February, 2003

Representations of therapists by patients with personality disorders

Donna S. Bender
Barry A. Farber
Charles A. Sanislow, *Wesleyan University*
Ingrid R. Dyck
Jesse D. Geller, *Yale University*, et al.

Representations of Therapists by Patients with Personality Disorders*

DONNA S. BENDER, Ph.D.†
BARRY A. FARBER, Ph.D.‡
CHARLES A. SANISLOW, Ph.D.§
INGRID R. DYCK, M.P.H.‖
JESSE D. GELLER, Ph.D.#
ANDREW E. SKODOL, M.D.**

The purpose of this study was to investigate attributes of mental representations of therapists by patients with specific personality disorders (PDs), schizotypal (STPD), borderline (BPD), avoidant (AVPD), and obsessive-compulsive (OCPD), and a comparison group with Major Depressive Disorder and no PD (MDD). The Therapist Representation Inventory-II (TRI) measured characteristics of participants' extrasession thoughts about their therapists. Results showed that patients with STPD had the highest level of mental involvement with therapy outside the session, missing their therapists and wishing for friendship, while also feeling aggressive or negative. Patients with BPD exhibited the most difficulty in creating a benign image of the therapist. Variables such as gender, co-occurring Axis I disorders, and amount of individual psychotherapy received were significant covariates for a number of analyses. The importance of understanding the internal dynamics of patients' thoughts about their treatment relationship was underscored.

Over the past several decades, various notions of how people construct and use representations of themselves, others, and interpersonal interactions have infused both clinical theory and practice (1-8). Many theoretical

†Assistant Clinical Professor of Medical Psychology, Department of Psychiatry, Columbia University College of Physicians and Surgeons. ***Mailing address:*** New York State Psychiatric Institute, 1051 Riverside Drive, Box 129, New York, NY 10032.

‡Professor, Director of Clinical Training, Department of Counseling and Clinical Psychology, Teachers College, Columbia University.

§Assistant Professor, Department of Psychiatry, Yale University School of Medicine.

‖Masters Statistician, Department of Psychiatry and Human Behavior, Brown University.

#Associate Clinical Professor, Department of Psychiatry, Yale University School of Medicine.

**Professor of Clinical Psychiatry, Department of Psychiatry, Columbia University College of Physicians and Surgeons

*Supported by NIMH grants R10 MH 50837, 50839, & 50850. This publication has been reviewed and approved by the Publications Committee of the Collaborative Longitudinal Personality Disorders Study.

perspectives, invoking terms such as internalized object relationships or maladaptive schemas, view the intrapsychic representation of a person's earliest relationships as the focal point for understanding how one characteristically relates to others as an adult (3, 9-12). Furthermore, it is well accepted that patients' typical ways of interacting with, and thinking about, others become manifest in relationships with mental health professionals, and greatly influence psychosocial adjustment.

In searching for clues as to how the therapist might anticipate the nature of his or her function in the patient's representational scheme, various theories and classification systems have been considered. Considerable attention has been given to personality disorders and associated symptomatology as a way of understanding how a patient might typically utilize various defenses and construct views of his or her intrapsychic and interpersonal world. Indeed, a growing body of empirical evidence (3, 9, 13, 14) supports the notion that various pathologies may be differentiated on the basis of characteristic modes of conceptualizing and experiencing internalized objects and relationships. The purpose of the current study was to explore specifically the nature of therapist representations for patients afflicted with a broad range of personality disorders.

PATIENTS' REPRESENTATIONS OF THE TREATMENT RELATIONSHIP

Pine (15) has asserted that "change comes about through the *use* the patient makes of the therapist, whether the therapist wills it or not—in parallel to the use the child makes of the parent. The patient uses the therapist as an object of *identification*, a source of *education*, and a source of *confirmation*" (p. 171). This is a point of view that transcends theoretical orientation (at least within a broad range of psychodynamic and cognitive perspectives), and presumes that the patient goes through the process of symbolizing the therapist and the therapy relationship. Loewald (16) has characterized therapeutic action as being based on the patient's opportunity to internalize a new object relationship (with the therapist) so that more adaptive ways of relating to self and others can be established. Ideas such as these have increasingly become the focus of empirical investigations.

Using an indicator of the degree of differentiation and relatedness (17) reflected in descriptions of parents, self, and therapist, Stayner (18) found that only the mother and father representations were correlated at the beginning of treatment. However, by the time termination was reached, significant correlations of differentiation-relatedness were observed among all four of the descriptions. This demonstrates that the process of therapy

somehow activates both self and therapist constructs that become part of the internal representational language of the patient.

As noted earlier, pathological images of self and others may be related to psychosocial functioning, and so modifying these representations may be a powerful mutative factor in treatment. One study (19) demonstrated that changes over time in the qualities of patients' descriptions of mother, self, and therapist predicted changes in the severity of psychiatric disturbance. That is, increased differentiation-relatedness of descriptions was positively related to improvements in patient symptoms. Similarly, several other studies (1, 20) found that changes in self and object representations paralleled the work occurring in the patient-therapist relationship.

In trying to understand the role of therapist representations in the therapy process, Dorpat (10) became interested in how patients think about and utilize fantasies of the therapist when they are outside of the treatment room. He began to systematically note what he referred to as "analyst introject fantasies" of various patients. A common theme that emerged was the use of active representations of the transactions of psychotherapy, observations and interpretive functions of the therapist, indicating that the relationship is somehow internalized for use in continuing the therapy work between sessions. Further, it was noted that these images were often evoked when patients were attempting to gain comfort and understanding, as well as to regulate disturbed functioning.

Identifying a need to examine these phenomena in a more empirical manner, Geller, Cooley, and Hartley (21) created the Therapist Representation Inventory (TRI), a self-report instrument designed to yield a profile of various characteristics of patients' thoughts about the therapist and therapy relationship, including the content, forms, and functions of the representations. Underscoring the observation that patients use therapist images during times of separation from treatment, and that improving our understanding of the nature of these dynamics, might yield important insights into pathology and treatment efficacy. The TRI focuses specifically on patients' symbolization of the treatment process outside of the actual session, asking patients about their thoughts and emotions regarding the therapist and therapeutic experience. The TRI has been the basis for an ongoing multi-site research effort investigating patients' use of therapist representations (7, 22-25).

The initial standardization study (21) demonstrated that the most vivid and frequently evoked representations of the patients' therapists occur during times of stress, echoing the formulations of Dorpat (10). In a later study, Geller and Farber (7) explored the factors affecting the nature,

evocation, and use of therapist representations between sessions and after termination. The results showed that both current and former psychotherapy patients more frequently invoked therapist representations when experiencing painful emotions, and the more sessions they had of therapy, the greater the likelihood they would use therapist representations to continue working on problems. Another analysis (26) showed that female patients were more likely than male patients to use images of their therapists outside sessions when addressing problems, and women with male therapists were more likely to miss their therapists between sessions. Thus, there is evidence that patients mentally bring to life and continue the work of therapy in the absence of their therapists.

In addition to conditions under which patients utilize therapist representations, the TRI also assesses the functions the images may serve, measured by the Therapist Involvement Scale (TIS). Items of this subscale are individually informative, but are also analyzed based on a factor analysis that generated the following factors: *Sexual/Aggressive Involvement, Wish for Reciprocity, Continuing the Therapeutic Dialogue, Failure of Benign Internalization*, *Effort to Create an Introject,* and *Mourning*. Two studies (7, 22) employing the TRI have demonstrated a significant relationship between *Continuing the Therapeutic Dialogue* and positive therapeutic outcome. Similarly, *Failure of Benign Internalization* has been significantly correlated with lack of improvement in treatment.

PERSONALITY DISORDERS

It has been suggested that different kinds of psychopathology may be distinguished by contrasts in particular patterns of internalized object relations (11). Personality disorder (PD) typology is a taxonomic paradigm that can serve as a proxy for recurrent or established patterns in representations of others. Individuals with PDs, by definition, have characteristic and problematic ways of thinking about self and others. For instance, Schore (27) has maintained that borderline pathology is associated with unstable internal representations that "encode a dysregulated self-in-interaction-with-a-misattuning-other" (p. 38). And Shapiro (28) has asserted that those with obsessive-compulsive character styles, with a constant eye toward rules and regulations and a never-ending list of "shoulds," guard against any meaningful consideration of their impulses toward others.

Blatt and Lerner (9) tested the hypothesis that there may be different types of distortions of representations of others associated with various forms of psychopathology. Applying an object-relational scoring system to

Rorschach human-figure responses, they showed that there are, in fact, significant differences between representational patterns of psychotic, depressed, borderline, and hysterical patients. With a nonparanoid schizophrenic patient, representations were both inaccurate and at low levels of differentiation. The content was essentially barren with little interaction among human figures. The representations of depressed patients were usually accurate, with superficial elaboration, portraying people as frightening and undependable. As testing progressed, the borderline patients showed deterioration from essentially accurate, fully formed figures to inaccurate, inappropriately elaborated ones. Individuals diagnosed as hysteric, while able to produce accurate descriptions, focused more on physical details rather than personal attributes. Several other studies (3, 13, 14) showed borderline patients exhibiting much more malevolent representations, compared to other groups.

One exploratory analysis (29) using the TRI, demonstrated a significant positive correlation between patients' avoidant, dependent, passive-aggressive, self-defeating, and schizotypal tendencies, and resistance to, or impairment in, forming a benign therapist introject. In addition, those with borderline, self-defeating, and passive-aggressive traits exhibited a preoccupation with negatively tinged therapist images. However, schizotypal traits were also associated with longing for gratifying aspects of the treatment, and dependent attributes were significantly correlated with the attempt to continue the therapeutic dialogue outside of sessions. Furthermore, these patterns of cognitions became apparent after only a few sessions of treatment. This study also found significant negative treatment outcome associated with failure to create a benign internalization of the therapist and preoccupation with negative thoughts about therapy, and a significant positive relationship between various outcome variables and patients' ability to continue the therapeutic dialogue outside of sessions.

Patients with PDs inevitably display certain characteristic patterns of thinking and behaving that are associated with disturbances in functioning, particularly in the interpersonal realm. The ability to participate productively in any treatment endeavor is influenced to a considerable extent by the way the patient is apt to think about and use the relationship with the therapist. Clinically, we know that patients with PDs are more difficult to treat because their impairments are fundamentally social in nature, which may, in turn, interfere with the ability to perceive the therapist as a helpful entity. Moreover, patients may behave in sessions in certain ways while being reticent, because of paranoia or other inhibitions, to reveal what they might actually be thinking, or simply because they are unaware of certain

thoughts and feelings about the therapy relationship. Both theoretical and clinical approaches to patients with PDs can be better informed by empirical data regarding their representational worlds in the context of the treatment relationship.

The Collaborative Longitudinal Personality Disorders Study (CLPS) has afforded the opportunity to pursue this line of inquiry. CLPS is an NIMH-funded, multi-site project designed to assess treatment-seeking patients meeting criteria for specific PDs representing the spectrum of character pathology, schizotypal (STPD), borderline (BPD), avoidant (AVPD), and obsessive-compulsive (OCPD), and a comparison group of patients with major depressive disorder and no personality disorder (MDD). (A more detailed description of the sample, including the overview and rationale for the CLPS, is available elsewhere [30]). This is a heterogeneous population, and is the first application of the TRI to a rigorously diagnosed sample.

Assessing the five CLPS study groups using the TRI, we explored the functions of patients' extrasession representations of their therapists, as measured by the TIS subscale. In order to evaluate the role of variables previously addressed in the literature, and others of potential concern, we examined the effects of co-occurring Axis I disorders, gender, age, race, number of co-occurring PDs, and lifetime number of months of individual psychotherapy received. In addition, we analyzed the relationship between attributes of therapist representations and level of psychosocial functioning.

METHOD

Participants

For this study, treatment-seeking individuals, aged 18 to 45 years, were recruited from clinical services affiliated with two of the four CLPS sites, Columbia and Yale. Potential participants were prescreened to exclude patients with active psychosis; acute substance intoxication or withdrawal; or a history of schizophrenia, schizoaffective, or schizophreniform disorders. All eligible participants who began the assessment signed written informed consent after the research procedures had been fully explained. The total number of participants was 201, and each of these individuals was assigned to one of the five study groups at intake: STPD (N=25), BPD (N=49), AVPD (N=51), OCPD (N=59), or MDD (with no PD) (N=17). The sample is 70% female, 66% Caucasian, 16% African-American, 15% Hispanic, 3% Asian. The group is also evenly distributed across all sectors of 18 to 45 age range.

Measures

The Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV; 31) was used to assess participants for PDs, and the follow-along version of the Longitudinal Interval Follow-up Evaluation Adapted for the Personality Disorders Study (LIFE-PS; 32) measured psychosocial functioning, Axis I pathology, and treatment received. All participants were interviewed by experienced masters or doctoral-level raters trained to adequate levels of diagnostic reliability (33) using live or videotaped interviews under the supervision of certified LIFE trainers at Brown University and one of the CLPS investigators and co-author of the DIPD-IV at McLean Hospital (M. Zanarini).

Participants were assigned to one of five CLPS cells, determined by an a priori algorithm. Cell assignment was based on DIPD-IV diagnoses, supplemented with convergent information from the Schedule for Nonadaptive and Adaptive Personality (SNAP; 34) and the Personality Assessment Form (PAF; 35). For inclusion in the MDD comparison group, participants had fewer than 15 total criteria on the DIPD-IV, and did not have features (i.e., at least two criteria below threshold) of any PD diagnosis.

The Therapist Representation Inventory-II (TRI; 36) was used to assess participants' mental representations of their therapists. Participants at the Columbia and Yale sites were asked to complete the instrument along with the standard CLPS protocol administered at either six months or one year after intake. The TRI is a self-report instrument that consists of five sections: an outcome scale, the Therapist Involvement Scale (TIS), the Therapist Embodiment Scale (TES), a Feelings Scale, and a request for an open-ended response to the directive "Please describe your therapist (take five minutes)." Only the TIS results were analyzed for the present study.

The TIS is a 37-item inventory investigating conscious content, or function, of the patient's thoughts about the therapist outside of sessions. Items like "I imagine being held by my therapist," "I wish more of my relationships were like the one with my therapist," and "I hope I never have to be in therapy again" are rated on a 9-point scale ranging from 1 = "Not at all typical" to 9 = "Highly typical." Factor analyses (21) of the TIS generated six factors (alpha reliabilities ranged from .67 to .86):

1. *Sexual/Aggressive Involvement*, having to do with fantasies of being physically involved with therapist, e.g., "I imagine having sex with my therapist" and "I imagine hurting my therapist in some way."
2. *Wish for Reciprocity*, involving wishes to interact with the therapist

in more informal and personal ways, such as "I imagine our sharing a meal" and "I wish I could be friends with my therapist."

3. *Continuing the Therapeutic Dialogue*, characterized by active mental effort on the patient's part to utilize the work done in treatment. Item examples are "I try to solve problems the way my therapist and I worked on them in psychotherapy" and "When I am having a problem, I try to work it out with my therapist in mind."
4. *Failure of Benign Internalization*, reflecting difficulty in productively using treatment, or pessimism about its prospects. Sample items are "I don't think therapy will have a lasting effect on me" and "I wish I had a different therapist."
5. *Effort to Create a Therapist Introject*, associated with attempts to strengthen the constancy of the representations of the therapist relationship, such as "I find myself looking for my therapist when I am out in a crowd" and "I daydream about my therapist."
6. *Mourning*, experiencing the pain of separation from the therapist, evidenced in statements like "I miss my therapist" and "I think about contacting my therapist."

As a number of participants were treated by more than one mental health professional, each person was asked to identify the specific treatment they were thinking about when answering the TRI questions. Most people (80% or 161) were participating in or had recently had individual psychotherapy. An additional eight percent (n = 16) specified their group therapy leaders, and twelve percent (n = 24) designated their psychiatrist seen for medication follow-ups.

Data Analysis

Means and standard deviations were calculated for the TIS items and factors. For an overall involvement variable (a sum of all the TIS items) and the six TIS factors, SAS general linear models were used to compare means among the five study groups, including Duncan post hoc comparisons. In each model, race, gender, age, number of co-occurring Axis I disorders, number of co-occurring Axis II disorders, and lifetime number of months of individual psychotherapy were controlled. Pearson product-moment correlations (two-tailed) were used to relate the TIS factors to two measures of psychosocial functioning: Global Assessment of Functioning (GAF; 37) and the participant's level of overall satisfaction (SAT), both assessed as part of the LIFE-PS procedure. SAS was used to conduct all analyses (38).

RESULTS

Functions of Therapist Representations

Table I presents a group comparison of the TIS total score, which serves as a proxy for the overall amount of extrasession mental involvement with thoughts of therapy reported as characteristic. Results show that the STPD patients reported significantly more involvement with therapy representations than the AVPD, OCPD and MDD groups. Gender, Axis I, and amount of individual treatment received also contributed to group differences.

For the six TIS factors, the STPD group had the highest mean, except for *Failure of Benign Internalization*, where the BPD mean was the highest. Significant differences among the groups were found for *Sexual/Aggressive Involvement*, *Wish for Reciprocity*, *Continuing the Therapeutic Dialogue*, and *Mourning*. However, in no case did assignment to a PD or MDD group primarily account for the differences. For the *Sexual/Aggressive Involvement* factor, the significant variables in the model were gender and length of treatment. Gender and number of Axis I disorders accounted for differences in *Wish for Reciprocity*, while Axis I explained the *Continuing the Therapeutic Dialogue* variation, and treatment was the significant covariate for the *Mourning* analysis. Post hoc analyses for the six factors showed an interaction effect between STPD and gender, namely, the male schizotypal patients reported the highest means. The number of co-occurring Axis I disorders was also positively correlated with the factors, as was lifetime months of individual psychotherapy.

Table II presents the three highest means and the three lowest means by group for the individual TIS items. Although Items 22, 24 and 33 had the highest means for all of the PD groups, emphasis varied by type of PD. The highest means for each group were: STPD — Item 33, "I look forward to returning to sessions with my therapist" (M=5.4); BPD – Item 22, "I would like my therapist to be proud of me" (M=5.0); AVPD (M= 4.6) and OCPD (M=4.0) – Item 24, "I try to solve my problems in the way my therapist and I worked on them in psychotherapy." While items 22 and 24 were also among the highest means for the MDD group, the item most strongly endorsed by these participants was Item 15, "I hope I never have to be in therapy again (M=4.2)." All of the groups, except the BPD patients, rated Item 36, "I imagine hurting my therapist in some way," as one of the three phrases least likely to characterize thoughts of their therapists. Although STPD patients rated Item 34, "I imagine being sexually involved with my therapist," as one of the lowest, on average, the

Table I. COMPARISON OF GROUP MEANS: TIS TOTAL SCORE, FUNCTIONS, AND EMOTIONS, CONTROLLING FOR DEMOGRAPHICS, CO-OCCURRING AXIS I AND AXIS II DISORDERS, AND LIFETIME MONTHS OF INDIVIDUAL PSYCHOTHERAPY

	STPD (N = 21) Mean (SD)	BPD (N = 46) Mean (SD)	AVPD (N = 47) Mean (SD)	OCPD (N = 54) Mean (SD)	MDD (N = 14) Mean (SD)	Group Differences
Therapist Involvement Scale-Total Score (TIS)[1] (Range: 37–258)	117.1 (61.4)	99.4 (40.4)	90.2 (31.4)	83.1 (33.5)	80.4 (21.3)	S > A, O, M
Functions						
Sexual/Aggressive Involvement[2] (Range: 5–41)	9.7 (12.0)	6.8 (6.1)	6.2 (3.7)	5.4 (1.1)	5.2 (2.2)	S > B, A, O, M
Wish for Reciprocity[3] (Range: 9–67)	28.1 (16.0)	22.3 (11.8)	20.6 (11.7)	18.3 (10.1)	17.0 (8.5)	S > A, O, M
Continuing the Therapeutic Dialogue[4] (Range: 4–35)	16.6 (8.7)	12.7 (6.6)	12.6 (6.5)	11.5 (7.1)	11.4 (5.7)	S > B, A, O, M
Failure of Benign Internalization (Range: 9–69)	26.6 (15.7)	28.3 (13.4)	23.3 (9.3)	22.0 (11.7)	23.6 (10.2)	
Effort to Create a Therapist Introject (Range: 5–32)	9.7 (8.0)	7.0 (5.1)	6.9 (3.4)	6.7 (3.2)	5.8 (2.3)	
Mourning[4] (Range: 7–55)	26.4 (13.9)	22.2 (11.8)	20.6 (10.3)	19.2 (11.3)	16.4 (7.5)	S > O, M

[1] $p < .001$
[2] $p < .0001$
[3] $p < .01$
[4] $p < .05$
Note: Unadjusted means are reported.

mean of 2.4 is twice that of the OCPD group who also rated that item as one of their lowest.

TIS Factors and Levels of Psychosocial Functioning

The analysis of the relationship between the TIS variables and the Global Assessment of Functioning (GAF) and Level of Satisfaction (SAT) scores for each group yielded only several significant findings. For the BPD group, SAT was positively correlated with *Mourning* ($r = .31$; $p \leq .05$), indicating that the lower the level of life satisfaction for that group, the more likely the therapist will be missed between sessions. The AVPD group was less likely to attempt to create a therapist introject the more dissatisfaction is experienced ($r = -.33$; $p \leq .05$), and the OCPD patients were more likely to fail at creating a benign therapist internalization, at higher levels of dissatisfaction ($r = .28$; $p \leq .05$). Similarly, the MDD group was more likely to report failure of benign internalization the more impaired ($r = -.67$; $p \leq .01$), and less satisfied they were ($r = .58$; $p \leq .05$), while at the same time, dissatisfaction also served as a motivator for increasing efforts at creating a therapist introject ($r = .53$; $p \leq .05$). The TIS Total Score, and the *Sexual/Aggressive Involvement*, *Wish for Reciprocity,* and *Continuing the Therapeutic Dialogue* had no significant bearing on either measure of functioning for any group.

DISCUSSION

The central objective of this study was to explore how extrasession characteristics of therapist representations may differ across the spectrum of personality disorders. Results showed that there is variation across groups in how patients make use of thoughts about therapy, but PD diagnosis in and of itself was insufficient in explaining these differences. The relationship of PD pathology to TIS factors varied depending on gender, co-occurring Axis I disorders, and history of individual psychotherapy.

While it should not be overlooked that, for the majority of the TIS variables, there were no significant differences between the STPD and BPD means, the fact that the STPD patients reported the highest means on most of the TIS factors seems, at first glance, puzzling, given the profound interpersonal discomfort and social isolation associated with this type of pathology. For instance, one would not necessarily expect this group to have the highest score on the *Wish for Reciprocity* factor. However, it is often the case that individuals with STPD have few, if any, close relation-

Table II. THERAPIST INVOLVEMENT SCALE: HIGHEST AND LOWEST ITEM MEANS BY GROUP

STPD	*Mean (SD)*
Highest:	
33. I look forward to returning to sessions with my therapist.	5.4 (3.0)
22. I would like my therapist to be proud of me.	5.2 (3.0)
24. I try to solve my problems the way my therapist and I worked on them in psychotherapy.	5.2 (2.4)
Lowest:	
36. I imagine hurting my therapist in some way.	1.4 (1.3)
34. I imagine being sexually involved with my therapist.	2.4 (2.8)
9. I find myself looking for my therapist when I am out in a crowd.	2.4 (3.0)
BPD	*Mean (SD)*
Highest:	
22. I would like my therapist to be proud of me.	5.0 (2.7)
24. I try to solve my problems the way my therapist and I worked on them in psychotherapy.	4.8 (2.6)
33. I look forward to returning to sessions with my therapist.	4.7 (2.9)
Lowest:	
23. I imagine being the parent of my therapist's child.	1.3 (1.1)
9. I find myself looking for my therapist when I am out in a crowd.	1.3 (1.3)
18. I imagine my therapist and me kissing each other.	1.3 (1.3)
AVPD	*Mean (SD)*
Highest:	
24. I try to solve my problems the way my therapist and I worked on them in psychotherapy.	4.6 (2.3)
33. I look forward to returning to sessions with my therapist.	4.4 (2.6)
22. I would like my therapist to be proud of me.	4.1 (2.4)
Lowest:	
36. I imagine hurting my therapist in some way.	1.1 (.56)
29. I imagine my therapist hurting me in some way.	1.1 (.56)
23. I imagine being the parent of my therapist's child.	1.2 (1.0)
OCPD	*Mean (SD)*
Highest:	
24. I try to solve my problems the way my therapist and I worked on them in psychotherapy.	4.0 (2.8)
22. I would like my therapist to be proud of me.	4.0 (2.6)
33. I look forward to returning to sessions with my therapist.	3.6 (2.5)

Table II. (Continued)

OCPD (continued)	*Mean (SD)*
Lowest:	
18. I imagine my therapist and me kissing each other.	1.0 (.13)
34. I imagine being sexually involved with my therapist.	1.1 (.22)
36. I imagine hurting my therapist in some way.	1.1 (.44)
MDD	*Mean (SD)*
Highest:	
15. I hope I never have to be in therapy again.	4.2 (3.4)
24. I try to solve my problems the way my therapist and I worked on them in psychotherapy.	4.1 (2.7)
22. I would like my therapist to be proud of me.	4.1 (2.6)
Lowest:	
18. I imagine my therapist and me kissing each other.	1.0 (.00)
20. I daydream about my therapist.	1.0 (.00)
36. I imagine hurting my therapist in some way.	1.0 (.00)

Note: Items were rated by participants on a 9-point Likert-type scale ranging from 1 = *not at all characteristic* to 9 = *highly characteristic.*

ships. Consequently, the therapy relationship may be their primary source of meaningful interpersonal contact. This would certainly explain the higher scores on *Wish for Reciprocity*, as this factor captures the desire for elements of friendship, such as having meals or social conversations with the therapist outside the therapy session.

At the same time, it is likely that those individuals with STPD who seek treatment are quite challenged in some ways by having to engage in a relationship with the therapist. This is apparent in the significantly higher score of the STPD group on the *Sexual/Aggressive Involvement* factor. These interpersonal interactions may stir up wishes and anxieties that disturb permeable ego boundaries and exacerbate disorganization of thoughts and affects (39).

Although we have not systematically analyzed the content of the open-ended descriptions of the therapists that were obtained as part of the assessment, excerpts from several of the patients in the STPD group who scored particularly high on the TIS factors shed some light on the nature of the internalizations of these types of patients:

Very beautiful and attractive in a sense that I yearn to have a sexual relationship with her. She's very smart and educated. She knows what she wants out of life and I wish I were working for I could take her out to the movies and dinner. She turns me on and I desperately want to make love to her eternally. She's my life and knowing she doesn't feel the same, I live in dreams.

. . .is one of the best, most considerate, pretty and intelligent therapists I have ever had in my life. I know if she were my wife I could accomplish anything, climb heights and be a success in life. I love her in my heart and my soul and this will never change. She will always be in my soul and thoughts. I will miss her very much as she was not overly critical and at the same time objective. This is not an obsession but rather a mental observation!

He's highly intelligent, kind, caring, loving. I love to hear his voice. He relaxes and soothes me with it. There is so much to say about him, I don't know how to continue. Anyway, I love to see him, I wish we could "hang out" together. He's great! He's special to me in many ways. He seems to say all the right things and seems to know me very, very well and he also understands me to the point where I think and feel he can see right through me.

These descriptions were all written by male patients with STPD, the first two heterosexual males with female therapists, and the third a gay man with a male therapist. The tenor of these descriptions may assist in understanding the interaction of gender with STPD diagnosis and TIS factors. That male patients with STPD would be more preoccupied with their therapists is contrary to the previous finding (26) that, in general, female patients with male therapists were more likely to think about and miss their therapists between sessions. However, the gender effect gives us additional clues about the types of issues that certain patients may have with participating in a treatment relationship. Furthermore, seeing the ardent nature of these descriptions illustrates the importance of exploring the representational world, as the typically socially aloof behavior of patients with STPD often belies important underlying dynamics.

The role of Axis I disorders in explaining the higher STPD means for the total involvement measure, *Wish for Reciprocity*, and *Continuing the Therapeutic Dialogue* may have to do with greater levels of acute impairment and distress due to co-occurring anxiety, mood or substance-use disorders frequently found with this group. A recent analysis of the larger CLPS sample showed the STPD group as having significantly more co-occurring Axis I disorders than the AVPD, OCPD and MDD groups (40). Thus, the STPD group may be, on average, more disturbed, having more evident symptoms of depression and anxiety and, being more preoccupied with their problems, more motivated to think about, and be with, their therapists outside of sessions.

Prior findings showed significant positive correlations between number of sessions attended and *Sexual/Aggressive Involvement*, *Wish for Reci-*

procity, *Continuing the Therapeutic Dialogue*, and *Mourning*, indicating the more sessions one has had, the more likely there will be engagement with these types of thoughts about therapy outside of sessions (7). Both this prior finding and the current result showing a significant relationship between amount of individual psychotherapy and differences in overall involvement, in sexual and aggressive elements, and in the tendency to mourn the therapist between sessions, reflect active ambivalence about the therapist. Consequently, it is not surprising that the patients with STPD and BPD have the highest means on these variables. On average, patients with STPD and BPD have more total months of treatment compared to the other groups (41), despite continuing to have greater levels of distress and impairment (42). In naturalistic studies such as this one, it is typically found that the sickest patients have also received the most treatment. BPD pathology is also associated with more tumultuous relationships, which is consistent with the apparently more conflicted nature of this group's therapist representations when compared with the OCPD, AVPD and MDD groups.

On the other end of the spectrum, the OCPD patients consistently had the lowest mean scores of the four PD groups on the TIS factors, indicating relatively little involvement with therapist representations outside of therapy. Patients with obsessive-compulsive tendencies are considered to have more stable object relationships, compared with people with STPD and BPD, but much of their defensive operations are reaction formations centered on the repression of instinctual needs. Millon (43) has characterized the compulsive style as having "concealed internalizations," where "gratification is highly regulated," and "personal and social conflicts defensively denied" (p. 24). If we examine the lowest means for individual items for the OCPD group, as shown in Table II, we can see that these patients were highly unlikely to endorse items of a sexual or aggressive nature.

Focusing on individual TIS items with the highest means also provides some indication of what might be more typical concerns for patients. While several statements were assessed as most characteristic across all five groups,"I would like my therapist to be proud of me" and "I try to solve my problems the way my therapist and I worked on them in psychotherapy," only the MDD group endorsed "I hope I never have to be in therapy again" as one the items most characteristic of their thinking. This may reflect the difference in treatment utilization attitudes and experiences by patients suffering from an acute Axis I disorder without associated character pathology and those who have

more complicated sets of problems related to PDs. It was apparent in a recent study that the PD groups use a great deal more mental health services than the MDD patients (41). Thus, there may be awareness by the PD patients that their difficulties are more chronic rather than episodic and require ongoing treatment, while many of the MDD patients may be encountering the mental health system for the first (and they hope, the last) time.

In examining the relationship between therapist representations and psychosocial functioning, previous findings regarding *Continuing the Therapeutic Dialogue* and improved functioning were not replicated. It is possible that continuing the therapeutic dialogue for portions of this population serves more ambivalent purposes, such as being secretly preoccupied with the negative aspects of their experience of the treatment relationship. The contrast in results may also be due, in part, to the self-report assessment of therapy improvement used in prior studies, rather than the clinician-interviewer assessed GAF and SAT used in the present study.

That some of our findings are inconsistent with previous work in this area is probably due, at least in part, to the broad range of psychopathology and impairment of our sample. In addition, the use of categorical diagnoses presents certain limitations. Further efforts at exploring the relationship between character pathology and internal representations should include dimensional measures of personality.

We have confirmed that patients on the "more disturbed" end of the PD spectrum are likely to have more consciously available, conflicted views of their therapists. This supports the notion that with more severely impaired patients, the therapist is often more helpful, at least in the first phase of treatment, by providing a containing and clarifying function rather than one that targets unconscious motivations and disavowed transferences (44). Conversely, those who exhibit tendencies on the OCPD and MDD end of the spectrum may be better assisted by encouragement to explore possibly repressed feelings and ideas they may have about the treatment relationship. Because this relationship is a primary vehicle for change, enhanced understanding of the patients' views of the therapist can guide interventions and improve outcome. Furthermore, anticipating how certain types of patients think about their therapists will better inform us about how we might ease the way for prospective patients to approach the mental health system and receive appropriate treatment.

REFERENCES

1. Blatt SJ, Auerbach JS (2001). Mental representation, severe psychopathology, and the therapeutic process. *Journal of the American Psychoanalytic Association, 49,* 113-159.
2. Diamond D, Kaslow N, Coonerty S, Blatt SJ (1990). Changes in separation-individuation and intersubjectivity in long-term treatment. *Psychoanalytic Psychology, 7,* 363-397.
3. Lerner HD, St. Peter S (1984). Patterns of object relations in neurotic, borderline, and schizophrenic patients. *Psychiatry, 47,* 77-92.
4. Westen D (1990). Towards a revised theory of borderline object relations: Contributions of empirical research. *International Journal of Psycho-Analysis, 71,* 661-693.
5. Blatt SJ, Behrends RS (1987). Internalization, separation-individuation, and the nature of therapeutic action. *International Journal of Psycho-Analysis, 68,* 279-297.
6. Bricker D, Young JE, Flanagan CM (1993). Schema-focused cognitive therapy: A comprehensive framework for characterological problems. In K. T. Kuehlwein & H. Rosen (Eds.), *Cognitive therapies in action* (pp. 88-125). San Francisco, CA: Jossey-Bass Inc.
7. Geller JD, Farber BA (1993). Factors influencing the process of internalization in psychotherapy. *Psychotherapy Research, 3,* 166-180.
8. Strupp H (1978). The therapist's theoretical orientation: An overrated variable. *Psychotherapy: Theory, Research, & Practice, 15,* 314-317.
9. Blatt SJ & Lerner H (1983). The psychological assessment of object representation. *Journal of Personality Assessment, 47,* 7-28.
10. Dorpat TL (1974). Internalization of the patient-analyst relationship in patients with narcissistic disorders. *International Journal of Psycho-Analysis, 55,* 183-188.
11. Kernberg O (1987). An ego psychology-object relations theory approach to the transference. *Psychoanalytic Quarterly, 56,* 197-221.
12. Masterson JF (1988). *The search for the real self: Unmasking the personality disorders of our age.* New York: The Free Press.
13. Stuart J, Westen D, Lohr N, et al. (1990). Object relations in borderlines, major depressives, and normals: Analysis of Rorschach human figure responses. *Journal of Personality Assessment, 55,* 296-318.
14. Nigg JT, Lohr NE, Westen D, et al. (1992). Malevolent object representations in borderline personality disorder and major depression. *Journal of Abnormal Psychology, 101,* 61-67.
15. Pine F (1985). *Developmental theory and clinical process.* New Haven, CT: Yale University Press.
16. Loewald HW (1980). On the therapeutic action of psychoanalysis. In H.W. Loewald, *Papers on psychoanalysis.* New Haven, CT: Yale University Press. (Original work presented in two parts at meetings of the Western New England Psychoanalytic Society, 1956-57.)
17. Diamond D, Blatt S, Stayner D, Kaslow N (1992). *The Differentiation-relatedness scale of self and object representations.* Yale University, New Haven, CT.
18. Stayner DA (1993). The relationship between clinical functioning and changes in self and object representations in the treatment of severely impaired patients. *Dissertation Abstracts International a (Humanities and Social Sciences), 55(6-A),* 1511.
19. Blatt SJ, Stayner DA, Auerbach JS, Behrends RS (1996). Change in object and self representations in long-term, intensive, inpatient treatment of sersiously disturbed adolescents and young adults. *Psychiatry, 59,* 82-107.
20. Gruen RJ, Blatt SJ (1990). Change in self and object representation during long-term dynamically oriented treatment. *Psychoanalytic Psychology, 7,* 399-422.
21. Geller JD, Cooley RS, Hartley D (1981-82). Images of the psychotherapist: A theoretical and methodological perspective. *Imagination, Cognition and Personality, 1,* 123-146.
22. Wzontek N, Farber BA, Geller JD (1995). Patients' post-termination representations of their psychotherapists. *Journal of the American Academy of Psychoanalysis, 23,* 395-410.
23. Rosenzweig DL, Farber BA, Geller JD (1996). Clients' representations of their therapists over the course of psychotherapy. *Journal of Clinical Psychology, 52,* 197-207.
24. Honig MS, Farber BA, Geller JD (1997). The relationship of patients' pretreatment representations of mother to early treatment representations of their therapist. *Journal of the American Academy of Psychoanalysis, 25,* 357-372.
25. Bender DS, Farber BA, Geller JD (1997). Patients' representations of therapist, parents, and self

in the early phase of psychotherapy. *Journal of the American Academy of Psychoanalysis, 25,* 571-586.
26. Farber BA, Geller JD (1994). Gender and representation in psychotherapy. *Psychotherapy, 31,* 318-326.
27. Schore AN (1997). Interdisciplinary developmental research as a source of clinical models. In M. Moskowitz, C. Monk, C. Kaye, & S. Ellman (Eds.), *The neurobiological and developmental basis for psychotherapeutic intervention* (pp. 1-71). Northvale, NJ: Jason Aaronson, Inc.
28. Shapiro D (1965). *Neurotic styles.* New York: Basic Books, Inc.
29. Bender DS (1996). The relationship of psychopathology and attachment to patients' representations of self, parents, and therapist in the early phase of psychodynamic psychotherapy. *Dissertation Abstracts International A (Humanities and Social Sciences), 57(5-B),* 3400.
30. Gunderson JG, Shea MT, Skodol AE, et al. (2000). The Collaborative Longitudinal Personality Disorders Study: Development, aims, design, and sample characteristics. *Journal of Personality Disorders, 14,* 300-315.
31. Zanarini MC, Frankenberg FR, Sickel AE, Yong, L (1996). *Diagnostic Interview for DSM-IV Personality Disorders.* Belmont, MA: McLean Hospital, Laboratory for the Study of Adult Development.
32. Keller M, Nielson E (1989). *Longitudinal Interval Follow-up Evaluation Adapted for the Personality Disorders Study.* Providence, RI: Brown University School of Medicine, Department of Psychiatry and Human Behavior.
33. Zanarini MC, Skodol AE, Bender DS, et al. (2000). The collaborative longitudinal personality disorders study: Reliability of axis I and II diagnoses. *Journal of Personality Disorders, 14,* 291-299.
34. Clark LA (1993). *Schedule for Nonadaptive and Adaptive Personality.* Minneapolis, MN: University of Minnesota Press.
35. Shea MT, Glass DR, Pilkonis PA, et al. (1987). Frequency and implications of PDs in a sample of depressed inpatients. *Journal of Personality Disorders, 1,* 27-42.
36. Geller JD, Behrends R, Hartley D, et al. (1989). *Therapist Representation Inventory-II.* New Haven, CT: Department of Psychology, Yale University.
37. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders, 4th ed. (DSM-IV).* Washington, DC: American Psychiatric Association.
38. SAS Institute (1999). *SAS Version 8.* Cary, NC.
39. Millon T, Davis RD (1995). *Disorders of personality: DSM-IV and beyond.* New York: John Wiley & Sons, Inc.
40. McGlashan TH, Grilo CM, Skodol AE, et al. (2000). The Collaborative Longitudinal Personality Disorders Study: Baseline Axis I/II and II/II diagnostic co-occurrence. *Acta Psychiatrica Scandinavica, 102,* 256-64.
41. Bender DS, Dolan RT, Skodol AE, et al. (2001). Treatment utilization by patients with personality disorders. *American Journal of Psychiatry, 158,* 295-302.
42. Skodol AE, Gunderson JG, McGlashan TH, et al. (2002). Functional impairment in schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *American Journal of Psychiatry, 159,* 276-283.
43. Millon T (1987). *Manual for the MCMI-II.* (Available from NCS Professional Assessment Services, P. O. Box 1416, Minneapolis, MN 55440).
44. Bach SB (1985). *Narcissistic states and the therapeutic process.* Northvale, NJ: Jason Aronson, Inc.