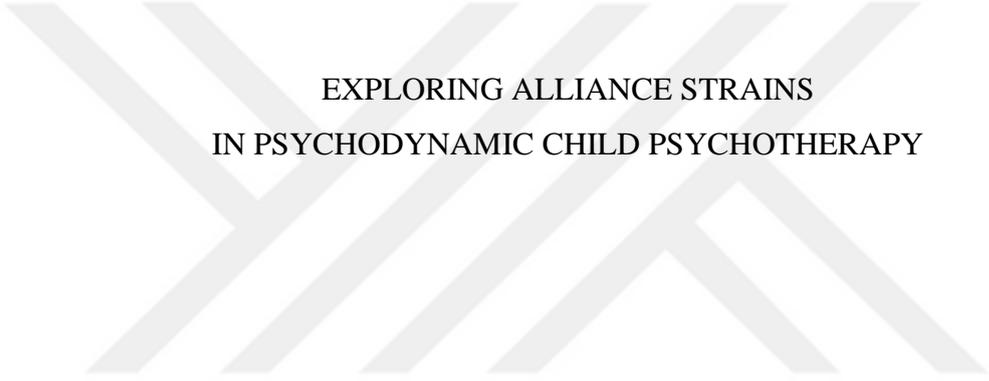İSTANBUL BİLGİ UNIVERSITY

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CLINICAL PSYCHOLOGY MASTER'S DEGREE PROGRAM

EXPLORING ALLIANCE STRAINS
IN PSYCHODYNAMIC CHILD PSYCHOTHERAPY

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Exploring Alliance Strains in Psychodynamic Child Psychotherapy

Psikodinamik Çocuk Terapisinde Terapötik İttifaktaki Kırılmaların Araştırılması

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABSTRACT

Strain or rupture in the therapeutic alliance is manifested by disagreement on therapy tasks and goals, as well as tension in affective bond between psychotherapist and patient. Studies have shown that, if ruptures are dealt with properly, they can be beneficial in terms of therapeutic change. In adult psychotherapy, rupture and resolution processes had been studied for different patient groups; however, little is known about the dynamics of the phenomenon for child psychotherapy. This study aimed to explore how strains occur and operate in the child psychotherapy while considering pretreatment characteristics of the patients. By using multilevel linear modeling low alliance sessions were determined based on Therapeutic Alliance Scale for Children (TASC) forms, obtained from both therapists and patients. After determining sessions with alliance strains, 43 sessions of 24 children were coded with an observer-based measure, 3RS (Rupture Resolution Rating System), to detect within session ruptures. It was observed that there is a trend towards rupture markers being less frequent, and resolution strategies being more effectively used for children with internalizing symptoms, compared to children with externalizing behavior problems. Additionally, predominant rupture markers were detected for children with different problem types. For gender, a trend towards more frequent and influential ruptures were observed for boys, compared to girls. These trends in frequency and impact of the rupture markers and resolution strategies could not be statistically supported, due to small sample size. Also, age was found significantly and negatively correlated with rupture significance. The current study contributes to our knowledge of therapeutic alliance, as a process, in psychodynamic child psychotherapy, by providing micro-analytic investigation of alliance strains and resolutions.

Keywords: Therapeutic alliance, alliance strains, rupture-repair processes, psychodynamic child therapy, pretreatment factors

ÖZET

Terapötik ittifaktaki gerilim ya da kırılma, terapist ve hasta arasında terapi görevleri ve hedefleri üzerindeki anlaşmazlık ve / veya duygusal bağda gerilim şeklinde kendisini gösterir. Çalışmalar, doğru bir şekilde ele alındığı takdirde bu kırılmaların terapötik değişim açısından faydalı olabileceğini göstermiştir. Erişkin psikoterapisinde farklı hasta grupları için ittifakta kırılma ve onarım süreçleri incelenmesine rağmen, çocuk psikoterapisinde kırılma ve onarım süreçlerinin dinamikleri hakkında çok az şey bilinmektedir. Bu çalışma, hastaların tedavi öncesi özelliklerini göz önünde bulundurarak, çocuk psikoterapisinde ittifakta kırılmaların nasıl oluştuğunu ve çözüldüğünü araştırmayı amaçlamıştır. Hem terapistlerden hem de hastalardan elde edilen Çocuklar İçin Terapötik İttifak Ölçeği formlarına dayalı olarak, çok düzeyli doğrusal modelleme ile düşük ittifaka sahip, 24 çocuğa ait 43 seans belirlenmiştir. Bu seanslar, seans içi kırılmaları tespit etmek için gözleme dayalı bir ölçek olan Terapötik İttifakta Kırılma ve Çözülmeleri Derecelendirme Sistemi ile kodlanmıştır. İçe yönelim belirtileri olan çocuklarda, dışa yönelim davranış sorunları olan çocuklara göre kırılmaların daha az sıklıkta olduğu ve çözümleme stratejilerinin daha etkin kullanıldığı yönünde bir eğilim olduğu gözlenmiştir. Ayrıca, bu çalışmada farklı problem tiplerine sahip çocuklarda, bazı kırılma tiplerinin daha baskın olduğu görülmüştür. Erkeklerde kızlara göre daha sık ve etkili kırılmaların olduğu bir eğilim gözlemlenmiştir. Problem tipine ve cinsiyete göre gözlemlenen farklı eğilimler, küçük örneklem büyüklüğü nedeniyle istatistiksel olarak desteklenememiştir. Son olarak yaş değişkeni, kırılma skoru ile anlamlı ve olumsuz bir şekilde ilişkili bulunmuştur. Mevcut çalışma, psikodinamik çocuk psikoterapisinde terapötik ittifak süreç araştırmaları literatürüne, seans içi kırılma ve çözülmeleri araştırarak katkıda bulunmaktadır.

Anahtar Kelimeler: Terapötik ittifak, terapötik ittifakta gerilim, ittifakta kırılma-onarım süreçleri, psikodinamik çocuk terapisi, tedavi öncesi faktörler

INTRODUCTION

For the last three decades the concept of therapeutic alliance (TA) has been studied as an important component of a therapy process (Horvath et al., 2011) and more recently it has become one of the most frequently explored concepts in psychotherapy research (Safran & Muran, 2006). Existing studies report that it is one of the most effective predictors on therapy outcomes across various treatment approaches (Martin et al., 2000).

The most widely used conceptualization of therapeutic alliance is Bordin's (1979), which includes three factors, namely; affective bond, agreement on therapeutic goals and tasks. Initially, the concept has been considered as a stable phenomenon over the course of treatment, and many studies explored its relationship with treatment outcome. Later, second generation alliance research has focused on changing nature of therapeutic alliance through the psychotherapy process which include strains (Safran et al., 2011). These strains in the alliance were most commonly referred as ruptures and can be identified as "deteriorations in the quality of the relationship between patient and therapist" (Safran & Muran, 1996, p. 447). Studies have shown that these ruptures can be repaired and resulted in better therapeutic outcome (e.g. Horvath, 2000; Safran et al., 2011). Safran and Muran (2006) suggested that repairing the ruptures both consolidates the alliance and provides an important opportunity for change in itself as corrective emotional experience.

Although there is an emerging significance of ruptures within therapy process, little is known about the dynamics of the phenomenon for child psychotherapy (Nof et al., 2019). Even the literature on therapeutic alliance with children has been growing only recently, especially for psychodynamic psychotherapy (Halfon et al., 2019). According to Shirk and Karver (2003) therapeutic alliance dynamics in child psychotherapy has its own unique features and needs more attention.

Several meta-analytic reviews and metanalyses were published (e.g. Karver et al., 2018; McLeod, 2011; Shirk & Karver, 2003, McLeod & Weisz, 2005), and found small to moderate link between therapeutic alliance and treatment outcome for youth and child psychotherapy, the link is weaker when compared to the studies with adult patients. Second generation studies in child-youth focused on the trajectory of therapeutic alliance through treatment process and the number of studies is limited. Like the findings of outcome research in child literature, results of the process studies were contradictory. Some of the studies found positive linear growth in alliance (Liber et al., 2010), some indicated negative linear trajectory over the course of treatment (Hudson et al., 2014). Other studies showed that rather than linear growth or decline, therapeutic alliance has concave (e.g. Chu et al., 2014; Kendall et al., 2009) or U-shaped trajectory (e. g. Hurley et al., 2013; Halfon et al., 2019). These studies showed that clinical and demographic factors such as diagnosis, problem type (externalizing, internalizing problem behaviors), age and gender of the children, as well as therapeutic approach effect the average therapeutic alliance and its growth trajectory.

Aforementioned, the number of studies that explore rupture-repair process in child psychotherapy is scarce, although the alliance has distinct characteristics with child patients. Goodman and collogues (2017) studied rupture-repair sequences for the therapy process of a child with autism spectrum disorder. Nof and colleagues (2019) highlighted research gap on investigating rupture-repair processes in child psychotherapy and introduced Child Alliance Focused Approach based on model suggested by Safran and Muran (2000). Neither of the studies explore the rupture events for the children with distinct demographic and clinic characteristics. Therefore, the main aim of this study was to explore how strains occur and operate in the child psychotherapy with considering pretreatment characteristics of the patients.

In the following literature review, given the limited research on alliance rupture-repair processed in child psychotherapy, theoretical and empirical literature

with adult patients was initially discussed. Subsequently, therapeutic alliance in child psychotherapy literature and, recent studies on therapeutic alliance and rupture-repair processes in child and adolescent psychotherapy were reviewed.

CHAPTER 1

LITERATURE REVIEW

1.1. PSYCHODYNAMIC BACKGROUND OF THERAPEUTIC ALLIANCE AND ALLIANCE STRAINS

1.1.1. Therapeutic Alliance and Alliance Strains in Adult Psychotherapy

The concept of therapeutic alliance was originated from psychoanalytic theory, however later seen as a transtheoretical concept, adopted by the other psychotherapy approaches, and become a central focus for psychotherapy research (Safran & Muran, 1996). One of the most widely used conceptualization is Bordin's (1979) who defined the term with three factor model, that are therapist and client's agreement on *goals* of therapy and the *tasks* needed to reach these goals, as well as the emotional *bond* set between them.

The term therapeutic alliance stemmed from S. Freud's early writings on transference (1912). According to him positive transference was required for the patient to trust the analyst and facilitate collaboration between them. He believed that positive attachment between the therapist and patient increases the possibility of patient's belief in therapists' interpretations, however, for him this positive attachment referred to transference rather than a real relationship, and major task for the therapist is to interpret the transference. Initially, Zetzel (1956) used the term therapeutic alliance by putting emphasis on real aspects of the relationship apart from transference. Later, Greenson (1965) argued that the therapeutic relationship is composed of three parts which are the transference, the real relationship and the working alliance. The real relationship refers to a genuine relationship without transference distortions, and the working alliance corresponds to patient's conscious and rational responses to the therapist or patients' ability to work

collaboratively. Greenson (1965) saw therapeutic process as striking a balance between transference and the real relationship, using real relationship to repair neurotic attachment patterns reflected in transference.

With the publication of Carl Rogers' book *Client-centered Therapy* (1951), for the first time, rather than therapeutic techniques, the quality of the relationship provided by the therapist was seen a predictor of effective therapy (as cited in Safran, 1993a). For Rogers, therapist's most influential contribution to the progression in therapy is interpersonal rather than technical. Later taking into account all aspects of alliance, Gaston (1990) asserted that therapeutic alliance has three levels, "1. The alliance as being therapeutic in and of itself; 2. The alliance as being a prerequisite for therapist interventions to be effective; and 3. The alliance as interacting with various types of therapist interventions" (Gaston, 1990, p. 148).

According to Safran and Muran (2006) the sustained interest in the concept of therapeutic alliance is related with the paradigm shift in therapy approach, which highlights the importance of relational factors in psychotherapy. Adopting an interpersonal perspective in practice led recognition of therapeutic relationship as an important component of therapeutic mechanism (Safran, 1993a). Furthermore, by the 1970s, a various psychotherapy approaches claimed their success in relieving symptoms and none of them were found to be superior. The theoreticians started to search for common factors in psychotherapy and tried to find more comprehensive definitions for therapeutic alliance (Horvath, 2000). In 1980's regardless of the therapeutic approach, therapeutic relationship gained importance among theoreticians and practitioners as a tool for change (Safran, 1993a).

In 1975, Bordin presented a pan-theoretical conceptualization of the working alliance, which suggested that alliance refers to a conscious, here-and-now relationship in psychotherapy. In addition to Rogers (1951) who emphasized the therapist factors, Bordin highlights the bidirectional nature of alliance by introducing three components which are "a mutual understanding and agreement about change, *goals* and the necessary *tasks* to move toward these goals, along with

the establishment of *bonds* to maintain the partners' work" (Bordin, 1994, p. 13). According to him agreement on goal and task, both affects and be affected by the quality of the emotional bond (Safran, 1993a). Moreover, for Bordin, rather than being a prerequisite for other therapeutic factors, alliance has a therapeutic nature itself (Lingiardi & Colli, 2015). Later, it was well established that the alliance could both work as a facilitating environment for any successful treatment and as an active component which is therapeutic in itself (Nof et al., 2019).

Aforementioned, at 1990's there was a clear shift in psychotherapy towards an interpersonal perspective and therapeutic relationship has started to be recognized as an important mechanism for change (Safran, 1993a). Rather than focusing on the relationship between alliance and therapy outcome, Safran and Muran (1996) concentrated on the aspects that make alliance therapeutic and investigate alliance through the treatment process. It has become evident that although a good alliance is required in the early phases of therapy, the quality of the alliance is not stable over the treatment course and it is exposed to strains and disruptions during the therapy process (Horvath, 2000). Furthermore, Safran (1993a) emphasized that with some clients it is difficult to constitute good therapeutic alliance at the initial phases of the psychotherapy. Therefore, according to him it was crucial to explore these disruptions or difficulties in establishing and maintaining good therapeutic alliance.

For Safran (1993a) strains or breaches in the alliance was based on an essential dilemma of human existence "i.e., the need to reconcile our innate desire for interpersonal relatedness and the reality of our separateness" (p. 12); therefore, it is inevitable to find strains in therapeutic alliance. Although strains are inevitable, what distinguishes treatment success from treatment failure is therapists' attentiveness to catch these strains and abstain from getting into negative interactional cycles with their clients. Therefore, for Safran it is crucial for future psychotherapy research to focus on working with the negative interactional cycles and resolution of them.

The idea of working with negative interactional cycles and providing new and corrective experience to a client could be traced back to early days of psychoanalytic thinking, discussed under transference/countertransference dynamics (Ferenczi, 1931, Balint, 1935). Some theorists pointed out these negative interactional cycles or vicious cycles when explaining projective identification process (Ogden, 1986; Tansey & Burke, 1989) (as cited in Safran, 1993a). Some other theorists asserted that these vicious cycles are based on dysfunctional and maladaptive coping strategies (e.g. Safran 1990). Later, Bordin (1994) emphasized the significance of *tear and repair* processes over the course of psychotherapy. For him, problems within the therapeutic relationship are inevitable and repairing them are essential.

Later, Safran and Muran (1996) explore rupture-repair processes in the alliance and stated that ruptures frequently occur when therapists unknowingly engage in maladaptive interpersonal structures, which are similar to those seen in client's other relationships and validating client's dysfunctional self and other representations. For Safran and Muran (1996), these ruptures can be fruitful in terms of therapeutic change, if they are dealt with properly. By detecting and exploring these ruptures in alliance, therapists can provide a novel interpersonal experience to the patient with which patients can transform their dysfunctional interpersonal patterns.

Recently, based on Greenson's tripartite model on alliance, Gelso and Kline (2019) asserted that the ruptures have distinct effect on alliance depending on the component of the relationship they experienced (the transference, the real relationship, the working alliance). According to them, ruptures in the *real relationship* have more adverse effects on the therapeutic relationship than those occur in *working alliance*. They highlighted the need for making distinction between strains in working alliance and deteriorations in real relationship which could have threatening effects on the therapeutic relationship.

1.1.2. Therapeutic Alliance and Alliance Strains in Child Psychotherapy

Parallel with the adult psychotherapy, therapeutic relationship has been seen as an important factor for change in child psychotherapy (Shirk & Karver, 2003). Starting with the psychodynamic tradition, other therapy approaches later attributed importance to the therapeutic relationship when exploring factors that lead to positive treatment outcome (Shirk & Karver, 2003).

The importance of therapeutic relationship in child psychotherapy stems from the works of Anna Freud (1946). She remarked that good relationship between the child and the therapist is required for later work in child psychotherapy. According to her, alliance refers to the affective component of the relationship between child and therapist which lets the child work on his/her problems. She further mentioned about different levels of therapeutic alliance when working with children. At the most superficial level, only the relationship itself experienced as therapeutic. These are the children who probably were neglected by their caregivers and experienced relationship with the therapist as fulfilling. Secondly, A. Freud mentioned about more mature and preferred level of therapeutic alliance. This kind of alliance occurs when child had positive feelings towards the therapist and accepts therapeutic interventions as a help or support for overcoming his/her difficulties. Therefore, she stated that therapeutic alliance has two qualities which are relationship-based and work-based aspects; and the relationship-based aspect seen as a catalyst for supporting therapeutic work.

Different than A. Frued's view that therapeutic relationship has a serving function to enable child work collaboratively, Axline (1947) argued that the relationship between therapist and child is therapeutic itself. According to her, rather than therapeutic interventions, interpersonal dynamics between therapist and children leads to improvement. Looking from a developmental point of view, she puts emphasis on importance of therapist's warmth, nonjudgmental attitude, respect with setting proper limits to the child for the therapeutic growth (Shirk & Saiz,

1992). Like Axline, Rogers (1957) also emphasized the role of therapeutic bond as an active ingredient for therapeutic growth. He highlighted therapists' being empathic, genuine and having unconditional positive regard towards the child as crucial factors for the positive treatment outcome. It can be said that in psychodynamic tradition, emotional bond between child and therapist appeared as a core component of alliance.

Other theorists further explored the curative nature of therapeutic relationship by focusing on the missattunement or miscommunication moments and corrective emotional experience that psychotherapy provides to patients. In his theory, Winnicott's (1965) highlighted the importance of mother's being *good enough,* by sometimes imperfectly attuning to child's needs or emotions. For Winnicott this helps the child to accept the other as a subject, and to see self and other as separated entities. Furthermore, Mahler's work on separation/individuation process contributed the importance of therapeutic relationship in terms of balancing the paradoxical need of being separated and connected at the same time (1974). She theorized that the infant has wish to both be in a symbiotic union with the mother and inclination to separation. It necessitates mother's emotional availability, to provide infant to safely explore the world. In the healthy mother-infant relationship, the mother both provides emotional availability and encouragement of autonomy. However, sometimes because of consistent misattunement or mother's not being emotionally available, a child can experience difficulties in relating him/herself to others. In psychotherapy, miscommunication moments are expected to occur with those patients. With providing a holding environment and being good enough, therapists are able to help their patients to balance between needs of being connected and separated.

Furthermore, attachment theorists highlighted the importance of emotional availability in providing secure base for the infant. According to them (e.g., Ainsworth, 1978; Bowlby, 1975) the first bond established between caregiver and child is significant for the child's representations of self and others. If caregiver is

sensitive and responsive to baby's needs, the child feels secure about the outer world and himself. On the other hand, if caregiver is unresponsive, negligent, and not capable of providing a secure base for the child, the infant feels persistent distress and be insecure about the external world. In therapy context, therapist also emerges as a new attachment figure and establishes an emotional bond with the child. According to Fitton (2012), therapy provides a chance for the children who has insecure attachment styles to repair their early attachment experiences. Moreover, Bowlby (1975) emphasized therapist's role as a temporary attachment figure who should skillfully balance being both an internal representation of the primary caregiver and an external real person at the same time. With the contribution of attachment theory, the actual aspect of therapeutic relationship between child patients and therapists has started to be given more importance compared to the projection-based dynamics between the therapist and patient.

Tronick (1989), by using Bowbly's model of internalization, suggested that absence in attunement at infant-mother dyad leads to formation of dysfunctional interpersonal schema for infant. The process of affect attunement plays a crucial role in helping to organize infant or child's emotional experience and a healthy representation of self which is relatable and communicable to others. In the process of both healthy and dysfunctional dyads, there are affective misattunement moments. However, in healthy infant-mother dyads, these moments of misattunement are expected to be followed by repair of the affective miscoordination. Similarly, in psychotherapy, with the therapists' ability to attune feelings of anger or hurt, child's dysfunctional schema can change.

When examining therapeutic relationship between child and therapist, it is crucial to mention about play as a distinct mode of communication. For children, play provides a medium for expressing their thoughts, feelings and wishes, which might be conflictual and troublesome for some of the child. Besides being a way of self-expression for the child, play provides an area both for child and therapist to engage in their experiences at another level. The play area is outside the individual,

but it is not the external world at the same time, and in psychotherapy two areas of play (patient and therapist's) overlaps (Winnicott, 1991). Furthermore, Chethik (2001) examined the function of play in establishment of therapeutic alliance in child psychotherapy. He stated that owing to play, traces of early object relations can be visible, but at the same time it facilitates formation of new object relationship, by which children can achieve proper and enduring adaptations in their relational patterns. According to Chethik (2001), the therapist functions as an affect regulator by gradually becoming a dependable other, enabling the child to express troublesome and intense emotions linked with his or her internal relational patterns. Early troubling relationship patterns, combined with the intense disruptive emotions might cause ruptures in the therapeutic alliance. However, with the help of therapist's empathy, dependability and attunement, ruptures were gradually resolved and the child internalizes these therapeutic functions (Halfon, 2019).

Moreover, Gardner (1993) emphasized that the transference relationship could contain negative transference reactions and might demonstrate pathological relationship patterns and child might treat the therapist in a confrontational way. Gardner (1993) also stated that strongly established emotional bond with the therapist and providing healthy emotional experiences, enables child to work on these negative transference reactions.

Similarly, according to Chused (1999), for some child patients, therapist's attentive listening, attunement to the emotions is not enough for maintaining good therapeutic alliance, and the disruptions in the alliance are inevitable. She stated that this is frequently the case for child patients with immature ego functioning, learning disabilities, and for the patients who do not have object constancy, self and other differentiation, reality testing. She considered child's expression of aggression through the session and therapist's authentic response of these expressions are essential part of the therapeutic work.

Considering the theoretical literature on therapeutic alliance in child psychotherapy, it can be seen that there is a consensus on components of therapeutic

alliance which are *affective and collaborative relationship*, (Shirk et al., 2011). Although the distinction between the two components is not clear, affective relationship was seen more prominent for therapeutic change especially in psychodynamic child therapy (Shirk & Saiz, 1992). Parallel with the Bordin's tripartite conceptualization of therapeutic alliance, (agreement on therapy goals, tasks and emotional bond between therapist and client), after the emergence of cognitive and behavioral therapy for children, the role of collaboration on therapy goals and tasks on establishment of alliance has started to gain importance. Collaboration on therapy goals and tasks in child psychotherapy has distinct dynamics than adult psychotherapy, because unlike adults, children not generally seek treatment for themselves. Mostly, parents or caregivers refer psychotherapy for children which might cause reluctance to participate in and continue psychotherapy for children. According to Chethik (2003) because their ego functioning is still developing, children are unaware of experiencing difficulties and not willing to seek for help or able to set goals for psychotherapy. Furthermore, child psychotherapists generally faced with setting multiple tasks and goals for parents and children. Especially agreement on goals is a complicated issue depending on whose goals are considered. Hawley and Weisz (2005) found that therapists, parents, and child's agreement on goals was one of the most important problems in psychotherapy. Moreover, in terms of therapeutic tasks, there are rules in the therapy room that children are expected to follow. According to Axelman (2006) limit setting is important for establishing alliance. The rules conveyed by the therapist provides a medium for the child to explore the limits of self and other, boundaries of the relationship between the two. The boundaries of therapy setting contributes establishment of therapeutic alliance by allowing the child to explore his inner world in a safe and unrestricted manner (Chethik, 2003).

1.2. EMPIRICAL LITERATURE ON THERAPEUTIC ALLIANCE AND ALLIANCE STRAINS

1.2.1. Therapeutic Alliance and Alliance Strains in Adult Empirical Literature

After Bordin's representation of the therapeutic alliance, reliable measures were developed to investigate alliance and outcome relation. Horvath and Symonds (1991) in their meta-analysis showed that quality of the therapeutic alliance is a robust predictor of treatment outcome. Later studies (e.g. Martin et al., 2000; Horvath & Bedi, 2002) also demonstrated consistent findings of the moderate to strong relationship between the alliance and treatment across various treatment types, clinical populations, type of outcome measure employed, time of alliance assessment and type of alliance rater. These first-generation studies in alliance research were primarily focused on establishing the link between a strong alliance and better therapy outcome (Nof et al., 2019). Furthermore, in one of the most recent meta-analyses, Flückiger and colleagues (2018) found similar results, presenting a moderate but significant relationship between alliance and treatment outcome.

The recent studies in alliance have focused on two main issues which are evaluation of therapeutic alliance over the course of therapy and different quality of alliance for the specific clinical populations (Horvath, 2000). It was found that the quality of alliance is not stable over the therapy course and has distinct features depending on patient factors (Horvath, 2000). Several studies were conducted with different clinical populations (e.g. Constantino et al., 2005; Couture et al., 2006; Smith-Hansen & Probert, 2014; Zuroff et al., 2000) showed that patients' diagnosis, attachment pattern, social factors and age effected quality of the alliance for the different phases of psychotherapy.

Moreover, with the shift in focus towards the interpersonal dynamics in psychotherapy, in the last three decades, the "second generation" of alliance research has emerged, the focus of which is alliance development process through the treatment (Safran et al., 2014). In the these studies, therapeutic alliance was measured at multiple time points through the psychotherapy process. Some of the studies showed stable alliance (e.g. Golden & Robbins, 1990; Kramer et al., 2009), some of them revealed linear growth in alliance (e.g. Hilsenroth, Peters, & Ackerman, 2004), some presented U-shaped growth (e.g. Gelso & Carter, 1994; Horvath & Luborsky, 1993; Kivlighan & Shaughnessy, 2000) and lastly some studies demonstrated that there are V-shaped patterns (e.g. Stiles et al., 2004; Strauss et al., 2006) in alliance over the treatment course. Moreover, relation between the different patterns of alliance and treatment outcome has been explored for the distinct clinical populations. De Roten and colleagues (2004) conducted a study with patients diagnosed with anxiety, depression and personality disorders. The results revealed that better treatment outcome is associated with linear increase in therapeutic alliance. On the other hand, Kramer and colleagues (2009) found that stable pattern in therapeutic alliance is related with symptom reduction for the patients with similar diagnosis. Furthermore, some of the studies portrayed that curvilinear pattern, which is composed of deteriorations and improvements in alliance, is associated with better treatment outcome (Safran et al., 2011). The dynamics of the relationship between rupture-repair processes and therapy outcome were further explained in the following sections.

1.2.1.1. Operational Definitions of Low Alliance and Rupture-Repair Processes

There are many overlapping constructs referring the phenomenon such as emphatic failure (Kohut, 1984), weakening (Lansford, 1986), therapeutic alliance breach (Safran, 1993b), misunderstanding (Rhodes et al., 1994), misattunement

(Beebe & Lachmann, 2002), tear in the alliance (Bordin, 1994), therapeutic resistance (Freud, 1923), threats (Bennett, Parry, & Ryle, 2006), impasses (Safran & Muran, 2000), and transference-countertransference enactments (Safran & Muran, 2006), and challenges. According to Safran and Muran (1996) each description "provides a somewhat different conceptual lens with specific underlying assumptions and therapeutic implication." (p. 447).

Initially, the concept *alliance rupture* was defined by Safran (1993b, p. 34) as "a negative shift in the quality of the therapeutic alliance or an ongoing problem in establishing one". Later Safran and Muran (1996, p.288) defined alliance ruptures in different ways "such as a breakdown in the collaborative process, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset". All of these definitions, however, found to be problematic in certain ways. According to Safran and Muran (1996), for example, when "a breakdown in the collaborative process" is used to point out rupture, it emphasizes the collaboration aspect, but it fails to capture exploring alliance ruptures as difficulties in relatedness between patient and therapist. Later, as Safran and colleagues would like to emphasize authentic bond between client and therapist while defining alliance ruptures, and they defined it as "poor quality of relatedness". The recent definition was presented by Eubanks, Muran and Safran (2018, p. 508), according to which rupture refers to "a deterioration in the therapeutic alliance, manifested by a disagreement between the patient and therapist on treatment goals, a lack of collaboration on therapeutic tasks, or a strain in their emotional bond."

Moreover, Safran and Muran (2006) highlighted the importance of intensity of the breakdown in collaboration, while defining alliance rupture. According to them making decisions about the intensity of ruptures depends on one's therapeutic and research objectives. For Eubanks, Muran and Safran (2018) some studies use the term *rupture* with referring more dramatic deteriorations in the therapeutic relationship, on the other hand many of them use alliance rupture to refer subtle tensions. According to Safran and Muran (2006) "From a therapeutic

perspective, even the most subtle fluctuation or limitation in quality of relatedness can be worth exploring and can pave the way for a resolution process that facilitates an important change in the patient's relational schema and self-defeating patterns of relating to both self and others" (p. 289). Later researchers make the distinction between confrontation and withdrawal ruptures which was found useful for reliably observing rupture markers with different intensities (Safran & Muran 1996). "In withdrawal ruptures, the patient moves away from the therapist and the work of therapy, for example, by avoiding the therapist's questions or by hiding his or her dissatisfaction with therapy by being overly appeasing. In confrontation ruptures, the patient moves against the therapist by expressing anger or dissatisfaction with the therapist or treatment, or by trying to pressure or control the therapist." (Eubanks et al., 2018, p. 509). They also stated that some ruptures could both have withdrawal and confrontation components.

For the positive therapy outcome, ruptures are expected to be resolved and, patient and therapist start collaborating on tasks and goals with a repaired affective bond. Eubanks, Muran and Safran (2018, p. 509) examined rupture-resolution strategies under the four categories, which are direct/indirect and immediate/expressive strategies. They explained that "Strategies for resolving alliance ruptures include direct strategies, which involve the therapist and patient explicitly acknowledging the rupture, and indirect strategies, whereby the rupture is resolved without being explicitly acknowledged. Resolution strategies can also be characterized according to whether they are immediate strategies, focused on repairing the rupture expeditiously and returning to or changing the therapeutic task the dyad was engaged in before the rupture, or expressive strategies that aim to shift the focus of the therapy session to exploring the rupture and the patient's needs or concerns that underlie it". Moreover, resolution strategies can occur promptly after rupture, within a single session (Safran et al., 1994); or it take series of sessions to repair the ruptures which are detected as fluctuations in alliance scores (e.g. Strauss et al., 2006).

1.2.1.2. Empirical Findings on Alliance Strains and Rupture-Repair Processes

Recently, Eubanks, Muran and Safran (2018) examined the relation of rupture repairs and outcome. They conducted a meta-analysis by including 11 studies which investigated the relation between rupture-repair sequences and therapy outcome. Their results showed a moderate relation between rupture-resolution and positive therapy outcome. Findings of the individual studies on rupture-repair processes and treatment outcome were summarized below.

Sommerfeld and colleagues (2008) investigated the associations between rupture occurrence and changes in clients' core conflictual relationship patterns, which indicated that occurrence of ruptures provides opportunity for working on client's dysfunctional interpersonal themes. Muran and colleagues (2009) examined the relationship between rupture and resolution processes in early alliance and outcome with patients diagnosed with personality disorders. They reported that lower rupture intensity predicted good outcome in terms of interpersonal functioning, and higher rupture resolution predicted continuity to psychotherapy. In their study with patients diagnosed with Posttraumatic Stress Disorder, McLaughlin and colleagues (2014) identified three distinct patient groups, namely; repaired rupture, unrepaired rupture and no rupture. Their results showed that unrepaired ruptures were associated with poorer treatment outcome. Zilcha-Mano and Errázuriz (2017) examined the effect of early alliance patterns on treatment outcome, with the patients mostly diagnosed by depressive disorder. They found that effect of early alliance trajectory on outcome was moderated by pretreatment interpersonal problems. For the participants with better pretreatment interpersonal functioning, rupture-repair sequences lead to better outcome. On the other hand, it was found that patients with worse interpersonal functioning at the beginning of the treatment, early unrepaired ruptures predict better treatment outcome. They stated that these early alliance ruptures might resolved later in treatment and lead to

positive therapeutic outcome. Moreover, Larsson and colleagues (2018) explored the effect of different alliance patterns (rupture, repair and no rupture patterns) on treatment outcome in primary care (patients diagnosed with depression and anxiety disorders). It was found that the rupture pattern leads to inferior treatment outcomes, on the other hand, the repair pattern was associated with better treatment outcome compared to the no rupture pattern. Recently, Lipner and colleagues (2021) conducted a study with patients having comorbid Axis I and Axis II diagnoses, with excluding the participants with cluster B personality disorders. They found that there is a positive relationship between rupture-repair episodes and treatment outcome.

Furthermore, number of studies attempted to clarify the relation between alliance patterns and treatment outcome. In addition to stable and linear trajectories, patterns with rupture-resolution processes also showed positive outcome. Kivlighan & Shaughnessy (2000) identified U-shaped pattern in alliance development which is associated with better treatment outcomes in terms of having less interpersonal problems. Stiles and colleagues (2004) attempted to replicate Kivlighan & Shaughnessy's (2000) study. Their data drawn from brief psychotherapy treatment with patients who have depression. As a result, they differentiate four patterns of alliance growth, however, they were not able to find U-shaped trajectory as found in previous study. Moreover, none of the four patterns was found to be associated with good treatment outcome. When they further examine their data, they identified brief V-shaped patterns rather than U-shaped trajectory and it was found that patients with a V-shaped patterns in the alliance, had better treatment outcome than the other patients. Lastly, Strauss and colleagues (2006) conducted a study with patients diagnosed with avoidant personality disorder or obsessive-compulsive personality disorder. Their findings showed that more improvement in symptoms was predicted by stronger early alliance and occurrence of rupture-repair sequences.

When findings of these studies were considered, it can be said that there is a variation in results according to methodological factors (measurement of ruptures)

and clinical factors (patient and treatment characteristics). Number of studies investigated patient related factors and found that increased occurrence and intensity of ruptures was found to be associated with patient's attachment style (Eames & Roth, 2000), diagnosis (e.g. Coutinho et al., 2014; Tufekcioglu et al., 2013; Colli et al., 2017), personality traits (e.g. Boritz et al., 2018) and having core conflictual relationship themes (Wiseman & Tishby, 2017). Clients with preoccupied attachment style, personality disorder and clients who have hostile and defensive personality traits were found to have ruptures in greater frequency and significance. Tufekcioglu and colleagues (2013) examined the relationship between personality disorder diagnosis and quality of therapeutic alliance. They found that high impulsivity, dysregulation and lability were associated with higher ratings of rupture intensity in alliance. Colli and colleagues (2017) conducted a study to revise Collaborative Interactions Scale (CIS; Colli & Lingiardi, 2009). In their second study, they tested validity of revised CIS by comparing patients with personality disorder (PD) and patients not being diagnosed by PD. Their results confirmed that patients diagnosed by PDs tend to have strains in the alliance in a more explicit, confrontational and aggressive way, compared to the patients without PD.

1.2.1.3. Measuring Rupture-Repair Sequences

As mentioned before, ruptures could differ in nature and severity, some are more subtle (withdrawal ruptures), some of them appears in a more dramatic and hostile way (confrontation ruptures). Moreover, ruptures can occur within a single session or continue over number of sessions without resolution. As stated by McLaughlin and colleagues (2014) it is important to make the distinction between rupture events and rupture patterns. Stiles et al. (2004) distinguished the V-shaped event from the U-shaped pattern, that an event is a brief and sharp decrease in the alliance which improves relatively quickly. In contrast, the U-shaped pattern represents an alliance trajectory, that begins high but decreases through the middle

part of treatment, and then rises through end of the treatment. Stiles and colleagues (2004) defined rupture events as, they likely to occur randomly and be repaired relatively expeditious way, in one or two sessions. Moreover, Lipner and colleagues (2021) employed control chart method to define rupture-repair events with distinct severities. They also differentiated between effect of partially and totally resolved ruptures on treatment outcome and stated that even if the alliance scores after the repair process did not return to the level of average alliance, it is still associated with the positive treatment outcome.

Moreover, in the psychotherapy research, ruptures can be identified from different perspectives namely, patient, therapist and observer viewpoints. As Safran and Muran stated (2006, p. 289). "The perspective the researcher chooses will be guided by the questions in which he or she is interested. For example, if one focuses on rupture events that have been identified by both patient and therapist, one is more likely to identify more dramatic ruptures. If one focuses only on the patient's perspective (without regard to the therapist's perspective), instances in which the therapist has not consciously attempted to address the rupture will be included in the sample."

The measures can be classified in to two categories which are self-report and observer-based measures. Self-report measures rely on therapist's and patient's awareness, openness, willingness to report their views (C. F. Eubanks et al., 2018). Tryon, Blackwell and Hummel (2007) found that patients are more prone to report higher alliances than therapists. In their meta-analysis, Eubanks and colleagues (2018) also showed that in most of the studies patients report fewer ruptures than therapists. A meta-analysis conducted by Safran and colleagues (2011) demonstrated that the rate of ruptures reported by the patients is between 19-42%, for the therapists the rate changes between 43-56% and external raters observe ruptures in 41 to 100% of sessions. Eubanks and colleagues (2018) explained this difference with the possibility of patients being uncomfortable about reporting ruptures or their difficulties in recognizing ruptures.

Furthermore, Hill (2010) represented difficulties that therapists faced while reporting ruptures. Eubanks, Burckell and Goldfried (2018a) also supported this view, by adding that identifying withdrawal ruptures is more challenging for the therapists than confrontation ruptures. Chen and colleagues (2018) highlighted the importance of therapist's sensitivity towards alliance ruptures and suggested that therapist's ability to accurately identify ruptures is essential to resolution of them, which enables improvement in alliance and therapy outcome.

Self-report measures were categorized under two topics which are direct and indirect self-report measures. An example for direct self-report measure is the Post Session Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1992) which offers information from the patient's and therapist's perspectives. The PSQ includes two sub-measures and both of them showed sound psychometric properties; however, it has other sub-measures which has limited psychometric support (Muran et al., 2009). In some of the studies, rupture-repair patterns were identified by using indirect self-report measure such as Agnew Relationship Measure (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998), California Psychotherapy Alliance Scale (CALPAS; Marmar, Weiss, & Gaston, 1989) and Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989). Rather than asking directly about rupture, the researchers use overall alliance scores to identify rupture-repair sequences with this measure.

Observer-based methods, on the other hand, are more sensitive about determining ruptures and may identify the ruptures that patients and therapists are not aware of (Eubanks et al. 2010). Moreover, using observer-based measures is advantageous that they can identify within session fluctuations in alliance. On the other hand, one disadvantage of using observer-based measure might be that observers are not participate in the therapeutic relationship and, thus, might overlook patient and therapists' feelings of anger, sadness or avoidance (C. F. Eubanks et al., 2018a). Examples of observer-based methods were summarized below.

Collaborative Interactions Scale (CIS; Colli & Lingiardi, 2009) is a transcript-based method for assessing ruptures and resolutions in the therapeutic alliance through psychotherapy process. It showed good inter-rater reliability (Cohen's Kappa ranging from .66 to .81). One of the most frequently used observer-based measure of rupture is Rupture Resolution Rating System (3RS; Eubanks et al., 2014) . The scale "yields ratings of withdrawal ruptures, confrontation ruptures, and therapist attempts to resolve ruptures. Coders rate the frequency of rupture markers and resolution strategies in 5-minute intervals." (Eubanks et al., 2018, p. 509). Coders are expected to complete frequency ratings, as well as evaluate impact of ruptures and resolution strategies on alliance.

In this current study, both observer-based and self-reported measures were used in order to capture the ruptures in a comprehensive way by taking into account both therapist's and patients' different views on ruptures, as well as their difficulties in labeling and reporting these strains. Another reason to select observer-based measures for analysis, is to detect within-session fluctuations in alliance. The measures employed in the current study were explained in the methods sections.

1.2.2. Therapeutic Alliance and Alliance Strains in Child Empirical Literature

1.2.2.1. Operational Definitions and Empirical Literature on Therapeutic Alliance

In child empirical literature, operational definitions of therapeutic alliance were based on adult literature. According to Shirk and Karver (2003), before the concept of therapeutic alliance has been prevalently used, the researchers have been using terms such as therapy bond, treatment involvement, therapist warmth to refer therapeutic relationship in child psychotherapy. Later, it was found that these variables represent different facets of therapeutic alliance.

Aforementioned, in adult psychotherapy research Bordin's (1979) tripartite model was most frequently used which includes affective bond, agreement on therapy goals and tasks to achieve goals of the psychotherapy. However, some of the studies with youth did not fully support the three-factor model. These studies showed a single factor solution, therefore suggesting that dimensions of the alliance may be less differentiated at younger ages (Digiuseppe et al., 1996; Faw et al., 2005). Some other studies demonstrated that affective bond and collaboration on tasks represent discrete but correlated dimensions in child psychotherapy (Estrada & Russell, 1999; Shirk & Saiz, 1992).

Although the majority of the studies on the therapeutic alliance conducted in adult psychotherapy field, there is growing evidence that the therapeutic alliance plays an essential role in psychotherapy with children (e.g., Shirk & Karver, 2003; McLeod, 2011). There is also growing interest in child psychotherapy process research about factors effecting therapy outcome (e.g. Halfon, 2019, Goodman et al, 2017).

The most recent meta-analysis by Karver and colleagues (2018) on therapeutic alliance-outcome relation, revealed a small to medium effect size. They included 28 studies in which both behavioral and non-behavioral treatment approaches were employed for the treatment of internalizing, externalizing, and comorbid internalizing and externalizing problems. They showed that the relation between alliance and outcome varied depending on child's diagnosis, therapy type, study design and treatment setting (inpatient/outpatient). In general, the meta-analytic reviews demonstrated that pre-treatment factors such as pre-treatment patient characteristics (type of clinical problem, age of child) (e. g. Karver et al., 2018; McLeod, 2011) and methodological factors (timing and type of outcome and alliance measurement) (McLeod et al., 2017) are consistently found moderators of alliance-outcome association.

Moreover, the factors related to dropouts are investigated in child psychotherapy research. Some of the studies focused on pre-treatment factors

related to children, parents and therapists (e.g. Kazdin & Mazurick, 1994; Eslinger et al., 2014). On the other hand, some put emphasis on relational factors that occur through therapy process between child and therapist (e.g. Schneider et al., 2010; Goodman & Athey-Lloyd, 2011; Goodman, 2015; Ramires et al., 2017). It is reported that factors such as age, gender, psychosocial functioning, diagnosis of the child, socioeconomic disadvantage, history of antisocial behavior, child's externalizing behaviors, caregiver age, adverse child-rearing practices are the pretreatment factors that undermine formation of therapeutic alliance at child psychotherapy (Halfon et al., 2019; Kazdin & Mazurick, 1994; Eslinger et al., 2014). Furthermore, in child psychotherapy, parent-therapist alliance was found to be effective on treatment outcome. According to Hawley and Weisz (2005) therapeutic alliance with the parents was found to be related with the premature termination or dropout; on the other hand, alliance with children predicts decrease in symptom severity.

Recently, the studies in child psychotherapy focused more on changes in the therapeutic alliance throughout treatment, and its relationship with treatment outcome, because exploring alliance trajectories present more reliable findings (Bickman et al., 2012). However, studies that measure therapeutic alliance repeatedly over the course of treatment are scarce and mostly acquired from studies conducted with children with anxiety problems in cognitive behavioral treatment (e.g. Chiu et al., 2009; Hudson et al., 2014; Kendall et al., 2009). In psychodynamic child psychotherapy, few studies explored the relationship between therapeutic alliance and the outcome considering differences in the alliance over the course of treatment (Halfon, 2021; Halfon et al., 2019, 2020). The findings of the process studies were summarized below.

In their study with children who have anxiety syndromes, Chiu and colleagues (2009) found that positive changes in alliance through therapy process was associated with symptom reduction at the end of the treatment. On the other hand, Liber and colleagues (2010) found no significant correlation between linear

growth of alliance and symptom reduction for the children diagnosed by anxiety disorder. There are other studies reported a concave growth curve for the treatment of anxiety symptoms (e.g. Chu et al., 2014; Kendall et al., 2009) which showed that therapeutic alliance grows fast at the beginning, then the growth slows down for the later phases. Some of the studies found negative linear slope (Hudson et al., 2014) for the therapy process of children with anxiety disorder. Hurley and colleagues (2013) , on the other hand, in their study conducted with youth having disruptive behaviors, showed that over the course of therapy, therapeutic alliance followed a U-shape pattern which means it decreases at the initial phases, leveled off in the middle phase and started to increase at the end phases.

More recently, Halfon and colleagues (2019) aimed to investigate development and characteristics of therapeutic alliance, as well as its relation with treatment outcome in psychoanalytic child therapy. It was reported that the average level of therapeutic alliance across the sessions, and high-low-high quadratic pattern of alliance growth were accounted for significant proportions of outcome variance independent from pretreatment factors. In other words, children who have average level of mean alliance and "with faster changes from down-ward to the upward trends experience more improvement in symptoms" (p. 613). Their findings pointed the importance of resolving the ruptures in therapeutic alliance in a more rapid way. They explained finding U-shaped growth trajectory, with the characteristics of psychodynamic treatment, at the middle phases of which, the patient's core issues become more apparent in the therapeutic relationship. Moreover, according to them, another reason for finding the quadratic trajectory might be related with the children's changing emotion regulation capacity over the treatment course. As the therapist become more dependable other through the middle phases, children can more easily express troubling emotions which stem from their internal relational patterns.

The robustness of therapeutic alliance-outcome relation varies according to demographic and clinical characteristics of the children. The ability to establish

alliance differs depending on the clinical characteristics such as having externalizing, internalizing or comorbid problems, and depending on demographic characteristics such as age and gender (Shirk & Karver, 2003).

First of all, problem type was found to be a significant moderator (DiGiuseppe et al., 1996; Shirk & Karver, 2003). Youth and children with externalizing behaviors were reported to have lower average therapeutic alliance (Halfon et al., 2019; Ayotte et al., 2016; Bickman et al., 2012). Moreover, for the adolescents and children with interpersonal problems and oppositional behaviors it was found that alliance formation was strongly predictive of outcome (Halfon et al., 2019; Eltz et al., 1995). On the other hand, it was found that youngsters with internalizing problems may establish therapeutic alliance more easily than their externalizing counterparts due to having greater motivation to reduce internal distress with their therapists (Shirk & Karver, 2003). Consequently, the formation of a therapeutic alliance found to be both more difficult and more critical for outcome for adolescents with externalizing rather than internalizing problems (Eltz et al., 1995).

Secondly, gender was found to be a significant moderator of therapeutic alliance-outcome association for youth and children. Accurso and Garland (2015); Halfon and colleagues (2019) showed that girls had higher mean therapeutic alliance score. Furthermore, Halfon and colleagues (2019) found that boys show declining alliance trajectory. Accurso and Garland (2015) also revealed that for the girls, therapeutic alliance improved over time, but remained constant for the boys with disruptive behaviors. This was explained by the high number of female therapists in the samples of the studies and easiness to establish therapeutic alliance with the same-sexed therapist.

Lastly, in terms of age, it was found that for the younger children therapeutic alliance-outcome relation is stronger when compared with their older counterparts (McLeod, 2011). They explained their findings with the fact that children generally were referred to therapy by their parents, therefore, quality of

alliance might be functional in leading positive treatment outcome. On the contrary, there are studies which did not find age as a factor that predicts alliance formation and quality (Chu et al., 2014; Karver et al., 2018; Halfon et. al., 2019). Halfon and colleagues (2019) explained their finding with referring the sample characteristics of the study, which was homogenous and composed of children at younger ages. Some previous studies reported a significant and negative correlation between age and therapeutic alliance (e.g. Abrishami & Warren, 2013; DeVet et al., 2003). Abrishami and Warren (2013) reported that towards adolescent, the need of autonomy increases and leads to difficulties in forming and sustaining therapeutic alliance.

In this current study, considering their influence on forming and maintaining alliance; problem type, gender and age of patients were taken into account while exploring strains in alliance.

1.2.2.2. Measures of Therapeutic Alliance and Rupture-Repair Processes in Adolescent and Child Psychotherapy

For assessing the quality and characteristics of therapeutic alliance, several measures have been used in the literature which varies according to the agent, from which the information was taken. Some of the measures evaluate therapeutic alliance based on child's declaration (e.g. Child's Perception of Therapeutic Alliance, Kendall, 1994; Working Alliance Inventory for Children and Adolescents, Horvath & Greenberg, 1989; Children's Alliance Questionnaire, Roest et al., 2016). One of the most frequently used form that assesses child's perspective is Therapeutic Alliance Scale for Children (TASC) which was developed by Shirk and Saiz (1992). They adapted Bordin's model, which is composed of bond, task and goal; and considering the distinct features of therapeutic alliance with children, they included two dimensions, namely emotional bond and collaborative work (task). Shirk and Saiz (1992) developed two forms for

children and therapists which are composed of twelve 4-point Likert items. Both the therapist and children forms include same but reworded items. They explored the psychometric properties of both forms and revealed moderate internal consistency for child form and good internal consistency for therapist form. Moreover, Hawley and Weisz (2005), in their study with 65 children, showed good internal consistency for the child form. The predictive validity (Hawley & Weisz, 2005) and convergent validity (McLeod & Weisz, 2005) of the two forms were found to be good. According to McLeod and colleagues (2013), TASC is one of the most widely used therapeutic alliance measures for children (as cited in Özsoy, 2018).

However, as Shirk and Karver (2003) mentioned, because of the developmental incompetency in self-monitoring, perspective taking, and meta-cognition, it might be difficult for children to express their views on therapeutic alliance. Thus, it was stated that using observer-based measures will provide empirically more reliable and valid results on alliance-outcome association. Several measures were developed to assess therapeutic alliance by independent observers (e.g. WAI-O; Darchuk et al., 2000; Child Therapeutic Alliance Scale - CTAS; Grienenberger & Foreman, 1993; Therapy Process Observational Coding System-Alliance scale; McLeod and Weisz, 2005).

As stated before, both observer-based and self-report measures has its advantages and limitations. It is possible that child patients might not view moments of withdrawal as a rupture and only consider moments with more intense and adverse emotions; on the other hand, observer-based measures might be overdetermine ruptures in the alliance. Therefore, in the current study, both type of measures were used in assessing alliance strains.

1.2.2.3. Empirical Findings on Alliance Ruptures in Adolescent and Child Psychotherapy

The 3RS (Eubanks-Carter et al., 2014) has been used in adolescent psychotherapy research by few studies (e.g. Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). These studies found withdrawal ruptures occurring more frequently than confrontation ruptures and all studies showed that unresolved alliance ruptures at the early phases of psychotherapy leads to dropout with adolescent patients. In their study with youth diagnosed with borderline personality disorder, Gersh and colleagues (2017) demonstrated ruptures increasing in the middle and later phases of treatment, especially the confrontation ruptures, and followed by increasing rupture resolutions. Schenk and colleagues (2019) studied trajectories of alliance ruptures with adolescents diagnosed with borderline personality pathology. Their findings supported an inverted U-shaped trajectory of alliance ruptures. They also found that alliance ruptures occur non-linearly and can be detected in single peak sessions, in addition to the rupture-repair patterns which may take series of sessions. Both of the studies found that the degree of rupture resolution increases as the treatment progressed. O'Keeffe and colleagues (2020), in their study with adolescents having depressive symptoms, aimed to explore rupture-repair markers and their relationship with different types of treatment ending. They identified three groups which were completers, dissatisfied dropouts and got-what-they-needed dropouts. They found that more ruptures occur and the ruptures were mostly unresolved for the dissatisfied dropout group. Consequently, they highlighted the importance of early identification of ruptures and effectively resolving them for preventing dropout. Daly and colleagues (2010) in their study with adolescent diagnosed with borderline personality disorder tested the effectiveness of nine stage rupture resolution model in cognitive analytic therapy. They found that effective rupture resolution is associated with positive treatment outcome. Recently, Cirasola and colleagues (2022) aimed to better understand

rupture-resolution processes and its contribution to good treatment outcome for the case of a depressed adolescent. Their results supported that, if ruptures were explored by therapists and patients properly, they contribute positive treatment outcomes. Evolution of the relationship between therapist and the patient was referred as the main treatment factor which is responsible for the positive changes in depressive symptoms.

For the child psychotherapy, the number of studies that explore rupture-repair process is even less. Goodman and collogues (2017) studied rupture-repair sequences for the therapy process of a child with autism spectrum disorder. Segmented version of WAI-O (S-WAI-O; Berk, Eubanks-Carter, Muran, & Safran, 2010) was used for the analysis. To identify repair processes in psychotherapy, they used Rupture Resolution Rating System (3RS; Eubanks-Carter et al., 2014) in conjunction with S-WAI-O. They focused on the relations among therapeutic alliance, adherence to child centered play therapy and symptoms in their single case study. They concluded that, for the children with autism spectrum disorder the results were paradoxical that ruptures (without resolutions) resulted in immediate decrease in symptoms. The result highlighted the importance of moderators such as diagnosis and developmental level which have distinct effects on the process-outcome relation. Nof and colleagues (2019) also put emphasis on research gap on investigating rupture-repair processes in child psychotherapy and introduced Child Alliance Focused Approach suggesting intervention techniques for detecting and repairing ruptures in the alliance between the child and the therapist in child psychotherapy. They developed the model based on the framework proposed in adult psychotherapy (Safran & Muran, 2000).

However, neither of the studies explore rupture-resolution processes in psychodynamic child psychotherapy, with considering effect of various pretreatment factors such as diagnosis, age and gender. In this current study the aim was to explore, how ruptures occur and function considering unique characteristics of the alliance in child psychotherapy.

1.3. RESEARCH GAP AND PURPOSE OF THE STUDY

The information on rupture-repair processes gained mainly from research with adult and partially from the adolescent population. However, as reviewed in the previous sections the alliance has conceptually and empirically distinct qualities for adult, youth and child population. These differences also affect conceptualization of ruptures in these groups. In child psychotherapy the distinction among the aspects of therapeutic alliance (tasks, goals, and bonds) is less distinguished (Faw et al., 2005) and therapeutic alliance is most commonly operationalized by putting emphasis on two components which are affective and collaborative aspects (Shirk et al., 2011). Because of the parent involvement, and developmental limitations of children in terms of determining and negotiating on therapy objectives, the third aspect of alliance (collaboration on therapy goals and tasks) is considered to be less influential on therapeutic relationship, especially for the psychodynamic therapy. Therefore, it would be important to explore ruptures by considering the different characteristics of alliance for child patients. Exploring the impact of ruptures, considering the distinction between the real relationship and the working alliance, as well as taking play relationship into account were also expected to provide further insight about qualities of effective psychotherapy with children.

As Safran stated (1993a) therapists are often not aware of detecting rupture moments, especially the subtle ones, and therefore missing the opportunity to resolve these ruptures. Detecting rupture events at early stages of psychotherapy is very important for therapeutic change. Therefore, one of the aims of the current study was to provide rupture patterns for child patients. Previous studies with child patients showed that pretreatment factors such as problem type, gender and age were considered as the most influential factors determining alliance (e.g. Accurso & Garland, 2015; Ayotte et al., 2016; Bickman et al., 2012; Chu et al., 2014; Karver et al., 2018; Halfon et al., 2019; Goodman et al., 2017). Considering the difficulties

in forming and maintaining a therapeutic alliance, in this study it was hypothesized that (1) children with externalizing problems and boys have more frequent and significant ruptures and, it was expected that (2) rupture resolution score would be less for children with externalizing behavior problems. It is also expected to find (3) predominant rupture markers for the children with different problem types (externalizing, internalizing), gender. Lastly, in terms of age, findings of the previous studies were contradictory. Therefore, differences in rupture-resolution processes were explored based on age in the current study.

CHAPTER 2

METHOD

2.1. PARTICIPANTS

2.1.1 Children

The data was obtained from Istanbul Bilgi University Psychotherapy Research Laboratory which is in coordination with Psychological Counseling Center. The center offered low-cost outpatient psychodynamic psychotherapy service in a face-to-face format before COVID-19 pandemic. In this study because the focus was on alliance in face-to-face therapy processes, patients who received psychotherapy between the years of 2017-2020 were included.

Corresponding to the center procedures, an initial examination was made by a licensed clinical psychologist to evaluate whether the children met the inclusion criteria. For participants to be included in psychotherapy process, the children should be aged between 4-10 years old, did not have psychotic symptoms, developmental disability, risk of suicide or substance abuse. 136 of the children met those criteria between Fall 2017 and Fall 2019 and gave consent to be involved in research project, through which the sessions were recorded and questionnaires were delivered to both parents and children. Before starting to psychotherapy process, the parents submitted a written consent for the use of the data collected through the psychotherapy process for research purposes. This study was approved by Istanbul Bilgi University Ethics Committee. Among the 136 participants, only for the 42 of them, Therapeutic Alliance Scale for Children (TASC; Creed & Kendall, 2005) were filled by both children and their therapists, at least for one session through the treatment process, which composed the final sample for this study.

The children were all Turkish citizens, most of them resided in urban areas and had middle socioeconomic status (SES). 14 % of the children were between ages 4 and 5; 43 % were between 6-7 years old and 43 % of them were 8-10 years old. In terms of gender, 60 % of the sample was composed of males and 40 % of them were females. The most frequently appeared reasons for referral were behavioral problems (33 %), learning problems (24 %), and anxiety problems (% 14). To assess effectiveness of psychotherapy, standardized symptom measure (CBCL) was used which were answered by parents before and after the treatment (see Table 2.1.). In order to explore whether there is a significant therapeutic change paired samples *t*-test was conducted with pre- and post-test total problems scores. The difference was found to be statistically significant. The effect size was found to be medium to large (*d*= 0.66). When pre-treatment CBCL Checklist (CBCL; Achenbach, 1991) categories were considered, most of the children were at *clinical* (*N* = 27) and *borderline* (*N*= 7*)* levels of functioning. In terms of problem categories, 31 % of the children were found to have internalizing problems, for the 21 % of them, externalizing problems were reported, and lastly 29 % of the children were categorized as having both internalizing and externalizing problems.

Table 2.1.

Comparison of Pre-Treatment and Post-Treatment Scores for Outcome Measure

	Pre-Treatment		Post-Treatment		Change	
	Mean	*SD*	*Mean*	*SD*	*t*	*Cohen's d*
CBCL Total Problems	65.92	6.94	59.77	10.61	3.68**	0.66

**p < .01.

2.1.2. Therapists

The therapists were composed of 17 clinicians at Istanbul Bilgi University clinical psychology master's program. Except one, all of the therapists were female. Therapists' ages varied between 23 and 33 years old. All therapists had the same level of clinical experience (1 to 2 years). Their theoretical education was mostly based on psychodynamic child psychotherapy principles. Moreover, the therapists received 4 hours of supervision (1 hour of individual and 3 hours of group supervision) per week throughout therapy process from the experts having psychodynamic orientation.

2.1.3. Treatment

At Istanbul Bilgi University Psychological Counseling Center (PCC) the standard treatment was based on psychodynamic child psychotherapy model. The treatment begun with an assessment process. At the first session, clinical interview was carried out with the parents to obtain comprehensive information about reason for referral and child's developmental history. After the first session, parent's completed symptom checklist (CBCL; Achenbach, 1991). During the next two sessions Parental Development Interviews (PDI-R, Slade et al., 2004) were carried out with parents. Fourth session was held with the children during which the therapist introduced the therapy process, playroom and materials; and gave information about the therapeutic frame (rules, frequency and duration of the sessions). After the assessment process, the feedback session was fulfilled with the parents and regular meetings with children was held afterwards. The treatment procedure at the PCC generally planned as weekly sessions with children and monthly sessions with parents. The duration of the sessions were 45-50 minutes. The treatment process was not time-limited and the duration of therapy process was decided with parents considering needs and progress of the children. Total number of sessions ranged between 10 to 77 ($M = 34$, $SD = 19.48$).

At Istanbul Bilgi University PCC, the treatment process was not manualized. However, both therapists and supervisors had psychodynamic orientation following the principles of psychodynamic child psychotherapy. This therapy model emphasizes following child's lead during therapy session and aiming to facilitate child's self-expression through conversation or play. The therapist sees and confirms the emotional and behavioral expressions of the child and communicates with the child to create meaning for those expressions. Also, in the transference relationship, therapists address children's internal conflicts, emotional difficulties and dysfunctional relational patterns. Gradually, with the therapists' repetitive interpretations of these conflicts, containment of the emotions, making connections between wishes, needs, emotions and play themes; child's internal representations of self and other, affect regulation and reflective function capacities has changed.

2.2. MEASURES

2.2.1. Therapeutic Alliance Scale for Children-Revised – Child and Therapist Versions (TASC-C and TASC-T)

Therapeutic Alliance Scale for Children-Revised – Child and Therapist Versions (TASC-C/T; Creed & Kendall, 2005) are self-report scales that assess therapeutic alliance by considering two factors: the emotional bond and, collaboration on therapeutic tasks and goals between therapists and children. Both scales are composed of 12 items and developed as parallel forms for the children and therapist. TASC-C (see Appendix A) was based on child's report on child-therapist alliance. Similarly, TACS-T (see Appendix B) was developed to assess therapist perception on therapeutic alliance with his/her patient. The 12 items are scored on a 4-point Likert scale (from 1= not true at all, to 4= very true). Both forms reported to have excellent internal consistency and good test-retest reliability

(Creed & Kendall, 2005; Hawley & Weisz, 2005; Shirk & Saiz, 1992) and have moderate to large relationship with other scales that measure relationship quality (Shirk et al., 2008). The scales did not have Turkish adaptation. For the current study, internal consistency for the total alliance score was found good ($\alpha = .86$) for the TASC-T, and moderate ($\alpha = .62$) for the TASC-C.

2.2.2. Rupture Resolution Rating System (3RS)

Rupture Resolution Rating System (3RS; Eubanks et al., 2014) is an observer-based instrument for identifying alliance ruptures and resolution of them in psychotherapy sessions. The video recordings of the sessions were coded by researchers in order to determine alliance rupture and resolution markers within five-minute segments. Ruptures represented by deteriorations in collaboration on tasks and goals, or strains in the affective bond between children and therapists. Coders also need to make decision about the type of rupture (withdrawal or confrontation) and corresponding rupture markers. Withdrawal rupture markers can be listed as: (1) denial; (2) minimal response; (3) abstract communication; (4) avoidant storytelling and/or shifting topic; (5) deferential and appeasing; (6) content/affect split; (7) self-criticism and/or hopelessness. Confrontation rupture markers can be listed as: (1) complaints/concerns about the therapist; (2) patient rejects therapist intervention; (3) complaints/concerns about the activities of therapy; (4) complaints/concerns about the parameters of therapy; (5) complaints/concerns about progress in therapy; (6) patient defends self against therapist; (7) efforts to control/pressure therapist. In addition to rupture markers, coders mark the resolution strategies employed by the therapist which can be listed as: (1) therapist clarifies a misunderstanding; (2) changes tasks or goals; (3) illustrates tasks or provides a rationale; (4) invites the patient to discuss thoughts or feelings with respect to the therapist or some aspect of therapy; (5) acknowledges his/her contribution to a rupture; (6) discloses his/her internal experience; (7) links

the rupture to larger interpersonal patterns between the patient and the therapist; (8) links the rupture to larger interpersonal patterns in the patient's other relationships; (9) validates the patient's defensive posture; (10) responds to a rupture by redirecting or refocusing the patient (Eubanks-Carter et al., 2014).

While watching the video recording of the sessions in five-minute segments, coders use *checks* on the score sheet for any rupture or resolution marker that they detect; and use *check-minus* when they are not certain about whether the rupture or resolution event fit the criteria. When calculating frequency scores for each rupture marker and resolution strategies, a check is counted as 1 point, and a check-minus is counted as 0.5 points. Additionally, total frequency scores of withdrawal and rupture markers and resolution markers can be calculated. After watching the entire session, coders also expected to score significance of each rupture and resolution marker and significance of overall withdrawal and confrontation markers. Significance represents the influence of rupture and resolution markers on therapeutic alliance and coders are expected to score significance on a 5-point Likert scale (1 = *no significance* to 5 = *high significance*). Lastly, coders evaluate *the degree to which ruptures are resolved* and *the therapist's contribution to ruptures* considering the entire session by using a 5-point Likert scale (1 = *poor resolution* to 5 = *very good resolution*) (Eubanks-Carter et al., 2014).

Considering the psychometric properties, 3RS has showed good inter-rater reliability (ICCs = .85 - .98) and predictive validity considering the drop-out (C. F. Eubanks et al., 2019). In the current study, low alliance sessions were detected and randomly assigned to the two pairs of coders. The coders showed good to excellent inter-rater reliability, ICCs ranging between 0.72 and 1.00 ($M = 0.88$, $SD = 0.07$). For the current study internal consistency was found to be moderate for significance ($\alpha = 0.75$) and frequency ($\alpha = 0.78$) of the markers.

2.3. PROCEDURE

2.3.1. Adaptation of 3RS to Child Psychotherapy

The scale was developed for adult patients, and it has been employed in few studies with adolescent participants (e.g. Cirasola et al., 2022; O'Keeffe et al., 2020; Schenk et al., 2019). In the current study, the scale was used with the children in a multiple case study for the first time.

Firstly, four graduate students including the author obtained the 3RS manual and learning materials through consulting Cathrine F. Eubanks, PhD; J. Christopher Muran, PhD and Sibel Halfon, PhD. Then, coders started practicing with the session videos ($N = 8$) of adult patients which were coded before with 3RS by Cathrine F. Eubanks and her team. Regular meetings were arranged with Sibel Halfon to discuss markers in the videos. After achieving adequate interrater reliability (ICC = 0.70) for the sessions with adult population, 5 sessions of child patients were selected to code with 3RS. The sessions were belong to the children who were from different gender and age groups, and had distinct referral reasons. Regular meetings were held with Sibel Halfon to discuss markers appeared in child sessions with considering distinct dynamics of alliance in psychodynamic child psychotherapy. The sessions were coded with good to excellent ICCs (0.70-1) ($M = 0.91$; $SD = 0.07$).

While coding sessions with child patients, some of the 3RS items were modified. *Avoidant storytelling and/or shifting topic* marker was expanded and when shift in play activity was observed, it was also coded with this marker. Moreover, when children violated the rules (e.g. leaving the room during the session, damaging the materials in room) it was coded with *complaints/concerns about the parameters of therapy* marker, however, a new marker related to violation of the rules was considered necessary. Also, while coding the sessions, the distinction was made between the ruptures occur within real relationship and play

relationship. For some cases, it was not easy to identify whether the alliance rupture occurred between therapist and children or, between therapist's and children's play characters. In such cases the ruptures were coded with check-minus (0.5). Similarly, while coding the resolution strategies, sometimes therapists pointed out ruptures via play characters, rather than directly referring the real relationship between children and themselves. These events also coded with check-minus (0.5). In session examples for rupture markers and resolution strategies were included in Appendix C.

2.3.2. Data Collection

For the alliance measure, TASC forms were delivered to the children and therapists, once every five sessions through the therapy process. Both therapists and children completed the TASC-C and TASC-T forms after the same session. The therapists completed the scale on Qualtrics, whereas for the children the questions were asked by research assistants after the session.

Aforementioned, for the 42 of the cases both therapist and children filled out the TASC forms. In the present sample, total number of sessions for the participants were 285. The treatment process ranged between 10 to 77 sessions ($M = 33$, $SD = 19$). Collected TASC scores were used for determining sessions with low alliance ($N = 49$). In the current study, therapists' and clients' subjective experiences of rupture was aimed to be explored, therefore even the subtle ruptures were included for the analysis. For detecting subtle ruptures Safran and Muran (2006) suggested to establish a minimum criterion compatible with the research purposes in order to reduce "noise in the sample" and found meaningful rupture events. As they stated "… a dip in the patient's rating of the session therapeutic alliance score of less than one standard deviation from his or her other session alliance ratings may not yield a rupture event that is particularly interesting." (Safran & Muran, 2006, p. 289). Therefore, in this current study at least one

standard deviation below the mean was established as a criterion. 49 sessions were detected below one standard deviation and 6 of them were excluded from the study because 4 of the sessions held with parents and for the 2 of them, there were problems about audio and video recordings of the sessions. Videotapes and transcripts of the 43 sessions of 24 participants were assigned randomly and coded with using 3RS by four graduate students.

CHAPTER 3

RESULTS

3.1. DATA ANALYSIS

To explore the effect of rupture-resolution processes on treatment outcomes (in terms of changes in behavioral problems and emotion regulation capacity), first, low alliance sessions were determined to be coded by 3RS. In the collected data, psychotherapy sessions ($N = 285$) were nested within patients ($N = 42$) who were nested within therapists ($N = 17$). In order to determine sessions with low alliance, a multilevel modeling approach was conducted with TASC scores, by using MLWin Version 3.05 (Charlton, Rasbash, Browne, Healy & Cameron, 2020). After the low alliance sessions were determined and coded with 3RS, to explore different characteristics of rupture-resolution processes for the distinct groups of children in terms of problem type, gender and age; descriptive statistics and Mann-Whitney U tests were conducted by using SPSS Version 22.

3.2. RESULTS

3.2.1. Determining Low Alliance Sessions

Total TASC-Children (TASC-C) and total TASC-Therapist (TASC-T) scores were calculated for each session by using individual items of each scale (see Table 3.1.). Then, total TASC-C and total TASC-T scores were analyzed with multilevel linear modeling to determine sessions with low alliance.

Table 3.1.

Descriptive Statistics for TASC-C and TASC-P Scores

	N (Valid)	*N* (Missing)	*Mean*	*S.D.*
TASC-C	176	109	39.38	5.29
TASC-T	245	40	35.44	6.89

In the data, sessions were nested in patients who were nested within therapists. Because multiple patients were treated by the same therapists, the level of interdependency due to therapists was examined first. Two-level (sessions nested within patients) and three level (sessions nested within patients nested within therapists) "empty" multilevel models were employed, where therapeutic alliance was entered as the outcome variable with no predictor variables. The therapist level ICC was 0.00, *ns.*, indicating that therapists accounted for about 0 % of the variance in therapeutic alliance, implying that the variance in the session measures is not due to differences between therapists. On the other hand, the patient level ICC was found to be 0.54 to 0.56 for TASC-C and TASC-T measures ($p < 0.01$), accounting for an average 55 % of the variance in therapeutic alliance. This implied that not all variance is attributable to session level, and a two-level model fits the data better. Hence, only two-level model was employed in the analysis.

Then, to identify sessions which deviated significantly from the mean TASC-C and TASC-T scores, latent individual scores per each child and therapist were taken from the MLM model using the formula below:

$\beta_{0j} = \beta_0 + u_{0j} + e_{0ij}$ where β_0 represents the grand mean intercept of alliance scores and u_{0j} represents each child and therapist's individual deviation from the grand mean intercept and "e_{0ij}" represents the session level residuals of each child and therapist, interpretable as the deviation of each TASC raw score from the fitted curve (see Table 3.2).

Table 3.2.

Multilevel Model of Mean TASC-C and TASC-T Scores

	TASC-C			TASC-T		
	β	SE	t	β	SE	t
Intercept (β_0)	35.18	0.89	39.57**	39.25	0.66	59.02**

**p < .01.

In the current study the sessions which were at least one standard deviation below the mean were selected ($N = 43$) to be further analyzed with 3RS (Eubanks et al., 2014).

3.2.2. Descriptive Statistics

After coding the sessions with 3RS, frequency of rupture markers and resolution strategies were calculated to evaluate differences in rupture-repair processes for child patients treated with psychodynamic psychotherapy. *Minimal response* and *avoidant storytelling* rupture markers (see Table 3.3); and *invite/discuss thoughts/feelings*, *redirecting or refocusing the patient* and *validating the patient's defensive posture* resolution strategies were observed as most frequently appearing markers (see Table 3.4). On the other hand, *abstract communication*, *deferential*, *self-criticism and/or hopelessness, complaint about progress in therapy* and *defend self against therapist* (see Table 3.3); and resolution strategies such as *changing tasks or goals*, *providing rationale for treatment* and *linking rupture to pattern in the patient's other relationships* were found as rarely observed markers (see Table 3.4).

Table 3.3.

Descriptive Statistics for Rupture Markers

	Mean	*SD*	*Range*	*Sum*
Denial	.628	.985	5.00	27.00
Minimal Response	3.59	2.66	9.00	154.50
Abstract Communication	.076	.208	1.00	3.25
Avoidant Storytelling	1.88	1.99	7.75	80.75
Deferential	.180	.417	2.00	7.75
Content Affect Split	.762	1.58	7.50	32.75
Self-Criticism Hopelessness	.180	.587	3.00	7.75
Complaints about Therapist	1.27	1.53	5.00	54.50
Reject Intervention	.663	1.18	4.50	28.50
Complaint About Activities	.296	.479	1.50	12.75
Complaint About Parameters	1.26	1.97	7.00	54.00
Complaint About Progress	.081	.216	1.0	3.5
Defend Self Against Therapist	.116	.507	3.25	5.00
Control/Pressure	1.06	1.483	5.25	45.50

Table 3.4.

Descriptive Statistics for Rupture Resolution Markers

	Mean	*SD*	*Range*	*Sum*
Clarifying Misunderstanding	.081	.392	2.5	3.5
Changing Tasks or Goals	.076	.228	1.25	3.25
Providing a Rationale	.122	.258	1.00	5.25
Invite/discuss Thoughts/feelings	1.64	1.83	6.50	70.50
Acknowledging Contribution	.430	.648	2.50	18.50
Disclosing Internal Experience	.360	.718	3.5	15.5
Linking Rupture to pattern between the patient and the therapist	.110	.310	1.50	4.75
Linking Rupture to pattern in the patient's other relationships	.058	.195	1.0	2.5
Validating the Patient's Defensive Posture	.483	.646	2.50	20.75
Redirecting or Refocusing the Patient	.523	.917	3.50	22.50

3.2.3. Characteristics of Ruptures for Different Problem Types, Gender Groups and Age

It was hypothesized that children with externalizing problems and boys have more frequent and significant ruptures; and for the children with externalizing behavior problems, it was expected that rupture resolution scores would be less compared to children with internalizing behavior problems. It is also expected to find distinct rupture markers for the children with different problem type (externalizing, internalizing) and gender. After coding sessions with 3RS, following scores were computed: number of confrontation, withdrawal and total (combined) rupture markers; significance of confrontation, withdrawal and total (combined) markers; rating of how much therapist contributed ruptures in the session; number

of each resolution strategies; significance of each resolution strategies and rating of to what extend ruptures were resolved in the session.

Descriptive statistics were conducted in order to explore the trends of rupture-resolution processes for the children with different problem types (internalizing, externalizing) and gender. Mann-Whitney U test was conducted to test whether the difference between children with externalizing and internalizing problems; and between boys and girls are significant, in terms of rupture and resolution scores.

For problem type, 4 categories were identified which are internalizing ($N = 22$), externalizing ($N = 5$), comorbid ($N = 11$) and not having clinical-level problems ($N = 5$). Table 3.5. shows mean rupture and resolution ratings, as well as therapist's contribution to rupture for each problem type.

Table 3.5.

3RS Mean Frequency and Significance Ratings of Rupture and Resolution

	Problem Type			
	None	Internalizing	Externalizing	Comorbid
Total Rupture Frequency	9.75	12.01	14.45	12.02
Total Rupture Significance	4.60	5.00	5.10	4.77
Total Withdrawal Significance	2.1	2.9	2.2	2.9
Total Confrontation Significance	2.5	2.1	2.9	1.9
Total Withdrawal Frequency	4.20	7.59	6.05	8.68
Total Confrontation Frequency	5.55	4.42	8.40	3.34
Total Resolution Significance	11.7	12.34	12.10	12.50
Total Resolution Frequency	2.65	3.93	4.80	3.93
Rupture Resolution	2.70	2.25	2.10	2.09
Therapist's Contribution	1.70	1.86	2.60	1.91

Figure 3.1, demonstrates differences between groups in terms of mean rupture frequency ratings. Even though the differences between the groups were not found to be statistically significant ($U_{withdrawal} = 42.5$, $p = .447$; $U_{confrontation} = 37.5$, $p = .284$), it was observed that children with internalizing problems have more frequent withdrawal ruptures than the ones having externalizing problems. On the other hand, confrontation ruptures appeared to be more frequent for the children with externalizing problems. For the children with comorbid problem behaviors, withdrawal ruptures appeared more frequently than confrontation rupture markers.

Figure 3.1.

Mean Frequency Ratings of Withdrawal and Confrontation Ruptures for Problem Types
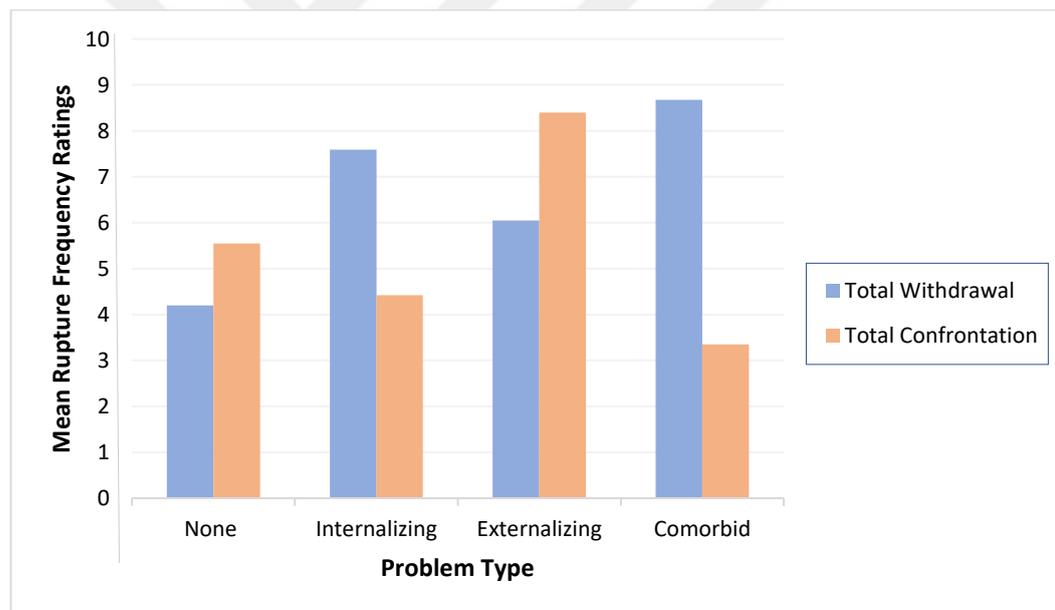
In terms of rupture markers, it was found that *minimal response* (*M*= 4.1), *avoidant storytelling* (*M*= 1.9) and *complaining about parameters* (*M*= 1.5) were the most frequently occurring ruptures for children with internalizing problems. On the other hand, *complaining about parameters* (*M*= 2.3), *complaining about therapist* (*M*= 2.1) and *control/pressure* (*M*= 2.2) were the most frequently

observed markers for the children with externalizing problems. Some of the examples for rupture markers were given below.

Examples of rupture segments for children with externalizing behavior problems:

1. Children (C): Throw them away (While throwing the toys) (***Efforts to Control/Pressure Therapist***).

   Therapist (T): These furniture in the house are so unnecessary. You want the house to be empty and not have any furniture.

   C: I'll take these home, okay? Promise me (***Efforts to Control/Pressure Therapist***).

   T: You want to take them home.

   C: I'll take it, of course. I don't need to ask you! *(**Efforts to Control/Pressure Therapist**),* (throwing toys at the therapist) *(**Complaint about therapist and parameters**).*

   T: I understand that you want to play by throwing, but you can put them slowly (while taking the toys away from the child).

   Ç: I said put these here! *(**Efforts to Control/Pressure Therapist**).*

2. T: Our last 10 minutes.

   C: Time runs out quickly! *(**Complaint about therapist and parameters**).* Don't come nearby! (Shooting the gun towards therapist in the play) *(**Complaint about therapist and Efforts to Control/Pressure Therapist**).*

   T: You got very angry when I told you we had little time *(**Invite/Discuss Thoughts and Feelings**).*

   C: I will kill you. (Starts hitting therapist) *(**Complaint about therapist and parameters**).*

3. T: What kind of things, what makes those things bad?

   C: Enough, I won't talk about things anymore! *(**Patient Rejects Therapist Intervention; Control/pressure therapist**)*

   T: What should we do instead? *(**Change task/goals**)*

   C: I don't want to say. *(**Patient Rejects Therapist Intervention**)*

Examples of rupture segments for children with internalizing behavior problems:

1. C: How many minutes left? What will we do with our remaining time? (These questions come regularly during the session) *(**Complains/Concerns About Parameters of Therapy**)*

   T: You are confused about what to do here. You're worried about how the remaining time will pass. *(**Invite/Discuss Thoughts or Feelings**)*

2. T: It was next to the box. Let's not put your feet on the chair. Take a seat yourself.

   C: OK, I always forget.

   T: Aah, the rules here are so annoying. *(**Therapist validates the patient's defensive posture**).*

   C: Mmm, it is not a problem. *(**Deferential and Denial**)*

3. T: It's like you came here planning what you're going to do today. I was wondering what are you going to do?

   C: (The child does not answer, continues to scribble) *(**Minimal response**).*

   T: Hmm, his whole face was covered.

   C: (Silence) *(**Minimal response**).*

   T: Just like that, you let go and paint completely, then you stop yourself at some point. It is very difficult for you to let go of yourself completely.

C: (child continues to scribble) *(**Minimal response**).*

T: His whole face is covered but you want to show his eyes.

C: (silence) *(**Minimal response**).*

In terms of rupture resolution significance, although the difference was not statistically significant ($U = 53$, $p = .928$), it was found that rupture resolution score was higher for the children with internalizing problems compared to the ones with externalizing problems (see Table 3.5). Lastly, in terms of therapist's contribution to rupture, although the difference was not found statistically significant ($U = 31$, $p = .146$), for the children with externalizing problems ($M = 2.60$) therapist's contribution to rupture has more impact, compared to children with internalizing behavior problems ($M = 1.86$).

Secondly, in terms of gender groups, although the differences were not found statistically significant ($U_{withdrawal} = 216$, $p = .824$; $U_{confrontation} = 168$, $p = .164$), it was observed that girls ($N = 18$) experienced more withdrawal ruptures than boys ($N = 25$). On the other hand, boys experienced more confrontation ruptures than girls (see Figure 3.2). Some of the examples for rupture markers and resolution strategies were given below.

Examples of rupture segments for boys:

1. C: I made a tree house.

    T: You made a tree house. Hmm, this tree house has stairs.

    C: How will they go down without a ladder?

    T: Mm they can't go down without a ladder.

    C: Then what would happen if there was no tree?

    T: Hmm, I wonder if there was no tree.

    C: There would be no oxygen.

    T: There would be no oxygen, you know that. The tree gives oxygen.

C: Well.

T: So.

C: You always repeat what I say, don't! *(Complaint about therapist)*

T: You want me not to repeat what you said. I guess it made you angry, I won't repeat it. *(Therapist acknowledges his / her contribution to a rupture)*. You will draw the grass with a different pencil. In this picture, there is both a tree house and a normal house. We have a minute left.

C: One minute? Oh, it's so funny, very funny indeed! *(Complaint about therapist and Complaint about parameters)*

T: It's annoying to you that you have one minute left. And you finished it in one minute.

2. (Therapist and child are playing Jenga).

   C: You had to put them in the middle without touching them, but you couldn't! *(Complaint about therapist)*.

   T: It is hard to trust me (*Invite/Discuss Thoughts and Feelings*).

   C: You shouldn't touch it with your finger. You did it again!

   T: You have trouble trusting me.

   C: If you want to play, do it without moving them, you always move them! *(Complaint about therapist)*.

3. C: (Long silence) *(Minimal response).* So? *(Control pressure)*

   T: So?

   C: Why did it suddenly get so quiet in here? *(Complaint about therapist)*

Examples of rupture segments for girls:

1. T: The family is weird. Do they have a hard time putting things in their place? Or are they constantly changing places?
   C: They are constantly changing places.
   T: Hmm. I wonder why? Can't they stay in place?
   C: I don't know. *(**Minimal Response)**

2. T: Trying to do everything right is difficult. Are there things in your life that you find difficult?
   C: (turning to playing with Legos) Let's move on to the blue ones now. I will finish these ones. (***Avoidant Storytelling/ Shifting Topic/ Shifting Play).***

3. T: Actually, this is as if the thing about your older brother is also valid for you, there is a disease that you don't actually have, and you thought as if you were experiencing it yourself.
   C: Yes. I also feel very different emotions. I mean, it's like it's happening to me, I ask myself what's wrong with you A., I felt like something is hurting, something happened to me, If feels very different when it happens. (***Abstract communication)***

Figure 3.2.

Mean Frequency Ratings of Withdrawal and Confrontation Ruptures for Girls and Boys
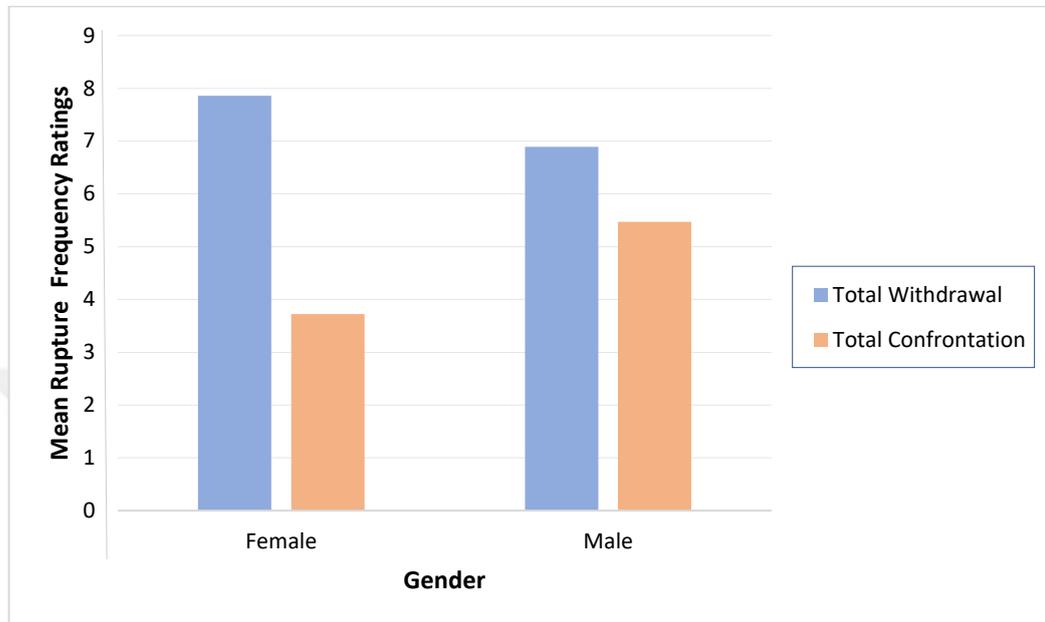
Lastly, in terms of the relationship between age and total rupture significance, the two variables were found significantly correlated ($r = -.331$, $p = .030$). Some of the examples for rupture markers and resolution strategies were given below.

Examples of rupture segments for younger children (Ages between 4-7):

1. C: Are you deaf? (in an angry way) *(Complaint About Therapist)*
   T: (sighs) I couldn't understand you at all. *(Therapist Acknowledges his / her Contribution to Rupture)*

2. C: Whoever gets the most black pawns wins.

   T: Oh, now it's the race to get the most blacks. While we are drawing a picture, suddenly a race begins between us.

   C: OK.

   T: You like competition.

   C: That's enough, don't take that much. *(Efforts to Control/Pressure Therapist)*

   T: You don't want me to have more. *(Invite/Discuss Thoughts and Feelings)*. You want to decide who gets more.

   C: Now you will do the same as me. Do what I do. *(Efforts to Control/Pressure Therapist)*. But I'm already done.

   T: I have to catch up immediately, I can never catch up with you.

   C: You have to catch up with me but you can't reach. *(Complaint About Therapist)*

3. C: Why are you imitating me? *(Complaint about therapist)*

   T: I do things similar to you. How does it feel to do similar things? *(Invite/Discuss Thoughts and Feelings)*

   C: (silence) *(Minimal response)*

Examples of rupture segments for older children (Ages between 8-10):

1. T: You didn't believe what I said, you checked it yourself. *(Invite/Discuss Thoughts and Feelings)*

   C: Because it (the paper money of the board game) can get under this (the box) sometimes… Okay, if it's the last house, then game is over. Who won? This time you won or we can continue the game.

   T: You want the game to continue instead of me winning. *(Invite/Discuss Thoughts and Feelings)*.

C: We can continue the game, there is such a rule about it, or you can win *(**Deferential**)*. If we look at the time, I think we can keep the game going. Because we still have 25 minutes.

T: Hmm.

2. T: Oh, your brother attacked you… As if your father attacked you in that war game.

C: (laughing) Yes. *(**Content/Affect Split**)*

T: Your brother did it on purpose, and you were very upset.

3. T: It's easier to play than to talk *(**Redirecting or Refocusing the Patient**)*

C: What?

T: It's easier to play than to talk.

C: Huh. Is it a game?

T: It hard to explain… Sharing what you are going through...

C: Now it's time to catch up in the trap... *(**Avoidant Storytelling/ Shifting Topic/ Shifting Play**)*

T: Traps... You didn't want to talk too much. *(**Invite/Discuss Thoughts and Feelings**)*

CHAPTER 4

DISCUSSION

The main purpose of the current study was to explore rupture-resolution processes in psychodynamic child psychotherapy while considering effect of pretreatment factors, namely problem type (internalizing and externalizing), gender and age. By using multilevel linear modeling low alliance sessions were determined based on TASC forms obtained from both therapists and patients. After determining sessions with alliance strains, these sessions were further coded with an observer-based measure, 3RS, to detect within session strains. 3RS provides data for frequency and impact of rupture markers (withdrawal and confrontation); frequency and impact of resolution strategies; as well as impact of therapist's contribution to rupture. Due to small sample size, a non-parametric test was used to compare groups according to problem type and gender based on their rupture-resolution ratings obtained from 3RS. The results did not show statistically significant difference between children with internalizing and externalizing problems based on their rupture and resolution ratings, as well as ratings of therapist's contribution to ruptures. However, it was observed that there was a trend towards rupture markers being less frequent, and resolution strategies being more effectively applied for children with internalizing symptoms, compared to the ones with externalizing symptoms. Moreover, trends in the data showed that therapist's contribution to the alliance ruptures is more considerable for the children with externalizing problems, compared to the ones with internalizing symptoms. Lastly, consistent with the expectations, distinct predominant rupture markers were observed for the children with externalizing and internalizing symptoms.

In terms of gender, though not statistically significant, it was observed that there was again a trend towards more frequent and substantial ruptures for boys. Also, it was found that, age and total rupture significance were negatively

significantly correlated which means that younger children have more significant ruptures than the older ones. The findings are further discussed below.

4.1. CHARACTERISTICS OF RUPTURES BASED ON PROBLEM TYPE, GENDER AND AGE

4.1.1. Problem Type

Taking into account their difficulties in forming and maintaining alliance (e.g. Accurso & Garland, 2015; Chu et al., 2014; Karver et al., 2018; Halfon et al., 2019; Goodman et al., 2017), it was hypothesized that children with externalizing problems, would have more frequent and significant ruptures compared to the children with internalizing symptoms. It was also expected that rupture-resolution significance rating would be less for the children with externalizing problems, compared to the children with internalizing problems. Studies conducted with adult and adolescent patients diagnosed by depression, anxiety disorders, and borderline personality disorder, identified rupture markers and resolution strategies through therapy process and reported predominant rupture markers in terms of frequency and impact (e.g. Boritz et al., 2018; Cirasola et al., 2022; Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019). For example, Boritz and colleagues (2018) found significantly higher proportions of confrontation rupture markers, compared to withdrawal markers, for the adult patients diagnosed with borderline personality disorder. Moreover, in their single case study with an adolescent with depressive symptoms, Cirasola and colleagues (2022) reported that they found mostly withdrawal ruptures compared to confrontation rupture markers.

In this current study, it was also expected to find differences in frequency and significance of ruptures based on problem type. Though not statistically significant, trends in the data showed that rupture markers were less frequent, and resolution strategies were more effectively applied for children with internalizing

symptoms, compared to the ones with externalizing symptoms. Different trends in rupture-resolution markers for children with externalizing and internalizing behavior problems can be explained especially by referring to the difference in their capacity for forming relationships, affective range and regulation.

Internalizing behaviors are less noticeable because they refer interiorized self-directed difficulties (Achenbach & Edelbrock, 1978) which include worry, sadness, lack of interest and pleasure (Olivier et al., 2020). Children with internalizing behavior problems portray withdrawn, inhibited and shy manners in the therapy sessions, and show limited range of emotions in terms of richness and depth (Halfon et al , 2019). Compared to children with externalizing behavior problems, they are more prone to engage in therapeutic relationship and collaboratively work on therapeutic tasks (Özsoy, 2018). Moreover, these children generally turn their aggression inward, therefore, they are less likely to express it towards their therapists or confront them. Oldehinkel and colleagues (2004) found that children with internalizing problems have high affiliation (desire for warmth and closeness with others) score and might be inclined to seek therapists' attention and support in the sessions. Therefore, it can be said that their tendency to engage in therapeutic relationship, and their will to prevent and solve strains in the alliance, deceases the number of alliance ruptures (especially the confrontation ruptures) and increases the influence of rupture resolution strategies for the children with internalizing behavior problems.

On the other hand, externalizing behaviors can be defined as easily noticeable and disruptive behaviors which include hyperactivity, attention problems, conduct problems, opposition and defiance (Achenbach & Edelbrock, 1978). For the children with externalizing problems experiencing relational difficulty is a key feature (Midgley et al., 2017). These children represent range of social-cognitive difficulties, including deficits in theory of mind (Hughes & Ensor, 2008). They are also more prone to have hostile attributions to others' minds (Sharp & Venta, 2012) and show abnormalities in their trust behavior, especially when

their emotional arousal is high (Sharp et al., 2011). Compared to the other children, they are inclined to see malevolent intentions of others, creating epistemic mistrust which prevents them from learning from their social context (Midgley, 2017). For the children with externalizing behavior problems, it can be inferred that, these interpersonal difficulties and deficits in emotion regulation, increase the frequency and significance of the rupture markers (especially the confrontation markers), and decrease the effectiveness of resolution strategies. As opposed to the children with internalizing behaviors, pointing out the relationship between therapist and children as a resolution strategy, might sometimes create even more frustration within therapeutic relationship.

Similarly, findings of previous studies conducted with adult and adolescent participants showed that interpersonal problems and hostility are predictor of alliance difficulties. Colli and colleagues' (2017) found that patients diagnosed with personality disorder showed more explicit, confrontational and aggressive ruptures in the alliance compared to patients without personality disorder. On the other hand, they reported that patients without personality disorder have higher capacity for expressing confrontation in a collaborative way. According to them "The therapeutic relationship with these patients seems to be a minefield in which the therapist's interventions may represent a wound to the patient's fragile self-esteem, and patients may experience the therapist as critical and devaluing" (Colli et al., 2017, p. 10). Some research findings revealed that therapists are more likely to face problems in forming and maintaining alliance with these patients, because they showed longstanding and rigid patterns of emotional and interpersonal difficulties (e.g. Benjamin, 1993; and Livesley, 2001). Tufekcioglu and colleagues (2013) argued that rather than having diagnosis of personality disorder, high impulsivity, dysregulation, and mood lability were associated with greater degree of rupture intensity declared by the patients. These patients' emotional liability negatively influences therapist's capacity to empathize and hindered the effectiveness of therapist's interventions (Kiesler, 1996).

Furthermore, in the current study, although the difference was not found statistically significant, therapist's contribution to rupture showed a trend towards being higher for children with externalizing problems compared to the ones with internalizing problems. Trends also showed that, even though the frequency of resolution strategies were higher for children with externalizing symptoms, impact of these strategies were lower for them compared to the children with internalizing symptoms. According to Hoffmann and colleagues (2015) children with externalizing problems can easily evoke negative countertransference and therapists might be overly involved in patients' dysfunctional interpersonal styles (Safran & Muran, 2000) which undermines the effectiveness of therapist's interventions.

Moreover, when withdrawal and confrontation rupture markers were distinguished, it was observed that children with internalizing problems tend to have a trend towards more frequent and considerable withdrawal ruptures than the ones having externalizing problems. On the other hand, trends in the data showed that confrontation ruptures appeared to be more influential and frequent for the children with externalizing problems. In this study, it was also expected to find predominant rupture markers for the children with internalizing and externalizing problems. *Minimal response*, *avoidant storytelling* and *complaining about parameters* were found to be the most frequently observed rupture markers for children with internalizing problems. On the other hand, *complaining about parameters*, *complaining about therapist* and *control/pressure* were most frequently observed markers for the children with externalizing problems.

The predominant rupture marker's characteristics for children with internalizing and externalizing problems were found to be consistent with the patient characteristics. Children with internalizing problems may be more inclined to interpersonal withdrawal and declare their disagreement with the therapist in a deferential manner, rather than explicitly conflict with their therapists. Therefore, finding *minimal response*, *avoidant story-telling* as most frequent rupture markers

was consistent with the expectations. *Complaining about parameters* marker mostly appeared within the sessions, in the form of asking about the remaining time. Rather than directly stating their negative emotions such as being bored or not wanting to stay in the room, these children state their unpleasant feelings in a more implicit way. It was also observed that some of the children complained about parameters, in order to state their discontent or complaint about the therapist in a more indirect way. On the other hand, externalizing children are inclined to attribute hostile intentions to others' minds and experience difficulties in regulating their emotions, therefore express their anger in a more explicit and confrontational way through the sessions. *Complaining about therapist* marker generally seen in the form of devaluation or blaming the therapist. *Complaining about parameters* marker was generally used when children violate the rules, such as harming toys, or materials or leaving the room while session continues. Lastly, *control/pressure therapist* marker was observed when children talked to therapist in a commanding way or tried to manipulate the therapist.

Studies conducted with adult and adolescent patients with different diagnoses (e.g. Cirasola et al., 2022; Gersh et al., 2017; O'Keeffe et al., 2020; Schenk et al., 2019) found distinct rupture markers and resolution strategies based on the stages of treatment process. For example, Gersh and colleagues found that (2017) ruptures increase through treatment the process, especially the confrontation rupture markers, for youth with borderline personality disorders. They also stated that early alliance ruptures were associated with poor outcome. O'Keefe and colleagues (2020) showed that impact and frequency of confrontation and withdrawal rupture markers change through the treatment process for the patients with different therapy outcomes (completers and dropouts). Therefore, in addition to problem type, future studies need to consider differences in rupture markers and resolution strategies at different phases of treatment for child psychotherapy.

While assessing the difference between children with internalizing and externalizing problems in terms of their rupture-resolution processes, it was

important to consider the psychodynamic approach's way of addressing ruptures. In psychodynamic psychotherapy the focus is on exploring ruptures on a relational and emotional basis (Gersh et al., 2017), rather than focusing on collaboration on tasks and goals. For the externalizing children, relational discourse of the therapist might trigger interpersonal working models which create further resistance, tension or withdrawal, and influence the effectiveness of rupture-resolution on alliance (Gersh et al., 2017). On the other hand, psychodynamic psychotherapy was found to be more effective for internalizing than externalizing symptoms (Midgley et al., 2021). For internalizing problems, psychodynamic treatment's focus is on relational dynamics between therapist and children to understand and work on conflictual self-other representations of children (Muratori et al., 2003). Future study needs to explore rupture-resolution patterns for different therapy approaches.

4.1.2. Gender

Previous studies suggested that girls form stronger therapeutic alliance compared to boys (e.g. Accurso & Garland, 2015; Langer, McLeod, & Weisz, 2011; Zorzella et al., 2015; Halfon et al., 2019). In the current study, although the differences were not found to be statistically significant, it was observed that boys had more frequent and significant ruptures than girls. When the distinction between withdrawal and confrontation markers were made, the trends in that data showed that girls experienced more frequent withdrawal ruptures than boys. On the other hand, boys experienced more frequent confrontation ruptures than girls. This difference can be understood by distinct interpersonal communication styles of boys and girls. According to Benenson and colleagues (1997) girls are more prone to be involved in dyadic interactions, on the other hand boys are more inclined to participate in group interaction. This might positively affect their participation in one-to-one communication with their therapists. Moreover, it was found that girls are more open share their problems and ask for advice compared to the boys (Gould

& Mazzeo, 1982). In the therapeutic relationship, this characteristic makes girls to be more prone to work collaboratively with their therapists on solving their problems. Furthermore, according to Zahn-Waxler (1993) referral problems change according to gender. It was found that externalizing symptoms are more frequently seen among boys, on the other hand, girls tend to exhibit more internalizing symptoms. While, the offensiveness seen mostly in the form of physical aggression for boys, the type of aggression observed in the girls is mostly expressed as relational aggression, such as expelling one another from the peer group, gossip and slander (Liu, 2006). It might be possible that problem type and gender interact with each other and affect characteristics of alliance strains. The interaction effect can be tested by future studies. Lastly, the findings could be explained by considering gender characteristics of the therapists. In the current study, except one, all of the therapists were female. It was found that patients form alliance more easily with the same-sexed therapist (Langer et al., 2011).

4.1.3. Age

Previous studies reported significant and negative correlation between age and therapeutic alliance (e.g. Abrishami & Warren, 2013; DeVet et al., 2003). It was also found that for the younger children therapeutic alliance-outcome relation is stronger when compared with their older counterparts (McLeod, 2011). There are studies which did not find age as a factor that predicts alliance formation and quality (Chu et al., 2014; Karver et al., 2018; Halfon et. al., 2019). In the current study, age and rupture significance were found significantly and negatively correlated, which means that younger children experience more significant ruptures. Mentioned before, children generally do not refer themselves to therapy, and having difficulties in identifying their problem and working collaboratively with their therapist. The sample of the current study was composed of children between ages 4 to 10 and most of them were between ages 6 and 8. Therefore, this might explain the negative

relationship between age and rupture frequency and difficulties in repairing ruptures. Previous studies also showed that for younger children emotional bond was more influential on formation of therapeutic alliance, however, for older children collaboration aspect of alliance was more predominant in predicting alliance (Kronmüller et al., 2002). Future study might consider this distinction and evaluate impact and frequency of ruptures for different age groups, based on different dimensions of alliance.

Moreover, when the examples of rupture segments for the children with different age groups were differentiated, it was seen that for the children with younger ages *complaint about therapist*, *efforts to control/pressure therapist* and *minimal response* markers were the prominent ones. On the other hand, for the children with older ages, the prominent rupture markers were listed as *deferential*, *content/affect split* and *avoidant story telling/changing topic*. This difference between the younger and older children on prominent rupture markers, supported finding a negative correlation between age and rupture significance. For the younger children prominent rupture markers such as *complaint about therapist*, *efforts to control/pressure therapist* were more confrontational and explicit, compared to the predominant rupture markers for children with older ages such as *deferential*, *content/affect split* and *avoidant story telling/changing topic*.

4.2. IMPLICATIONS FOR CLINICAL PRACTICE

4.2.1. Clinical Implications

This study was one of the first studies in child psychotherapy, that explored alliance strains considering clinical and demographic characteristics of patients. Previous studies with adult and adolescent population showed that occurrence of strains in the alliance is inevitable and being attuned to these stains and exploring them within the treatment process are crucial for positive outcome. Sometimes

therapists can be less sensitive to strains in the alliance, especially to the subtle ones, and might miss the opportunity to properly deal with them (Safran, 1993a). Detecting rupture events and attending to explore them on time is very important for therapeutic change.

In the current study, rupture patterns were provided for distinct clinical and demographic groups, which can be useful for the clinicians work with children. For the children with internalizing behavior problems, most frequently seen rupture markers were *minimal response*, *avoidant storytelling* and *complaint about parameters*. It was also observed that these rupture markers had more disruptive effect on therapeutic alliance. It is difficult but at the same time helpful for children with internalizing problems to express their negative thoughts and feelings towards the therapist. Therefore, it is crucial for clinicians to detect the subtle ruptures, generally in the form of *minimal response*, *avoidant storytelling* and *complaint about parameters* and explore these feelings further within therapeutic relationship. On the other hand, for children with externalizing behavior problems, *complaining about therapist*, *complaining about parameters* and *control/pressure therapist* markers were the most frequently observed markers. These ruptures were easy to detect within sessions, however, it is more difficult for the clinicians to deal with them effectively. These ruptures are more explicit, confrontational and aggressive, therefore, easily trigger negative countertransference which hinders the effectiveness of therapist's interventions (Hoffman et al., 2015). It would be important for therapists to respond these intense ruptures in a non-defensive way, and to accept their contribution to alliance ruptures.

The current study also showed that although the trends in the data for frequency of resolution strategies was higher, effectiveness of these strategies was lower for the children with externalizing symptoms compared to the ones with internalizing behavior problems. In terms of clinical implications, different resolution strategies can be considered for internalizing and externalizing children. For the children with externalizing symptoms, rather than explicitly relating the

rupture to relational dynamics, primary intervention might be validating defensive posture of the patient or changing tasks or goals, to prevent further ruptures in the alliance. On the other hand, for the children with internalizing symptoms, explicitly pointing to the rupture and inviting the patient to explore his/her own experience of rupture and relational dynamics between therapist and patient might be effective. Future study might focus on finding effective strategies for resolving ruptures for the children with distinct symptoms.

4.2.2. Research Implications

3RS (Eubanks-Carter et al., 2014) was used for the first time in the child psychotherapy research with the patients with different symptoms. Although few modifications were required, the scale was used as a reliable tool in this study. The observations on using 3RS for child psychotherapy was discussed further below.

After coding the sessions with 3RS, it was observed that *self-criticism and/or hopelessness, complaint about progress* markers *and* resolution strategy of *changing tasks or goals*, *providing rationale for treatment* were the most rarely used markers. This can be explained by the developmental limitations of children in terms of determining and negotiating on therapy objectives (Shirk et al., 2011). Moreover, this finding can be explained by the principles of psychodynamic child psychotherapy, the emphasis of which is generally not on collaboration on tasks or goals. Moreover, it was observed that *abstract communication* and *deferential* were rarely used markers while coding child sessions. Compared to adult patients, rupture markers with children were easier to detect, because strains in alliance are more explicit or direct with children. This can be explained by children's still developing ego functions and theory of mind capacities. Children before age 8, have difficulty in considering the viewpoint, thoughts and feelings of others while determining their own actions, which makes them more prone to directly express themselves compared to adults (Schuwerk et al., 2015). Furthermore, for the

violation of the rules (e.g. leaving the room during the session, damaging the materials in room) new makers were needed while coding the sessions, because therapeutic frame has distinct characteristics in child psychotherapy. Lastly, considering the distinction between *the real and play relationship* in child psychotherapy few modifications were made in markers and scoring. *Avoidant storytelling and/or shifting topic* marker was expanded and *shifting play* was added. Moreover, check-minus (0.5 point) was used when the distinction couldn't be made whether the alliance rupture occurred between therapist and children or, between their characters at play. Similarly, when coding the resolution strategies, check-minus (0.5 point) was used where therapists point out ruptures via play characters, rather than directly referring to the real relationship between children and themselves.

Although 3RS was employed as a useful tool to detect and identify ruptures in child psychotherapy, future studies need to adapt and validate this scale for child patients.

4.3. LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

The current study employed both self-reported and observer-based measures, in order to capture the ruptures in a comprehensive way by taking into account both therapist's and patients' different views on ruptures, as well as considering their difficulties to detect alliance strains by adding observer perspective. Also, by using these scales, both macro analysis of therapy process, and micro analysis of within session processes were considered while evaluating strains in the alliance. However, it has limitations that need to be considered.

First limitation of this study was the small sample size. A larger sample size would provide more meaningful results, while comparing rupture and resolution patterns of children, based on their problem type and gender. Secondly,

in this study parents' contribution to therapeutic alliance was not considered while determining low alliance sessions. However, for child psychotherapy, parent's effect is crucial in terms of forming and maintaining alliance. Thirdly, TASC forms obtained from patients and therapists were employed to determine sessions with low alliance, however, the scale was not adapted to Turkish, therefore the scale's accuracy to reflect psychological properties of alliance for Turkish culture was questionable. Moreover, in this study alliance ruptures were explored without considering the cultural characteristics of Turkish society, therefore future studies are recommended to take cultural differences into account while investigating alliance ruptures. Another limitation of the study was that coders were not blind to the aim of the study, which can be considered as a source of bias.

Research on rupture-repair processes in child psychotherapy is scarce and further research was needed contribute understanding distinct characteristics of rupture-repair processes in child psychotherapy. First of all, previous research with adult patients investigated the relation between rupture-repair sequences and therapy outcome and reported that if ruptures are dealt with properly, they are fruitful in terms of providing better treatment outcomes. Future study was suggested to explore the influence of rupture-repair processes on treatment outcome in child psychotherapy. It was reported that repairing the ruptures both reinforces the alliance and provides a crucial opportunity for change in itself as corrective emotional experience. Empirical findings supported the relationship between therapeutic alliance and changes in emotion expression. As found in Fisher and colleagues' study (2016) therapeutic alliance and emotion processing interact through the working phase of psychotherapy and together predict good treatment outcome. Future study also needs to explore the specific relation between rupture-resolution processes and affect regulation, as well as effect of their interaction on treatment outcome. Moreover, to better assess complex change mechanisms of psychotherapy process, 3RS can be used together with other process measures, such

as CPTI (Kernberg et al., 1998) to assess emotion regulation, and BPM (Achenbach et al., 2011) to track changes in symptoms.

CONCLUSION

The current study is one of the first studies that explored alliance strains in child psychotherapy while considering effect of pretreatment factors such as type of behavioral problem (internalizing, externalizing), gender and age; by using both self-report and observer-based measures. The study revealed that there are different trends in frequency and impact of the rupture markers and resolution strategies based on problem type and gender. However, due to the small sample size, these observations were not statistically supported. It was observed that there is a trend towards rupture markers being less frequent, and resolution strategies being more effectively used for children with internalizing symptoms, compared to children with externalizing behavior problems. Trends in the data also showed that therapist's contribution to ruptures is more considerable for children with externalizing symptoms. Additionally, predominant rupture markers were detected for children with different problem types. For gender, a trend towards more frequent and influential ruptures were observed for boys, compared to girls. Also, age was found significantly and negatively correlated with rupture significance rating. The current study contributes to our knowledge of therapeutic alliance, as a process, in psychodynamic child psychotherapy, by investigating in-session rupture-resolution processes.

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APPENDICES

Appendix A: Therapeutic Alliance Scale for Children - Patient Form (TASC-C)

Danışan ID ve Baş Harfler	
Seans No	
Tarih	
Terapist	

Lütfen terapistinizle ilişkinizi, son seansınızı düşünerek, aşağıdaki sorulara göre değerlendiriniz. Her madde için, değerlendirmeniz ile örtüşen puanı değer kısmına yazınız.

TASC-C	1: Uygun Değil	2:Biraz Uygun	3: Çoğunlukla Uygun	4: Tamamen Uygun
1. Terapistimle vakit geçirmekten hoşlanırım.				
2. Hayatımdaki problemleri çözmek için terapistimle birlikte çalışmakta zorlanırım.				
3. Terapistimin benim tarafımda (müttefikim) olduğunu ve bana yardımcı olduğunu düşünürüm.				
4. Terapistimle sorunlarımı çözmek için çalışırım.				
5. Terapistimle birlikteyken seansların hızla bitmesini isterim.				
6. Çocuk terapi seanslarını dört gözle bekler.				
7. Terapistimin sorunlarımın üzerinde çalışmak için olması gerekenden fazla zaman harcadığını hissederim.				
8. Terapistimle görüşmektense başka şeyler yapmayı tercih ederim.				
9. Terapistimle geçirdiğimiz zamanı hayatımda değişiklikler yapmak için kullanırım.				
10. Terapistimi severim.				
11. Terapistimle sorunlarım üzerine çalışmamayı tercih ederim.				
12. Sorunlarımla başa çıkmak için terapistimle iyi bir şekilde çalıştığımızı düşünürüm.				

Appendix B: Therapeutic Alliance Scale for Children - Therapist Form (TASC-T)

Danışan ID ve Baş Harfler	
Seans No	
Tarih	
Terapist	

Lütfen **danışanınızla** ilişkinizi, son seansınızı düşünerek, aşağıdaki sorulara göre değerlendiriniz. Her madde için, değerlendirmeniz ile örtüşen puanı değer kısmına yazınız.

TASC-T	1: Uygun Değil	2: Biraz Uygun	3: Çoğunlukla Uygun	4: Tamamen Uygun
1. Çocuk sizinle (terapistle) vakit geçirmekten hoşlanır.				
2. Çocuk, hayatındaki problemleri çözmek için sizinle birlikte çalışmakta zorlanır.				
3. Çocuk, onun tarafında (müttefiki) olduğunuzu düşünür.				
4. Çocuk sorunlarını çözmek için sizinle beraber çalışır.				
5. Çocuk, siz (terapist) ile birlikteyken seansların hızla bitmesini ister.				
6. Çocuk terapi seanslarını dört gözle bekler.				
7. Çocuk, sizin (terapistin) onun sorunları üzerine çalışmak için gereğinden fazla zaman harcadığınızı hisseder.				
8. Çocuk terapiye gelmeye dirençlidir.				
9. Çocuk sizinle geçirdiği zamanı hayatında değişiklikler yapmak için kullanır.				
10. Çocuk size (terapiste) olumlu duygular ifade eder.				
11. Çocuk terapide sorunları üzerine çalışmamayı tercih eder.				
12. Çocuk sorunları ile başa çıkmak için sizinle iyi bir şekilde çalışabilmektedir.				

Appendix C: Examples for Withdrawal and Confrontation Markers and Resolution Strategies

1. Ç: Ya! (tahta eve bakıyor, ayağını yere vuruyor)

   T: Uf, bir şey kızdırdı seni.

   Ç: Kızdırmadı. (**Both** *Denial and Patient Rejects Therapist Intervention*)
   Benim gibi konuş! (*Efforts to Control/Pressure Therapist*)

2. T: Aslında ayakkabılarını çıkarabileceğini biliyordun ama benim söylememi bekledin galiba.

   Ç: Yoo. (*Denial*)

3. T: Ç. senin zorlandığın şeyler varsa, kötü hissettiğin şeyler varsa onları da konuşabiliriz burada tamam mı?

   Ç: Yok kötü hissettiğim bir şey yok. (*Denial and Patient Rejects Therapist Intervention*)

4. T: Off, neler yapıyorlar burada acaba bu çocuklar?

   Ç: Neler neler yapıyorlar. (şarkı mırıldanıyor) (*Minimal Response*)

5. T: Aile değişik. Bir şeyleri yerlerine koymakta mı zorlanıyorlar? Yoksa sürekli yer mi değiştiriyorlar?

   Ç: Sürekli yer değiştiriyorlar.

   T: Hmm. Neden acaba? Duramıyorlar mı yerlerinde?

   Ç: Bilmem. (*Minimal Response*)

6. T: Her şeyi tam yapmaya çalışmak zor. Kendi hayatında zorlandığın şeyler oluyor mu?

   Ç: (Legolara dönerek) Mavilere geçeyim şimdi. Bu malzemeleri bitireceğim. (*Avoidant Storytelling/ Shifting Topic/ Shifting Play*)

7. T: Hıı evet. Belki de korkunu geçirebilmek için bugün tableti getirdin.

   Ç: Mesela bu uygulamada da bir reklam gibi bir şeyler var. Iıı, nasıl diyeyim böyle çok değişik bir şey. (*Avoidant Storytelling/ Shifting Topic/ Shifting Play*)

8. Ç: Kaç dakika kaldı? Ne yapacağız kalan zamanda? (Belirli aralıklarla seans süresince geliyor bu sorular) (*Complains/Concerns About Parameters of Therapy*)

   T: Burada ne yapacağın konusunda kafan karışıyor. Kalan zaman nasıl geçer endişelisin. (*Invite/Discuss Thoughts or Feelings*)

9. Ç: Sizden daha iyi bir terapi şeyde çıktı. Haberlerde, Show haberlerde. Ama sizden daha iyi bir terapiymiş. (*Complaints/Concerns About Therapist or Progress in Therapy*)

   T: Daha iyi bir terapiymiş. Nasıl bir terapiymiş?

   Ç: Bilmiyorum. (*Minimal Response*)

10. Ç: Oynayacak bir şey bulamadım. (*Complaint/Concern About Parameters of Therapy*)

    T: Oynayacak bir şey bulamayınca jimnastik dersinde öğrendiklerini yapıyorsun.

    Ç: (şarkı mırıldanıyor)

11. Ç: Hangi akıllı bunu buraya doldurdu? Şimdi sen doldurmuşsun. Tamam bu kadar.

    T: Kızdın onu oraya doldurana galiba.

    Ç: Dedim ya hangi akıllı bunu buraya doldurdu diye. Sen doldurmuşsundur, sana! (*Complaints/Concerns About Therapist*)

12. Ç: Bak bak, şu kapısı. Hazır mısın bak? Kafan yetmiyor Ayşe (terapistin oyundaki karakteri), Ayşe. Kafan yetmiyor. (*Complaints/Concerns About Therapist- 0.5 points*)

T: Bunu beğenmedin galiba.

13. Ç: Eveet Ayşegül (terapistin oyundaki karakteri). Bu kadar mı safsın anlamıyorsun ? (*Complaints/Concerns About Therapist – 0.5 points*)

T: Ayşegül'ü bir türlü beğenmiyor galiba Ali (çocuğun oyundaki karakteri). (*Invite/Discuss Thoughts or Feelings- 0.5 points*)

14. Ç: Senin kulağın mı duymuyor? (*Complaint About Therapist*)

T: Hiç anlayamadım seni ya? (*Therapist Acknowledges his/her Contribution to Rupture*)

15. (Çocuğun kural ihlalinden sonra)

T: Bugün bu kurallara uymak ne kadar zor oldu. (*Therapist Validates the Patient's Defensive Posture*)

16. T: Bana baktın, sonra oyunu sıkıcı buldun. Ne oldu acaba bana bakınca?

Ç: Çünkü bu oyunu her gün oynuyoruz, sıkılıyoruz. (*Complaints/Concerns About Activities of Therapy*)

T: Hıı... Hep bu oyunu seçiyorsun ama sıkılıyorsun da aynı zamanda.

Ç: Evet.

17. T: Sanki anlatmaktansa oyun oynamak daha kolay... (*Redirecting or Refocusing the Patient*)

Ç: Ne?

T: Anlatmaktansa oyun oynamak daha kolay.

Ç: Hı. Oyun mu?

T: Hıhı. Anlatmak neden zor acaba? Paylaşmak, neler yaşadığını...

Ç: Şimdi tuzakta yetişip... (***Avoidant Storytelling/ Shifting Topic/ Shifting Play***)

T: Tuzaklar...Fazla konuşmak istemedin. (***Invite/Discuss Thoughts and Feelings***)

18. T: Yine bir sürü savaş yaptık, askerler öldü, bombalar atıldı, tuzaklar kuruldu, çok yorucuydu, şimdi sakin sakin boya yapıyorsun. Sanki biraz böyle ... sessizlik oluyor. Acaba hoşuna mı gidiyor?
(Ç boyamaya devam ediyor.)
Ç: Evet.
T: Demin çünkü sıkıldın benden. Belki biraz fazla geldi. (***Invite/Discuss Thoughts or Feelings and Therapist Validates Defensive Posture***)
Ç: Hangi renge boyayım? Kapalı mı, açık mı? (***Avoidant Storytelling, Shifting Topic, Shifting Play***)

19. T: Aa abin sana saldırmış ya… Sanki o savaş oyununda babanın da saldırdığı gibi.
Ç: (gülerek) Evet. (***Content/Affect Split***)
T: Abin bilerek yapmış, çok üzülmüşsün ya.

20. Ç: Kahverengi sür sür boyaaa. Şimdi renk çıkacak.
T: Nasıl yani?
Ç: Bakalım renk çıkacak mı?
T: Bakalım.
Ç: Olmadı.
T: Ha öyle mi? Tamamen seni takip edemediğimi düşünüyorsun. Ben oysaki takip etmeye çalışıyorum ama yine beceremiyorum, yani tam olarak iyi yapamıyorum. (***Therapist Clarifies Misunderstanding, Therapist Discloses his/her Internal Experience of the Patient-Therapist Interaction***)

21. Ç: Bu ne biliyor musun?

   T: Ne resmi acaba?

   Ç: A'yla başlıyor.

   T: A'yla başlıyor.

   Ç: Ağaç ev yaptım.

   T: Sen ağaç ev yaptın. Mm merdivenleri var bu ağaç evin.

   Ç: Merdiven olmazsa nasıl aşağı inecekler?

   T: Mm merdiven olmazsa aşağı inemezler.

   Ç: Peki sonra ağaç olmasaydı ne olurdu?

   T: Hmm acaba biliyor muyum ağaç olmasaydı.

   Ç: Oksijen olmazdı.

   T: Oksijen olmazdı, sen onu biliyorsun. Ağaç oksijen veriyor.

   Ç: E yani.

   T: Yani.

   Ç: Tekrarlama tekrarlama. (***Complaint about therapist***)

   T: Söylediğini tekrarlamamamı istiyorsun. Seni öfkelendirdi galiba tekrarlamam. (Therapist acknowledges his/her contribution to a rupture). Çimeni farklı bir kalemle çizeceksin. Bu resimde hem ağaç ev var hem normal ev var. Bi dakikamız kaldı.

   Ç: Yaa. Bir dakika mı? Aman çok komik. (***Complaint about therapist and Complaint about parameters***)

   T: Bir dakikanın kalması sana komik geldi. Ve bir dakikada resmi yetiştirdin. Bitti vaktimiz. Çıkabiliriz istersen.

22. Ç: Hadi ateş et! Ateş! Hücum! Tırrr!

   T: Pırrrrr

   Ç: Adam! Adam, dur.

   T: Of ne kadar da öfkelisin.

   Ç: 10 saniye… Terörist… (***Complaint about therapist - 0.5 point***)

   T: Off çok kızgınsın gerçekten baya sert atıyorsun. Aaa

   Ç: Puf! Puf!

23. T: Kutunun yanındaymış. Birlikte çıkalım olur mu? Bir saniye bekle beni. Hadi koltuğa ayağı koymuyoruz. Kendin koltuğa otur.

Ç: Tamam.

T: Ya da o şekilde.

Ç: Habire unutuyorum.

T: Off buranın kuralları da böyle can sıkıcı birazcık. (*Therapist validates the patient's defensive posture*)

Ç: Evet ama bir şey olmaz. (*Deferentiall*)

T: Bir şey olmaz kabul ettin. Bugün bu Türk askerleri teröristlere çok öfkeliydi, çok. Çok çetin bir savaş oldu burada.

24. T: Anlat bakalım. Bu arada beş dakikamız hatta iki dakikamız kalmış.

Ç: Tamam, hemen yapalım. Heh, çardak, heh çardak! Çardak olması yeter benim için. Çardak komşuların toplandığı yer.

T: Neyin toplandığı yer?

Ç: Komşuların hani toplandığı yer.

T: Hı, hı.

Ç: İsterseniz siz de yapın, zamanımız geçmeden. (*Deferential*)

T: Tamam hemen bir şey yapayım.

25. Ç: Evet. (*Minimal response*)

Ç: Eee? (*Control pressure*)

T: Eee.

Ç: Neden bir anda burası böyle sessizleşti? (*Complaint about therapist*)

26. T: Sanki fragman dışında da seni korkutan bir şeyler var.

Ç: Yok. (*Denial*)

T: Çünkü daha önceden tek başına yattığını biliyorum. Belli bir zamandan sonra birileriyle yatmaya başladın. Burada babaannenle yatıyordun şimdi babanla yatıyorsun. Tek yatsan nasıl olurdu acaba? Ya da tek yatıyor olsan hmm ne olsa bu durum korkmamanı sağlardı?

Ç: (kendi kendine mırıldanıyor) (*Minimal response*)

T: Ne oldu?

Ç: Hiç bir şeye baktım. Şey bu otobüs kartım. (*Avoidant story telling/Shifting topic*)

27. Ç: Son bir (sevinçli bir şekilde söylüyor). (*Complaint about parameters*)

    T: Dakika sayıyorsun. Hemen çıkmak mı istedin acaba bugün? (*Invite/discuss feelings*)

    Ç: Yorgunum. (*Minimal response; 0.5 point Deferential*)

    T: Yorgunsun.

28. T: Aslında bu abinle ilgili olan şeyde de sanki geçerli, orada da aslında senin yaşamadığın bir hastalık var ve sen sanki kendin yaşıyormuşsun gibi acaba bende de var mı diye düşünmüştün mesela.

    Ç: Hı hı. Çok değişik duygular hissediyorum ben de. Yani karşımdaki bende oluyormuş gibi, A. ne oldu falan yapıyorum böyle, içim sızlıyor sanki kendimi, bana bir şey oldu, çok değişik hissediyorum kendimi böyle olduğu zaman. (*Abstract communication*)

29. Ç: Hayatında hiç korku oyunu oynadın mı?

    T: Sen oynadın mı?

    Ç: Oynuyorum.

    T: Şu an oynuyorsun. Belki de öyle hissetmenin nedeni çok kızgın olduğun içindir. Olabilir mi?

    Ç: Hayır, korku oynamak istediğim için. (*Denial*)

30. T: Ne gibi bir şeyler, nasıl kötü bir şeyler?

    Ç: Tamam bir şeylerle konuşmayalım artık. (*Reject intervention; Control/pressure*)

    T: Ne yapalım peki onun yerine? (*Change task/goals*)

    Ç: Söylemek istemiyorum. (*Patient Rejects Therapist Intervention*)

31. Ç: Seans ne kadar sürecek? (*Complaint about parameters*)

T: Sen merak ettin.

Ç: Yoo, (*Denial and Patient Rejects Therapist Intervention*) annem artık para vermeyecek buraya (*Complaint about parameters*).

32. Ç: Bunları çöpe at gereksiz eşya (*Efforts to Control/Pressure Therapist*).

T: Evin eşyaları çok gereksiz ya. Bom boş olsun ev eşya kalmasın istiyorsun.

Ç: Bunları eve götüreceğim tamam mı? Bana söz ver (*Efforts to Control/Pressure Therapist*).

T: Sen bunları eve götürmek istiyorsun.

Ç: Götürücem tabii sana mı soracağım lan (*Efforts to Control/Pressure Therapist*) (oyuncakları terapiste fırlatıyor) (*Complaint about therapist and parameters*)

T: Fırlatarak oynamak istiyorsun anlıyorum ama (elinden alıyor oyuncakları therapist) Yavaşça koyabilirsin.

Ç: Bunları koy dedim buraya (*Efforts to Control/Pressure Therapist*).

33. T: Sanki bugün ne yapacağını planlayıp gelmişsin. Merak ettim acaba ne yapacaksın?

Ç: (Çocuk cevap vermiyor, karalama yapmaya devam ediyor) (*Minimal response*).

T: Hımm, bütün yüzü karalandı.

Ç: (Sessizlik) (*Minimal response*).

T: Tam böyle kendini bırakıp tamamen boyuyorsun, sonra bir noktada durduruyorsun kendini. Kendini tamamen bırakmak çok zor oluyor senin için.

Ç: (çocuk karalama yapmaya devam ediyor) (*Minimal response*).

T: Tüm yüzü kapandı ama sen gözlerinin görünmesini istiyorsun

Ç: (sessizlik) (*Minimal response*).

34. T: Son 10 dakikamız.

Ç: Ne çabuk bitiyor süre (*Complaint about therapist and parameters*).
Yaklaşma lan (silahı sıkıyor terapiste) (*Complaint about therapist and Efforts to Control/Pressure Therapist*)

T: Az zamanımız kaldığını söyleyince çok sinirlendin bana (*Invite/Discuss Thoughts and Feelings*).

Ç: Öldürürüm seni. (Vurmaya başlıyor terapiste) (*Complaint about therapist and parameters*).

35. T: Canın sıkkın görünüyor.

Ç: (Sessizlik) (*Minimal response*).

T: Sessiz de kalabiliriz... Bir yerde bir şeyler oldu ve sen bana çok kızdın (*Invite/Discuss Thoughts and Feelings*). Belki ben seni anlamadım (*Therapist acknowledges his / her contribution to a rupture*).

Ç: (Sırtını dönüyor terapiste) (*Patient Rejects Therapist Intervention*).

36. (Terapist ve çocuk Jenga oynuyor).

Ç: Bunları ellemeden ortasına koyman gerekiyordu, yapamadın (*Complaint about therapist*).

T: Bana güvenemiyorsun (*Invite/Discuss Thoughts and Feelings*).

Ç: Parmağını dokundurmaman gerekiyor. Yine yaptın.

T: Bana güvenmekte zorlanıyorsun.

Ç: Bir şeyi de oynatmadan oynasan, hep oynatıyorsun (*Complaint about therapist*).

37. Ç: En bol siyahları alan kazanır.

T: Oo şimdi de en bol siyahları alma yarışı. Bir anda resim çizerken aramızda bir yarış başlıyor.

Ç: Tamam.

T: Rekabet etmeyi, yarışmayı seviyorsun.

Ç: Yeter sen de o kadar çok alma. (*Efforts to Control/Pressure Therapist*)

T: Daha çok almamı istemiyorsun. *(Invite/Discuss Thoughts and Feelings)*. Kimin daha çok alacağına sen karar vermek istiyorsun.

Ç: Şimdi benim aynımı yapacaksın. Ben ne yapıyorsam öyle yap. *(Efforts to Control/Pressure Therapist).* E ben bitirdim ama.

T: Hemen yetişmem lazım, hiç yetişemiyorum sana.

Ç: Bana yetişmen lazım. Yetişemiyooor, yetişemiyoor.

38. Ç: Niye taklidimi yapıyorsun? (*Complaint about therapist*)

    T: Sana benzeyen şeyler yapıyorum. Benzer şeyler yapmam nasıl hissettiriyor? *(Invite/Discuss Thoughts and Feelings)*

    Ç: (sessizlik) *(Minimal response).*

39. T: Benim söylediğime inanmadın, kendin kontrol ettin. *(Invite/Discuss Thoughts and Feelings)*

    Ç: Şunun altına girebiliyor çünkü bazen de… Tamam, son evse oyun bitti. Kim kazandı? Bu sefer siz kazandınız ya da oyunu devam ettirebiliriz.

    T: ben kazanacağıma oyun devam etsin istiyorsun. *(Invite/Discuss Thoughts and Feelings)*.

    Ç: Oyunu devam ettirebiliriz, öyle birşey de var ya da siz kazanabilirsiniz *(0.5 point Deferential)*. Zamana bakarsak ama bence oyunu devam ettirebiliriz. Çünkü daha 25 dakikamız var.

    T: Hımm.

40. Ç: Yine aynı şeyleri mi yapacağız, aynı oyunları mı oynayacağız. (*Complaint about parameters*)

    T: Burası özgür bir oda, istediğini yapabiliyorsun.

    Ç: Ben resim çizeceğim ya da adam asmaca oynayalım.

ETHICS BOARD APPROVAL

Ethics Board Approval is available in the printed version of this dissertation.