THESIS TO OPT TO THE DEGREE OF DOCTOR IN PSYCHOTHERAPY

REGULATORY FUNCTION OF MENTALIZATION IN RUPTURE-RESOLUTION SEQUENCE OF THE THERAPEUTIC ALLIANCE DURING PSYCHOTHERAPY PROCESSES WITH ADOLESCENTS

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ABSTRACT

Introduction: Mentalization, operationalized as reflective functioning (Fonagy, Target, Steele & Steele, 1998), can be conceptualized as a complex psychological function, developmentally critical during adolescence due to brain changes that affect social cognition areas, that “supports” the therapist-patient exchanges, rather than a global capacity that "improves" through psychotherapy.

Based on the consideration that among adolescents, mentalization would accomplish a relevant role in understanding the regulatory processes experienced by therapists and patients during moments of impasse (rupture) and its resolution (Morken, Karterud & Arefjord, 2014; Lingiardi & Colli, 2015) this study aims to describe how mentalization of therapist and adolescent patient is expressed and configured within episodes of rupture and resolution and determine the relationship between these configurations and the result of the resolution (repair v/s not repair).

Method: Five individual psychotherapy process with adolescents from 14 to 19 years old were analyzed. Five pairs of judges trained in the 3RS system (Eubanks-Carter, Muran, & Safran, 2014) jointly rated the sessions of transcribed and videotaped therapies, identifying rupture-resolution (R-R) sequences of the therapeutic alliance. Once R-R was identified, the same pairs of judges established the extent to which the rupture was repaired through the "therapeutic relationship compromise" of Sexton, Littauer, Sexton and Tømmerås (2005). Once the rupture-resolution sequences were identified therapist and patients mentalization was coded through the Observational System of Mentalization in Psychotherapy for adolescents (OSMP-A, Morán, Martínez & Arce, unpublished).

Therapist and patients mentalization ratings were described and compared through multilevel linear regression analysis. Configurations of mentalization were establish trough Multilevel Latent Class Analysis. Post-hoc analysis determined the probability for each configuration of therapist and patient mentalization to be repaired.

Results: in most of the assessed dimensions both patients and therapists achieved lower ratings of mentalization during episodes of rupture in comparison with episodes of resolution and, with the exception of contingent communication, therapists tended to show higher means of mentalization than patients. Statistically significant differences in mentalization between actors and interactive scenarios of rupture-resolution, as well as interaction effects on some specific dimensions, showed that it is possible to explain the variance of mentalization from each of...
these predictors (actor and interactive scenario) and, to evaluate the presence of possible specific configurations of mentalization between actors in episodes of rupture and episodes of resolution. As it was observed, 3 interactive scenarios in rupture and 4 interactive scenarios in resolution showed the best fit to describe the possible configurations of therapist-patient mentalization. In turn, each combination of rupture-resolution configurations showed different probabilities of being repaired.

**Conclusion:** These results show that mentalization assumes a regulatory function of therapeutic interaction during R-R sequences that can be described in clinical terms. It is proposed that therapist actions have a central role in explaining ruptures of patients' mentalization during ruptures, but also for mentalization recovery during resolutions. A contingent response and focusing patients on the present moment would favor both an increase in patients' mentalization and a higher probability of repairing ruptures.
1. INTRODUCTION

Mentalization or reflective function (RF), as it has been operationalized by Fonagy, Target, Steele and Steele (1998), can be defined as a form of imaginative mental functioning that allows for perceiving and interpreting human behavior in terms of intentional mental states (Bateman and Fonagy, 2012). Its study has made it possible to establish a relevant body of knowledge to understand, from an evolutionary perspective, the links between early attachment experiences and the emergence of neurobiological structures (Frith, & Frith, 2003; Schore, & Schore, 2007) and the mental processes that enable affect regulation and the organization of the self (Fonagy, Gergely, Jurist, & Target, 2002). It has also promoted the emergence of comprehensive models of psychopathology that have had an impact on their diagnosis and treatment, particularly contributing to the understanding of personality disorders (e.g. Bateman & Fonagy, 2005).

While the study of mentalization has played an important role in psychotherapy research in recent years, coming to be considered a generic factor of change (Fonagy & Bateman, 2006), most of its development in this field has focused on the evaluation of interventions with adults. Although in adolescence (the age group on which this project focuses) some studies have shown that mentalization would also function as a mechanism of change (Rossouw and Fonagy, 2012), there is a significant gap in clinical evidence in this age group (Bevington, Fuggle, Fonagy, Target, Asen, 2013). Despite progress in research with adults, there are at least two reasons not to extrapolate these results directly to adolescents. On the one hand, the interventions with adolescents are susceptible to the distinctive evolutionary features of this group. In this way, unlike adults, psychotherapy tends to be characterized by a mayor influence of the family on treatment (Hawley & Weitz, 2003), a generally external motivation to consult (DiGiuseppe, Linscott & Jilton, 1996), the presence of multiple sources of information, in addition to the adolescent himself, such as the family or school (Achenbach, McConaughy & Howell, 1987) and a therapeutic alliance that tends to be weaker and more unstable than adults (Horvath, Del Re, Flückiger, & Symonds, 2011) that requires to be established both with the adolescent and other members of the family. (Shirk, & Karver, 2011).

On the other hand, according to an evolutionary approach to the study of mentalization, adolescence is considered a critical period in the life cycle, due to the reemergence of changes in brain architecture that compromise the functioning of RF-related structures. (Fonagy & Luyten, 2009). As a result, impairments in mentalization have the potential to impact adolescents' ability to cope with the multiple biological, behavioral, and social changes they
normatively face (Steinberg et al, 2006). In other words, adolescence is likely to be a vulnerable period to the activation or reactivation of risk conditions underlying the development of mental disorders (Bleiberg, Rossouw and Fonagy, 2012).

Therefore, since the study of mentalization in adolescents emerges as a recent research field that must also fit the specific characteristics of this age group, many questions are opened regarding the specific features of its performance through psychotherapy, its role, its manifestations and, for this specific study, the moments of the therapeutic process in which its assessment may become more relevant.

In this sense, some authors (Morken, Karterud & Arefjord, 2014; Lingiardi & Colli, 2015) have recently proposed as potentially relevant interactive scenarios to understand the deployment of RF during psychotherapy, those moments of therapist-patient interaction linked to the establishment of the therapeutic alliance, in particular, rupture and resolution moments (Safran, Muran, & Eubanks-Carter, 2014).

Several studies have emphasized that the therapeutic alliance would be one of the key aspects to consider in the psychological treatment of adolescents; some even consider it as a more relevant factor of change than in psychotherapy with adults (Kazdin, 1990; Bhola, & Kapur, 2013). Therefore, this would be a variable that needs to be permanently addressed by therapists due to the various relational difficulties that characterize interventions with adolescents (Shirk, Karver, & Brown, 2011). From this perspective, the therapeutic relationship is conceived as a continuous process of intersubjective negotiation between patient and therapist that can be interrupted by moments of impasse - "rupture of the therapeutic alliance" according to Safran and Muran (2000) - or re-established through attempts to resolve these ruptures (Safran, Muran, & Eubanks-Carter, 2011). For these authors, ruptures are situations that inevitably occur throughout the process, and although they may lead to early drop-out, their repair may be strongly associated with therapeutic change (Safran, Muran, & Samstag, 1994).

For Coutinho, Ribeiro and Safran (2009) the repair of ruptures has effects on the therapeutic outcome because these challenging moments would be a unique opportunity to intervene and modify profound aspects linked to dysfunctional relational patterns of patients. Based on the evidence in adolescent developmental psychopathology (Steinberg et al, 2006) this is precisely a critical aspect that is at stake at this age.

The link between these moments of rupture and resolution of the alliance, and the role that the FR would play on them, is not yet clear in psychotherapy research. It has been speculated that
the mentalization could be related to these interactive scenarios because addressing therapeutic relationship tensions would require a systemic exercise of this function and could even be an opportunity to promote its development (Katzow, 2010). Consistently Fonagy and Allison (2014), have stressed that mentalization would constitute a means for restoring the capacity for emotional regulation, favoring in the patient the possibility of trusting and learning from another at times when internal operating models are rigid and impermeable.

Based on these observations, the current study aims to provide insight into how mentalization is expressed during episodes of rupture and resolution of the alliance in individual psychotherapy with adolescents, and the role it plays in this interactive scenario as a regulatory agent of the therapeutic interaction.

Choosing such episodes not only assumes that these moments would be relevant for observing mentalization in adolescents, but also that its expression is not static or isolated, but takes place in a dyadic regulatory context, inherent to psychotherapy, involving as much the patient as the therapist. Luyten and colleagues (2012) have highlighted this dynamic feature as a key aspect for the assessment of RF. Accordingly, this study can also be described as process research in psychotherapy.

The rupture-resolution interactive scenarios are also of relevance for the study of mentalization because of their theoretical similarity with the moments of relational coordination-discoordination (Beebe & Lachmann, 2002) underlying the dynamic regulation systems from which RF emerges and evolves (Fonagy, Gergely, Jurist & Target, 2002). Research in this area has suggested that the caregivers’ ability to effectively re-establish dyadic coordination is what favors the development of self-regulatory skills in infants, and thus, attachment security (Bowlby, 1969; Tronick, 1989; Powell, Cooper, Hoffman, & Marvin, 2009). This proposal is consistent with the results of a study conducted by Martínez and collaborators (2013) that concluded that there would be differences regarding the regulatory processes on the basis of rupture-resolution sequences depending on whether they are or not repaired.

Based on these findings it is hypothesized that in individual psychotherapy with adolescents it would be possible to identify diverse configurations therapist-patient mentalization during rupture-resolution sequences, which according to their nature, would have the potential to repair the ruptures.

In this way, this study might contribute to understand the contribution of mentalization as a structural function that potentially regulates therapeutic interaction during this type of
interactive moments. This kind of results could be highly relevant both for the incipient study of mentalization in psychotherapy with adolescents and for its use by psychotherapists.
2. THEORETICAL AND EMPIRICAL BACKGROUND

During the last few years, the field of psychotherapy with adolescents has been strongly influenced by the arising of empirical evidence that has broaden the comprehension of the psychological, biological and social development during this stage of the life cycle, relieving the role of the context (Kolb, 1999; Weisz, Yi, Rutt, Lau, & Masland, 2013) and the multiple interactions between these dimensions (Oetzel, & Scherer, 2003; Allen, 2008). This evidence has driven to overtake the traditional monadic comprehension and adultcentrism strongly influenced by an intrapsychic emphasis (Dishion, & Stormshak, 2007), which historically dominated psychotherapy with adolescents, and gradually incorporate more the relational paradigm that considers the particularity of the phenomenon of change that youngsters go through, rooted in a complex interaction between innate, temperamental and cognitive aspects as well as contextual, such as the availability of affective and social models (Delgado, Strawn, Pedapati, 2015). This perspective has had special convergence with the progress in the field of developmental psychopathology, discipline for which adolescence, regarding its transitional, formative and open to change nature, is conceived as the most important period of the life cycle to study the psychopathological development (Steinberg et al, 2006). Therefore, adolescence may be a critical period, of high vulnerability in the activation of current or pre-existent risk conditions (Boyce & Keating, 2004) associated with the origin of disorders in mental health that are maintained in adulthood (Kessler et al, 2005). From this perspective, the psychopathological development would rather be reflecting dysfunctions in nuclear processes and mechanisms involved in the socioemotional adaptation that have an evolutionary nature and emerge in the context of interactive systems (Masten, 2006). The evidence in neuroscience suggests that an important part of these vulnerabilities would be associated to changes that the adolescent brain lives, particularly to the level of regions responsible to the social cognition, and more specifically, over processes involved in the functions of mentalization (e.g. Allen & Fonagy, 2006; Bateman & Fonagy, 2012).

2.1. Mentalization: general conceptual aspects

Mentalization is a type of social cognition defined, from a tradition in philosophy of the mind (see Dennett, 1978), as a preconscious and imaginative mental activity, that allows to interpret human behavior in terms of intentional mental states (Allen & Fonagy, 2006). It is formed by a series of cognitive skills such as the capacity to comprehend emotional states, the earnest control
of attention, the capacity to establish judgments over subjective states and being able to think explicitly about mental states. In combination, these functions, which possess both a self reflexive and interpersonal component, do early prepare a child to distinguish the internal and external reality and the mental and emotional processes characteristic of interpersonal events, making human behavior comprehensible and predictable, becoming a key determinant to the organization of the self (Fonagy, 2008). The concept of mentalization was originally introduced by the French psychoanalysis (e.g., Luquet, 1987; Marty, 1990) but its empirical development rather emerges as an answer to the critics from the scientific world to the lack of attention of the relational aspects and associated with the emotional regulation in the investigation program in evolutionary psychology predominant during the 80s centered in the study of the theory of the mind (Wimmer & Perner, 1983, Baron-Cohen, 1994). Since then, its study was diversified through different disciplines such as neuroscience (Spunt, Satpute, & Lieberman, 2011), developmental psychology (Meins, Fernyhough, Rosnay, Arnott & Leekam, 2012), cognitive psychology (Ruffman, Slade, & Crowe, 2002) and psychotherapy (Bateman & Fonagy, 2006) among others, reaching establishment at present as an integrated research program of wide explicative power.

Divers authors (e.g. Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Meins, Fernyhough, Fradley, & Tuckey, 2001) have linked the origin of mentalization, or RF, as it has been operationalized by Fonagy, Target, Steele and Steele (1998), to the early attachment relations. These authors agree that interactions with the primary care taker would be responsible for the emergence of regulatory mechanisms in the baby that may mediate between genetic predisposition and the adult functioning. According to Fonagy (2003) the emergence of these group of regulatory functions accomplishes a key role for the development since they make the social environment evaluation possible preparing the individual for a collaborative existence with others; function for which the brain was phylogenetically designed. In this way, this perspective reformulates the original proposal of Bowlby (1969), which states that the main selective advantage of attachment is neither in giving protection to the child nor establishing operating internal models that govern the representation of future relationships, but it would correspond to the opportunity that he or she may give for the development of social intelligence (Fonagy & Target, 2002). It is considered then that the ability to give meaning to the psychological experiences is possible as a result of
the development of skills to reflect and comprehend reflectively that the actions of others and the own actions are motivated by underlying mental states (Fonagy, Gergely & Target, 2007).

2.2. Attachment, regulation and mentalization.

As it has been stated, the relation of attachment could be the substrate for the development of a structure that allows the social comprehension and regulation that as a result leads to the organization of the self. Fonagy, Gergely, Jurist and Target (2002) denominated this hypothetical structure: “Interpretative Interpersonal Mechanism (IIM)”, a neural structure that may allow the processing of social information that underlies to the RF and that, recursively, would depend, among other processes, on the capacity of emotional regulation and the specific skills of mentalization (Fonagy, 2008). From the evolutionary frame it is possible to understand this process viewing that the self regulation requires co-regulation for its consolidation (Mikulincer, Shaver, & Pereg, 2003). Therefore, the theory of mentalization states that affective regulation, which emerges in the bosom of the early attachment relations, is the precursor for mentalization, and once it has happened, it is possible to transform the nature of affective regulation (Zucchi, Huerin, Duhalde, & Raznoszczyk de Schejtman, 2006). Then, it is necessary to distinguish between the affective regulation as a type of adjustment of the affective states and a more sophisticated variation, where affections are used to regulate the “self”, which is constituted as an evolutionary goal that remains for the rest of the human’s life (Bateman y Fonagy, 2012). That’s how Fonagy (2008) refers to RF as a quantified index of mentalization in attachment contexts. During the first moment, the dyadic regulation is accomplished as part of the boundary of primary attachment, through the capacity of the care taker to associate the behavior of the child with his mental states, which permits the mother to develop a mental model of the experience of the infant. These type of interactions are constituted over time in patterns of regulation that the child internalizes until being capable of mentalizing his affections (mentalized affectivity, see Fonagy, Gergely, Jurist & Target, 2003), and so regulate them. This process that Fonagy and Target (2002) denominate social biofeedback, allows the child to develop a second order representational system for his mental states from the internalization of the emphatic answer of the mother to her own emotional state and at the same time, recognize her influence over the emotional answer reflected by the care taker as its own, but elaborated (Allen & Fonagy, 2006). In this way, his affective experience can be seen as something different to the primary representation, mainly somatic (Bateman y Fonagy, 2004). So, it is not the
attachment itself, but rather aspects of parenting, particularly an adult mind interested in the
mental state of a child, which would be critical for the establishment of the RF in the infant
In a second phase, once mentalization is acquired, it becomes a skill that permits a mayor
consciousness of mental states and therefore, favors the regulation of affection and, increasingly,
the negotiation of the exchanges that occur at interpersonal relations level (Holmes, 2006). This
proposal would be the core of the psychopathological development, regarding the absence of a
speculated contingent answer from the mother which would be responsible for the emergence
of vulnerabilities to the regulation level of arousal that would limit the capacity to control the
emotion, generating affections of which virtue and intensity may turn unpredictable and not
controllable. (Fonagy, Bateman & Luyten, 2012).

2.3. Regulatory Function and mentalization dimensions
The conceptualization of the mentalization as a mental activity that has a regulatory function of
the affections has had a support in neuroscience proposing that diverse brain processes, probably
linked to social cognition, would be equally linked, at least anatomically, with the regulation of
the emotional experiences (Fonagy, Gergely & Target, 2007). Specifically, it has been
postulated the existence of a paradoxical relation between attachment, stress and mentalization
(Luyten, Fonagy, Lowyck, & Vermonte, 2012). Thus, neuroscientific evidence has proved that
the activation of the attachment system, has a brain correlation in the activation of the
mesocorticolimbic dopamine reward system (Strathearn, Fonagy, Amico, & Montague, 2009),
and, simultaneously, participates in the inactivation of the arousal systems and emotional
regulation, likewise over neurocognitive systems implicated in the mentalization such as the
prefrontal cortex, medial parietal cortex and anterior cingulate cortex (Fonagy, Luyten, &
Strathearn, 2011). This new evidence has had an impact at least over two nuclear aspects of the
theory: a) it has permitted to set the basis for a model of specific intervention as of the
paradoxical arousal-mentalization consideration (Bateman & Fonagy, 2006) and b) it has
proposed that mentalization is not a unitary phenomenon. On that subject, it has been proved
that in the face of the emotional arousal, a change would be experienced, from the activation of
areas associated with the mentalization that have a more executive character, to the use of
subcortical systems that imply a more automatic functioning (Mayes, 2006). The previous point
supports the idea that mentalization would rather have a dynamic character associated to a specific brain functioning that can be dimensionally described.

This proposal provides answers to diverse critics appeared in the last years regarding the concept of mentalization, which have signaled that the scope of the concept equally is converted into a weakness of itself since it is, however, harder to operationalize (Choi-Kain & Gunderson, 2008; Holmes 2005).

Thus, based on diverse social, cognitive and of neuroimages research, it has been proposed that it is possible to characterize the mentalization from the following polarities: automatic/controlled, external/internal, self/other oriented and emotional/cognitive (Fonagy & Luyten 2012). Each of these polarities possesses a diverse neuronal correlate, and as a whole they offer a comprehensive matrix for the conceptualization and evaluation of the diverse aspects of the mentalization. Besides, it permits to clarify its relation with other close constructs, such as the theory of mind, empathy, mindfulness, alexithymia, emotional intelligence, and insight (Fonagy, Bateman & Luyten, 2012).

2.3.1. Automatic Mentalization (implicit) versus controlled (explicit):

The explicit mentalization is characterized for being conscious, verbal and generally reflexive as far as it implies an effort for identifying an explanation based on mental states about behavior. It involves a serial and relatively slow process that requires attention and effort. On the contrary, automatic mentalization is neither conscious, verbal nor reflexive; and it is characteristic of the conversations and human everyday communications in which not reflexive judgments and opinions about the reasons behind the own and others behavior are issued. Its processing is parallel and, therefore, faster and requires less effort (Satpute & Lieberman, 2006).

Studies of neuroimaging suggest that the automatic mentalization is associated to the amygdala, basal ganglia, the ventromidial prefrontal cortex, the lateral temporal cortex, and the anterior cingulate cortex; while the controlled mentalization has been related with the prefrontal lateral cortex, the lateral prefrontal cortex, the prefrontal medial cortex, the parietal lateral cortex, the parietal medial cortex, the medial temporal lobe and the cingulate rostral anterior cortex (Lieberman, 2007).

Apparently, the implicit mentalization involves brain circuits phylogenetically older that are activated from sensorial information, while its counterparty, explicit, may use newer brain circuits, involved in the linguistic process and symbolic material.
2.3.2. Mentalization based on internal characteristics versus external of itself and others.
Mentalization focused on internal aspects makes reference to mental processes that focus on internal aspects of itself and others (thinking, feelings, and experiences). While mentalization focused on the external, is referred to the mental processes that focus on physical aspects and visible of the actions of itself and others. This distinction is relevant for the evaluation therefore allows comprehending why some patients look severely affected in their capacity to read aspects of the mental states of others, but they show themselves as hypersensitive to the emotions as result of observation to aspects of facial expression and body posture.
Neuro-biologically, mentalization focused on external aspects has been associated to the functioning of the frontotemporal parietal lateral network which is the one associated to less controlled and reflexive processes, while the focus on internal aspects activates the frontoparietal medial network that leads to more controlled and reflexive mental processes (Satpute & Lieberman, 2006).

2.3.3. Mentalization in relation to the self versus others
As in psychopathology of development and the investigation of neuroimaging, it is suggested that the capacity to distinguish between the self and others is fundamental to comprehend the social world (Fonagi & Luyten, 2012). There have been signaled two neuronal circuits associated to this polarity. The first of these, linked to the comprehension of the actions and emotions of the others, involves the activation of the mirror neurons system for the understanding of actions and the visceromotor centers for the comprehension of affections (Rizzolatti, Fogassi & Gallese, 2006). This system is mainly visceral, automatic and typically studied in the investigation about affective empathy. The second circuit is located in the prefrontal medial cortex, the anterior cingulate cortex and the precuneus. This system is less based in the corporeality and processes the information about the self and others in a more abstract and symbolic manner (Uddin et al., 2007). It is this system the one that inhibits the automatic and imitative responses and allows the differentiation between itself and other. From that differentiation is that the attention can be focused on one or the other of these poles (Lanza, 2011). From this view, to comprehend the mental state of others implies the recognition that they have minds with desires, thinking and emotions that can be different than the own. Precisely the first theoretical formulations about mentalization emphasized this system strongly related to
the evidence around the theory of mind, the false belief, perspective taking and cognitive empathy (Choi-Kain & Gunderson, 2008).

2.3.4. Cognitive Mentalization versus Affective
Cognition and affection are two aspects of mentalization easily distinguishable. Therefore, while sometimes mentalization could be oriented to beliefs, to the comprehension of mental states, in other moments the focus could be about feelings, affections and emotions. An adequate mentalization implies the integration of both aspects as it has been expressed in concepts like affective empathy and mentalized affection (Fonagy et al., 2002). Cognitive mentalization involves diverse areas of the prefrontal cortex, while its effective counterparty is particularly related to the ventromedial prefrontal cortex that plays an important role in providing affective information to the mental representations of the self and others and in that way be integrated to the cognition (Fonagy, Bateman & Luyten, 2012).

The lack of inhibition, deactivation or simply dysfunction of one or both systems can be associated to the psychopathology, being able to lead, for example, to the dissociation between emotion and cognition, or to the difficulty to integrate them both.

2.4. Characteristics of neurobiological brain development in adolescents
Adolescence is a moment of the life cycle of special relevance to the study of mentalization due to the changes at neurodevelopment level that affect specially the brain areas associated to the functions that are part of it, increasing significantly the vulnerability in the light of the psychopathology. During this stage, it is possible to show changes in the arousal and the motivation, triggered by the pubertal development that precede the regulatory competences development so there is a gap between the emotional experience of the adolescent and its ability to regulate the arousal, the motivation and the emotion, which have an impact over the capacity to regulate their own behavior (Steinberg et al, 2006). Bleiberg, Rossouw and Fonagy (2012) warn that the neurobiological functioning and the information processing of those patients diagnosed with borderline personality disorder show important similarities with these normative changes of the adolescent’s brain.

The brain of the adolescent faces, particularly at the prefrontal cortex level, on the one hand, a process of synaptic formation followed by neuronal pruning and, on the other hand, a process of axonal myelination that increases the efficiency of neuronal transmission in the prefrontal
cortex, the temporal cortex and other cortical areas (Fonagy et al, 2014). Nelson, Leibenluft, McClure and Pine (2005) have proposed that this phenomenon can be comprehended to the light of an evolutionary model of the social information processing composed by a first moment that matures through childhood, in which the capacity to detect social keys is developed; a second moment that achieves the objective of giving emotional meaning to these keys that matures through adolescence and a stage of cognitive regulation that allows the behavioral inhibition which matures in late adolescence and early adulthood. This proposal is consistent with the findings linked to a rising of the frontal and prefrontal activity associated to tasks of social cognition between childhood and adolescence, moment in which the synaptic connections are still being developed (Yurgelun-Todd & Killgore, 2006), and the reduction of the neuronal activity between adolescence and adulthood, moment in which the pruning takes place (Wang, Lee, Sigman, & Dapretto, 2006).

At the behavioral level, these changes have an observable correlate that can explain the behavior of risk that many adolescents show. Findings in neuroscience have shown that the reorganization of the prefrontal lobe and the interconnected brain regions can result in failures around the executive function, inhibition of the answer, effortful attention control and emotional self control (Casey et al, 2000). On its behalf, the mesocorticolimbic regions of the brain associated to the regulation of stress, could be involved in the risk tendency or novelty seek (Le Moal & Simon, 1991).

2.5. Mentalization and psychotherapy with adolescents

Although it has been hypothesized that the processes of neurobiological change that adolescents experience at the brain areas involved in the capacity of mentalization are at the basis of psychopathological development at this stage (Bleiberg, Rossouw & Fonagy, 2012), there is evidence that permits to say that these changes can be equally comprehended as a window of opportunity in the development. This is particularly important in early adolescence, moment that could be critical for the intervention in the processes of mentalization, especially for those youngsters that show more unfavorable attachment stories (Fonagy & Luyten, 2011). Hauser, Allen and Golden (2006) give evidence to this hypothesis from a monitoring study with adults who had a record of psychiatric hospitalization during adolescence and that showed satisfactory index of adaptation ten years later. There were identified as protector key factors, from qualitative interviews, the presence of reflexive capacities, agency and tendency to establish
relations with others characterized as open to accept different perspectives. On the other hand, Rossouw y Fonagy (2012) contribute with results related to the effects of focus work in mentalization with adolescents. It is in a randomized clinic trial with patients that maintained self-destructive behaviors that they compared the effect of a therapy based on mentalization and treatment as usual (TAU). Even though it was observed that both groups were benefited by the treatment, the index of recovery (44% v/s 17%) was mayor for those patients with therapy based on mentalization

Mentalizing in psychotherapy would be relevant for adolescents since it may favor the learning capacity in a relational specific context such as therapist-patient relation, from new social experiences permitting to change the understanding of their relations and their own behaviors and actions. In other words, for Fonagy and Allison (2014) this would be the way to establish epistemic trust, that is, confidence in authenticity and personal relevance of the information transmitted interpersonally. In this way, the experience that our subjectivity is understood (mentalized) is converted into a trigger necessary to receive and learn from the social knowledge, and in that way potentially change the perception of the world and ourselves. This is particularly relevant during adolescence since it is a stage characterized by a growing need to regulate the affections and behavior according to the goals and specific consequences, generally not counting with the presence of adults that have given regulatory structure and orientation during childhood. So, adolescents must be every time more capable of controlling by themselves their affections and actions as of principles, and possible risks and rewards that are not emotionally evident at the moment. This learning does not merely imply being capable of understanding the consequences of the actions, but requires that the adolescent can be capable of developing the skill to use that knowledge in a reliable manner in absence of adults supervision (Steinberg et al, 2006).

Therefore, psychotherapy promotes mentalization in the adolescent in a way in which it gives an opportunity to reflect about the self and others. In this context it takes more relevance for patients and therapists the story of attachment. To interpret a “mentalizing duet” in an effective manner, both must trust in the competences acquired through development. At any time, its performance will depend upon the same factors: security during attachment, manifested in mutual confidence in the relation, and an optimum level of arousal (Allen & Fonagy, 2006).
2.6. Mentalization and rupture-resolution episodes of the therapeutic alliance

Previously, it was signaled that the context in which this research seeks to identify the manifestations of the RF correspond to the episodes of rupture and reparation of the therapeutic alliance. One episode of rupture is a segment of interaction where communication markers are identified that evidenced decay of the therapeutic alliance manifested by a lack of collaboration between patient and therapist about goals and tasks or tension in the emotional boundary (Safran, Muran, & Eubanks-Carter, 2011). From this perspective, the establishment of the therapeutic alliance corresponds more to an intersubjective negotiation process in which the patients and the therapist mutually regulate the interaction (Beebe & Lachman, 2002; Safran & Muran, 2006).

The emergence of ruptures represents obstacles to the development of these processes even contributing to the patient’s abandonment of the therapy (Eubanks-Carter, Muran, & Safran, 2011; 2014). For that reason, the reparation of ruptures through strategies of resolution oriented to negotiate tensions in the relation emerge as an important task that has as an objective to reestablish the therapeutic communication (Safran & Muran, 2000).

To Safran et al (1990), the satisfactory resolution of the rupture of the alliance can be a powerful means of change giving a learning relational experience that permits the patient to represent the other as potentially available and the self as capable of reestablishing the proximity even in front of an impasse.

Despite that this idea has been developed by diverse authors (Luborsky, 1994; Safran, Muran, & Samstag, 1994; Lingiardi, & Colli, 2015), literature has been less precise at the moment of signaling which therapeutic actions effectively have as a result the reparation of a rupture. Likewise, Martínez et al (2014) have signaled that not all the interventions oriented to resolving an impasse effectively achieve that purpose. Specifically, they propose that the regulatory processes of interaction sequences that lead to reparation differ from those that don’t do that.

This idea is important for this investigation purposes, considering as a core hypothesis the idea that mentalization could exactly accomplish a relevant function at self regulation and mutual regulation levels in psychotherapy of adolescents.

Even when literature that links mentalization and the therapeutic alliance is limited, there are some investigations that have stated that these variables could be related. In relation to it, Morken, Karterud y Arefjord (2014) pointed that the reparation of ruptures of the alliance would be facilitated by three specific interventions of the therapy based on mentalization: a)
authenticity and transparency; b) explicit work about therapeutic alliance and c) the position of “not knowing.” On the other hand, a study with patients diagnosed with depression showed that RF would be correlated with the therapeutic alliance evaluated through the Helping Alliance Questionnaire (HAQ). The researchers conclude that patients with higher score of RF would establish a therapeutic alliance easily compared with those with lower score (Staunl, Kessles, Buchheim, Kächele & Taubner, 2010). In another study, Reading (2013), reported a strong predictive relation between RF of the therapist and the tendency of this to work upon not solved ruptures of the Alliance. Finally, Liotti y Gilbert (2011) have pointed the ability of the therapist to identify and repair ruptures could be a factor that may activate exploration in the patient, favoring an optimum exercise of the skills of mentalization about their own and other minds.

According to this evidence, mentalization could accomplish a relevant role as support to the establishment of the alliance, being a skill that is used by the patient as well as the therapist and then would be susceptible of being affected in both by factors that tend to drive up or disturb its functioning (Allen & Fonagy, 2006).

This means that, far from manifesting as a stable trait in therapy, the RF would be expressed as a dynamic and malleable capacity susceptible to specific events that emerge in the patient-therapist interaction (Fonagy, Gergely, Jurist, & Target, 2002).

The results from the psychotherapy research support the idea by virtue of the inconsistency of the findings of studies that have used mentalization as a result variable (see Hörz-Sagstetter, Mertens, Isphording, Buchheim, & Taubner, 2015), which has lead, in recent times, to the development of psychotherapy process research that has chosen to go in depth in its comprehension as a mechanism of change (Forster, Berthollier, & Rawlinson, 2014), giving rise to the search for new evidence associated to the comprehension of the way the RF is manifested during psychotherapy (Martínez, Tomicic, de la Cerda, Krause, & Pérez, 2015) and how it acquires a moderator or mediator effect of the change (Katznelson, 2014).

To summarize the background presented so far, it is possible to highlight four basic considerations on which this research is articulated:

1. Adolescence is a critical moment in which changes emerge at a neurobiological level that affect the processes involved in mentalizing and so they make relevant its investigation at that moment of the life cycle.
2. The study of mentalization in psychotherapy with adolescents has proved to be of relevance, as this is a context that may favor its development as a protective psychological function against psychopathology.

3. Ruptures of the therapeutic alliance are recurrent and characteristic of the processes of psychotherapy with adolescents. In this context, the reparation of ruptures could be a relevant factor associated to change.

4. The RF would accomplish a regulator role of the therapeutic interaction during rupture and resolution episodes, so different specific and complex interactions could be conceived between patient and therapist, some of which can have as a result the reparation of ruptures.

Thus, this study aims to understand how mentalization manifests itself during episodes of rupture and repair in individual psychotherapy with adolescents and how this manifestation is associated to repair of ruptures of the therapeutic alliance. Methodologically this research proposes a multivariate approach to the phenomenon of study, highlighting the interactive aspects that shape the regulatory expression of Mentalization in psychotherapy.

The findings of this research, in addition to contributing to the understanding of the role of mentalization in psychotherapy, seek to provide evidence that can be applied to clinical practice in the field of intervention with adolescents.

Finally, the research questions that guide this study are the following:

a) How is the quality of adolescents patients and therapists mentalization during interactional sequences of rupture-resolution in psychotherapy?; b) What differences are observed in the mentalization of therapists and patients when comparing interactive scenarios of rupture and resolution? c) What configurations emerge within therapists and patients regarding the quality of mentalization during interactional sequences of rupture and resolution? d) Is it possible that certain mentalization configurations are more likely to be repaired than others?
3. OBJECTIVES

3.1. General Objective:

To determine and characterize the manifestations of mentalization in interactional sequences of rupture-resolution in individual psychotherapy with adolescents.

3.2. Specific Objectives:

1. To identify and determine the quality mentalization used by therapists and patients in interactional sequences of rupture and resolution in psychotherapies with adolescents.
2. To compare the quality of mentalization used by therapists and patients in sequence of rupture and resolution in psychotherapies with adolescents
3. To determine the configurations of mentalization in the therapeutic interaction between therapist and patient in the sequence rupture-resolution in psychotherapies with adolescents.
4. To determine the association between the configuration of mentalization in the therapeutic interaction in psychotherapy with adolescents and the result of the rupture-resolution sequence.
4. HYPOTHESIS

1. During episodes of rupture of the therapeutic alliance mentalization will have lower ratings in patient as well as in therapist, than during episodes of resolutions.

2. Therapists will have higher ratings of mentalization than patients during ruptures and resolution episodes.

3. Mentalization will be organized according to distinguishable configurations both for the patient and the therapist during episodes of rupture and resolution.

4. Configurations of mentalization will differ in terms of the probability of being repaired.
5. METHOD

5.1. General design of the investigation

This investigation corresponds to a study of psychotherapy process. A mixed design was employed using a) qualitative procedures for the determination of rupture episodes, resolutions and the results of the rupture-resolution sequences; and for the assessment of the patients’ and therapists’ mentalization during each sequence; and b) quantitative analyses for the establishment of differences in the mentalization ratings for patients and therapists during those rupture-resolution sequences as well as for the determination of configurations of mentalization within these episodes and possible associations between these configurations and the results of the rupture-resolution sequences.

5.2. Participants

The sample was comprised of 61 sequences of rupture and resolution identified in 96 sessions within 5 individual adolescent psychotherapy processes (see table 1). The patients were 4 women and 1 man between 14 and 19 years old, with a mean of 16.6 years of age. All the consultants presented mild to moderate depressive symptomatology and additionally, one patient met the diagnostic criteria for the development of borderline personality disorder. The therapists were four women and one man whose professional experience ranged from 3 to 20 years. All participants were recruited through public and private health centers in Santiago, Chile. At the beginning of the study, both therapists and patients signed informed consents (see Annex 2 to 4). Adolescents under the age of 18 signed an informed consent form and a responsible adult provided written consent to participate in the study. All sessions were audio and videotaped and subsequently transcribed. The study was approved by the bioethics committee of the Faculty of Medicine of the Universidad de Chile (see Annex 1).
Table 1. Description of the analyzed psychotherapies

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Sex (T-P)</th>
<th>Patient age</th>
<th>State of the process</th>
<th>Session quantity</th>
<th>Therapeutic approach</th>
<th>R-R Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F - F</td>
<td>14</td>
<td>Discharge</td>
<td>10</td>
<td>TAU</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>F - F</td>
<td>15</td>
<td>Drop out</td>
<td>15</td>
<td>CBT</td>
<td>13</td>
</tr>
<tr>
<td>3</td>
<td>F - F</td>
<td>17</td>
<td>Drop out</td>
<td>8</td>
<td>CBT</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>M - M</td>
<td>18</td>
<td>Discharge</td>
<td>9</td>
<td>Integrative</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>M - F</td>
<td>19</td>
<td>Ongoing process</td>
<td>54</td>
<td>Psychodynamic</td>
<td>17</td>
</tr>
</tbody>
</table>

R-R= Rupture-Resolution sequences

5.3. Procedures

Five pairs of judges trained in the 3RS system (Eubanks-Carter, Muran, & Safran, 2014) jointly rated the sessions of 5 audio and videotaped therapies, identifying rupture-resolution (R-R) sequences of the therapeutic alliance. An R-R was defined as an interactional segment composed of an episode of rupture that is immediately followed by an episode of resolution. The episodes of rupture in which a resolution was not subsequently identified were discarded from the study. Once R-R was identified, the same pairs of judges determined the extent to which ruptures were repaired through the "therapeutic relationship engagement scale" of Sexton, Littauer, Sexton and Tømmerås (2005). It was decided to use this scale because the 3RS does not have a specific index to assess the degree of repair of specific rupture episodes.

The rating of the rupture-resolution sequences and their repair was validated through intersubjective agreements between the judges (see Flick, 2009).

Once the rupture-resolution sequences were defined, another group of five pairs of judges trained in the Observational System of Mentalization in Psychotherapy for adolescents (OSMP-A, Morán, Martínez & Arce, unpublished) rated the mentalization of patients and therapists within these segments.

The reliability of the ratings was calculated using the interclass correlation coefficient (ICC). For focus on mental states the ICC was .80; for opaqueness of mental states, the ICC was .70; for contingent communication the ICC was .79; for dynamism of mental states, the ICC was .74; for causality of mental states, the ICC was .71; and for focus in the present moment, the ICC was .62.
The procedure and instruments used are illustrated in the following figure:

![Study procedures flowchart](image)

**Figure 1. Study procedures flowchart**

### 5.4. Measures

5.4.1. Identification of Rupture-Resolution Sequences (R-R):
The identification of R-R was based on the 3RS (Eubanks-Carter, Muran, & Safran, 2014). The 3RS is a system of observation of therapeutic activity that possesses criteria for the identification of interactive segments of rupture and resolution of the therapeutic alliance.

An episode of rupture corresponds to an interaction sequence in which patients either take distance from therapists or the therapeutic work or confront them, directly expressing anger, or dissatisfaction with the therapist or the therapeutic process (see annex 6).

On the other hand, an episode of resolution corresponds to an interactive sequence that begins with the presence of an indicator of the resolution of the rupture by the therapist (see Annex 7). For the purposes of this study, both types of episodes lasted at least 1 minute.

5.4.2. Assessment of reparation
Since the 3RS does not have a scale to determine the degree of reparation of a specific segment, the "therapeutic relationship engagement scale" by Sexton, Littauer, Sexton, & Tømmerås (2005) was used (see annex 5). This instrument is a 5-point observation scale that rates the degree of commitment of patients to the therapeutic process along the following continuum: (1) they do not seem to be focused at all on what is happening, (2) They seem somewhat distracted and not participating in response to the therapist, (3) They listen to what has been said and / or refer to what has been said, but do not seem entirely committed to the process, (4) They are clearly focused and committed, but not as clearly as in point 5; and (5) Very focused, with an intensity that is reflected in their posture, face and manner of speaking.

5.4.3. Assessment of mentalization within R-R.

For the rating of mentalization during R-R, the observational system of mentalization in psychotherapy (OSMP-A; Morán, Martínez & Arce, unpublished) was used. The OSMP-A (see Annex 8) is an observation system that rates the mentalization of therapist and patient on a five-points scale, based on video therapy segments and transcriptions.

The instrument allows rating therapist interventions that promote (scores 3, 4 and 5) or inhibit (scores 1 and 2) patients' mentalization; and patients' responses to these interventions that show an attempt to mentalize (scores 3, 4 and 5) or a failure in their mentalizing response (scores 1 and 2). Thus, as designed, the instrument has a cut-off score of 3 points.

Due to the relevance of this instrument for the development of this study, and to favor a better understanding in the reader of the results presented in the next chapter, a detailed description of the dimensions of the OSMP-A is presented below.

5.4.3.1. Focus on mental states dimension.

This dimension refers to the capacity of therapists and patients to establish and maintain a consistent focus on cognitions and affects related to the internal world of both self and others, as well as to the possibility of integrating descriptions to them arising from observable behavior and various events. Thus, a mere reference to the psychological aspects of self or others is not a sufficient criterion for assuming that there is an attitude of focusing on mental states. In the case of therapists, this focus is observed, for example, in actions characterized by the continuous
demand for their patients to mentalize, even in the face of their refusal, as shown in the following vignette:

\[ T: \text{And what's the worst thing that could happen if you give him a chance?} \]
\[ P: \text{No, it's just that I do not want to do it, and I have not thought about doing it} \]
\[ T: \text{and what could happen, let's think} \]
\[ P: \text{because I don't want to} \]
\[ T: \text{but let's think, let's pretend, you're not telling anyone here, you're telling me.} \]
\[ P: \text{I don't know if we would get along, but I don't want to} \]

Another way of maintaining a focus on mental states is through actions that actively interrupt adolescents when they are not focused on the mental sphere, redirecting them to internal aspects of their speech, as seen in the following vignette:

\[ T: \text{how was your week?} \]
\[ P: \text{normal} \]
\[ T: \text{normal, what is that? What is normal?} \]

Therapy 4.

In the case of patients, their focus on mental states is observed in the adoption of a reflective position in response to the therapist's interventions or, possibly, as a spontaneous expression, showing in some cases an intrinsic motivation to share and explain their inner experience, linking it to concrete situations:

\[ T: \text{what do you think about it?} \]
\[ P: \text{It's frustrating, because, I don't know, I guess like everything else I have to ask for help too to feel better, but at the end it's worse, and all the time that happens to me, I mean, because when I was arguing with my partner, I was like asking for help.} \]

Therapy 5.

On the other hand, it is possible to observe interactions where therapists promote the description of events or the focus on observable aspects, without connecting them to the internal world. When these types of interventions occur during moments where the adolescent is trying to mentalize, this process is stopped; or, the interventions are added to interactions that have a focus on the external and observable issues, without connecting it to affections or cognitions, thus, therapists lose valuable opportunities to favor mentalization in their patients. Moments in which the therapists are constantly passive or silent in front of their patients are examples of this type of interventions.
In the case of patients, a low focus on mental states is observed during situations in which, despite adolescents being invited to focus on internal states, they remain at a descriptive level and focused on events, behaviors or merely observable elements. As an example, the following vignette shows how the therapist and the patient remain focused on specific aspects when addressing a topic of great relevance for the adolescent:

T: did it catch your attention that you slept through the math exam?
P: later when I mentioned it, people were like "hey, how could you fall asleep?"
T: who said that?
P: my friends, they asked me on WhatsApp 'how did it go?' and stuff, and I was like 'hm... I don’t really know, I fell asleep' and they said 'but how could you fall asleep?' and stuff... and I was like: 'I don’t really know, I just fell asleep'. I mean, it's not like a big deal to me, but like, thinking about it as the most important exam of the year I do get the feeling it was kind of a big deal (laugh)
T: you described to me that before entering you were more anxious than sleepy.
P: yeah, I mean, I actually had to eat like two chocolate bars before the exam, but I still fell asleep (laugh).

Therapy 5

5.4.3.2. Opaqueness of mental states dimension.

This dimension refers to the degree of certainty that both therapists and patients demonstrate about the internal experience and intentionality of others, which reflects the ability to recognize the impossibility of having direct and omniscient access to the minds of others.

At the verbal level, this can be observed by the form assumed by the discourse, which, can range from the use of the first singular person, whenever it is made explicit that it is a personal point of view and not "the reality" to which reference is made, up to the use of expressions that show a “quality of doubt” about the reality of the internal experience of the other, such as: "maybe" or "it is possible that", among others. In general, this type of interactions is characterized by an attitude of curiosity that motivate speculation and the elaboration of questions as a way of looking for information that allows for a more precise reflection, yet not totally accurate with respect to the minds of others. When the story includes certainty about the intentionality of others, the reasons for these beliefs are usually explained, as seen in the following vignette:

T: can you explain it to me a little more?
P: it’s just that I don’t know, I keep thinking that there must be a much deeper bond for someone to care about someone else, like me with my dad.
T: m-m
P: I know that he cares about me because he lives with me, he’s with me all the time, all that, so he knows all my problems, he knows everything - and I thought that with my schoolmates something similar could happen... for the time that has passed, because we spend a lot of time together... that’s why... here, it’s like... it’s a little different, or maybe, well, now, thinking about it, you may care about me even more, since you know everything I've lived, then, considering that, there may be a little more caring because others don’t know everything.
T: it seems there is a part of you that asks yourself, will I care about you? what place will you occupy? Am I going to be present or am I going to care about what happens to you?
P: I mean, it has always worried me; I've asked myself whether a psychologist cares about what happens to his patients because it's like telling everything about me, it's kinda weird.

Therapy 5.

Its counterpart can be observed through interactions that denote certainty of what goes on in the minds of others, without any basis in prior knowledge, or assuming "how things are or should be". During these moments, therapists and patients are positioned as experts on the experience of others, being able to assume attitudes of control and show little curiosity. A therapist in the following vignette when confronting a consultant due to his low academic motivation is not interested in reflecting on it. From this perspective, the therapist inquiries about his general affection:

T: how are you doing?
P: good
T: uhhh... I see you’re kind of, I don’t know if you are sleepy or what, but I see you in a lower mood, with less energy
P: yes, I am sleepy
T: okay, but sometimes it's not just being sleepy... or is it just that?
P: that’s it...
T: mmm... (with an attitude of disbelief)
Q: I’m very sleepy
T: mmm... (with an attitude of disbelief)

Therapy 2
In this case, the question "how are you?", far from being exploratory, was aimed at giving the therapist the opportunity to express his opinion about the mental state of the patient. The use of "sometimes", has a rather ironic sense and strengthens the assumption of the therapist that the mental state of the patient is not what he explicitly states.

As the vignette shows, this type of interaction can occur during moments of increased tension during therapy, and may be, in other cases, accompanied by overflowing affection and / or discourses characterized by a degree of inconsistency from a logical point of view.

5.4.3.3. Contingent communication dimension.
This dimension is based on the assumption that psychotherapy can be considered as a dialogical context of mutual influence between a patient and a therapist. From this perspective, a collaborative and emotionally attuned interaction is expected where both parties actively attempt to work together in the construction of a shared coherent narrative that supports the progress of therapy. In other words, there is a sense of connection between one's proposals and the other's responses, consequently, a fluid and coherent dialogue that allows the therapist to explore deeper into and gain more knowledge of the adolescent's experience can be observed. Thus, it can be considered as a complex process that requires the ability to understand and relate discourse and emotion according to the context.

In the case of therapists, contingency is characterized by interventions that have the quality of being verbally and non-verbally attuned to the patient's behavior, emotion, and speech. This is observed by the inclusion in their discourse of relevant elements transmitted by the adolescent and / or the explicitation of contents that, although not expressed directly by the patient, logically and plausibly can be deduced from his / her discourse.

Another hallmark of contingent therapists involves their ability to formulate interventions at a complexity level that the adolescent can easily understand. In addition, these tend to be connected to previous interventions, or adapt flexibly to changes in the conversation. Contingency is observed in patients through an active collaborative role, reflecting in an profound way in response to the interventions of the therapist; or in a more passive way, while keeping attentive to the interaction, but by means of brief responses to express their agreement or disagreement to the therapist's proposals.
T: is it something that, like, you say that what I ask is something you can’t explain to me?
P: is that... actually... if I was sure, I could explain, but I'm not sure and I'm clueless.
T: so, you feel like you're bouncing with what I'm asking you? (laughter). I don’t expect you to have things clear, but in this conversation, to understand how things happen to you, how this came about, and with this previous matter about never having feelings for Fernanda, why do you have feelings now? because sometimes people look at us in a way or say something or do something to make us think in a different way and that it is not the same way for all people. Maybe another person wouldn’t find it important, but you give it importance and that's what I'm trying to understand, not if it's the right way or if it's appropriate way or not, do you understand me? But this way I understand how things happen to you
P: it's just that it always happens with her, it's kind of confusing, because I always take things as a joke, then how things have happened between us I thought it might be real, but on the other hand I thought no, probably not, probably is not true ... and that's when I started with the thing.

Therapy 2.

Therapists' actions characterized as non-contingent are mainly characterized by a lack of consideration of the adolescent's perspective. These are expressed as an imposition of personal points of view and/or do not incorporate the contents transmitted by the patients. Examples of these interventions can be observed through sudden topic changes, interruptions, decontextualized interpretations and overly theoretical interventions, which are irrelevant, critically oriented and/or with a complexity level that is difficult for the patient to understand. As a rule, therapists can be described during such interventions as emotionally non-syntonic with adolescents.

On the one hand, patients show their lack of contingency through actions in which they seem not to be following their therapist, giving the sensation of a monologue or even not listening to them. Their answers may range from a lack of correspondence with the interventions of the therapists, to abrupt topic changes, avoidance or even clear attempts to gain control over the therapist. On the other hand, there is a type of response that may be pseudocontingent, with a rather self-affirmative nature, and even though they may constitute a clear exemplar of mentalization, due to their monological positioning, they are not really aimed at favoring a context of shared dialogue.

The following vignette shows an interaction where it can be seen how a therapist tries to convince a teenager about the need to pay attention in classes. The patient responds with evident
displeasure by escalating in a discussion that ends with a categorical refusal to consider the position that the therapist insistently attempts to impose:

T: Yeah, of course, I’m not telling you not to study, but I’m telling you ... that's what I meant about your abilities, that you are capable and I told you that even though you don’t have a notebook you still did well, I mean, if you wrote something down, you took notes, your performance would go up.

P: what for to take notes if I’m not going to read them

T: To give you an example of the capacities that you have, make you aware of them and for you to exploit them in that way

P: Also, classes are just slide presentations and they send them out after, so what for to pay attention, I can just sleep... it’s way easier

T: Sure, but later that spare time you had you’ll have to spend it studying because you slept in class, that's what classes are for, to save you time and later when you leave school, you can study a little, but also dedicate yourself to other things

P: No

5.4.3.4. Dynamic nature of mental states dimension.

This dimension characterizes those interventions that include an acknowledgment of the complexity of mental states in discourses that makes explicit (or at least implicitly consider), that there is not only one version of a mental state or, that these are not static.

One way of accounting for the dynamism of mental states, both in therapists and in patients, is in interactions that reveal discursively the existence of different points of view (P: I felt sad, but I think they thought nothing was wrong with me). Another kind of actions are those in which the ability to recognize, tolerate and integrate contradictions of mental states is evident. This also includes the recognition of mixed emotions (T: but that is on the one hand, but on the other hand, when it appears it does seem to be worrying ... theoretically you don't care, but actually it seems you do). Finally, the recognition of the changing nature of affects and cognitions is an example of this type of interactions, either by the passage of time (Generally speaking, when you arrived for this consultation, do you remember a little how you got here, because you were another Sandra than what I am seeing right now... much calmer, how did you feel at that time? How do you feel now? Do you feel that there has been some change or not?), or, for the possibility of manipulating them at will, and thus, for example, being able to hide or regulate them (P: it’s just that it’s like... talking about my ex-girlfriend, it’s like something that is a core phenomena... but when it’s just personal things... it’s like I don’t tell anyone... I always have to save it... so I can keep it away from them...).
aspect of me, so, it's like I remember and like... I see the mirror and like I skip things, I still tell them, but when I say it, I was already forgetting.

In this dimension failures of mentalizing are observed, in the case of therapists, when they lose the opportunity to promote its use in the patient, with clear opportunities to do so, when the dynamic nature of mental states is stated as a cliché ("well, that's the way things are, there are always people who think differently") and / or when they are incorporated as a way of imposing personal ideas rather than promoting the mentalization of the adolescent.

In the case of patients, the failure in its use it is observed when this type of content is omitted in response to interventions by therapists who demand mentalizing or are incorporated in a way that seems unnatural and emotionally inconsistent, giving the impression of a utilitarian action, like trying to convince the therapist, being condescending, or trying to "get out of the way". All these actions could be characterized as being only apparently reflexive and as having the quality that the patient's speech is not credible, is irrelevant to the process and / or has an exclusively self-serving objective.

The following vignette shows how the therapist insists on the idea that the discomfort referred by the patient may be related to initiating a therapeutic process, which also takes place in a room with a two-way mirror. In this case, consideration of different alternatives to explain the patient's mental state occurs through interventions that impose a viewpoint on which the patient is urged to reflect:

\[
T: \text{do you associate it only to studying and tests?} \\
P: \text{I think so, I mean...} \\
T: \text{I thought that this situation... how does it feel to you? because you are initiating a therapy process, and there is a two-way mirror} \\
P: \text{yeah, but no, it’s not about that} \\
T: \text{have you thought about that?} \\
P: \text{No, I just try not to think about it.} \\
T: \text{but maybe let’s think a bit about that because it is present here}
\]

Therapy 5

5.4.3.5. Causality of mental states dimension.

The consideration of the causality of mental states can be observed in verbalizations of therapists and patients who implicitly or explicitly consider in a coherent and plausible manner the multiple ways in which behaviors, affects and cognitions of oneself and others can be mutually influenced, or; have an effect or be affected by relational dynamics. The following vignette exemplifies this aspect:
T: there is something that is not clear to me, what is it that you do not like about your dad's new partner?
P: everything
T: but there is something that must be particularly more complex, because even before you met her, you already had a negative predisposition towards her.
P: It was the same thing that happened to me when my parents were together, that I didn't like to see them get along because I knew they were going to have a fight later.

Failures regarding this dimension, for both therapists and patients, meet the same criteria as those related to the "dynamic nature of mental states". On the one hand, for therapists, it is considered a failure to miss the opportunity to promote the use of mental states in the patient, the use of clichés and the use of causality of mental states to impose personal ideas rather than promote the mentalization of adolescents. On the other hand, for patients, a failure in causality is observed in its omission when it is demanded by therapists, or when it is incorporated into discourse in such a way that it seems unnatural, utilitarian, emotionally inconsistent, and / or has an exclusively self-serving objective.

Here, for example, a teenager responds in a concrete way to a question that demands reflection:

*T: So, you said that the venting helped you
P: (Nods)
T: Is that so? Why do you think venting helped you?
Q: Because I vent*

5.4.3.6. Focus in the present moment dimension.
This dimension characterizes those actions of therapists and patients that tend to focus or promote the focus of the other in the “here and now”. On the one hand, this kind of actions can be observed at a verbal level when the actors make explicit use of the present time, through phrases such as "now that I think about it...", "that makes me feel..." or as a direct invitation to focus the other on the present. This is more characteristic of the role that therapists assume. Interventions are often characterized by reviewing past experiences or future expectations, however, they are considered focused in the present moment as soon as they have the quality to analyze these events without losing a positioning in the current and immediate experience. Thus, the mere mention of the present time is not a sufficient condition to be focused on the here and
now. In addition, attempts to protect this capacity through actions that actively stop the reflections that stagnate patients in the past or future can be considered as a non-verbal criterion that complements this dimension.

For patients, a discourse focused on the here and now, as seen in the following vignette, can convey a sense of being spontaneously and vividly connected with emotions and thoughts in the present:

**T:** *that's something that makes you very sad to think about*

**P:** *yes*

**T:** *because we all at the same time depend on people around us in some way to a greater or lesser extent*

**P:** *yeah but (sighs) if people are not around, I'm not really going to go look for people*

**T:** *how do you feel about that idea of loneliness where people are not around or that things are over or that you shouldn’t get your hopes on or that you shouldn’t depend on someone or something or be too close*

**P:** *it makes me sad, I mean (cries)*

**T:** *because that must be worked on and a distance must be maintained and that is something complicated, I find, isn’t it? because this is an intimate space by definition.*

**P:** *yes*

**T:** *then, to try to make it not intimate or less intimate*

**P:** *it’s just that; for me, this space is already super intimate because when I tell my things, when I tell; and really, they are things that I haven’t even told my boyfriend about. Like, the other time I started crying at home and he saw me and he said, ‘why are you crying?’ and I said to him like ‘(sigh) everyone is pulling me down' in reality and that's why I'm feeling like this, and like I told him only the most superficial, but nothing more.*

Therapy 5

The lack of focus on the present is observed in therapists through actions that promote the deregulation of the patients' affections, or when they fail to make the patient focus on the present by stagnating them in non-mentalizing discourses related to past or future scenarios. During this situations, therapists passively respond, allowing the client to remain focused outside the here and now, or actively collaborate with stagnation or deregulation, encouraging the client to focus on the recount of past stories or future plans without taking into account the present experience. In adolescents, emotional overflow, stagnation or responses that have the quality of being automatic may be observed. In the latter, although the adolescent does not seem emotionally
overwhelmed, it generates the impression that he / she refuses to be here and now. A clear example is the use of monosyllables.

Another form of low-focus in the present corresponds to self-affirmative discourses, in which the adolescent seems to be stubbornly trying to convince the therapist of a point of view or the truthfulness of his or her experience.

During an extensive intervention of the therapist in which he analyzes the reason for the adolescent's consultation, the patient is initially attentive, however, as the therapist deepens the analysis, the patient seems to be increasingly affected and deregulated, assuming a nervous attitude, moving feet and hands, and retreating from the interaction. The above seems not to be noticed by the clinician, who maintains his intervention. At the end, it is evident that the patient was unable to attend to what the clinician had said.

T: I don’t know what you think of this monologue
P: yeah (his voice trembles)
T: yes, sir? Yes, I swear? (joking)... what do you think
P: that... it could be... I mean... that is... I don’t have much of an opinion

Therapy 4

5.5. Data analysis procedure

For objective 1, a description was made of the means obtained by therapists and patients in each one of the dimensions of the OSMP-A in episodes of rupture and episodes of resolution. In addition, effect size was incorporated (Cohen, 1977) to interpret the magnitude of the differences observed within actors when comparing the means obtained in both episodes.

For objective 2, a multilevel linear regression analysis was carried out using STATA 15.0, considering the nested nature of the data, as a way to evaluate differences between and within subjects (patients and therapists) and episodes (rupture and resolution). For this, a model that considered the therapy number (1 to 5) as level-3, the session number (1 to 54) as level-2 and the R-R sequence (61) as level-1 was established. At this final level the dependent variables (dimensions of mentalization) and the independent variables (type of episode and actor) are located. The longitudinal nature of the data was modeled through the order of appearance of each sequence as a random slope at level-2, as a control variable.
For objective 3, a multilevel latent class analysis was carried out using LatentGOLD 5.1 (Vermunt & Magidson, 2000) in order to establish the presence of mentalization configurations in the R-R sequences. LCA is a statistical method for finding subtypes of discrete, mutually exclusive latent classes of individuals, based on their responses to a set of observed categorical variables (Lanza, Collins, Lemmon, & Schafer, 2007). In this case, the observations correspond to the ratings of the judges on the performance, in terms of mentalization, of therapists and patients during each R-R, and the configurations correspond to the unobserved subgroups (latent classes).

For the analysis, the scores of therapists and patients in each of the scales of the OSMP-A were dichotomized, assigning "0" to low scores of mentalization (1 and 2) and "1" to medium to high scores (3, 4 and 5), which will be referred to as "high mentalization probability" (HMP). The latent class model was made on the basis of the dimensions focus on mental states, opacity, contingent communication and focus on the present moment of therapists and patients in rupture and then in resolution (see figure 2). The analysis took into account the nested nature of the data, considering rupture and resolution episodes (1 to 61) as level-1 and therapy (1 to 5) as level-2. The dimensions "dynamism of mental states" and "causality of mental states" were treated as covariates. In terms of the analysis, this procedure consists of evaluating the probability of occurrence of low scores versus medium to high scores in these dimensions, as well as the presence (coded as "1") versus no presence (coded as "0") of each dimension for each latent class. This analysis was carried out after the determination of the latent classes. The decision to treat both dimensions as covariates was due to a better fit of latent class models.

Additionally, to evaluate the presence of differences between actors when comparing the mentalization scores obtained in ruptures and resolutions, a mean comparison analysis was carried out using the Wilcoxon signed-rank test for related samples in SPSS. This non-parametric test was used due to the low number of observations for each R-R combination. The results of this test were used as auxiliary indicators for the interpretation of each configuration.
For objective 4, the probability of membership of the distal result "repair" to each of the combinations of latent classes of rupture and resolution obtained in objective 3 was evaluated. For this, the values of the "therapeutic relationship engagement scale" were dichotomized. Values "1" (Seems to not be focused at all on what is happening), "2" (Seems somewhat distracted and not participating in response to the therapist) and "3" (Listening to what has been said and / or refers to what has been said, but does not seem committed to the process) were recoded as "0" (not repair). A value of "1" (repair) was given to scores "4" (Clearly focused and committed, but not as clearly as in point 5) and "5" (Very focused, with an intensity that is reflected in his posture, face and manner of speaking).

Thus, for each of the combinations of latent classes, it was possible to establish a probability of repair on a scale of 0 to 100.

Figure 2. Multilevel LCA diagram
6. RESULTS

Throughout this section, the results of this study according to each objective are shown. First, the unit of analysis, comprising the 61 rupture-resolution (R-R) sequences identified along the five analyzed processes of psychotherapy, will be described.

Table 2. Description of rupture-resolution sequences identified throughout five processes of psychotherapy

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Sessions</th>
<th>R-R sequences</th>
<th>Withdrawal ruptures</th>
<th>Confrontation ruptures</th>
<th>Repaired R-R (%)</th>
<th>Ratio R-R/therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>12</td>
<td>8</td>
<td>4</td>
<td>6 (50%)</td>
<td>1,2</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>13</td>
<td>12</td>
<td>1</td>
<td>5 (39%)</td>
<td>0,9</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>4</td>
<td>6 (60%)</td>
<td>1,3</td>
</tr>
<tr>
<td>4</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>6 (67%)</td>
<td>1,0</td>
</tr>
<tr>
<td>5</td>
<td>54</td>
<td>17</td>
<td>11</td>
<td>6</td>
<td>12 (71%)</td>
<td>0,3</td>
</tr>
</tbody>
</table>

Total 96 61 46 15 35 (57%) 0,9

As can be seen in table 2, in all therapies the presence of withdrawal ruptures was more frequent, accounting for 75.4% of the R-R sample. In most processes at least 50% of R-Rs were repaired. In general, the presence of ruptures, can be considered as a frequent phenomenon that occurs, on average, about once per episode. However, its distribution was variable according to each psychotherapy process, concentrated mainly between sessions 5 and 10. This corresponds to the second half of the psychotherapy process for therapies 1, 2, 3 and 4 (see figure 3)
6.1. Identification and determination of the quality of mentalization used by therapists and patients in interactional sequences of rupture and resolution

In order to identify and determine the quality of mentalization, each of the 61 R-Rs were analyzed through OSMP-A (Morán, Martínez & Arce, unpublished). The results are shown below for each dimension of this instrument according to each episode (rupture and resolution) and actor (therapist and patients). Due to the descriptive nature of this sub-section, inferential statistical tests were not carried out to evaluate group differences; however, the effect size within actors was pointed out as a way of interpreting the extent of observed differences.

By examining the overall means, as shown in figure 4, it is possible to note that therapists tended to achieve higher scores of mentalization than patients in most dimensions, both in episodes of rupture and in episodes of resolution. This trend is not maintained in contingency, where equal averages are observed for both actors.

Regarding differences within actors, all dimensions showed higher mean values during resolution. For therapists, a medium effect size in opaqueness (d=,55) and a large effect size in contingency (d=,79) was observed. In turn, patients showed even larger effect sizes than the former, with medium size effects in focus on mental states (d=,59) and present moment (d=,50),
and large effect sizes in *contingency* (\(d=0.91\)), *dynamism* (\(d=0.77\)) and *causality of mental states* (0.92).

When analyzing results according to the OSMP-A 3-point cut-off score, therapists showed a larger number of dimensions than patients with means above this criterion. This is observed in the *focus on mental states*, both in rupture and resolution, while *opaqueness, contingency, dynamism and present moment*, only averages higher than the cut-off score are observed during resolution.

For patients, only average scores above 3 points are observed during resolution episodes in *contingency*.

Figure 4. Summary of OSMP-A means of therapists and patients according to episodes of rupture and resolution

By segmenting results according to repaired and unrepaired sequences, the tendency of therapists to interact with higher mentalization ratings than patients and to show more frequently scales that exceed the 3-point cut-off score is maintained.

When analyzing the averages obtained within the actors within the resolution episodes, a tendency is observed, both in the patients and in the therapists, to reach higher scores during the repaired sequences. However, important differences are observed when analyzing effect sizes by actor: in the case of therapists, with the exception of *contingent communication* (\(d=0.72\)), small effect sizes were observed; while in patients medium effect sizes were detected, and in all cases, these were higher than therapists.
Figure 5. Summary of OSMP-A means of repaired v/s unrepaired sequences
6.2. Comparison of the quality of mentalization used by therapists and patients within interactional sequences of rupture and resolution.

The results of the multilevel regression analysis for each of the OSMP-A dimensions, treated as dependent variables, are presented below. The predictors of level 1 correspond to actor (therapist = "0"; patient = "1"), episode (rupture = "0"; resolution = "1") and the interaction between them. Level 2 corresponds to the session number, defined as an ordinal variable with values between 1 and 54, and level 3, to the therapy id number, defined as a nominal variable with values between 1 and 5. The following figure summarizes the multilevel model used for the analysis:

![Multilevel diagram](image)

Figure 6. Multilevel diagram

Additionally, the longitudinal nature of the data was modeled considering the order of appearance of each R-R as a random slope at level 2, as a control variable of the temporal dimension.

As a first step, the variance explained by each of the nesting levels between a null model (without predictors) and a model with predictors (independent variables) for each of the OSMP-A dimensions was compared. The statistic used for this procedure was the interclass correlation coefficient (ICC) which reflects the percentage of variance explained for each model. Based on this, a hypothesis test that evaluated the gain in specifying a
Table 3. Multilevel linear regression analysis summary

<table>
<thead>
<tr>
<th></th>
<th>Focus on mental states</th>
<th>Opaqueness</th>
<th>Contingent communication</th>
<th>Dynamism</th>
<th>Causality</th>
<th>Present moment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed effect</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>3.046 (.195)**</td>
<td>2.945 (.168)**</td>
<td>2.647 (.147)**</td>
<td>3.166 (.127)**</td>
<td>2.806 (.133)**</td>
<td>2.806 (.144)**</td>
</tr>
<tr>
<td>Actor</td>
<td>-1.161 (.144)**</td>
<td>-0.530 (.137)**</td>
<td>-0.061 (.137)</td>
<td>-1.145 (.180)**</td>
<td>-0.919 (.155)**</td>
<td>-0.451 (.118)**</td>
</tr>
<tr>
<td>Episode</td>
<td>0.145 (.143)</td>
<td>0.416* (.123)**</td>
<td>0.982 (.136)**</td>
<td>0.146 (.179)</td>
<td>0.428 (.152)**</td>
<td>0.313 (.117)**</td>
</tr>
<tr>
<td>Actor x Episode</td>
<td>0.495 (.203)*</td>
<td>0.083 (.188)</td>
<td>-0.063 (.193)</td>
<td>0.507 (.256)*</td>
<td>0.403 (.219)*</td>
<td>0.243 (.166)</td>
</tr>
<tr>
<td><strong>Random effects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3 (Therapy)</td>
<td>0.917 (.085)</td>
<td>0.088 (.071)</td>
<td>0.031 (.046)</td>
<td>0.000 (.000)</td>
<td>0.017 (.023)</td>
<td>0.062 (.051)</td>
</tr>
<tr>
<td>Level 2 (Session)</td>
<td>0.088 (.114)</td>
<td>0.007 (.048)</td>
<td>0.002 (.000)</td>
<td>0.000 (.000)</td>
<td>0.001 (.034)</td>
<td>0.007 (.038)</td>
</tr>
<tr>
<td>sequence (a)</td>
<td>0.001 (.002)</td>
<td>0.001 (.001)</td>
<td>0.001 (.001)</td>
<td>0.001 (.000)</td>
<td>0.000 (.000)</td>
<td>0.001 (.001)</td>
</tr>
<tr>
<td>Level 1 (R-R)</td>
<td>0.801 (.089)</td>
<td>0.483 (.057)</td>
<td>0.701 (.076)</td>
<td>0.718 (.095)</td>
<td>0.740 (.090)</td>
<td>0.415 (.045)</td>
</tr>
<tr>
<td><strong>ICC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Null model</td>
<td>.18</td>
<td>.16</td>
<td>.04</td>
<td>.00</td>
<td>.02</td>
<td>.14</td>
</tr>
<tr>
<td>Random fx model</td>
<td>.32</td>
<td>.25</td>
<td>.17</td>
<td>.00</td>
<td>.012</td>
<td>.19</td>
</tr>
<tr>
<td>Log likelihood</td>
<td>-220,605</td>
<td>-165,993</td>
<td>-206,357</td>
<td>---</td>
<td>---</td>
<td>-177,222</td>
</tr>
</tbody>
</table>

* = p < .05; ** = p < .01; ICC = Intraclass correlation coefficient; --- = no se calculó para variables que no demostraron estructura anidada de los datos
model that considers the hierarchical structure of the data with respect to a model that considers the variance in a single level was carried out. A p-value below .05 allows to reject the null hypothesis indicating that there are no differences between both models and accept the alternative hypothesis that proposes that a hierarchical structure provides a better fit to the regression model. It was determined that the dimensions focus on mental states, opaqueness, contingent communication and focus in the present moment demonstrated a nested structure, whereas for the dimensions dynamism and causality of mental states, the null hypothesis was accepted. In this case it was decided to carry out multiple linear regression analysis considering a single level.

Table 3 summarizes the results of the regression analysis described in this subsection.

6.2.1. Mean differences between actors

The means of therapists tended to be significantly higher than the patients' means in the dimensions focus on mental states (β = -1.161; p < .01), opaqueness (β = -0.530; p < .01), dynamism of mental states (β = -1.145; p < .01), causality of mental states (β = -0.919; p < .01) and focus in the present moment (β = -0.451; p < .01). Exceptionally, in the contingent communication dimension no differences were found between actors (β = -0.061; p > .05).

6.2.2. Mean differences between episodes

Differences were found in the means according to episode in the dimensions opaqueness (β=.416; p < .01), contingent communication (β=.982; p < .01), causality of mental states (β = .428; p < .05) and focus in the present moment (β=.313; p < .01). In all these cases, the scores obtained during resolution episodes were greater than the scores attained during rupture episodes.

No differences were observed according to episode in the dimensions focus on mental states (β=.145; p > .05) and dynamism of mental states (β=.146, p > .05).
6.2.3. Interaction effect actor x episode

An actor x episode interaction effect was found in the dimensions *focus on mental states* ($\beta = .495; p < .05$), *dynamism* ($\beta = .507; p < .05$) and *causality of mental states* ($\beta = .403; p < .05$). Thus, although there are differences in the means of actors in rupture episodes, these are not maintained during resolutions. The following figure shows the interaction effects:

![Interaction Effects](image_url)

**Figure 7. Interaction effects actor x episode**
6.3. Configurations of mentalization between therapist and patient in the sequence rupture-resolution in psychotherapies with adolescents.

In order to identify mentalizing configurations, a latent class analysis (LCA) was performed. As described in section 5.3, LCA is a statistical method for finding subtypes of latent, discrete, and mutually exclusive classes, based on a set of observed categorical variables. According to the steps outlined in the LCA (Collins, & Lanza, 2010), the following sub-section is organized as follows:

a) For both rupture episodes and resolution episodes, the number of latent classes that show the best fit was selected. For this purpose, the fit obtained for a number from one to five classes was compared. The Bayesian Information Criteria (BIC ng) was used as fitting criteria according to the recommendations of Lukociene and Vermunt (2010). These authors adjust the algorithm for the Log-likelihood Statistics calculation by incorporating the number of expected groups (BIC ng) instead of the sample size (N) for multilevel latent class analysis. For the interpretation of this information criteria, lower values indicate a better fit.

b) After selecting the number of classes that show the best fit, each one of them is described considering the probability for each actor to interact through ratings coded as "1" (medium to high ratings, PMHR). In addition, the probability of interacting from the dynamism and causality of mental states and the MHR probability of these interactions are shown for each of the observed classes. Finally, the type of rupture (withdrawal v/s confrontation) most likely associated with each class was estimated.

c) In order to favor a clinical understanding of the results, each configuration of rupture and resolution was labelled, and a description of the therapeutic interaction was made, accompanied by vignettes from the same analyzed cases.

1 Throughout objectives 3 and 4, the concept of "PMHR" will be used to abbreviate "Probability of medium to high ratings". "PMHR" stands for "the probability of getting 3 points (average scores), 4 points or 5 points (high scores)". Since the latent class analysis carried out for this study aims to evaluate the probability of achieving medium to high ratings, this abbreviation will be used to facilitate the reading of the document considering that this concept is reiterated on multiple occasions from this point on.
6.3.1. Latent class model for rupture episodes

As described earlier, class selection was conducted on the basis of the BIC. According to this criterion, lower values indicate a better fit. The 3 latent classes model showed the best fit when compared to models for 1, 2, 4 and 5 classes (see table 4).

Table 4. Selection of latent classes for rupture episodes

<table>
<thead>
<tr>
<th>N Clases</th>
<th>BIC (LL,ng)</th>
<th>N par</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>591,97</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>520,24</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>489,36</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>494,35</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>499,94</td>
<td>44</td>
</tr>
</tbody>
</table>

The following table shows the results of the LCA for 3 classes, both for the dimensions that make up the observed classes as well as for the covariates analyzed. All the values can be interpreted in terms of the membership probability in each class, on a scale of 1 to 100. In the following subsection each of these classes is described.

The denomination "RUP-" + "class number" was used to label each observed class at rupture. For example, the observed class "1" at rupture was named: "RUP-1".
6.3.1.1. Description of class RUP-1: “Empathetic-pseudocontingency mismatch”

This class was observed in 27.2% of the sample and was characterized - compared to the other classes - by a higher probability of patient-therapist interaction, with medium to high values of mentalization in the four dimensions evaluated. Although the PMHR of patients in focus on mental states was less than 50% (42%), this probability was even lower in the remaining (RUP-2 = 0.02% and RUP-3 = 11%). As can be seen in figure 8, this class is characterized by a higher PMHR in patients than in therapists in opacity (97% v/s 87%), contingent communication (75% v/s 57%) and focus at the present time (97% v/s 93%).
Additionally, as explained at the beginning of this section, analyses were carried out in order to: a) evaluate the probability of occurrence in each actor of the covariates *dynamism* and *causality of mental states*, and b) to evaluate the probability of these exemplars obtaining average (3 points) to high (4 or 5 points) values (MHR).

It was found that the probability of occurrence of *dynamism* and *causality of mental states* was high both for therapists and patients, though higher in the latter. The PMHR of these covariates was high in therapists in both dimensions, while in the case of patients, this probability was high only for the *dynamism of mental states* dimension.

Finally, as shown in table 7, one out of every four observations belonging to this class is likely to be confrontation ruptures.

During this type of interaction therapists actively tend to encourage their patients to focus on internal states (focus on mental states), proposing topics for joint reflection (focus on the present), by means of medium to high level demand questions (dynamism and/or causality of mental states). Clinicians tend to position themselves non-verbally in an attitude of "not knowing" (*opacity*), although the content of their interventions eventually reflects that they are oriented towards an end that is not syntonic with the content and/or affection of the patients. The following vignette exemplifies this type of interactive scenarios.
Context: The patient speaks about his lack of motivation to go to school and his lack of a ties with his classmates. This has led him to stop attending classes. The therapist focuses instead on the search for strategies so that the patient can catch up with the contents he has lost due to his absences:

T: How do you do it to catch up later?
P: Hm, I don’t catch up, I just copy on my notebook the stuff they reviewed in class. (Contingent response: attempts to "adapt" to the therapist's intervention immediately, although before he was focused on expressing negative affects related to attending classes).
T: Hm, because I imagined that for you, considering that you are trying to put a little more effort into going to school, even though I know you don’t like it very much (opacity indicator)
P: (Nods) (maintains the contingent response oriented to "follow" the intervention of the therapist)
T: Sometimes you tell me that there are subjects that are sometimes difficult for you, right? I imagine skipping several days (opacity indicator)... one feels a little lost, right? (incorporates mental states)
P: Mhm (nods) (maintains contingent response)
T: Right? It's like arriving a bit like ‘I missed a chapter, didn’t I?’ (Maintains quality of opaqueness).
P: Yeah, one is lost. Also, if I try to borrow all the notebooks, I won’t manage, cus’ I’ll borrow them the day after. (Maintains contingency, but this time proposes arguments to justify his position)
T: And for example, what if you call a schoolmate so he takes his notebook for you even if you don’t have that subject that day? (the response of the therapist counterarguments the patient and ignores his scarce bond with his peers).
P: (Nods) I hadn’t thought about it ("pseudo-contingency." Agreement with the intervention of the therapist, but on a non-verbal level there is irony in his answer)
T: Ah
P: But I’m gonna do it (laughs) (Maintains "pseudo-contingency") (withdrawal indicator)
T: So, why do you think it hadn’t occurred to you? (demand question about the causality of mental states)
P: I don’t know, it’s just that, it just hadn’t occurred to me, it’s just that I don’t have my classmates’ phone number, I have two classmates, three, yeah, I'll tell one to take their notebooks for me. (Establishes focus on non-psychological aspects, it seems that his answers are only "to get by")
T: Mhm now, eh, I was thinking about that because, for example, you have to kind of use strategies, you know? Of perhaps anticipating things that may happen.
P: Mhm (nods)
T: As long as you want it
P: (Nods) I'll get them (maintains pseudo-agreement quality with the therapist and evidences even more withdrawal)

Rupture episode extract, Therapy 2
As can be seen in this vignette, in the face of this type of intervention, which seems to subtly impose a different point of view, ambivalent responses are observed in adolescents. On the one hand, they try to cooperate with therapists (contingency), but at the same time they tend to position themselves from self-assertive discourses, denoting suspicion and even annoyance. Patients' contingency, which may even be higher than that of therapists, could be an index of their intention to maintain a connection, rendering this type of rupture more subtle. This is complemented by the quality of opacity and affective regulation (focus on the present moment) inherent to his speech and non-verbal behavior.

Summarizing, based on the lack of attunement of therapists to the affections and predominant contents of their patients, and the ambivalent response of the latter, this type of interactive scenarios was called "Empathetic-pseudocontingency mismatch".

6.3.1.2. Description of class RUP-2: **promotion of mentalization under stress**

This observed class represents 35.4% of observations. It was characterized by the difference in the PMHR of mentalization between therapists and patients in all the evaluated dimensions, as shown in Figure 9 in this class, therapists obtained the highest PMHR in opaqueness (99%) compared to the other observed classes (87% in RUP-1 and 13% in RUP-3). Patients showed the lowest PMHR in focus in mental states compared to the other classes, with only 0.02%.

![Figure 9. Latent class profile for RUP-2](image-url)
The probability of occurrence of *dynamism* (74%) and *causality of mental states* (79%) in therapists was the highest in comparison to the other two classes. In patients, a high probability of occurrence of both dimensions was also observed (69% and 75%), however, the PMHR for these (14% in *dynamism* and 4% in *causality*) was the lowest of the three classes observed. On the contrary, for therapists, the PMHR was elevated for both covariates, especially in *causality of mental states* (.97).

In other words, there was a high probability of occurrence of exemplars of *causality* and *dynamism*, however, the quality of these differs according to the actor, with a high probability for therapists to interact through MHR.

Regarding the type of rupture, the probability of confrontation is the lowest of the three classes, with 17%.

In clinical terms, during this type of rupture, therapists show a constant attempt to lead the conversation to internal aspects of mentalizing, through interventions that tend to demand the use of reflective function. On the contrary, in patients, a focus on concrete and observable aspects stands out, with a low level of *causality* and *dynamism* of mental states. In general, patients appear "not really in the here and now" (low level of focus in the present), as evidenced by a withdrawn attitude (low level of *contingent communication*) or, on the basis of unregulated affection.

During these moments, therapists can perform actions that coincide with the 3-point indicator in *contingency*, that is: "although they connect with the patient's speech at least in its most superficial aspects, interventions tend to be too theoretical or have a level of complexity that can sometimes be difficult for the patient to understand". Additionally, the high *opaqueness* of therapists during this type of interactional scenarios could be understood, from the perspective of patients, as an attitude of neutrality that evidences affective distance at times when support is required.

This interactional pattern characterized by a therapist who actively promotes mentalization and a patient who evidences markers of affective deregulation was denominated as *promotion of mentalization under stress*.

One way this type of intervention typically takes shape is through positioning therapists as expert adults, giving sermons and advice:
Context: This interaction is the continuation of an extensive speech given by the therapist to motivate the patient to recognize his own strengths. Corporally, the patient seems very anxious, his voice trembles, he touches his face with his hands, and he presses his hands together.

*T*: I’ve seen several teenagers (clarifies his role as an expert) where, ehm, the issue of laziness is like a rival to overcome, it’s as if laziness wasn’t easy to leave aside, but there is always more... too much laziness to be able to do other things. **What do you think of that?** (attempts to promote a focus on mental states, expresses curiosity, but seems to force the patient’s participation. Promotes reflective functioning)

*P*: that, yeah... (yawns) (seems distracted, withdrawal indicator)

*T*: you didn’t smoke a joint before coming, right?

*P*: no (laughs)... I haven’t smoked in a while

*T*: hmm

*P*: but no, I mean yes, it holds me back... (responds in a non-reflective way, just to agree with the therapist's affirmation)

*T*: so, **what do you think of yourself taking the initiative to look for a job?** (The therapist reformulates the previous question as an explicit demand question about causality of mental states)

*P*: **How do I feel?** (does not seem to understand the question, psychomotor agitation is observed)

*T*: Yeah... because you're breaking ties with laziness.

*P*: Good, cus’... (responds in a non-reflective way)

*T*: You’ll be able to start going out, do other things. **I think this can be very useful to you** (opaqueness), very, because you’ll be transforming yourself into a person who sets themselves goals and strives to achieve them. You will be, eh, doing things, to get other things... that is... deep down you’ll be learning to, not so much to feel better, but to create your life as you want to live it. (The therapist answers the question he had made to the patient, maintaining the role of expert; contingent intervention linked to superficial aspects that due to the nervousness of the patient seems to be difficult to understand for him at the moment)

*P*: yes

*T*: right?

*P*: (silence)

*T*: **what do you think?** (simulates with his hands a microphone for the patient to speak) **what do you think?** (He insists on promoting the patient's reflection. When joking, he remains an expert).

*P*: yeah... yeah

Rupture episode extract, Therapy 4
As seen in the vignette, the therapist maintains the quality of *opaque ness* by explaining that "it is only his point of view" and constantly requests for the opinion of the adolescent about these ideas.

6.3.1.3. Description of class RUP-3: “*control-resistance dynamic*”

This class, consisting of 35.4% of observations, was characterized both by a low PMHR in all the dimensions evaluated in therapists and patients, as well as by a higher probability of rupture by confrontation (about 1 in 3 episodes of rupture), in comparison to the other classes. As in RUP-1, the probability of obtaining medium to high *contingency* ratings was higher in patients (29%) than in therapists (5%).

![Figure 10. Latent class profile for RUP-3](image)

The probability of occurrence of dynamism exemplars was higher in patients (64%) than in therapists (33%), however, the quality of these (in patients) was low (17% of PMHR). The likelihood of occurrence of exemplars of causality of mental states was around 50% in both actors, with a low PMHR in both patients (20%) and therapists (46%).

In this class, therapists obtained the lowest PMHR for both covariates in relation to the other two classes.
In clinical terms, this type of interactive scenario is shaped by evident disagreements between both actors, characterized by a low level of use of mental states (low focus on mental states), which are generally used to describe situations and argue in favor of personal ideas and/or against the other. During this type of ruptures, therapists tend to attempt to control patients, demonstrating a low level of attunement with them (contingency) and positioning themselves as experts (low opacity) by imposing points of view that are openly resisted by patients. As shown in the following vignette, it is characteristic to find in both actors emotions of anger that are only partially regulated (low focus in the present) and that accompany the whole episode. This type of interaction was denominated "control-resistance dynamic ".

**Context:** The therapist insists on the need for the patient to enroll in a group workshop in order to carry out new activities because she is spending too much time alone at home.

*T:* you have everything at home, you're pampered, you are prepared and served food, you have to cooperate I imagine... wash the dishes sometimes, you know? (confronting the patient) Eh... let's make the decision to enroll in a workshop.

*P:* yeah, yeah, but not a free one or something like that, I don’t like that (lowers the volume of her voice, avoids eye contact)

*T:* have you ever gone to a workshop? (confronts the patient, shows signs of anger)

*P:* no

*T:* aha, so, how do you know you're not going to like it? (demands the patient to reflect in a defiant tone and anger)

*P:* but, not really... (refuses to reflect, stays closed in her point of view)

*T:* how do you think it’ll be? (Insists on demanding the patient to reflect in a challenging attitude that has a communicational intention of "challenge")

*P:* I don’t know, might be full of low-lives

*T:* we don’t know that (silence)... we do not know that

*P:* hm (facial expression of anger)

*T:* maybe you’ll meet a lot of girls who are going through the same thing as you are, it’s a good chance to meet, you can meet all sorts of people like low-lives or rich people, we are all human in the end, you’re discriminating people you don’t even know (assumes expert position: low opaqueness)

*P:* it isn’t discrimination, but like... I don’t know, sometimes I feel... with you because you’re asking a lot from me, what I’m going to do is because you’re telling me to, not because I’d like to (responds with obvious annoyance: indicator of rupture by confrontation)

Rupture episode extract, Therapy 3
6.3.2. Latent class model for resolution episodes

For selecting the number of classes that best fit in resolution episodes, as in the case of rupture episodes, the BIC was used as adjustment criteria. According to this criterion, the 4-class model was chosen (see table 6).

Table 6. Selection of latent classes for resolution episodes

<table>
<thead>
<tr>
<th>N Clases</th>
<th>BIC (LL,ng)</th>
<th>N par</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>506.96</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>430.27</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>415.11</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>406.44</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>412.55</td>
<td>44</td>
</tr>
</tbody>
</table>

The following table presents the results of the LCA for 4-classes both for the dimensions that make up the observed classes as well as for the covariates analyzed. In order to differentiate this group of classes from those found in ruptures, the nomenclature "RES-" + "observed class number" was used. Thus, for example, observed class 1 in resolutions was denominated "RES-1".

The analysis of the type of rupture was not considered since it is not relevant in the case of resolution episodes. In the following subsection, each of the observed classes is described: RES-1, RES-2, RES-3 and RES-4.
6.3.2.1. Description of class RES-1: “**effective promotion of mentalization**”

This observed class is composed of 39.3% of observations. It is characterized by a high probability, close to 100%, of medium-high ratings in all the dimensions of mentalization evaluated in therapist and patients, as can be seen in the following figure:
In both actors, the probability of occurrence of instances of causality of mental states was also the highest, in comparison to the other classes (see table 7). In fact, this is the only class in which this dimension shows a probability of occurrence higher than 50% in both therapists (57%) and patients (71%). For this configuration, the probability of exemplars of dynamism in mental states is high only in patients (88%).

Finally, the probability of interaction through MHR in both covariates is also high and exceeded 80% in both actors.

In clinical terms, this type of interactive scenarios is characterized, both by therapists' actions that contingently promote mentalization, and by reflective responses of patients to these interventions. It is important to remember that for the latent class model, a distinction was made between low ratings (1 and 2 points) and medium to high ratings (3 to 5 points) of the OSMP-A; for this reason, this class does not reflect only high mentalization ratings, but rather that the therapist's actions are effective in promoting patient mentalization. The above can be observed in the following vignette:

*T: There’s an expectation of yours to get help, but you also think that this help won’t come and will only produce pain... and at the same time when you think about coming to psychotherapy you feel that there’s also the possibility that it’ll just cause you pain (indicator of focus on mental states and dynamism of mental states). It is difficult to be in that situation (demonstrates contingency: understanding of the affect), where
asking for help will only bring painful consequences that hurt you (indicator of causality of mental states). What do you think of that? (explicitly invites to focus on the present moment).

P: It burns me out, because I think that I have to ask for help in everything to be able to feel better, but in the end it’s worse and it always happens to me (responds contingently to the therapist and maintains a focus on mental states)... though I guess it’s the same for everyone. When I got in a fight with my boyfriend, what I asked my friend for the most was for help and in the end... (low opaqueness indicator)

T: but you don’t want to come here when you feel bad (the therapist resumes intervention that links the tendency to isolate when in discomfort to skipping psychotherapy sessions)

P: yeah, but that’s when I’m really distressed, when I cannot take it anymore.

T: and that’s when you have the expectation that I won’t be able to help you

P: I think in those moments one can’t ask for help because one is so closed. At least I’m like that (explicit opaqueness), I mean, when I’m really sad I prefer to stay calm, to sleep, or I don’t know, to do anything to forget what’s going on, to realize... whether I really have a problem and how to fix it (speaking turn: indicator of causality, dynamism of mental states and focus on mental states).

Resolution episode extract, Therapy 5

As this example shows, the therapeutic intervention begins with an action that contingently recognizes the patient's affect and promotes the revision of this experience in the present. From the beginning, the patient connects with the therapist and gradually increases his level of opacity. Finally, he manages to focus on mental states evidencing verbal indicators of causality and dynamism.

Eventually these types of resolutions are characterized by a meta-analysis of the interaction, incorporating the perspective and experience of the therapist during the rupture. This is observed even more clearly in the next vignette: T: is it something that, like, you say that what I ask is something you can’t explain to me?

P: is that... actually... if I was sure, I could explain, but I'm not sure and I'm clueless.

T: so, you feel like you're bouncing with what I'm asking you? (laughter). I don't expect you to have things clear, but in this conversation, to understand how things happen to you, how this came about, and with this previous matter about never having feelings for Fernanda, why do you have feelings now? because sometimes people look at us in a way or say something or do something to make us think in a different way and that it is not the same way for all people. Maybe another person wouldn't find it important, but you give it importance and that's what I'm trying to understand, not if it's the right way or if it's appropriate way or not, do you understand me? But this way I understand how things happen to you

P: it's just that it always happens with her, it's kind of confusing, because I always take things as a joke, then how things have happened between us I thought it might be real,
but on the other hand I thought no, probably not, probably is not true ... and that's when I started with the thing.

6.3.2.2. Description of class RES-2: “Collaborative reciprocity”

The RES-2 class, composed of 27.5% of observations, is characterized by the difference in ratings between therapists and patients in all dimensions. As in RUP-2 (see figure 9 in rupture), therapists showed a higher PMHR than patients in all the dimensions evaluated.

In this class, patients obtained the lowest PHMR in the focus on the present moment dimension (1%) when compared to other classes in resolutions.

![Figure 12. Latent class profile for RES-2](image)

Regarding the analysis of covariates, the probability of occurrence of both was higher in patients, however, in all cases it was less than 50%. On the contrary, when evaluating the PMHR in both dynamism and causality of mental states, values that exceeded 50% were found in both actors.

This type of configuration resembles RUP-2 ("promoting mentalization under stress"), but with a lower PMHR in focus in mental states and focus in the present in therapists, and a higher PMHR of contingency in patients. In clinical terms, this reflects an attempt to connect (high contingency) by patients despite the discomfort (low focus in the present) as a response to interventions aimed at describing and specifying (lower focus on mental states). This
pattern reflects an attempt by therapists to regulate the affect of patients and a contingent response of patients to this relational offer, which reflects collaborative reciprocity. Still, these interventions promote a certain level of arousal (lower focus in the present) that, if not supported by the patient, could constrain the repair of the rupture, as shown in the following vignette:

*T:* but, think about how deep down what matters is your wellbeing, be that as it may, the rest...

*P:* Yesterday lots of people talked to me, so I’m collapsed (it reflects affective deregulation)

*T:* what did they say?

*P:* I find it difficult to even think, I don’t know what to do (demonstrates a need of the therapist’s help: contingency; and affective dysregulation: low focus in the present)

*T:* (laughs) aw let’s solve it, let’s evaluate it, let’s do an activity that will help us evaluate the advantages and disadvantages of all the alternatives we have, what do you think? (low focus on mental states, focuses on actions) to start thinking, whether deep down there is a problem, that needs to be eh: solved, okay? because the idea is that you feel good so that we can advance in other things that also have to do with you, not with your mom’s problems, you know? (provides the reasons for the intervention: opacity indicator)

*P:* hm (nonverbally stays attentive to the intervention of the therapist)

*T:* you see? because your problems: where are they? You don’t see them. Yeah, because they have to do with your mom's needs, you see? What your grandparents say, what your aunt says, but what about you? I don’t see you here... as a woman, as a teenager, as a friend: missing, you see? Could it be that you’re appropriating the problem of the family? (dynamism of mental states)

*P:* it’s just that they get me in it (self-assertive action: low opacity)

Resolution episode extract, Therapy 1

6.3.2.3. Description of class RES-3: “clarifying interaction”

RES-3 class is composed of 21.1% of observations. It is characterized by a high PMHR for both actors in opaqueness (99% in therapists and 77% in patients), contingency (92% in therapists and 99% in patients) and a focus in the present moment (99% in therapists and patients). On the contrary, in the case of the focus on mental states, both have a low PMHR
(38% in therapists and 1% in patients). Particularly in patients, this probability is the lowest when compared to the other observed classes.

As in the RES-2 class, the probability of occurrence of exemplars of the *causality* and *dynamism of mental states* dimensions was less than 50% in both actors, however, their PMHR was high, reaching 86% in the case of the *causality of mental states* in therapists. That is, there was a low occurrence of exemplars of *causality* and *dynamism*, but these tended to have a medium to high quality.

In clinical terms, this type of interactive scenarios is characterized by *clarification interventions*, which promote description and details provision. As a result, a low focus on mental states predominate. The high probability of MHR of *opaqueness*, *contingency* and *present* in both actors shows coordination in the dyad (*contingency*), openness to the discovery of new aspects (*opacity*) and a low level of arousal (*present*).

*T: hmm, let’s see, from what I know you, you give very short answers! (laughs) (promotes a focus on superficial aspects of the patient's personality)*

*P: yeah (laughs) (non-verbally demonstrates agreement and interest)*

*T: what do you mean yeah?*

*P: yeah (laughs) (again uses humor to agree)*

*T: yeah, yeah, yeah... and of course, you are brief. So, sure, I... have you always been brief about words? (incorporates question that superficially promotes dynamism of mental states)*

*P: yeah (laughs) (maintains humor to agree)*
T: yeah (laughs). So, for example, when you are with your friends, when you are, I don’t know, laughing, you, do you speak a little and then you go silent? (includes opaqueness and takes the intervention to a concrete plane)
P: not always (the patient is able to distinguish aspects of his behavior that are not stable at a basic level: dynamism)
T: No? what, what do you mean not always?
P: because I'm not always, I mean sometimes I talk a lot, and it depends on the situation
T: so, for example, what are the situations that make you talk more? (maintains exploratory curiosity: opaqueness)
P: I don’t talk much when there’re people that I don’t know and there’s someone with me, but when I’m with my closest friends, I talk freely (speech partially reaches more depth, making distinctions for different contexts in his response).

Resolution episode extract, Therapy 4

Throughout this extract it can be noticed how the therapist engages the patient after a rupture by including humour, a touch of irony, while keeping the intervention at a concrete level, which seems to be comforting for the patient. Even so, he maintains interventions that gradually and consistently promote reflection on dynamic aspects which allow the patient to draw at least superficial distinctions.

6.3.2.4. Description of class RES-4: “control-submission”

The RES-4 class represents 12.1% of the sample. Except for the contingent communication dimension in the patient, this class is characterized by a low PMHR in all the other dimensions (less than 50%) both in therapists and patients (see figure 14).

Figure 14. Latent class profile for RES-4
While in all of the episodes analyzed, examples of dynamism of the mental states of the therapists were identified, in none of them causality of the mental states was observed. Because of this, only the PMHR in dynamism was analyzed. In this case, the probability for therapists was 41% and in the case of patients 57%.

In clinical terms, this type of interactional scenario is characterized by an expert positioning over reality by both actors. A certain level of deregulation and stagnation can be observed in patients, which is exacerbated by the actions of therapists on the basis of criticism, theorization and, in general, lack of attunement (contingency) with the patient's affection. During these moments it is possible to observe in patients a certain passivity that may lead to the validation of the point of view imposed by the therapist (as shown in the following vignette) or to a new rupture. In short, there is a persistent pattern of control by the therapist and a contingent response that has the relational effect of submission (passive acceptance) by the patient as can be seen in the following vignette:

_T: it’s really difficult to make you do something, so (laugh) that won’t happen (refers to the patient with irony). Look (reads the text that the patient wrote) "my mom feels bad and that’s what makes me feel sad". Yeah, well, actually, you're afraid of your mom breaking up. We don’t know if she’s going to separate, right? It's a distorted cognition, okay? Because in the end that's predicting a catastrophe, that ‘my mom is going to start going out and she's going to break up’ but we don’t even know what's going to happen. It is as possible as it is impossible, you know? It's not certain your mom will break up. And if she does, it's not your problem. Now, your problem is that you have a grudge with this person (referring to the mother's new partner). (theorizes: low contingency, imposes a point of view, low opaqueness)_

_P: mm_

_T: there’s a movie where two people are in this situation, they’re tense in their place, one person here and another there, right? Which one will you be? (indicates two objects) ok and this is her... (laugh) (mocks the patient: low contingency and low focus in the present, theorizes: low opaqueness) what’s his name?_  

_P: m-hm... Andrés_

_T: Andrés. Right, do you think he has done something to get close to you?_  

_P: yeah, all the time (shows anger directed at the subject she is referring to)_  

_T: and you? What have you done? How have you behaved? (focuses on actions)_  

_P: I have to behave well, or else he feels bad and starts to cry. I want to have some distance, but I’m not allowed to. (low opaqueness quality)_
T: you can’t (laugh), no, but you’re closer, you’ve come a little closer. It’s just that I think that you also want to get close to him a little bit. For your mom. (imposes point of view)

P: No, but my mom wants me to. I do everything because of her, not because I want to get closer.

T: no, I think that... you are granting Andres space because for your mom, because you want to go live with her, you miss her, you're better off with her... everyone is better off with their mom (low opacity). Do you stay there some weekends?

P: Some (seems to accept the therapist’s intervention, regulates her affection)

Resolution episode extract, Therapy 1

In summary, a 3-class model demonstrates the best fit to describe how the mentalization of therapists and patients is configured during episodes of rupture, while a 4-class model demonstrates the best fit for episodes of resolution.

In the case of rupture, as shown in Figure 15, a) RUP-1, shows a higher probability of interaction of medium to high ratings, both in therapists and in patients (with the exception of the focus in mental states of patients), with a high focus in the present in both actors and less contingency of the therapist, b) RUP-2, characterized by the distance in the probability of interaction through medium to high scores of mentalization between therapists and patients (with a higher probability for therapists); and c) RUP-3, presenting a high probability of low ratings in mentalization in both actors.

![Figure 15. Summary of observed classes in episodes of rupture](image-url)
During resolutions, as shown in Figure 16, a) RES-1, is characterized by a high probability, close to 100%, of the dyad interacting through medium to high mentalization ratings, b) RES-2, demonstrates a distance in the probability of medium to high ratings between therapists and patients in all the dimensions, b) RES-3, shows a high probability of medium to high ratings in both actors with the exception of focus on mental states dimension; and d) RES-4 is characterized by a high probability of low ratings in both therapists and patients.

Figure 16. Summary of observed classes in episodes of resolution
6.4. Association between the configuration of mentalization in the therapeutic interaction in psychotherapy with adolescents and the result of the rupture-resolution sequence.

To determine the association between R-R configurations and the result of this sequence, the step-3 tool from LatentGOLD 5.1 (Vermunt & Magidson, 2000) was used. It allowed to evaluate the probability of membership of the distal outcome "repair" to each combination of classes in rupture and resolution observed in objective 3.

Repair was established based on the results obtained by patients in the "engagement therapeutic relationship scale". Values of "1" (the patient does not seem focused at all on what is happening), "2" (the patient seems somewhat distracted and not participating in response to the therapist) and "3" (the patient is listening to what has been said and/or refers to what has been said, but does not seem completely committed to the process) were recoded as "0" (no repair). A value of "1" (repair) was given to scores "4" (the patient is clearly focused and committed, but not as clearly as in point 5) and "5" (the patient is very focused, with an intensity that is reflected in his posture, face and manner of speaking).

Figure 17 presents the analysis procedure. Thus, as can be seen, it was sought to establish the probability of "patient engagement" for each of the RUP / RES combinations:
Additionally, as noted in the methodology section, the differences in mentalization between rupture and resolution episodes in each of the R-R were estimated using the Wilcoxon rank test. The results of this test were used as a complement for interpreting changes in the MHR probability between the two interactional scenarios, as it provides information about the means differences. The latter is not considered by the LCA because it requires dichotomous data. Thus, a small increase in the PMHR between ruptures and resolutions, for example from 50% to 60%, could correspond to a statistically significant difference in the means, for example, from 2 points in ruptures to 4 points in resolutions.

It is important to note the rather complementary character of this analysis since this objective was focused on evaluating differences in the probability of occurrence of MHR in mentalization.

The results presented below were organized based on the configurations found in ruptures (RUP-1, RUP-2 and RUP-3). As in section 6.3., once the quantitative results have been described, each R-R sequence will be commented on in clinical terms and, when pertinent, vignettes from the same sessions analyzed will be included.

6.4.1. Configurations of mentalization and their association with repair in R-R according to class RUP-1

The following table summarizes the probability of repair for each of the rupture-resolution sequences for class RUP-1:

<table>
<thead>
<tr>
<th>R-R sequence</th>
<th>N</th>
<th>Probability of repair</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUP-1/RES-1</td>
<td>55%</td>
<td>78%</td>
</tr>
<tr>
<td>RUP-1/RES-2</td>
<td>23%</td>
<td>25%</td>
</tr>
<tr>
<td>RUP-1/RES-3</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>RUP-1/RES-4</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

2 It is reminded to the reader that MHR corresponds to “medium (3) to high ratings (4 or 5)”. “PMHR” corresponds to the probability of occurrence of MHR.
Next, each of these sequences is described, indicating the probability of medium to high ratings (MHR) of each dimension of mentalization, both in ruptures and resolutions, as well as the differences between both episodes, expressed in percentage points. When relevant, it is indicated if there are statistically significant differences in the within actors means of mentalization (see table 9).

Table 9. Mean differences within actors in dimensions of mentalization for R-R according to class RUP-1

<table>
<thead>
<tr>
<th>Dimension</th>
<th>R-R</th>
<th>Patient</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rupture</td>
<td>Resolution</td>
<td>p</td>
</tr>
<tr>
<td>Focus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUP-1/RES-1</td>
<td>2.78</td>
<td>3.33</td>
<td>.096</td>
</tr>
<tr>
<td>RUP-1/RES-2</td>
<td>2.00</td>
<td>1.75</td>
<td>.317</td>
</tr>
<tr>
<td>RUP-1/RES-3</td>
<td>3.00</td>
<td>2.00</td>
<td>.180</td>
</tr>
<tr>
<td>Opaqueness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUP-1/RES-1</td>
<td>3.00</td>
<td>3.25</td>
<td>.157</td>
</tr>
<tr>
<td>RUP-1/RES-2</td>
<td>3.33</td>
<td>3.33</td>
<td>1.00</td>
</tr>
<tr>
<td>RUP-1/RES-3</td>
<td>3.00</td>
<td>3.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Contingency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUP-1/RES-1</td>
<td>3.22</td>
<td>3.78</td>
<td>.025</td>
</tr>
<tr>
<td>RUP-1/RES-2</td>
<td>2.50</td>
<td>3.00</td>
<td>.458</td>
</tr>
<tr>
<td>RUP-1/RES-3</td>
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<td>3.00</td>
<td>.564</td>
</tr>
<tr>
<td>Present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUP-1/RES-1</td>
<td>3.11</td>
<td>3.44</td>
<td>.083</td>
</tr>
<tr>
<td>RUP-1/RES-2</td>
<td>3.00</td>
<td>3.75</td>
<td>.059</td>
</tr>
<tr>
<td>RUP-1/RES-3</td>
<td>3.00</td>
<td>3.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dynamism (MHR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUP-1/RES-1</td>
<td>2.57</td>
<td>3.43</td>
<td>.059</td>
</tr>
<tr>
<td>RUP-1/RES-2</td>
<td>3.00</td>
<td>2.00</td>
<td>.157</td>
</tr>
<tr>
<td>RUP-1/RES-3</td>
<td>2.50</td>
<td>1.50</td>
<td>.317</td>
</tr>
<tr>
<td>Causality (MHR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUP-1/RES-1</td>
<td>2.43</td>
<td>3.43</td>
<td>.034</td>
</tr>
<tr>
<td>RUP-1/RES-2</td>
<td>2.00</td>
<td>1.50</td>
<td>.317</td>
</tr>
<tr>
<td>RUP-1/RES-3</td>
<td>2.50</td>
<td>1.50</td>
<td>.317</td>
</tr>
</tbody>
</table>

6.4.1.1. Sequence RUP-1/RES-1.

The **RUP-1/RES-1 sequence** represents 55% of the R-R for class RUP-1. This combination showed a repair probability of 78% (see table 9).

As shown in Figure 18, there is an increase in the probability of interactions of MHR in all dimensions in resolutions episodes. The shift found in both actors in the *contingent*
communication dimension is particularly relevant, with an increase in the PMHR of 47 percentage points in therapists (Z = -2.401; p = .016) and of 24 points in patients (Z = -2.236; p = .025). This is the only dimension in which statistically significant differences are found in the means of both actors. The shift found in patients in the focus on mental states dimension from a PMHR of 42% in ruptures to 98% in resolutions is also important.

Regarding the dimensions used as covariates, this was also the only sequence in which a statistically significant difference was found. Particularly, there is an increase in the means of patients in causality of mental states (Z = -2.121; p = .034) from 2.43 points in ruptures to 3.43 points in resolutions. That is, there is a shift from an interaction that, on average, is below the 3 points in ruptures, to a rating above the cutoff score during resolutions.

![Figure 18. Sequence RUP-1/RES-1](image)

The increase in contingent communication and focus on mental states that characterizes this type of sequence can be seen in the following vignette:

**Context:**

The sequence begins with the narration of a patient about a crisis moment he experienced during the week. In response, the therapist reminded him that after this situation the patient requested for an extra session by telephone. The therapist assumed that the patient knew that an extra session could not be scheduled and interpreted that perhaps the client was testing him, as he does with other relationships. Considering this, the therapist insisted on talking about the teenager's beliefs about the genuine concern that he may have about his patients, which ultimately leads to a confrontation rupture:
T: So, you don’t think I can genuinely worry about my patients?
P: I don’t know. It's just that... you’re like a doctor and a doctor isn’t going to worry a hundred percent about her patients until they have a terminal illness. Because I don’t know how many patients you see per day, you know? (há) so (patient focuses his discourse on observable and concrete aspects)
P: So?
T: that’s the reason, I just don’t think there’s a giant concern... that's what I think (laugh) I don’t know if it's right or wrong, but that’s what I think (opaqueness) (indicator of rupture by confrontation)

After this rupture, an important change occurs in the therapist's stance. As it will be seen next, he attempts to explain why he carried out the previous intervention, transmitting understanding (contingent communication), explicitly showing concern (by concretizing his affection), and always maintaining a focus on the therapeutic relationship (focus in the present moment). This reopens and favors the expression of the patient's affections (focus on mental states) through a genuine connection (not pseudocontingency) on which they jointly reflect.

T: but it’s something relevant to the work we’re doing here, whether I worry or whether I care or not. That's why I associated it to asking me for flexibility... to ask me whether I can make some time different to the one we had stipulated for you to come here (causality of mental states and contingent communication)
P: it’s just that I really needed it, I mean, like…
T: I know, but it also implies that I have to worry and come here on a different day or change the appointment or wait for you. It’s in that sense that I asked you whether there could be something like a test about my real concern, because I do care about what happens to you.
P: mmmm I mean, just seeing you and everything already makes me feel that there’s a concern because moving everything like that and doing everything possible for today means there is a concern, but when I called it was because I really needed to talk to someone or, like, to talk to someone because I was, fuck, feeling super bad that day, like, I remember it and it makes me feel bad because... (cries) (focus on mental states)
T: what happens to you when you remember it? (causality of mental states)
P: it’s like, I feel bad (cries) I was never mean to them (cries) I always tried to help them with what they needed, I tried doing everything and if I couldn’t, crap, sorry.

Rupture-resolution sequence extract, Therapy 5
6.4.1.2. Sequence RUP-1/RES-2

The **RUP-1/RES-2 sequence** corresponds to 23% of the R-R organized based on the RUP-1 class. This combination obtained a repair probability of 25%. In this sequence, a decrease in the PMHR in the *focus on mental states* dimension, both in therapists (28 percentage points) and in patients (23 percentage points) was found. Only in this dimension, and particularly in the case of therapists, statistically significant differences ($Z = -2.000; p = .046$) in the means of ruptures ($x = 3.50$) in relation to resolutions ($x = 2.50$) were found.

Both in the *opaqueness of mental states* and in the *contingent communication* dimensions, therapists tend to increase their PMHR, while patients tend to a significant decrease in these dimensions.

![Figure 19. Sequence RUP-1/RES-2](image)

Clinically, this type of interaction is characterized by an increase in the *contingent communication* of therapists through actions that seem to aim at decreasing the obvious discomfort of patients during ruptures. For this purpose, therapists tend to redirect the conversation towards more specific and descriptive aspects (lesser *focus on mental states*), which in turn, generates a drop in the focus on the mental states of patients. This kind of actions seems to "banalize" the dialogue in order to overcome the impasse. As an example of this type of sequences the following vignette is presented. This is the continuation of a rupture episode previously analyzed (p. 56), in which the therapist explores strategies for the patient to get up to date with the contents of the classes he missed. As it can be seen, it starts with a change of topic:

*T:* Yeah, mm now, you haven’t been to school, so you've been more at home.
*P:* Yeah
*T:* And, how have you been? what is it like being at home?
P: Mm... I've spent all these days on the computer
T: Mhm...
P: watching stuff and... (silence)... that’s it (silence)
T: just watching stuff or hanging out with people too?
P: No, just watching series... (silence).
T: Ok and how are things with your mom at home?
P: Mn... with my mom fine, it has always been the same, so there isn’t much to say.

Resolution episode, Therapy 2

As seen in this vignette, the increase in contingent communication of the therapist seems to be intended as a strategy to "get out of the way". In the case of patients, maintaining the level of contingent communication accompanied by an important decrease in the focus on the present moment exposes a certain quality of withdrawal that seems to exacerbate and make more explicit a pseudocontingent positioning found in the rupture. This type of actions shows one of the lowest probabilities of achieving the commitment of patients (25%).

6.4.1.3. Sequence RUP-1/RES-3

The RUP-1/RES-3 sequence (figure 20) represents 22% of observations for this combination of observed classes. This sequence shows a 33% probability of reparation.

The decline in the PMHR in focus on mental states in both actors is characteristic (from 92% to 38% in therapists and from 42% to almost 0% in patients). In contrast, there is an increase in the PMHR in contingent communication in the dyad going from 57% to 92% in therapists and from 75% to 99% in patients. Finally, unlike the RUP-1/RES-2 sequence, the PMHR in focus on the present moment tends to remain high in both actors.

![Figure 20. Sequence RUP-1/RES-3](image-url)
In clinical terms, these results seems to indicate that therapists recognize the implicit mismatch that caused the rupture, and therefore, focus their intervention on the interests of the other, gathering information the adolescents had not had the opportunity to provide before. Thus, the decline in the promotion of mental states is because therapists tend to inquire about descriptive and concrete aspects in order to better understand the problem, closer to how the patient sees it. This implies an increase in opaqueness of mental states based on increasing curiosity for the real experience of the adolescent and a focus on the present, as interventions tend to verbally explicitate the therapist's understanding of the patient's point of view.

No analyses were carried out for the **RUP-1/RES-4 sequence** because there are no exemplars that represent this sequence.

### 6.4.2. Configurations of mentalization and their association with repair in R-R according to class RUP-2.

The following table summarizes the probability of repair for each of the rupture-resolution sequences for class RUP-2:

<table>
<thead>
<tr>
<th>R-R sequence</th>
<th>N</th>
<th>Probability of repair</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUP-2/RES-1</td>
<td>40%</td>
<td>78%</td>
</tr>
<tr>
<td>RUP-2/RES-2</td>
<td>27%</td>
<td>40%</td>
</tr>
<tr>
<td>RUP-2/RES-3</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>8%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Next, each of these sequences is described, indicating the probability of MHR and their changes between episodes of rupture and resolution. As in point 6.4.1., Whenever relevant, the presence of statistically significant differences in the within actors means of mentalization is indicated. They are detailed in table 11.
Table 11. Mean differences within actors in dimensions of mentalization for R-R according to class RUP-2

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Focus</th>
<th>Rupture</th>
<th>Resolution</th>
<th>p</th>
<th>Therapist</th>
<th>Rupture</th>
<th>Resolution</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUP-2/RES-1</td>
<td>1.67</td>
<td>3.22</td>
<td>.006</td>
<td></td>
<td>3.89</td>
<td>3.78</td>
<td>.564</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-2</td>
<td>1.20</td>
<td>2.40</td>
<td>.063</td>
<td></td>
<td>3.00</td>
<td>3.20</td>
<td>.564</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-3</td>
<td>1.67</td>
<td>2.00</td>
<td>.157</td>
<td></td>
<td>3.00</td>
<td>2.50</td>
<td>.180</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>1.50</td>
<td>1.00</td>
<td>.317</td>
<td></td>
<td>2.50</td>
<td>1.00</td>
<td>.180</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-1</td>
<td>2.00</td>
<td>3.75</td>
<td>.102</td>
<td></td>
<td>3.44</td>
<td>4.11</td>
<td>.014</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-2</td>
<td>1.67</td>
<td>2.00</td>
<td>.655</td>
<td></td>
<td>3.00</td>
<td>3.60</td>
<td>.083</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-3</td>
<td>2.23</td>
<td>2.75</td>
<td>.157</td>
<td></td>
<td>3.50</td>
<td>3.17</td>
<td>4.14</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>3.00</td>
<td>2.00</td>
<td>----</td>
<td></td>
<td>3.00</td>
<td>2.00</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-1</td>
<td>2.78</td>
<td>3.89</td>
<td>.023</td>
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<td>4.11</td>
<td>.011</td>
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<td>RUP-2/RES-2</td>
<td>2.00</td>
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<td>.317</td>
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<td>3.25</td>
<td>3.50</td>
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</tr>
<tr>
<td>RUP-2/RES-3</td>
<td>2.66</td>
<td>3.50</td>
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<td>3.17</td>
<td>2.83</td>
<td>.180</td>
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<td>2.50</td>
<td>1.50</td>
<td>.317</td>
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<tr>
<td>RUP-2/RES-1</td>
<td>1.78</td>
<td>3.11</td>
<td>.006</td>
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<td>2.89</td>
<td>3.22</td>
<td>.083</td>
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<tr>
<td>RUP-2/RES-2</td>
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<td>2.00</td>
<td>.317</td>
<td></td>
<td>2.40</td>
<td>2.80</td>
<td>.157</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-3</td>
<td>2.00</td>
<td>3.00</td>
<td>.046</td>
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<td>2.83</td>
<td>3.00</td>
<td>.317</td>
<td></td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
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<td>2.00</td>
<td>1.00</td>
<td></td>
<td>3.00</td>
<td>2.00</td>
<td>.157</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Opaqueness</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUP-2/RES-1</td>
<td>2.00</td>
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<tr>
<td>RUP-2/RES-2</td>
<td>1.67</td>
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<td>RUP-2/RES-3</td>
<td>2.23</td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>3.00</td>
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<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Contingency</th>
</tr>
</thead>
<tbody>
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<td>RUP-2/RES-1</td>
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<td>RUP-2/RES-3</td>
<td>2.66</td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>2.00</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Present</th>
</tr>
</thead>
<tbody>
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<td>RUP-2/RES-1</td>
<td>1.78</td>
</tr>
<tr>
<td>RUP-2/RES-2</td>
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<tr>
<td>RUP-2/RES-3</td>
<td>2.00</td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>2.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Dynamism (MHR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUP-2/RES-1</td>
<td>1.71</td>
</tr>
<tr>
<td>RUP-2/RES-2</td>
<td>1.75</td>
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<tr>
<td>RUP-2/RES-3</td>
<td>2.67</td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>----</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Causality (MHR)</th>
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</thead>
<tbody>
<tr>
<td>RUP-2/RES-1</td>
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<td>1.33</td>
</tr>
<tr>
<td>RUP-2/RES-4</td>
<td>----</td>
</tr>
</tbody>
</table>

---- = due to the low number of exemplars it is not possible to carry out inferential statistical analysis.

6.4.2.1. Sequence RUP-2/RES-1

The **RUP-2/RES-1 sequence** represents 40% of the R-R organized from the RUP-2 class. This combination, like RUP-1/RES-1, showed a probability of reparation of 78% (see table 11).
This sequence is characterized by the increase in the PMHR of patients in all dimensions. As shown in Figure 21, patients maintain a PMHR lower than 50%, in the dimensions focus on mental state, opaqueness and contingent communication, which increases almost up to 100% in resolutions.

This information is corroborated by the analysis of means, finding significant differences in the focus on mental states ($Z = -2.274; p = .006$), contingent communication ($Z = -2.271; p = .023$) and focus in the present moment ($Z = -2.762; p = .006$) dimensions.

Additionally, in patients, and only in this dimension, a significant increase in the means of dynamism of mental states ($Z = -2.232; p = .026$) and causality of mental states ($Z = -2.232; p = .026$) was found.

In the case of therapists, the PMHR tends to remain high in both interactional scenarios, with the highest increase in focus on the present moment going from a probability of 71% in ruptures to 99% in resolutions ($Z = -2.762; p = .083$). For this actor, a statistically significant increase was found in the means of opaqueness of mental states ($Z = -1.633; p = .014$) and contingent communication ($Z = -2.271; p = .011$).

Figure 21. Sequence RUP-2/RES-1

In clinical terms, the most salient aspect regarding this type of sequences is related to therapists' actions that accurately address (contingency) main aspects underlying the deregulation of the patient's affection, by positioning them in the present to be jointly mentalized (focus in the present moment). In this sense, the interaction moves from the promotion of mentalization under stress, to the mentalization in the present of aspects at the base of the current stress. This sequence is exemplified in the following vignette:
Context: The therapist promotes reflection on the patient's discomfort when crying in front of the cameras. The patient remains labile and finally connects to feelings of hopelessness:

T: in theory they're not a concern, but in practice it seems that they are
P: it’s not that; Look... I don’t like when people see me cry (laugh) it's kind of like that, because it kind of makes me look like, I don’t know... I'm inferior, like they can hurt me or take advantage of me
T: that you are lesser than...
P: lesser person, like I'm worth less
T: do you think that feeling sensitive or that that part of you diminishes you or makes people think bad about you?
P: no, but, like, I feel less protected, I mean, well right this moment I feel much less protected because I have no one (cries) but in the end I say, hell, I was born alone I'm going to die alone, so I should protect myself

In response, the therapist addresses the central aspect of the patient's affect associated to a need for dependence and a sense of loneliness, actively promoting reflection on it, as can be seen below:

T: but that at the same time is something that makes you very sad when you think about it
P: yeah
T: because people at the same time depend on others around them in some way
P: m-m
T: to a greater or lesser extent
P: yeah, but if there’s no one, I won’t go looking
T: what happens to you when you think about that loneliness? where there’s no one, or where things are over, or where there’s no reason to get excited, or where you can’t depend on or be too close to anyone
P: It makes me feel really bad, I mean (cries)
T: because we have to work on this subject... and to have to maintain a distance while doing it...
P: m-m
T: I think that’s a complicated area, isn’t it?
P: well...
T: because this is an intimate space by definition...
P: yeah
T: so, to try to make it less intimate...
P: yeah; like, for me this space is super intimate because when I speak about myself... it’s stuff that I haven’t even told my mom

Rupture-resolution sequence extract, Therapy 5
6.4.2.2. Sequence RUP-2/RES-2

The RUP-2/RES-2 sequence represents 27% of exemplars organized from the class RUP-2 and is the one that shows the lowest probability of reparation (40%).

Graphically, as figure 22 shows, in resolution episodes the distance in the PMHR between patients and therapists found in ruptures is maintained.

In the case of therapists, it is important to note the decrease in the PMHR in the focus on mental states (from 91% in ruptures to 64% in resolutions) and focus on the present moment (from 71% in ruptures to 48% in resolutions) dimensions. On the contrary, in patients there was a tendency to the increase of the PMHR, which is more clearly observed in the case of contingent communication, where it goes from 41% in ruptures to 65% in resolutions.

Finally, it is interesting to observe the pattern of covariates for patients, with an increase in PMHR from 0.14 in dynamism and 0.04 in causality of mental states during rupture, to 0.53 in resolution for both dimensions. Therapists in both scenarios maintain PMHR above 80% in these dimensions.

If it is considered that a central aspect of ruptures of this type of sequences is the emotional deregulation of patients, as can be seen graphically, this type of affect is maintained during resolutions despite attempts by therapists to promote a focus on non-psychological elements. In this manner, an attempt by consultants to collaborate more with the therapist (increase in contingent communication) during resolutions, despite the negative affect (lower focus on the present moment) can be found, however, in 40% of the analyzed sequences ruptures can`t be repaired.
6.4.2.3. Sequence RUP-2/RES-3

The **RUP-2/RES-3 sequence** (see figure 23) represents 25% of observations. This R-R combination showed a 50% chance to be repaired. This sequence is characterized by an increase in the PMHR of patients *opaqueness of mental states* (26% to 77%), *contingent communication* (41% to 65%) and *focus on the present moment* (6% to 99%) dimensions. In the latter, a statistically significant difference (Z = -2.000; p = .046) can also be found in the patients' means.

In therapists the PMHR in *focus on mental states* decreased by 53 percentage points, while in *focus on the present moment* it increased from 71% to a probability of almost 100%.

As in the RUP-2/RES-2 sequence, therapists maintained a PMHR higher than 80% in *dynamism* and *causality of mental states*, while patients showed an increase from .14 to .62 in *dynamism* and from .04 to .51 in *causality*.

![Figure 23. Secuencia RUP-2/RES-3](image)

In clinical terms, this type of sequences are characterized by interventions primarily aimed at reducing the patient's arousal (*focus in the present moment*) by means of actions that seek to clarify, in a concrete way (low *focus on mental states*), aspects that seem to be of concern to patients. As a result, patients are more likely to collaborate actively (*contingency*) and overcome "certainty about how things are" (low opaqueness) (see vignette RES-3, p. 68-69). However, sometimes therapists achieve this same goal through questions that explore other topics that are less uncomfortable for patients.
6.4.2.4. Sequence RUP-2/RES-4

The **RUP-2/RES-4 sequence** was found in only 8% of the cases within this combination of classes based on the RUP-2 class. Like the RUP-2/RES-3 sequence, these observations had a 50% chance of repair. It is important to note that this is the R-R that shows the highest probability of repair for the RES-4 class, however this should be taken with caution given the low number of exemplars evaluated.

As seen graphically in Figure 24, this sequence is characterized by a significant decrease in the probability of MHR in therapists, which in all the evaluated dimensions was inferior to 35%, which is replicated in the covariates.

![Graph showing sequence RUP-2/RES-4](image)

In these cases, therapists tend to resort to actions that seek to normalize or de-dramatize the affect of patients, for example, through by using humor. In general terms, they seem unreflective and focused on irrelevant aspects. In this way, it is patients who tend to sustain the interaction, trying to provide arguments for and transmit to their therapists central aspects of the problem. In these cases, the possibility of repair would be explained more by the motivation of the patient than by actions of the therapist explicitly oriented to repair the rupture, as shown in the following vignette.

**Context:** During the rupture episode the patient expresses concern about his mother's romantic relationship. He expresses fear of this relationship ending and the problems associated to that. Faced with various confrontational actions by the therapist, the patient finally withdraws from the interaction. Below is a segment of what happens after this rupture:

---

85
T: Your mom... (laugh) she must be having a blast
P: no, not everything is cool (shows anger)
T: maybe at first it was fun
P: they moved in immediately (stays angry)
T: but it's a grown-up relationship, people are not dating and holding their hands anymore.
P: he’s not a grown-up
T: (laughter) he’s more like my age, isn’t he? (laughter)
P: eewww
T: is he ugly?
P: yeah
T: do you have a picture?
P: No, why am I going to have pictures of him?
T: ok (laugh)
P: I mean, it’s just that I think he’s stupid, he’s my brother’s age.

Rupture-resolution sequence extract, Therapy 3

6.4.3. Configurations of mentalization and their association with repair in R-R according to class RUP-1.

The following table summarizes the probability of repair for each of the rupture-resolution sequences organized from the RUP-3 class:

<table>
<thead>
<tr>
<th>R-R combination</th>
<th>N</th>
<th>Probability of repair</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUP-3/RES-1</td>
<td>28%</td>
<td>67%</td>
</tr>
<tr>
<td>RUP-3/RES-2</td>
<td>36%</td>
<td>63%</td>
</tr>
<tr>
<td>RUP-3/RES-3</td>
<td>18%</td>
<td>100%</td>
</tr>
<tr>
<td>RUP-3/RES-4</td>
<td>18%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Each R-R configuration is described, indicating the probability of MHR and changes between episodes of rupture and resolution. Each time it is relevant, the presence of statistically significant differences in the within actors means of mentalization are indicated. The latter are detailed in table 13.
Table 13. Mean differences within actors in dimensions of mentalization for R-R according to class RUP-3.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>R-R</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
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<td>Resolution</td>
<td>p</td>
<td>Rupture</td>
<td>Resolution</td>
<td>p</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td>2,75</td>
<td>.063</td>
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<tr>
<td></td>
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<td>.180</td>
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<td>2,60</td>
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<td>.180</td>
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<td>.059</td>
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<td>2,40</td>
<td>1,00</td>
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<tr>
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<td>3,00</td>
<td>.221</td>
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<tr>
<td></td>
<td>RUP-3/RES-2</td>
<td>1,75</td>
<td>3,00</td>
<td>.102</td>
<td>2,50</td>
<td>3,17</td>
<td>.157</td>
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<tr>
<td></td>
<td>RUP-3/RES-3</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>1,50</td>
<td>3,00</td>
<td>.180</td>
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<tr>
<td></td>
<td>RUP-3/RES-4</td>
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<td>----</td>
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<tr>
<td>Causality (MHR)</td>
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<td>2,00</td>
<td>1,00</td>
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<tr>
<td></td>
<td>RUP-3/RES-4</td>
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</tbody>
</table>

---- = due to low number of exemplars it is not possible to carry out inferential statistical analysis

6.4.3.1. Sequence RUP-3/RES-1

The RUP-3/RES-1 sequence represents 28% of exemplars organized from the RUP-3 class. This sequence shows a 67% probability of repair.
This R-R configuration is characterized by the increase in the PMHR, during resolutions, of all the dimensions evaluated in both patients and therapists. Except for the opaqueness of mental states in patients ($Z = -1.414; p = .157$), all other dimensions that make up the sequence show statistically significant differences in their within actors means. This phenomenon is repeated in the covariables, with a PMHR found in ruptures of less than 50% in both actors, which later surpasses 80% in resolutions.

![Graph showing dimensional changes](image)

**Figure 25. Sequence RUP-3/RES-1**

During these types of sequences therapists dramatically move from a control position to an openness to explore emerging patient meanings. In clinical terms, a central aspect corresponds to the increase in opaqueness, which shows a shift from certainty to curiosity. During these moments, therapists tend to focus their interventions assertively on aspects that patients recognize as important to them (contingent communication). It is characteristic to observe a change in the rhythm of the conversation, moving from an interaction that reveals tension, to a moment that invites to pause in order to reflect together on aspects that are at the base of the impasse. Exceptionally, this type of resolution invites patients to meta-analyze the therapeutic relationship.

The following vignette shows how the therapist, after confronting the patient about his demotivation with school, takes a short pause and redirects his intervention to aspects that are particularly relevant and that apparently had not been considered by the patient:

*T: Mm, I was thinking about what you told me, you know?* (focus in the present moment) *I got a feeling… I get the feeling that sometimes you have many ideas, like, a lot of enthusiasm… uh your head is very creative* (contingent communication)
P: Yeah (laughs) (connects again with the therapist: contingent communication)
T: Eh, and you have very broad interests, right?
P: (Nods)
T: Reading... you like it, right? everything you've told me, right? and I think is something super interesting. There's a whole creative thing that one could develop, very active, very dynamic, I think
P: (Nods)
T: And when you talk to me, I see all that enthusiasm in you... and when you tell me, like, all the things that you want to do, like, suddenly, boom! (pointing out that something is falling) (focus in the present moment)
P: Yeah (laugh) there're a lot of ideas in my head, that I would like to do, but I don't think I will be able to accomplish them... so, I don't even try (focus on mental states, causality of mental states)
T: And it's like your head, at the same time, sets a lot of barriers to accomplish those things (dynamism of mental states, causality of mental states)
P: Mm (nods) Or I'm trying to... for example... I had a drawing in mind, but I couldn’t draw it because it wasn’t the same drawing that I wanted to create. I just ripped the page out and just left it there (contingent communication)

Rupture-resolution sequence extract, Therapy 2

6.4.3.2.Sequence RUP-3/RES-2

The **RUP-3/RES-2 sequence** concentrates 36% of observations and shows a probability of repair of 63%. These sequences are characterized by an increase in the PMHR of all the dimensions of therapist mentalization. This probability was higher the opaqueness of mental states and contingent communication dimensions. In the first (opaqueness of mental states) an increase of 83 percentage points was found ($Z = -2.333; p = .020$) and in the second (contingency), of 90 percentage points ($Z = -2.428; p = .015$).

An increase in PMHR was also found in patients, except in focus in the present moment.
The dimension that shows the greatest increase in the PMHR between ruptures and resolutions corresponds to contingent communication (36 percentage points). In it, a statistically significant difference was found ($Z = -2.530; p = .011$) when comparing the means of rupture ($x = 2.5$) and resolution ($x = 3.5$).
The dynamic and causal dimensions of the mental states behaved similarly to the RUP-3/RES-1 sequence, with MHR probabilities lower than 50% in both dimensions for both actors, and an increase, during resolution, higher than 80% in therapists and 50% in patients.
During this type of interaction therapists focus on aspects that stagnated or deregulated patients during rupture (increase in focus in the present moment), abandoning the expert positioning (increase in opaqueness) and establishing a consistent focus on mental states associated to the problem. Faced with these actions, patients tend to maintain a low level of regulation of their affect (lower focus in the present moment), although they make efforts to collaborate with the therapists' interventions (contingent communication). The following vignette exemplifies this type of interactions:

**Context:** during the rupture the therapist actively confronts the patient about the inconsistency of his speech, about being independent and autonomous, but ultimately maintaining a passive behavior. The patient firmly defends his point of view throughout the rupture, but eventually withdraws:

*T:* but these behaviors go against that, so: how do you understand that part of you that wants to become independent or more self-sufficient, and that other part that seems... as if your actions went the other way, huh?

*P:* yeah, but I don’t know... no (withdraws)

The following interaction is observed next:

*T:* but let’s think about it here – let’s take the chance (focus in the present moment)

*P:* it’s just that... I don’t know... I think I want things to be easy and fast (for the first time does not provide purely self-assertive arguments)

*T:* do you think that what is happening is easy?
P: no, it's just that... I don't know how to make things easy, I mean, it's not... When I go to school, I like it. I remember that when I started to go this year, I liked it, but I think it's more the laziness of getting up in the morning and all that, like... (makes basic distinctions between his motivation and behavior)

T: m-hm

P: like maybe if it was next to my house, I think I would go every day - and there are times that I want to go, but I can't get up

T: and what do you do all day?

P: just lie in bed... today I did till twelve o'clock or so. Then I planned on going shopping. Actually... I've been forgetting about myself; this year I haven't even bought new clothes, I haven't done anything, like, for me... (low focus on mental states)

T: yeah, that's the feeling I get, that there're things you could do that would be more beneficial (basic intervention of causality of mental states)

P: yeah, in fact there're times when I didn't even want to do it... besides the city center is a mess, but I think I have to do it – like, to be able to advance (cries), like, ok "lighten up!" (cries), but I don't know why I feel like this (cries) (she can't regulate her affect, but she maintains an attitude of contingent collaboration with the therapist and recognizes the possibility that there is a problem)

Rupture-resolution sequence extract, Therapy 5

6.4.3.3.Sequence RUP-3/RES-3

The RUP-3/RES-3 sequence concentrates 18% of observations of this subgroup of R-R. This sequence demonstrated a probability of repair of 100%, which was observed only in this case.

As can be seen in Figure 27, in both actors there is an increase in the PMHR of the opaqueness of mental states (from 13% to 99% in the therapist, and from 19% to 77% in patients), contingent communication (from 5% to 92% in therapists, and from 29% to 99% in patients), and focus on the present moment (from 19% to 99% in therapists, and from 5% to 99% in patients) dimensions, keeping a low probability of MHR in the focus on mental states dimension in resolutions (33% in therapists and 20% in patients).

As in the RUP-3/RES-1 and RUP-3/RES-2 sequences, an increase in the PMHR in dynamism and causality of mental states higher than 80% in therapists and values close to 50% in patients was found.
As in the previous configuration (RUP-3 / RES-3), during resolutions therapists show an important change regarding ruptures, abandoning the position of control to assume an empathic role and an attitude of curiosity. However, instead of directly addressing the affect associated to the deregulation and/or stagnation, they tend to actively promote the description of events and behaviors, providing the patient with space so that they can freely refer to their experience.

6.4.3.4. Sequence RUP-3/RES-4

Finally, the **RUP-3/RES-4 sequence** is composed of 18% of the sample. The visual examination of Figure 28, allows the reader to observe the similarity between the shape assumed by the RUP-3 and the RES-4 classes. In fact, the analysis of means verifies that these remain stable in therapists when comparing both interactional scenarios.

The increase in the dimension of *contingent communication* stands out among patients, going from a PMHR of 29% in ruptures to 59% in resolutions.

In the case of *dynamism* and *causality of mental states*, when comparing both episodes, only a slight decrease in the probability of MHR in therapists is observed (1 percentage point in *dynamism of mental states* and 11 percentage points in *causality of mental states*), while in patients there is an increase in the PMHR from 17% in *dynamism* and 20% in *causality*, during ruptures, to 57% in both dimensions during resolutions.

In general, during this type of sequences, no clinically relevant differences are found in the therapist-patient dynamics between ruptures and resolutions. The probability of repair is 0%.
The following figure summarizes the results of this subsection. Each of the rupture-resolution configurations is shown along with the probability of reparation of each one. The percentage of exemplars that make up each configuration is indicated in parentheses:
Figure 29. Summary of rupture-resolution combinations and their repair probability
7. **DISCUSSION**

A discussion of the main results of this research will follow. This section is organized according to the objectives of this study.

7.1. **About the quality of mentalization used by therapists and patients in interactional sequences of rupture and resolution**

Regarding the quality of the mentalization of the therapists and patients, it was observed that the former, as a rule, tended to show higher values both in ruptures and in resolutions. Unfortunately, no studies were found that compared the quality of mentalization of adolescent patients and therapists during psychotherapy in order to have an evidence-based criterion for interpreting these results. In fact, as can be found in the literature (see Katznelson, 2014), research in this area has tended to focus mainly on patients' unfolding and changes in mentalization, rather than therapeutic interaction. Those few studies that have addressed both actors in psychotherapy are recent and have been conducted with adults (see Hörz-Sagstetter, et al. 2015; Martínez et al. 2017).

However, there are aspects linked to the particular characteristics of each actor that could help to understand the differences in the ratings obtained. On the one hand, there is evidence based on the normative characteristics of adolescent brain development that proposes that areas linked to mentalizing related functions show less efficient connections and a more diffuse activity during this adolescence (Wang et al, 2006). For example, Dumontheil, Apperly & Blakemore (2010) propose that throughout this stage it is possible to detect deficits at the level of social cognition that are manifested through a greater number of errors in tests of theory of mind in comparison to adult’s performance. It is important here to emphasize that the overall structure of the network that subserves mentalization may be in place by age 5 (Saxe et al, 2009). Thus, deficits in the capacity of mentalization of adolescents would be rather associated to functional changes. In other words: the difficulties that are observed in mentalization capacities of young people are normative and occur in response to demands of the context. For authors like Bleiberg, Rossouw, Sharp & Fonagy (2012) The impact of adolescent brain changes would lead to increased vulnerability to breakdowns of mentalization during psychotherapy. This phenomenon could be particularly evident when
experiencing intense emotional arousal triggered by challenging interpersonal situations such as rupture-resolution moments.

On the other hand, these results could be explained considering the role assumed by the therapist, designed to fit the needs of patients (Stiles, Hill, & Elliott, 2015), adapting moment by moment to their relational offers, regardless of the interactional scenario (Morán et al, 2016). In other words, therapists are expected to maintain a higher mentalizing capacity that supports interaction. This could be verified by checking the within actor’s effect sizes of mentalization between rupture and resolution. As observed, this index tended to be higher in patients, with "large effect sizes" (d>.08) in two dimensions. That is, patients are the actors who show the biggest differences in their mentalization when comparing rupture and resolution. This would support the hypothesis that therapists tend to maintain more stable mentalizing functioning, while patients would be significantly affected during ruptures and would resume their baseline functioning during resolutions.

Nevertheless, it is important to note that mentalization was also diminished in therapists during ruptures, which is verified by observing that the latter, on average, remained below the cutoff score of 3 points during this type of episodes. As will be discussed below, it is possible to propose that this decrease in therapists mentalization during ruptures, as in the case of patients, could be explained as a failure in the capacity of explicit mentalization that originates or is a response to the confrontation/withdrawal of patients, and not as a deliberate action aimed at "approaching" to the patients mentalization level.

When comparing episodes according to the result of the resolution (repaired versus non-repaired episodes), there is also a tendency to observe differences on each actor performance. On the one hand, therapists showed a rather homogeneous performance at mentalizing both in ruptures and in resolutions during repaired and unrepaired sequences. Exceptionally, the contingent communication dimension showed higher means in repaired episodes, with a "medium effect size" (d =.72). This phenomenon suggests that repaired sequences would rather be associated with interventions carried out by therapists during resolution, particularly characterized by an increase in their contingent communication.

On the other hand, for patients, contingency seems to be the main dimension that seems to differentiate ruptures of repaired and unrepaired sequences, being particularly low in the latter cases. Thus, it is possible to hypothesize that a low level of contingent communication,
as defined by the OSMP-A as "a scarce response to the interventions of therapists through attitudes such as self-referential positioning or the use of evasive or irrelevant responses; which ultimately do not allow the construction of a shared context", is an early predisposition so that a rupture cannot be repaired.

It is important to point out that these kinds of patient’s responses were either found within withdrawal and confrontation ruptures, which lead to propose that it was not the way in which the rupture is manifested, but rather the refusal to establish contact with the therapist the hallmark of unrepaired sequence ruptures.

Finally, unlike therapists, there are various dimensions of mentalization that, considering the effect size obtained, would present a relevant increase during the resolution of repaired sequences in patients. Since the OSMP-A is designed to evaluate the actions of patients in response to the interventions of their therapists, it is plausible to think that this phenomenon would be particularly associated to an increase in the contingency of therapists.

7.2. About the differences in the quality of mentalization between therapists and patients within interactional sequences of rupture and resolution.

Point 7.1. descriptively approached the general behavior of the dimensions of mentalization, proposing broad hypotheses that could explain the performance of therapists and patients in R-R sequences. The following sub-section aims to deepen these observations, analyzing the performance of both actors, no longer globally, but based on each dimension of mentalization. For this, statistical inference tests were carried out that allowed to compare the mentalization of therapists and patients both in ruptures and in resolutions.

In the focus in mental states dimension, therapists obtained higher mean ratings during episodes of rupture, but this difference with patients is not maintained in resolutions. That is, therapists maintained a stable performance in both episodes, while patients presented significantly lower means in ruptures, which increase in resolutions, reaching ratings that are not different from those obtained by therapists. In clinical terms, this implies that, regardless of the type of episode, therapists tend to carry out actions aimed at promoting the use of mental states, while patients, are more reluctant to focus on them during ruptures, unlike in resolutions. It is worth wondering if this type of intervention by therapists, who consistently attempt to promote a focus on mental states at a time when their patients are more focused
on observable and external aspects, could be a cause for rupture, as exemplified by the following vignette:

*T:* so, what’s the worst that could happen if you give it a chance?  
*P:* No, it's just that I don’t want to do it, and I haven’t thought about doing it  
*T:* but what could happen, let's think  
*P:* I don’t want to do it  
*T:* but let's think, let's play, you're not telling anyone here... you're telling me.  

Rupture episode extract, Therapy 3

Bateman and Fonagy (2006), in their work with patients diagnosed with borderline personality disorder, propose that one of the basic principles to be followed by a therapist who seeks to promote mentalization in their patients is the active establishment of a focus on the mental sphere. However, they warn about the negative effects of forcing this type of process at times when the content to be mentalized is beyond the possibilities and/or motivation of patients at certain moments of therapy. As they point out, "Coercing the patient to talk is a nonmentalizing and unnecessarily confrontational, shaming, and undermining act that at best is likely to induce pseudomentalizing but is more likely to reinforce withdrawal" (page 217).

Regarding the **opaqueness of mental states**, therapists showed higher ratings than patients in both episodes, without the presence of an "actor x episode" interaction effect. Additionally, both subjects showed an increase in their means during resolutions. These results seem to indicate that the **opaqueness of mental states** is a dimension in which therapists characteristically manage to interact with higher ratings, demonstrating lower degrees of certainty about the internal experience and intentionality of others. Several studies have proposed that this type of process, which requires the establishment of perspective-taking skills, matures in adulthood, but is in development during adolescence (Choudhury, Blakemore, & Charman, 2005; Van der Graaff et al. 2014; Kilford, Garrett & Blakemore, 2016). Thus, low opaqueness ratings during ruptures would be expected in adolescents since an expert positioning would be an automatic response that is developmentally more complex to regulate than in adulthood. This type of prementalizing functioning has been described in different studies with clinical population, such as adolescents with severe self-injurious behavior (Rossouw, 2018), patients
with eating disorders (Robinson et al., 2016), addictions (Philips, Wennberg, Konradsson, & Franck, 2018), antisocial personality disorder (Bateman & Fonagy, 2012), among others. However, the group that has been most researched and where the most clinical evidence has emerged with respect to this type of prementalizing functioning is that of adults with borderline personality disorder (Bateman & Fonagy, 2012). These authors have denominated this phenomenon as "psychic equivalence mode", where reality loses its "as if" status and leads to thoughts and affects being experienced as reality itself.

Interestingly, this type of functioning, which demonstrates a generalized failure of mentalization in adult patients with borderline personality disorder, is a common feature in the adolescents evaluated in this study during ruptures. However, it is even more striking that these adolescents, on average, tended to show a sudden improvement in this dimension during resolutions, that is, immediately after ruptures. That is to say, although their capacity to position themselves with opaqueness when approaching the minds of others was strongly affected during ruptures, this capacity tended to be soon restored by the therapists' resolution actions.

This type of observations could become incipient clinical evidence about the sensitivity and openness of the adolescent brain to the influence of the social context on the development and regulation of executive functions (Fiske, 2009; Choudhury, 2010; Blakemore & Mills, 2014), something that only recently neuroscience studies have begun to demonstrate in this age group.

**Contingent communication** is the only dimension where no differences were found between therapists and patients neither in ruptures nor in resolutions. However, both actors showed a significant increase in their ratings during resolutions.

There are at least two hypotheses that would explain the low ratings obtained by both actors during rupture episodes. On the one hand, it is possible that low patient ratings are in response to low-contingency interventions by their therapists. In this sense, it would be the therapists themselves who would promote impasses. A recent study (Morán, Díaz, Martínez, Varas & Parra, 2019) that investigated the experience of clinicians during ruptures with adolescents, showed that for therapists, a frequent cause of ruptures corresponds to what was called "failure in the recognition of the adolescent's experience". This phenomenon is described as a lack of consideration for the adolescents’ immediate experience conveyed by the
adolescent, both at the level of affect and content, or as moments when the adolescent patients’ history and their previous experience were not being considered. As pointed out by the interviewees, this failure to consider the patient's experience is manifested during interventions that have been described as non-contingent and focused on the therapist's experience, who frequently assumes a position of expert. On the other hand, this study also proposes that due to the intensity with which adolescents experience their internal world, many ruptures are characterized by the emergence of overwhelming emotions, which generate intense emotions in therapists, often expressing feelings such as tension, paralyzing anguish, confusion, fear or even perplexity. In this manner, the intensity of affect that adolescents sometimes experience would be difficult for therapists to deal with contingently.

The dimensions **dynamism** and **causality of mental states**, unlike the other scales, exclusively assess verbal aspects of mentalization. It is important to clarify that, as the OSMP-A is designed, the **dynamism** and **causality of mental states** dimensions are only considered when there are demand questions, or interventions that implicitly demand the use of reflective functioning. Thus, the results of these dimensions should be interpreted in terms of the effect of the occurrence of exemplars of these dimensions and their quality on the therapeutic interaction in each type of episode.

Therefore, the fact that therapist’s higher means of **dynamism** and **causality** than patients during episodes of rupture, in clinical terms, would imply that the use of questions that demand the use of reflective functioning at times when the therapeutic alliance has been affected (and therefore the reflective capacity of patients), could favor withdrawal or confrontation responses. The following vignette exemplifies this:

*T:* Well, we talked about your friend who was having a very bad time and about how he was going to therapy and you said his situation troubled you because you thought he was kinda lost, like... you didn’t know how to help him.

*P:* Oh, that’s over now (the patient shows that he does not want to refer to the topic proposed by the therapist)

*T:* Is it?

*P:* Yeah

*T:* Ok, so it's over. How?

*P:* Eh, because he’s feeling better... Anyways, it doesn’t matter (the patient makes it even more explicit that he is not interested in addressing the topic proposed by the therapist)
T: What doesn’t matter?
P: I don’t care so much about problems
T: You don’t care so much about problems anymore?
P: (Nods) (a withdrawal indicator is observed based on the patient’s minimal response and non-verbal expression of obvious discomfort)
T: And how did you do it not to care so much anymore? (the therapist makes a demand question in response to the patient's withdrawal)
P: (shrugs) (withdrawal becomes more evident)
T: You don’t know how you did it, this like... letting go a little?
P: (Nods) (withdrawal is maintained)
T: You don’t?
P: Nope
T: In other words, you could say that deep down, something about the situation that brought you here has improved? which was your desire not to feel so affected by what others did
P: Yeah
T: So, what do you think? and what do you think it is that helped you about coming here? What has helped you do that? (The therapist answers with a new demand question)
P: That I have been able to vent (the patient responds in a concrete manner and with an attitude of displeasure)
T: Ok, so, what tools do you think you’ll be able to use once you stop coming here? (Therapist answers with a new demand question)
P: I don’t know (the patient withdraws again, but this time also refuses to reflect)
T: What do you mean you don’t know?
P: I do not know (patient again refuses to reflect)
T: Because then, maybe you are going to be able to vent too, right? But with someone else
P: I don’t know (patient refuses to reflect)

Episode of rupture extract, Therapy 1

On the other hand, the presence of an interaction effect would indicate that the level of these dimensions does not differ significantly from that of therapists during resolutions. Thus, unlike what happens in ruptures, this could be an ideal moment for the promotion of explicit mentalization.

Finally, it is interesting to note that the focus in the present moment maintains the same pattern as the opaqueness dimension, as therapists obtained significantly higher ratings than patients in both scenarios. In the opaqueness dimension, it was hypothesized that deficits in
the capacity of perspective taking, which characterize the normal development of adolescents, could be a factor that could explain these differences. Similarly, patient scores lower than therapists in this dimension, regardless of the type of episode, could be associated with another neurobiologically developing area at this stage: the emotional regulation capacity (Ahmed, Bittencourt-Hewitt, & Sebastian, 2015). According to Powers and Casey (2015) an ongoing brain development renders adolescents less able to successfully regulate their emotions, setting them at greater risk for anxiety and stress related disorders. Although not all adolescents experience these states, "storm" and stress is more prevalent during adolescence than at any other age (Arnett 1999).

Thus, faced with the manifestation of affective deregulation and the difficulty of adolescents’ in regulating these states, it is likely that therapists will be constantly challenged to carry out actions aimed at dealing with this type of affects that, at a global level, interfere with the ability of patients to mentalize. Several studies have shown that a precondition for restoring mentalizing is the restoration of emotional control because hot emotional processing interferes with explicit-controlled mentalizing and the processing of new information (Allen, 2012).

7.3. About the configurations of mentalization between therapist and patient in the sequence rupture-resolution and its association to repair

As proposed by Fonagy (2003), mentalization emerges in human beings as a faculty of advanced intersubjective communication, based on early attachment relationships, which organize and prepare the individual for cooperative existence with others. Thus, a secure base not only promotes exploration, but also the development of an essentially collaborative system of intersubjective communication (Cortina, Liotti & Silverman, 2012). This proposal, based on a social-constructivist perspective, challenges innate models such as the primary intersubjectivity model (see Trevarthen, 1993; Stern, 1995) that argues that from birth human beings have pre-wired perceptual and inferential systems that ensure the understanding of the social environment. Conversely, Csibra and Gergely (2006) propose that what is really innate to human beings is a mutually designed social communication learning system that evolved to ensure the rapid and efficient transfer of relevant cultural knowledge among co-specifics. They call it the "natural pedagogy" theory. The implementation of this role by the pedagogue
- or the diverse figures who exercise this role throughout life - and the apprentice's openness to learn the culture in the light of this type of experience, shape the neurobiological structures in charge of the mentalization processes. Therefore, mentalizing enables us to comprehend in a flexible way a complex context of human interactions inhabited by desires, beliefs and emotions that have an effect on one's own behavior and that of others. On the one hand, mentalizing allows us to regulate the self, and on the other hand, as influence is exerted within a relationship or relationships matrix, it participates in regulating interactions.

Psychotherapy is a clear example of a context that aims to exercise this pedagogical role, challenging the therapist to become a source of epistemic knowledge for an adolescent who typically does not seek psychological help, thus generating multiple situations of impasse. During these ruptures the distinction between the primary intersubjectivity approach and the social development approach as proposed by Fonagy (2011) becomes even more evident since what is "broken" in the patient is not the intrinsic desire to share his experience - as supporters of innatism propose -, but rather, the openness to expose their internal world to an external mind that seems not to recognize him.

This idea seems to be consistent with the results of this study. By reviewing the mentalization configurations identified during episodes of rupture, it is possible to propose that it is therapists who generate conditions that lead to rupture; either by: a) an empathic mismatch, based on proposals that do not attune to the patient's experience, subtly and strategically taking them to planes that are arbitrarily chosen as relevant; b) promoting mentalization at times when patients are experiencing high levels of arousal, or when there is a demand to reflect on issues that are currently difficult to address by the adolescent., or; c) by the establishment of explicit actions of control. Coincidentally, during these three interactive scenarios, failures in the capacity of contingent communication of therapists are evidenced, which to a lesser or greater extent are manifested through controlling actions over adolescent patients. As has been observed throughout this study, when these control actions take place, ruptures tend to emerge. That is, to withdraw or to confront, would rather be a strategy that seeks to protect the self of an adult therapist who seems unavailable to be used as a source of social learning.
Why does a therapist, whose mission is to positively favor the therapeutic change of an adolescent who presents mental health problems, carry out actions that negatively impact the therapeutic process? A hypothesis is proposed to explain this phenomenon.

There is vast evidence indicating that clinical work with adolescents generates conditions that compromise the ability of therapists to maintain optimal levels of arousal (Russell, Shirk & Jungbluth, 2008; Fernández-González, Herrera-Salinas & Escobar-Martínez, 2016). Common issues such as the overwhelming emotions provoked by their intense inner world or the challenging task to maintain a level of awareness and constant alert about the relational effect of all the therapeutic interventions in a complex interactional context (Morán et al, 2019), would favor the emergence of non-mentalizing states in therapists. In this case, the state of psychic equivalence, characterized by the certainty that personal beliefs and perceptions represent reality, would be of particular relevance (see Bateman & Fonagy, 2006). The expert knowledge positioning provides the therapist with possible ways to redirect the process, without losing control of the clinical situation at times when their stress increases, but their ability to maintain focus in the present moment decreases. The lack of a “objectivity in parentheses” (see Maturana, 1997; Maturana & Pörksen, 2004) limits their curiosity and therefore their ability to contingently attune to the current affect of the patient. That is to say: although in the three interactional rupture scenarios that were identified a decrease in contingency was found, as hypothesized, this would rather be in response to a generalized failure of the opaqueness dimension.

From this moment, once control has been re-established, therapists would use their mentalization capacity in favor of their own objectives, maybe as a self regulatory strategy. This is why it would be possible to observe high levels of mentalization in the other dimensions, which would actually be permeated by a basic failure at the level of opaqueness. This type therapists responses would be experienced by patients as experiences of non-recognition, activating epistemic hypervigilance mechanisms that are particularly sensitive during this stage of the life cycle in situations such as these. As Church (1994) points out: "Because of their desire for autonomy, adolescents may be very sensitive to situations where they believe others are asserting their power or authority" (p. 105). As a result, as shown throughout this study, the mentalization of adolescents collapses during ruptures. This breakdown would follow the same pattern as in therapists: a) a drop in the focus in the present moment, which shows a difficulty in regulating affection, which; b) interferes with the ability
to maintain a position of opacity, which in turn; c) leads to the abandonment of collaboration and rather focuses on self-affirmation, revealing a decline in its level of contingency. However, unlike therapists, during these types of interactions, patients do not seem to be able to deploy efficient actions on their own to recover their capacity of mentalization.

To understand why the mentalization of young people is reactivated this radically during episodes of resolution, and in general, why it is possible to repair a situation that compromises the therapeutic bond this dramatically, it is necessary to remember an aspect that is at the basis of the concept of ruptures of the alliance. In the words of Safran and Muran (2006):

“Our conceptualization of the alliance rupture is compatible with contemporary psychoanalytic thinking about therapeutic enactments, insofar as it emphasizes the role of unconscious mutual influence between patient and therapist. To our way of thinking, alliance ruptures are essentially transference–countertransference enactments. They always contain both patient and therapist contributions” (p.288)

Thus, a rupture not only represents an action of withdrawal or confrontation against the immediate actions of the therapist, but also implies the reactivation of implicit and automatic, non-mentalized response patterns that are re-enacted in the present. Based on this conception, alliance ruptures become an opportunity for the negotiation of a mutual recognition, i.e. an existential encounter as persons (Kramer, Pascual-Leone, Despland, & De Roten, 2014). From the framework proposed by the theory of mentalization, reestablishing collaboration is a key aspect in working with adolescents. On the one hand, the recognition of the individuality of the other evidences the separation of minds, favoring a sense of autonomy - an aspect that has already been pointed out as central to adolescent development - and on the other hand, it allows for the deployment of the pedagogical role of the therapist, generating conditions for the strengthening of mentalization. This coincides with one of the few explicit references that Fonagy makes to connect the concepts of mentalization and rupture of the therapeutic alliance: "the patients’ devastation of having not been accurately perceived forces the dyad beyond the illusion of shared consciousness and creates an opportunity for each to have a 'mind of their own' at least in the patient's experience"(Fonagy, Gergely & Target, 2007, p.312).
According to the configurations that emerged in episodes of resolution it was found that at least in 88% of the cases, therapists establish actions that could be considered as potentially promoting the reactivation of the mentalization of adolescents for its use in collaborative terms. Despite that, there are interesting differences around the way these actions take place. In the first case ("effective promotion of mentalization"), which corresponds to almost 40% of all episodes of resolution, therapists seem to deliver a contingent response, syntonic to central aspects of the adolescents’ discomfort, inviting them to talk about them with a high focus in the present moment. This has the effect of an optimal restoration of the patient’s mentalization. On the other hand, in the case of the configurations denominated "collaborative reciprocity" and "clarifying interaction", which correspond to approximately 50% of resolutions, the actions of therapists seem to have as a central focus the regulation of the patients' stress, either based on a change in the level of the conversation, taking the intervention to a more concrete level, or based on an accompaniment in reviewing jointly and step by step, chronological and observable aspects that make up the focus of the discomfort.

These results show, on the one hand, that the mentalization of adolescents seems to be highly sensitive to being reactivated by the actions of therapists that contingently recognize the discomfort of patients. This questions, in a certain way, the idea that the therapeutic space is inherently resisted by adolescents. Rather, it seems that the resistance is against an adult who does not recognize the present experience of the adolescent and instead imposes models that do not resonate with him. In fact, a study that compared the communicative actions of adolescents and therapists during episodes of rupture and resolution evidenced that during resolutions, patients tended to use more frequently communicative intentions oriented towards achieving attunement with their therapists than the latter did with patients (González, Kremer, Pérez, Ulloa, & Morán, 2018).

Attachment theory, for example, emphasizes the need of adolescents to have other significant figures such as peers and other adults different to their parents, to fulfill attachment functions. This would play a developmental role because, as children grow older, they face a growing number of challenges and threats in settings in which only peers and nonparental adults are immediately accessible (Kobak, Rosenthal, Zajac, & Madsen, 2007). Thus, it seems that young adolescents need opportunities to form
relationships with adults who understand them and who are willing to support their development (Caskey & Anfara, 2007).

On the other hand, these results reflect that therapists preferably use strategies aimed at regulating the affect of patients instead of strategies that would allow for the meta-analysis of the interaction (which eventually occurs in resolutions denominated "effective promotion of mentalization"), an aspect central to the resolution of a rupture, as noted by Safran, Muran, Stevens & Rothman (2007):

“Once the rupture has been detected and the therapist realizes that both he or she and the client are caught in a cycle, the disembedding process, in which both the therapist and the client attempt to step back and communicate about what is going on, can begin. This process involves the therapist metacommunicating his or her observations about the cycle to the client (communicating about the communication process). No matter how the rupture began, the therapist must recognize, and be able to talk about, his or her own contribution to the cycle” (p 139).

In contrast to the proposal of these authors, if we consider that in many adolescents the capacity for mentalization manifests itself as a vulnerable and developing process, directly addressing the relationship level can be a highly challenging task for them. Bleiberg (2013) called this type of actions as "mentalizing the transference” and recommends it’s use as the final link in a chain of interventions aimed at promoting mentalization, only as the adolescent's level of arousal decreases. Rossouw (2017), on the other hand, explains that “many adolescent may suffer from profound feelings of inadequacy associated to great difficulty in regulating self-experience and experiencing positive self-regard. So, the first task is to reestablish an empathic alliance which could be oriented to promote concrete thinking in order to then restore mentalization” (p. 419). Thus, establishing a therapeutic alliance with an adolescent requires not only the act of promoting mentalization, but rather, the availability of the therapist to do so in a contingent manner and in line with the patient's current resources. This would be a key aspects to restoring collaboration and thus repairing the rupture.

An exception to the three resolution strategies previously described corresponds to the configuration called "control-submission". From what has been pointed out until now, the
low probability of reparation of this type of interactive scenario could be explained by a poor promotion of mentalization in the patient, produced by a low mentalization of the therapist. This reaffirms the hypothesis that the capacity of mentalization of the patient depends on the capacity of mentalization of therapists to reactivate it during these moments.

It is interesting to observe that during this type of configurations some adolescents seem to sustain the intervention, raising their levels of contingency - as if trying to "bring their therapists back" -, which coincides with what has already been pointed out before regarding the need of adolescents to have a figure of support for their mental states.

It is especially striking to see that during these interactive scenarios the repair of ruptures are characterized by the passive acceptance of what the therapist imposes, assimilating non-contingent mental states. This is coincident with what the literature has called alien-self (Fonagy, Gergely, Jurist, & Target, 2002; Bateman & Fonagy 2006; Bateman & Fonagy, 2012), that is, the introjection of a non contingent representation with one's own experience as a product of a failure in the empathic response of the adult, in this case, of the therapist.

8. CONCLUSION

The purpose of this study was to explore, from a psychotherapy process perspective, the role that mentalization would accomplish during ruptures and resolution episodes of the therapeutic alliance during interventions with adolescents. These moments have been theoretically defined as highly relevant for the advancement of psychotherapy with young people, however, to date, they have been scarcely studied during psychotherapy.

According to the hypotheses that guided this study, the results showed that in most of the evaluated dimensions both patients and therapists achieved lower ratings of mentalization during episodes of rupture in comparison to episodes of resolution (hypothesis 1) and, with the exception of contingent communication, therapists tended to show higher means of mentalization than patients (hypothesis 2). The presence of statistically significant differences in mentalization between actors and rupture-resolution interactive scenarios, as well as interaction effects for some dimensions, demonstrated that it is possible to explain
the variance of mentalization using each of these predictors (actor and interactive scenario) and, what is even more relevant for this investigation, to evaluate the presence of possible specific configurations of mentalization between actors in episodes of rupture and episodes of resolution. As it was possible to observe, 3 interactive scenarios in ruptures and 4 interactive scenarios in resolutions showed the best fit to describe the possible configurations of therapist-patient mentalization (hypothesis 3). In turn, each combination of rupture-resolution configuration demonstrated to have different probabilities of being repaired (hypothesis 4).

Taking these results together, in substantive terms, it is possible to argue that the mentalization processes of therapists and patients fulfill a regulatory structural function that allows for the description and explanation of the complex transactions experienced by therapists and adolescent patients during moments of rupture and resolution, and, to a certain extent, for the prediction of their outcome. This has several implications that will be reviewed below:

1. From the standpoint of dynamic systems, the existence of a regulatory function in psychotherapy, implies that all behaviors are simultaneously unfolding in the individual while at the same time continuously modifying and being modified by the changing behavior of the partner. In this way, therapeutic communication can be seen as a transaction, where relationship patterns reside in the dyadic system, not only in the individual (Fogel, 1992b; Stern 1989). Mentalization would be at the base of the self-regulation and co-regulation processes during rupture-resolution sequences, as a sort of background (Morán, Martínez, Arce & Tomicic, 2018), that moment by moment shapes and supports the verbal and non-verbal interactions that the therapist-patient dyad experiences (Beebe & Lachman, 1998).

Thus, the disturbances of mentalization could be a good model to explain ruptures of the therapeutic alliance since they virtually interrupt intersubjective communication, promoting states of hypervigilance in adolescents that limit their openness to be part of a system of actors that influence each other.

2. This idea, which can originally be attributed to Ferenczi (1932) and then to Alexander (1948) from the well-known concept of "corrective emotional experience", emphasizes conflict at the level of antagonistic motivational systems; an idea that since Freud has been a common element of psychoanalytic theory.
On the contrary, establishing a focus on structural aspects at the base of interactive scenarios of rupture and resolution involves conceptualizing these as resources and failures at the level of cognitive-emotional-procedural processing (OPD Working Group, 2008). This view, although not antagonistic to the proposal of Safran and Muran, may be relevant as a comprehensive model for psychotherapy with adolescents, since during this stage, as diverse evidence in neuroscience has shown, it is precisely the functions and structures that allow for the regulation of affect and intersubjective communication that are affected by the maturation of the brain, which in turn activates, and in some cases re-activates, conditions of vulnerability for the emergence/re-emergence of psychopathology.

The results of this study are consistent with this view, demonstrating that most of the therapists’ resolution strategies were aimed at favoring the regulation of the patients' affect (focus in the present moment), implicitly transmitting or explicitly demonstrating recognition (contingent communication) of their emotional experience, instead of promoting a meta-analysis of the historical and relational conditions associated to the rupture. Thus, and if future evidence supports it, it might be more appropriate to think of a model of discoordination-recoordination of the therapist-patient dyad than a model of rupture-resolution for working with adolescents.

This idea is consistent with Sander (1987): “when the directionality of both partners becomes joined, specificity of recognition becomes transforming, giving new continuity of coherence to the organization of both individual consciousness and the organization of both partners as a system” (p. 589). In the same way, Seligman (1991) describes the therapeutic process in terms of a renegotiation between therapist and patient of the terms and content of recognition.

3. From an ontogenetic conception, mentalization capacities would be, in part, a reflex of an attachments history that have led to the development of self-regulatory skills and social competence. That is, a sensitive caregiver who has "the mind of the child in mind" (Meins, 2001) is the basis for him or her to develop reflective skills that are vital for adaptation in complex interpersonal contexts. Far from being a static process, according to Beebe and Lachman (1994), the first year of life stresses interactive regulation because of the occurrence of ruptures and repairs that are crucial for the development of representation and internalization capacities.
By translating this idea into psychotherapy, it is possible to propose that this type of processes are re-updated in the clinical situation. Thus, addressing ruptures requires and promotes the development of mentalization and generates conditions for the consolidation of a therapeutic bond that allows the adolescent to trust in the mind of another source of cultural knowledge (Gergely & Csibra, 2006). For adolescents who evidence psychopathology, this is a pivotal notion, since the possibility of having a figure that promotes reflection, agency and relational capacity is a factor of resilience that has been shown to have a long-term protective effect (see Hauser et al. 2006). In the words of Winnicott (1969):

“Adolescence implies growth, and this growth takes time. And, while growing is in process, responsibility must be taken by parent figures. Adults are needed if adolescents are to have life and liveliness. Let the young alter society and teach grownups how to see the world afresh. But where there is the challenge of a growing boy or girl, there let an adult meet the challenge” (p.756).

4. Even though ruptures have been conceptualized as a phenomenon that responds to the interaction and mutual influence of the relational matrix of both subjects in psychotherapy, during this moments the role that both of them play seems to be particularly unequal. A clinical reading of the results of this study proposes that they are frequently triggered from a control positioning of the therapists, which is resisted by the patients. In particular, an increase in arousal in the face of interactions that are difficult to manage, eliciting prementalizing states has been proposed. This type of mentalizations promote interactions that also destabilize the mentalization of patients.

This phenomenon draws attention to the need for specialized training and the constant supervision of therapists working with adolescents. As has been commented throughout this work, it is evident that the establishment of a therapeutic alliance with adolescents tends to be a complex process that stresses the work of clinicians at all times and is subject to the emergence of multiple impasses with diverse members of the system that are often difficult to manage. This would explain the increase in stress and the possible effect on the mentalization capacity of therapists. However, until now nothing has been said to explain the controlling actions carried out by therapists, which, as they were described in this study (see Class-3 rupture, Class-4 resolution), may even have an iatrogenic nature or profoundly affect
the therapeutic alliance. Although several hypothesis underlie this, there is one that can be especially enlightening: infant-adolescent psychotherapy has been persistently characterized by the presence of adult-centered views, which historically have excluded girls, boys and adolescents and have tended to position adults as experts (Castillo-García, Castillejos-Zenteno, & Macias-Esparza, 2017), who asymmetrically faces an "underaged" person who is still in a developing stage into a moment in life when they will be able to fully integrate socially and to be respected" (UNICEF, 2013).

Recognizing that phenomena such as this could be at the basis of many of the ruptures experienced with adolescents invites us to question the cultural practices of therapists working with young people, and not only stimulate a review of one's own history, but also to promote a perspective of law as a central element in the training and supervision of adolescent psychotherapists.

Finally, it is important to address the main strengths, weaknesses and projections of this research. Regarding the strengths, the contribution of this study to psychotherapy process research with adolescents stands out, an area that, as has been pointed out throughout this work, has been less studied than adulthood. Particularly, this investigation attempts to contribute to the field of psychotherapy with adolescents, in the words of Hardy and & Llewelyn (2015), in the "development of theories, which provide the underpinning rationale and consequently offer a sound structure to the work of therapy "(p185). For this, it has been sought to integrate two variables that have proven to be relevant for the study of change in psychotherapy with adults, and to evaluate their contribution to the study of interventions with adolescents. To this extent, this research has sought to build bridges between theory, research and their application to clinical practice.

A second aspect to be highlighted is the use of latent class analysis to identify discrete categories of interventions with a clinical sense. This type of multivariate analysis has traditionally been used to identify groups using static data, for example through the response to questionnaires. In this case, it has been used to cross-sectionally analyze data that have a dynamic nature, serving as an input to propose possible patterns that shapes therapist-patient. The potential of LCA to propose discrete groups of interactions can be an interesting innovation for its use in psychotherapy process research. Third, the use of the OSMP-A is highlighted. This instrument, in its pilot version, proved to be reliable when used by
independent coders and allowed for an on-line observation of a complex phenomenon such as mentalization. Fourth, due to the essentially relational nature of mentalization, when studying ruptures and resolutions of the alliance through this perspective, it is impossible not to recognize the contribution of both actors to what happens in psychotherapy. This is relevant given that one of the main criticisms to the 3RS has been the lack of indicators to accurately identify the therapist's responsibility in ruptures (Colli & Lingiardi, 2009).

Among the main weaknesses of this study is the low number of psychotherapy processes analyzed. Although they allow to establish relevant conclusions about clinical work with adolescents, they do not necessarily reflect all possible interactions during ruptures. An example of this is that the cases analyzed are of medium and low complexity, with adolescents who had, in general, a good adherence to treatment (all completed at least 10 sessions). This does not reflect what the literature has termed "hard to reach patients" (Baruch, Fonagy, & Robins, 2007). In contexts like those, a study of this kind could be highly appropriate.

A second weakness of this study corresponds to the omission of the longitudinal nature of the data in the LCA. Due to the exploratory nature of this research, what was sought here was to identify interactive scenarios regardless of when they occurred, prioritizing nesting according to therapies. Despite that, it is possible to hypothesize that the inclusion of a longitudinal level could be rather associated to certain types of configurations having a higher probability of occurring at certain moments of the therapy, rather than having an effect on the type of configurations that emerge.

Third, "neutral episodes" were not evaluated to ensure that reflective functioning during ruptures or resolutions really differs from what occurs at other times and, therefore, it is not possible to ensure that these moments (rupture-resolution) are really distinctive for the study of therapeutic processes with adolescents. Despite that, the accumulated evidence seems to be consistent about the idea that this type of episodes would have a special relevance in the case of adolescents, and this is how the research problem was posed.

Regarding the projections of this study, at least three general ideas that may be relevant for the development of a future research line are proposed: a) As a way to validate these results in different groups, it is necessary to replicate this research with a greater number of cases, and the addition of more complex cases, or, considering specific populations such as:
adolescents with depression, suicidal ideation, behavioral disorders, eating disorders, substance use or borderline development of personality; b) To evaluate the association that exists between the frequency of occurrence of certain configurations and results such as therapeutic success and desertion. Of special interest for research in mentalization may also be to assess whether certain configurations are associated to improvements in reflective functioning; c) Conduct comparative studies between adolescents and adults, or adolescents and adults with similar diagnoses. This is relevant given that throughout this investigation it has been proposed that certain phenomena observed here would be characteristic of therapeutic processes with adolescents, and; d) In the field of clinical training, it is of particular interest to evaluate if this type of results allow for the establishment of intervention models with adolescents whose effectiveness can be evaluated.

REFERENCES


Lamey, A., Hollenstein, T., Lewis, M.D., & Granic, I (2004). Grid Ware (Version 1.1) [Computer software].


Meins, E., Fernyhough, C., Fradley, E., & Tuckey, M. (2001). Rethinking maternal sensitivity: Mothers' comments on infants' mental processes predict security of


Annex 1: Ethics Committee Approval Certificate
ACTA DE APROBACIÓN DE PROYECTO

FECHA: 27 de Septiembre de 2016.

PROYECTO: "FUNCION REGULADORA DE LA MENTALIZACIÓN EN LA SECUENCIA RUPTURA-RESOLUCIÓN DE LA ALIANZA TERAPEUTICA DURANTE PROCESOS DE PSICOTERAPIA CON ADOLESCENTES".

INVESTIGADOR RESPONSABLE: PSICÓLOGO JAVIER MORÁN KNEER.

INSTITUCIÓN: PROYECTO DE TESIS PARA OPTAR AL GRADO DE DOCTOR EN PSICOTERAPIA.TUTOR PROF. CLAUDIO MARTÍNEZ GUZMAN. DEPARTAMENTO DE PSICOLOGÍA UNIVERSIDAD DIEGO PORTALES Y PROFESOR JUAN PABLO JIMÉNEZ, DEPARTAMENTO DE PSIQUIATRÍA HOSPITAL SALVADOR, CAMPUS ORIENTE, FACULTAD DE MEDICINA, UNIVERSIDAD DE CHILE.

Con fecha 27 de Septiembre de 2016, el proyecto ha sido analizado a la luz de los postulados de la Declaración de Helsinki, de la Guía Internacional de Ética para la Investigación Biomédica que involucra sujetos humanos CIOMS 1992, y de las Guías de Buena Práctica Clínica de ICH 1996.

Sobre la base de la información proporcionada en el texto del proyecto el Comité de Ética de Investigación en Seres Humanos de la Facultad de Medicina de la Universidad de Chile, estima que el estudio propuesto está bien justificado y que no significa para los sujetos involucrados riesgos físicos, psíquicos o sociales mayores que mínimos.

En virtud de las consideraciones anteriores el Comité otorga la aprobación ética para la realización del estudio propuesto, dentro de las especificaciones del protocolo.

Este comité también analizó y aprobó el correspondiente documento de Consentimiento Informado en su versión Original de fecha 08 de Julio de 2016.

Se extiende este documento por el periodo de un año a contar desde la fecha de aprobación prorrogable según informe de avance y seguimiento bioético.

LUGAR DE REALIZACIÓN DEL ESTUDIO:

- Centro de Atención Psicológica (CAPSI) Escuela de Psicología Universidad de Valparaíso.

Teléfono: 29789536  - Email: comiteceish@med.uchile.cl
Annex 2: Inform Consent for responsible adult

CONSENTIMIENTO INFORMADO ADULTO RESPONSABLE

PATROCINANTE: Ps. Claudio Martínez, PhD.
Nombre del Investigador principal: Ps. Javier Moran
R.U.T. 13.848.452-1
Institución: Universidad de Chile
Teléfonos: +56 9 82339156, +56 32 2508603

Invitación a participar: Estamos invitando a ___________________________ a participar en el proyecto de investigación “Función reguladora de la Mentalización en la secuencia ruptura-resolución de la alianza terapéutica durante procesos de psicoterapia con adolescentes”. Este estudio se lleva a cabo como respuesta a la necesidad de conocer más sobre los momentos en que surgen problemas en la relación entre los terapeutas y pacientes adolescentes. Estos problemas se manifiestan generalmente como desacuerdos y dificultades mutuas en la forma de llevar adelante la terapia. Otras investigaciones han mostrado que cuando estos problemas se resuelven, muchas veces ayudan a que la terapia tenga más aporte para los pacientes. De lo contrario, cuando no se resuelven y se reiteran, pueden llevar a que los pacientes terminen prematuramente los tratamientos.

Objetivos: Esta investigación tiene por objetivo conocer el rol que cumple la capacidad de reflexión de terapeutas y pacientes durante momentos de la terapia en que se observan problemas en la relación entre ellos, y luego, en momentos en que intentan resolver estas dificultades. El estudio incluirá a un número total de 15 pacientes adolescentes entre los 14 y los 20 años que vayan a iniciar un proceso de psicoterapia.

Procedimientos: Si Ud. acepta que el menor de edad del cual es usted responsable participe, el único procedimiento involucrado consistirá en la grabación de todas las sesiones de psicoterapia a las que éste asista en formato audio-video a través de una cámara.

Riesgos: No se estiman riesgos en los procedimientos de este estudio. Sin embargo, a veces el uso de cámaras puede generar incomodidad durante el transcurso de las sesiones. En caso de ser así, esto podrá ser comunicado al terapeuta que realiza la intervención y eventualmente detener el proceso de grabación.

Costos: la participación en este estudio no implica costos adicionales para usted.

Beneficios: Además del beneficio que este estudio significará para el progreso del conocimiento en el área de la psicoterapia con adolescentes y el mejor tratamiento de futuros pacientes, su participación en este estudio le permitirá tener un proceso de psicoterapia sin costo para el adolescente del cual usted es responsable.

Alternativas: Si Ud. decide no participar en esta investigación, el adolescente del cual es usted responsable de todas maneras recibirá el tratamiento psicoterapéutico adecuado y que se aplica habitualmente en el centro de salud.

Compensación: Ud. no recibirá ninguna compensación económica por su participación en el estudio.

Confidencialidad: Toda la información derivada de la participación del menor en este estudio será conservada en forma de estricta confidencialidad, lo que incluye el acceso de los investigadores o agencias supervisoras de la investigación. El material de esta investigación se mantendrá guardado en un computador con clave en la Escuela de Psicología de la Universidad de Valparaíso del que será responsable el investigador principal, y podrá ser utilizado solamente con fines de análisis para esta investigación u otros estudios futuros similares. Cualquier publicación o comunicación científica de los resultados de la investigación será completamente anónima. Las transcripciones de las sesiones, omitirán cualquier mención a nombres y lugares. El producto de la observación de videos será traspasado a bases de datos anonimizadas.
Tanto los transcriptores como los codificadores quienes tendrán acceso a los videos, firmarán un compromiso de confidencialidad.

**Usos potenciales de los resultados de la investigación:** los resultados de esta investigación podrían ser publicados en revistas de difusión científica o ser presentados en congresos y jornadas académicas, resguardando siempre la confidencialidad y el anonimato.

**Información adicional:** Ud. o el terapeuta del adolescente bajo su responsabilidad serán informados si durante el desarrollo de este estudio surgen nuevos conocimientos o complicaciones que puedan afectar su voluntad de continuar participando en la investigación.

**Voluntariedad:** Su participación en esta investigación es totalmente voluntaria y se puede retirar en cualquier momento comunicándolo al investigador y al terapeuta del adolescente a su cargo, sin que ello signifique modificaciones en el proceso de psicoterapia del que actualmente se participa. De igual manera el terapeuta o el investigador podrán determinar el retiro del adolescente a su cargo del estudio si consideran que esa decisión va en beneficio de éste.

**Complicaciones:** No se considera que existan complicaciones derivadas del proceso de registro de las sesiones. Si así fuera, el proceso puede ser detenido por voluntad del paciente, del terapeuta, o de ambos.

**Derechos del participante:** Usted recibirá una copia íntegra y escrita de este documento firmado. Si usted requiere cualquier otra información sobre su participación en este estudio puede comunicarse con:

Investigador: Javier Morán. Teléfono: +56 32 2508603
Autoridad de la Institución: Gonzalo Lira. Teléfono: +56 32 2508600

**Otros Derechos del participante**
En caso de duda sobre sus derechos debe comunicarse con el Presidente del “Comité de Ética de Investigación en Seres Humanos”, Dr. Manuel Oyarzún G., Teléfono: 2-978.9536, Email: comiteceish@med.uchile.cl, cuya oficina se encuentra ubicada a un costado de la Biblioteca Central de la Facultad de Medicina, Universidad de Chile en Av. Independencia 1027, Comuna de Independencia.

**Conclusión:**
Después de haber recibido y comprendido la información de este documento y de haber podido aclarar todas mis dudas, otorgo mi consentimiento para la participación de ______________________________________________ en el proyecto “Función reguladora de la Mentalización en la secuencia ruptura-resolución de la alianza terapéutica durante procesos de psicoterapia con adolescentes”.

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Si se trata de un paciente con discapacidad psíquica o intelectual, registrar nombre del paciente y de su apoderado, en cumplimiento artículo 28 ley 20.584.

**Annex 3: Agreement for adolescents under 18 years**
ASENTIMIENTO INFORMADO PARTICIPANTE

PATROCINANTE: Ps. Claudio Martínez, PhD.
Nombre del Investigador principal: Ps. Javier Moran
R.U.T. 13.848.452-1
Institución: Universidad de Chile
Teléfonos: +56 9 82339156, +56 32 2508603

Invitación a participar: Le estamos invitiendo a participar en el proyecto de investigación “Función reguladora de la Mentalización en la secuencia ruptura-resolución de la alianza terapéutica durante procesos de psicoterapia con adolescentes”. Este estudio se lleva a cabo como respuesta a la necesidad de conocer más sobre los momentos en que surgen problemas en la relación entre los terapeutas y pacientes adolescentes. Estos problemas se manifiestan generalmente como desacuerdos y dificultades mutuas en la forma de llevar adelante la terapia. Otras investigaciones han mostrado que cuando estos problemas se resuelven, muchas veces ayudan a que la terapia tenga más aporte para los pacientes. De lo contrario, cuando no se resuelven y se reiteran, pueden llevar a que los pacientes terminen prematuramente los tratamientos.

Objetivos: Esta investigación tiene por objetivo conocer el rol que cumplen las capacidades de reflexión de los terapeutas y de los pacientes durante momentos de la terapia en que se observan problemas en la relación entre éstos y momentos en que se intenta resolver estas dificultades.
El estudio incluirá a un número total de 15 pacientes adolescentes entre los 14 y los 20 años que vayan a iniciar un proceso de psicoterapia.

Procedimientos: Si Ud. acepta participar, el único procedimiento involucrado consistirá en la grabación de todas las sesiones de psicoterapia a las que asista en formato audio-video a través de una cámara.

Riesgos: No se estiman riesgos en los procedimientos de este estudio. Sin embargo, a veces el uso de cámaras puede generar incomodidad durante el transcurso de las sesiones. En caso de ser así, esto podrá ser comunicado al terapeuta que realiza la intervención y eventualmente detener el proceso de grabación.

Costos: la participación en este estudio no implica costos adicionales para el adulto responsable de usted.

Beneficios: Además del beneficio que este estudio significará para el progreso del conocimiento en el área de la psicoterapia con adolescentes y el mejor tratamiento de futuros pacientes, su participación en este estudio le permitirá tener un proceso de psicoterapia sin costo para usted.

Alternativas: Si Ud. decide no participar en esta investigación recibirá el tratamiento que se aplica habitualmente en el centro de salud.

Compensación: Ud. no recibirá ninguna compensación económica por su participación en el estudio.

Confidencialidad: Toda la información derivada de la participación del menor en este estudio será conservada en forma de estricta confidencialidad, lo que incluye el acceso de los investigadores o agencias supervisoras de la investigación. El material de esta investigación se mantendrá guardado en un computador con clave en la Escuela de Psicología de la Universidad de Valparaíso del que será responsable el investigador principal, y podrá ser utilizado solamente con fines de análisis para esta investigación u otros estudios futuros similares. Cualquier publicación o comunicación científica de los resultados de la investigación será completamente anónima.
Las transcripciones de las sesiones, omitirán cualquier mención a nombres y lugares. El producto de la observación de videos será traspasado a bases de datos anonimizadas.
Tanto los transcriptores como los codificadores quienes tendrán acceso a los videos, firmarán un compromiso de confidencialidad.
Usos potenciales de los resultados de la investigación: los resultados de esta investigación podrían ser publicados en revistas de difusión científica o ser presentados en congresos y jornadas académicas, resguardando siempre la confidencialidad y el anonimato.

Información adicional: Ud. o terapeuta serán informados si durante el desarrollo de este estudio surgen nuevos conocimientos o complicaciones que puedan afectar su voluntad de continuar participando en la investigación.

Voluntariedad: Su participación en esta investigación es totalmente voluntaria y se puede retirar en cualquier momento comunicándolo al investigador y a su terapeuta, sin que ello signifique modificaciones en el proceso de psicoterapia del que actualmente participa. De igual manera su terapeuta o el investigador podrán determinar su retiro del estudio si consideran que esa decisión va en su beneficio.

Complicaciones: No se considera que existan complicaciones derivadas del proceso de registro de las sesiones. Si así fuera, el proceso puede ser detenido por voluntad del paciente, del terapeuta, o de ambos.

Derechos del participante: Usted recibirá una copia íntegra y escrita de este documento firmado. Si usted requiere cualquier otra información sobre su participación en este estudio puede comunicarse con:

Investigador: Javier Morán. Teléfono: +56 32 2508603
Autoridad de la Institución: Gonzalo Lira. Teléfono: +56 32 2508600

Otros Derechos del participante
En caso de duda sobre sus derechos debe comunicarse con el Presidente del “Comité de Ética de Investigación en Seres Humanos”, Dr. Manuel Oyarzún G., Teléfono: 2-978.9536, Email: comiteceish@med.uchile.cl, cuya oficina se encuentra ubicada a un costado de la Biblioteca Central de la Facultad de Medicina, Universidad de Chile en Av. Independencia 1027, Comuna de Independencia.

Conclusión:

Después de haber recibido y comprendido la información de este documento y de haber podido aclarar todas mis dudas, otorgo mi consentimiento para participar en el proyecto “Función reguladora de la Mentalización en la secuencia ruptura-resolución de la alianza terapéutica durante procesos de psicoterapia con adolescentes”.

Nombre del sujeto ____________________ Firma ____________________ Fecha __________
Rut. ____________________

Nombre de informante ____________________ Firma ____________________ Fecha __________
Rut. ____________________

Nombre del investigador ____________________ Firma ____________________ Fecha __________
Rut. ____________________

Si se trata de un paciente con discapacidad psíquica o intelectual, registrar nombre del paciente y de su apoderado, en cumplimiento artículo 28 ley 20.584.
Annex 4: Inform Consent for therapist

CONSENTIMIENTO INFORMADO TERAPEUTA

PATROCINANTE: Ps. Claudio Martínez, PhD.
Nombre del Investigador principal: Ps. Javier Moran
R.U.T. 13.848.452-1
Institución: Universidad de Chile
Teléfonos: +56 9 82339156, +56 32 2508603

Invitación a participar: Le estamos inviando a participar en el proyecto de investigación “Función reguladora de la Mentalización en la secuencia ruptura-resolución de la alianza terapéutica durante procesos de psicoterapia con adolescentes”. Este estudio se lleva a cabo como respuesta a la necesidad de conocer más sobre los momentos en que surgen problemas en la relación entre los terapeutas y pacientes adolescentes. Estos problemas se manifiestan generalmente como desacuerdos y dificultades mutuas en la forma de llevar adelante la terapia. Otras investigaciones han mostrado que cuando estos problemas se resuelven, muchas veces ayudan a que la terapia tenga más aportes para los pacientes. De lo contrario, cuando no se resuelven y se reiteran, pueden llevar a que los pacientes terminen prematuramente los tratamientos.

Objetivos: Esta investigación tiene por objetivo conocer el rol que cumplen las capacidades de reflexión de los terapeutas y de los pacientes durante momentos de la terapia en que se observan problemas en la relación entre éstos y momentos en que se intenta resolver estas dificultades.
El estudio incluirá a un número total de 15 pacientes adolescentes entre los 14 y los 20 años que vayan a iniciar un proceso de psicoterapia.

Procedimientos: Si Ud. acepta participar, el único procedimiento involucrado consistirá en la grabación de todas las sesiones de psicoterapia que realice con un paciente adolescente en formato audio-video a través de una cámara.

Riesgos: No se estiman riesgos en los procedimientos de este estudio. Sin embargo, a veces el uso de cámaras puede generar incomodidad durante el transcurso de las sesiones. En caso de ser así, esto podrá ser comunicado al investigador responsable y eventualmente detener el proceso de grabación.

Costos: la participación en este estudio no implica costos adicionales para el consultante.

Beneficios: Además del beneficio que este estudio significará para el progreso del conocimiento en el área de la psicoterapia con adolescentes y el mejor tratamiento de futuros pacientes, la participación en este estudio le permitirá a su paciente tener un proceso de psicoterapia sin costo.

Alternativas: Si usted o su paciente deciden no participar en esta investigación, se realizará el tratamiento que se aplica habitualmente en el centro de salud.

Compensación: Ud. no recibirá ninguna compensación económica por su participación en el estudio.

Confidencialidad: Toda la información derivada de su participación en este estudio será conservada en forma de estricta confidencialidad, lo que incluye el acceso de los investigadores o agencias supervisoras de la investigación. El material de esta investigación se mantendrá guardado en un computador con clave en la Escuela de Psicología de la Universidad de Valparaíso del que será responsable el investigador principal, y podrá ser utilizado solamente con fines de análisis para esta investigación u otros estudios futuros similares. Cualquier publicación o comunicación científica de los resultados de la investigación será completamente anónima. Las transcripciones de las sesiones, omitirán cualquier mención a nombres y lugares. El producto de la observación de videos será traspasado a bases de datos anonimizadas.
Tanto los transcriptores como los codificadores quienes tendrán acceso a los videos, firmarán un compromiso de confidencialidad.

**Usos potenciales de los resultados de la investigación:** los resultados de esta investigación podrían ser publicados en revistas de difusión científica o ser presentados en congresos y jornadas académicas, resguardando siempre la confidencialidad y el anonimato.

**Información adicional:** Ud. o su paciente serán informados si durante el desarrollo de este estudio surgen nuevos conocimientos o complicaciones que puedan afectar su voluntad de continuar participando en la investigación.

**Voluntariedad:** Su participación en esta investigación es totalmente voluntaria y se puede retirar en cualquier momento comunicándolo al investigador, sin que ello signifique modificaciones en el proceso de psicoterapia que actualmente conduce. De igual manera usted o el investigador principal podrán determinar el retiro de su paciente del estudio si consideran que esa decisión va en su beneficio.

**Complicaciones:** No se considera que existan complicaciones derivadas del proceso de registro de las sesiones. Si así fuera, el proceso puede ser detenido por voluntad del paciente, del terapeuta, o de ambos.

**Derechos del participante:** Usted recibirá una copia íntegra y escrita de este documento firmado. Si usted requiere cualquier otra información sobre su participación en este estudio puede comunicarse con:

Investigador: Javier Morán. Teléfono: +56 32 2508603
Autoridad de la Institución: Gonzalo Lira. Teléfono: +56 32 2508600

**Otros Derechos del participante**
En caso de duda sobre sus derechos debe comunicarse con el Presidente del “Comité de Ética de Investigación en Seres Humanos”, Dr. Manuel Oyarzún G., Teléfono: 2-978.9536, Email: comiteceish@med.uchile.cl, cuya oficina se encuentra ubicada a un costado de la Biblioteca Central de la Facultad de Medicina, Universidad de Chile en Av. Independencia 1027, Comuna de Independencia.

**Conclusión:**
Después de haber recibido y comprendido la información de este documento y de haber podido aclarar todas mis dudas, otorgo mi consentimiento para participar en el proyecto “Función reguladora de la Mentalización en la secuencia ruptura-resolución de la alianza terapéutica durante procesos de psicoterapia con adolescentes”.

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Si se trata de un paciente con discapacidad psíquica o intelectual, registrar nombre del paciente y de su apoderado, en cumplimiento artículo 28 ley 20.584.

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<th>Description</th>
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<tr>
<td>5 pts</td>
<td>Very focused, a focused intensity that is reflected in the posture and face and manner of speech</td>
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<tr>
<td>4 pts</td>
<td>Clearly focused and engaged, but not as intense as above</td>
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<td>3 pts</td>
<td>Hears what is being said and/or may be talking some, but appears to somehow not be as engaged in the process (speech may lack descriptive detail).</td>
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<tr>
<td>2 pts</td>
<td>Seems to be somewhat distracted and not really reacting in consort with the therapist</td>
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<tr>
<td>1 pts</td>
<td>Does not appear focused on what is transpiring/ being said at all</td>
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<th>Withdrawal</th>
<th>Description</th>
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<td>Denial</td>
<td>Patient denies a feeling state that is manifestly evident, or patient denies the importance of interpersonal relationships or events (e.g., rationalization). Note that this is not the same as “being in denial” or denial as a defense mechanism.</td>
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</table>
|                             | Therapist: *You look upset.*  
Patient: *I’ll be fine. Don’t worry about me.*                                                                            |
| Minimal response            | Patient gives minimal responses to therapist’s efforts to explore and understand patient’s experience (e.g., patient responds with short, clipped answers to open-ended, exploratory questions). Giving no response—going silent—would be the ultimate minimal response. However, note that the minimal response must be in the context of a withdrawal—a short response that is appropriate to the situation is not coded here. |
|                             | Therapist: *That sounds like it was very difficult. How did it make you feel?*  
Patient: *(Shrugs.)*                                                                                     |
| Abstract Communication      | Patient avoids contacting painful or negative feelings by using abstract language when talking about difficult interpersonal situations or issues. The patient may intellectualize by focusing on rational concepts and complex terminology. Or the patient may make vague, global statements that allude to an issue that is relevant to the therapeutic relationship, rather than directly stating his/her true feelings. |
|                             | Therapist: *Did it bother you when I said that?*  
Patient: *I was confused, but I think it’s OK for things to be confusing a little every once in a while. It makes you think about it more and you can learn from it.* |
| Avoidant Storytelling and/or Shifting Topic | Patient tells stories and/or shifts the topic in an effort to avoid distressing topics or issues or situations. This can include trying to avoid conflict with the therapist by telling entertaining stories. These stories may be long and overly elaborate, or they can be relatively brief. They may go off on a tangent, or they may eventually return back to the topic at hand. The key is that by shifting the topic and/or telling a story, the patient avoids clear, direct communication with the therapist. Remember that the story or topic shift must be part of a withdrawal. Thus, for example, if a patient shifts the topic not to avoid, but rather to enhance the work of therapy, this would not be coded here (e.g., “I know that we were talking about my job, but I just remembered something that happened with my boyfriend that I really want to discuss with you…”).  
A story that is relevant and productive, but still seems to have an avoidant quality (e.g., somewhat circumstantial, somehow shutting out the therapist), could receive a check minus.  
Talking about someone else’s reactions or the reactions of “most people” in an effort to avoid talking about oneself should also be coded here. |
|                             | Therapist: *How do you think things are going so far in our work together?*  
Patient: *That sounds like a performance review question. I had a performance review at work last week, and it was so stressful…* |
| Deferential and appeasing    | Patient appears overly compliant and submits to the therapist in an excessively deferential manner.                                                                                                         |
|                             | Therapist: *How was the homework?*  
Patient: *Oh, it was so helpful. You give such wonderful advice.*                                                      |
| Content/Affect split        | Content of patient’s narrative does not match his/her affective expression                                                                                                                                   |
Therapist: It’s hard for you to tell me about those sad feelings.
Patient (smiling): Yes, it is. It’s not easy to talk about.

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<th>Self-criticism and/or hopelessness</th>
<th>The patient withdraws from the interaction with the therapist by becoming absorbed in a depressive process of self-criticism and/or hopelessness that seems to shut out the therapist and close off any possibility that the therapist or the treatment can help the patient. The patient may engage in this process as a means of avoiding conflict with the therapist. Note that patients can be self-critical or hopeless but still be engaged in the interaction with the therapist, and can explore these feelings with the therapist in a collaborative way. To receive the self-criticism/hopelessness code, the patient’s behavior must be contributing to a withdrawal. Therapist: That sounds important. Can you tell me more about that? Patient: (Sighs). What’s the point? It’s not going to make me feel better. I’m too far gone.</th>
</tr>
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| Confrontation | Complaints/concerns about the therapist | Patient feels negatively about or toward the therapist. Patient may feel negative feelings (e.g., angry, impatient, distrustful, manipulated, hurt, judged, controlled, rejected), or may feel that therapist has failed to support, encourage, or respect him/her. The patient may criticize the therapist’s interpersonal style, or express doubts about the therapist’s competence. Patient: I was thinking about some of the things that you said last week. I wasn’t very happy about them. Not so much what you said, actually, more the way you said them. You were pushing me into a corner. I wouldn’t have thought that was the way to go about helping people. |
|---|---|
| Complaints/concerns about the activities of therapy | Patient expresses dissatisfaction or discomfort with therapy tasks and/or goals in a noncollaborative manner. Patient: I really don’t understand what you’re asking me to do on these thought records. I don’t see the point of them at all. |
| Complaints/concerns about the parameters of therapy | This includes complaints and concerns about the therapy schedule (e.g., appointment times, session length, number and frequency of sessions) and the research contract (e.g., completing questionnaires, being videotaped). Patient: (hostile tone). Once a week is not enough. How on earth can I get better if I only come once a week? |
| Complaints/concerns about progress in therapy | Patient is doubtful of the progress that can be made or has been made in therapy. Patient: I’ve been coming here for four weeks now, and I really can’t think of anything that has changed. Maybe this has all been a waste of time. |
| Patient defends self against therapist | Patient defends his/her thoughts, feelings, or behavior against what he/she perceives to be the therapist’s criticism or judgment of the patient. Do not code if the patient is defending him or herself against criticism from another person. Note that the therapist does not have to actually criticize the patient for the patient to anticipate criticism and become defensive. |
Therapist: *That makes a lot of sense.*
Patient: *Of course it does! I’m not an idiot!*

| **Direct efforts to control/pressure therapist** | Patient directly attempts to control the therapist, e.g., patient tells the therapist what to do, patient puts pressure on therapist to fix the patient’s problems quickly.  
Patient: *I’m tired of wasting time. I want to know how this therapy works. Tell me how it’s going to help me with my problems. And none of that fancy therapist talk; I want a direct answer.* |
| **Miscellaneous** | A rupture that does not fit in any of the above categories. Ruptures where the patient seems to be doing something inappropriate in the context of the therapy relationship fit here. For example, patient is flirtatious and seductive; patient calls the therapist “hon”; patient says “Yo, what’s up?” to the therapist in a way that feels inappropriately casual. |
| **Miscellaneous (e.g., seductive behavior, overly friendly and casual behavior)** |

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<th>Resolution Strategies</th>
<th>Example</th>
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| Therapist clarifies a misunderstanding. | Therapist clarifies a misunderstanding. Generally, the resolution effort stops here; the therapist does not go on to explore the underlying significance of the misunderstanding or to try to link it to the patient’s core themes.  
Therapist: *You seem a little distant right now.*  
Patient: *Well, I guess I was a little bothered about what you said about how I should apologize to my sister.* Therapist: *No, no, I said that I think your sister should apologize to you.* Patient: *Oh (smiling). I must have misheard you. I wish she would apologize...* |
| Therapist changes tasks or goals. | Patient: *We’re getting off track again. I don’t think this is getting us anywhere.* Therapist: *I’m willing to follow your lead right now. What direction would you like to go in?* |
| Therapist illustrates tasks or provides a rationale for treatment. | This resolution strategy involves providing a justification of the treatment. Do not code if the therapist simply demonstrates how to do homework, for example. The therapist must take an additional step of providing an explanation or rationale for how the task or treatment works.  
Therapist: *I’d like to spend some time trying to understand what’s going on between us right now. My hope is that this type of exploration may provide us with some clues as to what may go on for you in your relationship with other people.*  
Sometimes this may be in the form of reframing the meaning of tasks or goals in response to the patient’s concerns/complaints. When the therapist reframes the meaning of tasks or goals, he/she describes the tasks or goals in a way that is more appealing to the patient.  
*An patient is reluctant to complete a homework assignment that involves increasing social contact because he fears rejection. The therapist reframes the assignment as “putting yourself into the anxiety-provoking situation in order to self-monitor your cognitive processes.”* |
| Within the context of a rupture, the therapist invites the patient to discuss thoughts or feelings with respect to the therapist or some aspect of therapy. | The therapist invites the patient to directly express negative sentiments or vulnerability that the patient has been communicating in an indirect or equivocal manner. This involves more than simply reflecting the patients’ negative or vulnerable feelings; the therapist actively encourages the patient to stand behind a complaint or to contact vulnerable feelings. Patient: *I’m feeling a little irritated, but it’s not a big deal.* Therapist: *I understand that you’re uncertain about how important your concerns are. But if you’re willing to go into it, I’d be interested in hearing more.* |
| Within the context of a rupture, the therapist discloses his/her internal experience of the relationship. | Therapist 3: *I’m trying to answer your question, but I get the sense that nothing I say to you will be satisfying right now. I’m concerned I will antagonize you further if I continue to try.* |
| Within the context of a rupture, the therapist explicitly acknowledges his/her contribution to a problem in the relationship | Therapist1: *I could see how this could be frustrating for you. You’re asking me for a direct answer and I keep putting the ball back in your court.*  
Therapist 2: *I’m aware of my attention wandering right now...I’m not sure what is going on but I think it may have something to do with the distant sound in your voice.* |
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<tr>
<th>Therapist links the rupture to larger interpersonal patterns between the patient and the therapist.</th>
<th>The patient has difficulty articulating what she wants to focus on in the session, and criticizes herself for being confused and disorganized. The therapist observes how the patient tends to blame herself for any misunderstandings that arise between them.</th>
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<tr>
<td>Therapist links the rupture to larger interpersonal patterns in the patient’s other relationships.</td>
<td>The patient has difficulty asking the therapist for a different session time. The therapist links this to the patient’s lack of assertiveness in her relationships with her family and co-workers.</td>
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<tr>
<td>Therapist justifies the patient’s defensive posture.</td>
<td>Therapist allies with the resistance. Instead of challenging the patient’s defensive behaviors, the therapist validates the ways in which they are understandable and adaptive. This is more than just reflecting back the patient’s own explanations for his/her behavior—this involves explicitly stating that the patient’s position is legitimate and valid. A patient cries in session, and then becomes self-conscious and begins to speak in a distant, intellectualized fashion. The therapist observes that the patient now seems distant from her pain, and says, “Perhaps it’s adaptive for you to have some distance from it right now.”</td>
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**Annex 8: OSMP-A coding system scales**

**Focus on mental states scale**: assess the capacity to establish and maintain a productive/consistent focus on mental states, including cognitions and affects (personal/inner world) linked to descriptions of observable behavior and events (shared/external world).

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<tr>
<td>Therapist</td>
<td>Therapist is excessively focused on observable and external aspects such as behavior or concrete events, so that mental states are not considered. As a result, an important opportunity to enhance mental states for the patient is lost.</td>
<td>Mental states may be mentioned but they are not linked clearly to present and past behavior. As a result, therapeutic remarks about mental states do not appear to enhance reflective functioning in the patient. Therapist assumes a passive attitude (silent/disavowing) or is too focused on external aspects to enable full inclusion of mental state considerations. Opportunities to promote the usage of mental states on the patient are very limited.</td>
<td>Addressing mental states on the patient can be considered as a part of the intervention, although they do not appear to be the main focus. As a result, the usage of mental states is partially promoted in the patient, but important opportunities to enhance their usage in a deeper way are not picked up.</td>
<td>The majority of interventions are clearly oriented to enhancing the usage of mental states in the patient. Therapist performs interventions that demand reflection on cognitions/beliefs/considerations and affects/feelings/wishes re self and others. As a result, the usage of mental states could be significantly enhanced.</td>
<td>Therapist can clearly be described as actively enhancing the usage of mental states in the patient by elaborating questions and performing interventions that demand reflecting about cognitions and affects on self and others. Events and behavior can be integrated as an important complement that enriches reflection. As a result, the usage of mental states could be clearly and deeply enhanced.</td>
</tr>
<tr>
<td>Patient</td>
<td>Patients discourse is predominantly focused on behavior, actions and description of events, without explicit reference to mental states. If demand questions are made, a focus on external aspects remains.</td>
<td>Mental states are just circumstantially considered, thus not a relevant part of patients discourse. The main focus of it’s discourse is oriented to describe observable actions and events instead of reflexing on cognition and affects. If demand questions are made, mental states keeps being circumstantially used.</td>
<td>Mental states are clearly considered in the patients discourse, however not as its main focus. Unlike descriptions of external events and behavior, reflection processes can be identified.</td>
<td>Patients discourse is predominantly focused on mental states which can be clearly used for reflection over a mere description of events and behavior.</td>
<td>Patient shows an intrinsic motivation to establish a focus on mental states, which can be seen as a spontaneous desire to reflect, share and explain in deep its experience.</td>
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Opaqueness of mental states scale: assesses the explicit effort to mark out the separateness of minds in a dialogical stance which reflects that one can’t be sure of the experience of others, including the therapist. Its counterpart implies assertions which denote the listener “knows” or is “completely sure” of what is happening on the mind of others, a phenomenon that has been called psychic equivalence by Bateman & Fonagy (2016).

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<tr>
<td>Therapist</td>
<td>Therapist seems to know for sure what is going on in the mind of the patient or &quot;how things really are&quot;, assuming an expert attitude relative to his/her inner world. Intervention lacks curiosity regarding the patients experience.</td>
<td>Unlike an expert attitude relative to patients inner world, that makes the therapist looks like knowing for sure what is going on in the mind of it party or &quot;how things really are&quot;, some interventions oriented to ask the patient for aspects still unclear are made.</td>
<td>Therapist makes an effort towards an understanding of the experience of the patient, showing curiosity and assuming a collaborative role. Interventions are oriented to understand the patient's experience, not strategically directed towards an objective that is intended to be pointed out. As a whole, the recognition of the opaqueness of mental states can be only deductively established because of the attitude of the therapist.</td>
<td>Most of their interventions denotes curiosity and explicit uncertainty of the experience of the patient. The impossibility of directly accessing the others (including the patient) inner world can either be explicitly pointed out or more implicitly integrated into the discourse (&quot;I wonder if...&quot;, &quot;that makes me think about...&quot;) indicating that the intervention is based on the therapist own experience. As a whole, the recognition of the opaqueness of mental states is considered and integrated into the intervention, but not as a central aspect of it.</td>
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<tr>
<td>Patient</td>
<td>Patients seems to know for sure what is going on in others minds and &quot;how things really are&quot;, experiencing its own mental states as the only truth. It is possible to appreciate an increase of the arousal, manifested to as overflowing affection and non-integrated, inaccurate or even bizarre speech.</td>
<td>Although his attitude denotes certainty about the inner mental states of others (therapist included) and &quot;how things really are&quot;, yet shows aspects of the others that are beyond its knowledge and understanding.</td>
<td>Patient talks about the mental states of others (therapist included), offering additional information that allows to recognize the possible accuracy of these perceptions. Though he/she does not assume an expert attitude upon others inner world, the opaquenes of mental states is not explicitly shown and can only be deductively established by its curiosity and/or opennes to imagine mental states on other.</td>
<td>Patient talks about the mental states of others (therapist included) offering additional information that allows to recognize the possible accuracy of these perceptions and includes some assertions that explicitly show that this is its own point of view (&quot;I think...&quot;, &quot;I believe...&quot;) and is not completely sure (&quot;maybe...&quot;, &quot;perhaps...&quot;). Most of the time assumes an open and curious attitude in relation to others mental states.</td>
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**Contingent communication scale**: This dimension is rooted on the assumption that psychotherapy can be considered as a dialogical context of mutual influence between a patient and a therapist. Since that consideration, is expected a collaborative interaction in which, no matter the role, both parties actively try to work together in the construction of a coherent shared narrative. In other words, there is a sense of connection between the responses and answers of the other party, so it can be observed a fluid and coherent dialogue that permits to deepen in the patients experience. Contingency can be considered as a complex process by which mentalizing is express, which requieres the capacity for understanding and matching discourse and emotion based on the context.

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<th>Contingent communication scale</th>
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<tr>
<td><strong>Therapist</strong></td>
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<td>Without considering the patient's speech, therapist makes interventions that impose a personal point of view and does not take into account the current therapeutic interaction. Examples of this are: sudden topic changes, interruptions to impose a personal idea or interpretations without context or evidence. As an overall, the therapist can be described as not emotionally attuned to his/her patient, and thus, not being following him/her.</td>
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<td>Despite taking into account the current therapeutic interaction, the therapist is not attuned and/or not following what the patient tries to communicate, assuming a controlling role. Additionally, their interventions may be in excess theoretical or have a level of complexity that make it difficult to understand for the patient.</td>
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<td>Therapist seems to be connected to his/her patient discourse, but his intervention is oriented to more basic and superficial aspects, without taking into account the most relevant elements that his patient shows. When focus or topic needs to be changed, the intervention remains oriented to superficial aspects. Some interventions may be in excess theoretical or have a level of complexity that could be difficult to understand for the patient.</td>
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<td>Therapist is clearly connected to his/her patients discourse and, most of the time, emotionally attuned. Thus, most of its interventions are &quot;in line&quot; with either verbal and non verbal aspects shown by the patient, taking into account important aspect of what he/she communicates. When focus or topic needs to be changed, the intervention remains oriented to important aspect of the patients discourse. Most interventions are formulated at a complexity level that can be easily understood by the patient.</td>
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<td>Therapist seems to be verbally and non-verbally attuned with its patients experience, and seems to be “in line” with either behavior, emotion and discourse of the patient. Therapist takes into account the most important aspect shown by the patient, and can participate in expliciting others not yet seen. Interventions are formulated at a complexity level that can be easily understood by the other party. The intervention is related to a previous one, but can flexible be adapted (ie. contingently follows the patients in a change of topics if necessary) in order to contingently follows the patient or create opportunities to deepen on his/hers experience.</td>
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<td><strong>Patient</strong></td>
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<td>The patient seems not to be following his therapist, giving the feeling of a monologue. His answers do not correspond to the therapist's questions, being able to observe sudden changes of subject or attempts of control over the other.</td>
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<td>Patient takes into account the therapist's interventions and even responds eventually to it, however the focus of his speech is oriented to address aspects of the conversation that are more self serving and/or irrelevant to the current interaction. Continuous interruptions or changes of subject can be observed. This may occur despite the therapist's insistence.</td>
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<td>The patient follows passively the therapist's interventions, demonstrating a certain degree of agreement and complacency. Some of the interventions seem to be used to reflect, but at a concrete and / or superficial level.</td>
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<td>Most of the time the patient collaboratively follows the therapist interventions, taking advantage of this context to promote reflection on mental states. Nevertheless, he/she points out when disagreed or considers that a new theme or specific aspect needs to be addressed.</td>
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<tr>
<td>The patient actively and collaboratively participate on the construction of a therapeutic context that enhance mentalizing. Nevertheless, he/she actively points out when disagreed or considers that a new theme or specific aspect needs to be addressed.</td>
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**Dynamic nature of mental states scale:** A core feature of mental states is its dynamism, a reflex of its complex nature that can be identified on interactions that take into account that there is not only one version of a particular mental state. This dynamic aspect can be discursively identified by: a) the consideration of different points of view, b) the capacity to recognize, tolerate and integrate contradictions within mental states (including the existence of blending emotions) and; c) the recognition of their changing nature across time.

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<tr>
<td><strong>Therapist</strong></td>
<td>The therapist does not take into account the dynamic nature of mental states during his intervention, losing a clear possibility of favoring this aspect in the patient.</td>
<td>The therapist performs interventions that incorporate the dynamic nature of mental states. These interventions could use clichés, impose ideas, or make general comments in regard to mental states without actually becoming a therapeutic action oriented to invite the patient to reflect on this aspect.</td>
<td>Therapist performs interventions that enhance reflecting on the dynamic nature of mental states in a basic and concrete way by elaborating general comments, closed-ended questions (&quot;do you think they have the same perception?&quot;) or decontextualized demand questions.</td>
<td>Therapist performs some interventions that significantly enhance reflection on the dynamic nature of mental states, using relevant and contextualized demand questions.</td>
<td>Therapist actively promotes a clear and deep reflection on the dynamic nature of mental states performing highly relevant and contextualized interventions.</td>
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<tr>
<td><strong>Patient</strong></td>
<td>The patient does not consider the dynamic nature of mental states either spontaneously or in response to the therapist's questions, even though there was an opportunity to do it.</td>
<td>The patient takes into account the dynamic nature of mental states in a way that seems unnatural and emotionally unattuned, giving the impression of utilitarian action such as trying to convince the therapist, be condescending, or try to &quot;get out of the way&quot;. All these actions could be characterized by being just apparently reflective. The coder might have the impression that the consultant's speech is not credible and/or has an exclusively self-affirmative objective.</td>
<td>The patient incorporates in his discourse the dynamic nature of mental states in a basic and/or concrete way, at a rather descriptive level: for example, he/she realizes the existence of different points of view, or contradictory emotions, but he/she does not refer to its implications. It is possible to observe the use of clichés in this category. Unlike point 2, here we can see a reflexive intention associated with the causality of mental states.</td>
<td>The patient incorporates in his discourse dynamic aspects of mental states, being able to recognize, tolerate and integrate contradictions, different points of view and/or the change of these over time, both in oneself and in others. The emotion that accompanies the discourse is emotionally attuned, and may give the impression of a genuine emergence of new knowledge to the coder.</td>
<td>The patient incorporates in his speech dynamic aspects of mental states, being able to recognize, tolerate and coherently integrate contradictions, different points of view and/or the change of these over time, both in oneself and in others. The emotion that accompanies the discourse is emotionally attuned, and may give the impression of a genuine emergence of new knowledge to the coder.</td>
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**Causality of mental states:** This dimension evaluates the capacity to consider in a coherent and plausible manner the multiple ways in which mental can influence some other mental states, relational dynamics, psychological development, and behavior; or vice-versa. This is an aspect of mental states that has been well captured by the Reflective Functioning Scale more specifically as reference to the “capacity to evaluate mental states from the point of view of their impact on behavior of self and others”, and more generally as “recognition of developmental aspects of mental states” (Fonagy, Target, Steele & Steele, 1998).

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</thead>
<tbody>
<tr>
<td><strong>Therapist</strong></td>
<td>The therapist does not take into account causal relations of mental states during his intervention, loosing a clear possibility of favoring this aspect in the patient.</td>
<td>The therapist performs interventions that incorporate the causality of mental states. These interventions can use clichés and general comments on mental states without actually becoming a therapeutic action oriented to the patient to reflect on this aspect.</td>
<td>Therapist performs interventions that enhance reflecting on the causality of the mental states in a basic and concrete way by elaborating general comments, closed-ended questions (&quot;do you think B was due to A&quot;, B generated C?) or decontextualized demand questions.</td>
<td>Therapist performs some interventions that significantly enhance reflection on the causality of mental states, using relevant and contextualized demand questions.</td>
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<tr>
<td><strong>Patient</strong></td>
<td>The patient does not consider the causality of mental states either spontaneously or in response to the therapist’s questions, even though there was an oporunity do it.</td>
<td>The patient takes into account the causality of mental states in a way that seems unnatural and emotionally un-attuned, giving the impression of utilitarian action such as trying to convince the therapist, be condescending, or try to &quot;get out of the way&quot;. All these actions could be characterized by being just apparently reflective. The coder might have the impression that the consultant's speech is not credible and/or has an exclusively self-affirmative objective.</td>
<td>The patient incorporates in his discourse the causality of mental states in a basic and/or concrete way, at a rather descriptive level: for example, he/she refers to difficulties in regulating fear due to early experiences, but does not specify how the latter relate to this difficulty. It is possible to observe the use of clichés in this category. Unlike point 2, here we can see a reflexive intention associated with the causality of mental states.</td>
<td>The patient incorporates in his discourse the causality of the mental states, being able to deepen the description of the connections between the mental states, the behavior, the relational dynamics and/or the psychological development.</td>
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**Focus in the present moment:** The capacity for being focused in the present moment can be considered as a basic pre-condition for Reflective Functioning in terms of its intimate relation to arousal suppression, an index of self-regulation.

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<td>The therapist performs actions that promote the deregulation of the affection of the patient. Therapist promotes or collaborates with the consultant's stagnation in a reiterative speech characterized by the retelling of stories associated with past or future events associated to an emotion that fails to regulate. The therapist could perform therapeutic actions that maintain stagnation, or remain in a passive attitude. Therapist includes the present moment in its speech (&quot;now that I think about it,&quot; &quot;that makes me feel ...&quot;, &quot;are you sad?...&quot;). however most of his actions do not invite the consultant to focus on the present. Many of the therapeutic actions performed by the therapist are oriented to focus the patient in the present time, which is observed through discourse (&quot;now that I think about it&quot;, &quot;that makes me feel ...&quot;) and as an explicit invitation (&quot;¿What are you feeling now?&quot;). Therapist actively brings the patient into the present moment, stopping reflections that sticks the interaction in the past or in future events. These interventions assume the form of an invitation and are coherent and contingent, even when the therapist insists when a patient explicitly or implicitly refuses to stay in the present.</td>
<td>Patient shows an overflowing negative affect over which all the focus of his attention is oriented. The emergence of this emotion is not associated with insight or other process related to therapeutic change. Patient is stuck in a reiterative speech characterized by the recounting of stories associated with past or future events with an affect that he/she fails to regulate: for example, to remain in a self-serving speech. Patient's discourse is focused on past or future events, however he/she is able to occasionally reflect on them in the present moment (&quot;now that I think about it ...&quot;, &quot;that makes me feel ...&quot;). Despite the former, the story maintains a quality of being told in the past or in the future and not the present time. Patient's discourse refers to past and/or future events, however, these are addressed through emotions that allow him/her to actualize this experience in the present. The focus of the patient's discourse is referred to the present, so that the reference to past or future aspects only gives an overall context to what seems to be experiencing in the now moment. The quality of the story gives the impression to the coder to be spontaneously and vividly connected with emotions and thoughts in the present.</td>
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