Reverie and Psychotherapeutic Technique: Public Surveys on Therapist Attention, Understanding, and the Therapeutic Alliance

by

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Abstract

Reverie, or a therapist's daydreaming during therapy, is theorized to represent an aspect of transference-countertransference that provides a unique opportunity for attending to the experience of clients. However, the processes that underlie using reverie might affect the therapeutic alliance through perceived therapist inattention and understanding. Consequently, it is unclear whether this classical psychoanalytic technique is applicable to modern psychotherapy in which the therapist and client face one another. To maximize experimental control and avoid the need to violate the confidentiality of real therapy clients, vignettes were used to study how the processes that underlie the use of reverie could affect the therapeutic alliance. Specifically, participants completed an online survey that involved multiple steps. First, the participants read a brief description of a therapist and client and rated their therapeutic alliance using the Working Alliance Inventory – Short Form C bond scale. Next, they read one of four brief session transcripts between the therapist and client that were randomly assigned and represented the presence and absence of therapist attention and understanding as processes that underlie using and ignoring reverie. Then, the participants rated the therapeutic alliance using the Working Alliance Inventory Form C bond scale. Finally, participants completed a manipulation check and demographic questionnaire. After establishing that the manipulation was effective, statistical analyses revealed that the levels of therapist attention and understanding affected ratings on the therapeutic alliance for the clinical

vignettes. Furthermore, the effect size for the condition of therapist understanding was larger than the effect size for the condition of therapist attention, meaning that ratings on the therapeutic alliance for the four session transcripts differed. These results imply that the processes underlying the use and ignoring of reverie might affect the therapeutic alliance. Also, the positive impact of understanding client experience could help partially offset the negative impact of therapist distraction while using reverie during therapy. This pattern is consistent with theories on reverie suggesting that using reverie for attending to the experience of clients might produce better outcomes than ignoring it when therapists are daydreaming during therapy.

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I. Introduction

Relational psychoanalysis has replaced the view that transference and countertransference are located solely in the patient and psychoanalyst, respectively, with a transference-countertransference matrix in which the patient and analyst mutually influence "an evolving, dynamic process occurring between them" (Reis, 1999, p. 338). Consequently, psychoanalysts spent the last half of the 20th century changing their view that interpretations should be made about the patient's intrapsychic dynamics to one in which "interpretations should be about the *interaction* of patient and analyst *at an intrapsychic level*" (O'Shaughnessy, 1983, p. 281). Ogden (1994) suggested that the transference-countertransference can be recognized by analysts in "the most mundane, everyday aspects of the background workings of the mind (which appear to be entirely unrelated to the patient)…. and other forms of bodily sensations and body related fantasies" (pp. 4-5). He uses Bion's (1962/1984) term *reverie* for this "motley collection of psychological states that seem to reflect the analyst's narcissistic self-absorption, obsessional rumination, daydreaming, sexual fantasizing, and so on" (Ogden, 1994, p. 9). For Ogden (1994), "reveries are not simply reflections of inattentiveness, narcissistic self-involvement, unresolved emotional conflict, and the like" (p. 12). Rather, they represent "a vehicle for the understanding of the conscious and unconscious experience of the analysand" (p. 17) as an aspect of the transference-countertransference that is addressed in speaking from the shared experience between patient and analyst (Ogden, 1994).

Reveries are theorized to provide unique opportunities for attending to the experience of clients (Ogden, 1994), which is listed among psychotherapist techniques positively affecting the therapeutic alliance (Ackerman & Hilsenroth, 2003). Specifically, they are thought to represent experience in the transference-countertransference from which analysts can form interpretations reflecting the inner experience of patients that otherwise may be impossible (Ogden, 1994). Using reverie involves analysts welcoming their daydreaming during analysis, which is thought to increase its frequency. Although this involves analysts being distracted from listening to patients, which is listed among therapist characteristics that negatively affect the therapeutic alliance (Ackerman & Hilsenroth, 2001), distracted analysts are less likely to be noticed when they use the couch and are out of view from patients. However, clients facing their therapist are more likely to notice that the therapist is distracted while daydreaming during therapy, respond with negative feelings, and experience poorer psychotherapy outcomes. Because using reverie may involve therapist characteristics and techniques that hurt or help the therapeutic alliance (Ackerman & Hilsenroth, 2001, 2003), which is a moderate predictor of psychotherapy outcomes (Martin, Garske, & Davis, 2000), it is unclear whether this psychoanalytic technique is applicable to psychotherapy in which the therapist and client face one another. Particularly, one must consider the question of whether the positive impact of attending to client experience helps offset the negative impact of therapist distraction while using reverie during face-to-face therapy as measured by client ratings of the therapeutic alliance.

Transference-Countertransference and Reverie

Reveries are described by Ogden (1994) as an aspect of transference-

countertransference. Transference was described by Freud (1910/1973b) as a spontaneous phenomenon that occurs in all human relationships when someone directs feelings towards another that are "based on no real relation between them" (p. 51). Freud argued that transference occurs in every patient due to the influence of analysts on their unconscious and is the true means of therapeutic influence. Specifically, he traced these phenomena "back to old wishful phantasies of the patient's which have become unconscious…. [and] re-experienced… in relation to the physician" (p. 51). This convinced patients of the existence and power of their unconscious in attempt to gain control of it and "guide psychical processes towards the desired goal" (p. 51).

Countertransference was described by Freud (1910/1973c) as transference occurring in analysts due to the influence of patients on their unconscious. Freud first insisted that analysts recognize and overcome their countertransference through self-analysis. Later, he (Freud, 1912/1973d) recommended training analysis so that analysts can turn their "own unconscious like a receptive organ towards the transmitting unconscious of the patient" (p. 115-116). Although this suggested that the unconscious of analysts could be used to understand the unconscious of patients, "very few contributors disagreed with the view that countertransference must be considered solely an interference in the analytic procedure" (Boyer, 1993, p. 2).

Countertransference was first suggested to be helpful by Hann-Kende (1933/1953). It was first noted as a guide to interpretation by Rosenfeld (1947). The vast majority of authors who have written about the transference-countertransference, including Rosenfeld, use Klein's (1946) concepts of splitting and projective and introjective identification (Boyer, 1993). Klein (1946) described projective identification

as an infantile omnipotent phantasy of splitting off bad or good parts of the self and projecting them into an object, such as the mother. She (Klein, 1946) saw this as vital for both normal and abnormal development and based it on the ego defense mechanism called projection. Freud (1920/1973a) described projection as a natural defense against anxiety in which inner experience with too much displeasure is treated as though it is coming from the outside. This becomes pathological when people excessively "project outwards on to others what they do not wish to recognize in themselves" (Freud, 1922/1973e, p. 226), as with jealousy and paranoia.

Projective identification was expanded by Bion (1962/1984) as enabling infants to act in ways that engender in their mothers feelings that they do not want, or which they want their mothers to have. This includes reverie as a maternal state of mind that is open to receiving any projective identifications from an infant and can contain its intolerable frustrations so that they become tolerable. Consequently, Klein's (1946) "work has been the most powerful single influence for this shift of perspective" (O'Shaughnessy, 1983, p. 281) from transference and countertransference as separate phenomena to an interdependent process. By the 1960's, neo-Kleinians began receiving credit for "countertransference as an affirmative instrument facilitating perception, enhancing sensitive awareness of the analyst's incipient reactions to the patient, [and] leading to a richer and more subtle understanding of the patient's transference striving" (Boyer, 1993, p. 8).

Another major influence in the shift to transference-countertransference was Winnicott's views on the subjectivities of an infant and mother as interdependent (1965a) and a third area of experiencing in "*the potential space*…. that exists (but cannot exist)

between the baby and the object" (1971a, p. 107). He applied them to psychotherapy by describing it as taking "place in the overlap of two areas of playing, that of the patient and that of the therapist" (Winnicott, 1971b, p. 38). Winnicott also said that "there is no such thing as an infant, meaning… that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (Winnicott, 1960/1965b, p. 39, fn.). Ogden (1994) interpreted this to mean that "the mother-infant unity coexists in dynamic tension with the mother and infant in their separateness" (p. 4). Consequently, he (Ogden, 1994) expanded this by writing that "there is no such thing as an analysand apart from the relationship with the analyst, and no such thing as an analyst apart from the relationship with the analysand" (p. 4).

Ogden (1994) sees the analytic process as reflecting the interplay of three subjectivities: that of the analyst, the analysand, and the intersubjectivity of the analyst-analysand. He refers to this third subjectivity as *the analytic third*, which is a creation of the analyst and analysand that "coexists in dynamic tension with the analyst and the analysand as separate individuals" (Ogden, 1994, p. 4). Although jointly created, the analytic third is experienced differently by analyst and analysand in the context of their own personality systems, personal histories, psychosomatic make-ups, and so on. It is also an asymmetrical construction because "the past and present experience of the analysand… is taken by the analytic pair as the principle (although not exclusive) subject of the analytic discourse" (p. 17). The analytic third is a view of transference-countertransference as an interdependent process (Ogden, 1994).

The analytic third is seen by Ogden (1994) as an experience that alters, and is therefore represented by, the analyst's reveries. He expanded Bion's (1962/1984) term

reverie for "psychological states that clearly reflect the analyst's active receptivity to the analysand" (Ogden, 1994, p. 9) to include "a great deal (in some instances, the majority) of his experience with the analysand" (p. 12). For Ogden (1994), "the analytic task involves an attempt to describe as fully as one can the specific nature of the experience of the interplay of individual subjectivity and intersubjectivity" (p. 4). Consequently, he has developed a theory for using reverie to recognize what is happening in the analytic relationship on an unconscious level (Ogden, 1994, 1997b, 2004a) and interpret from the transference-countertransference experience (Ogden, 1995, 1997a) what is emotionally true to patients (Ogden, 1996, 1999a, 2003b). This is theorized to help patients dream their experiences and selves more fully (Ogden, 2003a, 2004b).

Ogden (1994) demonstrated the use of reverie in a session with a patient named Mr. L. During the session, Ogden found himself looking at an envelope on the table next to his chair. The envelope carried a letter from a colleague who had written about a delicate matter to be kept in strict confidence. At that moment, Ogden noticed for the first time that the envelope had machine-made markings and uncancelled stamps "that seemed to indicate that the letter had been part of a bulk mailing" (p. 5). Ogden "was taken aback by a distinct feeling of disappointment" (p. 5) with such seemingly impersonal communication about a delicate matter. Despite being physically present for weeks, the envelope carried "psychological meanings, that had not existed prior to that moment" (p. 9) and reflected "the fact that a new subject (the analytic third) was being generated by (between) Mr. L. and" (p. 9) himself. Ogden wondered how this reverie "might be related to what was going on at that moment between" (p. 5) himself and the patient. Ogden soon thought that his disappointment with such seemingly impersonal

communication reflected Mr. L's experience in life and with Ogden. Thus, Ogden tried to talk to the patient about his experience with Ogden as mechanical, inhuman, and stifling. The patient loudly reported sleeping "with the windows wide open for fear of suffocating during the night" (p. 7) and often waking up terrified that someone is suffocating him, "as if they have put a plastic bag over" (p. 7) his head. Mr. L's response to this intervention involved a new "fullness of voice that reflected a fullness of breathing (a fuller giving and taking)" (p. 11) without fear of suffocating. All from reveries, "which appear to be entirely unrelated to the patient" (p. 5) and "seem to reflect the analyst's… daydreaming… and so on" (p. 9).

Daydreaming and Mind Wandering

Daydreaming has been described over time as thoughts that are fanciful, unrelated to the immediate task, or spontaneous (Klinger, 2000). Recently, daydreaming was described by Giambra (2000) as "an internally generated spontaneous switch in the contents of consciousness unrelated to the task at hand. The contents of daydreams may be fantastic in nature but are more likely to be mundane" (p. 147). Such spontaneous ideation occurs while awake (Klinger, 1999), dreaming (Payne, Stickgold, Swanberg, & Kensinger, 2008), and in slow-wave sleep (Steriade, 2006). Across the lifespan, daydreaming frequency, absorption, emotion, and imagery decrease with age (Giambra, 2000). Furthermore, hallucinatory and auditory daydreaming is low at all ages and shows little change with age. Daydreaming of the future decreases with age in adulthood, whereas daydreaming of the past is lowest in middle adulthood and daydreaming of the present peaks in middle adulthood. These unintentional, universal, and lifelong aspects of daydreaming make it inevitable during every human experience (Giambra, 2000),

including that of psychotherapists in therapy. Traditionally, daydreaming has been viewed as counterproductive because it usually distracts "from whatever the daydreamer is doing" (Klinger, 2000, p. 438). Yet, an increasingly common view is "the problem solving activity of an efficient biological system operating in an essentially uncontrollable environment" (Giambra, 2000, p. 200). This view is shared in the fields of cognitive psychology and neuroscience.

Daydreaming is referred to in cognitive psychology and neuroscience as mind wandering. Mind wandering was theorized by Smallwood and Schooler (2006) to be an executive function in which attentional resources are used for implicit problem solving loosely related to the immediate task. This has been supported by evidence that mind wandering uses attentional resources in the executive network neural system. First, mind wandering was positively related to activation in the default network neural system during a practiced task (Mason et al., 2007). Then, mind wandering was positively related to activation in the default and executive networks during a constant task (Christoff, Gordon, Smallwood, Smith, & Schooler, 2009). This suggests that mind wandering uses attentional resources, which supports the theory that mind wandering is an executive function. Although mind wandering is increasingly viewed as a problem solving activity, it is unclear how this relates to psychotherapy outcomes. Specifically, the outcome of therapy in which clients notice their therapist daydreaming remains subject to the efficacy of daydreaming as problem solving.

Psychotherapy Outcomes and the Therapeutic Alliance

Psychotherapy outcome research has studied the relationship between client progress and various factors for over six decades (Lambert & Barley, 2002). These

factors include 1) extratherapeutic factors such as spontaneous remission, fortuitous events, or social support; 2) expectancy such as placebo effects; 3) techniques specific to the prescribed therapy; and 4) factors common in most therapeutic relationships such as empathy, warmth, acceptance, encouraged risk taking, client and therapist traits, confidentiality, the therapeutic alliance, or therapy processes. Of the factors most closely related to the therapist, psychotherapy outcomes are best predicted by the therapeutic relationship (Lambert & Barley, 2002).

The therapeutic relationship was described by Greenson (1967) as involving transference, the working alliance, and the real relationship between patient and analyst. Tranference was expanded by Greenson as *transference reactions* to reflect the range of transference phenomena. The working alliance was described by Greenson as "the relatively nonneurotic, rational rapport which the patient has with his analyst" (1967, p. 192). It centers on "the patient's capacity to work purposefully in the treatment situation" (p. 192) and "is formed by the patient's motivation to overcome his illness, his sense of helplessness, his conscious and rational willingness to cooperate, and his ability to follow the instructions and insights of the analyst" (p. 192). The real relationship between patient and analyst was described by Greenson as "the realistic *and* genuine relationship between analyst and patient" (1967, p. 217). This is in contrast to transference reactions which are genuine despite being unrealistic and the working alliance which is realistic despite being "an artifact of the treatment situation" (p. 217). Of this tripartite model of the therapeutic relationship, psychotherapy outcomes are best predicted by the working alliance (Horvath & Symonds, 1991).

The working alliance was expanded by Bordin (1979) as involving agreement on

goals, assignment of tasks, and development of bonds. Development of bonds was expanded by Gaston (1990) as a "patient's affective relationship to the therapist" (p. 145), which he referred to as *the therapeutic alliance*. The therapeutic alliance is a moderate predictor of psychotherapy outcomes (Martin et al., 2000). It is positively affected by therapist characteristics "such as being flexible, honest, respectful, trustworthy, confident, warm, interested and open" (Ackerman & Hilsenroth, 2003, p. 1) and "techniques such as exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience" (p. 1). It is negatively affected by therapist characteristics "such as being rigid, uncertain, critical, distant, tense, and distracted" (Ackerman & Hilsenroth, 2001, p. 171) and "techniques such as over structuring the therapy, inappropriate self-disclosure, unyielding use of transference interpretation, and inappropriate use of silence" (p. 171). Therapist distraction and attending to client experience are both involved in using reverie.

Therapist Distraction and Client Experience

Therapist distraction can negatively affect the therapeutic alliance through therapists being less attentive to and involved in the therapeutic process, as shown by research using different measures. Specifically, therapists who were less involved (Marmar, Weiss, & Gaston, 1989) and had difficulty engaging (Price & Jones, 1998) in the therapeutic process were judged to have poorer overall therapeutic alliance. Also, clients recalled responding with negative feelings to their therapist doing things that they did not like or want, such as being inattentive, in a study using client memories of therapist misunderstandings (Rhodes, Hill, Thompson, & Elliot, 1994). Similarly, clients rated session quality as lower when therapists were perceived as distracted (Saunders,

1999).

Attending to the client's experience can positively affect the therapeutic alliance. Specifically, attending to client experience might contribute to a stronger alliance through helping clients feel understood by their therapist or gain a greater understanding of their experience (Ackerman & Hilsenroth, 2003). Both feeling understood by therapists and gaining understanding of experience were perceived as conducive to a positive alliance by a small sample of clients at a university department clinic (Bachelor, 1995). Feeling understood also predicted higher alliance ratings using psychodynamic therapies with both small and large samples (Najavits & Strupp, 1994; Price & Jones, 1998; Saunders, Howard, & Orlinsky, 1989). Gaining understanding during therapy intake interviews was positively related to a stronger alliance and continuing therapy (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991). Lastly, attending to experience was related to improved alliances with adolescent clients (Diamond, Liddle, Hogue, & Dakof, 1999). This suggests that therapist distraction and attending to client experience can hurt or help the therapeutic alliance (Ackerman & Hilsenroth, 2001, 2003), thereby producing related psychotherapy outcomes (Martin et al., 2000), while using reverie during face-to-face therapy.

Using reverie is thought to be a process in which therapist distraction while daydreaming during therapy provides unique opportunities for attending to the experience of clients (Ogden, 1994). To date, no known quantitative research related to using reverie has been published. Specifically, no known research has measured whether daydreaming can help therapists attend to client experience and the closest research suggests that daydreaming might hurt the alliance through therapist distraction

(Ackerman & Hilsenroth, 2001). Nor has any research measured the effect of therapist attention and understanding levels on the therapeutic alliance as processes that underlie using or ignoring reverie. Moreover, it is unknown if using reverie is a common enough psychotherapeutic technique for its effect on the therapeutic alliance to be measured. If so, studying how using reverie affects real therapy requires the violation of client confidentiality, experimental use of a technique without sufficient data to support such use, and consent of research participants.

To address the limitations of experimentally studying the use of reverie with real therapy clients, alternative research methods might provide initial contributions to the understanding of the processes that underlie using reverie. Specifically, the psychological phenomenon of *assumed similarity*, in which judges accurately resemble familiar targets by simply projecting their self-concepts onto them (Kenny & Acitelli, 2001; Neyer, Banse, & Asendorpf, 1999; Watson, Hubbard, & Wiese, 2000), might possibly be used so that members of the general public accurately rate the therapeutic alliance for a clinical vignette as if they were the client in the vignette by projecting their self-concepts onto the client. While the phenomenon of assumed similarity has not been used with vignettes, this could be done because vignettes about other people have been demonstrated to affect participants (Cavallo, Fitzsimons, & Holmes, 2009; Cavallo, Holmes, Fitzsimons, Murray, & Wood, 2012; Murray et al., 2011). Given that individuals may be more or less able to project themselves onto a client in a vignette based on their prior therapy experience, it is necessary to examine interaction effects between prior therapy experience and therapeutic alliance ratings when relying on participant projection onto vignettes.

Purpose of the Present Study

The purpose of the present study was to explore the potential conflict that may arise from the processes that underlie using reverie during face-to-face therapy. In theory, the effective use of reverie can lead clients to feel more understood by their therapist and believe that the therapist knows the same as or more than them about themselves. Still, therapists attempting to use reverie while facing their clients risk ignoring them in ways that negatively affect the therapeutic alliance. Consequently, the present study was designed to assess whether clients feeling understood by their therapist might help offset the negative impact of being ignored on the therapeutic alliance. The primary goal of the study was to learn how the processes that underlie using and ignoring reverie could affect the therapeutic alliance. Furthermore, the researcher aimed to examine whether perception of the therapeutic alliance is a function of prior therapy experience.

Significance to Counseling Psychology

The significance to counseling psychology of the present study is its implications for psychotherapeutic technique. Specifically, an analyst's daydreaming during analysis "is often viewed as something that the analyst must get through, put aside, overcome, etc. in his effort to be both emotionally present with and attentive to the analysand" (Ogden, 1994, p. 12). Consequently, if ignoring reverie affects the therapeutic alliance more positively than using it, this view may produce better psychotherapy outcomes. However, if using reverie affects the alliance more positively, a counterintuitive view of daydreaming as problem solving in which reveries are used to form interpretations reflecting the inner experience of patients may produce better outcomes. Thus, the

results of the present study will inform psychotherapy researchers of whether further studies related to reverie are needed to recommend that therapists either use or ignore reverie for the best outcome. Also, the study is the first known quantitative research related to using reverie. Because the core values of counseling psychology include a scientist-practitioner orientation that leads to both good science and good practice (Howard, 1992), the present study is an attempt at good science that improves the practice of psychotherapy as it relates to the therapeutic technique of using reverie.

Research Questions

Two research questions (RQ) were explored by the present study.

RQ1. Do levels of therapist attention and understanding affect ratings on the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie, and if so, how?

RQ2. Does prior therapy experience affect ratings on the therapeutic alliance for vignettes that vary on levels of therapist attention and understanding?

Operational Definitions

The operational definitions of the present study were as follows. Levels of therapist attention were defined as either an attentive or inattentive therapist. The attentive therapist was defined by the client in the clinical vignette seeing the therapist as looking at, paying attention to, and listening to the client. The inattentive therapist was defined by the client seeing the therapist as not looking at, paying attention to, or listening to the client. Levels of therapist understanding were defined as either a therapist with more or less understanding. The therapist with more understanding was defined by the client in the vignette believing that the therapist knew the same as or more than the

client about what was going on inside of the client. The therapist with less understanding was defined by the client believing that the therapist knew less than the client about what was going on inside of the client. Ratings on the therapeutic alliance were measured by participant responses to modified Working Alliance Inventory Form C (Horvath, 1984; WAI(C)) and Working Alliance Inventory – Short Form C (Tracey & Kokotovic, 1989b; WAI-S(C)) bond scales. Clinical vignettes were defined as one of four session transcripts that have identical descriptions of a psychotherapist and client and client monologues, yet vary on levels of therapist attention and understanding. Using reverie was operationally defined as a psychotherapy interaction in which an inattentive therapist with more understanding knows the same as or more than a client. Ignoring reverie was operationally defined as a psychotherapy interaction in which an inattentive therapist with less understanding knows less than a client. Hence, the inattentive therapists represented using and ignoring reverie for the purpose of exploring the effect of noticeable therapist distraction that may occur while daydreaming during therapy. Prior therapy experience was defined by participant responses of yes to the question, "Have you ever received counseling or psychotherapy?"

II. Literature Review

Because no known quantitative research related to using reverie has been published to date, the current literature on reverie is limited to theoretical and qualitative studies. Alongside these studies, the first known quantitative research related to reverie is informed by quantitative studies of its underlying processes. As a process in which therapist distraction while daydreaming during therapy provides unique opportunities for attending to the experience of clients (Ogden, 1994), the processes that underlie using reverie include therapist distraction and attending to client experience. In addition to the psychotherapy outcome research on how therapist distraction and attending to experience affect the therapeutic alliance, these processes are also informed by quantitative studies from social psychology. Specifically, therapist distraction is thought to affect the therapeutic alliance through the psychological experience of being ignored (Ackerman & Hilsenroth, 2001) and attending to client experience is thought to affect the alliance through the experience of feeling understood (Ackerman & Hilsenroth, 2003). Furthermore, the psychological phenomenon of assumed similarity might possibly be used to measure the effect of using reverie on the alliance as an alternative research method to address the limitations of experimentally studying the use of reverie with real therapy clients. Consequently, the following literature review supports the present study and theoretical basis of how using reverie might affect the therapeutic alliance. Theories on reverie are explained, as well as a review of the research to date regarding the experiences of being ignored and feeling understood in general and specifically in

psychotherapy. Also, the current literature on how the alliance has been measured and the phenomenon of assumed similarity is explored.

Reverie

Reverie, or a therapist's daydreaming during therapy, was theorized by Ogden (1994) using Bion's (1962/1984) term for a maternal state of mind that is open to receiving any projective identifications from an infant and can contain its intolerable frustrations so that they become tolerable. By using this term for a therapist's state of mind, Ogden (1994) suggested that daydreaming during therapy represents projective identifications from a client that can be contained so these intolerable frustrations become tolerable. For Ogden, reverie is an aspect of the interdependent transference-countertransference process. From this view, theories on reverie have been published by Ogden and others.

Ogden's literature on reverie is easily divided into the theoretical basis of reverie and how he practices using these theories. His writings on the basis of reverie originated as expansions on the theories of Bion (1962/1984). Specifically, Bion theorized that it is through reverie as a maternal state of mind which alpha-function first occurs. Alpha-function was defined by Bion as the way in which emotional experience is transformed for use in dream thoughts, unconscious waking thinking, dreams, and memory. Bion viewed emotional experience in sleep as no different from that during waking life. Because Freud theorized that dreaming preserves sleep, "failure of alpha-function means the patient cannot dream and therefore cannot sleep…. and cannot wake up" (Bion, 1962/1984, p. 7). Consequently, Bion attributed failure of alpha-function to "the serious disturbances ordinarily associated with excessive obtrusion of the psychotic elements of

the personality" (p. 54).

Bion's theory of alpha-function was expanded by Ogden (2003a) theorizing that alpha-function is the psychological work of dreaming. Much like Bion (1962/1984) viewed emotional experience in sleep and waking life, Ogden (2003a) viewed dreaming as occurring continuously day and night. However, our awareness of dreaming while awake is limited to derivative form, such as daydreaming in general or specifically during therapy. For Ogden, the work of dreaming allows thought, repression, memory, amnesia, grief, reverie, learning from experience, and so on, whereas people who cannot dream are unable to differentiate between experiences and can lead therapists to experience "'reverie-deprivation' and brief periods of countertransference psychosis" (2003a, p. 17). This is in contrast with not being able to remember dreams. Thus, Ogden suggested that therapy contribute to an enhanced capacity for genuine dreaming by both client and therapist in sleep, while awake, and during therapy.

Although Ogden viewed dreaming as an ongoing process, he did not view all psychological events occurring in sleep as warranting the name dream (2004b). Specifically, psychic events in sleep that resemble dreams are not viewed as such if they do not involve the unconscious psychological work of dreaming. This includes "'dreams' for which neither patient nor analyst is able to generate any associations, hallucinations in sleep, dreams consisting of a single imageless feeling state, the unchanging dreams of post-traumatic patients and… night terrors" (2004b, p. 859). Furthermore, Ogden suggested that clients unconsciously and ambivalently seek help in dreaming these night terrors and nightmares. He understood night terrors as undreamt or undreamable dreams that represent psychotic parts of the personality and nightmares as

dreams that are interrupted when the emotional experience being dreamt becomes too painful and reflects neurotic aspects of the personality. Hence, Ogden viewed the analytic task as dreaming with clients "their undreamt dreams and interrupted cries" (2004b, p. 857). For Ogden, therapists participate in a client's dreaming mostly through reverie. Through this conjoint dreaming, therapists could say something true to what is happening in the therapeutic relationship on an unconscious level in a way that helps clients dream their experiences and selves more fully. Much like Bion (1962/1984) theorized that maternal openness to receiving projective identifications from an infant can contain its intolerable frustrations so that they become tolerable, Ogden (2004b) theorized that therapist openness to dreaming a client's "undreamt dreams and interrupted cries" (p. 857) through reverie can contain their intolerable frustrations so that they become tolerable.

By participating in a client's dreaming, Ogden (2004b) did not view therapists as simply understanding the client. Rather, he viewed the client and therapist as living together the previously "undreamt dreams and interrupted cries" (p. 857) in the transference-countertransference. Through this process, clients more fully come into being and therapists get to understand who the client is becoming. As clients dream their experiences and selves more fully, Ogden saw them as being alive to more of the spectrum of human experience. For him, this is due to the conjoint dreaming between therapists and clients being both "their own dreams… and those of a third subject who is both and neither" (2004b, p. 858) of them. Specifically, Ogden (2004a) saw living with clients within this intersubjective third as changing therapists in a way that they can speak from and about to clients who have also been changed by that experience. This reflects

his view of the transference-countertransference as an intersubjective construction generated and experienced separately and individually by therapists and clients (Ogden, 1995).

Because Ogden (2004b) viewed therapists as participating in a client's dreaming mostly through reverie, he viewed reverie as indispensable in understanding and interpreting the transference-countertransference (1997a). Although reverie may be the dimension of a therapist's experience that feels least worth scrutiny, Ogden viewed these mundane, personal, and private psychological events that often involve the minutiae of daily life as intersubjective constructions reflecting the transference-countertransference. This conceptualization of "reverie as both an individual psychic event and a part of an unconscious intersubjective construction" (1997a, p. 569) relies upon a dialectical conception of therapists and clients together contributing to and participating in an unconscious intersubjectivity. Consequently, Ogden tried to not dismiss any reverie as his 'own stuff' such as a reflection of his own unresolved conflicts, state of fatigue, or tendency to be self-absorbed. Even his distress regarding real and important events in his current life was thought to be contextualized differently by his experience with each client. For example, a therapist whose child has a chronic illness may feel intense helplessness about relieving the pain that the child is experiencing while with one client, envy for friends with healthy children at another moment in the session or with a different client, or terrible sadness about imagining living without the child while with yet another client.

Ogden (1997a) described reverie as usually feeling unobtrusive and inarticulate, more like an elusive unsettling than arriving at an understanding. He believed this

emotional disequilibrium to be among the most important ways that therapists can sense what is happening in the therapeutic relationship on an unconscious level. Thus, Ogden relied heavily on reverie as an emotional compass that he could not clearly read to gain his bearings during sessions. Because reverie usually feels like one is not being a therapist through the "failure to be receptive, understanding, compassionate, observant, attentive, diligent, intelligent, and so on" (1997a, p. 571), it is difficult to use and its proximity, immediacy, and ambiguity makes this difficulty even more understandable. Also, using reverie is even more difficult because its close examination involves problems of technique and potentials for emotional growth unique to that specific moment in that particular session. Hence, "there are no 'run-of-the-mill' problems in the effort to make use of reverie" (1997a, p. 572).

Because Ogden (1997a) conceptualized reverie as part of an intersubjective construction, he did not view it as solely reflecting the unconscious work of either himself or clients (2003b). Rather, Ogden (1997a; 1997b) viewed his images, thoughts, feelings, and sensations as aspects of his internal object world that were elaborated by and strongly reflected the most pressing unconscious constructions of each client. Yet, he did not conceive of his internal object world as being "'called into play' (like keys on a piano being struck) by the" (Ogden, 1997a, p. 589) projective identifications of clients. Instead, Ogden conceived of their unconscious intersubjectivity as creating events that had never previously existed in their affective lives. Specifically, 'recollecting' elements of past experience does not equal remembering that experience because knowing whether its recollected aspects had been a part of it is impossible and does not matter (Ogden, 2003b). Still, it does matter that elements of past and present experience were available

to him in a reverie that was emotionally true to his experience with the client at that moment. In this way, therapists dream through reverie some of their night terrors and nightmares that overlap with those of their clients (Ogden, 2004b).

Because Ogden (1997a) conceived of therapists and clients as contributing to and participating in an unconscious intersubjectivity, he tried to convey "the dialectical movement of subjectivity and intersubjectivity" (1994, p. 8) during sessions. Consequently, Ogden considered his thoughts, feelings, and sensations to be different than they were or will be outside the specific, continually shifting intersubjective context. Specifically, he conceived of the shifting between his reveries and conscious attention to what clients were saying as never 'returning' him to where he had been seconds or minutes earlier because he considered each reverie as changing him, sometimes only in imperceptibly small ways. In this way, reverie is almost unobservable rather than magical or mystical.

Ogden (1997b) viewed using indirect and associational methods such as reverie for catching the drift of intersubjective constructions as necessary because unconscious experience is outside of conscious awareness by definition. Moreover, he viewed reverie and all other unconscious derivatives as metaphorically expressing what unconscious experience is like rather than glimpses into it. Specifically, Ogden experienced therapists and clients as elaborating and modifying their unself-consciously introduced metaphors such as reverie, dreams, symptoms, and so on. Thus, he saw using reverie as allowing therapists to re-present their unconscious intersubjective experience with clients to themselves in verbally symbolic metaphors that they can hear, feel, and link with other feelings and thoughts. These metaphors draw experiences into relationships of similarity

and difference that inherently create between them unfilled spaces of possibility and are in contrast to relationships of equivalence (Ogden, 1999a).

Although Ogden (1994) saw the thoughts and feelings of therapists as being always contextualized and altered by their experience with clients, he believed that using the term countertransference for everything therapists think, feel, and experience sensorially obscures the dialectic of subjectivity and intersubjectivity. For this term to have more meaning, he continually re-grounded it in the dialectic between therapists as separate entities and therapists as creations of their intersubjectivity with clients, neither of which exists in pure form. However, these aspects of life "are rarely discussed with colleagues, much less written about in published accounts" (Ogden, 1994, p. 12). Furthermore, great effort is required to seize the unself-reflective reverie and think about how it represents the interplay of subjects. Although Ogden considered his thoughts, feelings, and sensations to be different than they were outside the specific intersubjective context, he did not consider them to be entirely different and felt that a primary factor contributing to their undervaluation is the disturbing form of self-consciousness involved with acknowledging them. Specifically, analyzing this part of the transference-countertransference requires examining how and what we think "in a private, relatively-undefended psychological state" (Ogden, 1994, p. 12) and attempting to consciously hold thoughts, feelings, and sensations foregoes a privacy that people unconsciously rely on to separate inside from outside (Ogden, 1997a). This transforms the unselfconscious subjectivity of therapists into an object of their scrutiny.

Ogden also discussed some other reasons why using reverie is difficult. Some reasons are that "reverie may occupy only a few moments of time" (Ogden, 1997c, p.

161) and not even need silence from the therapist. Written accounts of reverie may give misleading impressions of this because they occupy a page of text or more. Other reasons are that reverie may inversely grow in intensity and specificity over time, be unavailable for reflective thinking or verbal symbolizing, and simply feel the way things are (Ogden, 1997a). This unconscious waking dreaming is more difficult to use than dreaming in sleep because it is unframed by sleeping and waking. Specifically, dreams are usually differentiated from other psychological events because they occur between the times people fall asleep and wake up whereas reverie melts seamlessly into other psychic states without clearly delineated points of departure or termination separating it from more focused secondary thought processes that precede or follow it. Reverie is also rarely translatable as a one-to-one way of understanding what is happening in the therapeutic relationship. Hence, attempting to immediately use reverie usually produces superficial interpretations. Rather, using reverie requires tolerance of being adrift without rushing it to closure because any value in reverie is usually discovered retrospectively and almost always unanticipated. This tolerance of not knowing requires therapists losing themselves and finding themselves apparently directionless (Ogden, 1999b). Although reverie is often how therapists unwittingly participate for considerable periods of time in the unconscious intersubjective analytic third, their possibilities for doing so are endless and include acting-out, acting-in, or somatic delusions.

Ogden (1996) was explicit that he viewed the circumstances required for reverie as necessary for analysis. Consequently, Ogden (2003a) viewed experiencing chronic reverie-deprivation with clients as much like sleep deprivation in that it can precipitate a psychosis. This countertransference psychosis was experienced by him as something like

being unable to dream while asleep or awake. Reverie-deprivation was experienced by him as great difficulty staying awake. In this half-sleep state, he dreamt fleeting dreams similar to those in sleep that seemed to reassure him he is capable of dreaming, "represent an unconscious effort to dream the dream that the patient is unable to dream at that point" (Ogden, 2003a, p. 28), or often be auditory hallucinations substituting dreams and disguising their inability to dream at that moment. By observing their inability to dream, Ogden viewed it as possible for them to create an intrapsychic-interpersonal field for dreaming the transference-countertransference and verbally symbolizing their responses to that dream through interpretations that helped them better dream and live their experience together, which kept changing as they kept dreaming it. He viewed this awareness and verbal symbolization of experience in the intersubjective analytic third as the task of therapists over time (Ogden, 2004b). Eventually, therapists may speak to clients from their experience of what is happening in the therapeutic relationship on an unconscious level in an attempt to engage clients in conscious thinking that functions with and may facilitate their unconscious work of dreaming.

As with other deeply personal emotional experiences, Ogden (1997a) did not often speak with clients directly about his reverie. Rather, he attempted to speak with clients from what he was thinking and feeling by informing what he said through being aware of and grounded in his emotional experience with them. In this way, Ogden (2003b) tried to articulate with clients what is emotionally true in a fashion that is utilizable by them for psychological change. Specifically, he saw what is true to an emotional experience as independent from its formulation by therapists. Thus, Ogden saw therapists as participant observers and scribes rather than inventors of emotional

truths. Yet, he understood the act of thinking and verbally symbolizing what therapists feel is true to the unconscious experience of clients as altering that truth. Through interpreting, Ogden conceptualized therapists as contributing to the creation of potentially new experiences of what is true with which clients and therapists may do psychological work. This effort toward tentative understandings of emotional truth is in contrast with attempting to change clients and create them in the image of therapists. He also thought offering clients interpretations with some truth to them that is useful for conscious, preconscious, or unconscious work gives verbal 'shape' to the previously non-verbal and inarticulate unconscious experience of clients.

Much like Ogden (1997b) viewed unconscious derivatives as metaphorically expressing what unconscious experience is like, he viewed language as metaphorically conveying what emotional experience feels like (2004b). Alongside new experience, he saw saying what emotional experience feels like as creating the uniquely human form of self-reflective consciousness mediated by verbal symbols. For Ogden, enriching this self-reflective consciousness is among the most important parts of a successful therapeutic experience. As the internal object relationships of clients came alive in the transference-countertransference, this is how he thought, spoke, and dreamt with them these emotional experiences (Ogden, 2003b). Ogden claimed no authorship for these spoken and unspoken relative understandings of emotional truths. Rather, he saw any author of them as "the unconscious third subject of analysis who is everyone and no one" (Ogden, 2003b, p. 605); a subject who is both his clients and himself, and none of them.

Ogden's writings on how he practices using the theoretical basis of reverie originated with a shift in his conception of the therapeutic process. Specifically, he

conceptualized personal meanings as having become inseparable from understanding the unconscious intersubjective context of those meanings (Ogden, 1999a). Hence, his inquiry, 'What does that mean?' gradually expanded into "What's happening between us consciously and unconsciously and how does that relate to other aspects of the patient's (and the analyst's) past and present experience, both real and imagined?" (p. 979). Ogden saw this shift as requiring a commensurate change in how therapists speak to themselves and their patients so that therapists can use language doing justice to both understandings and interpretations of conscious and unconscious meanings of client experience and the intrapsychic and intersubjective music of what is happening in the therapeutic relationship. Rather than attempt to unearth what lies 'beneath' the dreams or life events of clients, he attempted this change by trying "to listen to the sound and feel of" (Ogden, 1999a, p. 979) the music of what is happening. Ogden achieved this during sessions by attending to his reverie and relying heavily on it to recognize and symbolize what is happening on an unconscious level (1999a; 2004a).

Ogden (1994) described attempting to understand the interplay of the experience of therapists, clients, and the intersubjective analytic third through the reverie and somatic delusions of therapists. Specifically, he did not try teasing these experiences apart to determine which belong to each individual. Rather, Ogden tried to fully describe the experience of their interplay. This reflects his interdependent view of therapists and clients, mothers and infants, and subjects and objects. By living within and being changed by the analytic third, he tried to speak in his own voice about it with clients who had also been changed by that experience. Throughout every session, Ogden (1997b) attempted to sense what it feels like with a client and "the leading anxiety in the

transference-countertransference" (p. 729) at a given moment. Because he initially experienced both of these as largely unconscious, he depended heavily on his capacity to transform reverie "into more verbally symbolic forms that can be considered, reflected upon, and linked (in both primary and secondary process modes) to other thoughts, feelings, and sensations" (p. 729). Instead of describing what their relationship and attendant anxieties feel like to him, Ogden valued what these feel like for clients and how that relates to other real and imagined experiences they have had with him and others during their lives. For instance, he considered directly stating the metaphors that he created to speak to himself about his experience with clients as likely robbing clients of opportunities to create their own. By giving clients opportunities to make their own metaphors, Ogden viewed verbal symbols as being created that give the self shape and emotional substance and serve as mirrors for the self to recognize or create itself.

Ogden (1999a) discussed using his overlapping reverie with clients to understand the leading edge of their transference-countertransference anxiety and formulate transference interpretations or other interventions. First, he attempted to speak to himself about these always tentative understandings and then used his clinical judgment to dictate if he speaks to clients about them (Ogden, 1997c). Like transference and countertransference, Ogden viewed reverie as present from the first moment therapists speak to prospective clients before their initial session, even by telephone. However, he saw instances where offering transference interpretations about what is causing clients anxiety based in part on the reverie of therapists in the first day, month, or even year of therapy would be counter-therapeutic. As Ogden (1994) retrieved himself from reverie, he wondered how it could be related to what is currently going on between him and the

client. Although he previously put aside these 'lapses of attention' and tried to devote himself to understanding what clients are saying because he is inevitably a bit behind them when returning from reverie, his more recent effort to shift psychological states "felt like the uphill battle of attempting to 'fight repression'… experienced while attempting to remember a dream that is slipping away on waking" (p. 5). Consequently, Ogden (1997b) felt that reverie seeming fully available in conscious awareness at one moment will frequently seem to have 'disappeared' at the next moment and leave only a nonspecific feeling residue in its wake.

Because Ogden (1999a) experienced some reverie that at first were only subliminally available to him as more sensation than thought, he tried to recast them into more highly organized, verbally symbolized forms of speaking to himself and eventually clients about their affective meaning as they pertain to and are derived from what is occurring unconsciously in the transference-countertransference. Thus, he viewed reverie as needing allowance to accrue meaning without therapists or clients feeling pressure to immediately use them (Ogden, 1997a). Yet, Ogden (2003b) did not strive for Absolute Truth in what he says to clients because he considered himself fortunate if occasionally clients and him come very close to the feel and sound of the music of what is happening. Specifically, he discussed the countertransference as being implicitly presented in how he managed the therapeutic frame, "the tone, wording, and content of interpretations and other interventions" (Ogden, 1995, p. 696), the premium that he placed on symbolization as contrasted with tension-dissipating actions, and so on. Before Ogden (1994) began interventions, he rarely consciously planned to use images from his reverie to convey what he has in mind. Rather, he saw himself as often unconsciously

drawing on their imagery as reflections of how he speaks from his experience in the analytic third. At the same time, Ogden saw himself as speaking about the third from a position outside of it. Hence, he thought "this indirect communication of the countertransference contributes in a fundamental way to the feeling of spontaneity, aliveness and authenticity of the analytic experience" (Ogden, 1994, p. 11). This reflects his thinking that content and style, such as voice, tone, using metaphor, and so on, are inseparable (Ogden & Cooper, 2006).

Ogden (1999a) used metaphorical language to draw two aspects of client experience into a relationship creating new and previously non-existent ways of seeing and experiencing self. For clients to use this, he attempted to speak in terms that can only apply to one client at one moment and simultaneously hold true to general human nature (Ogden, 2003b). Specifically, Ogden (2004b) described speaking to clients so that what therapists say and how they say it could have been said by no other therapist to no other client as partly communicating a feeling that therapists understand who clients are. He tried communicating this feeling by restating what clients say with slightly different language and expanded meaning underscoring how clients know, without knowing that they know, about their unconscious experience (Ogden, 2003b). Although changes in the emotional field from which these interventions derive take time to understand, Ogden (1999b) described recognizing and naming them as involving therapists sensing that they are both creating something with clients and concurrently being created with clients at that moment in the session. He also described analyzing them as involving therapists sensing "the nature and history of the unconscious fantasies, anxieties, defenses and object relations comprising the third cocreated subject of analysis" (p. 489).

In order to verbally symbolize his reverie and eventually use them in the interpretive process, Ogden (1995; 1996) reconsidered three aspects of psychoanalytic technique. Specifically, he perceived symbolizing parts of the formerly unspoken and unthought internal object world of clients as requiring "conditions of privacy that must be safeguarded by analytic technique" (Ogden, 1996, p. 883). The aspects of technique that Ogden viewed as safeguarding these conditions include the role of using the couch, the 'fundamental rule' of psychoanalysis, and the analysis of dreams. Just as "Debussy felt that music was the space between the notes" (Ogden, 1996, p. 883), Ogden felt that the music of psychoanalysis is the reverie of therapists and clients between their spoken words composing the analytic dialogue. Although these techniques that therapists depend on to help them listen to this music are separate, he conceptualized them as having interrelated implications for understanding the relationship amongst privacy, communication, and the analytic third.

Because Ogden conceived of reverie as simultaneously private and unconsciously communicative, he re-conceptualized using the couch to facilitate a state of reverie in which the "analytic third might be generated, experienced, elaborated, and utilised by" (1996, p. 885) therapists and clients. Alongside helping provide conditions of privacy for therapists to enter a state of mind in which they give themselves over to their unconscious thoughts and render their own unconscious receptive to those of clients, he believed that clients using the couch might also experience respite from being watched and more easily give themselves over to their unconscious thoughts and those of therapists. Although Ogden viewed using the couch as important to the conditions for generating and utilizing reverie, he also viewed using it as just one set of contributing factors to this process.

Consequently, he did not insist in spoken or unspoken manner that every client always use the couch. However, neither did Ogden use the couch relative to the frequency of sessions. Similarly, he relied "no more on suggestion, exhortation, reassurance and the like in work with patients being seen once or twice per week than… with patients being seen four, five, or six times per week" (1996, p. 886).

Freud (1912/1973d) described the 'fundamental rule' of analysis as demanding that clients communicate everything occurring to them without criticism or selection. He also recommended that therapists not direct their notice to anything particular and maintain the same 'evenly-suspended attention' in light of all they hear as a necessary counterpart to the 'fundamental rule.' Yet, Ogden (1996) proposed that this rule fails to facilitate conditions for reverie to be generated by therapists and clients. Specifically, he suggested that a role for clients that was genuinely complimentary to what Freud envisioned for therapists would make catching the drift of the unconscious constructions they are generating more easy. Thus, Ogden re-conceptualized the rule for therapists and clients to turn their own unconscious like receptive organs toward the other transmitting unconscious and jointly created analytic third.

Ogden also believed that dreams dreamt in a course of therapy are in a sense dreams of the analytic third. Hence, he suggested that therapists and clients releasing themselves and one another from privileging client associations to dreams and instead treating them as psychological events being generated in an intersubjective analytic dream space significantly enhances their spontaneity and generative thought. Moreover, Ogden re-conceptualized viewing dreams as such products to free therapists and clients for receiving "the unconscious drift of the analytic third as reflected in their reveries,

their experiences of 'simply listening'" (Ogden, 1996, p. 896).

Others who use Ogden's theories on reverie have published peer-reviewed journal articles, doctoral dissertations, book reviews, and letters to the editor. Those using his theories in journal articles discussed subjects ranging from his approach representing a style of contemporary psychoanalysis (Safran, 2011) to the situation of his theories within a philosophic scheme (Reis, 1999). The style of Ogden represents contemporary analysis through emphasizing the potential role of a therapist's unconscious processes in understanding the unconscious of clients (Safran, 2011). Specifically, this way of therapists reflecting on their own associations or reverie to understand clients is similar to the approaches of many other contemporary analysts, including Bollas and Ferro. Furthermore, it is consistent with and was anticipated by the work of Reik (Safran, 2011).

Ogden's theories on reverie have been expanded by many other contemporary authors. For instance, Boccara, Gaddini, and Riefolo (2009) theorized that reflecting on reverie allows therapists to orient themselves toward an authentic process, which allows clients to feel that their un-representable aspects are effectively received. More specifically, authentic phenomena were presented as being located "in the sensorial and pre-symbolic communicative register" (p. 348). Boccara et al. believed that clients communicate to therapists aspects of themselves that were periodically excluded, which can block the vitality of clients and therapy, through vivid iconic and sensorial phenomena crossing the emotional field. Although this authenticity is regressive compared with verbal language, Boccara et al. described it as renewing vital contacts that therapists and clients probably feel have been suspended for a time and cannot be falsified.

Other contemporary authors have theorized that reverie offers many different ways of understanding clients and therapists. For example, reverie might aid in understanding clients who are incoherent, confused, and unable to finish sentences (Vaslamatzis, 2007). When these clients lead therapists to feel alienated, lethargic, and unable to understand, reverie was presented as playing a role "in grasping the inchoate part of the psyche" (p. 106). Moreover, reverie has been used to understand how therapists consider the implications of their interpretations (Cooper, 2008). This post-reverie thinking has been called the *ethical imagination* of therapists and refers to their thinking about various unconscious transference-countertransference enactments. Because reverie was discussed as often leading immediately into private, imagined interpretations of the psychic entanglement between clients and therapists, this thinking sometimes leads therapists to quite productively anticipate how these imagined interpretations might also involve particular transference-countertransference enactments. Examples include truncating elaboration of meaning, repeating the patterns of client objects in life, and so on. This ethical imagination can be understood as allowing therapists to explore how they are enacting patterns and the potential meanings or enactments that might accompany an interpretation. Furthermore, some believe that the ethical imagination is a precondition for illuminating the unconscious intrapsychic-interpersonal effects of an interpretive transition in how therapists understand clients.

Although the ethical imagination of therapists is only part of their imagination, it was thought to be distinct from therapists anticipating client experiences of their interpretive formulations. Consequently, the ethical imagination was described as covering territory lying partially outside of reverie. Specifically, this imaginative

formulation of reverie was considered to allow therapists associational drift regarding the usefulness of an understanding or its potential impact. For instance, a therapist could consider the different enactments that are involved with fantasies of helping a client understand something new or hurting or impinging upon the client. Still, therapists adrift in this way were believed to never entirely know in advance the usefulness or accuracy of an understanding for clarifying something. Thus, the uncertainty of this imagination or attempt to formulate what therapists are doing and about to do with clients reflects a sense of ethical responsibility or accountability. Also, these thoughts were described as constructions of what therapists imagine they are enacting. Rather than an injunction that therapists try to think about how they are and will be participating, this was viewed as what most therapists do as they utilize reverie and associational linkage, affect absorption, transference attributions, and so on.

Through describing the ethical imagination as covering territory lying partially outside of reverie, reverie was implicitly placed upon a continuum of mental contents. Such a continuum was expanded by theorizing that mental contents range from indirect to direct forms of associative dreaming (Cwik, 2011). The indirect end of this continuum included the inchoate reverie of Ogden whereas the direct end included well-formed cognitive theoretical formulations. Between these extremes lie general content toward the indirect end and myth and fairytales toward the other. General content included more formed images and identifiable feelings than the reverie of Ogden. In indirect associative processes, therapists may not be able to make clear links as to why they are thinking what they think whereas the connection can be quite obvious in direct associative processes. Indirect associations also included automatic thoughts, feelings, or sensations that

predominate with a sense they are having therapists rather than therapists are having them. This experience of not knowing what is coming into the minds and bodies of therapists at a given moment seemed to denote more access to the unconscious through primary process contents such as slips, dreams, and dream-like material. Direct associations included secondary process contents predominating with thinking and understanding that usually have the feeling therapists are having them instead of the opposite. According to theory, the full extent of this associative dreaming continuum expresses the analytic third. As therapists move toward the direct end of the continuum, they become more defensive against deeper affectivity that constellates in the therapeutic relationship because they are thinking about clients theoretically rather than empathizing with the unique experience of clients (Cwik, 2011).

On the associative dreaming continuum, a capacity for reverie was viewed as harvesting and metabolizing the projections of clients and returning them through timely interpretations that demonstrate therapists have understood deeply the current analytic third state (Cwik, 2011). Although using the couch was thought to allow therapists greater freedom to enter reverie states, such states were suggested as reachable even in face-to-face therapy through training and conditioning with Jungian active imagination work. Active imagination involved focusing on and following an inner image, concretizing it in some written or artistic form, and making clinical decisions about commenting on the material and exactly what to say, if anything, regarding it. If therapists say anything, whether they speak from their active imaginal engagement or share its actual content, depended on the capacity of clients to dream. Specifically, clients who have undreamt or undreamable dreams were understood as suffering from

damaged psychic equipment disabling their use of reverie, dream, or metaphor. Hence, therapists must always speak from their associative dreaming experience with such clients. Because these clients were described as developmentally unable to grasp metaphor or symbol, talking directly to them about the experience of therapists could confuse, alienate, and even anger them so that "they feel disconnected and treated like a clinical object" (Cwik, 2011, p. 25). However, therapists were free to speak from or about their associative dreaming with clients who suffer from interrupted dreams. Moreover, speaking from the associations of therapists is preferable during highly emotional states because speaking about their associations in these states might be distancing as therapists dissociate from deeper states resonating within.

Other authors have expanded on the theories of Ogden by theorizing about different ways of speaking from their reverie with clients. Specifically, reverie has been theorized as offering ways for therapists to vocally demonstrate that they understand deeply the "primitive, preverbal bodily longings and states" (Wrye, 1997, p. 367) of clients. Alongside the structural, denotative, and syntactical aspects of language, this powerfully evocative meaning of the sound of therapists relied on them listening to the guttural, tonal, and embodied parts of their speech. Furthermore, reverie has been theorized as burdening therapists with the power and responsibility to shape the selves of clients with language (Morton, 2003b). Although Ogden (1997b) discussed directly stating the metaphors that he created to speak to himself about his experience with clients as likely robbing them of opportunities to create their own, this did not "account for the powerfully therapeutic experience of discovering a new language with someone else" (Morton, 2003b, p. 454). Because clients were described as unable to conceive of their

metaphors in absolute privacy much like they cannot develop in absolute privacy, speak themselves into existence, or define themselves alone, their self-creation seemed subject to discovering a preexisting system of meanings through intimate relations with others. Consequently, clients and therapists were suggested to coauthor unique vocabularies for themselves. This argument for the mutual creation of metaphors considered the self as consisting of intersubjective metaphors.

Ogden's theories on reverie fit within a philosophic scheme through his solution to the *problem of alterity* (Reis, 1999). Also known as the problem of others, the problem of alterity asks how to recognize others as independent minds when doing so will reduce them to constitutes. His unique use of reverie was seen as solving this problem by using his subjectivity "as a medium for the appearance of the world from which he is not separated" (Reis, 1999, p. 390). Alongside using his mind to recognize the minds of clients, he used his subjectivity to recognize the subjectivity of clients as their subjectivity unconsciously influenced his. This transcended the debate over one-person and two-person psychologies by creating a truly dialectical, contemporary psychoanalytic theory of intersubjectivity, which is neither a one-person nor two-person psychology.

Those who use Ogden's theories in dissertations discussed subjects ranging from a qualitative study of client reverie during psychoanalysis (Ervin, 1999) to the production and consumption of reverie exchanged between clients and therapists as a product of the late-capitalism consumer society (Palmer, 2004). His theories have been integrated with Jungian formulations of reverie (Calfee, 2006) and the intersubjective countertransference approaches of Bollas and Stolorow (Morton, 2003a). In the arts,

reverie has been used to help therapists gain better insight into clients through a drawing technique (Futterman, 2007) and discuss the intersubjective experience between artists and their audience (Perl, 2001).

Although Ogden's theories on reverie were originally generated within the tradition of relational psychoanalysis (Mitchell & Aron, 1999), they have since been reviewed for use in greater psychoanalysis (Berman, 2007), psychotherapy in general (Berman, 2003) and specifically with children (Bradley, 2006) and family systems (S. Jones, 2004), social work (Wengraf, 2007), psychiatry (Chessick, 2003), and literary criticism (Sprengnether, 2004). Most of these reviews reflect the suggestion that reverie states are reachable even in face-to-face therapy (Cwik, 2011). Yet, clients could interpret the silence of therapists in reverie as therapists having fantasies, giving clients good reasons for distrusting them (Plaut, 1997). Because this distrust reflects how therapist distraction is thought to affect the therapeutic alliance through the psychological experience of being ignored, the research to date regarding this experience in general and specifically in psychotherapy is reviewed.

Being Ignored

The psychological experience of being ignored has been researched alongside the experiences of being excluded and rejected to form the current literature on ostracism. Specifically, the first known quantitative studies on the experience of being ignored are from social psychology and found that individuals being ignored evaluated both themselves and others ignoring them less favorably and rewarded those who ignored them less (Geller, Goodstein, Silver, & Sternberg, 1974). Furthermore, individuals who imagined being ignored made more negative self-statements (Craighead, Kimball, &

Rehak, 1979). These and other studies on being excluded and rejected led to the development of a theoretical model for ostracism, which Williams (1997) broadly defined as being ignored or excluded.

The theoretical model of ostracism developed by Williams (1997) conceptualized how four dimensions of ostracism threaten four fundamental needs with both short-term and long-term consequences. Williams' four dimensions of ostracism describe its visibility, motives, quantity, and causal certainty. Specifically, Williams referred to the visibility of ostracism as either social ostracism in which individuals are ignored while still visible to others and ironically may feel invisible or physical ostracism in which victims are not in the presence of those ignoring them and likely do not feel invisible. He considered the motives of ostracism to be not ostracism, role-prescribed, punitive, defensive, or oblivious. Not ostracism is perceived as ostracism that was unintentional because the ignorers were distracted and victims are overreacting. Role-prescribed ostracism is not perceived as intending to hurt because temporary roles dictate that one person ignores another such as when restaurant customers ignore servers. Punitive ostracism is perceived as deliberate and aversive such as the silent treatment, shunning, banishment, and exile. Defensive ostracism is preemptively used in anticipation of threats or expected ostracism from others and is meant more as protection or a way of maintaining control than an offensive weapon. Oblivious ostracism occurs when victims are perceived as unworthy of attention such as how people regard those in lower social classes. The quantity of ostracism refers to a continuum ranging from partial to complete social ostracism so as to not confound the qualitatively different reactions between complete social ostracism and physical ostracism. The causal certainty of ostracism

pertains to its perceived reasons as they range from causally ambiguous to certain such as an explicit declaration explaining its reason.

The four fundamental needs theorized by Williams (1997) as threatened through ostracism are belonging, self-esteem, control, and meaningful existence. Williams hypothesized that these threats have different short-term and long-term consequences. Specifically, he characterized the short-term consequences of ostracism as following two distinct stages (Williams & Gerber, 2004). The first stage is immediate, indiscriminant, reflexive, and painful at both psychological and neurophysiological levels with negative affect, anxiety, and reduced need satisfaction. The second stage is reflective and aimed at coping by regaining lost need satisfaction. However, remedial actions to repair thwarted belonging and self-esteem are more likely to be pro-social whereas actions aimed at increasing control or attention may be antisocial (Williams & Warburton, 2003). Also, explicit and transparent responses to ostracism may cause a pro-social attempt at impression management while disguised responses may allow antisocial venting of anger and frustration (Williams & Gerber, 2004). The long-term consequences of ostracism include depleted coping resources, accepted ostracism, feeling alienated and worthless, self-ostracism to prevent further rejection, and psychological difficulties such as high levels of reported depression, suicidal ideation, and suicidal attempts (Williams & Nida, 2011). This model of ostracism relies on a multi-method research program with "laboratory and field experimentation, role play, narratives, event-contingent diaries, Internet research, and structured interviews" (Williams & Zadro, 2001, p. 21).

Although the model of ostracism developed by Williams (1997) has not been used to conceptualize the experience of being ignored in psychotherapy, being ignored by a

therapist who is distracted while daydreaming during therapy would likely be referred to as social ostracism that is oblivious, partial, and causally ambiguous. He described social ostracism as increasing anger, hurt, persistent attempts to recapture attention, and retaliation with ostracism instead of allowing reflection. Because oblivious ostracism leads people to feel invisible and unworthy of attention, this was speculated to simultaneously threaten all four needs and be the worst form of ostracism. Partial ostracism has greater attributional ambiguity, making clear interpretations or appropriate reactions difficult. Highly ambiguous oblivious ostracism is proposed to threaten both self-concept and meaningful existence more because its victims manufacture countless self-depreciating internal attributions and doubt their existence.

Moreover, other studies on being ignored inform the risk of using reverie in therapy. Specifically, ignoring is hypothesized to be more frustrating, connected with feelings of lost control, and likely to cause an aggressive response (Williams & Gerber, 2004). Yet, being ignored was found to "produce a sense of failure to achieve social gain and lead to more promotion-focused responses, including reengagement in social contact, thoughts about actions one should have taken, and increased feelings of dejection" (Molden, Lucas, Gardner, Dean, & Knowles, 2009, p. 415). Regardless, ostracism has been found to be more threatening in closer relationships (Reichner, 1979; Williams & Zadro, 2001) and elicit its greatest aversive impact when supervisors use oblivious or punitive ostracism that is partial and ambiguous (Faulkner, 1999). Consequently, the aversive interpersonal experience of being ignored is thought to be how therapist distraction affects the therapeutic alliance. Still, it is unclear how this experience compares with the way that attending to client experience is thought to affect the alliance.

Thus, the research to date regarding the experience of feeling understood in general and specifically in therapy is reviewed.

Feeling Understood

The psychological experience of feeling understood has been researched using both naturally occurring and clinically based relationships to form the current literature on intimacy. The first known quantitative studies involving the experience of feeling understood are from social psychology and suggested that some individuals were unwilling to perceive themselves as typical out of their needs to appear individualistic and feel perceived as unique (Bachrach & Pattishall, 1960; Forer, 1949, 1968). Since then, other studies on the need to feel understood have included the role of this need in achievement, intimacy, and social relationships. Specifically, the need to feel understood was noted as a vital factor in the many ways people can achieve greater fulfillment and the core of feeling loved (Stein, 1979). Furthermore, a model for the intimacy process was proposed by Reis and Shaver (1988) as needing a person expressing feelings to feel understood, cared for, and validated by a supportive and empathic listener.

Most known quantitative research on the experience of feeling understood in natural relationships has used the intimacy process model of Reis and Shaver (1988). These studies include four facets of feeling understood that may be related and can be independent (Pollmann & Finkenauer, 2009). Specifically, these facets are 1) *self-reported understanding* such as Michelle feeling like she understands James; 2) *perceived understanding* such as Michelle feeling like James understands her; 3) *partner-reported understanding* such as James feeling like he understands Michelle, and 4) *partner-reported and perceived understanding* such as Michelle perceiving James as

understanding because he feels like he understands her. Both self-reported and perceived understanding predicted relationship wellbeing even when accurate knowledge of partners did not (Pollmann & Finkenauer, 2009). Also, these two facets of understanding are crucial to partner responsiveness, which Reis, Clark, and Holmes (2004) argued represents a cardinal intimacy process. However, perceived partner responsiveness predicted relationship satisfaction better than self-reported partner responsiveness (Lemay, Clark, & Feeney, 2007) and is based on the actual responsiveness of partners (Reis et al., 2004; Murray, Holmes, & Griffin, 2000). Moreover, perceived responsiveness helped the intimacy process more than self-disclosure (Lin & Huang, 2006), perceived understanding is related to self-verification, which also contributed to relationship wellbeing (Weger, 2005), and feeling understood predicted the relationship between communication expectations and relationship success (Flaherty, 1999). Together, this research demonstrates how the experience of feeling understood and its related constructs support relationships in general.

Alongside the quantitative studies on feeling understood in natural relationships, the intimacy model of Reis and Shaver (1988) is supported by clinical relationships. Although clinical relationships are atypical due to "their relative one-sidedness, special aims, and narrow range of activity" (Duck, 1977; as cited in Reis & Shaver, 1988, p. 368), many are therapeutic because they contain a rather pure form of clients self-disclosing in the presence of an empathic listener (Reis & Shaver, 1988). Even fulfilling the need to feel understood in medical relationships has contributed to information recall, medication adherence, and reassurance (van Dulmen, 2011). In therapeutic relationships, client-centered and psychoanalytic approaches most emphasize empathic listening for

understanding how clients see or experience the world (Elliott, Bohart, Watson, & Greenberg, 2011). Specifically, psychotherapist empathy was proposed as the foundation of client-centered therapy by Rogers (1961). For Rogers, combining empathy with non-judgmental and supportive listening formed unconditional positive regard, which encourages people to be more self-accepting and integrated and facilitates interpersonal trust.

The psychoanalytic theorist most similar to Rogers was Kohut (1977; Kahn, 1985), who developed 'self psychology.' For Kohut, "patients with various degrees of defects in their self-organization are engaged in an ongoing search for empathic responsiveness, acceptance, and understanding in order to complete development and achieve a sense of cohesion and wholeness" (Ornstein & Ornstein, 1996, p. 106). Consequently, empathic interpretive responses including acceptance, understanding, and explaining help clients feel understood, which "constitutes one of the most essential elements in the healing process" (Ornstein & Ornstein, 1996, pp. 109). More recently, some relational and intersubjective psychoanalysts view feeling understood by a therapist as creating mental space for thinking when present (Benjamin, 2004; Spezzano, 1996) and counter-therapeutic feelings when absent (Stechler, 2000). Furthermore, a transtheoretical empathy model sees therapists as helping clients feel understood, which fosters a sense of safety and gradually moves them into a more productive, exploratory reflection of their experience (Elliott et al., 2011).

Theories on therapist empathy are also supported by research. Specifically, most therapy studies measure four categories of empathy (Elliott et al., 2011). These categories are *expressed empathy* such as empathy rated by nonparticipants, *received*

empathy such as client-rated empathy, *empathic resonance* such as therapists rating their empathy, and *empathic accuracy* such as congruence between client and therapist perceptions of the client. A recent meta-analysis of these categories "indicated that empathy is a moderately strong predictor of therapy outcome" (Elliott et al., 2011, p. 43). Particularly, received and expressed empathy predicted outcomes better than empathic resonance. Although this relationship was equal for different theoretical orientations, it "was strongest for less experienced therapists" (Elliott et al., 2011, p. 43). Moreover, the effect size of empathy was slightly larger than a recent meta-analysis on the relation between the alliance and individual therapy outcome (Horvath, Del Re, Fluckiger, & Symonds, 2011). Thus, the experience of feeling understood through therapist empathy is thought to be how attending to client experience affects the therapeutic alliance. To measure the effect of therapist distraction and attending to experience on the therapeutic alliance, the current literature on how the alliance has been measured is explored.

The Alliance Measured

The therapeutic alliance has been "defined broadly as the collaborative and affective bond between therapist and patient" (Martin et al., 2000, p. 438). However, this construct has developed from varied understandings of the therapeutic relationship. Specifically, the alliance was conceptualized as representing one construct by some and several independent dimensions by others. Furthermore, different aspects of this relationship are described using various terms such as *helping alliance*, *working alliance*, *therapeutic bond*, and *therapeutic alliance*. Despite the differences among these conceptualizations, most of them share a collaborative relationship, an affective bond, and an agreement on goals and tasks (Martin et al., 2000).

The many alliance conceptualizations, derived from efforts to extrapolate and extend the alliance from psychoanalytic theory, encompass the collaborative relational aspects of all helping endeavors (Bordin, 1979; Luborsky, 1976; as cited in Horvath et al., 2011). Because early advocates of a pan-theoretical alliance concept chose to not offer a concise definition, numerous alliance measures that did not share a common point of reference were developed in parallel (Horvath et al., 2011). Consequently, some of these scales attempt measuring specific alliance concepts whereas others try assessing more eclectic blends of constructs (Martin et al., 2000). Also, they use different rating systems, have varied numbers of items, and purport measuring different amounts of alliance dimensions. Yet, most measure therapist-patient affective attachments and collaboration in the therapy process (Horvath & Luborsky, 1993).

Despite the differences between alliance measures, most of them share some commonalities. Specifically, most scales are based on psychoanalytic, pan-theoretical, or client-centered alliance concepts (Catty, Winfield, & Clement, 2007). Moreover, they measure the alliance using ratings by observers, clients, and therapists (Elvins & Green, 2008). Most use client ratings, followed by therapist and then observer. This likely reflects both the ease of obtaining client and therapist ratings compared to training observers (Martin et al., 2000) and past evidence that client alliance ratings predict outcomes better than therapist and observer, respectively (Horvath & Symonds, 1991). Still, recent evidence suggests that client, therapist, and observer alliance ratings predict outcomes similarly (Horvath et al., 2011; Martin et al., 2000).

Four "core measures" account for approximately 2/3 of alliance data (Horvath et al., 2011). These scales are the Vanderbilt Psychotherapy Process Scale (O'Malley, Suh,

& Strupp, 1983), Helping Alliance Questionnaire (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; HAq), California Psychotherapy Alliance Scale (Marmar, Gaston, Gallagher, & Thompson, 1989; CALPAS), and Working Alliance Inventory (Horvath & Greenberg, 1989; WAI). Although the shared variance among them has been less than 50% (Horvath, 2009; as cited in Horvath et al., 2011), they have received more empirical scrutiny than other alliance measures, moderately predicted outcomes, and been used for over 20 years (Martin et al., 2000). Furthermore, the HAq, CALPAS, and WAI share a "confident collaborative relationship" concept as their central common theme (Hatcher & Barends, 1996; Hatcher, Barends, Hansell, & Gutfreund, 1995). Of these scales, the WAI was recommended for most research projects (Martin et al., 2000).

The WAI is based on the pan-theoretical alliance concept of Bordin (1979), which involves goal agreement, task assignment, and bond development. Thus, the WAI was designed for all types of therapy (Martin et al., 2000). Specifically, it measures the total alliance, Bordin's (1979) alliance aspects of goals, tasks, and bond, therapist-patient affective attachments, and collaboration in therapy (Horvath & Luborsky, 1993) through client, therapist, and observer rated forms (Horvath, 1984) and client and therapist short versions (Tracey & Kokotovic, 1989b). Also, the WAI has shown better interrater reliability (Martin et al., 2000) and been used more (Horvath et al., 2011) than other alliance scales.

The WAI measures therapist-patient affective attachments through its 'bond' scale. Specifically, many bond scale items represent therapist contributions to a personal relationship with clients (Elvins & Green, 2008) and the bond scale has correlated highly with therapist empathy when assessed by the Relationship Inventory (Barrett-Lennard,

1986). Because client-rated empathy predicted outcomes better than other empathy categories (Elliott et al., 2011), the WAI client form (WAI(C)) and short version (WAI-S(C)) bond scales likely measure the effect of attending to experience on the alliance better than other alliance scales. Moreover, the bond scale items that assess affective relationships likely measure the effect of therapist distraction on the alliance better than other alliance scales. Hence, the WAI(C) and WAI-S(C) bond scales were used to measure how using reverie might affect the therapeutic alliance. As an alternative method to studying the use of reverie with real therapy clients, the current literature on the phenomenon of assumed similarity is explored.

Assumed Similarity

The psychological phenomenon of assumed similarity is the tendency to assume that others are similar to the self and often occurs when information related to their traits is not readily available (Beer & Watson, 2008). This phenomenon was initially discussed by Cronbach (1955), who argued that information about oneself could provide seemingly accurate judgments of close others because individuals tend to interact with others similar to themselves. Although the mechanisms underlying assumed similarity continue to be debated, the phenomenon has been firmly established (Beer & Watson, 2008). Specifically, assumed similarity has had many names suggesting somewhat different etiological theories. While this is perhaps a more prominent label for the rating strategy, other names include *perceived similarity* suggesting the same basic properties, *projection* such as attributing undesired characteristics to others rather than self, and *self-based heuristic* such as unconsciously filling in the gaps from unavailable trait information with self-relevant information (Beer & Watson, 2008).

Assumed similarity has traditionally been assessed by calculating the correlation between an individual's self-ratings and ratings of others (Beer & Watson, 2008). A more straightforward way of doing this was using what is referred to as a round-robin design, in which a group of people judge one another and themselves (Kenney & West, 2010). However, researchers assessing assumed similarity have increasingly practiced combining self- and other-ratings with knowledgeable informant reports to form composite indices of what people are like (Human & Biesanz, 2011). This provides more realistic and reliable measures of personalities and avoids rating shortcuts or shared method variance. Furthermore, this projection and accuracy were both stronger on Likert-type scales and opinion items when compared to consensus estimates and ability items, respectively (P. Jones, 2004). Because projection is conveyed and promoted as wrong, irrational, or exaggerated, reviewing further research on assumed similarity clarifies how this fosters accurate perceptions of social reality.

Although assumed similarity has typically been given serious consideration in acquainted samples, recent studies have assessed projection in strangers (Beer & Watson, 2008). Specifically, assumed similarity has shown no clear relation with acquaintanceship (Beer & Watson, 2008; Watson, et al., 2000). Also, assumed similarity is almost uninfluenced by real similarity when the other has characteristics that are relatively familiar and socially acceptable (Rodgers, 1959). While some data clearly demonstrated a negative correlation between assumed similarity and accuracy (Beer & Watson, 2008), a recent meta-analysis found a positive correlation at low levels (Kenny & West, 2010). Yet, more recent studies demonstrated that assumed similarity and accuracy are both independent within individuals and positively related with

psychological adjustment (Human & Biesanz, 2011, 2012). Particularly, well-adjusted people accurately viewed others as average while inaccurately seeing them as uniquely similar to themselves (Human & Biesanz, 2011). Consequently, using assumed similarity to measure how different therapist actions might be perceived may be possible through an analog design because individuals tend to both assume that others are similar to them and accurately judge those others on specific traits.

Assumed similarity has been attributed to both broad and trait-specific evaluations (Srivastava, Guglielmo, & Beer, 2010). Specifically, assumed similarity tends to be strongest when rating less visible traits such as affectivity (Watson et al., 2000). Thus, affective states have consistently shown stronger assumed similarity than more visible traits such as extraversion. Although rating affect in others is difficult, substantial accuracy with clearly established convergent validity can be attained through using multiple judges or a very highly acquainted sample (Watson et al., 2000). Moreover, assumed similarity has even explained how one person's perception of another's attitude toward a third tends to agree with the first person's attitude toward the third (Ohashi, 1956).

In summary, the preceding literature offers a possible way to use assumed similarity for measuring how processes that underlie using reverie could affect the therapeutic alliance. This approach allows for an initial quantitative exploration of processes underlying reverie without the need to violate client confidentiality by studying how using reverie affects real therapy. Individuals tend to assume that others are similar to them (Beer & Watson, 2008). Because vignettes about other people have been demonstrated to affect participants (Cavallo et al., 2009; Cavallo et al., 2012; Murray et

al., 2011), vignettes offer a mechanism to manipulate and measure how people respond to different situations. Particularly, this process involved multiple judges using Likert-type scales to rate someone's affect toward another in which the rated person is familiar and acceptable despite unacquainted and potentially dissimilar. Under these circumstances, assumed similarity and accuracy have been either stronger or almost uninfluenced. Hence, assumed similarity was used so that members of the general public rated the therapeutic alliance for a clinical vignette as if they were the client in the vignette by projecting their self-concepts onto the client.

III. Method

The method used in the present study included both experimental and descriptive research designs. An experimental design was used to explore the first research question. This design involved manipulating levels of therapist attention and understanding to explore how these two therapist variables affected ratings on the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie. A descriptive design was used to explore whether prior therapy experience affected ratings on the therapeutic alliance for vignettes that varied on levels of therapist attention and understanding.

Participants

The participants were a nonrandom sample of the general public who live in the United States and are at least 19 years of age. A statistical power analysis indicated that a medium effect size of .25 for an analysis of variance (ANOVA) with an alpha of .05 would require 64 participants in each comparison group to have power of .80 (Cohen, 1988). A medium effect was chosen because the clinical vignettes were not predicted to have a large effect and a small effect is less clinically significant. Consequently, sampling proceeded until at least 64 participants rated the therapeutic alliance for each of the four session transcripts, 64 participants reported prior therapy experience, and 64 participants reported no such experience.

Participants were recruited through the social networking website, Facebook.com. Specifically, possible participants were identified as those who responded to an

advertisement (See Appendix A) on Facebook.com. Because the advertisement did not recruit the minimum number of participants needed to validate the present study, the researcher posted an invitation for participation (See Appendix B) on his Facebook page. The advertisement and invitation linked to an information letter (See Appendix C), which linked to an online survey. Participation was voluntary and offered the incentive of entry into a random drawing to win one of six gift cards for $100.00 at Amazon.com using the True Random Number Generator powered by Random.org.

The sample involved 291 participants ranging in age from 19 to 70 (M = 33.10, SD = 10.512). The participants included 207 (71.13%) females and 84 (28.87%) males. Of these, 272 (93.47%) identified as White or Caucasian, 10 (3.44%) as Black or African American, 4 (1.38%) as American Indian or Alaska Native, 4 (1.38%) as Asian or Pacific Islander, 4 (1.38%) as Hispanic or Latino/a, 2 (.69%) as Arab or Middle Eastern, and 4 (1.38%) as other with 2 (.69%) specifying Indian and Jewish and 2 (.69%) unspecified. Because participants were able to select more than one ethnicity or race, the percentages for ethnicity and race exceed 100. Furthermore, 170 (58.42%) reported living in the South, 78 (26.81%) in the Midwest, 23 (7.90%) in the West, and 20 (6.87%) in the Northeast. Annual household income was estimated at $25,000.00 or less by 66 (22.68%), $25,000.00 to $50,000.00 by 81 (27.84%), $50,000.00 to $75,000.00 by 63 (21.65%), $75,000.00 to $100,000.00 by 47 (16.15%), and $100,000.00 or more by 34 (11.68%). A total of 196 (67.35%) participants reported prior experience with counseling or psychotherapy and 95 (32.65%) reported no prior experience with counseling or psychotherapy. For the session transcripts, 69 (23.71%) were randomly assigned to the attentive therapist with more understanding, 71 (24.40%) to the attentive therapist with

less understanding, 73 (25.09%) to the inattentive therapist with more understanding, and 78 (26.80%) to the inattentive therapist with less understanding.

Measures

The measures included the Working Alliance Inventory Form C (WAI(C)) and Working Alliance Inventory – Short Form C (WAI-S(C)) bond scales and a demographic questionnaire. Participants also responded to questions as part of a manipulation check.

WAI. The WAI(C) (Horvath, 1984) is a 36-item self-report measure of client ratings on the working alliance as expanded by Bordin (1979). Respondents indicate their feelings about the alliance using a 7-point scale ranging from 1 = never to 7 = always. Consequently, it yields a total alliance score and three subscale scores for goals, tasks, and bond. Twelve items comprise the WAI(C) bond scale, which measures "the complex network of positive personal attachments between the client and the counselor that includes issues such as mutual trust, acceptance, and confidence" (Horvath & Greenberg, 1989, p. 224). Sample WAI(C) bond scale items include "I feel uncomfortable with _____" and "_____ and I understand each other" (Horvath, 1984, p. 2). The WAI(C) bond scale is scored by summing item responses, with items 1, 6, and 11 reverse scored. Higher scores indicate higher levels of the therapeutic alliance. The range of possible scores for the WAI(C) bond scale is from -12 to 60. Evaluation of the psychometric properties of the WAI(C) supports the use of the WAI(C) bond scale (Horvath & Greenberg, 1989). Specifically, the WAI(C) bond scale reliability estimates ranged from .85 to .92 based on Hoyt's algorithm in a sample of adult clients in short-term therapy. Content validity was established by 94.80% agreement across 21 professional raters. Moreover, convergent validity was established

by a correlation coefficient of .83 with the Relationship Inventory Client Form Empathy scale. Lastly, concurrent validity was established by correlations ranging from .76 to .83 with the Counselor Rating Form Empathy scale (Hovarth & Greenberg, 1989).

The WAI-S(C) (Tracey & Kokotovic, 1989b) is a short form of the WAI(C) with 12 items chosen from a confirmatory factor analysis of the WAI(C) (Tracey & Kokotovic, 1989a). Specifically, a hierarchical bilevel model with one primary general factor and three secondary specific factors fit the WAI(C) factor structure better than a model with one general factor and a model with three specific factors. The four highest-loading items from each subscale formed the WAI-S(C), which underwent the same factor analysis and showed similar results. This established construct validity for both the WAI(C) and WAI-S(C). Respondents use the same 7-point scale for the WAI-S(C) as the WAI(C). Sample WAI-S(C) bond scale items include "I believe _____ likes me" and "I am confident in _____'s ability to help me" (Tracey & Kokotovic, 1989b). The WAI-S(C) bond scale is scored by summing item responses, with no items reverse scored. Higher scores indicate higher levels of the therapeutic alliance. The range of possible scores for the WAI-S(C) bond scale is from 4 to 28. Internal consistency of the WAI-S(C) bond scale was reported to be .92 (Tracey & Kokotovic, 1989a).

Evaluation of manipulation. The manipulation check questions were self-report items made for the present study to determine whether the manipulations for levels of therapist attention and understanding were supported. To check the effectiveness of the manipulations for therapist attention, participants answered the question, "How did the client see the therapist?" with multiple-choice answers of "As looking at, paying attention

to, and listening to the client" and "As not looking at, paying attention to, or listening to the client." To check the effectiveness of the manipulations for therapist understanding, participants answered the question, "What did the client believe?" with multiple-choice answers of 1) "That the client knew more than the therapist about what was going on inside of the client;" 2) "That the therapist knew the same as the client about what was going on inside of the client;" and 3) "That the therapist knew more than the client about what was going on inside of the client."

Personal information on participants. Participants completed a demographic questionnaire made for the study. The demographic questionnaire required participants to provide information about prior therapy experience, gender, age, ethnicity or race, national region, and estimated annual household income. Prior therapy experience was used to explore the second research question. The provided information was used to describe the sample demographics.

Procedures

After obtaining approval for the present study from the Auburn University Institutional Review Board, the advertisement that linked to the information letter was run on Facebook. The advertisement was run from December 9, 2012 to December 20, 2012, was shown 71,014 times, and received 16 clicks. Because the advertisement did not recruit enough participants, the researcher posted the invitation on his Facebook page as approved in the research protocol. The invitation and information letter also asked possible participants to forward the link to the letter to as many friends or family members who live in the United States and are age 19 or older as they want to make the results more accurate regardless of whether they decide to participate. This implemented

a convenience sampling system.

Those who decided to participate were linked from the information letter to the online Therapist Attention and Understanding Survey (See Appendix D), which was hosted by Qualtrics.com. The Therapist Attention and Understanding Survey included a clinical vignette with an initial rating prior to an experimental manipulation, the experimental manipulation, and a rating after the experimental manipulation, the manipulation check questions, and the demographic questionnaire. Prior to the experimental manipulation, participants read a brief description of a therapist and client and rated their therapeutic alliance using the WAI-S(C) bond scale. The experimental manipulation involved the participants being randomly assigned and reading one of four brief session transcripts between the therapist and client that varied on levels of therapist attention and understanding. After the experimental manipulation, they rated the therapeutic alliance using the WAI(C) bond scale, which included a second administration of the WAI-S(C) bond scale embedded within it. Then, participants completed the manipulation check and demographic questionnaire.

The four clinical vignettes were developed by condensing and simplifying the clinical vignette in which Ogden (1994) demonstrated using reverie. Specifically, the vignette by Ogden was changed to third-person narration with a neutral gendered client and therapist for the description of the therapist and client. The parts of the vignette by Ogden that the client experienced and concisely demonstrated using reverie formed the four session transcripts used in the present study. Original quotations were used when available and new quotations were formed from narrative in the style of the original quotes. The average reading level of the clinical vignettes was lowered by replacing

complex words and sentences with synonyms and using the Readability Test Tool (Simpson, 2010). The Readability Test Tool is a web-based software that tests text and "gives a score for the most used readability indicators" (Simpson, 2010) such as the Flesch Kincaid Reading Ease, Flesch Kincaid Reading Level, Gunning Fog Score, SMOG Index, Coleman Liau Index, and Automated Readability Index. According to the Readability Test Tool, the clinical vignettes have "an average grade level of about 8…. [and] should be easily understood by 13 to 14 year olds" (Simpson, 2010). The vignettes were reviewed for content validity by three counseling psychologists and revised until all three agreed that they clearly represented possible therapy sessions.

Furthermore, levels of therapist attention were added to the session transcripts to test the effect of noticeable reverie experiences on the therapeutic alliance. Levels of therapist attention and understanding were used to test the effect of using reverie. Consequently, the session transcripts included the client talking, the client seeing the therapist as either attentive or inattentive, the client continuing and therapist responding, and the therapist understanding either more or less than the client. The session transcript with an inattentive therapist with more understanding (See Appendix D) represents the processes that should be present when a therapist effectively uses reverie. The transcript with an inattentive therapist with less understanding (See Appendix E) represents the processes that should be present when a therapist experiences and ignores reverie. The attentive therapists with more (See Appendix F) or less (See Appendix G) understanding represent control conditions in which the therapist is not noticeably experiencing reverie despite having identical levels of understanding.

The WAI(C) and WAI-S(C) bond scales were modified for the Therapist

Attention and Understanding Survey by replacing the "_____" in each item with "my therapist." This is intended to increase the accuracy with which participants rate the therapeutic alliance for the clinical vignettes by facilitating their projection of self onto the client in the vignettes. Consequently, the WAI(C) and WAI-S(C) instructions were changed from "mentally insert the name of your therapist (counsellor) in place of _____in the text" (Horvath, 1984, p. 1) to "please respond how you imagine the client might think or feel about the therapist." Also, "if the statement describes the way you ***always*** feel (or think) circle the number 7; if it ***never*** applies to you circle the number one" (Horvath, 1984, p. 1) was changed to "If the statement describes the way you imagine the client always feels (or thinks) choose number 7; if you imagine it never applies to the client choose number 1."

The Therapist Attention and Understanding Survey was completed online at one time in approximately 10 to 15 minutes for each participant. Specifically, it was completed by participants reading the description of the therapist and client, responding to the WAI-S(C) bond scale how they imagine the client might think or feel, reading the session transcript, responding to the WAI(C) bond scale how they imagine the client might, and responding to the manipulation check questions and demographic questionnaire. Upon completing the survey, participants were offered entry into a drawing to win one of six gift cards for $100.00 at Amazon.com. Those who accepted entry into the drawing were linked from the Therapist Attention and Understanding Survey to a separate online Optional Drawing Survey (See Appendix H) where they submitted an email address that cannot be linked with their Therapist Attention and Understanding Survey data. Of the 291 participants, 264 (90.72%) accepted entry into

the drawing. Once data collection was complete, six email addresses were randomly drawn using the True Random Number Generator powered by Random.org on January 20, 2013. The gift cards were sent to these addresses in emails from Amazon.com.

Analysis

The analysis used to explore the research questions included Binomial tests, Fisher's Exact tests, Chi-Square tests, ANOVAs, and Steiger's Z-test. The Binomial, Fisher's Exact, and Chi-Square tests were used to determine whether the manipulations for levels of therapist attention and understanding were supported. A one-way between-subjects ANOVA with four levels was used to assess whether the therapeutic alliance for the identical descriptions of the therapist and client between the four session transcripts was rated similarly prior to the experimental manipulation. A 2 (therapist attention: attentive, inattentive) x 2 (therapist understanding: more, less) x 2 (WAI-S(C) bond scale administration: first, second) mixed-design ANOVA was used to assess if and how levels of therapist attention and understanding affected ratings on the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie. A 2 (attention perception: attentive, inattentive) x 2 (WAI-S(C) bond scale administration: first, second) mixed-design ANOVA was used to confirm the interaction between therapist attention and the WAI-S(C) bond scale administrations. Steiger's Z-test for correlated correlations assessed if the effect sizes of therapist attention and understanding were different. A 2 (therapist attention: attentive, inattentive) x 2 (therapist understanding: more, less) x 2 (prior therapy: yes, no) between-subjects ANOVA was used to assess whether prior therapy experience affected ratings on the therapeutic alliance for vignettes that varied on levels of therapist attention and understanding. A one-way between-subjects ANOVA

with four levels assessed if the therapeutic alliance for the four session transcripts was rated differently after the experimental manipulation.

IV. Results

The results of the present study were used to explore research questions regarding the effect of perceived therapist attention and understanding levels on ratings of the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie. Furthermore, the results were used to explore whether prior therapy experience affected ratings on the therapeutic alliance for vignettes that varied on levels of therapist attention and understanding. The study included both experimental and descriptive methods. Participants completed an online survey in which they read a brief description of a therapist and client, responded to the Working Alliance Inventory – Short Form C (WAI-S(C)) bond scale, read a brief session transcript, and responded to the Working Alliance Inventory Form C (WAI(C)) bond scale. The participants also responded to manipulation check questions and a demographic questionnaire. The sample included 291 members of the general public who reported living in the United States and being age 19 or older.

Before exploring the research questions, the researcher evaluated the effectiveness of the manipulations for levels of therapist attention and understanding. Binomial and Fisher's Exact tests were conducted to check the effectiveness of the manipulations for therapist attention. The Binomial test for the attentive therapist resulted in 99 of the 140 participants who were randomly assigned to the attentive therapist responding that the client saw the therapist as looking at, paying attention to, and listening to the client, which was statistically significant (*Observed Prop.* = .71, $p < .0005$) and better than what

would be expected to occur by chance. The Binomial test for the inattentive therapist resulted in 125 of the 151 participants randomly assigned to the inattentive therapist responding that the client saw the therapist as not looking at, paying attention to, or listening to the client, which was significant (*Observed Prop.* = .83, $p < .0005$) and better than expected by chance. Fisher's Exact test was used to confirm that the therapist attention levels were responded to differently with the below contingency table, which was significant with a large effect size ($p < .0005$, $\phi = .540$; See Table 1).

Table 1: Therapist Attention Contingency Table

	Attentive Therapist	*Inattentive Therapist*	*Row total*
Looking at, paying attention to, and listening to the client.	99	26	125
Not looking at, paying attention to, or listening to the client.	41	125	166
Column total	*140*	*151*	*291*

Consequently, the results of the Binomial and Fisher's Exact tests suggested that the manipulations for therapist attention were effective.

To check if the manipulations for therapist understanding were effective, Chi-Square tests were conducted. Specifically, a Chi-Square Goodness of Fit test for the therapist with more understanding resulted in 124 of the 142 participants who were randomly assigned to the therapist with more understanding responding that the therapist knew the same as or more than the client about what was going on inside of the client, which was statistically significant ($\chi^2(2) = 28.789$, $p < .0005$). A Chi-Square Goodness of Fit test for the therapist with less understanding resulted in 132 of the 149 participants randomly assigned to the therapist with less understanding responding that the client

knew more than the therapist about what was going on inside of the client, which was significant ($\chi^2(2) = 204.738$, $p < .0005$). A Chi-Square Test of Independence was used to confirm that the therapist understanding levels were responded to differently with the below contingency table, which was significant with a large effect size ($\chi^2(2) = 167.922$, $p < .0005$, $V = .760$; See Table 2).

Table 2: Therapist Understanding Contingency Table

	Therapist With More	*Therapist With Less*	*Row total*
The client knew more than the therapist about the client.	18	132	150
The therapist knew the same as the client about the client.	56	9	65
The therapist knew more than the client about the client.	68	8	76
Column total	*142*	*149*	*291*

To learn whether the therapist with more understanding was responded to as having known the same as or more than the client, Binomial and Fisher's Exact tests were conducted. A Binomial test for the attentive therapist with more understanding resulted in 27 of the 62 participants responding that this therapist knew the same as the client, which was not statistically significant (*Observed Prop.* = .44, $p = .374$). A Binomial test for the inattentive therapist with more understanding resulted in 29 of the 62 participants responding that this therapist knew the same as the client, which was not significant (*Observed Prop.* = .47, $p = .704$). Fisher's Exact test was used to confirm that the therapist with more understanding was responded to similarly with the below contingency table, which was also not significant ($p = .61$; See Table 3). Thus, the

Table 3: Therapist With More Understanding Contingency Table			
	Therapist With More	*Therapist With Less*	*Row total*
The therapist knew the same as the client about the client.	56	9	65
The therapist knew more than the client about the client.	68	8	76
Column total	*124*	*17*	*141*

results of these Chi-Square, Binomial, and Fisher's Exact tests suggested that the manipulations for therapist understanding were effective. Together, these results indicated that the manipulations for levels of therapist attention and understanding were supported.

Before exploring the first research question, the researcher assessed whether the therapeutic alliance for the identical descriptions of the therapist and client between the four session transcripts was rated similarly across all conditions using a one-way between-subjects ANOVA with four levels. Levine's Test of Equality of Error Variances was used with an alpha of .01 due to the ANOVA model being quite robust against the difference from a .05 alpha (D. George & P. Mallery, personal communication, June 2013) and homogeneity of variances was found for the first administration of the WAI-S(C) bond scale ($F(3, 287) = 2.664$, $p = .048$). This one-way ANOVA did not produce any statistically significant differences between the four transcripts ($F(3, 287) = .857$, $p = .464$) on the initial rating prior to the experimental manipulation. Table 4 contains the descriptive statistics for the first WAI-S(C) bond scale administration. Hence, the results of this one-way ANOVA indicated that the identical descriptions of the therapist and client were rated similarly across the four transcripts.

Table 4: First WAI-S(C) Bond Scale Administration for Session Transcripts					
	N	*M*	*SD*	*Range*	*α*
Attentive therapist with more understanding	69	14.51	4.010	7-23	.813
Attentive therapist with less understanding	71	14.49	3.469	7-24	.777
Inattentive therapist with more understanding	73	14.40	4.189	4-26	.896
Inattentive therapist with less understanding	78	15.26	3.325	8-23	.778
Total	*291*	*14.68*	*3.754*	*4-26*	*.821*

RQ1. To explore the first research question of if and how levels of therapist attention and understanding affected ratings on the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie, a 2 (therapist attention: attentive, inattentive) x 2 (therapist understanding: more, less) x 2 (WAI-S(C) bond scale administration: first, second) mixed-design ANOVA was conducted. Again, Levine's Test of Equality of Error Variances was used with an alpha of .01 and homogeneity of variances was found for the second administration of the WAI-S(C) bond scale ($F(3, 287) = 3.112$, $p = .027$). This mixed-design ANOVA for the therapist attention and understanding levels and first and second WAI-S(C) bond scale administrations resulted in three statistically significant main effects. Specifically, these significant main effects were for therapist attention with a small effect size ($F(1, 287) = 8.439$, $p = .004$, $\eta_p^2 = .029$), therapist understanding with a large effect size ($F(1, 287) = 82.483$, $p < .0005$, $\eta_p^2 = .223$), and the WAI-S(C) bond scale administrations with a small effect size ($F(1, 287) = 6.299$, $p = .013$, $\eta_p^2 = .021$). However, the three main effects were qualified by two statistically significant interactions. Particularly, one significant interaction was between therapist attention and the WAI-S(C) bond scale administrations with a medium effect

size ($F(1, 287) = 33.925$, $p < .0005$, $\eta_p^2 = .106$) whereas the other was between therapist understanding and the WAI-S(C) bond scale administrations with a large effect size ($F(1, 287) = 244.742$, $p < .0005$, $\eta_p^2 = .460$; See Table 5).

Table 5: 2 x 2 x 2 Mixed-Design ANOVA Summary

	df	*MS*	*F*	η_p^2
Tests of Between-Subjects Effects				
A. Therapist Attention	1	155.107	8.439	.029**
B. Therapist Understanding	1	1516.001	82.483	.223**
A x B Interaction	1	32.444	1.765	.006
Error	287	18.379		
Tests of Within-Subjects Effects				
C. Bond Scale Administration	1	49.886	6.299	.021*
A x C Interaction	1	268.675	33.925	.106**
B x C Interaction	1	1938.297	244.742	.460**
A x B x C Interaction	1	.188	.024	.000
Error	287	7.920		

*Note: ** = significant at .01 level; * = significant at .05 level*

Consequently, Simple Main Effects tests were used to understand these interactions.

Testing the simple main effects for the interaction between therapist attention and the pre- and post-experimental exposure administrations of the WAI-S(C) bond scale revealed that across administrations, scores on the WAI-S(C) bond scale significantly differed within the attentive therapist ($F(1, 287) = 5.296$, $p = .022$, $\eta_p^2 = .018$) and inattentive therapist ($F(1, 287) = 36.078$, $p < .0005$, $\eta_p^2 = .112$) levels with small and medium effect sizes, respectively. For the attentive therapist, an inspection of means revealed that ratings of the therapeutic alliance increased from pre- ($M = 14.50$, $SD = 3.762$) to post-exposure ($M = 15.22$, $SD = 5.189$) to manipulation of therapist attention.

For the inattentive therapist, the inspection of means revealed that ratings of the therapeutic alliance decreased from pre- (M = 14.84, SD = 3.753) to post-exposure (M = 12.78, SD = 4.619) to manipulation of therapist attention. The pattern of change in opposite directions on ratings of the therapeutic alliance by participants who were exposed to the attentive and inattentive therapists reached statistical significance for both therapist attention levels, which supported an effect for improved therapeutic alliance ratings when exposed to attentive therapists. The interaction between therapist attention and the WAI-S(C) bond scale administrations is plotted in Figure 1.

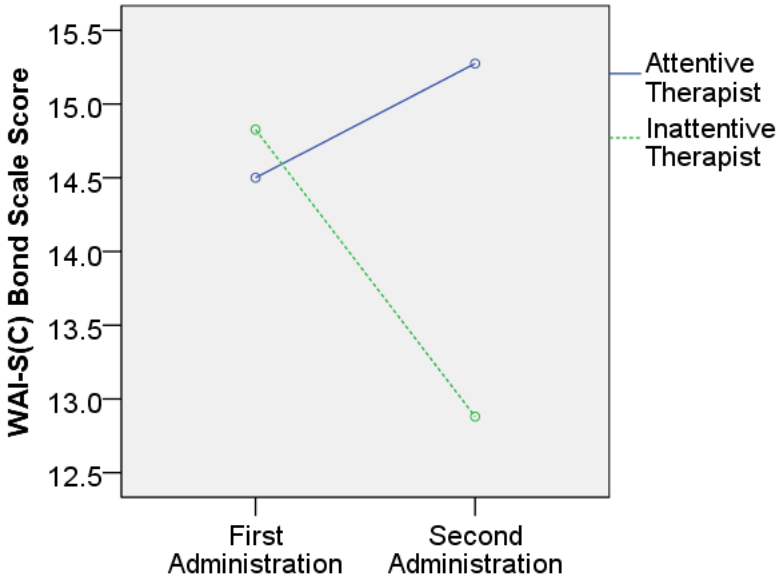

Figure 1. Therapist Attention and WAI-S(C) Bond Scale Administration Interaction.

Statistical analysis confirmed the pattern of change for therapist attention through t-tests of means. The therapist attention levels were not different for the first WAI-S(C) bond scale administration (F(1, 287) = .549, p = .459). Yet, the therapist attention levels were significantly different for the second WAI-S(C) bond scale administration (F(1,

287) = 34.148, $p < .0005$, $\eta_p^2 = .106$, medium effect size). Because mean scores on the second WAI-S(C) bond scale administration were higher for participants exposed to the attentive therapist, the significant difference indicated that the therapeutic alliance was rated more positively when individuals were exposed to the attentive therapist in comparison with the inattentive therapist. Combined with the significant simple main effects of WAI-S(C) bond scale administration, exposure to the attentive therapist increased therapeutic alliance ratings and exposure to the inattentive therapist decreased therapeutic alliance ratings.

Testing the simple main effects for the interaction between therapist understanding and the pre- and post-experimental exposure administrations of the WAI-S(C) bond scale revealed that across administrations, scores on the WAI-S(C) bond scale significantly differed within the therapist with more understanding ($F(1, 287) = 84.289$, $p < .0005$, $\eta_p^2 = .227$) and therapist with less understanding ($F(1, 287) = 168.723$, $p < .0005$, $\eta_p^2 = .370$) levels with large effect sizes each. For the therapist with more understanding, an inspection of means revealed that ratings of the therapeutic alliance increased from pre- ($M = 14.45$, $SD = 4.084$) to post-exposure ($M = 17.48$, $SD = 3.904$) to manipulation of therapist understanding. For the therapist with less understanding, the inspection of means revealed that ratings of the therapeutic alliance decreased from pre- ($M = 14.89$, $SD = 3.411$) to post-exposure ($M = 10.59$, $SD = 3.466$) to manipulation of therapist understanding. The pattern of change in opposite directions on ratings of the therapeutic alliance by participants who were exposed to the therapists with more and less understanding reached statistical significance for both therapist understanding levels, which supported an effect for improved therapeutic alliance ratings when exposed to

therapists with more understanding. The interaction between therapist understanding and the WAI-S(C) bond scale administrations is plotted in Figure 2.

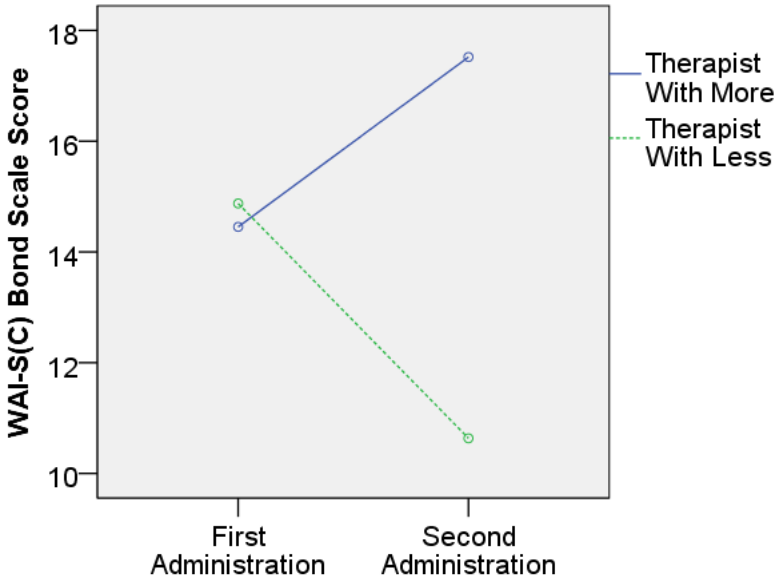

Figure 2. Therapist Understanding and WAI-S(C) Bond Scale Administration Interaction.

Statistical analysis confirmed the pattern of change for therapist understanding through t-tests of means. The therapist understanding levels were not different for the first WAI-S(C) bond scale administration ($F(1, 287) = .918$, $p = .339$). Still, the therapist understanding levels were significantly different for the second WAI-S(C) bond scale administration ($F(1, 287) = 282.469$, $p < .0005$, $\eta_p^2 = .496$, large effect size). Because mean scores on the second WAI-S(C) bond scale administration were higher for participants exposed to the therapist with more understanding, the significant difference indicated that the therapeutic alliance was rated more positively when individuals were exposed to the therapist with more understanding in comparison with the therapist with less understanding. Combined with the significant simple main effects of WAI-S(C)

bond scale administration, exposure to the therapist with more understanding increased therapeutic alliance ratings and exposure to the therapist with less understanding decreased therapeutic alliance ratings.

Because the manipulations for therapist attention were supported less than the manipulations for therapist understanding, a 2 (attention perception: attentive, inattentive) x 2 (WAI-S(C) bond scale administration: first, second) mixed-design ANOVA was conducted to confirm the interaction between therapist attention and the WAI-S(C) bond scale administrations. As before, homogeneity of variances was found for the first ($F(1, 289) = 1.593$, $p = .208$) and second ($F(1, 289) = .754$, $p = .386$) administrations of the WAI-S(C) bond scale. This mixed-design ANOVA for the attention perception responses and two WAI-S(C) bond scale administrations resulted in one statistically significant main effect for attention perception with a large effect size ($F(1, 289) = 57.926$, $p < .0005$, $\eta_p^2 = .167$). However, this significant main effect was qualified by a statistically significant interaction between attention perception and the WAI-S(C) bond scale administrations with a large effect size ($F(1, 289) = 60.289$, $p < .0005$, $\eta_p^2 = .173$; See Table 6).

Table 6: 2 x 2 Mixed-Design ANOVA Summary

	df	*MS*	*F*	η_p^2
Tests of Between-Subjects Effects				
A. Attention Perception	1	1163.776	57.926	.167**
Error	289	20.091		
Tests of Within-Subjects Effects				
B. Bond Scale Administration	1	22.416	1.742	.006
A x B Interaction	1	775.859	60.289	.173**
Error	289	12.869		

*Note: ** = significant at .01 level; * = significant at .05 level*

Thus, Simple Main Effects tests were used to understand the significant interaction.

Testing the simple main effects for the interaction between attention perception and the pre- and post-experimental exposure administrations of the WAI-S(C) bond scale revealed that across administrations, scores on the WAI-S(C) bond scale significantly differed between participants who perceived the therapist as attentive ($F(1, 289) = 18.203$, $p < .0005$, $\eta_p^2 = .059$, medium effect size) and inattentive ($F(1, 289) = 48.030$, $p < .0005$, $\eta_p^2 = .143$, large effect size). For the participants who perceived the therapist as attentive, an inspection of means revealed that ratings of the therapeutic alliance increased from pre- ($M = 14.98$, $SD = 3.888$) to post-exposure ($M = 16.91$, $SD = 4.574$) to manipulation of therapist attention. For those who perceived the therapist as inattentive, the inspection of means revealed that ratings of the therapeutic alliance decreased from pre- ($M = 14.45$, $SD = 3.646$) to post-exposure ($M = 11.72$, $SD = 4.166$) to manipulation of therapist attention. The pattern of change in opposite directions on ratings of the therapeutic alliance by participants who perceived the therapist as either attentive or inattentive reached statistical significance for both attention perceptions, which supported an effect for improved therapeutic alliance ratings when perceiving therapists as attentive. The interaction between attention perception and the WAI-S(C) bond scale administrations is plotted in Figure 3.

Statistical analysis confirmed the pattern of change for attention perception through t-tests of means. The attention perceptions were not different for the first WAI-S(C) bond scale administration ($F(1, 289) = 1.392$, $p = .239$). Yet, the attention perceptions were significantly different for the second WAI-S(C) bond scale administration ($F(1, 289) = 101.679$, $p = < .0005$, $\eta_p^2 = .260$, large effect size). Because

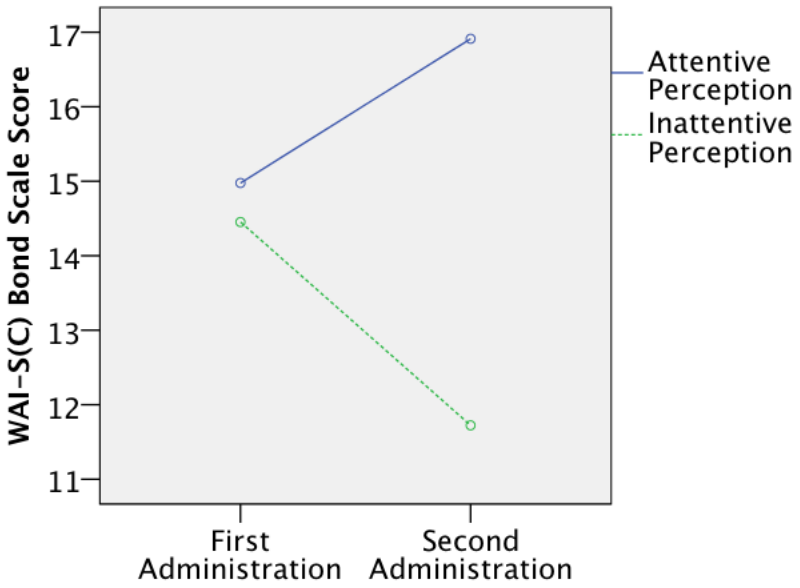

Figure 3. Attention Perception and WAI-S(C) Bond Scale Administration Interaction.

mean scores on the second WAI-S(C) bond scale administration were higher for participants who perceived the therapist as attentive, the significant difference indicated that the therapeutic alliance was rated more positively when individuals perceived the therapist as attentive in comparison with inattentive. Combined with the significant simple main effects of WAI-S(C) bond scale administration, perceiving the therapist as attentive increased therapeutic alliance ratings and perceiving the therapist as inattentive decreased therapeutic alliance ratings. The descriptive statistics for the second WAI-S(C) bond scale administration are listed in Table 7. Hence, the results of this mixed-design ANOVA confirmed the therapist attention and WAI-S(C) bond scale administration interaction using participant perception of attention.

To learn if the effect sizes of therapist attention and understanding were different using participant manipulation assignment, Steiger's Z-test was conducted. For this

Table 7: Second WAI-S(C) Bond Scale Administration for Session Transcripts					
	N	*M*	*SD*	*Range*	*α*
Attentive therapist with more understanding	69	18.97	3.569	12-26	.816
Attentive therapist with less understanding	71	11.58	3.710	4-20	.869
Inattentive therapist with more understanding	73	16.07	3.698	8-24	.872
Inattentive therapist with less understanding	78	9.69	2.977	4-20	.861
Total	*291*	*13.95*	*5.044*	*4-26*	*.930*

statistical analysis, the effect sizes of therapist attention (η_p^2 = .029) and understanding (η_p^2 = .223) and the interaction between therapist attention and understanding (η_p^2 = .006) were transformed from partial eta-squared to Pearson's *r* by calculating their square roots. The Z-test compared these transformed coefficients and revealed that the effect sizes of therapist attention and understanding were significantly different ($z = 4.122$, $p < .0005$). Together, these results indicated that levels of therapist attention and understanding affected ratings on the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie and the effect size of therapist understanding was larger than the effect size of therapist attention for these vignettes.

RQ2. To explore the second research question of whether prior therapy experience affected ratings on the therapeutic alliance for vignettes that varied on levels of therapist attention and understanding, a 2 (therapist attention: attentive, inattentive) x 2 (therapist understanding: more, less) x 2 (prior therapy: yes, no) between-subjects ANOVA was conducted. Homogeneity of variances was found for the WAI(C) bond scale scores ($F(7, 283) = 1.895$, $p = .07$). This ANOVA between the therapist attention and understanding levels and prior therapy levels resulted in two statistically significant

main effects. One significant main effect was for therapist attention with a medium effect size ($F(1, 283) = 34.393$, $p < .0005$, $\eta_p^2 = .108$) whereas the other was for therapist understanding with a large effect size ($F(1, 283) = 231.326$, $p < .0005$, $\eta_p^2 = .450$). The main effect for prior therapy was not significant ($F(1, 283) = .005$, $p = .942$; See Table 8).

Table 8: 2 x 2 x 2 Between-Subjects ANOVA Summary

	df	*MS*	*F*	η_p^2
Tests of Between-Subjects Effects				
A. Therapist Attention	1	2583.234	34.393	.108**
B. Therapist Understanding	1	17374.829	231.326	.450**
C. Prior Therapy Experience	1	.404	.005	.000
A x B Interaction	1	125.048	1.665	.006
A x C Interaction	1	.602	.008	.000
B x C Interaction	1	266.011	3.542	.012
A x B x C Interaction	1	.508	.007	.000
Error	283	75.110		

*Note: ** = significant at .01 level; * = significant at .05 level*

Because no significant main effect or interaction was found for prior therapy experience, the results of this ANOVA suggested that those with therapy experience and those without therapy experience did not rate the therapeutic alliance differently. The descriptive statistics for the prior therapy levels are listed in Table 9.

Table 9: WAI(C) Bond Scale Scores for Prior Therapy Experience

	N	*M*	*SD*	*Range*	*α*
Have received counseling or therapy	196	21.24	12.992	-5-54	.925
Have not received counseling or therapy	95	21.16	11.898	-1-50	.911
Total	*291*	*21.16*	*12.625*	*-5-54*	*.920*

Together, these results indicated that prior therapy experience did not affect ratings on the therapeutic alliance for vignettes that varied on levels of therapist attention and understanding.

To assess if the therapeutic alliance for the four session transcripts was rated differently, a one-way between-subjects ANOVA with four levels was conducted. Homogeneity of variances was found for the WAI(C) bond scale scores ($F(3, 287) = 3.474$, $p = .017$). This one-way ANOVA produced statistically significant differences between the four transcripts ($F(3, 287) = 109.789$, $p < .0005$) on the rating after the experimental manipulation. Consequently, the Bonferroni Post Hoc test was used to understand these differences. Specifically, pairwise comparisons for each possible pair revealed significant differences between all four transcripts ($p \leq .005$). The descriptive statistics for the WAI(C) bond scale scores are listed in Table 10.

Table 10: WAI(C) Bond Scale Scores for Session Transcripts

	N	*M*	*SD*	*Range*	*α*
Attentive therapist with more understanding	69	34.03	8.966	14-54	.869
Inattentive therapist with more understanding	73	26.18	9.959	0-44	.896
Attentive therapist with less understanding	71	15.27	8.048	0-35	.800
Inattentive therapist with less understanding	78	10.44	7.545	-5-35	.799
Total	*291*	*21.16*	*12.625*	*-5-54*	*.920*

Thus, the results of this ANOVA suggested that the transcripts were rated from highest to lowest as the attentive therapist with more understanding, the inattentive therapist with more understanding, the attentive therapist with less understanding, and the inattentive

therapist with less understanding.

To summarize, the results of the study were used to explore the experimental manipulation and research questions. After confirming that the manipulations for levels of therapist attention and understanding were supported, statistical analyses revealed that the identical descriptions of the therapist and client were rated similarly across the four session transcripts prior to the experimental manipulation. Moreover, analyses revealed that the therapist attention and understanding levels affected ratings on the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie. Specifically, the effect size of therapist understanding was larger than the effect size of therapist attention and the therapeutic alliance for the four transcripts was rated differently after the experimental manipulation. Prior therapy experience did not affect ratings on the therapeutic alliance for these vignettes.

V. Discussion

Reverie, or a therapist's daydreaming during therapy, is theorized to represent an aspect of transference-countertransference that provides a unique opportunity for attending to the experience of clients (Ogden, 1994). Although using reverie to help clients gain greater understanding was originally suggested for analysts who use the couch and are out of view from patients, this psychoanalytic technique has since been suggested for use in face-to-face therapy (Cwik, 2011). Because no known quantitative research related to the use of reverie has been published to date and its underlying processes might affect the therapeutic alliance through perceived therapist inattention and understanding (Ackerman & Hilsenroth, 2001, 2003), it is unclear whether this technique is applicable to psychotherapy in which the therapist and client face one another. Consequently, the present study was designed to assess whether clients feeling understood by their therapist could help offset the negative impact of being ignored on the therapeutic alliance.

To maximize experimental control and avoid the need to violate the confidentiality of real therapy clients, vignettes were used to research how the processes that underlie using reverie might affect the therapeutic alliance. This alternative method required using the phenomenon of assumed similarity (Beer & Watson, 2008). Because vignettes about other people have been demonstrated to affect participants (Cavallo et al., 2012), assumed similarity was used so that members of the general public rated the therapeutic alliance for a clinical vignette as if they were the client in the vignette by

projecting their self-concepts onto the client.

Due to the questions raised by the use of reverie and need for quantitative research related to reverie, the present study was designed to explore two research questions. The first question was, "Do levels of therapist attention and understanding affect ratings on the therapeutic alliance for clinical vignettes as processes that underlie using or ignoring reverie, and if so, how?" The second question was, "Does prior therapy experience affect ratings on the therapeutic alliance for vignettes that vary on levels of therapist attention and understanding?"

The results of the manipulation check indicated that the levels of therapist attention and understanding were sufficiently manipulated, which supported the internal validity of the study. Tests across the four conditions indicated that prior to the manipulation, ratings of the therapeutic alliance did not differ across groups, which decreased the likelihood that the differences found after the manipulation were due to unequal groups resulting from random assignment. Both the therapist attention and understanding levels resulted in significant differences on ratings of the therapeutic alliance and the effect sizes of each manipulation ranged from medium to large. The results indicated that participants who were exposed to the attentive therapist rated the therapeutic alliance more positively than both their initial ratings and individuals exposed to the inattentive therapist. In contrast, those exposed to the inattentive therapist rated the therapeutic alliance more negatively than their initial ratings. Similarly, participants who were exposed to the therapist with more understanding rated the therapeutic alliance more positively than both their initial ratings and individuals exposed to the therapist with less understanding. Those exposed to the therapist with less understanding rated the

therapeutic alliance more negatively than their initial ratings. Furthermore, the results indicated that the effect size of therapist understanding was larger than the effect size of therapist attention and the therapeutic alliance was rated differently between all four session transcripts.

The effect sizes of the significant interactions, main effects, and simple main effects ranged from small to large, which supports a need to explore the potential impact of therapist attention and understanding levels with real therapy clients. Because ratings of the therapeutic alliance did not differ across levels of prior therapy experience, it is unlikely that prior therapy experience accounted for how participants perceived the attentive and inattentive therapists with either more or less understanding. Alongside confirming how therapist distraction and attending to experience affect the therapeutic alliance (Ackerman & Hilsenroth, 2001, 2003), the results contribute to the psychotherapy outcome research through the positive impact of an attentive therapist and negative impact of a therapist with less understanding.

Although the research questions and their conclusions have implications for many psychotherapy processes, their significance for the therapeutic technique of using reverie is discussed. Because an analyst's daydreaming during analysis "is often viewed as something that the analyst must get through, put aside, overcome, etc. in his effort to be both emotionally present with and attentive to the analysand" (Ogden, 1994, p. 12), the present study informs psychotherapy researchers that further studies related to reverie are required to recommend whether therapists use or ignore reverie. Specifically, the conclusion for the first question that levels of therapist attention and understanding affected ratings on the therapeutic alliance for clinical vignettes implies that these

processes underlying the use of reverie affected the therapeutic alliance for the same vignettes. Thus, the processes that underlie using and ignoring reverie might affect the therapeutic alliance. Because no known research has measured whether levels of therapist attention and understanding affect the therapeutic alliance as processes that underlie using or ignoring reverie, this study is the first known quantitative research related to reverie.

The finding that the effect size of therapist understanding was larger than the effect size of therapist attention for the clinical vignettes implies that the positive impact of understanding client experience helped partially offset the negative impact of therapist distraction for these vignettes. Hence, the positive impact of understanding experience could help partly offset the negative impact of therapist distraction while using reverie during face-to-face therapy. These implications were confirmed by comparing the Working Alliance Inventory Form C (WAI(C)) bond scale scores for the session transcripts. Specifically, the mean transcript scores for this measure resulted in the transcripts being rated from highest to lowest as the attentive therapist with more understanding, the inattentive therapist with more understanding, the attentive therapist with less understanding, and the inattentive therapist with less understanding. These results suggest that between therapist attention and understanding levels, an attentive therapist with more understanding produces the best outcome.

Although many therapists strive to both pay attention to clients and attend to their experience, therapist distraction from these efforts is inevitable (Giambra, 2000). Consequently, quantitative studies are required to inform therapists to either use or ignore reverie. Because the transcripts with inattentive therapists with more and less

understanding represent processes that underlie using and ignoring reverie, these transcripts offer therapists information on the potential benefit and cost of this technique relative to therapist attention and understanding. Specifically, the inattentive therapist with more understanding was rated higher than the inattentive therapist with less understanding. Thus, using reverie might possibly produce better outcomes than ignoring it if using reverie can help therapists better attend to the client's experience than when ignoring it. However, this counterintuitive view remains subject to the efficacy of daydreaming as problem solving. Because no known research has measured whether daydreaming can help therapists attend to experience, the implications of the first question are limited and studies exploring if therapists can more effectively understand clients through their own daydreaming are needed.

Despite the limitations of the first question, its conclusions offer implications for the inevitability of therapist distraction. Specifically, the results suggest that therapists are to strive for both attention and understanding and attention is often needed for understanding. Yet, if daydreaming is a problem solving activity (Smallwood & Schooler, 2006), reverie potentially separates attention from understanding, each of which operated independently in the present study. Hence, what are therapists to strive for when they find themselves daydreaming during therapy? Ideally, therapists will resume striving for both attention and understanding. If they must privilege one over the other, the larger effect size of therapist understanding suggests that understanding is to be privileged. Regardless of whether therapists strive for both or privilege one, their use or ignoring of reverie will be determined by clinical skill and judgment. Particularly, using reverie requires knowledge of and skill with this technique and understanding of the

client. Theoretically, a therapist with knowledge of and skill with reverie could strive for attention and understanding by attempting the technique if his or her understanding of the client does not preclude doing so. If the therapist has knowledge, skill, and an understanding that precludes using reverie aloud at this time, he or she can strive for both through forming a silent interpretation (Spotnitz, 1985) to use later. A therapist with knowledge and either less skill or an understanding that precludes using reverie then is to privilege understanding and use attention as possible for this. Therapists with less knowledge of reverie will likely privilege attention in the service of understanding. These implications are consistent with the ethical imagination of therapists (Cooper, 2008) and Evidence-Based Practice in Psychology (APA Presidential Task Force on Evidence-Based Practice, 2006).

The finding that prior therapy experience did not affect ratings on the therapeutic alliance for vignettes that varied on levels of therapist attention and understanding implies that those with therapy experience and those without therapy experience rated the therapeutic alliance similarly for the same vignettes. Consequently, perception of the therapeutic alliance is not a function of prior therapy experience for these vignettes. Because no known research has measured whether public perception of the therapeutic alliance generalizes from those without therapy experience to those with therapy experience, the present study is the first known quantitative research on this generalization. This begins to establish external validity for the study across those with and without prior therapy experience.

The limitations of the present study include its method, design, and sample. Specifically, the method used clinical vignettes rather than in vivo research. To address

the limitations of experimentally studying the use of reverie with real therapy clients, vignettes were used as an alternative method to study the processes that underlie using reverie. Thus, the implications are limited to if and how the processes that underlie using and ignoring reverie could affect the therapeutic alliance and whether perception of the therapeutic alliance is a function of prior therapy experience for clinical vignettes. Furthermore, the study was designed to measure whether the processes that underlie using reverie support this technique as worthwhile when done effectively instead of its effectiveness. Because no known research has measured whether daydreaming can help therapists attend to client experience, the design found that efficacy studies on the technique are worthwhile. Hence, the implication that using reverie might possibly produce better outcomes than ignoring it is limited to the efficacy of daydreaming as problem solving. Also, the sample involved nonrandom members of the general public who live in the United States, use Facebook.com, and decided to participate in an online study rather than random members of the public in many countries.

The sample was limited by how representative it was of the general public in the United States. Although the sample was more representative of the United States in regard to age and annual household income, it was less representative regarding gender, ethnicity or race, and national region (U.S. Census Bureau, 2012). Specifically, the gender of the sample was 71.13% female compared with the United States having been 50.80% female in 2010. For ethnicity or race, 93.47% of the sample identified as White or Caucasian whereas 74.80% of the United States identified as such. Over half of the sample reported living in the South while more of the United States lived in the Northeast. These differences between the sample and United States are likely due to the

researcher posting the invitation for participation on his Facebook page.

The invitation for participation was initially visible to the researcher's friends on Facebook. These Facebook friends included 287 people of which 181 (63.07%) were female and 106 (36.93%) were male. Although the ethnicities or races with which these people identified are unknown, the researcher lived in the South from when he began using Facebook through the present study. Consequently, most of these friends lived in the South. Because the researcher was a doctoral candidate in counseling psychology during the study, 80 (27.88%) of his Facebook friends had experience providing counseling or psychotherapy. This ratio was higher than that of the United States and could have affected how these friends rated the therapeutic alliance for the clinical vignettes.

Due to the convenience system that was implemented through the invitation for participation and information letter, it is unclear whether the results generalize from this sample to others in the United States or other countries. Although this invitation helped recruit the minimum number of participants needed to validate the study, the anonymous survey made how representative the sample was of the researcher's friends unknown. Because the invitation was posted while the advertisement was running, the anonymous survey also made comparing those who responded to the advertisement with those who responded to the invitation impossible. Still, the advertisement received 16 clicks, making the maximum potential number of those who responded to the advertisement 16 and decreasing the likelihood that any differences from those who responded to the invitation significantly affected the results. Thus, the external validity of the implications is limited.

The study allowed for excellent control of the characteristics of the therapist and client reactions. Although this can increase internal validity, it ignores how therapist and client characteristics might affect client perception of therapist attention and understanding. For instance, clients who view therapists as experts could be more likely to believe that their therapist has the "definitive" understanding regardless of how they feel. Specifically, research has indicated that some clients prefer more directive therapists while others prefer less directive therapists (Fernbach, 1973). Because the clinical vignettes were limited with how they communicated nonverbal cues, the therapeutic alliance might have been rated differently for these vignettes than for other clinical presentations such as video recordings. Similarly, the manipulations for therapist attention were supported less than the manipulations for therapist understanding despite participants rating the therapeutic alliance congruently with both their assigned condition and perception of the therapist. This raises the question of what influences individuals to perceive the same therapist differently. Hence, differences in how therapist attention and understanding are conveyed and perceived limit the generalizability of the results.

Moreover, the limitations offer recommendations for further research. Specifically, methods using more direct alternatives to study the processes that underlie the use of reverie or in vivo research will more directly measure the effect of using reverie on the therapeutic alliance. Studies such as these would expand the implications of how the processes that underlie using and ignoring reverie could affect the therapeutic alliance to how using and ignoring reverie do affect the therapeutic alliance. Research designed to assess if daydreaming can help therapists attend to client experience will evaluate the efficacy of this technique. One future direction for exploring the use of

reverie involves therapists who are skilled at using reverie submitting summaries of the understandings that they derive from their daydreaming. If clients perceive these summaries as true to their experience, a next step of experimental study in therapy would be supported. This research would begin to establish whether using reverie might produce better outcomes than ignoring it. Samples involving others in the United States or other countries will clarify the generalizability of the results. Such studies would establish external validity for the implications.

In conclusion, the present study is the first known quantitative research related to reverie and whether public perception of the therapeutic alliance generalizes from those without therapy experience to those with therapy experience. The results imply that the processes underlying the use and ignoring of reverie might affect the therapeutic alliance. Furthermore, the positive impact of understanding client experience could help partly offset the negative impact of therapist distraction while using reverie during therapy, using reverie might possibly produce better outcomes than ignoring it, and perception of the alliance is not a function of prior therapy experience. Consequently, the results confirm how therapist distraction and attending to experience affect the therapeutic alliance (Ackerman & Hilsenroth, 2001, 2003) and contribute to the psychotherapy outcome research through the positive impact of an attentive therapist and negative impact of a therapist with less understanding. These implications were discussed in regard to their significance for therapeutic technique, limitations, and recommendations for further research. Together, the study begins dreaming the "undreamt dreams and interrupted cries" (Ogden, 2004b, p. 857) of quantitative research related to the use of reverie.

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Appendix A

Advertisement

Free $100 at Amazon.com!
Enter a drawing for 1 of 6 gift cards by taking a 10-15 minute anonymous survey on therapy

Appendix B

Invitation for Participation

Hi Friends! You are invited to participate in my dissertation study on therapy if you live in the U.S. and are age 19 or older. This study offers entry into a drawing to win 1 of 6 gift cards for $100 at Amazon.com by taking a 10-15 minute anonymous survey. Please click on the below link for more information and the survey. Regardless of whether you participate, please forward this information and link to others who live in the U.S. and are age 19 or older. Thank you!

https://auburn.qualtrics.com/SE/?SID=SV_diBfE92vRkmzl4N

Appendix C

Information Letter

Special Education, Rehabilitation and Counseling, 2084 Haley Center, Auburn, AL 36849, (334) 844-7676 phone, (334) 844-7677 fax, serc@auburn.edu

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT.)

INFORMATION LETTER
for a Research Study entitled
"Reverie and Psychotherapeutic Technique: Public Surveys on Therapist Attention, Client Understanding, and the Therapeutic Alliance"

You are invited to participate in a research study to learn what people imagine a client might think or feel about his or her psychotherapist during their most recent therapy session. The study is being conducted by Gregory J. Stevens, M.S., under the direction of John C. Dagley, Ph.D. in the Auburn University Department of Special Education, Rehabilitation and Counseling. You were selected as a possible participant because you live in the United States and are age 19 or older.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete a brief, anonymous, online survey. Your total time commitment will be approximately 10 to 15 minutes.

Are there any risks or discomforts? The risks associated with participating in this study are likely restricted to the possible emotional discomforts of imagining what a client might think or feel about his or her therapist during their most recent session. To minimize these risks, we will ask you brief anonymous questions about yourself afterward.

Are there any benefits to yourself or others? If you participate in this study, you can expect to learn what a client might think or feel about his or her therapist. We cannot promise you that you will receive any or all of the benefits described. Benefits to others may include improvement in the practice of psychotherapy based upon the implications of the results of this study.

Will you receive compensation for participating? To thank you for your time, you will be offered entry into a drawing to win one of six gift cards for $100.00 at Amazon.com. Entry requires submission of an email address that is separate from and cannot be linked with your survey.

If you change your mind about participating, you can withdraw at any time by closing your browser window. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Once you've submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation and Counseling, John C. Dagley, Ph.D., or Gregory J. Stevens, M.S.

Any data obtained in connection with this study will remain anonymous. We will protect your privacy and the data you provide by collecting no identifiable information other than an email address that is submitted separate from and cannot be linked with your survey. Information collected through your participation may be used to fulfill an educational requirement, published in a professional journal, and/or presented at a professional meeting, etc.

If you have questions about this study, please contact Gregory J. Stevens, M.S. at gjs0002@auburn.edu, (334) 332-1619 or John C. Dagley, Ph.D. at daglejc@auburn.edu, (334) 844-2978.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone at (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE CONTINUE BUTTON BELOW. YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

Regardless of whether you decide to participate, please forward the address for this webpage to as many friends or family members who live in the United States and are age 19 or older as you want. Doing so will make the results of this study more accurate. This webpage address is https://auburn.qualtrics.com/SE/?SID=SV_diBfE92vRkmzl4N.

Gregory J. Stevens, M.S. *12/5/2012*
Investigator Date

The Auburn University Institutional Review Board has approved this document for use from 12/1/12 to 11/30/13. Protocol #12-379 EP 1212.

CONTINUE WITH SURVEY

Appendix D

Therapist Attention and Understanding Survey (Session Transcript A)

Thank you for participating in this study! The following describes a psychotherapist and client and includes part of their most recent therapy session. As you read the description and part of their session, please imagine that you are the client. There are sentences that describe some of the different ways a person might think or feel about his or her therapist. As you read the sentences, please respond how you imagine the client might think or feel about the therapist. Below each statement 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 imagine the client always feels (or thinks) choose number 7; if you imagine it never applies to the client choose number 1. Use the numbers in between to describe the variations between these extremes.

The following describes a therapist and client:

> *The client has been working with the therapist for about three months. During this whole time, the client has been struggling to understand feelings and connect with other people. The client normally talks in a way that sounds tired and hopeless despite patiently struggling on in each session.*

Please respond how you imagine the client might think or feel:

I believe my therapist likes me.

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

I am confident in my therapist's ability to help me.

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

I feel that my therapist appreciates me.

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

My therapist and I trust one another.

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

The following is part of their most recent session:

Client: *When I drive up to my home, it's like it's not my home. When I walk inside, I'm greeted by "the family who lives there," but it's like they're not my family. It's like I'm not in the picture and yet I'm there. When I see that I don't fit in, it's a feeling of being separate, which is right next to feeling lonely. I know that I must be feeling something, but I don't have a clue as to what it might be!*

The client sees that the therapist is not looking at the client. The client feels like the therapist is not paying attention to the client. The client believes the therapist is not listening to the client, so the client continues talking:

Also, my friend is buried in work so we both feel drained at the end of the day, my other friend has lost all of his money so he will likely go bankrupt, and I was almost hit by a careless motorcyclist while jogging.

Therapist: *I think that you must feel like our time together is work you have to do and don't enjoy, something like a factory job where you punch in and out with a time card. I have the sense that it sometimes feels so hard to breathe in here with me that it must feel like being smothered by something that seems to be air, but actually sucks the air out.*

Client: *Yes! I sleep with the windows wide open because I am afraid of being smothered during the night! I often wake up scared that someone is smothering me, as if they have put a plastic bag over my head! It also feels smothering in here! When I walk into this room, it's always too warm and the air is too still. I never ask you to turn off the heater or open a window, mostly because I couldn't tell that I've felt smothered here until I said this to you. It's very moving to see how much you know about what's going on inside of me, even when a room feels too warm to me.*

Please respond how you imagine the client might think or feel:

I feel uncomfortable with my therapist.

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

My therapist and I understand each other.

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

I believe my therapist likes me.

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

I believe my therapist is genuinely concerned for my welfare.

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

My therapist and I respect each other.

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

I feel that my therapist is not totally honest about his/her feelings towards me.

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

I am confident in my therapist’s ability to help me.

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

I feel that my therapist appreciates me.

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

My therapist and I trust one another.

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

My relationship with my therapist is very important to me.

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

I have the feeling that if I say or do the wrong things, my therapist will stop working with me.

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

I feel my therapist cares about me even when I do things that he/she does not approve of.

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

Please respond for yourself rather than the client:

How did the client see the therapist?

- As looking at, paying attention to, and listening to the client
- As not looking at, paying attention to, or listening to the client

What did the client believe?

- That the client knew more than the therapist about what was going on inside of the client
- That the therapist knew the same as the client about what was going on inside of the client
- That the therapist knew more than the client about what was going on inside of the client

Please respond for yourself rather than the client:

Have you ever received counseling or psychotherapy?

- Yes
- No

What is your gender?

- Female
- Male

What is your age?

_____

What is your ethnicity or race?

- American Indian or Alaska Native
- Arab or Middle Eastern
- Asian or Pacific Islander
- Black or African American
- Hispanic or Latino/a
- White or Caucasian
- Other (please specify) _____

Where in the United States do you live?

- The Midwest
- The Northeast
- The South
- The West

What is your estimated annual household income?

- $25,000.00 or less
- $25,000.00 to $50,000.00
- $50,000.00 to $75,000.00
- $75,000.00 to $100,000.00
- $100,000.00 or more

In appreciation of your time, you are being offered entry into a drawing to win one of six gift cards for $100.00 at Amazon.com. To enter, you will be required to submit an email address so that you can be informed if you win. Your email address will be submitted to a separate survey that Qualtrics prevents from being linked with your anonymous responses to this survey. If you want to enter the drawing, please click on the link below.

LINK TO DRAWING

Appendix E

Session Transcript B

The following is part of their most recent session:

Client: *When I drive up to my home, it's like it's not my home. When I walk inside, I'm greeted by "the family who lives there," but it's like they're not my family. It's like I'm not in the picture and yet I'm there. When I see that I don't fit in, it's a feeling of being separate, which is right next to feeling lonely. I know that I must be feeling something, but I don't have a clue as to what it might be!*

The client sees that the therapist is not looking at the client. The client feels like the therapist is not paying attention to the client. The client believes the therapist is not listening to the client, so the client continues talking:

Also, my friend is buried in work so we both feel drained at the end of the day, my other friend has lost all of his money so he will likely go bankrupt, and I was almost hit by a careless motorcyclist while jogging.

Therapist: *These thoughts that include the idea of feeling drained, your friend going bankrupt, and the almost severe or even deadly accident, they reflect a theme that we have talked about before; your struggle to understand your feelings about all that you are talking about and how disconnected I feel from you and my own feelings.*

Client: *No! I sleep with the windows wide open because I am afraid of being smothered during the night! I often wake up scared that someone is smothering me, as if they have put a plastic bag over my head! It also feels smothering in here! When I walk into this room, it's always too warm and the air is too still. You never offer to turn off the heater or open a window, mostly because you couldn't tell that I've felt smothered here until I said this to you. It's very upsetting to see how little you know about what's going on inside of me, even when a room feels too warm to me.*

Appendix F

Session Transcript C

The following is part of their most recent session:

Client: *When I drive up to my home, it's like it's not my home. When I walk inside, I'm greeted by "the family who lives there," but it's like they're not my family. It's like I'm not in the picture and yet I'm there. When I see that I don't fit in, it's a feeling of being separate, which is right next to feeling lonely. I know that I must be feeling something, but I don't have a clue as to what it might be!*

The client sees that the therapist is looking at the client. The client feels like the therapist is paying attention to the client. The client believes the therapist is listening to the client, so the client continues talking:

Also, my friend is buried in work so we both feel drained at the end of the day, my other friend has lost all of his money so he will likely go bankrupt, and I was almost hit by a careless motorcyclist while jogging.

Therapist: *I think that you must feel like our time together is work you have to do and don't enjoy, something like a factory job where you punch in and out with a time card. I have the sense that it sometimes feels so hard to breathe in here with me that it must feel like being smothered by something that seems to be air, but actually sucks the air out.*

Client: *Yes! I sleep with the windows wide open because I am afraid of being smothered during the night! I often wake up scared that someone is smothering me, as if they have put a plastic bag over my head! It also feels smothering in here! When I walk into this room, it's always too warm and the air is too still. I never ask you to turn off the heater or open a window, mostly because I couldn't tell that I've felt smothered here until I said this to you. It's very moving to see how much you know about what's going on inside of me, even when a room feels too warm to me.*

Appendix G

Session Transcript D

The following is part of their most recent session:

Client: *When I drive up to my home, it's like it's not my home. When I walk inside, I'm greeted by "the family who lives there," but it's like they're not my family. It's like I'm not in the picture and yet I'm there. When I see that I don't fit in, it's a feeling of being separate, which is right next to feeling lonely. I know that I must be feeling something, but I don't have a clue as to what it might be!*

The client sees that the therapist is looking at the client. The client feels like the therapist is paying attention to the client. The client believes the therapist is listening to the client, so the client continues talking:

Also, my friend is buried in work so we both feel drained at the end of the day, my other friend has lost all of his money so he will likely go bankrupt, and I was almost hit by a careless motorcyclist while jogging.

Therapist: *These thoughts that include the idea of feeling drained, your friend going bankrupt, and the almost severe or even deadly accident, they reflect a theme that we have talked about before; your struggle to understand your feelings about all that you are talking about and how disconnected I feel from you and my own feelings.*

Client: *No! I sleep with the windows wide open because I am afraid of being smothered during the night! I often wake up scared that someone is smothering me, as if they have put a plastic bag over my head! It also feels smothering in here! When I walk into this room, it's always too warm and the air is too still. You never offer to turn off the heater or open a window, mostly because you couldn't tell that I've felt smothered here until I said this to you. It's very upsetting to see how little you know about what's going on inside of me, even when a room feels too warm to me.*

Appendix H

Optional Drawing Survey

You will be entered into the drawing to win one of six gift cards for $100.00 at Amazon.com by entering your email address in the box below. Your email address is submitted separate from and cannot be linked with your survey.

CONTINUE WITH SUBMISSION

Thank you!

You have been entered into the drawing. Amazon.com will send your gift card in an email if you win.