Clients' Internal Representations of their Psychotherapists Across Different Treatment Modalities

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Abstract

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Research suggests that internalization of the therapeutic relationship promotes a continuation of psychological development in between psychotherapy sessions and after termination. This study explored whether clients being treated by therapists adhering to different therapeutic modalities internally represent their therapists in significantly different ways. The study consisted of an online survey of 212 individuals who had undergone therapy in the past two years, and included questionnaires regarding the nature of their internal representations of their therapists and working alliance with their therapists. The study provided evidence in support of the hypothesis that there are indeed some modality-informed differences in internal representations of therapists, particularly in the themes and affects associated with internalizations.

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Chapter 1: Background

A growing body of research has examined important facets of psychotherapy patients' internal representations of their therapists. Internal representations refer to the manner in which people "transform personally experienced events into networks of emotionally charged representations of the self and others" (Farber & Geller, 1993, p. 167). Through internalization, "the subject transforms real or imagined regulatory interactions with [the] environment, and real or imagined characteristics of [the] environment into inner regulations and characteristics" (Schafer, 1968, p. 9). The concept of internal representations of therapists, then, refers to how patients may "take their therapists with them," so to speak, such that aspects of the therapist or of the therapeutic relationship become incorporated into the patient's self-talk, personality, or even identity. Taken as a whole, this research has supported the theory that the nature of clients' internal representations of their therapists correlates with and can have an influential role in treatment outcomes (Geller, 1984; 1987; Henry et al., 1990; Orlinsky et al., 1993).

A key aspect of this topic that has not been thoroughly researched, however, is the manner in which patients' internal representations of their therapists may differ based on therapeutic modality. (In the context of this paper, "therapeutic modality" will refer to the orientation or style of therapy employed, such as cognitive behavioral therapy or psychodynamic therapy.) This study works toward filling said gap by examining the ways in which patients experiencing varying therapeutic modalities may differ in internalizing their therapeutic relationships, as well as in later utilizing these internalized representations outside of the treatment setting. The primary aim of this study, then, is to investigate whether therapeutic modalities influence patients' internal representations of their psychotherapists. Differences in the nature, themes, and

situations in which internal representations of therapists are invoked are expected due to the differing priorities and foci of each modality.

Prior theoretical writings have laid the groundwork for elucidating the topic of patients' internal representations of therapists. Singer and Pope (1978) remarked, "[patients] in a sense adopt the therapists as a kind of imaginary companion, someone to whom they talk privately in their minds... gradually assimilating what in effect the [therapist] has been teaching [them] about a process of self-examination and heightened self-awareness" (p. 21). Strupp (1978) wrote in a similar vein: "since the internalization of bad objects has made the patient ill, therapy succeeds to the extent that the therapist can become a good object" (p. 15). In other words, these authors suggest that therapy succeeds insofar as the therapist becomes internalized as an adaptive, therapeutic entity in the psyche of the patient.

The topic of internalized representations of therapists has been highlighted in research as well. Early studies on the topic found that 90% of participating patients reported thinking about their therapists and therapy between sessions (Orlinsky & Tarragona, 1989; Tarragona & Orlinsky, 1987). These representations endured in some regard after the therapy was terminated as well. Indeed, Orlinsky et al. (1993) found that "the correlation between number of years since termination and frequency of experiencing representations was statistically significant [...] but the correlations of time since termination with the duration and vividness of representations were not" (pp. 602-603). In a previous study, Geller et al. (1981) had also found that patients experienced therapist representations most vividly, and evoked them most often, under stressful conditions, suggesting that the internal representation of the therapist was being evoked in order to help manage difficult emotions. A study by Barchat (1989) showed that during therapist-imposed breaks from therapy, patients' resentment at their therapists' absence correlated

inversely with the degree of vividness with which they visualized their therapists. In other words, the results suggested that when patients could not access a vivid internal representation of their therapist, they tended to feel more resentment at their therapist for being absent. This underscores the notion that vivid internal representations of therapists can "stand in" for the therapist's physical persona.

Research has shown that the manner in which patients internally represent their therapists can not only reflect but may also affect the outcome of therapy, comprising a critical element of the healing process (Knox et al., 1999; Geller, 1984; Geller et al., 2011). Indeed, various theorists and researchers assert that many of the most important experiences that occur in therapy are those which facilitate the construction and/or reactivation of influential cognitive–affective representations of the therapist (Dorpat, 1974; Edelson, 1963; Geller, 1984; Horwitz, 1974; Kohut, 1971; Loewald, 1960; Schafer, 1968; Strupp, 1978). Some research has also suggested that patients' improvement is related to the extent to which they are able to evoke representations of the therapist and the therapy relationship (Rosenzweig et al., 1996). Additionally, Geller et al. (1981) demonstrated that patients' perceptions of therapeutic benefit were positively correlated with the tendency to draw upon visual representations of their therapists, and with the tendency for such representations to be used in the service of continuing the therapeutic dialogue.

Research has shown that certain aspects of these representations are related to the nature of therapist-patient relationships overall, and to their therapeutic working alliances. For instance, a study by Knox et al. (1999) demonstrated that good therapeutic relationships correspond with patients invoking internal representations within sessions, beyond sessions, or both. Knox et al. found that these representations combined auditory, visual, and kinesthetic (i.e., felt presence) modalities; were triggered when clients thought about past or future sessions, or when distressed;

occurred in diverse locations; and varied in frequency, duration, and intensity. Not surprisingly, patients who felt positively about their relationships with their therapists felt positively about their representations thereof. Further, studies have shown that patients' improvement is connected to the extent to which patients are able to evoke representations of components of the therapy relationship, such as the therapist him- or herself (Knox et al., 1999; Rosenzweig et al., 1996).

In exploring *how* internal representations function to create therapeutic change, Orlinsky et al. (1993) found that patients' internal representations of therapists were linked to a concept known as "afterwork" (Bernard & Drob, 1989), through which patients would continue, post termination, processing and working on topics discussed in therapy. Freud (1937) originally alluded to the concept of afterwork when he said:

> We hope and believe that the stimulus received in the learner's own analysis will not cease to act upon him when that analysis ends, that the process of ego transformation will go on of their own accord and that all further experiences will be made use of in a newly acquired way. This does indeed happen and, in so far as it happens, it qualifies the learner who has been analysed to become an analyst (p. 352).

Various elements of a therapy may contribute to the achievement of fruitful "afterwork," and Geller et al.'s findings suggest that internal representations of therapists may constitute one such element; they found that patients with more vivid and positive representations of their therapists were more likely to apply their therapists' interventions in helping them solve or keep working on problems in between sessions. Further, Orlinsky et al. noted that the degree of participant endorsement of this "afterwork" was positively correlated with patients' perceptions of their improvement. Commenting on Orlinsky et al.'s research on this topic, Knox et al. (1999) wrote,

"Clients' internal representations may be the 'homework' of therapy, as well as the psychological connective tissue between successive sessions that enables clients to continue the work of therapy in the therapists' absence" (p. 3). Similarly, Geller and Freedman (2018) noted, "the readiness and ability to continue the therapeutic dialogue, representationally, in the physical absence of the therapist, is both a marker of having benefited from therapy, and a vehicle for transferring the influence of in-session interactions to extra-therapeutic situations" (p. 25). As Freud and others have discussed, the extension of therapeutic work into the real, broader lives of patients is an essential aspect of what makes therapy worthwhile and its effects enduring. Therefore, any understanding of conditions that enhance this afterwork could provide key insights on how to optimize therapeutic efforts and outcomes.

Indeed, the linked concepts of afterwork and internal representations of therapists are worthy of significant consideration, specifically with regard to their relationship to long-term effects of therapy. How does the therapy or therapist live on in the patient's life? Does the therapy as a whole become a memory that is stale and dormant, or do patients form schemas that are maintained in some form and can adapt to and impact new experiences in their lives? Geller and Freedman (2018) contend that as long as a patient "remains emotionally involved with, attached to, or dependent upon representations of the therapeutic dialogue to serve these psychological functions, he has not strictly speaking 'terminated' therapy" (p. 57).

1.1 Definition of Internal Representations

This study utilizes the definition of representations put forth by Orlinsky et al. (1993): "ideational events that are open to conscious introspection and self-report but, unlike perceptions, do not require (and typically do not have) the support of immediate sensory input" (p. 597). It also uses Farber and Geller's (1993) definition for internalization: "the concept of

internalization encompasses all those processes, including introjection and identification whereby individuals transform personally experienced events into networks of emotionally charged representations of the self and others" (p. 167). Whether referred to as "representations" in psychodynamic theory, or drawing more upon characteristics associated with "schemas," "scripts," or "mental models" from cognitive psychology conceptualizations, these constructs serve as "templates that guide feelings and behavior and direct expectations and interpretations of events" (Arnold et al., 2004, p. 292).

Internal representations of therapists are most commonly assessed through the survey instrument developed for this purpose, the Therapist Representation Inventory (TRI-II; Geller et al., 1992). This instrument aims to measure the degree of vividness of such representations, and the content and feelings evoked in patients' internal representations of their therapists. The three sections of the TRI which are relevant to this study are the Therapist Involvement Scale (TIS), the Therapist Embodiment Scale (TES), and the Affects Scale.

The Therapist Embodiment Scale is designed to assess the form of patients' representations of their therapists, determining which sensory modalities are enacted in the internal representation. In other words, it assesses the degree to which pictures, sounds, words, odors, and bodily sensations each contribute to the therapist representation. Answers on this scale are aggregated into scores on the following factors: Imagistic (referring to visual imagery, e.g., "I imagine my therapist sitting in his or her office"), Enactive (referring to kinesthetic or proprioceptive experience, (e.g., "I experience in myself certain characteristic bodily sensations" and "I am aware of a particular emotional atmosphere which gives me the sense that my therapist is "with me.'"), and Conversational-Conceptual (referring to real or imagined conversations with

the therapist, e.g., "I imagine a particular quality to the sound of my therapist's voice"; and "I think of my therapist as making specific statements to me.") (Geller & Farber, 1993).

The TIS focuses on "the functional themes that characterize the patient's involvement in consciously experienced thoughts, feelings, wishes, and fantasies about the therapist" (Orlinsky et al., 1991, p. 599). Results are scored based on Becker's factor analysis (2010) which produced three factors. The first factor was named Positive Internalization (e.g., "When I am having a problem, I try to work it out with my therapist in mind;" "I miss my therapist"). The second factor was labeled Failure of Benign Internalization and incorporated items such as, "I don't think that therapy had/will have a lasting effect on me". The third and final factor was labeled Sexual, Aggressive, and Extratherapeutic Themes (e.g., "I imagine being sexually involved with my therapist;" "I imagine my therapist and I eating together.")

Finally, the Affect Scale focuses on the feelings that patients have in association with the internal representation of the therapist. It asks patients to report the degree to which they experience each of 24 feelings (e.g., comforted, relieved, discouraged, angry, and anxious) when evoking a representation of their therapist.

This study hypothesizes that differences in the aforementioned outcome variables will be seen among different therapeutic modalities.

1.2 Modality-Based Differences

The primary aim of this study is to elucidate how treatment modality impacts patients' internal representations of therapists, an insight which could aid in the service of multiple goals. Not only would such findings help to clarify how treatment modalities compare on this construct, but they could help to identify factors that influence internal representations of therapists and others. Indeed, by delineating the effects of different therapies on internal representations, we

could learn not only about how to achieve better outcomes of therapy but also about the development and the emotional-cognitive experience of those internal representations that mediate these positive effects.

The present study hypothesizes that differences in the ways that varying therapeutic modalities approach the patient-therapist relationship in particular will correspond with differences in the nature of internalized representations. Internal representations will likely differ in the themes they invoke as well as the frequency, vividness, sensory modalities, associated affects, and situations in which patients invoke them.

Given that alternate modalities can have such different approaches to treatment, it is not only possible but likely that the manner in which patients relate to and internalize their therapists would differ based on modality. Indeed, some of the main elements of therapist-patient interaction vary widely across modality. For instance, therapists espousing different schools of thought may prioritize relational aspects of treatment to varying degrees. Contemporary psychodynamic therapies and humanistic/existential therapies tend to focus to a greater extent than various CBT schools on the relational rather than instrumental (more manualized) aspects of clinical work. It is likely that the extent to which a therapist invests in relational aspects of the therapy impacts the nature of ensuing internal representations.

Importantly, length of treatment may also play a role in influencing the nature of internal representations of therapists. Geller and Farber (1993) found that the greater the number of therapeutic sessions attended, the greater the likelihood that patients would use representations of their therapists to continue the work of therapy following termination. This suggests that patients who have been treated in long-term therapy are more likely to utilize therapist representations to a greater extent than those in shorter-term therapies. Length of treatment will be statistically

controlled for in order to clearly parse out the effects of modality characteristics -- other than length -- on internal representations.

Indeed, studies have shown that working alliance is also associated with internal representations of therapists. For example, patients' perceptions of a strong therapeutic alliance have been found to be associated with a pattern of supportive-guiding representations (Orlinsky & Tarragona, 1988; Tarragona, 1989). Further, Orlinsky et al. (1993) discuss the importance of having a positive internalized representation of the therapist in the service of maintaining a strong, productive therapeutic alliance:

> Access to such representations enables patients to retain, rehearse, and accumulate the therapeutic impact of successive sessions. Thus, a patient's schema of therapy-with-the-therapist comprises the psychological connective tissue between successive therapy sessions, which (for example) enables a series of affirmative interpersonal transactions to become a trusted therapeutic alliance capable of withstanding and counteracting the disruptive effect of negative transferences or momentary lapses in the therapist's empathy. (p. 598)

Differences in internal representations of therapists have not yet been studied based on therapists' theoretical orientations. However, the construct has been linked to other aspects of therapeutic modalities which are known to differ, namely working alliance and duration of therapy. Although these variables should be kept statistically separate from the variable of internalized representations, the fact that differences in these aspects of therapy produce differences in internalized representations lends credence to the notion that other differences in therapeutic modality will result in differences in internal representations of therapists.

Overall, the primary aim of this study is to investigate whether patients' ratings of the nature and content of their internal representations of their therapists differ significantly based on the modality of therapy with which they have been treated. That is, do different therapies correspond with statistically significant differences in the degree of vividness of patients' internal representations of therapists, the feelings evoked through these internal representations, when these representations are invoked, and specific fantasies associated with patients' internal representations of the therapists? The following sections will elucidate ways in which several therapeutic orientations differ from one another, and the ways in which these differences are expected to produce differences in internal representations of therapists.

Cognitive Behavioral Therapy (CBT)

> The goals of cognitive therapy are to correct faulty information processing and to help patients modify assumptions that maintain maladaptive behaviors and emotions… Cognitive therapy initially addresses symptom relief, but its ultimate goals are to remove systematic biases in thinking and modify the core beliefs that predispose the person to future distress (Beck & Weishaar, 2011, p. 290).

Combining the practices of cognitive and behavior therapies, cognitive behavioral therapists tend to take a directive approach with a goal of supplying their patients with a multitude of "tools" that can be used to modify maladaptive thinking and patterns of behavior (Owen, 2016; Riggenbach, 2012). Various aspects of their approach to therapy are distinct from other therapeutic modalities, which may create differences in internal representations among their patients.

Leahy (2008) has argued that CBT practitioners may differ from other therapists in that they tend to place less emphasis on incorporating the "microskills" that contribute to positive

therapeutic relationships, microskills which may, by extension, critically contribute to positive internal representations of therapists. Researchers have demonstrated that these microskills include active/reflective listening, regulating, and differentiating and attending (Ivey & Ivey, 2003; Gillespie et al., 2004). "These skills, considered to be important regardless of therapeutic modality, may often be overlooked in training cognitive behavioral therapists, since emphasis is often placed on techniques and processes thought to be sufficient for change" (Leahy, 2008, p. 770). Because the nature of internal representations of therapists is so connected to the nature of the therapeutic relationship overall, cross-modality differences in the use of skills that bolster such relationships may affect the kind of internal representation a given patient has of his/her therapist.

Cognitive-behavioral therapies tend to emphasize "collaborative empiricism" as a guiding principle for the therapist role (Beck & Weishaar, 2011; Tee & Kazantzis, 2011). In defining this term, Beck and Weishaar (2011) write, "The therapist and patient become co-investigators, examining the evidence to support or reject the patient's cognitions. As in scientific inquiry, interpretations or assumptions are treated as testable hypotheses" (p. 291).

Further, CBT therapists tend to focus on providing psychoeducation and teaching their patients skills that can be helpful in addressing maladaptive thoughts and behaviors. Thus, the focus of much of CBT tends to be instructive in a way that dynamic therapy tends not to be. Indeed, based on a thorough review of comparative psychotherapy literature, Blagys and Hilsenroth (2002) compiled a set of activities that distinguish cognitive behavioral therapy from psychodynamic-interpersonal therapies. Their set was comprised of the following: "(1) use of homework and outside-of-session activities; (2) direction of session activity; (3) teaching of skills used by patients to cope with symptoms; (4) emphasis on patients' future experiences; (5)

providing patients with information about their treatment, disorder, or symptoms; and (6) an intrapersonal/cognitive focus." (Blagys & Hilsenroth, 2002, p. 671).

For these reasons, it is likely that patients of CBT will show significant differences from patients of other therapies, in several aspects of internal representations of their therapists. For example, due to the relative lack of emphasis on the patient-therapist dyadic relationship, and the greater emphasis on a directive, task-oriented emphasis, patients may have less vivid internal representations of their therapists.

Interpersonal Therapy (IPT)

IPT stemmed from cognitive behavioral therapy and therefore many of its components and the associated hypotheses in this study are similar. Focusing on interpersonal role functioning and related reasons for psychopathology, a course of treatment in Interpersonal Therapy typically ranges in length between 12 and 16 sessions (Verdeli & Weissman, 2011). IPT therapists are "active, ask questions, and make comments" (p. 294) and are directive in that they guide patients in generating options, ideas, and resources (Verdeli & Weissman). IPT does not stress strength of therapeutic alliance as a necessity of therapy, but does value establishing rapport as a means of working together effectively.

Similar to CBT, it is likely that patients will have less vivid internal representations of their therapists than in psychodynamic therapy, due to the emphasis on the patient's symptoms in their external lives rather than his or her feelings toward the therapist.

Dialectical Behavioral Therapy (DBT)

DBT is a structured, time-limited, cognitive-behavioral therapy (Swales et al., 2009) that was originally constructed by Marsha Linehan for the purpose of treating patients with Borderline Personality Disorder. DBT pairs individual psychotherapy with concurrent group

therapy, in which patients are taught and coached through implementing skills which are grouped in the following modules: Core Mindfulness, Emotional Regulation, Interpersonal Effectiveness, and Distress Tolerance.

Similar to CBT, it is likely that patients will have less vivid internal representations of their therapists than in psychodynamic therapy, due to the emphasis on the patient's symptoms and behaviors rather than his or her feelings toward the therapist. We also hypothesize that DBT patients will endorse invoking their internal representations of therapists at times where they are trying to make decisions about their behavior.

Psychodynamic Therapy

In contrast to cognitive behavioral therapies, psychodynamic therapies tend to focus more on relational interactions and unconscious underpinnings thereof.

> *"Psychodynamic or psychoanalytic psychotherapy* refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than *psychoanalysis* proper. Session frequency is typically once or twice per week and the treatment may be either time limited or open ended. The essence of psychodynamic psychotherapy is exploring those aspects of self that are not fully known, especially as they are manifested and potentially influenced in the therapy relationship" (Shedler, 2009, p. 98).

Blagys and Hilsenroth (2000) delineated seven features that reliably and consistently distinguished psychodynamic therapy from other therapies: (1) focus on affect and expression of emotion; (2) exploration of attempts to avoid distressing thoughts and feelings; (3) identification of recurring themes and patterns; (4) discussion of past experience (developmental focus); (5)

focus on interpersonal relations; (6) focus on the therapy relationship; (7) exploration of fantasy life.

Underlying these technical features, certain principles and concepts inform psychodynamic practice. Transference and countertransference are often considered key elements of the therapy and constitute important areas of focus over the course of a psychodynamically oriented treatment (Luborsky et al., 2011). This often entails an examination of the manner in which patients project onto the therapist their internal representations of others. Due to this focus, and sometimes an encouragement of patients being aware and open to exploration of their feelings toward therapists, internal representations may be more readily accessible and frequently invoked by patients who are in a psychodynamic modality of treatment, as compared to patients who are in other treatment modalities.

> In contrast to other therapies in which the therapist may actively structure sessions or follow a predetermined agenda, psychodynamic therapy encourages patients to speak freely about whatever is on their minds. When patients do this (and most patients require considerable help from the therapist before they can truly speak freely), their thoughts naturally range over many areas of mental life, including desires, fears, fantasies, dreams, and daydreams (which in many cases the patient has not previously attempted to put into words) (Shedler, 2010, p. 99-100).

Person-Centered Therapy

Founded by Carl Rogers, person-centered, or client-centered therapy prioritized the therapeutic relationship and is characterized by core conditions known as “congruence, unconditional positive regard, empathic understanding of the client’s internal frame of reference” (Raskin et al., 2011). Client-centered therapists commit to being authentic in the moment with

their clients, while learning to inhibit judgmental reactions and critical responses by practicing empathic understanding of the client's perspective. Given the high priority client-centered therapists place on their clients' experience of their relationship, it is likely that clients of this modality will internalize therapists in a manner that they experience as favorable and supportive.

1.3 Other Factors Influencing Internal Representation

Several factors other than therapeutic orientation, including length of time in therapy, gender, age, and symptom intensity, may also affect client representations of therapists. Indeed, Geller and Farber (1993) have shown that length time in therapy is not significantly related to the frequency with which internal representations are evoked, but is significantly associated with the specific themes which characterize the representation. Interestingly, length of time since termination was *not* associated with a decrease in the vividness of internal representation but was associated with a statistically significant decrease in the frequency with which the internal representation was recalled (Geller & Farber, 1993).

Several studies found that gender – both of the patient and the therapist – was associated with significant differences in internal representations of therapists. (Farber & Geller, 1994; Bender et al., 2003). In examining the specific way this manifests, Farber and Geller (1994) found that "women are more likely to keep their therapists in mind (and for longer periods of time) when working on their problems outside of therapy" (p. 318). This study also showed that "women with male therapists are especially likely to daydream about therapy and acknowledge missing their therapist in between sessions" (p. 318). In light of these findings, the current study will examine whether the effects of gender interact with modality-related effects found in influencing clients' internal representations of their therapists. Other demographic variables will be included in order to rule out possible effects of individual identity factors on the internal

representation, but given the lack of research indicating substantial effects of most other demographic variables, interaction effects will only be examined for gender, which has historically been associated with significant effects on this variable (Bender et al., 2003; Farber & Geller, 1994).

Further research has also shown that certain presentations of psychopathology may correspond with differences in internal representations of therapists. Bender et al. (2003) found significant differences in the themes associated with internal representations of therapists. For instance, patients with schizotypal personality disorder "had the highest level of mental involvement with therapy outside the session, missing their therapists and wishing for friendship, while also feeling aggressive or negative" (p. 219). Additionally, they found that patients with borderline personality tended to have the most difficulty in establishing a benign image of the therapist. They also found that co-occurring Axis I disorders were significant covariates for a number of analyses on differences in internal representations.

Finally, as mentioned previously, working alliance in the therapeutic relationship is also related with internal representations of the therapist (Safran, 1993; Orlinsky & Tarragona, 1988; Tarragona, 1989). Indeed, studies have shown that clients' perceptions of a strong therapeutic alliance were significantly associated with their having representations that felt to them like a source of support or guidance (Orlinsky & Tarragona, 1988; Tarragona, 1989).

1.4 Research Questions:

1. Controlling for length of time in therapy, the therapeutic alliance, age, race, gender, and education level, will different therapeutic modalities significantly correspond with differences in the sensory modalities evoked by patients' internal representations of therapists (Imagistic, Enactive/Haptic, and Conversational-Conceptual)?

2. Controlling for length of time in therapy, the therapeutic alliance, age, race, gender, and education level, will different therapeutic modalities significantly correspond with differences in the functional themes evoked by patients' internal representations of therapists (Positive Internalization, Failure of Benign Internalization, and Sexual/Extratherapeutic Themes)?
3. Controlling for length of time in therapy, the therapeutic alliance, age, race, gender, and education level, will different therapeutic modalities significantly correspond with differences in the affects evoked by patients' internal representations of therapists?

Chapter 2: Method

2.1 Procedure

Participants were recruited through online platforms such as Craigslist and Facebook. Only participants who endorsed currently having or having had a psychotherapist for a minimum of three months were included. Participants were asked to complete an online questionnaire based on their experience with either a current or past therapist. Additionally, participants were asked to indicate whether they are currently in treatment with this therapist, as well as the length of treatment with this therapist thus far. Finally, participants were asked about their basic demographics such as age, gender, and race. This study did not include questions about therapist demographics in order to avoid the possibility of clients mistaking or misrepresenting their therapist's true demographics, which would result in significant ambiguity of any associated results. Participants were offered the chance to enter their email into a lottery wherein 4 individuals would be randomly chosen to receive a $50 Amazon gift card.

Table 1 presents characteristics of the sample, including demographic data, academic and professional information, and aspects of the participants' personal therapies. Not all participants completed the entire questionnaire; 22.6% did not make it through to the last question.

Of the 200 participants who completed the survey, the majority (76.5%) were female. Participants ranged in age from 18 to 73, with a mean of 30.47. Most were White (72.2%), with 3.8% identifying as Black/African American, 3.3% as Hispanic/Latinx, 5.2% as mixed race, 0.9% as Native American, and 2.4% as "other." Eighty-two participants, or 39% of the sample, were currently in therapy and 130, or 61% had terminated therapy.

2.2 Measures

The measures included in the questionnaire were the Therapist Representation Inventory (TRI; Geller et al., 1992), the Working Alliance Inventory (Short) (Horvath & Greenberg, 1989; Hatcher & Gillaspy, 2006)), and the The Multitheoretical List of Therapeutic Interventions (MULTI) (McCarthy & Barber, 2009; Solomonov et al., 2019).

The Therapist Representation Inventory (TRI)

The Therapist Representation Inventory (TRI; Geller et al., 1992) is a self-report instrument that is designed to measure the content and nature of patients' internal representations of their therapists and therapeutic relationship at a single time point. The TRI was developed in consideration of cognitive psychology research about the nature and components of internal representations and perceptual systems (Bruner, 1964; Gibson & Carmichael, 1966; Vygotsky 1962). It emphasizes the developmental complexity of the patient's representations, sensory modalities involved in their formulation, and the functions the representations serve for the patients. As Geller and Farber (1994) explain (p. 321):

> The TRI is a network of measures that is premised on several assumptions: that a partial view of the internalization process is accessible to consciousness; that mental representations of the therapeutic relationship have a number of distinct and measurable properties; and that some form of internalization has occurred if it can be demonstrated that these representations exert a recurrent influence on the conscious and preconscious processes that occur when patients are separated from their therapists and are attempting to cope with internal dangers and the stresses of the external world.

The measure consists of three main sections: the Therapist Involvement Scale (TIS), the

Therapist Embodiment Scale (TES), and a Feelings Scale. (Please see Appendix A, page 80, for the full measure.) The TIS factors used in this study were those delineated in Becker's 2010 study: Positive Internalization, Failure of Benign Internalization, and Sexual, Aggressive, and Extratherapeutic Themes, which had internal consistency (Cronbach's alpha values) of .90, .72, and .85, respectively. TES factors were Imagistic (Chronbach's $\alpha = .69$), Enactive (.62), and Conversational-Conceptual (.39) (Geller & Farber, 1993).

The Therapist Embodiment Scale is designed to assess the form of patients' representations of their therapists, distinguishing between the degree to which pictures, sounds, words, odors, and bodily sensations each contribute to the therapist representation. It consists of 12 items, each scored on a nine-point Likert-type rating scale with options ranging from "not at all characteristic" (1) to "highly characteristic" (9). In this scale, patients were asked to report the extent to which each item characterizes the means by which they evoke representations of their therapists, such as "I experience the odor or scent of my therapist's office." Factor analyses yielded three factors for the TES: Imagistic (alpha = .69), Enactive (.62), and Conversational-Conceptual (.39) (Geller & Farber, 1993). The "Imagistic" factor refers to clients' usage of visual imagery in imagining the felt presence of their therapist (e.g., "I imagine my therapist sitting in his or her office.") The "Enactive" factor reflects "experiences that are kinesthetically or proprioceptively felt rather than cognitively experienced" (Farber & Geller, 1994, p. 321) (e.g., "I experience in myself certain characteristic bodily sensations" and "I am aware of a particular emotional atmosphere which gives me the sense that my therapist is "with me.'" Finally, "Conversational Conceptual" factor is comprised of two items that "represent real and imagined conversations with the therapist" (p. 321). These items are: "I imagine a particular

quality to the sound of my therapist's voice"; and "I think of my therapist as making specific statements to me."

The TIS focuses on "the functional themes that characterize the patient's involvement in consciously experienced thoughts, feelings, wishes, and fantasies about the therapist" (Orlinsky et al., 1991, p. 599). Results are based on scores on the following factors: (a) Positive Internalization, (b) Failure of Benign Internalization, (c) Sexual, Aggressive, and Extratherapeutic Themes. These three factors emerged through a factor analysis study by Lauren Becker (2010), as referenced above.

The original factor analysis in the work of Orlinsky et al. (1991) produced six factors (Sexual and Aggressive Involvement, The Wish for Reciprocity, Continuing the Therapeutic Dialogue, Failure of Benign Internalization, Creating a Stable Representation, and Mourning. In a 2010 study, however, Becker (2010) produced a new factor analysis of the Therapist Involvement Scale that has been adopted in the analysis of this study. The first factor was named Positive Internalization (e.g., "When I am having a problem, I try to work it out with my therapist in mind;" "I miss my therapist"). This factor consisted of 20 items (25.08% of the total variance) and had excellent internal consistency (Cronbach's a = .90). The second factor consisted of seven items (9.29% of the variance). It was labeled Failure of Benign Internalization because it is very similar to the factor of the same name identified in previous analyses (e.g., "I don't think that therapy had/will have a lasting effect on me") (Geller et al., 1981-82; Geller & Farber, 1993; Geller & Schaffer, personal communication, January 31, 2010; Orlinsky et al., 1993). This factor also demonstrated adequate internal consistency (Cronbach's a = .72). The third and final factor was labeled Sexual, Aggressive, and Extratherapeutic Themes (e.g., "I imagine being sexually involved with my therapist;" "I imagine my therapist

and I eating together"). This 10-item factor explained 5.00% of the total variance and had very high internal consistency (Cronbach's a = .85). This third factor subsumes what was called "Sexual and Aggressive Involvement" in previous analyses, as well as items that were previously included in the factor called "The Wish for Reciprocity" (Geller et al., 1981-82; Geller & Farber, 1993; Orlinsky et al., 1993).

The third section of the TRI used in the current study is the Affect Scale. The Affect Scale assesses the feelings that patients have in association with the internal representation of the therapist. It consists of a 24 item, 9-point, Likert-type scale, which asks patients to report the degree to which they experience each of 24 feelings (e.g., comforted, relieved, discouraged, angry, and anxious) when evoking a representation of their therapist.

Finally, the TRI also measures "certain phenomenological properties of patients' representations of their therapists" (Farber & Geller, 1994, p. 322):

> The self-reported frequency of patients' recall is scored on a 10-point scale (1 = never; 10 = several times daily); the typical duration of recall is rated on a 10-point scale (1 = a few seconds or less; 5 = 60 seconds; 10 = an hour or longer); and the vividness of recall is assessed on a 4-point scale (1 = vague; 4 = very vivid). The frequency with which patients dream about their therapists is assessed on a 5-point scale (1 = never; 3 = sometimes; 5 = very often) as is the typical vividness of such dreams (1 = not at all vivid; 3 = moderately; 5 = highly) (p. 322).

Working Alliance Inventory (WAI)

The WAI (Horvath & Greenberg, 1989) was developed with the goal of assessing the working alliance, as defined by Bordin (1976). The WAI is made up of three subscales reflecting the three components of the therapeutic alliance described by Bordin (1976): Agreement on

therapeutic goals; Agreement on therapeutic tasks; Emotional bond between therapist and client. Reliability values using Cronbach's alpha were .90 for task, .88 for bond, and .91 for goal on the client scales.

The WAI was adapted and made into a shorter version, known as WAI-S (Hatcher & Gillaspy, 2006). A factor analysis indicated that the WAI-S demonstrated an adequate factor structure and retained its three subscales, each of which is comprised of four items. As such, the WAI-S is composed of 12 items that the client scores using a Likert-type scale ranging from 1 to 7 (please see Appendix B on page 86 for the full measure). Thus, total scores on the WAI-S range from 12 to 84. Tracey and Kokotovic (1989) also demonstrated a strong internal consistency of the WAI-S: Cronbach's alpha of 98.

The Multitheoretical List of Therapeutic Interventions (MULTI)

The Multitheoretical List of Therapeutic Interventions (MULTI) (McCarthy & Barber, 2009) assesses interventions from eight different psychotherapy orientations (behavioral, cognitive, dialectical-behavioral, interpersonal, person centered, psychodynamic, process-experiential) as well as common factors. Three versions of the MULTI exist, for completion by therapists, observers, and patients. This study employed the version of the scale that allows for patient completion. MULTI items were developed based on a review of therapeutic manuals and iterative consultations with experts. The MULTI has eight primary subscales, each representing a single orientation of psychotherapy, which are listed above, and a ninth representing common factors. Prior research has shown that the subscales adequately represent each theory based on face, content, and criterion validities, and confirmatory factor analyses across multiple samples have tested the overall structure of the measure (McAleavey, & Castonguay, 2014; McCarthy & Barber, 2009; Solomonov et al., 2019). The subscale items used in this study were those put forth

by Solomonov et al. (2019), and appear in Table 2; the full measure appears in Appendix C (page 88).

2.3 Analyses

An a priori power analysis was conducted using G*Power3 to test the sample needed for a small effect size (d = .15), and an alpha of .05. Result showed that a total sample of 136 participants was required to achieve a power of .90.

Hierarchical multiple regression analyses were used to assess whether differences exist between groups of patients in each therapy modality on the TRI scores, with scores on each of the subscales of the TRI used here constituting a dependent variable. The analyses control for demographics such as age, gender, race, and highest earned level of education, and length of therapy in order to isolate possible effects of these factors from effects of modality-based characteristics. The Working Alliance Inventory (WAI) was also analyzed as a covariate, in an effort to determine whether scores on this measure result in statistically significant variance additional to any modality-based differences found in TRI results. Interaction variables between gender and therapeutic modalities were also included in the regressions. Significance was established at an alpha of .05.

2.4 Clinical Significance

As discussed above, internal representations of therapists are hypothesized to be an essential part of the process of clients continuing to sustain therapeutic change while not in session (Geller & Freedman, 2018; Knox et al., 1999). The nature of these internal representations affects how well such work can be done. Therefore, it is important to understand how therapists of different modalities affect the formation of client representations, and whether there are in fact modality-based differences to be found. Deeper understanding of the factors affecting internalized representations of therapists can thus afford more clarity on how to optimize this process.

Chapter 3: Results

A series of hierarchical multiple regressions were performed in order to examine the above-mentioned research questions. Descriptive statistics of each measure are presented in Table 5, and correlations between measures are presented in Table 6.

In order to facilitate more effective comparison among measures, all of the above measures were standardized into Z-scores that were used in the regression analyses that follow. Thus, their means were 0 and the standard deviations were 1.

Reliability of the measures was conducted with the data collected in this study. For the Therapist Involvement Scale of the TRI, consisting of 37 items, Cronbach's alpha was measured at Chronbach's $\alpha = .95$. The Therapist Embodiment Scale consisted of 25 items and had Chronbach's $\alpha = .93$. The Affect Scale consisted of 24 items and Chronbach's $\alpha = .75$. The Working Alliance Inventory consisted of 12 items and Chronbach's $\alpha = .86$. The MULTI consisted of 60 items and Chronbach's $\alpha = .96$.

3.1 Research Question 1

Research question 1 aimed to explore whether (controlling for length of time in therapy, the therapeutic alliance, age, gender, race, and highest earned level of education) different therapeutic modalities would significantly correspond with differences in the sensory modalities evoked by patients' internal representations of therapists, as measured by the Therapist Embodiment Scale and distributed into three factors: Imagistic, Enactive (also known as Haptic in other studies), and Conversational-Conceptual. In order to examine this relationship, three separate hierarchical multiple linear regression analyses were used to develop a model for predicting participants' scores on the three factors of the TES based on their working alliance and their therapy modality.

To study the relationship among modality, working alliance, and Imagistic Embodiment, a hierarchical multiple regression analysis was performed. Independent variables were entered in a stepwise fashion, with the first step consisting of demographic variables (age, gender, race, and highest earned level of education), the second step adding current therapy, the third step adding time in therapy (in months), the fourth step adding participant scores on the Working Alliance Inventory, the fifth step adding therapy modality standardized scores from the MULTI, and the sixth step adding interaction terms between each modality and gender. The dependent variable was Imagistic Embodiment. In this hierarchical multiple regression analysis, none of the models were significant. These results appear in Table 8.

To study the relationship among modality, working alliance, and Haptic Embodiment, a hierarchical multiple regression analysis was performed. Independent variables were entered in a stepwise fashion, with the first step consisting of demographic variables (age, gender, race, and highest earned level of education), the second step adding current therapy, the third step adding time in therapy (in months), the fourth step adding participant scores on the Working Alliance Inventory, the fifth step adding therapy modality standardized scores from the MULTI, and the sixth step adding interaction terms between each modality and gender. The dependent variable was Haptic Embodiment. In this hierarchical multiple regression, none of the models were significant. These results appear in Table 9.

In the final analysis exploring Research Question 1, to study the relationship among modality, working alliance, and Conversational/Conceptual Embodiment, a hierarchical multiple regression analysis was performed. Independent variables were entered in a stepwise fashion, with the first step consisting of demographic variables (age, gender, race, and highest earned level of education), the second step adding current therapy, the third step adding time in therapy

(in months), the fourth step adding participant scores on the Working Alliance Inventory, the fifth step adding therapy modality standardized scores from the MULTI, and the sixth step adding interaction terms between each modality and gender. The dependent variable was Conversational /Conceptual Embodiment. Although the addition of therapy modalities to the analysis rendered the model significant F (17, 124) = 1.77, $p < .05$, none of the therapy modalities were significantly associated with Conceptual Embodiment in clients' internalization of their therapists. In step 6, with the addition of interaction terms between gender and modalities, the model was no longer significant, F (23, 116) = 1.50, $p > .05$. These results appear in Table 10.

3.2 Research Question 2

Research question 2 explored the relationship among modality, working alliance, and the functional themes evoked by patients' internal representations of therapists (Positive Internalization, Failure of Benign Internalization, and Sexual/Extratherapeutic Themes). In order to examine this relationship, three separate hierarchical multiple linear regression analyses were used to develop a model for predicting participants' scores on the three factors of the TIS based on their working alliance and their therapy modality. Basic descriptive statistics and correlations of the TIS measures are shown in Tables 2 and 3.

To study the relationship among modality, working alliance, and Positive Internalization, a hierarchical multiple regression analysis was performed. Independent variables were entered in a stepwise fashion, with the first step consisting of demographic variables (age, gender, race, and highest earned level of education), the second step adding whether clients were currently in therapy, the third step adding the length of time clients had been in therapy (in months), the fourth step adding participant scores on the Working Alliance Inventory, the fifth step adding

therapy modality scores from the MULTI, and the sixth step adding interaction terms between each modality and gender. The dependent variable was Positive Internalization of therapists. This hierarchical multiple regression revealed that at Stage one, demographic variables (age, gender, race, and highest earned level of education) did not contribute significantly to the regression model, F (4,130) = .80, $p > .05$. Introducing the variable of "Current Therapy" was not significant, F (5, 129) = .95, $p > .05$, nor was Time in Therapy, F (6, 128) = .84, $p > .05$. Adding working alliance to the regression model did not prove significant, F (7, 127) = 1.78, $p > .05$. However, the addition of Therapy Modalities to the model explained 30% of the variance in Positive Internalization and this change in R^2 was significant, F (15, 119) = 3.37, $p < .001$. Specifically, results showed that there was a significant relationship between psychodynamic therapy and Positive Internalization ($\beta = .43$, $p < 0.01$), after controlling for gender, race, length of time in therapy, and Working Alliance. Adding interaction terms between gender and modality variables retained the earlier stage's significance, F (23, 111) = 2.40, $p < .01$, but no specific coefficients emerged as significant. This model explained an additional 3% of variance. These results appear in Table 11.

In order to examine the relationship among modality, working alliance, and Failure of Benign Internalization, a hierarchical multiple regression analysis on these variables was performed. Independent variables were entered in a stepwise fashion, with the first step consisting of demographic variables (age, gender, race, and highest earned level of education), the second step adding whether clients were currently in therapy, the third step adding the length of time clients had been in therapy (in months), the fourth step adding participant scores on the Working Alliance Inventory, the fifth step adding therapy modality scores from the MULTI, and the sixth step adding interaction terms between each modality and gender. The dependent

variable was Failure of Benign Representation. The hierarchical multiple regression revealed that at Stage one, demographic variables did not contribute significantly to the regression model, F $(4, 134) = 1.41$, $p > .05$. With the Current Therapy variable added, the model was still not significant, F $(5, 133) = 1.55$, $p > .05$. Once the Time in Therapy variable was introduced, the model was significant, F $(6, 132) = 2.29$, $p < .05$, and explained 9% of the variance in Failure of Benign Representation. Adding Working Alliance to the regression model explained an additional 38.7% of the variance in Failure of Benign Representation and this new model was significant, F $(7, 131) = 13.44$, $p < .001$. In this model, which controlled for race, age, gender, highest level of education, current therapy, and length of time in therapy, results showed that there was a significant negative relationship between Working Alliance and Failure of Benign Internalization ($\beta = -.48$, $p < .001$). The addition of Therapy Modalities to the model explained an additional 5.9% of the variance in Failure of Benign Representation, F $(15, 123) = 7.48$, $p < .001$. Of these, person-centered therapy was significantly negatively associated with Failure of Benign Internalization ($\beta = -.23$, $p < .05$). Finally, adding interaction terms between gender and modality variables retained the earlier stage's significance, F $(23, 115) = 5.40$, $p < .01$, but no specific coefficients emerged as significant. This model explained an additional 4% of variance. These results appear in Table 12.

In order to examine the relationship among modality, working alliance, and Sexual, Aggressive, and Extratherapeutic Themes, a hierarchical regression analysis on these variables was performed. Independent variables were entered in a stepwise fashion, with the first step consisting of demographic variables (age, gender, race, and highest earned level of education), the second step adding a variable indicating whether the participant was currently in therapy, the third step adding time in therapy (in months), the fourth step adding participant scores on the

Working Alliance Inventory, the fifth step adding therapy modality scores from the MULTI , and the sixth step adding interaction terms between each modality and gender. The dependent variable was Sexual, Aggressive, and Extratherapeutic Themes.

The hierarchical multiple regression revealed that at Stage one, gender was a significant coefficient (β = -.18, p < .05) in an overall non-significant model, F (4, 134) = 1.21, p > .05. With the Current Therapy variable added, the model was still not significant, F (5, 133) = 1.43, p > .05, but gender was still a significant coefficient (β = -.18, p < .05); the same occurred once the Time in Therapy variable was introduced, F (6, 132) = 1.23, p > .05, with gender as individually significant (β = -.19, p < .05), as well as when Working Alliance was added, F (7, 131) = 1.08, p > .05, (gender: β = -.20, p < .05). When Therapy Modalities were added to the model, neither the model nor individual predictors were significant. However, once the interaction terms between gender and modalities were added, three individual variables were significant, though the overall model was not significant F (23, 112) = 1.23, p > .05. These variables were: Gender (β = -.23, p < .05), Psychodynamic Therapy (β = -.1.72, p < .05), and Gender*Psychodynamic (β = 1.90, p < .05). Gender was coded as a dummy variable with 0 = male; 1 = female; 2 = nonbinary. Given the statistical properties of this variable, this result suggests that males are more likely to score high on the Sexual, Aggressive, and Extratherapeutic themes scale, but is inconclusive. These results appear in Table 13.

3.3 Research Question 3

Research question 3 aimed to explore whether (controlling for length of time in therapy, the therapeutic alliance, and other demographic variables) different therapeutic modalities would significantly correspond with differences in the emotional affects evoked by patients' internal representations of therapists. Affects were sorted into two separate variables, one totaling any

positive affects endorsed and the other comprising a total of any negative affects endorsed. The Positive Affect variable included the following affects: Comforted, Relieved, Hopeful, Grateful, Energized, Accepted, Safe, Relaxed, Loving, Touched, Courageous, and Important. The Negative Affect variable was comprised of the following: Discouraged, Anxious, Angry, Sad, Ashamed, Defensive, Distant, Confused, Guilty, Frightened, Rejected, and Self-Critical. Scores on each of these items were marked 0 if not endorsed and 1 if endorsed. The items endorsed were totaled for each of the two categories (Positive and Negative Affect), such that the total score on either Positive or Negative ranged from 0-12.

In order to examine the relationship among modality, working alliance, and the Affect Scale, two hierarchical regression analyses on these variables were performed. Independent variables were entered in a stepwise fashion, with the first step consisting of demographic variables (age, gender, race, and highest earned level of education), the second step adding whether participants were currently in therapy, the third step adding time in therapy (in months), the fourth step adding participant scores on the Working Alliance Inventory, the fifth step adding therapy modality scores from the MULTI, and the sixth step adding interaction terms between each modality and gender. In the first of the two "Affect" hierarchical regression analyses, the dependent variable was Positive Affects evoked in internalization. The first three steps of the Positive Affect regressions did not garner significance. However, once Working Alliance was added in at Step 4, which controlled for gender, race, age, highest level of education, current therapy, and length of time in therapy, the model was significant, where $F\,(7, 132) = 4.45$, $p < .01$). In Step 5, which added therapy modalities, the model was still significant, where $F\,(15, 124) = 2.27$, $p < .01$) but the only significant coefficient was working alliance, ($\beta = .39$, $p < .01$),. In its final model (where $F\,(23, 116) = 1.86$, $p < .05$) which controlled for gender, race, age,

highest level of education, current therapy, length of time in therapy, Working Alliance, therapy modalities, and added interactions between gender and therapy modalities, results showed that Working Alliance was the only predictor that was in itself significantly associated with positive affect in internalization ($\beta = .40$, $p < .01$), and that no specific modality was a significant determining factor of positive affect in internalization. These results appear in Table 14.

In the second regression analysis, the dependent variable was Negative Affects evoked in internalization. The first three steps of the Positive Affect regressions did not show overall model significance. Interestingly, race was a significant coefficient in these nonsignificant models related with negative affect in internalization of therapists, such that in step 3, where F (4, 135) = 2.05, $p > .05$, which controlled for gender, education, age, time in therapy and current therapy, Race had $\beta = .08$, $p < .05$. However, in the fourth step, controlling for gender, race, highest level of education, whether currently in therapy, length of time in therapy, the model was significant, F (7, 132) = 2.55, $p < .05$ and the results showed that Working Alliance was significantly negatively predictive of negative affect in internalization ($\beta = -.25$, $p < .05$), whereas race was no longer significant. In Step 5, which added therapy modalities, the model was still significant, where F (15, 124) = 1.97, $p < .05$). In this model, psychodynamic therapy was significantly related with negative affect evoked in internalization of therapists ($\beta = .40$, $p < .05$). The final model, which controlled for gender, race, age, highest level of education, current therapy, length of time in therapy, Working Alliance, therapy modalities, and added interactions between gender and therapy modalities, was not significant, with F (23, 116) = 1.58, $p > .05$. These results appear in Table 15.

Chapter 4: Discussion

This study was conducted to determine whether clients being treated by therapists adhering to different therapeutic modalities internally represent their therapists in significantly different ways. The rationale for the study is based on the body of research suggesting that "internalization of the therapeutic relationship promotes a continuation of psychological development" (Rosenzweig et al., 1996, p. 203). Clarifying the degree and variation of which different modalities engender this kind of internalization is beneficial in elucidating the optimal conditions for promoting this aspect of therapeutic action. Overall, the study provided evidence in support of the hypothesis that there are indeed some modality-informed differences in internal representations of therapists, particularly in the themes and affects associated with internalizations.

4.1 Research Implications

The sample used in this study was more diverse than samples from former studies (e.g., Becker, 2010; Rosenzweig et al., 1997) that were made up of therapists or therapy trainees. The current study, which was open to the general public, includes lay people, most of whose role in therapeutic relationships was restricted to that of client; that is, they were not therapists themselves. As such, they may have been less attuned to the nuances they experienced in these relationships, but the effects of this role were able to be studied in more isolation, relative to prior studies.

The study approached its overarching inquiry by exploring three distinct research questions. Research Question 1 examined whether differences in modality would correspond with differences in the form of these internal representations, in other words, the degree to which pictures, sounds, words, odors, and bodily sensations each contribute to the therapist

representation. This was measured through the Therapist Embodiment Scale of the Therapist Representation Inventory and was analyzed in relation to therapy modality scores on the MULTI. Results showed that none of the therapy modalities were significantly associated with differences in any of the scale's three factors: Imagistic Embodiment, Enactive Embodiment, or Conversational /Conceptual Embodiment. In fact, there were no significant models highlighting any predictors for differences on this scale. Regardless of therapeutic orientation, then, there may be idiosyncratic consistency in the ways in which clients sensorily embody their therapists. In other words, there may be innate, personality-based or even physiological factors at play in determining the particular senses evoked in individuals' internal embodiments of other people, and that any differences there may be in the sensory styles in which people internally represent their therapists are unrelated to differences in therapeutic orientation. This is likely due to the way that therapy is structured—a structure that is only minimally (if at all) different across different types of therapy, with regard to the physical senses and sensory perception or embodiment involved. This finding suggests that, in practice, no therapy modality has traits that promote particular kinds of embodiment in terms of internal representations. Hence, this suggests that there is no need or use for therapists to strive toward particular embodiments as a goal that can be reached through their interventions.

In exploring the second research question, concerning the relationship between thematic factors as measured by the Therapist Involvement Scale (TIS) section of the TRI, several significant results emerged. Findings indicated that differences in clients' Positive Internalization of therapists were significantly related to distinct therapy modalities. Moreover, psychodynamic therapy and person-centered therapy emerged as significant predictors of Positive Internalization of therapists. This effect remained even after controlling for Working Alliance and time spent

working with the therapist. In other words, beyond the significant effects of Working Alliance and duration of therapy, clients who underwent psychodynamic therapy had significantly higher scores on the Positive Internalization factor than clients who had been treated in other therapy modalities. This suggests that the nature of psychodynamic therapy is especially conducive to engendering positive internalization of therapists among clients. This may be explained by the emphasis placed in psychodynamic therapy on this very goal. Indeed, as Geller and Farber (1993, p. 177) write:

> One of the goals of psychoanalytic psychotherapy is to promote the development and stability of the capacity for self-analysis. This attribute is frequently cited as a criterion of termination readiness, and its development is usually seen as mediated by the patient's identification with the analyst's 'analyzing functions.' Among other things, these functions refer to the therapist's knowledge, creativity, problem-solving, and decision-making abilities.

This finding, coupled with prior research findings regarding the often profound impact of positive internalizations of therapists (Knox et al., 1999; Geller, 1984; Geller et al., 2011)., implies that implementation of certain aspects of psychodynamic therapy could be beneficial for therapists of other brands of therapy who are interested in promoting positive internalization in the therapeutic relationship. For instance, they could make a point of integrating interventions that the MULTI studies identified as being associated with psychodynamic therapy (McAleavey, & Castonguay, 2014; McCarthy & Barber, 2009; Solomonov et al., 2019), such as Making connections between past and present; Exploring avoided emotions; and Exploring dreams, wishes, and fantasies. Addressing these and other typical foci of psychodynamic therapy may serve to work through barriers to positive internalization of other people in general, with this

effect extending to the internalization of the therapist as well. Alternatively, the working through of these issues in the therapeutic relationship may help to build a bond unique to this relationship. The work of Atzil-Slonim et al. (2015), which showed that increases in the positive internal representation of therapists predicted positive internalization of other important people in clients' lives, suggests that the work of addressing negative emotions in therapy and negative feelings toward the therapist is essential in promoting positive internalization of therapists, and that this then promotes positive internalization of others, in turn.

Further, differences in clients' scores on the factor measuring "Failure of Benign Representation" of therapists were significantly related with differences in therapy modalities. As Becker (2010) noted, "looking closely at the items that make up the Failure [of Benign Internalization] factor, it appears that many do not address internalization per se but rather indicate a general lack of engagement in therapy (e.g., 'I don't think that therapy had/will have a lasting effect on me;' 'I feel as though I were never in therapy')." (p. 47). Results of this study showed that person-centered therapy was significantly negatively associated with Failure of Benign Internalization. In other words, clients undergoing therapy higher in features of person-centered therapy were more likely to rank high in failure of benign internalization of their therapists, or, as per Becker's definition, high engagement in therapy. Benign internalization, then, indicates a high level of involvement, but the factor does not assign a valence to this involvement. As mentioned earlier in this paper, the subscale constituting the person-centered therapy score on the MULTI is comprised of items such as "paraphrasing," "exploring personal meaning," and "demonstrating interest in the patient's experience." These items represent interventions that are aimed at eliciting engagement from the client. Therefore, it makes sense that this modality would be associated with engagement in therapy, as represented by the lower

rates of Failure of Benign Internalization. Importantly, though, the characterizations and analyses put forth by the developers of the MULTI, with regard to the categorization of person-centered therapy as more concerned with client experience than other modalities, may be somewhat inaccurate or misleading. While high interest in client experience is certainly a signature element of person-centered therapy, the scale gives the impression that other therapies are *less* committed to client experience. Therefore, the idea that person-centered therapy is the clear leader in promoting engagement in therapy may be misleading and unproductive; it is likely far more accurate to conclude that the attitudes and interventions named under the MULTI's person-centered therapy umbrella can be employed by a therapist of any modality in order to promote this desired effect.

Additionally, and unsurprisingly, lower Working Alliance predicted Failure of Benign Representation of therapists. Taken together, these results indicate that, consistent with multiple studies and meta-analyses (Gaston et al., 1998; Horvath et al., 1991, 2011), a positive working alliance is critical in facilitating clients' meaningful engagement in therapy. Hence, apart from modality-specific interventions that can promote or detract from engagement in therapy, factors impacting alliance appear to be a precursor for meaningful engagement in therapy. Attitudes and interventions that promote alliance (e.g., apparent sense of concern for client, demonstrable understanding of client complaints and goals) are fundamental for therapists of any modality, and they alone can be instrumental in promoting engagement in therapy.

Sexual, Aggressive, and Extratherapeutic Themes of internalization were not significantly associated with any particular therapeutic modality, suggesting that this is a variable not impacted by specific interventions but perhaps more by physiologically-based factors. While gender, and the interaction between gender and psychodynamic therapy, were significant

coefficients, they did not contribute to overall significance of the model in a way that could meaningfully explain differences in this measure. Additionally, statistical properties of this variable make it difficult to make conclusive interpretations of this result, though it appeared that males were more likely than females and gender-nonbinary individuals to be high on the Sexual, Aggressive, and Extratherapeutic themes scale.

Research Question 3 related to affects endorsed when thinking about the therapist, and how, if at all, this was associated with other factors measured in this study. In exploring the relationship between positive or negative affects with clients' internal representations of their therapists, results showed that Working Alliance was a significant predictor of positive affect in internalization, and that modality was not a determining factor of positive affect in internalization. Working Alliance was significantly negatively predictive of negative affect in internalization. In other words, clients who rated their working alliance as high on the Working Alliance Inventory endorsed significantly less negative affect associated with their internal representations of their therapists. Taken together, these results indicate that, of the variables measured, Working Alliance was a key factor in facilitating the ability of the internal representation of therapists to evoke positive feelings such as courageous, hopeful, or accepted, and the most potent preventor of negative feelings such as discouragement.

Interestingly, while not an overall significant finding, the factor of client racial identity approached significance as related with negative affect in internalization of therapists, with clients who identified as being members of minority racial groups approaching significance in endorsing more negative affect associated with internal representations of their therapists than clients who identified as White. Once Working Alliance was added to the model, Race was no longer a relevant factor in the model, suggesting that a strong working alliance effectively

neutralized or compensated for negative impact that racial issues may bring about in the affect associated with internal representations of therapists. It is possible, then, that working alliance serves as a mediator in the relationship between variables such as modality and demographics, and the internal representation factors.

Moreover, this finding aligns with results of various studies in the field of multicultural counseling, showing that clients who identify as members of ethnic minority groups show preference for therapists who share their ethnic identity. For instance, meta-analyses by Coleman et al. (1995) and Cabral and Smith (2011) showed that clients have a tendency to perceive therapists of one's own race/ethnicity somewhat more positively than other therapists. Additionally, a study by Kivlighan et al. (2019) showed that therapists differed in their ability to produce changes in symptom-defined psychological distress as a function of clients' intersecting identities of race-ethnicity and gender. In light of this research, the finding from the current study suggests that, in the absence of strong working alliance, clients of racial minority groups may feel less comforted or encouraged when thinking about their therapists than White clients do. Given that this study did not collect data about the racial identities of participants' therapists, it is impossible to make more definitive conclusions about how these variables interact, and this constitutes an important area of further research on internal representations of therapists.

Finally, psychodynamic therapy was significantly related with negative affect evoked in internalization of therapists. This is particularly interesting when considering another finding of this study, showing that psychodynamic therapy was significantly associated with Positive Internalization of therapists. This underscores the point that Positive Internalization is a separate construct from positive affect and that the two are not mutually dependent. The factor known here as Positive Internalization captures a more nuanced and complex construct than positive

affect alone. Indeed, in Becker's (2010) factor analysis of the TIS, she found that "The current Positive Internalization factor (Factor I) appears to subsume the factors previously called Continuing the Therapeutic Dialogue, The Effort to Create a Therapist Introject (alternately, Creating a Stable Representation), and Mourning/Desiring Contact. This factor also includes elements of what was previously called The Wish for Reciprocity" (p. 46). Further, in their discussion of the internalization of therapists, Geller and Farber (1993) wrote: "In contrast to merely "remembering" information about their therapists, patients bring forth representations of themselves in relation to therapists to, among other things, regulate painful affects, assuage feelings of loneliness, and facilitate problem-solving and conflict resolution" (p. 176). All of this underscores the complexity and utility of internalization, and the distinction between internalization and mere affect.

Moreover, psychodynamic therapy embraces the utility of working with transference that clients bring forth in therapy, and this may evoke negative emotional affect at times. While transference and internal representations are two separate constructs, they are interrelated, and the valence of one may color that of the other. This is in line with research by Atzil-Slonim et al. (2015) in studying internal representation of therapeutic relationships among adolescents over the span of one year (see also Slonim et al., 2013). They found that, although positive representations of the therapist increased throughout treatment, negative representations remained steady. In explaining this finding, they note that, "contemporary psychodynamic perspectives highlight the importance of expanding individuals' range of emotions and perceptions through treatment rather than replacing negative perceptions with positive ones (Mitchell, 1993)" (Atzil-Slonim et al., 2015, p. 509). In summary, a strong internal representation (and strong working alliance, for that matter) may incorporate negative affect, and

both may be useful in effecting adaptive therapeutic change, perhaps especially in psychodynamic therapy, where negative affect would ideally be utilized and processed therapeutically.

Taken together, the general lack of findings lends support for the "common elements" argument, i.e., that seemingly disparate therapies are more alike than otherwise. Indeed, other factors that were not examined in this study, such as therapist personality, character, or style, or client personality differences may more substantially influence representations than theoretical orientation of the therapist.

4.2 Limitations and Future Directions

One limitation of this study is related to the very concept of distinct therapy modalities. Although many therapists consistently adhere to specific therapy modalities, many do not. Indeed, one study found that "eclecticism, or the increasingly favored term integration, is the most popular theoretical orientation of English-speaking psychotherapists" (Norcross & Beutler, 2011, p. 503). Therefore, delineating differences in internal representations based on modality may not be as practically applicable for therapists who integrate interventions and theory from multiple modalities. Indeed, the trend toward eclecticism among clinicians may render the results of this study less meaningful or useful, in that most clinicians do not ascribe to one school of thought in isolation. They may perform clinical work in a manner that integrates aspects of multiple therapies, further muddying the picture examined by this study.

However, in an effort to maximize the effectiveness of this analysis, the MULTI was chosen as a measure because it aggregates scores in each factor as continuous, rather than categorical variables. In other words, for each participant, the MULTI produced scores for the degree to which their therapist reportedly implemented each of the different modalities

measured, rather than producing a single, categorical score delineating one specific modality implemented. This allowed for the regression analyses to show relationships between the varying degrees of each modality implemented and the differences in internal representations. As such, it attempted to sort therapeutic modality based on individual interventions, rather than estimated labels put forth by clients or therapists, which may have captured a less objective reality.

Relatedly, a more nuanced limitation lies in the nature of the MULTI instrument, and the therapy modalities factors included therein. Although statistically, there was enough variance to justify this particular differentiation of the factors, some of the modalities that arose from McCarthy and Barber's factor analysis (2009) are not practically differentiated or up to date in the current psychotherapy culture. For instance, distinctions between cognitive therapy, behavior therapy, and cognitive behavioral therapy are not practically useful to therapists who currently view CBT as a blanket term for all of the above. Moreover, the characterizations and analyses put forth by the developers of the MULTI, with regard to the categorization of certain interventions as being most in line with particular modalities, seem at odds with common understandings of differences among therapeutic modalities. For instance, the idea that person-centered therapy is more concerned with client experience than other modalities seems overly simplified, and may require validation through further studies or reconfiguration of the scale.

Additionally, the lack of data on therapist demographics such as race and age, as well as years of experience, constitutes an important limitation of this study, making it more difficult to draw more confident conclusions about specific aspects of therapies that were distinct from therapist characteristics. Indeed, given the preliminary results on this subject that this study provided, more research on the ways in which the race of therapists and clients affect internalization of the therapeutic relationship would be worthwhile.

Going forward, the body of research on this topic would be enriched by the parallel study of clients' internal representations of therapists and therapists' internal representations of the clients. It would be informative to learn if there are meaningful relationships between the ways in which these internal representations predict or otherwise impact one another. One specific and important aspect of this relationship is the manner in which racial and cultural differences between therapists and clients impact internal representations.

4.3 Clinical Implications

An interesting implication for clinicians, which should be studied in far more depth in future research, is the salient role race may play in their clients' internalization of the therapeutic relationship. Clinicians should work to increase awareness and sensitivity of the ways in which members of minority racial or ethnic groups may have more difficulty forming positive internal representations of their non-minority therapists than others. They should be open to discussing this discomfort with clients, and consider possible ramifications this may have for the therapy more broadly.

One of the most clinically notable findings of this study is that positive internalization and negative affect are not necessarily mutually exclusive. As Atzil-Slonim et al. note (2015) in their study of the therapeutic relationship among adolescents, "although adolescents often experience negative emotions and perceptions in therapy as in other significant relationships, this does not necessarily block the development of positive emotions" (p. 502). Their comment was written in summarizing a finding that, over a yearlong course of psychodynamic therapy, adolescents reported significant increases in positive representations of their therapists, but did not report any significant changes-- increases or decreases-- in negative representations.

The current study had a similarly surprising set of findings, in that psychodynamic therapy was significantly associated with negative affect, even as positive internalizations were also significantly elevated among those treated in this modality. It would appear, then, that adolescents are not the only age group of patients who experience their therapists in simultaneously positive and negative ways. This push-and-pull may be an important part of the psychodynamic therapeutic model, which, while prioritizing the therapeutic relationship and alliance, does not shy away from negative transference or raising awareness of negative emotions in the therapeutic relationship. Clinicians of any therapeutic modality should keep this in mind and, as Atzil-Slonim et al. write, "should expect and be able to hear […] clients' positive and negative internal representations of themselves" (p. 502). Doing so may have an impact on the degree to which clients are able to take in and implement therapeutic interventions and insights in therapy, and continue to do so in the absence of the therapist.

The descriptions of the various therapeutic modalities offered here allude to the fact that, compared to psychodynamic and person-centered therapies, behavioral therapies (CBT, IPT, and DBT) tend to focus more on symptoms as they occur in clients' external lives (i.e., outside of the therapy room), and do not tend to bring much direct attention to ways in which clients perceive or relate with the therapists. The results of this study imply that this is an operative difference with regard to the nature of clients' internal representations of therapists. Indeed, the finding that clients in the psychodynamic or person-centered therapy modalities were more likely to have more positive and/or engaged internalization of their therapists suggests that making the therapeutic relationship and in-session experience a priority has a positive impact on internalization. It would be interesting to study how therapist personality variables play into this equation, and whether, for instance, someone more agreeable is significantly more likely to be

internally represented favorably. However, assuming that traits like agreeableness are evenly distributed among therapists across modalities, the results of this study suggest that the prioritization of relational factors in therapy seems to enhance those very factors. It is entirely conceivable that a CBT therapist would, intentionally or not, overlook the fact that a client is feeling upset or annoyed with them, seeing as the relationship is not a key point of emphasis in this treatment, and interventions can arguably be effectively administered even in the absence of positive regard. However, in psychodynamic therapies, the relationship is not only a point of emphasis but is seen as a key vehicle for change, and therefore the therapist would be more likely to actively engage in repair thereof. Perhaps, then, it is this set of priorities in psychodynamic/person-centered clinical work which aids in the process of developing positive internalization of the therapist. Thus, as noted in the Atzil-Slonim quote above, working through negative emotions could be instrumental in helping promote positive internalization.

As such, prioritizing positive internal representations and acting upon this priority in itself, allow clients to positively and meaningfully internally represent their therapists. An advantage of the MULTI instrument aggregating interventions associated with the categorization of different modalities presented here is that it allows for enumeration of specific interventions and attitudes that could contribute to particular outcomes. Intentionally prioritizing positive internalizing, then, could manifest as incorporating aspects of the MULTI whose ascribed therapies were associated with positive internalization outcomes, such as communicating about the relationship and addressing avoided emotions about the relationship in order to repair negative interactions and mitigate negative feelings toward the therapist. Prioritizing positive internalization could even be as simple, though surely not always easy as, “being [one’s] best self when doing the work” (J.D. Geller, 2021, private communication, August 18, 2021).

While not central to all therapeutic modalities in theory, interventions that focus on helping clients communicate openly and address negative feelings toward the therapist, and other means of intentionally working toward positive internalization, can be useful for any kind of therapy. Indeed, adaptive internalization of therapists allows clients to continue their psychological development without being in the physical presence of their therapists, a goal sure to be deemed worthwhile by therapists of every modality. Bringing more awareness, sensitivity, and emphasis to these relational interactions, then, is a shift that therapists of any modality can incorporate in their work, and it is a choice from which clients may truly benefit.

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Tables

Table 1

Demographic Descriptive Data of Sample (N = 212)

Variable	Frequency	Percentage*
Gender		
Male	43	21.5
Female	153	76.5
Non-binary	4	2
Race		
Asian/Pacific Islander/Asian American	13	6.1
Black/African American	8	3.8
Hispanic/Latinx	7	3.3
Native American	2	.9
White/Caucasian	153	72.2
Other	5	2.4
Mixed	11	5.2
Age Range		
18-20	3	1.5
20-29	69	33.8
30-39	48	23.5
40-49	12	5.9
50-59	4	2
60-69	2	1
70-79	1	.5
Highest Level of Education		
Grade School	1	.5
High School	8	4
Some College	14	7
Associate Degree	8	4
Undergraduate College	71	35.7
Graduate Degree	97	48.8
No response	12	
Total responses	200	

**Percentages listed for total number of non-missing cases*

Table 2
Subscale items of MULTI

Psychodynamic	2. Making connections between past and present. 12. Exploring avoided emotions. 20. Identifying the function of symptoms. 22. Making transference interpretations. 24. Exploring dreams, wishes, and fantasies.
Process-experiential	11. Identifying and labeling emotions. 13. Identifying defenses. 34. Identifying conflict splits and consequences. 47. Focusing on moment-to-moment experience.
Interpersonal	50. Focusing on a specific relationship problem. 51. Encourage change in relationships. 54. Exploring specific interpersonal behaviors. 60. Making connections between relationship problems and symptoms.
Person-Centered	10. Paraphrasing. 40. Exploring personal meaning. 46. Demonstrating interest in patient's experience.
Behavioral	15. Teaching new skills and behaviors. 16. Exposure to thing the patient is afraid of. 35. Encouraging behavioral change.
Cognitive	21. Exploring alternative explanations to behaviors. 37. Evidence search. 49. Challenging irrational thoughts.
Cognitive-Behavioral	1. Setting an agenda. 17. Assigning/reviewing homework.
Dialectical-Behavioral	56. Accepting and encouraging change. 58. Encouraging mindfulness.

Table 3
Therapist Embodiment Scale (TES)

<u>Factor I: Imagistic Mode</u>
- My therapist is wearing a particular type of clothing
- I imagine my therapist sitting in his/her office
- I picture a specific expression on my therapist's face
- I imagine a particular quality to the sound of my therapist's voice
- I see my therapist gesturing

<u>Factor II: Haptic Mode</u>
- I experience in myself certain characteristic bodily sensations
- I imagine my therapist and myself in physical contact
- I am aware of a particular emotional atmosphere which gives me the sense that my therapist is "with me"

<u>Factor III: Conceptual Mode</u>
- I imagine a particular quality to the sound of my therapist's voice
- I think of my therapist as making specific statements to me
- My image of my therapist is not tied to a specific time or place
- My image is limited to my therapist's head and face

Table 4
Factors for Items of the Therapist Involvement Scale (TIS) of the Therapist Representation Inventory—II (TRI-II)

Item
<u>Factor I: Positive Internalization</u>
10. When I am having a problem, I try to work it out with my therapist in my mind.
1. I miss my therapist.
22. I would like my therapist to be proud of me.
14. When I am faced with a difficult situation, I sometimes ask myself, "What would my therapist want me to do?"
37. I wish I were more like my therapist.
33. I look forward to returning to sessions with my therapist.
25. In a sense I feel as though my therapist has become part of me.
4. I wonder if my therapist ever thinks about me.
11. I wish I could be friends with my therapist.
24. I try to solve my problems in the way my therapist and I worked on them in psychotherapy.
7. I wish more of my relationships were like the one with my therapist.
12. I imagine my therapist telling me what he/she "really" thinks or feels about me.
3. I now find myself talking to other people the way I talk(ed) with my therapist.
8. I rehearse what I will say to my therapist if/when we meet again.
21. I doubt that anyone can replace my therapist in my life.
5. I think about contacting my therapist.
32. I miss talking about myself the way therapy permits (permitted) me to do.

13. There are times when I feel that I have lost some of the gains made in therapy.

16. I sometimes see people who remind me of my therapist.

27. I imagine myself helping my therapist

Factor II: Failure of Benign Internalization

19. I don't think that therapy had/will have a lasting effect on me.

6. I feel as though I were never in therapy.

26. I wish I had a different therapist.

35. I don't remember very much of what my therapist said in our talks together.

31. In stressful situations, I don't seem to be able to use what I previously learned in therapy.

2. I think my therapist would be disapproving of me.

15. I hope I never have to be in therapy again.

Factor III: Sexual, Aggressive, and Extratherapeutic Themes

34. I imagine being sexually involved with my therapist.

18. I imagine my therapist and me kissing each other.

17. I imagine being held by my therapist.

36. I imagine hurting my therapist in some way.

20. I daydream about my therapist.

23. I imagine being the parent of my therapist's child.

30. I imagine my therapist and I eating together.

28. I imagine our talking to each other outside of the therapy office.

9. I find myself looking for my therapist when I am out in a crowd.

29. I imagine my therapist hurting me in some way.

Table 5

Descriptive Statistics of Measures

Measure	N	Mean	SD	Min.	Max.
Positive Internalization	172	42.90	15.53	20	94
Failure of Benign Internalization	177	13.26	5.82	7	35
Sexual/Aggressive/Extratherapuetic Themes	174	13.55	6.99	10	45
Imagistic Embodiment	176	11.03	5.37	5	24
Haptic Embodiment	178	5.88	2.58	3	15
Conceptual Embodiment	178	8.74	3.37	4	18
Working Alliance	167	52.18	11.74	12	76
Interpersonal Therapy	164	12.43	4.12	4	20
Psychodynamic Therapy	163	16.01	4.37	5	25
Process-experiential Therapy	165	12.34	3.57	4	20
Person-centered Therapy	164	10.71	2.91	3	15
Behavioral Therapy	163	8.79	2.99	3	15
Cognitive Therapy	163	9.82	3.14	3	15
Cognitive Behavioral Therapy	167	5.77	2.30	2	10
Dialectical Behavior Therapy	163	7.04	2.21	2	10
Positive Affect	212	2.46	2.60	0	11
Negative Affect	212	1.23	2.09	0	11

Table 6
Summary of correlations for scores on the WAI and TRI measures

Measure	WAI	imag	haptic	conc	Pos_I	Fail_B	Sx/Ag	Pos_Aff	Neg_Aff
WAI	1	.21**	.17*	.23**	.27**	-.43**	-.03	.42**	-.22**
imag	.21**	1	.60**	.83**	.64**	.17*	.46**	.27**	.11
haptic	.17*	.60**	1	.66**	.63**	.29**	.57**	.19*	.05
conc	.23**	.83**	.66**	1	.71**	.24**	.49**	.28**	.08
Pos_I	.27**	.64**	.63**	.71**	1	.31**	.66**	.27**	.12
Fail_B	-.43**	.17*	.29**	.24**	.31**	1	.52**	-.31**	.40**
Sx/Ag	-.03	.46**	.57**	.49**	.66**	.52**	1	-.09	.13
Pos_Aff	.42**	.27**	.19*	.28**	.27**	-.31**	-.09	1	-.07
Neg_Aff	-.22**	.11	.05	.08	.12	.40**	.13	-.07	1

* $p < 0.05$; ** $p < 0.01$
"WAI": Working Alliance Inventory; "imag": Therapist Embodiment Scale, Imagistic factor; "haptic": Therapist Embodiment Scale, Haptic factor; "conc": Therapist Embodiment Scale, Conceptual factor; "Pos_I": Therapist Involvement Scale, Positive Internalization factor; "Fail_B": Therapist Involvement Scale, Failure of Benign Internalization factor; "Sx/Ag": Therapist Involvement Scale, Sexual and Aggressive Themes factor; "Pos_Aff": Affect Scale- Positive Affects; "Neg_Aff": Affect Scale- Negative Affects.

Table 7.

Summary of correlations for scores on WAI and MULTI measures

	Working Alliance	IPT	Psycho-dynamic	Process-exper.	Person-centered	Behavioral	Cognitive	CBT	DBT
Working Alliance	1.00	.44**	.54**	.38**	.49**	.38**	.53**	.25**	.59**
IPT	.44**	1.00	.66**	.59**	.54**	.48**	.60**	.29**	.54**
Psychodynamic	.54**	.66**	1.00	.71**	.60**	.47**	.63**	.22**	.55**
Proc-exper.	.38**	.59**	.71**	1.00	.65**	.61**	.61**	.38**	.60**
Person_centered	.49**	.54**	.60**	.65**	1.00	.49**	.59**	.17*	.69**
Behavioral	.38**	.48**	.47**	.61**	.49**	1.00	.60**	.59**	.52**
Cognitive	.53**	.60**	.63**	.61**	.59**	.60**	1.00	.32**	.61**
CBT	.25**	.29**	.22**	.38**	.17*	.59**	.32**	1.00	.32**
DBT	.59**	.54**	.55**	.60**	.69**	.52**	.61**	.32**	1.00

Table 8

Hierarchical Regression Analysis for TES Imagistic Embodiment in Internalization of Therapists (N = 134)

Variable	*B*	*SE (B)*	*β*	*F*	*p*
Step 1				1.65	.17
Gender	-.11	.19	-.05		
Age	.04	.03	.13		
Race	.00	.04	.00		
Education	.13	.07	.18*		
Step 2				1.40	.23
Gender	-.12	.19	-.05		
Age	.04	.03	.12		
Race	.00	.04	.00		
Education	.14	.07	.18*		
Current therapy	-.11	.17	-.06		
Step 3				1.76	.11
Gender	-.15	.19	-.07		
Age	.03	.03	.09		
Race	.00	.04	.01		
Education	.14	.06	.19*		
Current therapy	-.03	.17	-.02		
Time in therapy	.01	.00	.17		
Step 4				1.78	.10
Gender	-.14	.19	-.06		
Age	.03	.03	.10		
Race	.01	.04	.01		
Education	.13	.07	.17		
Current therapy	.01	.17	.00		
Time in therapy	.01	.00	.16		
Working Alliance	.01	.01	.12		
Step 5				1.71	.06
Gender	-.18	.20	-.08		
Age	.04	.03	.11		
Race	.01	.04	.03		
Education	.10	.07	.13		
Current therapy	.00	.18	.00		
Time in therapy	.00	.00	.14		
Working Alliance	.00	.01	-.03		

IPT	.07	.11	.07		
Psychodynamic	.11	.14	.11		
Process-Experiential	.03	.14	.04		
Person-Centered	-.15	.13	-.16		
Behavioral Therapy	-.24	.13	-.24		
Cognitive Therapy	.15	.12	.15		
CBT	.08	.11	.09		
DBT	.22	.12	.23		
Step 6				1.36	.15
Gender	-.29	.22	-.13		
Age	.04	.03	.13		
Race	.01	.04	.02		
Education	.08	.07	.11		
	-.05	.19	-.02		
Current therapy					
Time in therapy	.00	.00	.11		
Working Alliance	.00	.01	.01		
IPT	.04	.64	.04		
Psychodynamic	-.96	.72	-.97		
Process-Experiential	.44	.60	.46		
Person-Centered	.52	.66	.54		
Behavioral Therapy	-1.34	.74	-1.37		
Cognitive Therapy	.61	.73	.64		
CBT	.46	.64	.48		
DBT	.57	.56	.60		
Gender*IPT	.02	.33	.04		
Gender*Dynamic	.59	.38	1.12		
Gender*Proc-Exp	-.23	.32	-.44		
Gender*Person-Ctr	-.38	.35	-.72		
Gender*Behavioral	.56	.38	1.05		
Gender*Cognitive	-.23	.37	-.45		
Gender*CBT	-.18	.32	-.36		
Gender*DBT	-.19	.30	-.37		

Note. Step 1 R^2 = .05; Step 2 R^2 = .05, Δ R^2 = .00; Step 3 R^2 = .07, Δ R^2 = .02; Step 4 R^2 =.09, Δ R^2 = .01; Step 5 R^2 =.17, Δ R^2 = .09, Step 6 R^2 =.21, Δ R^2 = .04; p < .01; **p < .01; *p < .05.

Table 9
Hierarchical Regression Analysis for TES Haptic in Internalization of Therapists (N = 134)

Variable	*B*	*SE (B)*	β	*F*	*p*
Step 1				2.14	.08
Gender	-.44	.17	-.21*		
Age	.01	.03	.03		
Race	-.02	.04	-.04		
Education	.07	.06	.10		
Step 2				2.00	.08
Gender	-.45	.17	-.22*		
Age	.00	.03	.01		
Race	-.02	.04	-.04		
Education	.07	.06	.10		
Current therapy	-.18	.15	-.10		
Step 3				1.66	.14
Gender	-.46	.18	-.22*		
Age	.00	.03	.01		
Race	-.02	.04	-.04		
Education	.07	.06	.11		
Current therapy	-.18	.16	-.10		
Time in therapy	.00	.00	.01		
Step 4				1.62	.13
Gender	-.45	.18	-.22*		
Age	.00	.03	.02		
Race	-.01	.04	-.03		
Education	.06	.06	.09		
Current therapy	-.15	.16	-.08		
Time in therapy	.00	.00	.00		
Working Alliance	.01	.01	.10		
Step 5				1.28	.23
Gender	-.43	.19	-.20*		
Age	.01	.03	.03		
Race	-.01	.04	-.03		
Education	.05	.06	.07		
Current therapy	-.10	.17	-.06		
Time in therapy	.00	.00	-.01		
Working Alliance	.00	.01	-.02		
IPT	.07	.11	.08		
Psychodynamic	.17	.13	.19		

Process-Experiential	-.05	.13	-.05		
Person-Centered	.04	.12	.05		
Behavioral Therapy	-.04	.12	-.05		
Cognitive Therapy	.09	.11	.10		
CBT	.01	.10	.02		
DBT	-.04	.12	-.05		
Step 6				.95	.53
Gender	-.41	.21	-.20		
Age	.00	.03	.00		
Race	-.01	.04	-.02		
Education	.05	.07	.06		
Current therapy	-.10	.18	-.05		
Time in therapy	.00	.00	.00		
Working Alliance	.00	.01	-.01		
IPT	-.44	.61	-.51		
Psychodynamic	.62	.68	.68		
Process-Experiential	-.41	.57	-.45		
Person-Centered	.56	.63	.63		
Behavioral Therapy	.04	.71	.05		
Cognitive Therapy	-.48	.69	-.55		
CBT	.84	.61	.96		
DBT	-.14	.54	-.16		
Gender*IPT	.26	.32	.58		
Gender*Dynamic	-.24	.36	-.51		
Gender*Proc-Exp	.21	.30	.45		
Gender*Person-Ctr	-.29	.34	-.59		
Gender*Behavioral	-.05	.36	-.10		
Gender*Cognitive	.30	.36	.65		
Gender*CBT	-.43	.31	-.96		
Gender*DBT	.04	.29	.09		

Note. Step 1 R^2 = .06; Step 2 R^2 = .07, ΔR^2 = .01; Step 3 R^2 = .07, ΔR^2 = .00; Step 4 R^2 =.08, ΔR^2 = .01; Step 5 R^2 =.13, ΔR^2 = .05, Step 6 R^2 =.16, ΔR^2 = .03; $p < .01$; **$p < .01$; *$p < .05$.

Table 10
Hierarchical Regression Analysis for TES Conceptual in Internalization of Therapists (N = 134)

Variable	*B*	*SE (B)*	β	*F*	*p*
Step 1				1.01	.40
Gender	-.12	.18	-.06		
Age	.04	.03	.11		
Race	-.02	.04	-.05		
Education	.07	.06	.10		
Step 2				1.66	.15
Gender	-.14	.18	-.07		
Age	.02	.03	.07		
Race	-.02	.04	-.04		
Education	.08	.06	.11		
Current therapy	-.32	.16	-.18*		
Step 3				1.49	.19
Gender	-.16	.18	-.07		
Age	.02	.03	.06		
Race	-.01	.04	-.03		
Education	.08	.06	.11		
Current therapy	-.29	.16	-.16		
Time in therapy	.00	.00	.07		
Step 4				1.60	.14
Gender	-.15	.18	-.07		
Age	.02	.03	.07		
Race	-.01	.04	-.03		
Education	.06	.06	.09		
Current therapy	-.25	.16	-.14		
Time in therapy	.00	.00	.06		
Working Alliance	.01	.01	.13		
Step 5				1.77	.046
Gender	-.14	.18	-.06		
Age	.03	.03	.09		
Race	-.01	.04	-.01		
Education	.03	.06	.05		
Current therapy	-.23	.17	-.13		
Time in therapy	.00	.00	.05		
Working Alliance	.00	.01	-.01		
IPT	.18	.10	.20		
Psychodynamic	.15	.13	.16		

Process-Experiential	.02	.13	.02		
Person-Centered	-.11	.12	-.12		
Behavioral Therapy	-.18	.12	-.20		
Cognitive Therapy	.09	.11	.10		
CBT	.07	.10	.08		
DBT	.08	.12	.09		
Step 6				1.50	.08
Gender	-.23	.21	-.11		
Age	.03	.03	.09		
Race	-.01	.04	-.03		
Education	.03	.07	.05		
Current therapy	-.26	.17	-.14		
Time in therapy	.00	.00	.05		
Working Alliance	.00	.01	.02		
IPT	.24	.59	.27		
Psychodynamic	-.36	.66	-.39		
Process-Experiential	.05	.56	.05		
Person-Centered	.10	.61	.11		
Behavioral Therapy	-1.16	.69	-1.26		
Cognitive Therapy	1.02	.67	1.15		
CBT	.10	.59	.11		
DBT	.91	.52	1.03		
Gender*IPT	.00	.31	.00		
Gender*Dynamic	.27	.35	.55		
Gender*Proc-Exp	-.03	.30	-.07		
Gender*Person-Ctr	-.12	.33	-.25		
Gender*Behavioral	.48	.35	.95		
Gender*Cognitive	-.47	.35	-1.00		
Gender*CBT	.01	.30	.02		
Gender*DBT	-.45	.28	-.95		

Note. Step 1 R^2 = .03; Step 2 R^2 = .06, Δ R^2 = .03; Step 3 R^2 = .06, Δ R^2 = .01; Step 4 R^2 =.08, Δ R^2 = .02; Step 5 R^2 =.18, Δ R^2 = .02, Step 6 R^2 =.23, Δ R^2 = .05; $^{**}p < .01$; $^{*}p < .05$.

Table 11
Hierarchical Regression Analysis for Predictors of Standardized Positive Internalization of Therapists
(N = 134)

Variable	*B*	*SE (B)*	β	*F*	*p*
Step 1				.80	.52
Gender	-.30	.19	-.14		
Age	.00	.03	.01		
Education	-.03	.06	-.05		
Race	-.02	.04	-.05		
Step 2				.95	.45
Gender	-.32	.19	-.15		
Age	.00	.03	-.01		
Education	-.03	.06	-.04		
Race	-.02	.04	-.04		
Current therapy	-.20	.17	-.11		
Step 3				.84	.54
Gender	-.33	.19	-.15		
Age	-.01	.03	-.03		
Education	-.03	.06	-.03		
Race	-.02	.04	-.04		
Current therapy	-.18	.17	-.10		
Time in Therapy	.00	.00	.05		
Step 4				1.78	.10
Gender	-.31	.19	-.14		
Age	.00	.03	.00		
Education	-.06	.06	-.08		
Race	-.01	.04	-.03		
Current therapy	-.10	.17	-.06		
Time in Therapy	.00	.00	.02		
Working Alliance	.02	.01	.24*		
Step 5				3.37	.00
Gender	-.09	.18	-.04		
Age	.01	.03	.02		
Education	-.09	.06	-.12		
Race	-.02	.03	-.05		
Current therapy	-.20	.16	-.11		
Time in Therapy	.00	.00	.01		
Working Alliance	.00	.01	.05		
IPT	.15	.10	.16		

Psychodynamic	.41	.12	.43**		
Process Experiential	.06	.13	.07		
Person-Centered	-.25	.11	-.27*		
Behavioral	-.02	.11	-.02		
Cognitive	.00	.11	.00		
CBT	.14	.10	.16		
DBT	.00	.11	.00		
Step 6				2.40	.00
Gender	-.12	.21	-.05		
Age	.00	.03	.01		
Education	-.10	.06	-.14		
Race	-.03	.04	-.07		
Current therapy	-.21	.17	-.12		
Time in Therapy	.00	.00	.01		
Working Alliance	.01	.01	.06		
IPT	.15	.58	.16		
Psychodynamic	.16	.64	.17		
Process Experiential	-.52	.55	-.55		
Person-Centered	-.71	.60	-.77		
Behavioral	.21	.87	.22		
Cognitive	.15	.75	.17		
CBT	.37	.62	.40		
DBT	.72	.50	.79		
Gender*IPT	.00	.31	-.01		
Gender*Dynamic	.12	.34	.24		
Gender*Proc-Exp	.31	.29	.61		
Gender*Person-ctr	.24	.32	.48		
Gender*Behavioral	-.11	.45	-.22		
Gender*Cognitive	-.08	.39	-.15		
Gender*CBT	-.12	.32	-.25		
Gender*DBT	-.38	.27	-.79		

Note. Step 1 R^2 = .02; Step 2 R^2 = .04, Δ R^2 = .01; Step 3 R^2 = .04, Δ R^2 = .00; Step 4 R^2 =.09, Δ R^2 = .05, Step 5 R^2 =.30, Δ R^2 = .21, Step 6 R^2 =.33, Δ R^2 = .03, $p < .01$; **$p < .01$; *$p < .05$.

Table 12
Hierarchical Regression Analysis for Predictors of Standardized Failure of Benign Internalization of Therapists
(N = 138)

Variable	*B*	*SE (B)*	β	*F*	*p*
Step 1				1.42	.23
Gender	-.13	.19	-.06		
Age	.02	.03	.08		
Education	-.05	.07	-.06		
Race	.07	.04	.16		
Step 2				1.55	.18
Gender	-.11	.19	-.05		
Age	.03	.03	.10		
Education	-.05	.07	-.07		
Race	.07	.04	.15		
Current therapy	.24	.17	.12		
Step 3				2.30	.04
Gender	-.07	.19	-.03		
Age	.05	.03	.14		
Education	-.06	.06	-.08		
Race	.06	.04	.14		
Current therapy	.14	.17	.07		
Time in Therapy	-.01	.00	-.21*		
Step 4				13.44	.00
Gender	-.10	.15	-.05		
Age	.03	.02	.09		
Education	.02	.05	.03		
Race	.06	.03	.12		
Current therapy	-.06	.14	-.03		
Time in Therapy	-.01	.00	-.16*		
Working Alliance	-.06	.01	-.59**		
Step 5				7.48	.00
Gender	.02	.16	.01		
Age	.02	.02	.08		
Education	.02	.05	.03		
Race	.05	.03	.12		
Current therapy	-.16	.14	-.08		
Time in Therapy	.00	.00	-.14		
Working Alliance	-.05	.01	-.48**		

IPT	.08	.09	.09		
Psychodynamic	-.02	.11	-.02		
Process Experiential	.11	.11	.12		
Person-Centered	-.23	.10	-.24*		
Behavioral	.10	.10	.10		
Cognitive	-.09	.10	-.09		
CBT	.03	.08	.03		
DBT	-.12	.10	-.13		
Step 6				5.40	.00
Gender	-.03	.18	-.01		
Age	.02	.02	.06		
Education	.01	.05	.02		
Race	.04	.03	.09		
Current therapy	-.17	.15	-.09		
Time in Therapy	.00	.00	-.13		
Working Alliance	-.04	.01	-.46**		
IPT	-.15	.50	-.15		
Psychodynamic	-.40	.56	-.40		
Process Experiential	.20	.47	.21		
Person-Centered	-.43	.51	-.45		
Behavioral	.52	.58	.52		
Cognitive	.05	.57	.05		
CBT	-.12	.50	-.12		
DBT	.74	.44	.78		
Gender*IPT	.13	.26	.25		
Gender*Dynamic	.20	.30	.39		
Gender*Proc-Exp	-.05	.25	-.10		
Gender*Person-ctr	.09	.28	.18		
Gender*Behavioral	-.23	.30	-.43		
Gender*Cognitive	-.07	.29	-.14		
Gender*CBT	.08	.25	.16		
Gender*DBT	-.47	.23	-.93		

Note. Step 1 R^2 = .04; Step 2 R^2 = .06, Δ R^2 = .02; Step 3 R^2 = .10, Δ R^2 = .04; Step 4 R^2 =.41, Δ R^2 = .32, Step 5 R^2 =.48, Δ R^2 = .06, Step 6 R^2 =.52, Δ R^2 = .04, $p < .01$; **$p < .01$; *$p < .05$.

Table 13
Hierarchical Regression Analysis for Predictors of Sexual, Aggressive, and Extratherapeutic Themes in Internalization of Therapists
(N = 136)

	Variable	*B*	*SE (B)*	β	*F*	*p*
Step 1					1.21	.31
	Gender	-.36	.17	-.18*		
	Age	-.01	.02	-.03		
	Education	.03	.06	.04		
	Race	-.01	.03	-.02		
Step 2					1.43	.22
	Gender	-.37	.17	-.19*		
	Age	-.02	.02	-.05		
	Education	.03	.06	.05		
	Race	.00	.03	-.01		
	Current therapy	-.22	.15	-.13		
Step 3					1.23	.30
	Gender	-.38	.17	-.19*		
	Age	-.02	.03	-.06		
	Education	.03	.06	.05		
	Race	.00	.03	-.01		
	Current therapy	-.20	.15	-.12		
	Time in Therapy	.00	.00	.05		
Step 4					1.16	.33
	Gender	-.38	.17	-.20*		
	Age	-.02	.03	-.07		
	Education	.04	.06	.07		
	Race	.00	.03	-.01		
	Current therapy	-.22	.16	-.13		
	Time in Therapy	.00	.00	.06		
	Working Alliance	-.01	.01	-.08		
Step 5					1.08	.38
	Gender	-.28	.18	-.14		
	Age	-.02	.03	-.06		
	Education	.04	.06	.06		
	Race	-.01	.03	-.02		
	Current therapy	-.30	.16	-.18		
	Time in Therapy	.00	.00	.06		
	Working Alliance	.00	.01	-.06		
	IPT	.10	.10	.12		

Psychodynamic	.11	.12	.13		
Process Experiential	.03	.13	.03		
Person-Centered	-.16	.12	-.19		
Behavioral	.05	.11	.06		
Cognitive	-.02	.11	-.03		
CBT	.07	.10	.09		
DBT	-.11	.11	-.14		
Step 6				1.23	.24
Gender	-.46	.20	-.23*		
Age	-.01	.03	-.02		
Education	.02	.06	.03		
Race	-.02	.04	-.05		
Current therapy	-.32	.17	-.19		
Time in Therapy	.00	.00	.04		
Working Alliance	.00	.01	-.02		
IPT	-.35	.56	-.43		
Psychodynamic	-1.46	.63	-1.72*		
Process Experiential	1.04	.53	1.24		
Person-Centered	-.28	.58	-.34		
Behavioral	-.16	.65	-.19		
Cognitive	.33	.64	.41		
CBT	.30	.56	.37		
DBT	.69	.50	.83		
Gender*IPT	.23	.29	.53		
Gender*Dynamic	.85	.34	1.90*		
Gender*Proc-Exp	-.57	.28	-1.26		
Gender*Person-ctr	.06	.31	.13		
Gender*Behavioral	.11	.33	.23		
Gender*Cognitive	-.18	.33	-.42		
Gender*CBT	-.11	.28	-.25		
Gender*DBT	-.44	.27	-1.00		

Note. Step 1 R^2 = .04; Step 2 R^2 = .05, ΔR^2 = .02; Step 3 R^2 = .05, ΔR^2 = .00; Step 4 R^2 =.06, ΔR^2 = .01, Step 5 R^2 =.12, ΔR^2 = .06, Step 6 R^2 =.20, ΔR^2 = .08, $p < .01$; **$p < .01$; *$p < .05$.

Table 14
Hierarchical Regression Analysis for Positive Affect in Internalization of Therapists (N = 140)

Variable	*B*	*SE (B)*	*β*	*F*	*p*
Step 1				.96	.43
Gender	-.32	.20	-.14		
Age	.01	.03	.04		
Race	-.01	.04	-.03		
Education	.06	.07	.07		
Step 2				.77	.57
Gender	-.32	.20	-.14		
Age	.01	.03	.03		
Race	-.01	.04	-.03		
Education	.06	.07	.07		
	-.04	.17	-.02		
Current therapy					
Step 3				.72	.64
Gender	-.31	.20	-.14		
Age	.01	.03	.04		
Race	-.01	.04	-.03		
Education	.05	.07	.07		
	-.06	.18	-.03		
Current therapy					
Time in therapy	.00	.00	-.06		
Step 4				4.35	.00
Gender	-.29	.18	-.13		
Age	.03	.03	.08		
Race	-.01	.04	-.02		
Education	.00	.06	-.01		
	.07	.17	.04		
Current therapy					
Time in therapy	.00	.00	-.10		
Working Alliance	.04	.01	.41**		
Step 5				2.27	.01
Gender	-.29	.20	-.13		
Age	.02	.03	.07		
Race	-.01	.04	-.02		
Education	-.03	.07	-.04		
	.10	.18	.05		
Current therapy					

Time in therapy	.00	.00	-.11		
Working Alliance	.04	.01	.39**		
IPT	.09	.11	.09		
Psychodynamic	.07	.13	.07		
Process-Experiential	.04	.14	.04		
Person-Centered	-.02	.13	-.02		
Behavioral Therapy	-.20	.12	-.20		
Cognitive Therapy	.03	.12	.03		
CBT	.03	.10	.03		
DBT	.00	.12	.00		
Step 6				1.86	.02
Gender	-.16	.22	-.07		
Age	-8.28E-5	.03	.00		
Race	.00	.04	.00		
Education	-.03	.07	-.04		
	.09	.18	.04		
Current therapy					
Time in therapy	.00	.00	-.10		
Working Alliance	.04	.01	.40**		
IPT	-.11	.62	-.11		
Psychodynamic	1.11	.70	1.11		
Process-Experiential	-.95	.59	-.96		
Person-Centered	1.06	.64	1.08		
Behavioral Therapy	.04	.73	.04		
Cognitive Therapy	-.94	.71	-.98		
CBT	.83	.62	.86		
DBT	-.62	.55	-.65		
Gender*IPT	.09	.33	.18		
Gender*Dynamic	-.55	.37	-1.05		
Gender*Proc-Exp	.58	.31	1.09		
Gender*Person-Ctr	-.60	.35	-1.13		
Gender*Behavioral	-.14	.37	-.25		
Gender*Cognitive	.51	.37	.99		
Gender*CBT	-.42	.32	-.85		
Gender*DBT	.33	.29	.64		

Note. Step 1 $R^2 = .03$; Step 2 $R^2 = .03$, $\Delta R^2 = .00$; Step 3 $R^2 = .03$, $\Delta R^2 = .00$; Step 4 $R^2 =.19$, $\Delta R^2 = .16$, Step 5 $R^2 =.22$, $\Delta R^2 = .03$; Step 6 $R^2 =.27$, $\Delta R^2 = .05$ $^{**}p < .01$; $^{*}p < .05$.

Table 15
Hierarchical Regression Analysis for Negative Affect in Internalization of Therapists (N = 140)

Variable	*B*	*SE (B)*	*β*	*F*	*p*
Step 1				2.04	.09
Gender	.07	.20	.03		
Age	.03	.03	.10		
Race	.08	.04	.18*		
Education	-.08	.07	-.10		
Step 2				1.80	.12
Gender	.08	.20	.03		
Age	.04	.03	.12		
Race	.08	.04	.17*		
Education	-.09	.07	-.11		
Current therapy	.16	.17	.08		
Step 3				1.50	.18
Gender	.08	.20	.04		
Age	.04	.03	.12		
Race	.08	.04	.17*		
Education	-.09	.07	-.11		
Current therapy	.15	.18	.07		
Time in therapy	.00	.00	-.02		
Step 4				2.55	.02
Gender	.07	.19	.03		
Age	.03	.03	.10		
Race	.08	.04	.16		
Education	-.05	.07	-.07		
Current therapy	.06	.18	.03		
Time in therapy	4.08E-5	.00	.00		
Working Alliance	-.02	.01	-.25*		
Step 5				1.97	.02
Gender	.19	.20	.08		
Age	.04	.03	.11		
Race	.08	.04	.16		
Education	-.06	.07	-.08		
Current therapy	.02	.18	.01		

Time in therapy	.00	.00	-.07		
Working Alliance	-.03	.01	-.29*		
IPT	-.14	.11	-.14		
Psychodynamic	.40	.14	.39*		
Process-Experiential	-.12	.14	-.12		
Person-Centered	-.22	.13	-.22		
Behavioral Therapy	.10	.13	.10		
Cognitive Therapy	.01	.12	.01		
CBT	-.08	.11	-.08		
DBT	.08	.13	.08		
Step 6				1.58	.06
Gender	.14	.23	.06		
Age	.04	.03	.10		
Race	.09	.04	.20*		
Education	-.03	.07	-.04		
	.02	.19	.01		
Current therapy					
Time in therapy	.00	.00	-.03		
Working Alliance	-.03	.01	-.27*		
IPT	-.82	.65	-.84		
Psychodynamic	1.25	.73	1.23		
Process-Experiential	-.07	.61	-.07		
Person-Centered	.74	.67	.74		
Behavioral Therapy	-1.07	.75	-1.06		
Cognitive Therapy	-.17	.74	-.18		
CBT	.48	.65	.49		
DBT	.08	.57	.08		
Gender*IPT	.40	.34	.78		
Gender*Dynamic	-.47	.39	-.88		
Gender*Proc-Exp	-.02	.32	-.03		
Gender*Person-Ctr	-.51	.36	-.93		
Gender*Behavioral	.61	.38	1.10		
Gender*Cognitive	.10	.38	.20		
Gender*CBT	-.28	.33	-.55		
Gender*DBT	-.03	.30	-.06		

Note. Step 1 R^2 = .06; Step 2 R^2 = .06, Δ R^2 = .06; Step 3 R^2 = .01, Δ R^2 = .06; Step 4 R^2 =.00, Δ R^2 = .12; Step 5 R^2 =.19, Δ R^2 = .07, Step 4 R^2 =.24, Δ R^2 = .05; $p < .01$; $**p < .01$; $*p < .05$.

Appendix A

Therapist Representation Inventory II

Geller, Behrends, Hartley, Farber, & Rohde, 1992

Dear client: This study aims to understand more about how clients think about their therapists, parents and themselves. All answers will be treated confidentially. We greatly appreciate your cooperation.

Please answer the following questions:

1) How long have you been in this current therapy?__________

2) How many times a week do you attend therapy?__________

3) Have you been in therapy previously? __________

If yes:

1. How long were you in therapy?___________
2. How many times a week did you attend therapy?__________
3. How long ago did you terminate therapy?__________

I. 1. In between sessions you may sometimes think about your therapist. Under what circumstances does this tend to happen for you?
(check all that apply):

_____ when feeling sad or depressed
_____ when feeling hopeful or confident about my future
_____ when feeling inadequate or incompetent
_____when feeling anxious or fearful
_____ when feeling guilty
_____ when feeling lonely
_____ when feeling happy or pleased
_____ when feeling proud of an accomplishment
_____ when seeing someone who reminds me of my therapist
_____ when I'm with members of my family
_____ when trying to relax
_____ when trying to resolve a personal conflict
_____ when something important happens in my life
_____ when trying to make a specific decision
_____ when talking about therapy with others
_____ when near my therapist's office

_____ when thinking about something I haven't been able to talk about in therapy
_____ when doing something my therapist suggested

2. How frequently do you think about your therapist in between sessions?
_____ never
_____ rarely (once a week or less)
_____ sometimes (several times a week)
_____ frequently (daily)
_____ very often (several times a day)

3. How long do these experiences usually last? (of thinking about your therapist)
_____ non-existent (I don't have these experiences)
_____ fleeting (several seconds)
_____ briefly (about 1 minute)
_____ 2-5 minutes
_____ more than 5 minutes

4. How vivid or clear are these experiences?
_____ not at all vivid or clear
_____ slightly vivid
_____ moderately vivid
_____ quite vivid
_____ highly vivid

II. Please complete this section keeping in mind what you experience IN BETWEEN your therapy sessions.

Please use the following nine-point scale in answering the questions:

1	2	3	4	5	6	7	8	9
Not at all typical	Slightly Typical		Moderately Typical			Quite Typical		Highly Typical

Therapist Involvement Scale (TRI-Section 3)
IN BETWEEN THERAPY SESSIONS:

_____ 1. I miss my therapist.
_____ 2. I think my therapist would be disapproving of me.
_____ 3. I now find myself talking to other people the way I talk with my therapist.
_____ 4. I wonder if my therapist ever thinks about me.
_____ 5. I think about contacting my therapist.
_____ 6. I feel as though I were never in therapy.
_____ 7. I wish more of my relationships were like the one with my therapist.
_____ 8. I rehearse what I will say to my therapist when we meet again.
_____ 9. I find myself looking for my therapist when I am out in a crowd.
_____ 10. When I am having a problem, I try to work it out with my therapist in my mind.
_____ 11. I wish I could be friends with my therapist.
_____ 12. I imagine my therapist telling me what he/she “really” thinks or feels about me.
_____ 13. There are times when I feel that I have lost some of the gains made in therapy.
_____ 14. When I am faced with a difficult situation, I sometimes ask myself, “What would my therapist want me to do?”
_____ 15. I hope I never have to be in therapy again.
_____ 16. I sometimes see people who remind me of my therapist.
_____ 17. I imagine being held by my therapist.
_____ 18. I imagine my therapist and me kissing each other.
_____ 19. I don’t think that therapy will have a lasting effect on me.
_____ 20. I daydream about my therapist.
_____ 21. I doubt that anyone can replace my therapist in my life.
_____ 22. I would like my therapist to be proud of me.
_____ 23. I imagine being the parent of my therapist’s child.
_____ 24. I try to solve my problems in the way my therapist and I worked on them in psychotherapy.
_____ 25. In a sense I feel as though my therapist has become part of me.
_____ 26. I wish I had a different therapist.
_____ 27. I imagine myself helping my therapist.
_____ 28. I imagine our talking to each other outside of the therapy office.
_____ 29. I imagine my therapist hurting me in some way.
_____ 30. I imagine my therapist and I eating together

_____ 31. In stressful situations, I don't seem to be able to use what I previously learned in therapy.
_____ 32. I miss talking about myself the way therapy permits me to do.
_____ 33. I look forward to returning to sessions with my therapist.
_____ 34. I imagine being sexually involved with my therapist.
_____ 35. I don't remember very much of what my therapist said in our talks together.
_____ 36. I imagine hurting my therapist in some way.
_____ 37. I wish I were more like my therapist.

III. The experience of fantasizing or thinking about your therapist may consist of words, pictures, sounds, bodily sensations, and so on. When you do experience the presence of your therapist in between sessions, what typically stands out for you?

Please use the same nine-point rating scale in answering the questions.

1	2	3	4	5	6	7	8	9
Not at all typical	Slightly Typical		Moderately Typical			Quite Typical		Highly Typical

Therapist Embodiment Scale (TRI-Section 2)
WHEN I IMAGINE MY THERAPIST:

_____ 1. I imagine my therapist in his/her office.
_____ 2. I picture a specific expression on my therapist's face.
_____ 3. I see my therapist gesturing.
_____ 4. I imagine just my therapist's head and face.
_____ 5. I imagine my therapist dressed a certain way.
_____ 6. I imagine a particular quality to the sound of my therapist's voice.
_____ 7. I think of specific comments my therapist made to me.
_____ 8. I experience in myself certain bodily sensations.
_____ 9. My image of my therapist is not tied to a specific time or place.
____ 10. I imagine myself in physical contact with my therapist.
____ 11. I am aware of a particular emotional atmosphere which gives me the sense that my therapist is "with me".
____ 12. I think of specific statements I have made to my therapist.
____ 13. I recall my therapist's personal scent.
____ 14. I remember conversations we had.
____ 15. I do not remember my therapist's words.
____ 16. I sense the way my therapist moves.
____ 17. I find it difficult to imagine my therapist in any form whatsoever.
____ 18. I sense the rhythm and manner of my therapist's speech.
____ 19. I feel the gut sensation of what it's like to be with my therapist.
____ 20. I experience the odor or scent of my therapist's office.
____ 21. I imagine us talking to each other.
____ 22. I imagine just my therapist's office.
____ 23. I sense a particular emotional feeling.
____ 24. I picture my therapist alone.
____ 25. I imagine statements my therapist might say to me.

TRI, Affect Scale

IV. This section focuses on the feelings you may have when thinking about your therapist. When you experience the presence of your therapist in between sessions, which feelings typically stand out for you?

Please use the same nine-point rating scale in answering.

1	2	3	4	5	6	7	8	9
Not at all typical		Slightly Typical		Moderately Typical		Quite Typical		Highly Typical

WHEN I THINK ABOUT MY THERAPIST IN BETWEEN SESSIONS, I FEEL:

_____1. comforted
_____ 2. relieved
_____3. discouraged
_____ 4. anxious
_____5. angry
_____6. hopeful
_____ 7. sad
_____ 8. ashamed
_____ 9. grateful
_____ 10. energized
_____ 11. defensive
_____12. distant
_____ 13. confused
_____14. accepted
_____ 15. safe
_____16. guilty
_____ 17. relaxed
_____18. loving
_____ 19. frightened
_____20. touched
_____ 21. rejected
_____22. courageous
_____ 23. important
_____24. self-critical

Appendix B

Working Alliance Inventory Form C

Instructions On the following pages there are sentences that describe some of the different ways you might have thought or felt about your therapist . As you read the sentences mentally insert the name of your therapist in place of _____________in the text. Below each statement inside there is a seven point scale:

____ ____________________________

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

____ ____________________________ If the statement describes the way you always felt (or thought) circle the number 7; if it never applied to you circle the number 1. Use the numbers in between to describe the s between these extremes.

This questionnaire is CONFIDENTIAL; only the research team will see your answers. Work fast, your first impressions are the ones we would like to see.

(PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.) Thank you for your cooperation. © A. O. Horvath, 1981, 1984, 1992. WAI(C)

1. _______________ and I agree about the things I will need to do in therapy to help improve my situation.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

2. What I am doing in therapy gives me new ways of looking at my problem.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

3. I believe _______________ likes me.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

4. _______________ does not understand what I am trying to accomplish in therapy.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

5. I am confident in _______________ 's ability to help me.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

6. _______________ and I are working towards mutually agreed upon goals.

1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

7. I feel that _______________ appreciates me.
1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

8. We agree on what is important for me to work on.
1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

9. _______________ and I trust one another.
1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

10. _______________ and I have different ideas on what my problems are.
1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

11. We have established a good understanding of the kind of changes that would be good for me.
1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

12. I believe the way we are working with my problem is correct.
1 2 3 4 5 6 7
Never Rarely Occasionally Sometimes Often Very Often Always

Appendix C

The Multitheoretical List of Therapeutic Interventions (MULTI)

McCarthy & Barber, 2009

Instructions: The following items represent actions that may or may not have occurred in the session in which you just took part. Please rate each item using the scale provided. There are no right or wrong answers.

1: Not at all typical 2: Slightly typical 3: Somewhat typical 4: Typical of 5: Very typical of the therapy

1. My therapist set an agenda or established specific goals for the therapy session. 1 2 3 4 5
2. My therapist made connections between my current situation and my past. 1 2 3 4 5
3. My therapist focused on identifying parts of my personality that were in conflict, like one part that wanted to be close to
others and another part that did not. 1 2 3 4 5
4. My therapist asked me to visualize specific scenes or situations in detail. 1 2 3 4 5
5. My therapist encouraged me to identify specific situations or events that tended to precede my problematic behavior. 1 2 3 4 5
6. My therapist often focused on my recent experiences. 1 2 3 4 5
7. My therapist worked to give me hope or encouragement. 1 2 3 4 5
8. My therapist seemed convinced of the effectiveness of the methods he/she is using to help me.
1 2 3 4 5

9. My therapist and I discussed a plan for me to try to control (increase or decrease) specific behaviors, like: 1 2 3 4 5

a. Smoking. b. Eating. c. Exercising. d. Checking something repeatedly. e. Saying or thinking certain things. f. Hurting myself. 10. My therapist repeated back to me (paraphrased) the meaning of what I was saying. 1 2 3 4 5

11. My therapist encouraged me to identify or label feelings that I had in or outside of the session. 1 2 3 4 5

12. My therapist encouraged me to talk about feelings I had previously avoided or never expressed. 1 2 3 4 5

13. My therapist pointed out times when my behavior seemed inconsistent with what I was saying, like when I: 1 2 3 4 5

a. Suddenly shifted my moods or topics. b. Was silent a long time. c. Laughed, smiled, looked away, or was uncomfortable. d. Avoided talking about specific topics or people.

14. My therapist encouraged me to talk about whatever came to my mind. 1 2 3 4 5

15. My therapist taught me specific new skills or behaviors, like how to: 1 2 3 4 5

a. Relax my muscles.

b. Control my emotions.

c. Be assertive with others.

d. Act in social situations.

16. My therapist encouraged me to think about, view, or touch things that I am afraid of.

1 2 3 4 5

17. My therapist reviewed or assigned homework exercises, like: 1 2 3 4 5

a. Writing down certain thoughts or feelings outside the session.

b. Practicing certain behaviors.

18. My therapist was warm, sympathetic, and accepting. 1 2 3 4 5

19. My therapist pointed out recurring themes or problems in my relationships. 1 2 3 4 5 20. My therapist talked about the function or purpose that my problem might have, like how it:

1 2 3 4 5

a. Lets me avoid responsibility.

b. Keeps others away from me.

21. My therapist encouraged me to explore explanations for events or behaviors other than those that first came to my mind. 1 2 3 4 5

22. My therapist made connections between the way I act or feel toward my therapist and the way that I act or feel in my other relationships. 1 2 3 4 5

23. My therapist encouraged me to see the choices I have in my life. 1 2 3 4 5

24. My therapist and I discussed my dreams, fantasies, or wishes. 1 2 3 4 5

25. My therapist encouraged me to consider the positive and negative consequences of acting in a new way. 1 2 3 4 5

26. My therapist made the session a place where I could get better or solve my problems.

1 2 3 4 5

27. My therapist tried to help me identify the consequences (positive or negative) of my behavior. 1 2 3 4 5

28. My therapist and I worked together as a team. 1 2 3 4 5

29. My therapist gave me advice or suggested practical solutions for my problem. 1 2 3 4 5 30.

My therapist shared personal information with me. 1 2 3 4 5

31. My therapist listened carefully to what I was saying. 1 2 3 4 5

32. My therapist often explained what he/she was trying to do. 1 2 3 4 5

33. My therapist led the discussion most of the time. 1 2 3 4 5

34. My therapist focused on how disagreements between certain parts of my personality have caused my problems. 1 2 3 4 5

35. My therapist encouraged me to change specific behaviors. 1 2 3 4 5

36. My therapist focused on the ways I cope with my problems. 1 2 3 4 5

37. My therapist encouraged me to look for evidence in support of or against one of my beliefs or assumptions. 1 2 3 4 5

38. My therapist explored my feelings about therapy. 1 2 3 4 5

39. My therapist encouraged me to view my problem from a different perspective. 1 2 3 4 5 40.

My therapist encouraged me to explore the personal meaning of an event or a feeling.

1 2 3 4 5

41. My therapist often focused on my childhood experiences. 1 2 3 4 5

42. My therapist focused on improving my ability to solve my own problems. 1 2 3 4 5

43. My therapist encouraged me to list the advantages and disadvantages of a belief or general rule that I follow. 1 2 3 4 5

44. My therapist had me role-play (act out or rehearse) certain scenes or situations.

1 2 3 4 5

45. My therapist tried to help me better understand how I relate to others, how this style of relating developed, and how it causes my problems. 1 2 3 4 5

46. My therapist seemed interested in trying to understand what I was experiencing.

1 2 3 4 5

47. My therapist encouraged me to focus on my moment-to-moment experience. 1 2 3 4 5 48. My therapist tried to help me better understand how my problem was due to certain beliefs or rules that I follow. 1 2 3 4 5

49. My therapist encouraged me to question my beliefs or to discover flaws in my reasoning.

1 2 3 4 5

50. My therapist focused on a specific concern in my relationships, like: 1 2 3 4 5

a. Disagreements or conflicts.

b. Major changes.

c. Loss of a loved one.

d. Loneliness.

51. My therapist encouraged me to explore ways in which I could make changes in my relationships, like ways to: 1 2 3 4 5

a. Resolve a conflict in a relationship.

b. Fulfill a need.

c. Establish new relationships or contact old friends.

d. Avoid problems I had experienced in previous relationships.

52. My therapist reviewed the gains I had made while in therapy. 1 2 3 4 5

53. My therapist reviewed the difficulties that I was currently experiencing. 1 2 3 4 5

54. My therapist encouraged me to examine my relationships with others, like: 1 2 3 4 5

a. Positive and negative aspects of my relationships.

b. What I want and others want from me.

c. The way I act in relationships.

55. My therapist encouraged me to think about ways in which I might prepare for major upcoming changes in my relationships, like: 1 2 3 4 5

a. Learning new skills.

b. Finding new friends.

56. My therapist both accepted me for who I am and encouraged me to change. 1 2 3 4 5

57. My therapist encouraged me to identify situations in which my feelings were invalidated, like: 1 2 3 4 5

a. Times when a significant other told me my feelings were incorrect.

b. Situations in which I had strong feelings that seemed inappropriate.

58. My therapist encouraged me to think about or be aware of things in my life without judging them. 1 2 3 4 5

59. My therapist made it clear that my problem was a treatable medical condition. 1 2 3 4 5

60. My therapist tried to help me better understand how my problems were due to difficulties in my social relationships. 1 2 3 4 5