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Treating affect phobias: Therapeutic alliance as a moderator of the emotional experience effect on outcomes

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Abstract

Psychodynamic-oriented psychotherapies have demonstrated their efficacy in emotional disorders' treatment. However, it remains unclear what are the specific mechanisms accounting for change. In psychodynamic psychotherapeutic models as the Affect Phobia Therapy (APT), emphasis is placed on therapeutic relationship and the ability of clients to regain adaptive contact with their emotions. Specifically, it is argued that there must be a high therapeutic alliance for the emotions' exposure to lead to positive outcomes. This exploratory study aimed to examine whether the level of therapeutic alliance (high vs. low) moderates the contribution of emotional experience to outcomes. Twenty-six clients (65% females; *M*age= 25; *SD*= 7.26) with depressive and/or anxiety symptoms undergoing a psychodynamic psychotherapy on a university counselling centre were included. After each weekly session, clients answered measures of therapeutic alliance, emotional experience, and outcomes (Psychological Well-Being and Subjective Discomfort). Data were analysed using Hierarchical Linear Models for longitudinal data. Results indicated that effect of emotional experience on outcomes depends on levels of therapeutic alliance. In clients with low therapeutic alliance, higher levels of emotional experience contributed to a decrease in Psychological Well-Being and an increase in Subjective Discomfort across sessions. In clients with higher levels of alliance, both outcomes decreased significantly between sessions, regardless of the emotional experience effect. Our findings highlight that it is important to consider that exposure to adaptive emotions may have adverse effects when a strong alliance is not established.

Key words: psychodynamic therapy, therapeutic alliance, emotional experience, moderator, change mechanisms.

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Novelty and Significance

What is already known about the topic?

- Psychodynamic psychotherapy models have been systematically established their efficacy in the treatment for several psychological conditions.
- Therapeutic alliance and emotional experience are seen as key mechanisms for therapeutic change in psychodynamic treatments.

What this paper adds?

- This exploratory study examined whether the level of therapeutic alliance between clients and therapists moderates the effect of emotional experience on outcomes.
- A high therapeutic alliance was associated with reduced symptomatology throughout treatment. Also, the exposure to feared emotions has shown to be counterproductive when a strong alliance is not established.

The literature on psychotherapy research has grown significantly in recent decades, with the emergence of evidence-based treatments and various studies testing the efficacy of different therapeutic orientations (Altman, Shapiro, & Fisher, 2020; Wampold & Imel, 2015). Distinct psychotherapies, such as Short-Term Dynamic Psychotherapy (STDP), have systematically established their efficacy through meta-analyses presenting positive outcomes for different disorders (Abbass, Town, & Driessen, 2011), such as depression

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or Cluster C personality disorders (Leichsenring, Rabung, & Leibing, 2004). One of the models of STDP was proposed by McCullough and colleagues (2003) -in a manualized treatment named Affect Phobia Therapy (APT)-, which theorizes that psychopathology results from an emotional conflict, learned throughout past significant relationships. Research on this therapeutic model showed equatative results between APT and cognitive therapy in personality disorders treatment (Ryum, Stiles, Svartberg, & McCullough, 2010), and better results than a control group in the treatment of depressive and anxiety disorders (Johansson, Björklun, Hornborg, Karlsson, Hesser, Ljótsson, Rousseau, Frederick, & Andersson, 2013). APT was also effective in a study with a sample of pregnant women diagnosed with depression (Dornelas, Ferrand, Stepnowski, Barbagallo, & McCullough, 2010) and, in a case study including a client with anxiety and personality disorders (Bhatia, Rodriguez, Fowler, Godin, Drapeau, & McCullough, 2009).

Still, despite the proven efficacy of psychodynamic models, there is still a scarcity of investigations that empirically validate how therapeutic processes work (Berggraf, Ulvenes, Hoffart, McCullough, & Wampold, 2014; Ulvenes, Berggraf, Wampold, Hoffart, Stiles, & McCullough, 2014). On the field of psychotherapy research, the biggest ongoing debate concerns the specific mechanisms through which treatments operate, and the necessary conditions for therapeutic change. To overcome the existent lacks, several authors emphasize the need of studies addressing the causal relationships and interactions between proposed mechanisms for therapeutic change (e.g., Altman *et alia*, 2020; Ramseyer, Kupper, Caspar, Znoj, & Tschacher, 2014).

In psychodynamic therapies, emphasis is placed on the importance of common factors -such as therapeutic alliance- as necessary pre-conditions for the techniques to be effective and determine clients' improvement (Abbass *et alia*, 2011). For APT, pathology is understood as an Affect Phobia, similar to external phobias but related to internal emotional states (McCullough, Kuhn, Andrews, Kaplan, Wolf, & Lanza-Hurley, 2003). The authors of this therapy use the Malan's Two Triangles (Malan, 1979) for the etiological explanation of Affect Phobias, arguing that it arises when activating affects (e.g., sadness/grief, closeness, positive feelings towards the self) are blocked by inhibitory feelings (e.g., anxiety, guilt, shame), creating an intrapsychic conflict, which, in turn, is avoided, prevented, or diminished through defensive feelings, thoughts or behaviors (McCullough *et alia*, 2003). For instance, a person who is phobic about expressing anger may act quietly, cry, feel depressed, or, on the other hand, may lose control and act inappropriately. Because of their affect phobia, this person may not respond adaptively to feelings of anger and, as a defense, may set inappropriate boundaries in relationships with others. This defensive pattern is originated in past relationships and are re-enacted in their current relationships. Similarly, these defenses appear in the relationship with the therapist, making it possible to examine and work on them (McCullough & Andrews, 2001).

Considering the Affect Phobia Therapy framework, emotional experience takes a central role in this psychotherapy. As such, the major treatment goal is to restructure the phobia towards activating affects, allowing clients to be fully involved with their emotions. The treatment process implies a gradual exposure of clients onto activating affects, preventing defenses, until inhibitory feelings decrease (McCullough, 1999; McCullough *et alia,* 2003). This therapy is composed of two central phases: the Defense Restructuring phase (including Defense Recognition and Defense Relinquishing) and the Affect Restructuring phase (Emotional Experience and Emotional Expression).

The Defense Restructuring phase is the first stage of APT treatment, in which therapists help clients to identify their defenses, to understand where they come from

(Defense Recognition), and to develop motivation to give up defensive behaviors (Defense Relinquishing). The next phase is considered the key change mechanism of this treatment, named Affect Restructuring, which integrates the exposure to the avoided and conflicted affects (Emotional Experience), leading clients to gain awareness of their emotions at a bodily and cognitive level; and, consequently, includes the ability training in order to communicate feelings in-session and outside (Emotional Expression) (McCullough *et alia*, 2003). So, a circumstantial part of therapeutic change is obtained through the acquisition of a more adaptive emotional experience, allowing individuals to have an authentic relationship with their emotions (McCullough, 1999).

Attending to the importance placed on emotional experience and expression (Diener, Hilsenroth, & Weinberger, 2007), some research has begun to focus on emotions' contribution for the etiology and maintenance of psychological disorders and have concluded that emotional experience contributes to clinical outcomes in a significant way, providing clients with higher well-being in various psychotherapies (Greenberg, 2017; Greenberg & Pascual-Leone, 2006; Peluso & Freund, 2018). Results from a recent meta-analysis exploring the contribution of clients' emotional experience, found that it contributed for better therapeutic outcomes, with a small-to-medium effect (r= -.19 to -.29) (Pascual-Leone & Yeryomenko, 2017). Also, in a case study of a client undergoing APT treatment, an increase in emotional experience levels and a decrease in symptomatology were observed throughout the first ten sessions, suggesting that improvement was related to greater experience of adaptive affects (Bhatia et alia, 2009).

Besides the prominence given to emotions in psychodynamic therapies, a specific focus is also given to common factors (Wampold & Imel, 2015). Therapeutic alliance is considered one of the most important common factors for treatments' success (Cuijpers, Reijnders, & Huibers, 2019), being extensively supported as a dimension that explains an average of 8% of outcomes (Flückiger, Del Re, Wampold, & Horvath, 2018).

On therapies such as APT, it is believed that a safe relational context must exist for the emotions' exposure to be therapeutic (McCullough & Andrews, 2001). When a good therapeutic alliance is present, the therapist can more easily assume an accepting attitude and encourage clients to experience and express activating affects in sessions. Throughout the process, the therapist supports the clients' progress in experiencing more activating affects and less inhibitory ones, and therefore using less or more adaptively, their defenses. In this way, the client is re-enacting their conflicts in the therapeutic relationship, that in its turn allows the development of awareness about clients' problematic relational pattern and the chance to work on these patterns, enhancing the occurrence of a "corrective emotional experience" (McCullough *et alia*, 2003).

Thus, a good alliance is fundamental for this corrective emotional experience to occur. Empirical studies (e.g., Iwakabe, Rogan, & Stalikas, 2000; Owen & Hilsenroth, 2011) reinforce that a high alliance is vital for therapeutic treatments, once it contributes to an accurate response of therapists to clients' emotional expressions, to the identification of intrusive emotions in the therapeutic relationship, enabling this aspect to be worked on, helping clients to regulate themselves adaptively and, consequently, to solve their intrapsychic conflicts.

Taken these conclusions and the rationale of the Affect Phobia Therapy (APT) together, therapeutic alliance plays a preponderant role for the acquisition of a more productive emotional experience (Peluso & Freund, 2018), which, in turn, will lead to therapeutic change (Julien & O'Connor, 2017).

So, according to psychodynamic therapies, emotional experience and therapeutic alliance are determinant change mechanisms. Several authors (e.g., Greenberg & Pascual-

Leone, 2006; Peluso & Freund, 2018; Wheaton, Huppert, Foa, & Simpson, 2016) have suggested that the effect of emotion-focused therapeutic tasks depends on levels of therapeutic alliance. Here, the therapeutic alliance seems to emerge as a moderating factor for the specific rationale of these treatments. Nevertheless, very few studies link these two factors and explore their interactions to explain clients' improvements.

Several investigations that aimed to examine the process of clients undergoing psychodynamic and experiential therapies, found evidence for emotional experience as a mediator on the relationship between therapeutic alliance and outcomes (Auszra, Greenberg, & Herrmann, 2013; Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, & Peri, 2016; Pos, Greenberg, & Warwar, 2009). However, other studies showed distinct interrelationships such as alliance being a mediator on the relationship between in-session emotional experience and positive outcomes (Beutler, Clarkin, & Bongar, 2000). Apart from different results, the theoretical model suggests that the effect of emotional experience on outcomes is moderated by a good therapeutic alliance.

In the field of psychodynamic child psychotherapy, Halfon (2021) recently investigated the effect of therapeutic alliance and techniques using a sample of 79 children undertaking a psychodynamic treatment for child internalizing and externalizing problems. Child behaviors were reported by parents and teachers, and sessions were coded by trained raters that assessed the levels of therapeutic alliance and the intervention strategies applied. Results revealed an interaction between alliance and psychodynamic techniques, showing that, in cases with high therapeutic alliance, the use of techniques predicted fewer problematic behaviors. Conversely, in a context of a low alliance, psychodynamic interventions evoked more problematic behaviors. These findings suggest that a high alliance is essential to allow psychodynamic techniques help clients to achieve positive outcomes, whereas, in cases of lower therapeutic alliance, the use of these techniques can be harmful (Halfon, 2021).

This recent result is in line with the conclusions of Owen and Hilsenroth (2011), that failed to find a direct effect of psychodynamic techniques on outcomes but verified an interaction, between psychodynamic techniques and positive outcomes, only in contexts of higher therapeutic alliance. Thus, according to both findings, alliance has a moderator role, as it was proposed by APT authors.

In order to overcome the lack of studies on the interaction between the acquisition of an adaptive emotional experience and therapeutic alliance, we aimed to conduct an exploratory study to analyze if the effect of emotional experience on outcomes (Psychological Well-being and Subjective Discomfort) depend on the level of alliance (high vs. low).

METHOD

Participants

Participants were therapeutic dyads (clients-therapists) from a university counseling center. Clients were 26 adults undergoing a psychotherapeutic process with ages between 18-41 years old (*M*age= 25; *SD*= 7.26; 65% female) who presented depressive and/or anxious symptomatology. All clients were randomly assigned to two therapists (1 male and 1 female) that follow the Affect Phobia Therapy model in their practice. Between therapists, one was a senior clinician in psychodynamic psychotherapy, and the other a doctoral student and clinical psychologist with two years of experience. Therapists had

two hours of group supervision once a week. Psychotherapeutic processes of the sample had an average length of 14.50 sessions (*SD*= 9.37), with one-hour sessions per week.

Measures

Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006; Portuguese version, Machado & Ramos, 2008). The WAI-SR aims to assess therapeutic alliance divided into three factors: objectives (goals negotiated between client and therapist), tasks (the therapeutic tasks necessary to achieve the established objectives), and bond (the affective component of the therapist-client relationship). WAI-SR comprises 12 items rated on a 5-point Likert scale from "Rarely" to "Always", where higher scores indicate greater alliance between client and therapist. The portuguese version of the WAI-SR (Machado & Ramos, 2008) showed acceptable values of internal consistency, with α= .85 for total scale, α= .72 for tasks, α= .80 for objectives, and α= .64 for bond.

Emotional Experience Self Report (EE-SR; Fisher *et alia*, 2016). The EE-SR is a 1-item instrument built by, to assess in-session clients' emotional experience. It is a bipolar rating scale in which clients should evaluate the extent to which they consider that have feeling their emotions after every session. The item is rated on a scale that ranges from 0: "In today's session, I was disconnected from my emotions" to 7: "In today's session, I was emotionally involved, and I fully and vividly experienced my emotions". Higher scores correspond to higher levels of in-session emotional experience. Results from the original study confirm the stability, test-retest reliability, and convergent validity of EE-SR (Fisher *et alia*, 2016).

Outcome Questionnaire-10 (OQ-10; Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996; Portuguese version: Machado & Fassnacht, 2014). The OQ-10comprises 10-items that evaluate clients' symptomatology into two dimensions: Psychological Well-being (5 items) and Subjective Discomfort (5 items). Each item is rated on a 5-point Likert scale, in which 0 means "Never" and 4 means "Always". The ranking of Psychological Well-being items are reversed, which means that lower scores indicate higher Psychological Well-being. As in Subjective Discomfort, that lower scores suggest less emotional distress. Psychometric analysis to the OQ-10 original version showed excellent internal consistency (α between .82 and .92; Lambert *et alia*, 1996).

Procedure

Data collection procedure were part of the clinical routine practice of the university counselling service where the present study was conducted. All participants were invited to participate at the very first therapy session. Upon agreement subjects signed consent forms and were informed that they participation were voluntary and anonymous, with the possibility to withdraw at any time without jeopardizing their treatment. Clients completed EE-SR, WAI-SR, and OQ-10 after each psychotherapeutic session. Therapeutic processes and data collection were undertaken in compliance with the ethical code of applied psychology practice and the standards of the American Psychological Association.

Data Analysis

Analyses were performed throughout Hierarchical Linear Modeling (HLM, Bryk & Raudenbush, 1987), considering the repeated measures of emotional experience and symptomatology in every session (Level 1) were nested within client/individual (Level 2). The linear component was centered in the first session to facilitate the interpretation of estimated fixed parameters and as recommended by Wang and Maxwell (2015), the emotional experience was centered on the average of each participant in order to guarantee the stability of estimated fixed parameters. In turn, therapeutic alliance, was considered a factor associated to the client (Level 2). To differentiate clients based on their alliance

level over the course of therapy, we calculated the median (*Mdn*= 4.20) of all sessions from the whole sample. Then, each client's therapeutic alliance mean was computed, and the client was classified with reference to the sample median. Therefore, as a factor on Level 2, we defined a dichotomic variable: high level of therapeutic alliance (*n*= 10; *M*= 4.80, *SD*= 0.26); lower level of therapeutic alliance (*n*= 16; *M*= 4.02, *SD*= 0.58).

RESULTS

Tables 1 and 2 show the estimated fixed effects and covariance parameters that describe Psychological Well-being and Subjective Discomfort evolution differentiated by therapeutic alliance level. Additionally, it also provides the estimated fixed parameters for emotional experience effect on each profile of Psychological Well-being and Subjective Discomfort evolution.

Table 1 indicates that no significant differences were found on Psychological Well-being between clients with high and lower alliance levels ($\gamma_{00\text{-}ha}$ - $\gamma_{00\text{-}la}$= -0.46, *t*= -0.24, *p*= .809) at the beginning of therapy. However, the evolution of Psychological Well-being depended on the therapeutic alliance level. The Psychological Well-being tend to be stable between sessions for clients with a lower alliance ($\gamma_{10\text{-}la}$= -0.13, *t*= 1.32, *p*= .222), but increase significantly between sessions for clients with higher alliance ($\gamma_{10\text{-}ha}$= -0.36, *t*= 2.56, *p*= .030).

Looking at the effect of emotional experience on Psychological Well-being, it was verified that it depends on therapeutic alliance level. For clients with higher therapeutic alliance, emotional experience did not influence their well-being ($\gamma_{01\text{-}ha}$= 0.09, *t*= 0.45, p= .654). However, for clients who perceived a low alliance with their therapist, the higher the emotional experience, the lower their well-being ($\gamma_{10\text{-}la}$= 0.24, *t*= 1.96, *p*= .052) (Table 1).

Table 1. Estimated fixed effects and covariance parameters for the contribution of Emotional Experience to Psychological Well-being depending on high vs. low therapeutic alliance

			Estimate	*SE*	*df*	*t*	*p*	CI 95% Lower	CI 95% Upper
Estimates of Fixed Effects	Intercept γ_{00}	la	-0.46	1.51	26.00	-0.24	.809	-4.37	3.44
		ha	8.02	1.90	27.06	5.32	.000	4.92	11.11
	Slope γ_{10}	la	-0.14	0.10	7.96	-1.32	.222	-0.37	0.10
		ha	-0.36	0.14	9.30	-2.56	.030	-0.68	-0,04
	Emotional Experience Effect γ_{01}	la	0.24	0.12	195.66	1.96	.052	-0.02	0,49
		ha	0.10	0.21	194.09	0.45	.654	-0,32	0.51

			Estimate	*SE*	Wald's *Z*	*p*	CI 95% Lower	CI 95% Upper
Estimates of Covariance Parameters	Intercept variance	τ_0	18.27	6.02	3.03	.002	9.56	34.86
	Slope variance	τ_1	0.09	0.07	1.34	.182	0.02	0.38

Notes: Example= Psychological well-being ij (clients with high therapeutic alliance)= $\gamma_{00} + \gamma_{10}$ (session) + γ_{01} (emotional experience) + $\mu_{0i} + e_{ij}$; ha= Low Alliance; la= Low Alliance.

With regards to the covariance parameters (Table 1), we found that there is significant variance to explain related to the intercept (τ_0= 18.27, Wald' *Z*= 3.03, *p*=

.002), but not to the slope (τ_1= 0.09, Wald *Z*= 1.34, *p*= .182). These results suggest we should consider other variables to explain Psychological Well-being at the beginning of treatment.

As seen at Table 2, no significant differences were found on Subjective Discomfort between clients at the beginning of treatment ($\gamma_{00\text{-}ha}$ - $\gamma_{00\text{-}la}$= -0.17, *t*= -0.11, *p*= .915). However, the evolution of Subjective Discomfort between sessions depended on therapeutic alliance levels. For clients with lower therapeutic alliance, Subjective Discomfort remains stable throughout treatment ($\gamma_{10\text{-}la}$= -0.15, *t*= -1.78, *p*= .124), while it significantly decreased for individuals with higher alliance ($\gamma_{10\text{-}ha}$= -0.29, *t*= -2.47, *p*= .037).

Table 2. Estimated fixed effects and covariance parameters for the contribution of Emotional Experience to Subjective Discomfort depending on high vs. low therapeutic alliance

			Estimate	*SE*	*df*	*t*	*p*	CI 95% Lower	CI 95% Upper
Estimates of Fixed Effects	Intercept γ_{00}	la	-0.17	1.58	29.93	-0.11	.915	-3.40	3.06
		ha	10.78	1.26	31.60	8.55	.000	8.21	13.35
	Slope γ_{10}	la	-0.15	0.08	6.18	-1.78	.124	-0.35	0.05
		ha	-0.29	0.12	8.56	-2.47	.037	-0.55	-0,02
	Emotional Experience Effect γ_{01}	la	0.34	0.11	198.41	3.01	.003	0.12	0,56
		ha	0.02	0.19	197.08	0.12	.909	-0,35	0.40

			Estimate	*SE*	Wald's *Z*	*p*	CI 95% Lower	CI 95% Upper
Estimates of Covariance Parameters	Intercept variance	τ_0	11.03	3.88	2.84	.005	5.53	21.99
	Slope variance	τ_1	0.04	0.04	1.03	.302	0.01	0.27

Notes: Example= Subjective Discomfort $_{ij}$ (clients with high therapeutic alliance)= $\gamma_{00} + \gamma_{10}$ (session) + γ_{01} (emotional experience) + $\mu_{0i} + e_{ij}$; ha= Low Alliance; la= Low Alliance.

The effect of emotional experience also depended on levels of therapeutic alliance (Table 2). For clients with low alliance, greater emotional experience contributes to an increase in Subjective Discomfort ($\gamma_{01\text{-}la}$= 0.34, *t*= 3.01, *p*= .003). Among clients who perceived a high alliance with their therapist, there was no significant effect of emotional experience on Subjective Discomfort ($\gamma_{01\text{-}ha}$= 0.02, *t*= 0.12, *p*= .909).

Regarding the covariance parameters (Table 2), we found that there is significant intercept variance to explain (τ_0= 11.03, Wald' *Z*= 2.84, *p*= .005), but not in the slope (τ_1= 0.04, Wald' *Z*= 1.03, *p*= .302). As for Psychological Well-being, we need to consider other variables that could explain Subjective Discomfort variance at the beginning of treatment.

DISCUSSION

Emotional experience and therapeutic alliance are key components of psychological treatment, such as psychodynamic therapies, mainly the Affect Phobia Therapy. This model proposes that therapeutic alliance is a necessary pre-condition to allow that an adaptive emotional experience occurs and leads to positive outcomes (McCullough *et alia*, 2003). However, empirical validation on this theorized change process has not yet been achieved. In this study, we aimed to examine whether the effect of emotional experience on outcomes depended on alliance that clients have with their therapists.

Our results partially meet theorical expectations, as it was only possible to support that in clients with low therapeutic alliance, higher levels of emotional experience contributed to worst outcomes, i.e., a decrease in Psychological Well-Being and an increase in Subjective Discomfort. These findings suggest that exposure to emotional experience -as a specific component of psychodynamic treatments- has an adverse effect on clients who have not established a good alliance with their therapist. This conclusion is identical to one of the results found by Halfon (2021), in which the use of psychodynamic techniques in children with low therapeutic alliance contributed to the emergence of more behavioral problems, rather than symptomatologic improvement. It seems that psychodynamic treatments can lead to an initial discomfort and greater emotional distress as the individual is invited to bring his intrapsychic conflicts to consciousness. Thus, in situations where there is not a safe environment in which the client feels understood and supported, exposure to feared emotions can be difficult to tolerate and induce greater activation and worse outcomes (Halfon, 2021; Town, Diener, Abbass, Leichsenring, Driessen, & Rabung, 2012).

Thus, although it is proven that low alliance does not prepare the client for a more vivid emotional experience, it was not possible to verify a significant positive effect of emotional experience on outcomes in subjects with high therapeutic alliance. This failure to find data that fully supports the moderating role of therapeutic alliance undermines the empirical validation of Affect Phobia Therapy model and perpetuates the debate about the role of therapeutic alliance and emotional experience as change mechanisms. On psychotherapy process research, some authors have proposed distinct configurations for these two treatment factors. For example, Fisher *et alia* (2016) examined direct and indirect associations between clients' emotional experience, therapeutic alliance, and clients' level of functioning using a sample of 101 adults undergoing treatment in a university counseling center. They found that, higher therapeutic alliance at session one predicted higher emotional experience in the next session, and emotional experience in one session led to a change in functioning. It indicated that there is an indirect effect of alliance on the level of functioning, mediated by increased emotional experience. Conversely, in other studies, it was therapeutic alliance that mediated the relationship between emotional experience and outcomes (Beutler *et alia*, 2000) and psychodynamic techniques and outcomes (Baier, Kline, & Feeny, 2020; Kivlighan, Hill, Ross, Kline, Furhmann, & Sauber, 2019).

These inconsistencies show that there is still a lot of uncertainty about the psychotherapeutic change mechanisms and the interrelationships between variables that lead to outcomes. This may be due in part to the data analysis methods used, which perform more simplistic analyses, mostly assuming linear causality (Altman *et alia*, 2020). For instance, in the present study, the analysis method used was unable to explore how levels of therapeutic alliance can predicted or impact levels of emotional experience in a subsequent session, and how these two variables interact over time. Future studies should implement advanced methodologies such as cross-lagged models and time-series analysis (Falkenström, Solomonov, & Rubel, 2020; Ramseyer *et alia*, 2014) to capture the complexity of psychotherapeutic processes.

Nevertheless, when not taking in to account the emotional experience variable, we found that Psychological Well-being increased, and Subjective Discomfort decreased between sessions in clients with higher levels of alliance. This demonstrates that the alliance contributes to positive outcomes, having a direct effect on symptomatology throughout the sessions. Therapeutic alliance is consistently pointed out as one of the

most important dimensions for therapeutic success (Flückiger *et alia*, 2018), and our results allowed us to corroborate this assumption. As stated by various authors (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Leibovich, McCarthy, & Zilcha-Mano, 2020; Shateri & Lavasani, 2018; Zilcha-Mano, 2017), alliance can not only be a facilitator for the use of other techniques but also act as an active ingredient, leading to therapeutic gains by helping clients to meet their unmet interpersonal wishes and needs. Thus, this data reinforces the importance of building a good therapeutic alliance to enhance good therapeutic outcomes by itself.

Conclusions of this investigation should be considered in the light of some limitations. First, the small sample size may have precluded to detect distinct findings, even in the presence of a repeated measures design, whereas the low number of participants was attempted to be compensated. Secondly, other potential moderators, such as therapists' characteristics and clients' initial symptomatology level, were not included. Lastly, the third limitation concerns the statistical procedure used. Although it is widely used in this field, HLM can be pointed out as limited to analyze therapeutic processes, not being able to assess temporal variations between variables. Future research should consider a nonlinear dynamic systems approach and methods that examine temporal dependencies between time-series data.

Despite its limitations, this study highlights the importance of therapeutic alliance for psychotherapeutic processes and adds some knowledge to the debate on the proposed mechanisms that drive therapeutic change. There are two main findings to note: therapeutic alliance in psychodynamic therapies seems to be more than a prerequisite, also working as a specific factor that contributes to treatment efficacy; and exposure to an adaptive emotional experience should be carefully applied, since it may have a negative impact on subjects' well-being when there is a lower alliance. These conclusions have important practical implications, warning therapists to reinforce attention at the level of therapeutic alliance before the implementation of interventions that may foster an emotional experience. In cases where there is no safe relational context, the exploration of feared emotions may cause an arousal that can be averse to clients' symptomatology.

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