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Clients' Internal Representations of Their Therapists

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Abstract: Thirteen adults in long-term individual psychotherapy were interviewed regarding their internal representations (denned as bringing to awareness the internalized "image") of then-therapists. Results indicated that in the context of a good therapeutic relationship, clients' internal 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. Clients felt positively about their representations and used them to introspect or influence therapy within sessions, beyond sessions, or both. The frequency of, comfort with, and use of clients' internal

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representations increased over the course of therapy, and the representations benefited the therapy and therapeutic relationship. Therapists tended not to take a deliberate role in creating clients' internal representations, and few clients discussed their internal representations with their therapists.

Clients' internal representations of their therapists can be defined as clients bringing to awareness the internalized "image" (occurring in visual, auditory, felt presence, or combined forms) of their therapists when not actually with them in session. In these internal representations, clients have an image of the living presence of their therapist as a person. Despite its apparent significance, the phenomenon of clients' internal representations of their therapists has not received a great deal of attention in the literature. Related concepts include incorporation, introjection, identification, internalization, attachment, transference, and object relations (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1973, 1974, 1978, 1982, 1988; Fairbairn, 1952; Freud, 1912/1949, 1915/1949, 1900/1955, 1917/1957, 1905/1958; Geller, 1984; Geller & Farber, 1993; Guntrip, 1969, 1975; Laplanche & Pontalis, 1973; Loewald, 1960, 1962; Meissner, 1981; Mishne, 1993; Schafer, 1968; Winnicott, 1945). Each of these constructs, including internal representations, involves some form of an often covert relationship that clients experience with their therapists. Thus, these related and partially overlapping constructs all refer to variations on the theme of how clients "take in" their therapists, and fall under the conceptual umbrella of internalization processes. These variations have been discussed at a theoretical level, but have not been distinguished empirically. Our interest in this study was to investigate one of these internalization processes (i.e., internal representations) because we were interested in how clients "use" their therapists between sessions.

Internal representations of therapists may be helpful to clients. Singer and Pope (1978), for example, asserted that "[clients] 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). Likewise, Rosen (1982) related a case of a patient treated by Milton H. Erikson. The patient felt too embarrassed to tell Erikson of her problem in person. Instead, she drove to his house, parked in his

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driveway, and imagined his presence in the car with her, thus enabling her to think through her problem. The potent role and effect of such representations on clients' lives is further demonstrated by one client who wanted to take the therapist and zip her up inside his (the client's) body, a dramatic attempt to hold onto the therapist's presence by means of an internal representation.

Furthermore, theorists assert that clients' representations of their therapists are critical elements in the healing process, and that many of the most important experiences that occur in therapy are those that facilitate the construction and/or reactivation of benignly influential, enduring, cognitive–affective representations of the therapist (Dorpat, 1974; Edelson, 1963; Geller, 1984; Horwitz, 1974; Kohut, 1971; Loewald, 1960; Schafer, 1968; Strupp, 1978). Clients' improvement, furthermore, is believed to be related to the extent to which they are able to evoke representations of these benignly influential components of the therapy relationship (Rosenzweig, Farber, & Geller, 1996), such as the therapist himself or herself.

The importance of this phenomenon makes intuitive sense. In the same way that the growth and performance of those learning to play a musical instrument, or learning a particular sport, are enhanced by work and practice outside the scope of any formal lesson, so, too, may clients' healing and growth be enhanced by their continued therapeutic "work" beyond the actual consultation hour. Clients' internal representations may be the "homework" of therapy, as well as the psychological connective tissue between successive sessions (Orlinsky, Geller, Tarragona, & Farber, 1993) that enables clients to continue the work of therapy in the therapists' absence. As one client stated, "It was like a continuation of the analysis. I mean that was part of the way I would think about myself—sort of imagine myself being [in the consultation room], and what would happen there, and how I would think" (Kantrowitz, Katz, & Paolitto, 1990, p. 643).

Much of what we do know about clients' internal representations comes from the work of Geller and his colleagues, who developed the Therapist Representation Inventory (TRI; Geller, Cooley, & Hartley, 1981), a paper-and-pencil, self-report survey measure used to assess representations from the client's point of view. The TRI provides some data about certain categorical features (e.g., form, content) of clients'

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internal representations. It does not, however, provide an "inside view" of what clients actually experience with regard to these representations, a view that may be more accessible through an interview format. Furthermore, many of the participants in the extant studies were therapists or therapists-in-training, and thus do not represent the more typical therapy population. In addition, over the course of these studies, inconsistent versions of the TRI have been used, further clouding the results. Thus, there is a need for additional and potentially clarifying research.

We believed that a qualitative investigation of internal representations would be helpful, because such a method seeks to "get inside" and describe how clients create and use their internal representations, fostering the probing of inner experiences without predetermining the responses. We used the consensual qualitative research (CQR) methodology developed by Hill, Thompson, and Williams (1997). In this methodology, words rather than numbers are used to describe phenomena, a small number of cases is studied extensively, a consensual group process is used throughout the data analysis procedure, and conclusions are built inductively from the data. In addition, an auditor checks the consensus judgments yielded by the analysis process to ensure that all data have been considered and that the interpretations and conclusions are accurate and based on the original data.

We believed that the results of a qualitative study of clients' internal representations could be helpful for therapists, who could learn what aspects have the greatest impact on clients, what features may be less important, and how clients use the representations they create. If therapists have a clearer understanding of how clients experience and use internal representations, they may be able to intervene more effectively. A deeper understanding of this phenomenon may also yield benefits for clients. For example, clients who have internal representations may have little sense of whether others also create such representations of their therapists, and may thus be comforted and affirmed in simply knowing that this phenomenon is relatively common. This awareness may yield positive effects for clients both inside and outside the therapy setting, who might then more comfortably use their internal representations when desired. Further understanding of clients' internal representations of

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their therapists, then, may come through research that looks qualitatively at this phenomenon, providing an intimate and inside view of these experiences.

Hence, our purpose in this study was to use a qualitative approach to investigate clients' internal representations of their therapists. We focused on the circumstances under which clients' internal representations occurred; how the representations were used; how they were affectively experienced by clients; how they influenced the therapy, the clients, and/or the therapeutic relationship; how the representations changed over the course of therapy; whether therapists deliberately evoked clients' internal representations; and whether clients and therapists discussed such representations in the therapy.

Method

Participants

Clients: Thirteen clients (7 women and 6 men; 10 European American/White [non-Latino], 2 Asian American/Pacific Islander, 1 African American/Black) were recruited through their therapists in a large metropolitan area. Clients ranged in age from 25 to 54 years (M = 39.70, SD = 9.85), had been in therapy with their therapists from 6 to 42 months (M = 24.15, SD = 11.07), had had between 11 and 126 sessions (M = 81.42, SD = 37.45) with their therapists, and had no planned termination in sight. The number of times these clients had been in therapy, including the present therapy, ranged from one to greater than five ("too many to count"); the number of therapists seen, including the present therapist, ranged from one to five. In addition, clients were seeing their current therapists on average once or twice a week, anticipated doing so for at least another year, were determined by their therapists to be nonpsychotic and nonborderline, and were not themselves therapists. Clients identified their presenting problems (non-mutually exclusive) as the following: depression (n = 6), life transition–adjustment problems (n = 4); family–marital problems (n = 3), anxiety (n = 2), self-esteem–empowerment (n = 2), self-mutilation–suicidality (n = 1), and codependence (n = 1).

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Therapists: As described by the participating clients, the 11 female and 2 male therapists ranged in age from 37 to 60 years (M = 48.69, SD = 6.87). Twelve were identified as European American/White (non-Latino), and 1 was identified as African American/Black (non-Latino). Clients' assessments of their therapists' orientations (non-mutually exclusive) were the following: psychoanalytic–psychodynamic (4), behavioral–cognitive-behavioral (4), humanistic–experiential (3), eclectic (2), and other (2).

Interviewer and judges: A 37-year-old White woman, the principal researcher, conducted the audiotaped interviews, in addition to serving on the primary team. Three judges (the 37-year-old White woman, one 28-year-old White woman, and one 32-year-old White woman) participated in this project as the primary team. All three were graduate students in a counseling psychology PhD program. A 50-year-old White female professor served as the auditor. All were authors of the study.

Measures

The demographic form asked for basic demographic information about the participant: age, gender, and race of both participant and therapist; therapy history; and current therapy information (e.g., length of time in therapy, number of sessions in therapy, reason for seeking therapy), and so on. The form also asked participants to indicate the therapist's theoretical orientation by checking which label fit best. Finally, the form asked for a first name, phone number, and address to enable further contact.

The Client Satisfaction Questionnaire-8 (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979), an eight-item self-report measure, was used to assess clients' satisfaction with their therapy, thus providing additional descriptive information about these clients. The CSQ-8 evaluates several dimensions of such satisfaction, including physical surroundings, type of treatment, treatment staff, quality of service, amount of service, outcome of service, general satisfaction, and procedures. The scores for each item range from 0 to 4, with higher scores indicating greater satisfaction. Internal consistency of the CSQ-8 has ranged from .84 to .93, and analyses have consistently

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yielded a single factor in factor analysis (e.g., Nguyen, Attkisson, & Stegner, 1983). With respect to validity, the CSQ-8 has been related to clients' ratings of overall improvement and symptomatology, and to therapists' ratings of clients' progress and likability. In addition, less satisfied clients had higher drop-out rates. As in previous studies, (e.g., Rhodes, Hill, Thompson, & Elliott, 1994), the words *services* or *program* were replaced with *therapy* in each item.

The first interview began with a "grand tour" question asking participants to describe their current therapists; this question was used to encourage participants to re-evoke their internal representations of their therapists and to "re-enter" their experiences in therapy. The next question asked participants whether they thought about or imagined their therapists between sessions. Participants were informed, for example, that although clients may see their therapists for an hour or two each week, they may also think about or imagine their therapists when not actually in a session. They may hear their therapists' voice or words, may see an image of their therapists, or may sense the presence of their therapists. If participants responded affirmatively, the interview proceeded. In two cases, even after further probing, clients' responses indicated that they had no such thoughts or images of their therapists between sessions. The interviewer stated that the research was investigating those who do have such thoughts or images, thanked the clients for their interest, and ended the interview.

The third question asked participants to describe as specifically and concretely as possible how they thought about or imagined their therapists between sessions, and also asked participants to describe a recent and/or particularly vivid instance of between-session thoughts or images of the therapists. The fourth question asked when and where the thoughts or images occurred, in what situations or contexts the thoughts or images occurred, how often the thoughts or images occurred, the duration and intensity of the thoughts or images, and whether the therapist had ever said or done anything deliberately to evoke such thoughts or images. The fifth question sought to capture participants' affective experiences related to their thoughts about or images of their therapists, asking them to describe how they felt when having such thoughts or images. The sixth question asked participants to describe how they used these thoughts or images; the seventh

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question asked what, if any, effect thinking about or imagining the therapists between sessions had on the therapy or on the relationship with the therapists. The next question asked whether these thoughts or images had ever been discussed with the therapists, and if so, asked the participants to describe such conversations. The ninth question asked about any changes in these thoughts or images over the course of the therapy. Next, participants were asked to describe their relationship with their therapist; the eleventh question asked participants to evaluate their therapy experience. The next question asked participants why they chose to volunteer for the research. Finally, participants were asked to discuss any other thoughts or feelings they may have had regarding their internal representations of their therapists.

The follow-up interview gave both researcher and participants a chance to ask further questions that may have arisen after the first interview, clarify certain issues, and/or amend previous comments. It also provided the opportunity for both interviewer and participants to explore what, if any, other thoughts and reactions had been stimulated by the first interview and/or by completing the CSQ-8 and another measure (not included in the present study), which were completed and returned between the initial and follow-up interviews.

Procedures

Recruiting clients: Forty-four therapists known to or by the counseling psychology faculty at a large mid-Atlantic university were contacted by phone and asked to invite their clients to participate. Therapists were informed that the study would investigate the therapy relationship, but they were not told specifically that the study would examine clients' internal representations of their therapists because such knowledge might have biased therapists with respect to which clients they invited to participate.

The 26 therapists who agreed to help gave research packets to a random few (two to three) of their adult (at least 18 years old) long-term clients. The criteria were that the clients had to have already had at least 15 individual sessions with the therapist or have been in individual therapy with this therapist for at least 6 months (but not

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more than 5 years), had seen their therapists on average once or twice a week (and anticipated continuing to do so for at least another year), had no planned termination in sight, and were otherwise appropriate for the two phone interviews and two measures (i.e., the CSQ-8 and another measure not used in the analyses) required of participants. Finally, therapists were instructed not to give packets to clients who were borderline, psychotic, or both, or to those who were themselves therapists. Seventy packets were given to therapists, who distributed a total of 49 packets to clients who met these conditions.

The first contact between the primary researcher and the potential participants occurred through the research packet, distributed by the therapists to those clients who met the conditions described above. The packet included a letter to the client containing specific information about the nature of the study and assuring confidentiality, the client consent form, and the demographic form. Potential participants then decided whether to continue participation. For those who declined, this ended their involvement. Those who chose to participate were asked to complete and return the client consent form and the demographic form via a stamped envelope addressed to the primary researcher. The participant was also provided with a list of the questions that would be asked in the first interview. Finally, the participant was asked to list convenient times for this interview, and was thanked for his or her willingness to participate.

Upon receipt of the consent and demographic forms, the primary researcher called the participants to set up the first interview. Of the 15 clients who returned the materials, 2 indicated (early in the first interview) that they did not experience internal representations of their therapists, and were thus dropped from the study.

Interviewing: The primary researcher completed interviews with 13 clients using the interview protocols. At the end of each interview, the researcher made brief notes on the interview, noting how long the interview took, the interviewer's sense of participants' mood, and the interviewer's ability to build rapport with participants. At the conclusion of the first interview, a time for the follow-up interview in about 2 weeks was set. The participants were also reminded that they would soon receive two measures in the mail and

were asked to return them within a week after receiving them. (Note: One measure was not analyzed for the present study.) At the end of the second interview, the interviewer asked participants if they were willing to receive and then correct or amend the transcripts of the two interviews. The interview concluded with a short debriefing paragraph. The average length of the first interviews was 53.08 min (*SD* = 10.52). The average length of the follow-up interviews was 15.38 min (*SD* = 4.48).

Transcripts: The interviews were transcribed verbatim (except for minimal encouragers, silences, and stutters) for each participant. All identifying information was removed from the transcripts, and each participant was assigned a code number to maintain confidentiality. When completed, transcripts were sent to interested participants (*N* = 7) for corrections or additions. Two clients returned minor editorial corrections or amendments, which were incorporated into the final transcripts.

Bracketing biases: Prior to the coding of any data, all three judges and the auditor explored their expectations–biases by responding to each interview question as they expected participants to respond. The judges and auditor also recorded any significant biases they felt both as therapists and as clients about clients' internal representations of their therapists. In addition, the judges discussed these expectations–biases in an initial meeting to inform the group and encourage all to be aware of and on the lookout for any manifestations of these biases and expectations in the analysis of the data.

Three of the four researchers believed that the triggers for clients' internal representations would be either positive or negative, with two stating that clients' experiencing of emotions would likely trigger the representations. Three believed that the representations would occur anywhere, but would most likely occur when clients were alone. All four stated that the frequency and duration of clients' internal representations would vary, with two also stating that intensity would vary. Three researchers believed that clients would "accept" or "embrace" the representations rather than flee from them; all four stated that the affect associated with the phenomenon would be largely positive and that the representations would have a positive effect on the therapy and the therapeutic relationship. Three

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researchers stated that therapists would rarely evoke the representations deliberately, and that clients would be unlikely to discuss this phenomenon with their therapists. Two researchers, however, felt that if therapists knew of clients' internal representation experiences, they would actively foster such experiences as part of the therapy process. Three researchers stated that the representations would change over the course of the therapy. The judges and auditor were asked to bracket, or set aside, such suppositions and approach the data with fresh eyes, limiting as much as possible the influence of their own biases on the conceptualization and interpretation of the results.

Procedures for Analyzing Data

The data were analyzed using CQR methods (Hill et al., 1997). The heart of this type of qualitative research is arriving at consensus about the meaning, significance, and categorization of the data. Consensus is accomplished through team members discussing their individual conceptualizations, and then agreeing on a final interpretation that is satisfactory to all. At least some initial disagreement is the norm, and is then followed by eventual agreement (consensus) on the analysis of the data. Because the three members of the primary team were all graduate students and because they were respectful of each other, power dynamics were not a problem and could be discussed openly. The few disagreements that arose within the primary team occurred in the wording of core ideas. Such disagreements were resolved by means of a discussion among the team members, and were checked by the auditor.

Determination of domains: Domains (topic areas) were initially developed by the primary team by clustering the interview questions. The domains were modified on the basis of the first few transcripts and then refined by going through additional transcripts. Further changes were made throughout the process to reflect the emerging data best. The final domains appear in Table 1.

Domain coding: Using the final transcripts, the three judges independently assigned each meaning unit (one complete thought, ranging from a phrase to several sentences) from each transcript into

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one or more domains. The judges discussed the assignment of meaning units into domains until they reached consensus.

Core ideas: Each judge independently read all data within each domain for a specific case and wrote what she considered to be the core ideas that expressed the general ideas of the data in more concise and abstract terms. Judges discussed each core idea until they reached consensus about content and wording. A consensus version for each case was then developed, consisting of the core ideas and the corresponding interview data for each of the domains.

Audit of domains and core ideas: The auditor examined the consensus version of each case and evaluated the accuracy of both the domain coding and the wording of the core ideas. The judges then discussed the auditor's comments and again reached consensus for both the domain coding and the wording of the core ideas in the revised consensus version. The auditor again checked this revised consensus version. When no further changes were suggested or made, the consensus version was considered final.

Cross-analysis: The purpose of cross-analysis was to compare the core ideas within domains across cases. Following the method described by Hill et al. (1997), the initial cross-analyses were done on 11 of the 13 cases. Each member of the primary team examined the core ideas from all cases for each domain and independently developed categories that best fit these core ideas. The team then discussed to consensus the conceptual labels (titles) of the categories and the specific core ideas to be placed in each category. We sought to develop categories that meaningfully captured the similarities across cases, keeping in mind both the goal of identifying categories that fit a number of cases, and the goal of accurately reflecting the specific content of the core ideas, even if only a few cases fit that category.

After this initial set of categories was developed, the judges returned to the consensus versions of all cases to determine whether the cases contained evidence not previously coded for any of the categories. If such evidence was discerned (as determined by a consensus judgment of the primary team), the consensus version of the case was altered accordingly to reflect this category, and the core idea was added to the appropriate category in the cross-analysis.

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Categories and domains were continually revised until everyone felt assured that the data were well represented.

Audit of cross-analysis: The auditor then reviewed the cross-analysis. Suggestions made by the auditor were considered by the primary team and incorporated if agreed on by consensus judgment. The auditor again checked the revised cross-analysis. As with the determination of the core ideas, when no further changes were suggested or made, the cross-analysis was considered final.

Stability check: After the initial cross-analysis was complete, the remaining two cases (temporarily dropped in the initial cross-analysis; see above) were added to see if the designations of general, typical, and variant (see below) changed, and also to see if the team felt that new categories had to be added to accommodate the cases. The remaining cases did not alter the results substantially, and hence the findings were considered "stable."

Categories were considered general if they applied to all cases, typical if they applied to at least half (but not all) of the cases, and variant if they applied to fewer than half but at least two cases. Core ideas that fit for only one case were placed into the "other" category for that domain.

Cross-domain analysis: After the categories were determined to be stable, the team charted the results to explore whether any relationships existed among the domains as a way to focus and organize the information. Only those connections between general and typical categories were charted, ensuring that the results would be those that applied to more than half of the cases, and thus represented more consistent findings. The charts developed revealed no distinct pattern among any of the domains and categories; instead, we found that virtually all domains and categories were linked to each other.

Results and Discussion

Satisfaction With Therapy

The mean for the present clients on the CSQ-8 was 28.54 (*SD* = 2.67), and was within a standard deviation of the normative mean of 27.23 (*SD* = 3.95; Attkisson & Greenfield, 1995). Thus, the present sample was considered to be similar to the normative sample in terms of their satisfaction with therapy. Hence, these results are presented in the context that this was a group of clients who felt moderately satisfied with their present therapy. A comparison of more versus less satisfied clients yielded no differences in the qualitative results.

Examples of Internal Representations

Several examples of clients' representations of their therapists are presented as illustrations of the phenomenon. One client invoked a literal and complete re-creation of the therapy setting in her mind when she felt anxious as she drove in heavy traffic. She repeated words to herself that her therapist had told her about being a good problem solver. These words enabled her to avert a full-blown panic attack, and allowed her to do the things she wanted to do in her life. When another client was facing a particularly troubling family situation, she reached for the phone to call her therapist. Instead of calling, however, she evoked an internal representation as if she had called, and imagined what her therapist would say to calm her down, to get beyond the situation and see it from a different point of view. Yet another client saw her therapist's penetrating eyes pulling the client to do what she feared, saw the therapist's smile when the client succeeded in facing her fears and in taking care of herself, and imagined her therapist telling her to write in her journal as a way to get through difficult times. Another client reported envisioning her therapist extending her arms to the client, beseeching her to come for help when she considered self-mutilation. One client reported that she remembered what her therapist had said to her and tried to apply it in real-life situations by focusing on the therapist's words. In another example, a client placed herself mentally in the chair she (the client) occupied during sessions and experienced her therapist as a presence helping the client face her difficulties. One client described his internal

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representations as more dream-like, as nonliteral images of his therapist in which he experienced his therapist, much like a Disney cartoon or medieval painting depicting angels and devils, perched on the client's shoulder. As a final example, when one client had what felt like a breakthrough with a difficult colleague at work, he immediately found himself, via his internal representation, envisioning himself talking to his therapist to reinforce the things that had been discussed in therapy.

Description of Internal Representations

Table 1 includes the domains, categories, and exemplary core ideas that characterize the results for all of the domains below.

In looking at the subdomains for modality, triggers, locations, frequency, duration, and intensity, variation is a common theme. These clients' internal representations of their therapists occurred in auditory, visual, and felt presence forms. The representations were triggered by a range of stimuli, including times when clients thought about prior or future sessions, when they felt distressed or happy, or when they were in situations in which they could apply therapy to real life. Their internal representations occurred in varied locations, such as at home, in the car, at work or school, or in no particular setting. Clients' representations happened with varying frequencies, from once a month to daily. In addition, the representations' durations varied, with some clients reporting consistently brief durations and others indicating a range in how long their representations lasted. Finally, the intensity of the representations also varied: Some clients reported representations that were consistently moderate to high in intensity, and others reported variable intensities for their representations. These findings are not surprising, and are consistent with other research (Geller et al., 1981). It seems, then, that there is no singular or archetypical pattern to clients' internal representations; instead, they vary according to clients' internal and external conditions or needs at the time.

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Clients' Deliberate Use of Internal Representations

Clients typically used their internal representations to engage in introspection. As a second typical category, clients used their internal representations to influence the work of therapy within sessions, beyond sessions, or both. Variantly, clients used their internal representations as sources of soothing, comfort, and support.

These results suggest that clients continue the therapeutic processes outside of sessions. Thus, when not actually in their therapists' presence, the majority of these clients nevertheless maintained their connection with the therapy by means of their representations. They typically used them to continue self-reflective processes perhaps initiated by the therapy itself, and they also used them to influence even more directly the work of the therapy. The end of the consultation hour clearly did not mean the end of the work for these clients.

Similarly, previous researchers found that internal representations enabled clients to adopt their therapists as a kind of imaginary companion with whom they can talk privately as they assimilate and apply their therapy experiences between sessions (Orlinsky & Geller, 1993; Singer & Pope, 1978; Wzontek, Geller, & Farber, 1995). Researchers have also theorized that internal representations provide clients with self-guidance, which emerged in the present study both in the clients' introspections and in the influence of internal representations on the content of later sessions (i.e., clients' internal representations helped guide them with respect to what they wished to explore in therapy). Likewise, these clients' representations enabled them to "continue the therapeutic dialogue" with their therapists when not actually in their presence, as proposed by Geller et al. (1981). Clients' representations may indeed function as psychological connective tissue between sessions (Atwood & Stolorow, 1980; Orlinsky et al., 1993; Rosenzweig et al., 1996). Self-perceived improvement in therapy, in fact, has been positively correlated with clients' tendency to use their internal representations as a way to continue the therapeutic dialogue (Wzontek et al., 1995).

In the variant category (i.e., source of support, comfort, or soothing) emerging from this domain, the results are characterized not

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so much by clients continuing the cognitive processes (i.e., introspection, reflection, application of therapy to "real" life) of therapy outside of sessions, but rather by clients using their internal representations to re-create the equally important affective components of therapy (e.g., one client calmed herself by repeating her therapist's affirmative statements; another client used her representations to feel less lost and alone). The between-sessions function of such representations, then, is evidently not limited solely to the cognitive or analytical work and tasks of therapy, but also consists of the feel and emotions of therapy, each of which may prove vital to clients' healing and growth.

Such results are again consistent with the extant literature. Internal representations might, for example, serve restitutive–reparative functions, reuniting clients with a soothing image of their therapists when not physically present with them (Atwood & Stolorow, 1980; Geller, 1987). In addition, clients' internal representations may serve as healthier attachment or object relations experiences, in which therapists replace clients' earlier injurious attachment figures (Farber, Lippert, & Nevas, 1995; Perry, 1992; West, Sheldon, & Reiffer, 1989).

Clients' Affective Response to Internal Representations

Clients typically felt positively about their internal representations. Within this broad category three typical subcategories also emerged. In the first typical subcategory, clients felt calmed or comforted by their internal representations. The second typical subcategory involved clients feeling focused and grounded. As the final typical subcategory, clients felt general positive affect.

The clients' broadly positive affective responses related to their internal representations perhaps reflect their creation of a benignly influential representation of the therapeutic relationship, including the therapist, that Schafer (1968) suggested is pivotal to the goals of therapy. These affective responses might also be related to the operations of attachment. Bowlby (1974) conceived of attachment as a way for individuals to develop strong affectional bonds to specific others perceived as stronger and wiser. Further, Bowlby (1974) suggested that people develop internal representations of persons for whom they feel confident of their availability and responsiveness. The

internal representations experienced by these clients, then, may well reflect such processes: Clients may indeed consider their therapists as stronger and wiser, and thus develop positively valenced affectional bonds with them. In addition, the very existence of the internal representations may signify clients' trust in their therapists' presence, a trust that may also expectedly lead to a positive affective response. Such trust, in fact, echoes similar theories proposed by Ainsworth et al. (1978) and Mallinckrodt, Gantt, and Coble (1995), who described securely attached people as those who are able to place trust in relationships and who experience their therapists as responsive, sensitive, understanding, and emotionally available. Although not all of the present clients would be classified as "securely" attached (see below), most were nevertheless able to experience their therapists, by means of their internal representations, as responsive, sensitive, and reliable.

Looking more specifically at the affect described by these clients, the positive affective responses often depicted clients' experiences of comfort, calming, and focus. It seems, then, that internal representations soothed the clients, as Geller (1987) and Rosenzweig et al. (1996) suggested, reassured them in times of trouble or doubt, and enabled them to make use of the therapy itself. Such positive affective responses echo those suggested by Kantrowitz et al. (1990), who stated that clients' improvement and readiness for termination were indicated by their ability to take on the self-regulatory functions once served by the therapist. Given that the clients in this study were in the middle of therapy, one would expect that they were not yet ready to take on such functions (e.g., self-soothing, regulation of affect, more objective perspective on conflictual issues) solely by themselves; instead, they used their internal representations to serve such purposes in this intermediate, nontermination phase of their therapy.

Clients variantly experienced negative affective responses associated with their internal representations. For example, one client felt guilty about having to rely on his internal representations, and felt that he was violating his therapist's time through his representations; another client feared relying on her representations of her therapist, and felt sad to realize that there were not others in her life who were consistently present and attentive to her needs. Such negative

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emotional experiences reflected clients' dependency fears, anxiety, and sadness. Geller et al. (1981) described clients who were unable to internalize the therapist as a benignly influential other, as well as clients who mourned the loss of the therapist, either between sessions or after termination. The inability to internalize the therapist as a benign other may be reflected in those clients who expressed fears of being dependent, as well as in those who experienced anxiety. Mourning the loss of the therapist may also be reflected in those clients who feared depending on their therapists, as well as in those who felt sad. In addition, these negative affective responses may reflect clients' transference. Though we do not have the data to support this proposition at this time, future researchers may want to explore this possibility. In addition, clients' expressions of fear of dependence on their therapists may reflect anxious–ambivalent or avoidant attachment styles (Ainsworth et al., 1978). Likewise, expressions of sadness may be characteristic of the avoidant–fearful attachment style described by Mallinckrodt et al. (1995). Though we do not have the data to examine the present clients' attachment styles, it may be prudent to explore such hypotheses in future research.

We should note that a few clients experienced both positive and negative affect in response to their internal representations. Although only a few clients experienced this combined affect, such findings have been discussed in the literature. Bergmann (1988), for example, stated that clients' internal representations are bound to reflect their ambivalence about their therapists, demonstrating a mixture of gratitude for the guidance provided and less positive feelings for the human imperfections revealed by therapists as real persons. Therapists, then, may serve as both good and bad objects, alternately soothing and frightening clients (Volkan, 1994).

Finally, a few clients experienced neutral affect in response to their internal representations. (Note: No client experienced only neutral affect.) Given the often intense and intimate interactions of therapy, and the emotion-laden issues that are discussed, it would indeed be surprising if clients' internal representations of their therapists were devoid of affect.

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Effects of Internal Representations

Distinct from the feelings they associated with their internal representations, clients also typically reported positive, or at worst neutral, effects or consequences arising from their internal representations. In no instance did clients speak of negative effects of their internal representations. These results suggest that at least for these clients, internal representations were viewed as beneficial. Such information is relevant for therapists, who may understandably wonder about some of the potential effects of clients' internal representations (e.g., dependency, "merging" with therapists). More specifically, clients reported that their internal representations typically enhanced the benefits of and/or accelerated the therapy by increasing their investment in therapy or by eliciting "aha" experiences that moved the therapy. If clients use their representations to self-soothe, to introspect, or to influence the work of therapy within and beyond sessions, benefit to therapy is a likely result. This finding actually should not be surprising, given clients' deliberate use of their internal representations (see above). Similar connections may be made with the commonly beneficial effects of clients' internal representations on the relationship between therapists and clients: Clients' internal representations' typically benefited the therapy relationship either by making the relationship closer or stronger (e.g., clients stated that through their internal representations, they felt closer to their therapists), or by extending it beyond the sessions themselves. Given how clients used their representations, an ensuing closer or stronger relationship is not unexpected, nor is it unreasonable to expect the clients' sense of this relationship to extend beyond the consultation room. Internal representations epitomize, in fact, just such extensions. Furthermore, clients who use their representations in the service of comforting or supporting themselves, of having reflective imaginary conversations with their therapists to help them process events and emotions, may quite likely feel a stronger bond between themselves and their therapists, one that then facilitates the therapeutic work. Variantly, clients' internal representations had neutral effects on the therapy relationship. In light of the largely positive associations clients felt about their internal representations, the infrequency with which they reported neutral effects on the therapeutic relationship is not unexpected.

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In addition, clients' internal representations typically had neutral or unknown effects on the clients themselves. We wondered why the effects on clients arising from their internal representations were typically neutral or unknown. Perhaps clients had simply never considered such consequences, and so may not really have known how to answer this question. In addition, even if such consequences had been previously considered, it may have been difficult for clients to articulate such effects: It may have been harder for them to focus, looking solely at nonaffective elements, on themselves. It may be easier, for example, for clients to describe how they feel about their internal representations, how they use them, or what repercussions the representations had for the therapy or the therapeutic relationship. Or it may be that they subsumed the effects focusing on themselves under those related to the therapy or the therapy relationship. Perhaps, also, the effects clients deemed more important were those to the therapy or to the therapeutic relationship, not to themselves.

Changes in Internal Representations Over the Course of Therapy

Clients' internal representations typically increased in frequency over the course of therapy. Such an increase might have occurred because clients simply had enough time and experience with their therapists to give them the "material" (e.g., auditory, visual, felt presence) from which representations may arise. Clients' growing confidence in their therapists as reliable attachment figures might also help explain the greater frequency of internal representations over the course of therapy, as evidenced by the client who indicated that she had more representations as she grew to feel safe with her therapist. Thus, as clients trusted that their therapists were available and responsive to them, they might have allowed themselves to develop internal representations of their therapists (Bowlby, 1974; Kobak & Shaver, 1987). In addition, as described above, many clients used their representations to introspect, to influence the work of therapy beyond sessions, thus continuing the analytical processes. These clients' more frequent internal representations over the course of therapy may suggest that they had begun to take on active, agentic roles, enabling them to call upon the internalized presence of their therapists when desired.

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Secondly, clients typically became more comfortable with their internal representations and used them more over the course of therapy (e.g., one client stated that whereas earlier she had wanted to avoid her internal representations, she later found them welcome, reassuring, calming, and comfortable; a second client indicated that he later more actively used his internal representations as a way to solve situations by himself). It may be that with clients' greater comfort with their internal representations over time, they were able to more frequently apply their representations when appropriate.

Perhaps associated with the changes described above, clients variantly reported greater complexity and intimacy, and less urgency, in their internal representations. As they opened themselves up in the course of therapy, and as their psychological health improved, their representations may have reflected such developments. Instead of representations in which clients were themselves relatively passive, plaintively seeking their therapists' rescue or intervention, their later representations might have reflected more the character of clients closely and collegially interacting with rather than just responding to their therapists. Perhaps later in the therapy some clients were able to be active participants in, rather than passive recipients of, their internal representational experiences. Such changes in clients' internal representations, then, could illuminate other important changes occurring in clients. Client improvement, for instance, is believed to be related to the extent to which clients are able to evoke representations of the benignly influential components of the therapy relationship (Rosenzweig et al., 1996) and to their ability take on the self-regulatory functions that therapists once served (Kantrowitz et al., 1990).

Finally, clients also variantly experienced more internal representations during difficult times. Perhaps when facing distressing circumstances, they called upon their internal representations as one means of helping them through these rough situations. If therapists had proven themselves helpful in actual sessions, it is not surprising that when clients were especially troubled, they would seek the support of therapists by means of internal representations.

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Therapists' Role in Creation of Internal Representations

According to these clients, therapists typically did not deliberately evoke the internal representations. Thus, these clients needed no explicit prompting or suggestion from therapists for such representational experiences to occur, suggesting that internal representations likely occur without obvious therapist inducement. Of course, we should note that the clients may not have noticed therapists' behavior intended to evoke internal representations.

Little in the existing literature addresses the therapists' role in evoking clients' internal representations of therapists. When speaking of termination, Geller (1987) asserted that at the final stages of the therapy, therapists should work to facilitate clients' ability to hang onto the therapist, or the experience of the relationship with the therapist, in his or her physical absence through an intrapsychic representation of the therapist. Thus, at termination the client has ideally reached a point where he or she no longer needs the analyst, but retains the internal representation (Bergmann, 1988). Yet nowhere, even in these two citations, is any mention made of deliberate actions taken by the therapist to create, or maintain, clients' internal representations during therapy. It may be that such actions are not necessary, given that clients appear to create internal representations without direct therapist initiation. Future researchers may wish to explore, however, whether some clients might benefit from therapists taking a more active role in facilitating these internal representations. For instance, one client in this study stated that, when she was panicky, she repeated to herself a specific statement her therapist said to her, one that eased her panic. Though the therapist made such statements rarely, they were important to this client. She told the therapist of her use of this statement, and silently wished that he would give her more such statements so she could use them when necessary. (We have no information about whether the therapist complied with the client's wish.) Here, then, is an example of a client telling her therapist of her internal representation of him, in the hope that he would more deliberately, and more regularly, provide such statements as part of the therapeutic work. However, for those clients whose internal representations of their therapists were more negatively experienced, a rare occurrence among the clients in this study, therapists' direct

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facilitation of such representations may well not be beneficial. These findings suggest that, as with many therapy interventions, they be used cautiously and after due consideration of the possible consequences to clients.

Although the clients in the present study reported that their therapists typically did not direct them to have actual internal representation experiences, a few clients indicated that their therapists suggested other types (i.e., not internal representations) of between-sessions experiences. Such suggestions took the form of encouraging clients to think about the issues discussed in therapy, to apply things learned in therapy to nontherapeutic situations, or to take psychological care of themselves in times of stress. If these clients' perceptions and reports are accurate, it seems that their therapists were more likely to facilitate between-sessions phenomena that were less directly related to the therapists, and more related to the clients' issues or growth. Perhaps these therapists hesitated to evoke clients' internal representations for fear of clients becoming dependent on them; perhaps they chose to focus not on the therapists as the source of healing and support, but on the client; or perhaps they were simply unaware of the potential importance and use such representational experiences have for clients. Perhaps, also, the therapists refrained from deliberately evoking representations in these clients in particular. It may be, for example, that with more disturbed (e.g., psychotic, borderline) clients, whose reality-testing and ability to maintain contact with a relationship when not in the physical presence of another may be quite fragile, therapists are more inclined to take an active role in helping them sustain the relationship between sessions by means of internal representations of the therapist. With the nonpsychotic, nonborderline clients who participated in the present study, however, these therapists may have chosen not to take an active role in the representations for fear of influencing the transference. Also worthy of consideration, as stated above, is the possibility that the therapists did actively evoke clients' internal representations, but that clients remained unaware of such direct statements or suggestions.

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Clients' Discussion of Internal Representation With Therapists

Despite the potent place of internal representations in these clients' lives, only a few clients explicitly discussed these experiences with their therapists. When clients did discuss these experiences, their therapists' responses were predominantly supportive, suggesting that therapists were fairly positive about and comfortable with the idea of clients having such experiences. According to one client, her therapist even remarked that she somewhat expected the client to have such experiences because of the impact of the therapy, and also because the therapist knew of the clients' analytical tendencies and of the client's continuing the therapy processes outside of sessions. Other therapists responded with smiles, head nods, and comments about the helpfulness of such representations. These therapists, then, seemed to view their clients' internal representations as beneficial features of the larger therapy process, a sentiment that largely echoes that of the clients themselves.

A few clients, however, chose instead to talk about other (i.e., noninternal representation) between-sessions experiences, mentioning to their therapists that they thought about the therapy and therapists between sessions, but not that they actually had internal representations of their therapists. The reasons for this lack of explicit discussion of internal representation experiences could be many. This more indirect approach to discussing between-sessions experiences may reflect the difficulty of defining this phenomenon, which is discussed in more detail below (see *Limitations*). There may be quite a tenuous line between thoughts about therapy and therapists, and internal representations of therapists. Thus, when clients were asked in this study whether they discussed their internal representations with their therapists, some may have neglected to mention anything but the most explicit instances of discussing such representations. Clients also might have felt uncomfortable about their internal representations of therapists, fearing that such experiences were not normal, signaled pathology or dependency, or indicated a lack of progress in the therapy. Recall the client, for instance, who felt guilty about having to rely on his internal representations, and who also felt that his representations were a violation of the therapist's time and thus

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should not be occurring; another client tried to push away her internal representations because they reinforced the client's belief that she needed the therapist in her life because it was not filled by other people. With such feelings associated with their internal representations, it is not surprising that clients would choose not to discuss these experiences with their therapists. Researchers may want to explore whether those clients who took this potentially less threatening route ever, later in their therapy, took what may have felt like a risk by explicitly discussing their internal representations with their therapists.

In addition, although clients might have acknowledged their own private representational experiences, they may not have discussed them with their therapists because they might have been unaware that this phenomenon is in fact recognized as a part of the therapy. As a result, they may not have known how to approach such a discussion, how even to describe their experiences without the label of *internal representations* available to them. This uncertainty may have been exacerbated, as well, by therapists not mentioning or asking about such experiences. Clients may have waited for their therapists to make the first overture; when that did not come, the discussion never occurred. Such reticence on the part of therapists to discuss internal representations may be partially explained by the lack of research on this construct (Orlinsky et al., 1993). It may be, then, that therapists are as unaware as clients of this phenomenon. To increase such awareness, therapists may want to consider raising the topic of internal representations with their clients, asking them, for instance, whether they have such between-sessions occurrences and if so, how they are used and experienced. Such a discussion may normalize the phenomenon for clients and provide therapeutic data for therapists.

Limitations

Although data were collected and analyzed until the concepts, themes, and categories were fully developed and stabilized, the low number of participants remains a limitation. In addition, all clients and therapists were from one geographical region, most were European American/White, and all clients were seen by therapists in private practice. They were also all at a midpoint in their therapy, which limits

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our ability to generalize to clients at other points in the therapy process. Clients who agreed to participate may also have differed from those who declined, suggesting the possibility of self-selection. Other possible client characteristics, as well, may have created limitations. As explicated by Nisbett and Wilson (1977), people have varying abilities to recall their internal experiences. The limitation here became the degree to which the participants were aware of their internal representations of their therapists and the degree to which they could articulate their experiences with this phenomenon. Furthermore, the therapists who participated were a sample of convenience, and their affiliation with the counseling psychology faculty at a large, mid-Atlantic university may have influenced their desire to participate. Although they did not know the specific focus of the study, they may have asked only certain types of clients (e.g., the most compliant or successful) to participate. In addition, given the one client who spoke of self-mutilation and suicidality, it is possible that not all therapists adhered to the restrictions against including clients with borderline or psychotic diagnoses as participants. Their strong psychodynamic leanings also raise the question of how clients of therapists with other theoretical orientations experience internal representations, a question that future research may wish to explore. From this sample of therapists and clients, then, only tentative generalizations may be made.

Likewise, bias is always a concern in qualitative research. We tried to address this potential limitation by using three individuals on the primary team, as well as an auditor. Each team member and the auditor bracketed her expectations and biases, and then tried to set them aside. In addition, we tried to stay very close to the data, typically using the clients' own words in developing the core ideas. At the data analysis stage, the auditor's function was solely as an auditor, which provided her with even greater objectivity in scrutinizing the work of the primary team. This effort appears successful, in that we found results other than those that simply confirmed our expectations. As further assessments of validity, future researchers may want to send participants the consensus versions of their data as a way to check whether the team's and the participant's conceptualizations of internal representation experiences are consistent.

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A final potential limitation is the difficulty of defining the phenomenon of clients' internal representations of their therapists. Distinguishing it from other constructs (e.g., incorporation, introjection, identification, internalization) is clearly difficult, and is not something we tried to do. In addition, occasionally in the interview and data analysis processes, the researchers questioned whether the data really captured clients' internal representations of their therapists, or instead spoke of clients' between-sessions thoughts about or memories of therapists, therapy, or both. Clients, for example, may have thoughts about their therapists, may recall events that have occurred in the therapeutic interaction (e.g., clients may think about when they will next meet with their therapists, or may remember a particular topic discussed in therapy), but this does not mean that they necessarily experience an actual internal representation of their therapists in which they sense the living presence of their therapist as a person with them in some form. At times it was unclear whether clients understood this distinction as they spoke of their experiences. To address this potential limitation, the interviewer clarified the construct during the interviews and confirmed with the clients that they did indeed experience internal representations of their therapists, as defined in this study. In addition, in the data analysis stage both the primary team and the auditor closely examined the data to verify that they reflected clients' internal representations of therapists. Hence, we believe that the data do capture clients' internal representations rather than just thoughts or memories, but we admit that this is an ambiguous distinction. We encourage future researchers to explore such distinctions further, so that clearer conceptualizations of these phenomena may be developed.

It is also possible that the act of participating in the study somehow altered clients' awareness or experiences of their internal representations. Clients may have been unaware of their internal representations before, or may not have spent much time thinking about them prior to their participation in this study. We have no way of determining such possible effects, for at the moment a client receives a request to participate, the potential for such influence exists. With so interior a phenomenon as internal representations, we must rely on client account, and therefore must exercise prudence in our interpretation of these results.

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Implications

Knowing that representations are often triggered when clients think about past or future sessions, and that clients deliberately use them to influence the therapy within or beyond sessions, therapists may be able to use this phenomenon as a tool in therapy. If, as appears to be the case, clients are already doing "unassigned homework" between sessions, therapists may be able to direct this activity toward particular ends deemed beneficial to clients. In addition, because internal representations are also often triggered when clients are in distressing circumstances, and may be used for introspection or self-soothing, therapists may again be able to apply this knowledge to aid their clients. They may, for instance, suggest to clients that in times of particular trouble, clients deliberately invoke a representation of their therapists to get them through difficult experiences. The largely positive affect clients report related to their internal representations, as well as the beneficial effects clients described, could give comfort to therapists who may worry about the consequences of a more explicit role in the creation of clients' internal representations. Care should be taken with such an intervention, however, for (as discussed above) it may be that therapists' deliberately evoking clients' internal representations will influence the transference, and the therapy relationship in general. If this is the case (and that is itself a question worthy of examination), therapists should well consider the consequences, both positive and negative, of taking such an active role in creating clients' internal representations of therapists.

As suggestions for further research, researchers may want to explore the therapists' perspective regarding their feelings about and their degree of direct involvement in their clients' internal representations. One wonders, as well, how clients' attachment styles affect their internal representations. As was presented above, it may be that certain patterns of attachment are associated with particular internal representation experiences. Researchers may seek to learn if any relationship between these two phenomena exists, or if the onset of internal representations is associated with clients' beginning to use their therapists as attachment figures. Likewise, does cognitive style affect clients' internal representations? Do clients who possess a more

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obsessive cognitive style, for instance, have different internal representational experiences from those with less obsessional styles? Furthermore, although clients described how their internal representations changed over the course of their therapy, many questions regarding such changes still remain. Is improvement in psychological functioning, for example, related to changes in clients' internal representations? Are the dynamics of transference phenomena associated with changes in clients' internal representations? Are other interventions therapists may have used (e.g., guided imagery, dream interpretation) related to any changes in clients' representations. And what of the two clients who volunteered to participate, but did not report experiencing internal representations? How, if at all, do these clients, or their therapists, differ from the rest of the sample? Finally, it would also be of use to explore whether diagnosis or severity of pathology was related to clients' internal representations. Of the present clients, it is known only that they were nonborderline and nonpsychotic; a question for exploration may thus be whether there is any connection between diagnosis and internal representations.

Notes

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- Julie L. Goldberg, Department of Counseling and Personnel Services, College of Education, University of Maryland College Park.

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Appendix

Table 1
Domains, Categories, and Exemplary Core Ideas

Domain and category	Frequency	Exemplary core ideas
Modality		
Auditory	General	"Client heard therapist's voice"
Visual	Typical	"Client saw therapist's face"
Felt presence	Typical	"Client felt like therapist was right there in front of her"
Triggers		
When thought about past/future sessions	Typical	"When client thought about things discussed in therapy" "When client thought about upcoming session"
Negative	Typical	"When client was suicidal and considering self-mutilation" "When client felt hurt, angry, or sad"
Positive/neutral	Variant	"When client was in positive emotional situations"
When clients were in situations where they could apply therapy to real life	Variant	"When client was in life situations that were discussed in therapy and could apply discussions to present situation"
Locations		
Wherever clients were/no specific location	Typical	"Representations occurred anywhere"
At home	Typical	"Representations occurred when client was at home"
In car/at work or school	Typical	"Representations occurred when client was in car" "Representations occurred when client was at work or school"
Frequency		
A few times a week to once a month	Typical	"Occurred 2–3 times a week" "Occurred less than once a month"
Daily/almost daily	Variant	"Occurred 2–3 times a day" "Occurred almost daily"
Duration		
Varied	Typical	"Negatively triggered representations lasted longer (e.g., up to 20 min) than positively triggered representations (e.g., less than 1 min)" "Representations varied in length (e.g., from a few seconds to a few minutes) depending on significance of trigger event"
Brief	Variant	"Consistently lasted less than 1 min"
Intensity		
Varied	Typical	"Auditory were more intense than visual representations" "Representations were most intense immediately postsession"
Moderate to high	Variant	"Consistently at least moderately intense"
Deliberate use		
To introspect	Typical	"Client used representations as a way to 'take her temperature' about whether therapy was helping/whether client was getting better"
To influence therapy within/beyond sessions	Typical	"Representations were used as 'between-session mini-sessions'
To soothe/comfort/support	Variant	"Client repeated therapist's affirmative statements to herself to recapture good feelings of session and feel control/relief"
Affective response		
Positive	Typical	
Calmed/comforted	Typical	"Client felt supported, comforted, encouraged"
Focused/grounded	Typical	"Client felt concentrated and stabilized"
General positive	Typical	"Client felt good, positive, warm"
Negative	Variant	"Because feared relying on therapist, client pushed representations away" "Client felt guilty and worried that representations violated therapist's time"
Both positive and negative	Variant	
Neutral	Variant	"Representations did not evoke any feelings"
Effects of representations		
Benefited/accelerated therapy	Typical	"Increased client's investment in therapy" "Representations were 'aha' experiences that moved therapy"
Benefited therapy relationship	Typical	"Brought therapist and client closer"
Neutral/unknown effects on clients	Typical	"Client was unsure of effect of representations"
Neutral effects on relationship	Variant	"Representations had no effect on relationship"
Changes in representations		
Increased in frequency	Typical	"Representations more frequent now than earlier"
Greater client comfort with/use of representations	Typical	"Client earlier sought to avoid representations, but later found them welcome, reassuring, and calming" "Client was actively using representations to solve situations on own"
Representations more complex/intimate, less urgent	Variant	"Client was more interactive/less passive with therapist in representations" "Representations became more spontaneous and less desperate"
More frequent in difficult times	Variant	"Occurred more often in worst times"

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Table 1 (*continued*)

Domain and category	Frequency	Exemplary core ideas
Therapists' role in creating representations		
No deliberate role	Typical	"No deliberate suggestion for client to experience representations"
Deliberate suggestion of nonrepresentation experiences	Variant	"Suggestion that client think about issues discussed in therapy"
Discussion of representations		
Did discuss	Variant	"Client discussed representations with therapist"
Did not discuss	Variant	"Client never discussed representations with therapist"
Discussed nonrepresentation experiences	Variant	"Client told therapist that he thought about what was discussed in therapy"

Note. $N = 13$. General = category applied to all cases; typical = category applied to at least half of the cases; variant = category applied to fewer than half of the cases. Categories represented by only one case were dropped.