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Therapist in-session feelings predict change in depressive symptoms in interpersonal and brief relational psychotherapy

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Abstract
Objective: Brief Relational Therapy (BRT) includes the idea that the therapists use their in-session feelings in meta-communications about the therapy relationship to facilitate resolution of alliance ruptures. The current study aimed to explore the effect of therapist feelings on patient depressive symptoms in BRT compared to Interpersonal Psychotherapy (IPT).
Methods: The effects of therapist feelings were studied in 40 patients randomized to 16 sessions of IPT or BRT, using the Feeling Word Checklist—24, the Patient Health Questionnaire—9 and the Working Alliance Inventory. Data was analyzed using dynamic structural equation modeling.
Results: Negative therapist feelings predicted increase and positive feelings decrease in next-session PHQ-9 via the alliance and the patients’ engaged feelings, in both treatments. The direct effect of negative therapist feelings on PHQ-9 differed significantly between BRT and IPT, with more negative feelings predicting a decrease in PHQ-9 in BRT but not in IPT.
Conclusion: Negative therapist feelings may cause increase/less decrease and positive feelings more decrease in depressive symptoms via disruptions in the alliance. In BRT, if the alliance is unaffected by negative therapist feelings, the patient’s depressive symptoms may improve. Findings need replication in a larger sample.

Keywords: countertransference; depression; brief relational therapy; interpersonal psychotherapy

Clinical or methodological significance of this article: The findings of this study indicate that negative feelings experienced by therapists in sessions are related to worse working alliance and less engaged feelings in the patient, and positive feelings are related to a better working alliance and more engaged patient feelings. The working alliance and patient engaged feelings, in turn, predict outcome session-by-session. However, in a treatment focusing on using the therapist’s negative feelings in communications with the patient, negative feelings can predict positive outcome if they do not interfere with the working alliance or the patient’s sense of engagement in the session.

As therapists, regardless of school of therapy, years of experience, or technical competence, we will experience feelings when interacting with our patients. Some of these feelings may not be exclusively empathic or imply unconditional positive regard, the conditions that Rogers (1957), together with congruence, proposed as the necessary and sufficient conditions for therapeutic success. Freud (1910) introduced the term countertransference for the analyst’s unconscious reactions to the patient’s transference, warning doctors against acting on countertransference, and advising therapists to put aside all feelings towards the patient, even ambitions to achieve good therapy outcomes (Freud, 1912). In Freud’s view, countertransference represented the therapist’s unresolved unconscious conflicts, and it...
is the therapist’s ethical and professional responsibility to protect the patient from these. This definition is often referred to as the classical view of countertransference.

Later psychoanalysts broadened the meaning of countertransference to also include expected reactions to the patient’s behavior in the consulting room. For instance, Winnicott (1949) introduced the term objective countertransference, which meant any emotional reaction the therapist experiences towards her patient that is expected/understandable given the patient’s way of being with the therapist. This was a useful development, since it seems unlikely that all feelings that therapists experience with their patients are caused by unresolved internal conflicts in the therapists. In addition, being able to understand emotional responses to the patient’s habitual way of relating to others may yield valuable information that can inform therapy (Heimann, 1950; Kiesler, 1983). However, the idea of objective countertransference as something the therapist should be able to tease out, may increase the risk that the therapist blames the patient for the therapist’s own unresolved issues (e.g., Gabbard, 2001).

The integrative definition of countertransference combines these two perspectives (Hayes et al., 2011). In this definition, countertransference is seen as originating in the therapist’s internal emotional conflicts but is triggered by the patient and may be both conscious to the therapist or out of his or her awareness. This is thus close to the classic perspective but broadened in that reactions can be conscious as well as unconscious, in reaction to any behavior of the patient (not just to the patient’s transference), and that the form of expression is dependent on the patient’s interactive behavior. The term countertransference is still reserved for therapist reactions that originate in unresolved issues within the therapist, while other types of emotional responses to the patient are recognized but not defined as countertransference. Empirical research shows that countertransference reactions are related to worse therapy outcome, but that effective countertransference management can attenuate this relationship (Hayes et al., 2018).

In practice, it may be difficult for therapists to tease out which of their feelings that are due to their own unresolved issues, and which is due to their patient’s way of being with them. A common definition of countertransference within contemporary psychoanalysis is the totalistic view, which simply says that any feelings the therapist has towards his/her patient is called countertransference, regardless of origin. Some authors (e.g., Gelso & Kline, 2021) criticize this definition for diluting the concept of countertransference to the point of becoming meaningless. Because of the risk of confusion when using the same term to refer to different theoretical constructs, we will in this paper not use the term countertransference when discussing therapist in-session feelings without regarding the origin of these feelings.

In relational psychotherapy, therapist feelings are seen as invariably co-created by therapist and patient in an ongoing process between them (Benjamin, 2018; Maroda, 1991), and it is deemed impossible to fully tease apart aspects having to do with the patient from aspects having to do with the therapist (Safran & Muran, 2000). Thus, the therapist’s in-session feelings are seen as a valuable indicator of the ongoing process in the therapy relationship. Self-disclosure of the therapist’s feelings is used as part of a general strategy of meta-communication about the therapy relationship, aiming to increase awareness of the relational situation to make it open for reflection and facilitating the resolution of alliance ruptures. Communicating about therapist feelings is used to create curiosity about the mutual patient-therapist interaction, rather than seeing these feelings as, for instance, “projective identification,” (e.g., Ogden, 1982), induced (unconsciously) by the patient. Among relationally oriented therapists, the aim is rather to generate a “third position” (e.g., Aron, 2006; Britton, 1998), from which reflection about the relational process may be done.

There is some research showing positive effects of therapist self-disclosure (Henretty & Levitt, 2010), especially of so-called immediate self-disclosures—those in which the therapist reveals something about the experience with the client within the session (Ziv-Beiman et al., 2017). A recent study found that immediate self-disclosure predicted symptom reduction in sessions in which the patient’s symptom level was high (Alfi-Yogev et al., 2021). However, we have not found any studies specifically of therapist feelings in a particular session predicting symptom change to the following session.

The purpose of the present study was to explore whether therapist feelings predict therapy outcome in two contrasting therapies; Brief Relational Therapy (BRT; Safran & Muran, 2000), in which therapist feelings are explicitly used for therapeutic purposes, and Interpersonal Psychotherapy (Klerman et al., 1984) in which the therapist is discouraged from meta-communicating about feelings with the patient but rather to strive to be consistently supportive and keep focusing on the patient’s interpersonal problems outside of therapy. These treatments are both brief psychotherapies based on attachment and interpersonal theories, but they differ in type of relational focus. IPT is mainly focused on helping the patient solve specific interpersonal problems in the patient’s life outside therapy.
that are thought to maintain the patient’s problems (Markowitz & Weissman, 2004). BRT focuses on ruptures and resolution of the therapeutic alliance as a way of helping to develop a generalized self-reflection capacity (Safran & Muran, 2000). BRT thus resembles IPT in its theoretical roots, but it differs in being more focused on exploration of the therapy relationship than on interpersonal relationships outside therapy. The contrast, thus, is in terms of focus on relations outside or inside the therapy room. In the present study, data is used from a small pilot trial comparing these two therapies in patients with Major Depressive Disorder (MDD).

Our main research question was whether the therapists’ negative feelings in a particular session would predict change in patient depressive symptoms to the following session, and whether this prediction would differ between BRT and IPT. Negative feelings are more likely to interfere with the therapy process than positive ones, which is why we were most interested in the effects of these. However, as secondary research questions we also wanted to explore whether the therapist’s positive feelings predict patient depressive symptoms. We hypothesized that negative feelings would predict an increase/less decrease of depressive symptoms to the following session. Since therapists are instructed to use their feelings as a therapeutic instrument in BRT, we expected that this negative relationship between feelings and depressive symptoms would be stronger in IPT than in BRT (Hypothesis 1). Second, we hypothesized that the differential prediction of depressive symptoms from negative feelings between IPT and BRT would be mediated by the working alliance (moderated mediation; Hypothesis 2). Specifically, we expected that if the therapist reported negative feelings in a particular session, this would indicate a risk for deterioration in the working alliance, which in turn would predict less decrease or even worsening of depressive symptoms at the following session, and that this indirect effect would be larger in IPT than in BRT. We expected that positive feelings would predict decrease of patient symptoms via the working alliance (Hypothesis 3), with a larger effect in BRT than in IPT (Hypothesis 4).

Methods

Patients

Patients aged 17–65 fulfilling diagnostic criteria for MDD according to the Diagnostic and Statistic Manual for Mental Disorders 4th edition (APA, 2000) and scoring at least 17 (moderate depression) on the Hamilton Depression Rating Scale (HDRS; Hamilton, 1960) were recruited. Exclusion criteria were psychotic symptoms, severe neuropsychiatric problems, and ongoing substance abuse. There were nine men (22.5%) and 31 women among the included patients, and the mean age was 38 years (SD = 11.16). Their average HDRS score at intake was 23.05 (SD = 5.91).

Therapists

Therapists were psychologists or social workers with at least basic psychotherapy training, which in Sweden consists of two years of half-time theoretical study and supervised clinical work. In addition, before starting as therapists in the project they attended a two-year training (half-time) in the two treatments. This training comprised theoretical seminars, lectures and supervision of two therapies in each method. All therapists were trained to deliver both treatments, a so-called crossed therapist design (Falkenström et al., 2013). Thus, each patient was assigned to a therapist, and then randomized to IPT or BRT. The training for this study was the first formal training in both IPT and BRT in Sweden. Fourteen therapists (four men and ten women) provided treatment, and all except two treated patients using both IPT and BRT (the other two had only one patient each).

Treatments

Interpersonal psychotherapy (IPT; Klerman et al., 1984). IPT is an evidence-based, time-limited treatment originally developed for treating Major Depressive Disorder, although it has been extended and developed for Bulimia Nervosa and recently also for Post-Traumatic Stress Disorder. The treatment is structured and focuses on relieving depressive symptoms by targeting interpersonal problems in the patients’ current life situation. In the first four sessions, an interpersonal problem area is identified that is deemed to maintain the patient’s depression, and this problem area is agreed upon as a therapy focus. Four types of focus areas are used in IPT: grief, role transitions, interpersonal conflicts, and interpersonal deficits. In the middle phase of therapy, the agreed upon focus area is worked with in a problem-solving and emotionally supportive way, and the patient is also encouraged to seek interpersonal support from his or her environment. IPT has been established as an evidence-based treatment for Major Depression (Roth & Fonagy, 2005).

Brief relational therapy (BRT; Safran & Muran, 2000). BRT is a Short-Term Psychodynamic Psychotherapy, based on relational
psychoanalytic theory in combination with research on processes of rupture and repair of the therapeutic alliance. The therapeutic alliance, operationalized as the positive bond between patient and therapist in combination with agreement on tasks and goals of treatment, is the most studied process predictor of outcome in psychotherapy research (Flückiger et al., 2018). BRT was developed to help patients who had previously failed in psychotherapeutic treatment, presumably because of trouble in establishing a working therapeutic alliance with their therapist. Therapists are trained to be highly attentive to the therapeutic relationship and to signs of ruptures in the alliance, and to use self-disclosure and meta-communication about their perception of the therapy process, particularly when they become aware of ruptures, in order to repair the therapy alliance and at the same time help patients to develop a generalized capacity for observing self and others (mentalization). BRT has shown preliminary evidence for efficacy with patients who are at risk of negative outcome in psychotherapy (Safran et al., 2005) and with patients diagnosed with DSM-IV axis II personality disorders (Muran et al., 2005). A specific manual for BRT in MDD was developed for this project (Holmqvist, 2010).

Measures

Patient health questionnaire—9 (PHQ-9; Kroenke, 2001; Kroenke & Spitzer, 2002). The PHQ-9 is a brief self-report questionnaire for measuring the severity of symptoms of depression, demonstrating good reliability and validity in psychometric studies (Gilbody et al., 2007; Kroenke, 2001). Although developed as a screening measure for depression, the PHQ-9 has shown sensitivity to change (Cameron et al., 2008; Löwe et al., 2004, 2006). Internal consistency in this study was .91.

Working alliance inventory—short form revised (Falkenström et al., 2015; Hatcher & Gillaspy, 2006). The revised short form of the WAI is a 12-item patient-reported measure of the working alliance (Hatcher & Gillaspy, 2006). Several studies have shown the validity of the Swedish version of the WAI-SR in predicting symptom change during treatment (Falkenström et al., 2013, 2014, 2016; Larsson et al., 2018). The distinction between Goal and Task has consistently failed factor analytic tests, and the correlation between the Bond and the Goal/Task factor is also often high (Falkenström et al., 2015). For this reason, many researchers recommend using the overall mean of the WAI rather than subscales, and this is how we used it in this study. Internal consistency in this study was .95.

Working alliance inventory—short form (Hatcher et al., 2020). The WAI-S is another 12-item version of the WAI. It has shown satisfactory internal consistency, high correlations with the original WAI, and prediction of therapy outcomes in the expected direction (Busseri & Tyler, 2003). The therapist-reported version was recently found to have adequate psychometric properties in a fairly large study (Hatcher et al., 2020). In the present study, the therapist-reported version of the WAI-S and the patient-reported version of the WAI-SR were used. The reason for using different instruments was that although the WAI-SR is more thoroughly evaluated psychometrically, at the time the study was planned there was no psychometric evaluation of the therapist version of the WAI-SR. Internal consistency in this study was .95.

Feeling word checklist—24 (FWC-24; Lindqvist et al., 2017). The FWC-24 is a self-report instrument asking the clinician (or the patient) to report to what degree he or she has experienced various feelings during a therapy session. The 24 feeling words are rated on a scale ranging from 0 (not at all) to 3 (very much). Of the four subscales found by multilevel factor analysis (Lindqvist et al., 2017), only one consisted of negative feelings (“Inadequate”; consisting of feeling annoyed, shameful, bored, cold, helpless, indifferent, tense, and paralyzed). Of the other subscales, one measures clearly positive feelings (“Engaged”; feeling content, energetic, enthusiastic, free, happy, open, and playful). The remaining two subscales are Moved and Relaxed, both of which seem to capture more low-intensity positive (or perhaps the absence of anxiety, in the case of Relaxed) feelings. The Moved subscale had low internal consistency in this study (Movedtherapist: α = .55, Movedpatient: α = .44) and was therefore not used, while the other three subscales had adequate internal consistencies (Inadequatetherapist: α = .80, Engagedtherapist: α = .86, Inadequatepatient: α = .77, Engagedpatient: α = .83, Relaxedtherapist: α = .78, Relaxedpatient: α = .80). In the current study, we used only one of the patient subscales (Engaged).

Since the WAI is only one way of measuring the working alliance, and a recent review of working alliance theory notes that Bordino’s (1979) definition of the alliance (on which the WAI is based) is limited (Horvath, 2018). For instance, R. Hatcher (personal communication, 26 April 2021) noted that the term agreement between therapist and patient on tasks and goals is problematic and suggested that the
patient’s engagement in the work of therapy might be a better indicator of the presence of a working alliance. For this reason, we piloted the use of the FWC subscale “Engaged” as an additional potential indicator of working alliance in addition to the WAI.

The FWC-24 has previously been used to study for instance associations between therapist feelings and outcome (Holmqvist, 2000; Holmqvist & Armelius, 2000), the significance of specific therapist reactions (Holmqvist, 2001), and associations between therapist feelings and patient narratives (Holmqvist et al., 2002). However, more detailed validity analyses have to our knowledge not been done.

Treatment Adherence

Adherence was rated by nine undergraduate students. IPT adherence was rated using the Collaborative Study Psychotherapy Rating Scale (CSPRS; Evans et al., 1984), and BRT adherence was rated using the Beth Israel Adherence Scale (Spektor, 2007). In total, 119 sessions were rated for adherence, 62 in BRT and 57 in IPT, with average Intraclass Correlation ICC = .67 (IPT) and ICC = .75 (BRT). The sessions were taken from 29 treatments, with the number of sessions rated per treatment varying between one and six. The sessions were evenly spread out over treatment, with the earliest being session three and the latest session 15. Since the adherence scales for the two treatments were not created with the purpose of separating IPT from BRT, we also created four new items specifically aimed to distinguish IPT from BRT. These were: (1) Session focus: Did the therapist focus on events and relationships outside the therapy room, or on what happened inside the therapy room in the relationship between therapist and client? (2) Therapist stance: Did the therapist take an expert role in which she/he had a clear explanation to the client’s condition, or did the therapist convey that the client is an expert on her own condition/problems? (3) Change focus: Did the therapist focus on helping the clients solve interpersonal problems in their daily lives, or did the therapist focus on increasing the clients’ awareness of processes in the therapy room? (4) Approach to depression: Did the therapist speak about the client as a well-known and defined disease that the client had been afflicted by (assigning a sick role), or did the therapist approach the client’s condition as a unique subjective experience to be explored? These four items were rated on a seven-point Likert scale, with higher values being associated with BRT (the second choice in each item) and lower values with IPT (the first choice in each item).

The difference in adherence between IPT and BRT was tested by a random intercept model with repeated measures nested within patients. IPT adherence was higher in IPT (mean = 2.02, SD = 0.58) than in BRT (mean = 1.63, SD = 0.53), mean difference = 0.35 (SE = 0.17, p = .04). BRT adherence was significantly higher in BRT (mean = 2.56, SD = 0.68), than in IPT (mean = 1.75, SD = 0.49), mean difference = 0.67 (SE = 0.18, p < .001). Both treatments were rated similarly high on common factors adherence (e.g., warmth, empathy, encouragement; IPT mean = 4.08, SD = 0.74; BRT mean = 4.34, SD = 1.06; mean difference = −0.23, SE = 0.26, p = .38). Finally, the newly developed 4-item IPT vs BRT adherence scale showed adequate internal consistency (α = .83) and was rated with adequate inter-rater reliability (average ICC = .74). This scale showed clear separation between IPT and BRT, with BRT treatments scoring 1.56 points higher (i.e., in the direction of BRT adherence) than IPT treatments (SE = 0.37, p < .001).

To summarize, treatments could be differentiated by all treatment-specific adherence scales, while both treatments were high on common factors (as they should). The fact that IPT adherence was still fairly high in BRT can probably be explained by (1) BRT being a fairly unstructured treatment, with no proscribed interventions (meaning that therapists are allowed to do some IPT as long as they keep the main focus on the meaning of these interventions in terms of the patient-therapist relationship), and (2) some items on the IPT adherence scale are common to both IPT and BRT, such as attending to and exploring emotions.

Procedure

After inclusion, patients were randomized to IPT or BRT in blocks of six, stratified within therapists. That is, each therapist was to treat six patients, three using IPT and three using BRT. Sequences with the same treatment three times in a row were blocked to prevent therapists knowing too early the randomization sequence (which they would do if the same treatment appeared three times in a row). A random sequence was generated by the Random Allocation Software (Saghaei, 2004). The study was approved by the regional ethics board of Linköping (M59-08). Before each session, patients filled out the PHQ-9, and immediately after each session patients and therapists filled out the WAI-S/WAI-SR and the FWC-24.

Statistical Analysis

The data in this study is structured as panel data, with variation both between participants and within
participants across sessions. The choice of method for analyzing panel data depends on the combination of sample size (N) and length of time-series dimension (T). In this study, we had relatively small N (40 patients), but reasonably large T (16 sessions). This combination is suitable for dynamic structural equation modeling (DSEM; Asparouhov et al., 2018) which combines aspects of time-series analysis (traditionally used in single-case designs with large T — usually at least 30–50) with multilevel modeling (e.g., Snijders & Bosker, 2012) and Structural Equation Modeling (e.g., Kline, 2016). The combination of information on a time-series level from several persons makes it possible to estimate with smaller T than one-third (single-case) time-series analysis and smaller N than traditional cross-sectional analysis (Schultzberg & Muthén, 2018). More information on DSEM, effect size considerations, power analysis/tests of estimator performance, and calculation of long-run effects are given in the Online Supplement.

Results

Descriptive Statistics and Preliminary Analyses

Table I shows descriptive statistics for the included variables. As can be seen, there were no significant differences between the treatments on any of the variables. Multilevel intraclass correlations showed that about half to one-third of variance was on the repeated measures level. Therapist-level ICC:s (not shown in the table) were .00 for all patient-rated variables (PHQ-9, WAI-SR, Engaged and Inadequate), while for the therapist-rated variables it ranged from .04 for Engaged to .14 for WAI-S. However, average therapist differences are relegated to the between-patient level in the DSEM models, so these will not affect the within-patient estimates that we focus on (Falkenström et al., 2020a).

Hypothesis 1: Negative feelings predict stronger increase/less decrease of depressive symptoms to the following session IPT than in BRT

Based on the exploratory models together with theoretical considerations (see Online Supplement), we constructed our moderated mediation model, shown in Figure 1. Using this model, all within-patient effects are adjusted for between-patient differences, depression level at session t-1, and residual correlation between the two mediators (WAI_{it-1} and Engaged_{it-1}). The direct effect of Inadequate_{therapist, it-1} on PHQ-9_{it} was negative (-.11, se = .04, p < .01, 95% CI [-.21, -.03]), i.e., more negative therapist feelings predicted decrease in depressive symptoms to the following session. However, this was only the case in BRT, which was the reference category. The significant path from IPT \times Inadequate_{it-1} to the path from Inadequate_{it-1} \rightarrow PHQ-9_{it} indicates that in IPT, this effect was .09 weaker (se = .04, p = .02, 95% CI [.01, .18]), supporting Hypothesis 1. Thus, in IPT, the patient’s depression level was not predicted by the therapist’s Inadequate feelings in the previous session (conditional direct effect = .01, se = .04, p = .80, 95% CI [-.07, .08]).

Hypothesis 2: The differential prediction of depressive symptoms from negative feelings between IPT and BRT is mediated by the working alliance

Inadequate_{therapist, it-1} significantly predicted WAI_{it-1} (-.30, se = .04, p < .001, 95% CI [-.38, -.22]), which in turn significantly predicted PHQ-9_{it} (-.09, se = 0.04, p = .02, 95% CI [-.17, -.02]). The indirect effect of Inadequate_{therapist, it-1} on PHQ-9_{it} via WAI_{it-1} was -.30 \times -.09 = .03 (se = .01, p = .02, 95% CI [.01, .05]), meaning that increased negative therapist feelings indirectly predicted increase of the patient’s depressive symptoms to the next session, via deterioration in the alliance. This, however, did not differ between IPT and BRT (p > .48 for moderation of both “a” and “b” paths of the mediation model), thus rejecting Hypothesis 2.

In the second mediation path, Inadequate_{therapist, it-1} \rightarrow Engaged_{patient, it-1} \rightarrow PHQ-9_{it}, Inadequate_{therapist, it-1} predicted Engaged_{patient, it-1} significantly (.16, se = .04, p < .001, 95% CI [-.24, -.08]), and in turn Engaged_{patient, it-1} predicted PHQ-9_{it} (-.07, se = .04, p < .05, 95% CI [-.14, .00]). The indirect effect was -.16 \times -.07 = .01 (se = .01, p < .05, 95% CI [.00, .02]). Like the first indirect path (via the alliance), this did not differ between IPT and BRT (p > .79 for tests of both “a” and “b” paths of the mediation model); and increased negative therapist feelings predicted increase/less decrease of the patient’s depressive symptoms to the following session via the alliance.

These findings mean that in both IPT and BRT, when the therapist feels more negative feelings in a session, the alliance tends to be worse, and when the alliance is worse, the patient’s depression tends to decrease less or increase to the following session. However, in BRT (but not IPT) sessions, when the alliance is unrelated to the therapist’s negative feelings, the patient’s depressive
symptoms tend to decrease more to the following session.

Hypothesis 3 and 4: Positive Therapist Feelings Predict Decrease of Patient Symptoms via the Working Alliance, with a Larger Effect in BRT than in IPT

The therapist’s engaged feelings as predictor.

Based on the exploratory analyses (see Online Supplement) and theoretical considerations, we constructed our moderated mediation model for Engagedtherapist,it-1 (see Figure S2 in the Online Supplement). Although our exploratory analyses did not find moderated or unmoderated direct effect of Engagedtherapist,it-1 on PHQ-9it, we still included these terms in the initial model out of concern that not doing so might distort estimates for other paths. The estimates for the initial model showed that the interaction term IPTi × Engagedtherapist,it-1 was non-significant in the equations for WAIit-1 and PHQ-9it. Therefore, this term was removed from these equations and the model re-estimated. The final model included an unmoderated direct effect of Engagedtherapist,it-1 on PHQ-9it (estimate = .06, se = .03, p = .02, 95% CI [.01, .12]) and on WAIit-1 (estimate = .31, se = .04, p < .001, 95% CI [.22, .39]), and a moderated effect of Engagedtherapist,it-1 on Engagedpatient,it-1 (main effect = .21, se = .05, p < .001, 95% CI [.10, .32]; interaction effect = .12, se = .05, p = .01, 95% CI [.02, .22]). The indirect effect of Engagedtherapist,it-1 on PHQ-9it via WAIit-1 was -.02 (se = .01, p = .02, 95% CI [-.05, -.01]). The indirect effect of Engagedpatient,it-1 on PHQ-9it via Engagedpatient,it-1 was -.02 (se = .01, p = .03, 95% CI [-.04, -.00]) in BRT, and -.03 (se = .01, p = .03, 95% CI [-.06, -.00]) in IPT.

These results mean that in a session when the therapist felt more engaged, the alliance was better, and the patient felt less depressed by the next session, supporting Hypothesis 3. Similarly, when the therapist felt more engaged, the patient also tended to feel more engaged—and this was more so in IPT than in BRT—and when the patient felt more engaged, the patient’s depressive symptoms were lower by the next session. However, if the alliance and the patient’s engaged feelings were unrelated to the therapist’s engaged feelings, the patient reported decreased depressive symptoms in the following session. The findings support Hypothesis 3 (positive therapist feelings positively affect the working alliance), but not Hypothesis 4 (positive feelings have a stronger impact in BRT).

The therapist’s relaxed feelings as predictor.

The mediation model was constructed like the one for Engagedtherapist. The interaction term IPTi × Relaxedtherapist,it-1 was non-significant in all equations (all p > .10), so this term was removed and the model re-estimated. The only significant effect in the final model was the indirect effect of Relaxedtherapist,it-1 on PHQ-9it via WAIit-1 (Relaxedtherapist,it-1 → WAIit-1 → PHQ-9it: -.02, se = .01, p = .03, 95% CI [-.05, -.00]). These results mean that when the therapist felt more relaxed in a session, the alliance would be better in that session, and the patient would report decreased depressive symptoms in the following session (regardless of treatment model). The findings support Hypothesis 3 (positive therapist feelings positively affect the working alliance), but not Hypothesis 4 (positive therapist feelings have a stronger impact in BRT).

Long-run Direct and Indirect Effects

To estimate the prediction of outcome from therapist feelings on a longer timescale, we calculated two

| Table I. Descriptive statistics for variables included in analyses. |
|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| BRT              | IPT              | BRT              | IPT              | BRT              | IPT              | BRT              | IPT              |
|                 | N | M     | SD    | Min  | Max   | N | M     | SD    | Min  | Max   |
| Engaged          | 273 | 1.57 | 0.44  | 0.29  | 3.00  | 295 | 1.63 | 0.47  | 0.00  | 2.71  |
| Inadequate       | 273 | 0.56 | 0.46  | 0.00  | 1.71  | 295 | 0.57 | 0.42  | 0.00  | 2.43  |
| Relaxed          | 273 | 1.89 | 0.49  | 0.20  | 3.00  | 295 | 1.91 | 0.44  | 0.00  | 3.00  |
| WAI-S            | 273 | 4.92 | 0.79  | 2.92  | 6.92  | 295 | 5.09 | 0.86  | 2.33  | 7.00  |
| Engaged          | 275 | 1.24 | 0.61  | 0.14  | 3.00  | 285 | 1.37 | 0.61  | 0.14  | 3.00  |
| WAI-SR           | 278 | 5.33 | 1.09  | 2.10  | 7.00  | 288 | 5.59 | 1.02  | 2.58  | 7.00  |
| PHQ-9            | 278 | 12.27| 7.30  | 1.00  | 27.00 | 293 | 10.80| 6.10  | 0.00  | 27.00 |

aInternal consistency/Cronbach’s alpha.
bMultilevel ICC measuring degree of nesting (proportion between-patient variance to total variance).
cMean value for BRT minus mean value for IPT, estimated using random intercept model with repeated measures nested within patients.
kinds of long-run effects (for more information, see Online Supplement). We calculated the long-run effects separately for the direct and indirect effects, over various session lags. The left-hand part of Figure 2 shows the effect of a transient change in negative therapist feelings\(^1\) for the indirect effects of

![Figure 1. Dynamic structural equation model with working alliance (WAI, combined patient- and therapist ratings) and patient-rated Engaged feelings as mediators between therapist Inadequate feelings (I) and patient-rated depressive symptoms (PHQ-9). Since treatment did not significantly moderate the paths from I to WAI/Engaged or from WAI/Engaged to PHQ-9, these were constrained to enable calculation of the average indirect effect. Random intercepts are labeled \(u_{1i}, u_{2i}\) and \(u_{3i}\), while (Level-1) error terms are labeled \(\varepsilon_{1it-1}, \varepsilon_{2it-1}\) and \(\varepsilon_{3it}\).

![Figure 2. Long-run mediated effects of negative (inadequate) therapist feelings. The left-hand graph shows the effects of a one-standard deviation change in negative feelings at a single session on change in patient depression via working alliance and patient engaged feelings in terms of standard deviation units at one- to eight-session lags. The right-hand graph shows the effect of a sustained change in therapist negative feelings on change in patient depression in terms of standard deviation units at one- to eight-session lags. The black line shows point estimates, while the gray area shows 95% CI.](image-url)
Inadequate\textsubscript{therapist} on PHQ-9, via WAI and Engaged\textsubscript{patient} (combined) up to eight lags\textsuperscript{2}. What is shown is the effect of an increase/decrease in therapist feelings in a single session on PHQ-9 at various later lags, taking into account autoregression and feedback effects. This effect tends to diminish with increasing lags at a rate that is determined by the size of the coefficients involved. As can be seen, the effect diminishes rather slowly, due to the strong autoregression and feedback loops from PHQ-9\textsubscript{it} to WAI\textsubscript{it} and Engaged\textsubscript{patient, it} and back to PHQ-9\textsubscript{it+1}.

To also get an estimate of the potential effect of more sustained/chronic negative therapist feelings, we calculated the long-run effect of a stable change in Inadequate\textsubscript{therapist}. The right-hand part of Figure 2 shows the long-run effect of the combined indirect effects of Inadequate\textsubscript{therapist} on PHQ-9 via WAI/Engaged\textsubscript{patient}. As can be seen, this effect increases over increasing lags, but the increase diminishes as lag length increases. This effect approaches .20 over longer session lags, showing that although the indirect effect from one session to the next may seem small, the total effect over time is considerably larger. For the direct effect in BRT, Figure 3 shows the transient and sustained change estimates. As can be seen, the direct effect of a change in therapist negative feelings in a single session on depressive symptoms is reduced to half in about four sessions. A sustained change in therapist negative feelings, however, approaches -.50 at longer session lags\textsuperscript{3}.

**Discussion**

The therapist’s feelings have traditionally been considered problematic, as indicators of the therapist’s own problems evoked in the interactions with the patient. In contemporary variants of psychodynamic therapy, like BRT, an active use of therapist reactions in order to highlight problematic enactments in the therapy relationship in therapeutically useful ways has been proposed (e.g., Safran & Muran, 2000). In what we believe to be the first study on within-patient session-by-session prediction of outcome from therapist feelings, we analyzed the relationship between the therapist’s reported feelings and subsequent patient symptom reports in two therapies, one focusing on work in the therapeutic relationship, including meta-communication about therapist feelings (BRT) and one focusing on the patient’s relationship issues outside the therapy relationship (IPT) in which meta-communicating is not encouraged. We hypothesized that the relationship between therapist feelings and change in depressive symptoms would be different in the two treatments, with less negative/more positive predictions of depression from negative therapist feelings in BRT than in IPT—presumably due to the therapists’ use of in-session metacommunication about these feelings in BRT. We also expected this difference in prediction of depression symptoms from therapist feelings to be mediated by the alliance.

Our results suggest that if the therapist experiences more negative feelings in a particular session, the alliance gets worse, the patient feels less engaged, and depressive symptoms are likely to deteriorate to the following week. Conversely, if the therapist feels more positive/engaged feelings in a session, it is likely that the alliance is better, the patient feels more engaged, and that depressive symptoms will improve in the following week. In addition, when the therapist feels more relaxed feelings in a session, the working alliance will be better, and in turn the patient’s depression is likely to decrease to the following session. This is, according to our analyses, the same in both IPT and BRT, although the therapist’s engaged feelings predicted the patient’s engaged feelings stronger in IPT than in BRT.

In theory, it seemed likely that a differential effect between BRT and IPT of the therapist’s negative feelings on the patient’s depressive symptoms would be mediated by the working alliance (which is the primary mechanism of change in BRT), but this was not what we found. Instead, our findings suggest that if the therapist’s negative feelings in a BRT session do not affect the working alliance or the patient’s engaged feelings, the patient’s depressive symptoms will improve to the following session. This finding points to a modality-specific mechanism of change in BRT. One explanation for this surprising result might be that our analyses are done on a fairly small timescale, within single sessions or from one session to the next. On this timescale (within the same session), self-disclosure/meta-communication about negative feelings might not enhance the alliance, but it may still prevent negative feelings from impacting the alliance (i.e., blocking the paths from negative feelings to alliance/engagement, thus enabling the path from negative feelings directly to PHQ-9). Another possibility is that when conducting IPT the therapists would use some other means of repairing alliance ruptures that are more in line with IPT (e.g., asking about the patients’ emotions).

Another surprising finding that we had not hypothesized was that when the therapist felt engaged feelings in a session, but these feelings did not affect the alliance or the patient’s engaged feelings, the patient would improve less or even deteriorate to the following session. This finding, although not different between IPT and BRT, was similar to the positive direct effect of negative feelings in BRT in the sense that it seems counterintuitive that negative
feelings would predict better outcome and positive feelings worse outcome. One possibility is that these findings together reflect the difference between missing or picking up the patient’s painful affects in a session. If the therapist pursues painful affects in the session with the patient, this may lead to feelings of discomfort in both parties, but ultimately better outcome for the patient. On the other hand, a therapist who feels good in the session despite the patient not feeling good may be going along with the patient’s defenses, with the result that the patient feels abandoned.

Although the direct path from therapist feelings to depression change (by definition) are not explained by any mediators, this does not necessarily mean that there are no mediators for these paths. There may be unobserved mediators that explain the positive relationship between therapists’ negative feelings and patient improvement in BRT, and between therapists’ engaged feelings and deterioration in both treatments. Since one of the central interventions in BRT is self-disclosure by the therapist to facilitate meta-communication about the therapy relationship, one potential mediating variable—at least for negative feelings—might be the patient’s experience of the therapist’s openness and engagement in their relationship. Returning to Rogers (1957) account of the conditions for therapeutic change, this would be the factor of congruence, or authenticity. Another explanation could be that the patient’s mentalizing capacity is increased by mutual discussions about the therapeutic relationship, stimulating the patient to greater curiosity and enhanced learning in social interactions outside the therapy relationship, as suggested by Fonagy et al. (2015) in their communication systems model. It is also possible that the process of discussing negative feelings openly with the patient facilitates the therapist’s internal processing of these feelings, so that the therapist becomes less preoccupied with negative feelings during the session and as an effect able to express more empathy and positive regard for the patient.

The finding that the path between the therapist’s and the patient’s engaged feelings was stronger in IPT than in BRT may point to another difference in the way these treatments work. In IPT, the therapist may be more openly encouraging of therapeutic progress, especially regarding interpersonal problems that are part of the agreed upon interpersonal focus. Such open encouragement may mean that the therapist’s engaged feelings are transmitted to the patient more easily. In BRT, the focus on encouraging positive development is not as natural. Up till now, the interest in BRT has been on disclosing and exploring feelings about rupture events. Ways and reasons for disclosing positive feelings has been less developed in the literature and may be felt as less natural in the psychodynamic tradition.

Our findings indicated an indirect effect for Relaxed feelings on decrease in the patient’s depression via the working alliance. Previous research indicates that anxiety in the therapist is a common marker of countertransference (Hayes

Figure 3. Direct effect of therapist negative feelings in Brief Relational Therapy. The left-hand graph the effects of a one-standard deviation change in negative feelings in a single session on change in patient depression in terms of standard deviation units at one- to eight-session lags. The right-hand graph shows the effect of a sustained change in therapist negative feelings on change in patient depression in terms of standard deviation units at one- to eight-session lags. The black line shows point estimates, while the gray area shows 95% CI.
et al., 2018). Thus, in addition to the findings of positive effects of engaged therapist feelings, it may be that Relaxed feelings indicate an absence of problematic countertransference. This would explain its positive relationship with the working alliance, and indirectly with decrease in depressive symptoms.

The effects of therapist feelings on next-session depressive symptoms were mostly in the small range, according to the criteria we used (see Online Supplement). However, to get a sense of the total effect of therapist feelings on the patients’ depressive symptoms, we also calculated the long-run effects. This showed that although from one session to the next the effect of therapist feelings on patient depression was not very large, if therapist feelings were sustained over several sessions this effect accumulated to what is usually considered a small-to-medium sized effect (see Figures 2 and 3). To us, this shows the importance of taking into account long-run effects in session-by-session prediction models (Shamsollahi et al., 2021).

Our long-run effect calculations showed that a sustained change in therapist feelings can predict patient symptoms strongly at later lags (see e.g., right-hand part of Figure 3). Still, it is important to consider under what circumstances sustained changes are likely. For the direct effect of negative feelings on patient depressive symptoms, it may not be a realistic scenario that these feelings will remain for several sessions, with a continued positive effect on patient symptoms and that transient changes (left-hand part of Figure 3) are more realistic. Clinically and theoretically, it seems unlikely that a negative feeling that the therapist meta-communicates with the patient about will be sustained after having an initial positive effect on patient symptoms. In support of this, we found that the alliance in the previous session predicted negative feelings, that is, the better the alliance, the less negative feelings the therapist will report in the following session. Since, according to the model, decreases in depressive symptoms lead to increases in alliance scores, a decrease in depressive symptoms due to negative therapist feelings will feed back into decreased negative therapist feelings in the following session indirectly via a positive change in the alliance.

Interestingly, the opposite may be true for the indirect effect of negative therapist feelings on depressive symptoms. Increased negative feelings predict worse depressive symptoms via deterioration in the alliance, and deterioration in the alliance in turn predicts more negative feelings in the following session. This generates a negative feedback loop, in which negative feelings will be sustained for longer periods. Thus, for the indirect effects, the long-run sustained effects shown in Figure 2 (right-hand part) may be a realistic scenario. A clinical implication of this is that therapists need to be aware of the risk that negative feelings may cause deterioration in the alliance, which in turn may have negative consequences for therapy outcome and that this in turn may exacerbate the problem with negative feelings. Thus, when experiencing negative feelings, it is important that therapists take appropriate action to avoid these negative feelings affecting the work with the patient in deleterious ways. Supervision is one obvious way of doing this, but there are probably other ways that may differ between treatments. As mentioned, in the context of BRT, the therapists are encouraged to use their feelings in self-disclosure/meta-communication, but there may be other ways that are more appropriate in other treatments. Long-run effects of positive therapist feelings (engaged and relaxed feelings, see Online Supplement) can be interpreted in similar ways.

The findings suggest that these two therapy methods have partly different mechanisms of change with regard to the therapeutic interaction. Disclosure of negative therapist feelings may contribute to therapeutic change in BRT. In IPT, positive therapist feelings may engender similar feelings in the patient, leading to symptom reduction.

Strengths and Limitations

There are several strengths of the current study. The randomization of patients to IPT or BRT strengthen causal inference for the differential direct effect between treatments. Within-patient analyses, including robustness to detrending, also strengthens causal inference (Falkenström et al., 2017, 2020b). In addition, the use of session-wise measurements of clinically meaningful variables, analyzed by state-of-the art statistical methods, on a sample of patients diagnosed with Major Depressive Disorder, treated by therapists trained in both IPT and BRT are also strengths. The “crossed therapist” design, which has some disadvantages as a trial design (Falkenström et al., 2013), is here an advantage because we can rule out that the way therapist feelings are handled is solely a competence of the individual therapists. Since the same therapists provide both treatments, it must be something about conducting BRT that makes negative feelings a positive predictor of improvement in depression in this treatment. Importantly, though, this should not be understood as if BRT had better outcome than IPT, but that therapist feelings may be a mechanism of change in BRT but not in IPT (at least not a mechanism of improvement).
Limitations include a small Level-2 sample size (\( N = 40 \)). A larger sample would have enabled more complex modeling, e.g., including autoregression and feedback mechanisms between negative feelings and the alliance variables. This, in turn, would have enabled even more complex dynamic predictions over the course of therapy. Long-run effects were calculated from the model depicted in Figure 1, in which autoregression in Inadequate\textsubscript{therapist}, WA\textsubscript{I} and Engaged\textsubscript{patient} were ignored. Had these paths been included, long-run effects would likely have been stronger, since additional indirect effects would have been added.

Also, the ability to draw causal conclusions would have been stronger had we been able to show lagged predictions for the Therapist feelings \( \rightarrow \) Alliance/Engagement paths. However, for this we would have needed within-session measurements, since it seems unlikely clinically that potential effects of therapist feelings on alliance or patient engagement would take as long as a week to materialize. Alternatively, the alliance could be viewed as a moderator of the Inadequate \( \rightarrow \) Depression path. Analyzing the data this way showed similar results to the ones presented. Interestingly, the change in interpretation would be subtle; instead of saying that negative therapist feelings predicted worse alliance, which in turn predicted increase in symptoms, we would say that negative feelings in the context of a bad alliance would predict worse outcome.

Finally, the FWC subscales are insufficiently validated; more work needs to be done on the psychometrics—especially regarding validity—for these scales.

Conclusions and Recommendations for Future Research

Our findings are in line with previous research indicating detrimental effects of negative countertransference on patient outcome (Hayes et al., 2018). They also extend these findings by showing that the working alliance and patient feelings of engagement in the therapy sessions mediate the effect of therapist feelings on next-session depression level. Moreover, as far as we know for the first time, we found evidence of a positive effect of negative therapist feelings on outcome, specifically in a treatment in which therapist feelings is utilized for therapeutic purposes. We also found positive effects of positive (engaged and relaxed) feelings in the therapist on outcome. The findings indicate that clinicians should closely monitor their feelings during sessions. When negative feelings occur, the clinician should try to use whatever measures at their disposal so that these negative feelings do not lead to deterioration in the alliance and/or a reduction in the patient’s positive feelings. It seems likely that careful use of self-disclosure may be useful for that purpose, although we have no direct evidence for that from this study.

Future research should attempt to replicate these findings, since they should be seen as at least partly exploratory. It would be interesting with qualitative analyses of BRT sessions in which the therapist reports high levels of negative feelings, to see whether additional mediators of its positive effect on depressive symptoms can be identified. Such a study could also verify whether, as we suspect, therapists use self-disclosure of their feelings in these sessions. We also strongly recommend researchers to consider the longer-term implications of session-by-session predictions in dynamic systems by calculating long-run effects. As we hope to have shown, long-run effects via autoregression and feedback loops can have important clinical and theoretical implications.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

Supplemental Data

Supplemental data for this article can be accessed doi:10.1080/10503307.2021.1998700

Notes

1 This is called an impulse-response function in the methods literature (see Shamsollahi et al., 2021; Zyphur et al., 2020).
2 The change in effect with additional lags got close to zero and the number of indirect effects so large (> 2000) that calculation was complicated.
3 See Online Supplement for similar figures for Engaged and Relaxed feelings.

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