USING COMMON FATE MODEL IN EXAMINING DYADIC THERAPEUTIC PRESENCE AND SESSION QUALITY WITH WORKING ALLIANCE AS A MEDIATOR

by

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ABSTRACT

USING COMMON FATE MODEL IN EXAMINING DYADIC THERAPEUTIC PRESENCE AND SESSION QUALITY WITH WORKING ALLIANCE AS A MEDIATOR

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This study aimed to explore how therapeutic presence contributes to the development of the working alliance and overall session quality. The dataset comprised 15,145 sessions conducted by 409 master's-level trainee therapists with 2,242 clients in China. After each session, both therapists and clients completed measures assessing therapeutic presence, working alliance, and session quality. Results showed that: (a) from both client and therapist perspectives, therapeutic presence temporally predicted working alliance across the course of treatment—higher therapeutic presence at one session led to stronger working alliance at the subsequent session, but not vice versa. (b) Shared perceptions of therapeutic presence between therapist and client predicted their shared perceptions of session quality at both the between-session and between–therapist-client dyad levels. (c) Therapists' and clients' individual perception of therapeutic presence was positively related to their individual perception of session quality at the between-session and between therapist-client dyad levels, respectively. (d) Therapist-client shared perception of working alliance did not mediate the relationship between their shared perception of therapeutic presence and session quality at the between-session level.

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Finally, I dedicate this work to everyone who has been part of this journey—thank you for walking beside me.

Chapter One: Introduction

Problem Statement

Psychotherapy researchers have increasingly underscored the necessity of identifying the common factors contributing to the therapeutic relationship and session quality, as previous studies convincingly established that the differences in treatment outcomes depend minimally on specific interventions across different theoretical orientations (Norcross & Lambert, 2019). The focus of psychotherapy literature has thus been centered on the role of the therapist-client relationship and working alliance in facilitating positive changes in clients (e.g., Flückiger et al., 2018; Horvath & Greenberg, 1986; Norcross & Lambert, 2019; Watson & Greenberg, 2015). For example, in a recent meta-analysis summarizing 295 published studies with more than 30,000 clients over approximately 40 years, Flückiger et al. (2018) found that working alliance consistently and stably predicted various forms of psychotherapy outcome with a moderate effect size (aggregated correlation coefficient $r = .28$). However, important questions remain as to what therapist and client factors may contribute to the development of a strong working alliance and effective therapy sessions (Geller & Greenberg, 2022).

Therapeutic presence has been theorized as an indispensable and preliminary step to fostering a solid therapist-client relationship and successful treatment outcomes (Geller, 2020). Therapeutic presence is characterized by bringing one's whole self into the therapy, staying attuned to clients' here-and-now experiences, and fully engaging with them on multiple levels: physically, cognitively, emotionally, relationally, and spiritually. It requires the therapist to be well aware of their own bodily and emotional state and reactions to the client while engaging themselves fully in the therapeutic encounter in a manner that can be experienced *or* sensed by the client. Therapeutic presence differentiates a therapist's way of being from their choices of

counseling skills and techniques (Tannen & Daniels, 2010), and it is often viewed as one of the most valuable gifts therapists can provide for clients because of its power in healing (Shepherd et al., 1972).

Some empirical findings have also provided preliminary support for the positive associations between therapeutic presence, working alliance, and therapeutic effectiveness across various theoretical orientations. For example, research revealed that therapeutic presence might serve as a precursor to establishing a stronger working alliance and a positive therapeutic relationship (e.g., Allison & Rossouw, 2013; Dunn et al., 2013; Hayes & Vinca, 2017; Pos et al., 2011). In addition, it has been found that clients tend to obtain better treatment outcomes when their therapists are perceived as being therapeutically present with and for them in therapy sessions, regardless of therapists' theoretical approaches (Geller et al., 2010). However, most studies in this area of research share the limitation that they adopted a cross-sectional design and thus did not specifically explore the directionality between therapeutic presence and working alliance. In other words, we are not able to make any causal inferences and determine the direction of prediction between these two variables based on the existing studies. Moreover, in examining the relationship between therapeutic presence, working alliance, and session quality, researchers tended to focus either on the client's experience of the therapist, or the therapist' experience of themselves, which prevents us from understanding the dyadic nature of the psychotherapy process and gaining insights into such questions as how the therapist and client each perceives the psychotherapy process in their therapeutic encounters and how their shared and individual perceptions of therapeutic presence and working alliance predict the ratings of session quality or treatment outcome, respectively.

Therefore, the present study attempts to address these lingering questions by first examining how therapeutic presence may temporally predict working alliance across therapy sessions using Random Intercept Cross-Lagged Panel Models (RI-CLPM; Hamaker et al., 2015). After clarifying the directionality between therapeutic presence and working alliance, I will then explore the associations between therapeutic presence, working alliance, and session quality while considering both the therapist' and the clients' perspectives using Common Fate Model (CFM; Ledermann & Kenny, 2012). Based on existing theoretical propositions, I tentatively posit that the therapist-client shared perception of working alliance would be a potential mediator between therapist-client shared perception of therapeutic presence and their shared perception of session quality. Furthermore, to address the significant limitation of using only cross-sectional data in existing studies, I plan to apply longitudinal data to investigate the shared perception of these variables at the between-session and between therapist-client dyad levels (Zilcha-Mano et al., 2017). Below, I first present a review of the theoretical framework and conceptualization of therapeutic presence, followed by a synoptic summary of existing empirical research. I then specifically discuss three critical limitations in the existing research of therapeutic presence that this study is designed to address. Finally, I present the general aims of the current study and discuss how it can address these critical limitations by employing two advanced statistical models: the Random-Intercept Cross-Lagged Panel Model (RI-CLPM; Hamaker et al., 2015) and the Common Fate Model (CFM; Ledermann & Kenny, 2012).

Therapeutic Presence: Conceptualization and Theoretical Framework

Carl Rogers' (1951) identification of three necessary and sufficient conditions—accurate empathy, therapist congruence, and unconditional positive regard—remains the benchmark for measuring a therapist's contribution to positive therapeutic changes and successful treatment

outcomes (Campbell & Christopher, 2012; McAuliffe & Eriksen, 2011; Duncan et al., 2010). In his later writings, however, Rogers (1980) explored another essential healing component that he and subsequent client-centered scholars have termed "*presence*." He suggested that *presence* not only provides a foundation for but also encompasses the three core conditions offered by therapists. According to Rogers, *presence* is the primary underlying process in therapeutic interactions between therapists and clients (Baldwin, 2000). Theoretical writings on the concept of *presence* continued to evolve after Rogers, with significant contributions from Bugental (1987), Hycner & Jacobs (1995), Schneider & May (1995), and Geller & Greenberg, (2002). *Presence* has been proposed as a potential underlying contributor to a strong therapist-client relationship (Geller, 2001, 2017; Geller & Greenberg, 2002; Schmid, 1998).

Geller and Greenberg (2002) formalized and expanded the concept of "*therapeutic presence*," defining it as the practice of bringing one's whole self into therapy sessions. This involves staying attuned to clients' here-and-now experiences and engaging with them fully on multiple levels—physically, cognitively, emotionally, relationally, and spiritually— in a manner that can be experienced or sensed by the client. According to Geller and Greenberg (2010), therapeutic presence involves: (1) therapists maintaining moment-to-moment self-awareness while (2) staying receptive and open to clients' experiences and focusing on what is essential in the present moment. Additionally, this grounded and immersed awareness is integrated with (3) the therapists' efforts to be with the clients to facilitate the healing process. Therapeutic presence sets apart a therapist's personal engagement from their technical skills and methods (Tannen & Daniels, 2010), and is widely regarded as one of the most significant contributions therapists can make to their clients, given its profound impact on healing (Shepherd et al., 1972).

The concept of therapeutic presence was initially developed based on the principles of humanistic psychology. However, therapists from different theoretical orientations have expressed their views on the importance of therapeutic presence in enhancing the therapeutic relationship and promoting session quality (e.g., Epstein, 2007; Kanter et al., 2009; Reik, 1948; Stern, 2004). For example, traditional psychoanalysts have emphasized the development of 'a third ear' to deeply understand the verbal and physical expressions of clients' experiences through a state of attentive presence (Epstein, 2007; Reik, 1948). Contemporary therapists with a psychodynamic orientation stress the importance of the present moment within the therapeutic relationship and strive to engage their clients with an authentic, non-judgmental presence (Stern, 2004). Gestalt and Existential therapies emphasize the significance of immediate, here-and-now interactions, where therapists enhance their cognitive, emotional, and sensory awareness to facilitate changes in clients (Yontef, 2005). Moreover, the concept of therapeutic presence is fundamental in Emotion Focused Therapy (EFT; Geller, 2019). EFT therapists focus on strengthening the therapeutic relationship and assist clients in completing EFT tasks by being fully present, highly attentive, and responsive to clients' affective experiences (Geller & Porges, 2014). Furthermore, while therapists with a Cognitive-Behavioral orientation often rely on technical skills rather than personal qualities to facilitate change in clients' thinking and behavioral patterns, they recognize therapeutic presence as a vital element of therapeutic change, as being fully present with clients can enhance the efficacy of the delivery of the interventions (Kanter et al., 2009). In summary, therapeutic presence has been acknowledged as a common factor at the root of efficacious therapy across various theoretical orientations and populations (Epstein, 2007; Kanter et al., 2009; Reik, 1948; Stern, 2004).

Therapeutic Presence: Brief Review of Existing Empirical Findings

Besides the aforementioned theoretical and conceptual propositions, some empirical findings have also provided preliminary support for the positive associations between therapeutic presence and the effectiveness of various treatment approaches. For example, Geller and his colleagues (2010) found that clients who experienced their therapists as present in therapy sessions tended to report better treatment outcomes across Person-Centered therapy, Emotion-Focused therapy, and Cognitive Behavioral therapy. These results were consistent with those of Furrow et al. (2012), who found that a therapist's emotional presence was associated with heightened levels of client emotional experience in softening attempts, an indicator of successful treatment outcomes in Emotion Focused therapy, as well as Kanter et al. (2009) who found a positive link between therapeutic presence and the effectiveness of the delivery of CBT techniques. In addition, in a study carried out in Israel (Goldner, 2016), researchers aimed to examine the therapists' emotional needs and how those needs might impact their therapeutic presence and found that therapists' tendency to receive approval interfered with their ability to be fully present for their clients, which led to a less healthy therapeutic relationship and compromised the treatment outcome. Furthermore, in their examination of therapeutic presence in play therapy, Crenshaw and Kenny-Noziska (2014) highlighted two case studies where therapeutic presence was the key healing component for childhood trauma. They argued that the sense of safety and trust fostered by therapeutic presence significantly enhanced the therapeutic relationship and facilitated positive outcomes in play therapy sessions with children. Lastly, according to Lingiardi et al. (2011), session quality is referred to as what comes between the therapy process (the events that occur within a session) and treatment outcomes (the effects observed over a series of sessions or the entire course of treatment). Given that therapists and

clients consistently assess the quality of the session experience in which they participate (Myhra et al., 2023), and considering the significant positive associations identified between session quality and treatment outcomes (e.g., Kivlighan et al., 2015; Pesale et al., 2012; Stiles et al., 1990), it seems reasonable and meaningful to speculate that therapeutic presence could significantly predict session quality.

Moreover, the effect of therapeutic presence on establishing and maintaining a strong therapeutic alliance is also supported by some empirical findings (Oghene et al., 2010). For example, some studies have found that a client's perception of their therapist's presence significantly correlated with the strength of the working alliance (Colosimo & Pros, 2015; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011; Zhao et al., 2022). Besides quantitative studies, qualitative research has indicated that a therapist's focus on being present with the client during therapy significantly predicted the client's experience of the therapeutic bond and assisted in the development of therapeutic goals and tasks (Granick; 2011). Additionally, Banai et al. (2005) discovered that therapeutic presence mediated the association between therapists' desire for admiration for their achievements and the strength of the working alliance. Furthermore, given the meta-analytical findings establishing working alliance as a robust predictor of positive outcomes in psychotherapy, including session quality (Flückiger et al., 2018), it seems relevant to speculate that working alliance may mediate the relationship between therapeutic presence and session quality.

Critique of the Existing Literature

The aforementioned theoretical and empirical evidence suggest that therapeutic presence, as a common factor, is trans-theoretical in that it helps optimize the functioning of both parties in a therapeutic relationship across various theoretical orientations (Geller & Greenberg, 2022).

While therapeutic presence has been identified as a primary component contributing to the working alliance and session quality (e.g., Furrow et al., 2012; Geller et al., 2010; Goldner, 2016), several critical limitations are noteworthy in the existing literature. Below, I specifically discuss each of these critical limitations, which have motivated the design of the current study.

Limitation 1: Lack of Attention to the Dyadic Process

Therapeutic presence is characterized by the therapists being well aware of their own bodily and emotional state and reactions to the client (e.g., countertransference responses) while engaging themselves fully in the therapeutic encounter in a manner that can be experienced or sensed by the client (Geller, 2017; Geller & Greenberg, 2002, 2012; Geller et al., 2010; Hayes & Vinca, 2011, 2017). That being said, therapeutic presence is inherently dyadic, relational, and interdependent (Fraelich, 1989; Geller, 2020; Schmid, 2002). Geller and Greenberg (2022) further explained that the more therapeutically present the therapist is, the more likely the client is to engage in the therapy process and be present with the therapist and themselves, and the more engaged and present the client becomes, the greater the therapeutic presence the therapist develops and maintains during the session. This reciprocal influence underscores the dyadic and relational aspects of therapeutic presence (Geller & Greenberg 2022). Additionally, the dyadic and relational aspect of therapeutic presence was also emphasized by Schmid (2002) in his writings, as he pointed out that therapeutic presence is like "joint experiencing with the client" (p.65). In other words, the concept of therapeutic presence emphasizes that the sense of being with another in a meaningful, attentive way is not one-sided. Instead, both the therapist and the client contribute to and experience this state of presence together, creating a shared psychological space (Bernhardt et al., 2021; Geller & Greenberg 2022). While therapeutic presence has been found as a primary factor for the development of working alliance and

efficacious therapy, the existing studies failed to take a "two-person" or dyadic perspective when measuring and modeling therapeutic presence but focused solely on *either* the client's experience of the therapist (Geller, 2010; Granick, 2011) *or* the therapist's experience of themselves (Geller & Greenberg, 2012; Schwarz, 2018; Kelly & Papps, 2021), which overlooked an important possibility that the treatment outcome might be attributable to the shared perspectives of the therapist and the client. Furthermore, the domination of studies focusing on the effects of "individual perception" of therapeutic presence on working alliance and therapy outcome (Geller, 2010; Granick, 201; Geller & Greenberg, 2012; Schwarz, 2018; Kelly & Papps, 2021) in the existing literature may create barriers to understanding how therapeutic presence works specifically in therapy, gaining insights into the internal challenges (e.g., within the therapists) and external challenges (e.g., from the client or the therapeutic relationship) to engaging fully and intimately in the present moment in a therapeutic interaction, as well as developing specific approaches to cultivating and enhancing therapeutic presence (Barkham & Castonguay, 2021; Bernhardt et al., 2021; Geller & Greenberg, 2022).

An essential approach to understanding the dyadic nature of the psychotherapy process involves modeling and measuring the shared perspectives of therapists and clients on dyadic constructs—specifically, the elements both parties experience during therapy (Li et al., 2021; Kivlighan, 2007). In a therapeutic relationship, the "shared perception" of a relational construct represents the aspects that are co-created, perceived, and mutually acknowledged by both the therapist and the client. Besides this shared perception, both the therapist and the client may also hold "individual perceptions," which reflect the unique and non-shared aspects of each party's perspectives. For example, based on how therapeutic presence is conceptualized in the literature (Geller, 2017; Geller & Greenberg, 2002, 2012; Geller et al., 2010; Hayes & Vinca, 2011, 2017),

the shared perception of a high level of therapeutic presence can be that the therapist and the client feel in synchronicity with each other, and because of the attunement, both members perceive their interactions as flowing and rhythmic in which both parties are able to focus on the client's experiences at a deep and profound level (Geller et al., 2010; Geller and Greenberg, 2022). In contrast, the therapist's high rating of therapeutic presence might not be just due to the attunement but also their perception of being able to maintain a deep contact with and listen to their inner self, including their body, emotion, and reactions to clients (Geller and Greenberg, 2022). In this case, the "individual perception" of therapeutic presence would be the therapist's high rating (but not the client's) on their capacity to be aware of their own internal flow of experiencing (Geller et al., 2010). Being motivated by the lack of the understanding of the dyadic nature of the psychotherapy process in the literature, the current study attempts to model and measure the relational constructs in psychotherapy and uncover the associations between the shared perceptions of therapeutic presence, working alliance, and session quality using common fate model.

Limitation 2: Not Establishing the Directionality between Therapeutic Presence and Working Alliance.

Among the studies exploring the relationship between therapeutic presence and working alliance (e.g., Oghene et al., 2010; Pos et al., 2011; Geller & Greenberg; 2010), researchers tended to adopt a cross-sectional study design, which prevented us from inferring a causal relationship and determining the direction of causality between these two constructs. The focus of the contemporary psychotherapy literature has been centered on the role of the therapist-client relationship and working alliance in facilitating positive changes in clients (e.g., Flückiger et al., 2018; Horvath & Greenberg, 1986; Norcross & Lambert, 2019; Watson & Greenberg, 2015).

However, a gap in knowledge of which variables contribute to the establishment and development of working alliance still exists (Horvath, 1994; Geller & Greenberg, 2022). Therapeutic presence has been theorized as a precursor to a robust working alliance because, according to Geller & Greenberg (2010), it fosters a therapeutic bond between the client and therapist, providing the therapist with an opportunity to actively listen to, reflect on, and respond to clients' experiences. This, in turn, enhances the development of treatment goals and the agreement of the necessary therapeutic tasks that grow out of clients' deepest needs. Despite the theoretical propositions, however, the existing studies could only reveal that therapeutic presence is positively *correlated with* the therapeutic alliance (Colosimo & Pros, 2015; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011) without clarifying the *directionality* between these two constructs; Thus, therapeutic presence cannot be truly identified as a contributor to working alliance. Therefore, this study aims to further clarify the relationship between therapeutic presence and working alliance and empirically test whether therapeutic presence temporally leads to working alliance across therapy sessions.

Limitation 3: Not Differentiating the Levels of Associations

Lastly, most existing research in this area used cross-sectional data to explore the concurrent associations between therapeutic presence, working alliance, and session quality. Very few used longitudinal data and multilevel modeling to disaggregate the relationship between these variables at the session level (differences between session within individual clients) and therapist-client dyad level (differences across various therapist-client dyads). Although bivariate correlations from cross-sectional data might indicate potential links between different variables, such associations are confounded because one cannot determine whether the observed relationships stem from differences between sessions or from variations between

therapist-client dyads (Li et al., 2021; Zilcha-Mano et al., 2016). In contrast, separating different levels of effects allows us to determine whether and to what extent the associations between various variables can be attributed to session effects or to effects of therapist-client dyads, while holding constant the effects at the other level (Li et al., 2018). Practically, considering these multilevel distinctions helps us disentangle the contributions of therapist-client dyads and session differences (Baldwin & Imel, 2014). This understanding leads to significant clinical implications for our practices in therapist training and supervision (Li et al., 2018).

In the context of my study, disaggregating the shared perception of therapeutic presence will enable us to clarify the relationship between therapeutic presence and session quality at two different but clinically meaningful levels. For instance, at the between-session level, this study investigates whether, in sessions where both the trainee and client report a higher than average rating of therapeutic presence within the same therapist-client dyad, they also tend to jointly experience a higher session quality compared to their other sessions. At the between therapist-client dyads level, I will explore variations across different groupings. This investigation aims to uncover broader patterns, revealing whether therapist-client dyads that, on average, report higher levels of shared therapeutic presence also tend to report higher levels of shared session quality compared to those with lower levels of shared therapeutic presence. Furthermore, this study also aims to examine whether the shared perception of working alliance between the therapist and the client mediated the relationship between their shared perception of therapeutic presence and session quality at the between-session level. More specifically, within the same therapist-client dyad, I will explore whether, in sessions where both the trainee and the client report a higher-than-average rating of therapeutic presence, this joint perception correlates with a stronger shared working alliance, which further leads to higher shared session quality compared to their

other sessions. In summary, the findings of this study may provide a more nuanced understanding of the intricate, multilevel associations between therapist and client shared perceptions of therapeutic presence, working alliance, and session quality.

The Present Study

General Aims of the Study

To address the research gaps mentioned above, the present study attempts to first examine how therapeutic presence may temporally predict working alliance across therapy sessions using Random Intercept Cross-Lagged Panel Models (RI-CLPM; Hamaker et al., 2015). After clarifying the directionality between therapeutic presence and working alliance, I will then explore the associations between therapeutic presence, working alliance, and session quality while considering both the therapist' and the clients' perspectives using Common Fate Model (CFM; Ledermann & Kenny, 2012). Additionally, to overcome the significant limitation of relying solely on cross-sectional data in existing studies, I plan to use longitudinal data to explore the shared perceptions of therapeutic presence and session quality at both the between- session and therapist-client dyad levels (Zilcha-Mano et al., 2016). Lastly, I will examine the mediating effect of the shared working alliance on the association between shared therapeutic presence and session quality at the between-session level.

Exploring Directionality Using RI-CLPM

In the first part of the data analysis, I will examine how therapeutic presence may temporally predict working alliance across therapy sessions using Random Intercept Cross-Lagged Panel Models (RI-CLPM; Hamaker et al., 2015). Hamaker et al. (2015) proposed the random intercept cross-lagged panel model (RI-CLPM) as an extension of the traditional cross-lagged panel model (CLPM) to examine the reciprocal influences of multiple variables over

time. The RI-CLPM is more advantageous compared to traditional CLPM, because when the variable or construct of interest is somewhat trait-like and time-invariant in nature, the autoregressive relationships of the traditional CLPM may not fully account for this stability. Consequently, the lagged parameters obtained from the CLPM do not represent the actual within-person relationships over time. This discrepancy might lead to inaccurate or erroneous conclusions regarding the presence, predominance, and direction of causal effects. In contrast to the standard CLPM, the RI-CLPM separates within-person effects from stable between-person differences (Hamaker et al., 2015). This separation allows the model to account for trait-like, time-invariant stability as well as time-varying components, through the introduction of a random intercept.

In this study, I plan to use the RI-CLPM model to clarify the temporal directionality between therapeutic presence and working alliance. The conceptual model, depicted in Figure 1, illustrates this relationship: horizontal arrows represent autoregressive paths (i.e., *aT*, *aW*), diagonal arrows indicate cross-lagged paths (i.e., *W2T, T2W*), and double arrows (i.e., *rTW*) signify within-time correlations.

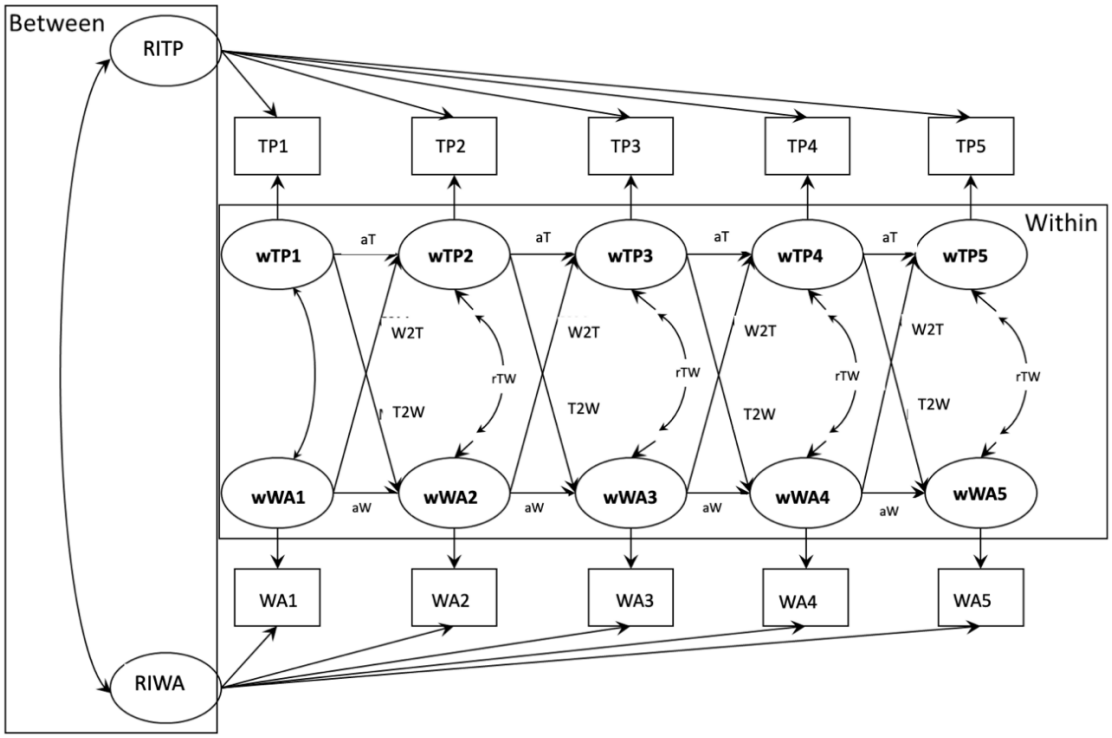


Figure 1: RI- CLPM between Therapeutic Presence and Working Alliance.
Note. TP = Therapeutic Presence; WA =Working Alliance. RI = Random Intercept, indicating the between-person component; "w" indicates the disaggregated within-person component of TP and WA. Parameter *aT* = autoregressive effect of within-person trainee therapeutic presence; Parameter *aW* = autoregressive effect of within-person working alliance; Parameter *T2W* = cross-lagged effect of within-person therapeutic presence on subsequent working alliance; Parameter *W2T* = cross-lagged effect of within-person working alliance on subsequent therapeutic presence; Parameter *rTW* = concurrent residual correlation between within-person therapeutic presence and working alliance. All parameters with the same label are held equal across time points.

More specifically, the two autoregressive paths (i.e., *aT, aW*) indicate the within-person, carry-over effects in the therapeutic presence and working alliance at each assessed time point. A significant autoregressive path in this study suggests that therapists or clients who perceive a higher level of therapeutic presence or working alliance in one session are more likely to experience a similarly higher level of therapeutic presence or working alliance in subsequent session.

Two cross-lagged paths (i.e., *W2T, T2W*) reflect the temporal dynamic relationship between therapeutic presence and working alliance, which is of primary interest in this study. For

example, if *T2W* is significant and *W2T* is not, it suggests that therapeutic presence temporally predicts subsequent working alliance but working alliance does not predict subsequent therapeutic presence; in other words, therapeutic presence temporally precedes working alliance which is consistent with the theoretical proposition (Geller, 2020) that therapeutic presence is a precursor in the development of working alliance. However, if *W2T* is significant and *T2W* is not, it indicates that working alliance temporally leads to therapeutic presence, but therapeutic presence does not lead to subsequent working alliance; in other words, working alliance temporally precedes therapeutic presence, suggesting that a strong working alliance is the precondition for the therapist to be more present. Lastly, if both *W2T* and *T2W* are significant, it means that there is a significant bidirectional relationship between therapeutic presence and working alliance where higher ratings of therapeutic presence contribute to a stronger subsequent working alliance while a stronger working alliance also contributes to higher subsequent ratings of therapeutic presence.

The concurrent correlations (i.e., *rTW*) represent to what degree deviations from the person-specific mean in one variable (e.g., therapeutic presence) are related to that in the other variable (e.g., working alliance) within the same session. A significant *rTW* means that there is a significant relationship between the residuals in therapeutic presence and working alliance within the same therapy session. In other words, a higher level of residuals in therapeutic presence is associated with a higher level of residuals in working alliance. Lastly, to separate the associations between therapeutic presence and working alliance at the within-person level from the between-person level, two between-person, latent random intercepts for therapeutic presence (indicated as "RITP" in Figure 1) and working alliance (denoted as "RIWA" in Figure 1) are introduced and specified with their path coefficients to all observed scores in the RI-CLPM

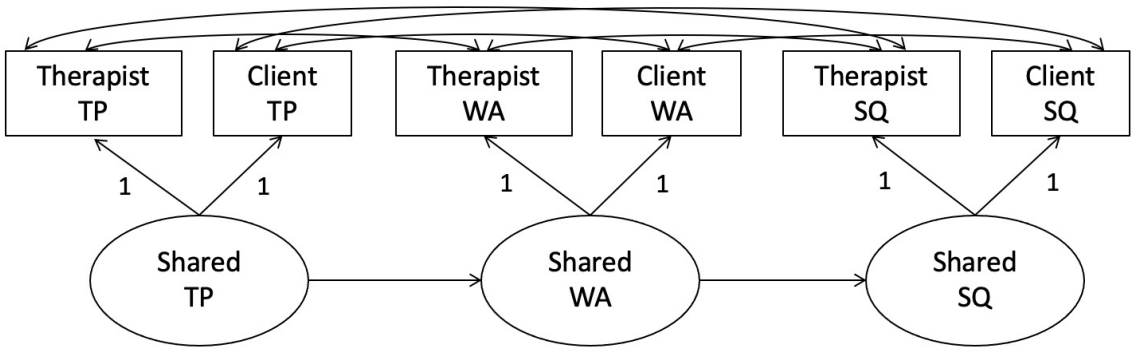
model fixed at one. A significant correlation between the RITP and RIWA means that the between-person differences in therapeutic presence are significantly correlated with the between-person differences in working alliance. In other words, if a therapist-client dyad on average reports higher therapeutic presence, they also tend to report higher working alliance. The analytical details are further discussed in the method section.

Modeling Dyadic Process Using Common Fate Model

In the second part of the data analysis, I will utilize the Common Fate Model (CFM; Ledermann & Kenny, 2012), also known as the Latent Group Model (LGM; Gonzalez & Griffin, 2002), to further explore the relationship between therapeutic presence, working alliance, and session quality. Developed to distinguish between "individual perceptions" and "shared perceptions" within dyads, the CFM posits that the ratings given by two members of a dyad on a specific relational construct are influenced by a shared latent variable, representing their "dyadic" or "common" perspective (Ledermann & Kenny, 2012; Li et al., 2021).

The conceptual model using the variables in this study is depicted in Figure 2. In this CFM, the therapist and client ratings of therapeutic presence, working alliance, and session quality are predicted by a latent variable of their "shared perception" of therapeutic presence, working alliance, and session quality. The factor loadings from the latent shared variable onto the individual ratings of the therapist and the client are fixed to be one to statistically identify the model (Ledermann & Kenny, 2012; Li et al., 2021). Regression paths between the dyadic latent variables of "shared perceptions" (Li et al., 2021) are then specified to examine whether the therapists' and clients' "shared perception" of therapeutic presence is predictive of their "shared perception" of session quality, with the "shared perceptions" of working alliance as a potential mediator.

Between-Session Level



Between Therapist-Client Dyad Level

Figure 2: Hypothesized CFM with TP, WA, and SQ.
Note. TP= therapeutic presence; WA = working alliance; SQ = session quality.

Moreover, the residual covariances between variables reported by the same party (either the client or the therapist) represent the links between research variables at the "individual perception" level (Li et al., 2021). For example, the residual terms between therapists' ratings of therapeutic presence and session quality, and similarly between clients' ratings of these variables, illustrate the associations between the therapists' and clients' individual perceptions after their "shared perceptions" have been accounted for and controlled through the latent dyadic factor regressions (Li et al., 2021).

Specific Research Hypotheses

Directionality between Therapeutic Presence and Working Alliance. Based on existing theoretical propositions (Geller & Greenberg; 2010) and preliminary empirical evidence (Colosimo & Pros, 2015; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011) reviewed above, I tentatively hypothesize that:

Hypothesis 1: therapeutic presence temporally predicts working alliance over the course of the treatment in that higher therapeutic presence at one time point leads to greater working alliance at the subsequent time point.

Alternative Models. Although stronger theoretical and empirical support exists for the aforementioned Hypothesis 1, another alternative model is also plausible where working alliance temporally predicts therapeutic presence, or there is a reciprocal association between therapeutic presence and working alliance. For the first scenario, a better working alliance may serve as the relational foundation on which the therapist finds it easier to connect and empathize with the client and thus be more present therapeutically (Shafran et al., 2016). For the second scenario, as Granik's (2011) qualitative study on therapeutic presence suggested that a stronger therapeutic bond, a component of working alliance, might enhance therapist's capacity of being therapeutically present. Meanwhile, when the therapist is therapeutically present for and with the client, it can enhance both parties' experience of the therapeutic bond, thereby strengthening the quality of the connection between them.

Associations between Therapeutic Presence, Working Alliance, and Session Quality. Though there has not been any prior research using CFM to explore the associations between the shared and individual perceptions of therapeutic presence, working alliance, and session quality, past studies focusing on either the clients' experience of the therapist or the therapists'

experience of themselves all indicated a positive link between therapeutic presence and therapy outcome (Geller, 2010; Granick, 2011; Geller & Greenberg, 2012; Schwarz, 2018; Kelly & Papps, 2021). Therefore, I tentatively hypothesize that within the CFM model, there exists a significantly positive relationship between individual and shared perceptions of therapeutic presence and session quality, both at the between-session level and between therapist-client dyad levels. More specifically, I propose the following:

Hypothesis 2: Therapist-client shared perception of therapeutic presence predicts their shared perception of session quality at the between-session and between therapist-client dyad levels, respectively (see Figure 3).

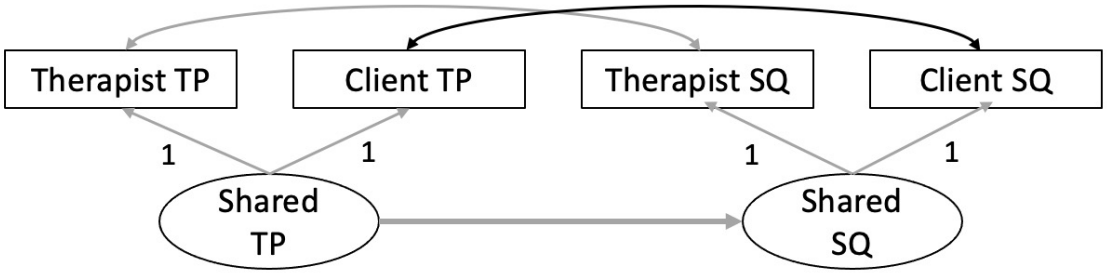


Figure 3: CFM with TP and SQ at the session and therapist-client level.
Note. TP= therapeutic presence; SQ = session quality.

Hypothesis 3: Therapists' and clients' individual perception of therapeutic presence is positively related to their individual perception of session quality at the between-session and between therapist-client dyad levels, respectively (As previously shown in Figure 3).

Finally, given the prior theoretical conceptualization regarding therapeutic presence as a precondition for the development of working alliance, and the established link between working alliance and session quality (Colosimo & Pros, 2015; Flückiger et al., 2018; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011; Zhao et al., 2022), I propose the last hypothesis

regarding a mediational model between working alliance, therapeutic presence, and session quality:

Hypothesis 4: Therapist-client shared perception of working alliance mediates the relationship between their shared perception of therapeutic presence and session quality at the between-session level (As previously shown in Figure 2).

Alternative Models. Additionally, if hypothesis 1 yields other results than hypothesized, I will need to test alternative mediation models. For example, if the findings from RI-CLPM indicate that working alliance temporally precedes therapeutic presence across therapy sessions, I will examine whether shared perception of therapeutic presence mediates the association between the shared perception of working alliance and session quality. The alternative model is depicted in figure 4.

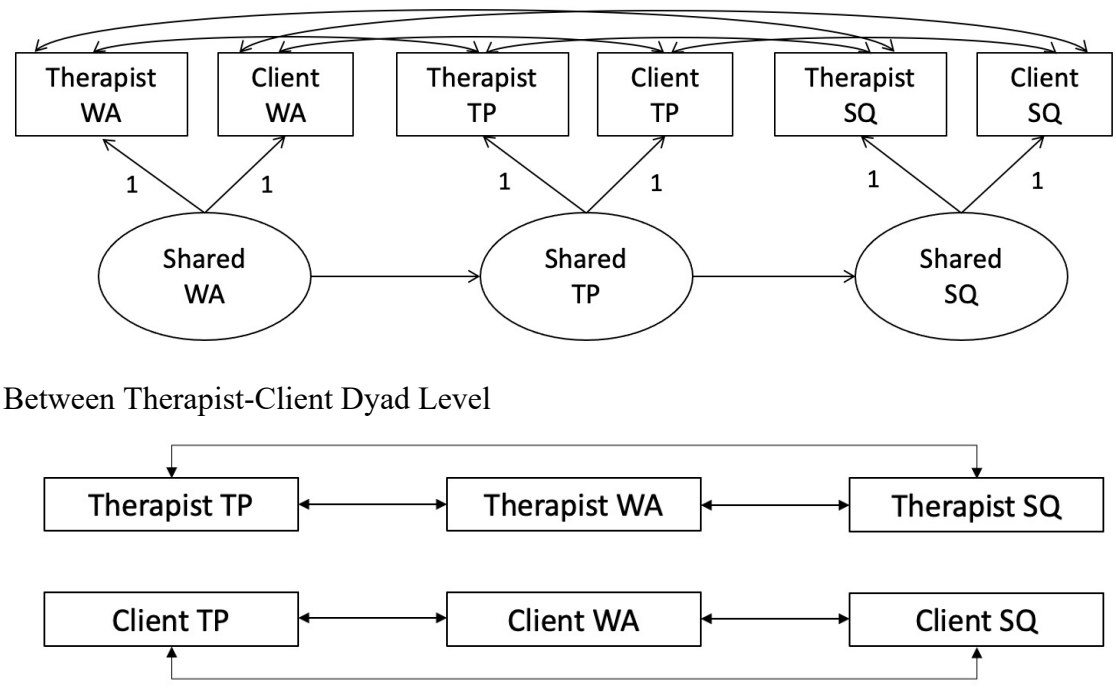


Figure 4: Alternative CFM with TP, WA, and SQ.
Note. TP= therapeutic presence; WA = working alliance; SQ = session quality.

Furthermore, if RI-CLPM reveals bidirectional relations between therapeutic presence and working alliance, I will test another alternative model where therapist and client shared perception of therapeutic presence is correlated with their shared perception of working alliance, both of which are then specified to predict their shared perception of session quality (see Figure 5).

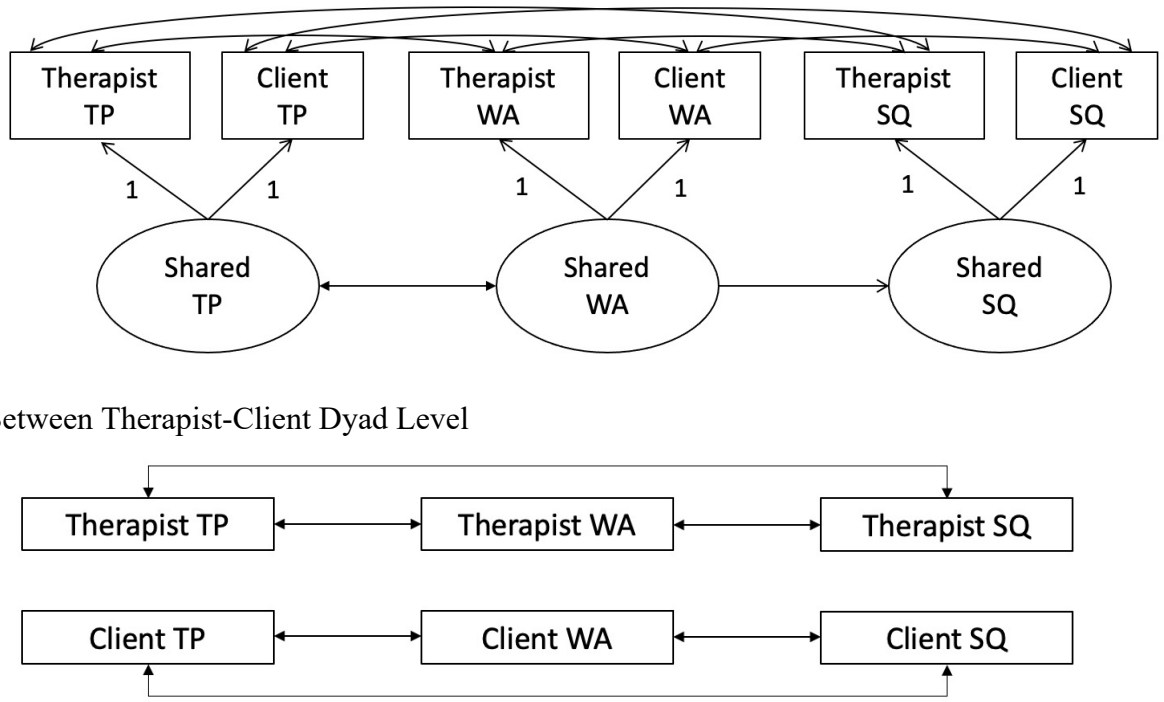


Figure 5: Alternative CFM with TP, WA, and SQ.
Note. TP= therapeutic presence; WA = working alliance; SQ = session quality.

Chinese Cultural Context and Therapeutic Presence

Last but not least, it is important to note that this study is conducted within the Chinese cultural context. To date, there has been limited research on therapeutic presence beyond the Western paradigm. Nonetheless, cultural values and customs may significantly influence how therapeutic presence is experienced and perceived by therapists and clients from diverse cultures

(Zhao et al., 2022). Compared to Western cultures, which emphasize maintaining interpersonal boundaries and independence in social relationships (Zhao et al., 2022), the teachings of Lao Zi and Confucius encourage the Chinese people to cultivate more interdependent social relationships. These relationships are characterized by harmony with others, guided by the principles of humanity and benevolence (Liu et al., 2021). In a relationship-oriented society like China, therapeutic presence, as a relational variable, plays a critical role in both the therapy process and its outcomes (Zhao et al., 2022). Additionally, Chinese culture places a high value on academic and professional achievements (Sun et al., 2021). The strong desire to be effective therapists and achieve better treatment outcomes may cause Chinese counseling trainees to experience heightened psychological distress and anxiety about their performance, particularly in the early stages of their training (Li et al., 2022; Zhao et al., 2022). It has been suggested that the distress and performance anxiety experienced by therapists can significantly impair their ability to remain therapeutically present during sessions (Bourgault & Dionne, 2019). Consequently, I speculate that certain aspects of Chinese cultural values may indirectly affect therapists' ability to establish and maintain therapeutic presence. This, in turn, may affect how therapeutic presence is experienced and perceived by their clients.

Furthermore, given the emphasis on the unity of self, others, and environment in social relations within the Chinese cultural context (Liu et al., 2021), it is relevant to consider both the therapist's and client's perspectives when examining therapeutic presence during psychotherapy. Taken together, therapeutic presence may be considered a culturally relevant variable for understanding both the professional development of counseling trainees and the dyadic nature of the psychotherapy process within the Chinese cultural context. The theoretical and practical significance of this common factor, coupled with the lack of empirical research on its

relationship with session quality in China, has collectively motivated me to conduct this study. Importantly, no data on cultural variables are collected in this study; therefore, I do not aim to test any hypotheses regarding cultural characteristics or differences. However, the aforementioned discussions highlight the cultural and practical importance of examining therapeutic presence in a sample of Chinese beginning trainees.

Chapter Two: Comprehensive Literature Review

Therapeutic Presence: Definition and Theoretical Considerations

Carl Rogers (1951) was one of the pioneering researchers in psychotherapy who dedicated much of his career to investigating the therapeutic relationship and the essential conditions required for therapeutic change, namely accurate empathy, therapist congruence, and unconditional positive regard. Toward the end of his career, however, Rogers reflected on his intense focus on the three core conditions and began to explore an additional essential component of healing in therapy, which he and subsequent person-centered psychologists have referred to as therapeutic presence (Baldwin, 2013). In his interview, he noted, "I recognize that when I am intensely focused on a client, just my presence seems to be healing, and I think this is probably true of any good therapist" (Baldwin, 2013, p.28). Rogers attempted to distinguish therapeutic presence from therapist-offered conditions (TOCs), suggesting that therapeutic presence might be a more extensive condition encompassing all three other core conditions (Baldwin, 2000). However, he was unable to deepen his understanding of the concept of therapeutic presence before his death (Geller & Greenberg, 2022). The nature of therapeutic presence and its effects on therapy outcomes continued to unfold after Rogers' death (Bugental, 1987; Schneider & May, 1995). For example, some researchers in psychotherapy have found a positive correlation between therapeutic presence and working alliance (Geller & Greenberg, 2002; Hayes & Vinca, 2011). In addition, it has been found that clients tended to attain better treatment outcomes when they sensed that their therapist was therapeutically present for them in therapy (Geller et al. 2010). Regardless of the broad acceptance and recognition of therapeutic presence, it remains a difficult concept to handle, with only broad theoretical definitions and explanations available to describe its components (Geller & Greenberg, 2012).

For instance, Bugental (1978, 1983, 1987) sought to define therapeutic presence in a concrete way by emphasizing three key elements: receptiveness and openness to all parts of the client's experience, an open attitude towards their own experience and reactions to clients when interacting with them in therapy, as well as the ability to respond to the client based on this experience. He highlighted the circular nature of his concept of therapeutic presence; specifically, the therapist assists clients in enhancing their capacity to be present by observing the client's level of presence and maintaining a therapeutic presence with and for them during sessions (Bugental, 1987). In addition, Bugental (1987) proposed, "presence is a quality of being in a situation or relationship in which one intends, at a deep level, to be as aware and as participative as one is able to" (p.27).

Buber characterized presence as the core of the I-Thou relationship (Buber, 1966; Hycner & Jacobs, 1995). In Buber's (1958) book I and Thou, he distinguished between two types of relational patterns in human interactions: I-It and I – Thou relationships. According to Buber (1958), the I-It relationship involves approaching a person from a distance, with a tendency to separate and objectify the other. In contrast, the I-Thou relationship is characterized by a natural connection and direct contact, engaging with the client's unique experiences without judging or objectifying them. Therefore, in an I-Thou relationship, therapeutic presence is reflected in the therapist offering their whole self to the client while remaining detached from their own assumptions about the client's concerns and refraining from the desire to facilitate changes in the client (Buber, 1956). As Clarkson (1997) pointed out, this state seems inherent in the transpersonal relationship.

Buber (1958) argued that it is the "meeting" between the therapist and client that facilitates healing and therapeutic changes. Levinas (1985), however, argued that the relationship

between two individuals goes beyond the "symmetrical co-presence" described in Buber's I-Thou relationship, proposing instead that the relationship is inherently asymmetrical. That being said, in a face-to-face encounter, individuals are required to take responsibility for responding to the other, placing each person in the service of the other (Levinas, 1985). In other words, therapeutic presence places a demand on the therapist to respond to their clients (Geller & Greenberg, 2022), and Levinas (1985) believed that it is the responsiveness as a result of being present that makes therapeutic presence healing in therapy.

In addition, therapeutic presence is also defined as a therapist's capacity to be aware of and get in touch with the various aspects of themselves while in therapy with the client (Robbins, 1998). As an art therapist, Robbins (1998) also viewed therapeutic presence as including an aspect of understanding what is happening through actively listening to the client's experience and identifying and reading their body language. In this context, therapeutic presence involves maintaining a balanced awareness of both the therapist's own experience and the client's experience, which was termed by Robbins (1998) as a "dual level of consciousness" (p.11). On one hand, a therapist's self-knowledge and self-awareness enable them to stay attuned to the client's experience, thereby creating a safe and accepting environment that encourages the client to bring up the material they wish to process (Robbins, 1998). On the other hand, being open and accepting of the client's complete experiences can lead to deeper and more meaningful interactions (Hycner, 1993; Moustakas, 1985; Robbins, 1998).

More recently, Geller and Greenberg (2002) defined therapeutic presence as bringing one's whole self into therapy, staying attuned to clients' here-and-now experiences, and fully engaging with them on multiple levels—physically, cognitively, emotionally, relationally, and spiritually— in a manner that can be experienced or sensed by clients (Geller & Greenberg,

2002). According to Geller and Greenberg (2010), therapeutic presence involves (1) therapists being aware of themselves from moment to moment while staying (2) receptive and open to clients' experiences and focused on what is essential in the present moment. In addition, this grounded and immersed awareness is integrated with (3) therapists' attempts to be with the clients when facilitating the healing process (Geller & Greenberg, 2010).

Although therapeutic presence has not been defined and conceptualized consistently across various therapy approaches, some essential qualities and similarities can be theoretically extracted from the existing literature on therapeutic presence. For example, therapeutic presence has been described as the therapist bringing their whole self to the engagement and being fully in the present moment with and for the client, without much self-centered intention or goal in mind (Craig, 1986; Hycner & Jacobs, 1995; Robbins, 1998; Webster, 1998). In addition, it appeared that therapeutic presence requires the therapist to remain mindful of their moment-to-moment experiences and reactions during interactions with the client. This awareness enables therapists to utilize this information to better understand and respond to the client and to intentionally assist the client in staying present during the session. Furthermore, the essence of therapeutic presence, as defined and conceptualized, involves a process where therapists shift their focus from themselves to the other, from internal processes to external interactions, and from being non-judgmental and receptive to becoming responsive.

In the current study, we adopted the definition of therapeutic presence from Geller and Greenberg (2002), which describes it as "bringing one's whole self into the encounter with the client, being completely in the moment on a multiplicity of levels—physically, emotionally, cognitively, and spiritually—in a way that can be experienced or sensed by clients" (p. 82-83). Counseling psychologists developed the concept of therapeutic presence through their practice

over the last fifty years (Geller & Greenberg, 2022). Meanwhile, some psychotherapy researchers have dedicated efforts to empirically test the existence of therapeutic presence (Pemberton, 1977; Phelon, 2001, 2004).

Research on the Concept of Therapeutic Presence

Empirical Evidence on the Concept of Therapeutic Presence.

Theoretically, therapeutic presence has been viewed as the foundation for quality therapy (Hycner, 1993; Moustakas, 1969; Rogers, 1986). In the last section, we reviewed how therapeutic presence was historically defined in the literature. Despite the existing gap between the rich theoretical speculations about therapeutic presence and its limited empirical research, considerable efforts have been devoted to narrowing this gap (Geller & Greenberg, 2022).

In addition to conceptual knowledge, empirical evidence has provided a more precise and nuanced understanding of therapeutic presence. Therefore, this section will explore the empirical findings related to the concept of therapeutic presence.

In an early, unpublished study, Pemberton (1977) sought to operationally define therapeutic presence and develop a model that explained how it is achieved, maintained, and lost. Pemberton (1977) interviewed five experienced therapists who were committed to maintaining therapeutic presence with their clients during sessions. After providing them with sufficient training—ranging from two weeks to two months—he observed these therapists' views on self, significant relationships, their perspectives on therapy, as well as their therapy sessions and supervision practices. Pemberton (1977) documented all his observations and reflections throughout this process. He then employed nine separate questioning strategies to gather data from the unstructured interviews, which he combined with insights from his own reflections and observations. Pemberton (1977) concluded that therapeutic presence was not an interpersonal but

intrapersonal process where only the therapist could be relied on for achieving the presence. More specifically, Pemberton (1977) observed that therapists who exhibited therapeutic presence typically demonstrated awareness, acceptance, and appreciation of themselves in relation to others. They tended to remain attuned to the present moment and be transparent with others. Consequently, Pemberton (1977) defined therapeutic presence as the therapist's ability to maintain a strong sense of their totality and integrity in the present moment.

In addition, this study also identified four factors contributing to therapeutic presence: *commitment, focusing, enfolding, and extending* (Pemberton, 1977). *Commitment* represents the therapist's determination to being present for both themselves and their clients. *Focusing* describes the therapist's ability to clear their mind and prepare for whatever may arise in therapy; it also aids in maintaining presence once established. *Enfolding* involves the therapist actively immersing themselves in the client's personal world, enhancing their understanding of the client at a deeper level and promoting a less self-centered approach to the client's issues. Finally, *extending* requires the therapist to expand his boundaries to approach the client, thereby creating a safe, receptive, supportive, and caring environment and atmosphere (Pemberton, 1977). In summary, starting with a foundation of commitment, the therapist endeavors to cultivate therapeutic presence through the use of "generating forces" such as focusing, enfolding, and extending (Pemberton, 1977, pp.94-97).

Pemberton (1977) provided an operational definition of therapeutic presence and sought to enhance our understanding of how presence is achieved and maintained in therapy. He proposed that therapeutic presence is primarily a function of intrapersonal and individual rather than interpersonal processes. However, these results were inconsistent with Merleau-Ponty's (1962) and Spiegelman's (1996) theories of human relations and therapeutic presence, in which

they suggested the therapist can't avoid or resist the pervasive and constant impact brought by the client in a therapeutic relationship. In addition to discrepancies with existing literature, two significant limitations of Pemberton's study should be noted. First, while all participants were experienced therapists who were famous for their therapeutic presence with clients, they were exclusively white individuals who maintained at least a middle-class standard of living. The lack of diversity among research participants might prevent us from understanding therapeutic presence from varied perspectives, potentially limiting the generalizability of the findings to a larger population. A second limitation concerns the absence of a clearly prescribed qualitative methodology. While the study appeared to resemble a multiple case study, the absence of a defined methodology meant there was no formal process in place to verify the main themes of therapeutic presence identified in the study.

Immediately following Pemberton (1977), there was another unpublished phenomenological research on therapeutic presence from the perspective of therapists, aiming at exploring and elaborating on a thematic model of therapeutic presence (Fraelich, 1988). Participants were six psychotherapists aged from 31 to 45 who received at least a master's degree in counseling psychology and were known for being therapeutically present with their clients (Fraelich, 1988). Fraelich (1988) interviewed these therapists and applied the phenomenological data analysis method to extract and organize the meaningful units from the transcriptions of the interviews. As a result, four core themes emerged: (a) presence as a spontaneous occurrence, (b) immersion at the moment, (c) openness of being, and (d) living on the cutting edge. Other thematic structures also contained self-sacrifice, the therapist's expression of themselves, immersed experience in clients' personal world, therapeutic bond with the client, and being genuine and authentic with self and the other.

Contrary to Pemberton (1977), Fraelich (1989) concluded that therapeutic presence was an interdependent or interpersonal experience. He defined therapeutic presence as "an intense and richly lived moment" that is jointly experienced by both the client and the therapist (Fraelich, 1989). One possible explanation for the discrepancy between Pemberton's and Fraelich's findings could be the different methodological approaches each researcher employed in their studies. However, both studies lacked clear explanations for their choice of methodology, which made it difficult to discern and understand the nuances of their differences more precisely.

Additionally, despite their shared interest in exploring the experience of therapeutic presence from the therapist's perspective and selecting similar populations for their research, neither Pemberton (1977) nor Fraelich (1989) designed their studies with the goal of reaching an empirical consensus on how therapists understand and perceive therapeutic presence during sessions. Even so, Fraelich (1989) insisted that his study has provided sufficient evidence for the existence of therapeutic presence. He proposed that therapeutic presence might play an essential role in therapy effectiveness and advocated for further research to examine the importance of therapeutic presence in therapy (Fraelich, 1989).

In response to methodological concerns raised by previous studies, a more recent study employed a combination of various methodologies, which the author termed "Intuitive Inquiry," to explore the themes and qualities of therapeutic presence (Phelon, 2004). Specifically, these methods involved conducting qualitative interviews with twelve individual therapists, observing therapists who engaged in personal therapy and experienced therapeutic presence as clients, and performing hermeneutic analysis of the transcribed interview texts. Based on this research, Phelon (2004) concluded that therapeutic presence is an indispensable component of therapy,

best understood as processes within the therapists' selves rather than as a list of their personal qualities.

Taken together, these earlier studies provided preliminary empirical evidence for the existence of therapeutic presence by elaborating on the concept and suggesting potential relationships between therapeutic presence and both the therapist-client relationship and therapy outcomes. Although these initial studies advanced our understanding of certain aspects of therapeutic presence, many remain unpublished and are not free from methodological concerns. Consequently, relying solely on these early findings may not yield a clear definition of therapeutic presence or a comprehensive understanding of its role in fostering a strong working alliance and enhancing therapeutic effectiveness. As a result, it is crucial to also consider research on therapeutic presence within modern empirical frameworks to obtain a more robust and clinically useful understanding

A Model of Therapeutic Presence

Geller & Greenberg (2002) conducted a qualitative study to develop a model of therapeutic presence. They recruited and interviewed seven senior psychotherapists who considered therapeutic presence to be essential to their practice. All participants had been practicing psychotherapy for at least ten years and were actively engaged in counseling practice at the time of their participation. Regarding theoretical orientations, four therapists were oriented towards humanistic or experiential approaches. The remaining participants included one therapist from each of the following backgrounds: Adlerian or transpersonal therapy, cognitive behavioral therapy, and Eriksonian therapy.

Therapists were initially provided with a basic definition of therapeutic presence from the literature and then asked to reflect on their own experiences of it after completing a session with

their clients. This reflection period lasted for two to three weeks, after which they participated in more in-depth interviews. During these interviews, therapists were encouraged to describe their experience of therapeutic presence across multiple dimensions: physically, emotionally, and cognitively. To analyze the interview transcripts, a method that combined condensation and categorization (Kvale, 1996) was employed. This approach allowed the researchers to qualitatively analyze and interpret the data, extracting the core elements of therapeutic presence from the transcripts and gradually refining them into meaningful and concise statements that captured the essence of therapeutic presence.

The therapeutic presence model emerging from the qualitative analyses consisted of three higher-order categories. The first overarching category is *preparing the ground for presence*, referring to therapists' intentions and behaviors in personal life and at the early stage of a session that can increase the possibility for therapeutic presence to be created and experienced in therapy. *Preparing the ground for presence* consisted of two subthemes: in life and in session. The second is the *process of presence*, involving the therapist's activities when presenting with a client. This emergent domain addressed subthemes of receptivity, inwardly attuning, extending, and contact. The last grouping is *embodied experience of therapeutic presence*, reflecting the actual experience of therapeutic presence itself in session. It focused on subthemes of grouping, immersion, expansion, and compassionately being with and for the client. Geller and his colleague (2002) suggested that therapeutic presence is not simply the sum of its components. According to them, it involves "a complex interplay of therapeutic skill and experience guided by the underlying intention and experience of fully being in the moment and meeting that experience with the depth of one's being" (Geller & Greenberg, 2012, p.42).

Development of the Therapeutic Presence Measures

Following the creation of the therapeutic presence model (Geller & Greenberg, 2002), Geller and his colleagues (2010) developed two measures aiming at assessing both the therapist's and client's perception and experience of therapeutic presence (i.e., Therapist Presence Inventory-Therapist, Therapist Presence Inventory-Client). The development of the TPI-T involves four successive stages (Geller et al., 2010; Geller & Greenberg, 2012): 1) item selection, 2) item refinement, 3) scale construction, and 4) scale refinement/construct validity. On the basis of the model of therapeutic presence (Geller & Greenberg, 2002), each stage was built upon the findings of the former phase. Additionally, a fifth stage was created to develop an initial measurement of the client's perception of their therapist's presence. As a result, this study generated two versions of the TPI with a seven-point Likert scale. Specifically, TPI-T contains twenty-one items to measure therapists' perception of therapeutic presence. At the same time, the TPI-C includes three items to measure the client's perception of the therapist's presence in the session.

Geller et al. (2010) perceived these two measures as possessing good face and construct validity, attributing this to their foundation in a well-established model of therapeutic presence. The authors further examined these two measures' reliability and validity by administrating TPI-T and TPI-C in two randomized controlled studies focused on the treatment of depression. Participants in these studies, including therapists and clients, were from York University, Ontario Institute for Studies in Education, and the University of Toronto. More specifically, in these two studies, 25 therapists with diverse theoretical orientations—including emotion-focused therapy, client-centered therapy, and cognitive behavioral therapy—worked with 114 clients diagnosed with major depressive disorder. All therapists were required to complete the Therapist Presence

Inventory (TPI-T) after every third session and the Relationship Inventory (RI; Barret-Lennard, 1973) after the sixth and twelfth sessions, respectively. These measures were used to explore the association between the therapist's perception of therapeutic presence and the core conditions of the therapist-client relationship. Meanwhile, TPI-C was administered to clients after every third session. Additionally, clients were instructed to complete the short version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and a post-session outcome measure called the Client Task Specific Measure (CTSC-R; Watson et al., 2010). These tools were used to explore the relationship between client-perceived therapeutic presence and in-session changes.

The results indicated that the measures exhibited good reliability across various therapy approaches (Geller et al., 2010). Furthermore, the therapists' ratings on TPI-T showed positive correlations with four aspects of the therapeutic relationship: congruence, empathy, acceptance, and unconditional regard. These findings provided empirical support for the measure's concurrent validity. Regarding the client's perception of therapeutic presence, research findings indicated a significant positive relationship between the clients' ratings of the therapist's presence and the working alliance and session outcome. In other words, when clients perceive their therapists as being fully present with and for them, they are more likely to experience a stronger working alliance and achieve better therapy outcomes, regardless of the therapists' theoretical orientation. Moreover, the researchers observed a discrepancy between therapists' and clients' ratings of therapeutic presence, with therapists often reporting higher levels of presence than their clients. One potential explanation for this incongruence could be that the therapists in this study may have struggled to communicate their presence in a manner that their clients could sense or feel in sessions. However, the researchers did not further explore how this disagreement

on therapeutic presence between therapist and client might influence clients' changes within the session.

In an effort to shorten the TPI-T (Geller et al., 2010) and retain only high-quality items that clearly capture therapists' perceptions of therapeutic presence, Zhao et al. (2022) developed a brief version of the Therapist Presence Inventory-Therapist (TPI-T-Brief) in a sample of 131 Chinese therapist trainees from a master's level clinical mental health counseling program at a university located in Northern China. Therapist trainees involved in the study completed the TPI-T, rating their perceptions of therapeutic presence, working alliance, and session quality for each therapy session. Additionally, 646 clients who were working with these trainees also participated in this study, completing the client versions of the working alliance and session quality measures. Utilizing multilevel item response theory (M-IRT), researchers successfully shortened the 21-item TPI-T into a brief version consisting of six items, with three items positively worded and three negatively worded.

The authors further examined the reliability and validity of the TPI-T-Brief within a multilevel analysis framework. For example, they used McDonald (1999) 's ω to estimate the reliability. Regarding validity, the researchers tested how TPI-T-Brief ratings might predict therapists' and clients' ratings of working alliance and session quality at both the between-person level across therapist-client dyads and the within-person level across sessions. Additionally, they explored the correlation between therapist presence and session quality, accounting for the effects of the therapists' and clients' shared perceptions of working alliance at both the session and dyad levels, using the Common Fate Model (CFM; Ledermann & Kenny, 2012).

The findings provided preliminary empirical support for the reliability and validity of the shortened version of the TPI-T, now referred to as TPI-T-Brief. Specifically, Zhao et al. (2022)

reported an omega coefficient of .85 for the full TPI-T-Brief scale, affirming its reliability. Regarding validity, they observed strong correlations between the total scores of the TPI-T-Brief and its original scale, the TPI-T, which supports its convergent validity. Additionally, Zhao et al. (2022) found that the total score of the TPI-T-Brief was significantly correlated with four criterion variables—namely, the therapist's and client's ratings of working alliance and session quality. These findings provided preliminary empirical support for the concurrent validity of the TPI-T-Brief. Moreover, the CFM analyses revealed that the ratings of the TPI-T-Brief were associated with the therapists' and clients' shared perceptions of session quality, even after accounting for the effects of their shared perceptions of working alliance at the session level. These results suggested that the TPI-T-Brief captured unique aspects beneficial to session quality, which were not reflected in the shared perception of the working alliance between therapists and clients

Therapeutic Presence and Therapy Outcomes

Therapeutic presence can potentially enhance the therapeutic relationship and improve session quality across various theoretical orientations and populations (Geller & Greenberg, 2022). Therefore, therapeutic presence is often considered a transtheoretical or a common factor (Geller, 2017; Hayes & Vinca, 2011). For example, therapeutic presence has been found to provide a foundation for therapists' empathy, the establishment of working alliance, and improvements in therapy outcomes (Geller et al., 2010). In this section, I will review the qualitative and quantitative studies on the effects of therapeutic presence on psychotherapy outcomes across various therapeutic approaches and populations.

Qualitative Research Findings

Haley (2014) conducted a phenomenological study to explore therapists' perceptions of therapeutic presence and its impact on counseling self-efficacy and therapy outcomes. The participants were four therapists who self-identified as Caucasian males and had been engaged in counseling practice for at least 17 years. All the therapists had experience teaching psychotherapy-related courses at the undergraduate or graduate level. They participated in semi-structured interviews that focused on their understanding of and experiences with therapeutic presence in therapy. The data collected from these interviews was then analyzed to identify overarching patterns and themes. Results indicated that therapeutic presence was understood as attending to, understanding, and being there with and for the client while observing their internal reactions to their clients and as a predictor of positive therapeutic outcomes. Additionally, the participants viewed therapeutic presence not merely as an inherent quality but as a therapeutic skill that contributes to counseling self-efficacy, client growth, and overall therapeutic efficacy. Given the significant impact of therapeutic presence on therapeutic effectiveness, Haley (2014) suggested that counseling psychology programs should offer training to help students develop this crucial skill.

In contrast to Haley (2014), Brodley (2000) focused on the clients-perceived qualities of therapeutic presence and conducted a naturalistic qualitative pilot study to understand the components of therapeutic presence and how it might affect treatment outcomes from the perspectives of clients who were treated with person-centered therapy. The researcher invited eight current or former clients to participate in the study and to describe their impressions of his presence in therapy within 10 words. Subsequently, participants were asked to use no more than 10 words to describe the presence of a therapist without therapeutic presence or with a counter-

therapeutic presence they worked with or observed in the past. Findings suggested that both therapists' subtle physical manifestations (e.g., emotionally stimulated changes in skin tone) and more overt expressions (e.g., postural adjustments) can contribute to clients' perceptions of therapeutic presence. Furthermore, clients in this study reported being positively influenced by the therapeutic presence, leading the researcher to conclude that therapeutic presence could significantly predict therapeutic outcomes. Brodley's findings also reinforced the idea that for therapeutic presence to be effective in fostering therapeutic relationships and enhancing treatment outcomes, it must be communicated non-verbally by the therapist and experienced and sensed by the client (Geller, 2017; Geller et al., 2010).

Therapeutic presence has been proposed as a precondition for providing effectively delivering EFT for couples (Feuerman, 2018; Furrow et al., 2012; Greenberg, 2015). Feuerman (2018) carried out a qualitative systematic literature review to explore the role of therapeutic presence in the practice of EFT. This review involved analyzing peer-reviewed journal articles that employed quantitative, qualitative, and mixed methods, and that focused on therapeutic presence, EFT, and the relationship between the two. Based on the research findings, Feuerman (2018) concluded that therapeutic presence significantly contributes to the effectiveness of EFT. Specifically, therapeutic presence bolsters therapists' abilities to establish and maintain a strong working alliance, repair ruptures in the therapist-client relationship, focus on emotions, recognize obstacles to the effectiveness of EFT, and facilitate positive changes in clients. This supports the idea that effective EFT practice requires more than just mastery of its techniques; it also necessitates developing the capacity to be fully present with and for clients.

The therapeutic presence is essential to successfully achieving key change events in EFT (Feuerman, 2018). Furrow and colleagues (2012) explored the role of the therapist's emotional

presence in emotionally focused couple therapy by analyzing videotaped EFT sessions conducted by Dr. Susan Johnson. Their study focused specifically on the blamer softening event—a pivotal moment in EFT where a partner, typically critical and dissatisfied, begins to soften and seek connection from the other partner. This event is significant as it often marks a major turning point in the therapeutic process of couple therapy. Specifically, transcripts of the audio or videotapes of five EFT sessions were coded utilizing the protocols that assessed client and therapist levels of emotional experience and vocal quality. In addition, experiencing scales and vocal quality scales were administrated with both the therapist and client to code their levels of emotional presence in successful and unsuccessful softening and blaming moments. Findings indicated a positive relationship between therapists' emotional presence (e.g., therapist awareness and responsiveness, softened vocal quality) and clients' increased depth of experience. The researchers also found that therapeutic presence could assist clients in getting in touch with their more profound emotional experiences, which was essential to successful treatment outcomes in EFT for couples.

Crenshaw and Kenny-Nozika (2014) explored the role of therapeutic presence in play therapy for children, noting that existing research predominantly focused on the experiences of adult clients, which might lead to the lack of attention to younger populations. These authors stressed the necessity of therapeutic presence and therapist-client relationship in play therapy. They presented two case studies in which the therapist's presence was considered the central healing component in the context of childhood trauma. These studies involved two children who had lost and witnessed the death of their mother, and a third child who suffered from complex trauma. Crenshaw and Kenny-Nozika (2014) concluded that therapeutic presence created trust

and safety in the therapeutic relationship, which, in turn, contributed to the progress in play therapy with these children.

Therapeutic presence is a crucial component of art psychotherapy (Geller & Greenberg, 2022). For example, Coles (2014) considered therapeutic presence as the spatial ground for what happens within art therapy, characterized by a quality of stillness and permanence that subtly adapts to the client's experiences from moment to moment. Schwarz et al. (2018) conducted a phenomenological study to explore art therapists' experiences of therapeutic presence. The study involved 14 experienced art therapists who also supervised other therapists in addition to their own clinical practice. Through semi-structured interviews, the research gathered information related to various aspects of therapeutic presence, including the therapists' theoretical orientations, their self-perception during therapy, the relational dynamics of their presence, and client feedback and progress. The authors then employed a grounded theory approach to analyze and code the interview transcripts, identifying and categorizing key concepts. Three primary categories of therapeutic presence emerged during the process: (a) components of therapeutic presence (e.g., attention to art, body, and emotion, joining with clients, being open-minded to the unknown, and sense of being fully present); (b) preparation for therapeutic presence (e.g., mental preparation, preparation through regular supervision, belief in the therapeutic presence, and the power of art); and (c) influences of therapeutic presence (e.g., clients' presence, treatment progress, external factors to the therapeutic presence). Based on these findings, Coles (2014) argued that by enhancing their understanding and practice of therapeutic presence, art therapists could become more attuned to their clients, thereby strengthening both the therapeutic relationship and treatment outcomes.

The qualitative studies previously reviewed focused on individual or couples therapy. However, other researchers have investigated the concept and impact of therapeutic presence in group therapy settings (Crane-Okada, 2012; Leszcz, 2018). For example, Crane-Okada (2012) used a sequential method to demonstrate the role of therapeutic presence in group therapy dynamics. Specifically, the first step focused on preparing and establishing the necessary conditions for group therapy, laying the groundwork for therapeutic presence. The second step emphasized the therapist's intention to build connections with group members, setting the stage for therapeutic presence in subsequent sessions. The third step involved navigating through two stages of group development as proposed by Yalom and Leszcz (2005): “storming” and “norming.” As therapeutic presence evolved during this step, the group became more mature, moving from a phase marked by conflict and hostility towards the facilitator to one of stability and cohesiveness, ultimately experiencing full presence. Throughout the process, group facilitators consistently strived to establish a strong alliance, regardless of the dynamics that emerged in the sessions. Step 4 involved a deeper and more authentic interaction between therapists and clients, where the development of therapeutic presence helped clients explore their own dispositions and experience transformative forces. The final step highlighted the importance of remaining present with feelings of anxiety and sadness that may arise at the group's conclusion and during reflections on the overall group process. Inspired by Yalom and Leszcz (2005), the author stressed the primary themes inherent to the five-step process of therapeutic presence in group psychotherapy. They noted that failing to successfully navigate any of these steps could lead to dissatisfaction among both therapists and group members.

Quantitative Research Findings

Geller (2010) examined whether therapeutic presence significantly predicted positive session outcomes across emotion-focused therapy, client-centered therapy, and cognitive behavioral therapy. Participants of this study, including therapists and clients, were from York University, Ontario Institute for Studies in Education, and the University of Toronto. More specifically, 25 therapists from various theoretical orientations (i.e., EFT, CCT, and CBT) worked with 114 clients with a diagnosis of major depressive disorder. After every third session, TPI-T and TPI-C were administered to all the therapists and clients to measure their respective perceptions of therapeutic presence. Clients were also asked to complete a post-session outcome measure, namely Client Task Specific Measure (CTSC-R; Watson et al., 2010), to investigate the association between the client-perceived therapeutic presence and in-session change. Results indicated that compared with CCT and EFT, both CBT therapists and clients tended to rate themselves lower on their perception of therapeutic presence. However, within the context of CBT, clients who rated their therapists higher on therapeutic presence perceived the session outcome as significantly better compared to those who rated their therapists lower on therapeutic presence. Geller (2010) argued that therapeutic presence might be vital in more manualized therapeutic approaches, including CBT, even though it is not traditionally practiced or integrated into the approach.

Zhao et al. (2022) tested how therapists' ratings of therapeutic presence might predict therapists' and clients' ratings of working alliance and session quality at both the between-person level across therapist-client dyads and the within-person level across sessions. They were also interested in whether therapist presence correlated with session quality after accounting for the effects of the therapists' and clients' shared perceptions of working alliance at the session and

dyad levels using the Common Fate Model (CFM; Ledermann & Kenny, 2012). Participants included 131 Chinese therapist trainees and their 646 clients from a master's level clinical mental health counseling program at a university located in Northern China. Therapist participants completed the TPI-T and the therapist versions of WAI-SR and SES to assess their perceptions of therapeutic presence, working alliance, and session quality at each therapy session. Meanwhile, 646 clients working with these therapist trainees also participated in the study and completed the client versions of WAI-SR and SES. Zhao et al. (2022) observed that the total score of TPI-T was significantly correlated to four criterion variables, including the therapist's and client's ratings of working alliance and session quality. Moreover, the CFM analyses showed that the ratings of the therapist presence were associated with the therapists' and clients' shared perceptions of session quality after accounting for the effects of their shared perceptions of working alliance at the session level. In other words, these findings suggested that the therapist presence uniquely captured some components beneficial for the session quality that was not measured in the therapists' and clients' shared perception of the working alliance.

Critique of the Existing Literature

All the above theoretical and empirical evidence suggest that therapeutic presence, as a common factor, is trans-theoretical in that it helps optimize the functioning of both parties in a therapeutic relationship across a wide breadth of theoretical orientations (Geller & Greenberg, 2022). While therapeutic presence has been identified as a primary component contributing to the therapeutic relationship and session quality (e.g., Furrow et al., 2012; Geller et al., 2010; Goldner, 2016), we should also draw our attention to a few limitations in the existing literature. First, therapeutic presence is characterized by the therapists being well aware of their own bodily and emotional state and reactions to the client (e.g., countertransference responses) while

engaging themselves fully in the therapeutic encounter in a manner that can be experienced or sensed by the client (Geller, 2017; Geller & Greenberg, 2002, 2012; Geller et al., 2010; Hayes & Vinca, 2011, 2017). That being said, therapeutic presence is inherently dyadic, relational, and interdependent (Fraelich, 1989; Geller, 2020; Schmid, 2002). Geller and Greenberg (2022) further explained that the more therapeutically present the therapist is, the more likely the client is able to be present with and accepting of themselves, and the more present the client becomes, the greater the therapeutic presence the therapist develops and maintains in session. Additionally, the dyadic and relational aspect of therapeutic presence was also emphasized by Schmid (2002) in his writings, as he pointed out that therapeutic presence is like "joint experiencing with the client" (p.65). Thus, the effects of therapeutic presence on the therapeutic relationship and session quality might be attributed to the perspective of both parties (Bernhardt et al., 2021). While therapeutic presence has been found as a primary factor for the development of working alliance and efficacious therapy, the existing studies failed to take a "two-person" or dyadic perspective when measuring and modeling therapeutic presence but focused solely on *either* the client's experience of the therapist (Geller, 2010; Granick, 2011) *or* the therapist's experience of themselves (Geller & Greenberg, 2012; Schwarz, 2018; Kelly & Papps, 2021), which overlooked an important possibility that the treatment outcome might be attributable to the shared perspectives of the therapist and the client. Furthermore, the domination of studies focusing on the effects of "individual perception" of therapeutic presence on working alliance and therapy outcomes (Geller, 2010; Granick, 201; Geller & Greenberg, 2012; Schwarz, 2018; Kelly & Papps, 2021) in the existing literature may create barriers to understanding how therapeutic presence works specifically in therapy, gaining insights into the internal challenges (e.g., within the therapists) and external challenges (e.g., from the client or the therapeutic relationship) to

engaging fully and intimately in the present moment in a therapeutic interaction, as well as developing specific approaches to cultivating and enhancing therapeutic presence (Barkham & Castonguay, 2021; Bernhardt et al., 2021; Geller & Greenberg, 2022).

In addition, most existing research in this area used cross-sectional data to explore the concurrent associations between therapeutic presence and therapy outcome. Very few used longitudinal data and multilevel modeling to disaggregate the relationship between these two variables at the session level (differences between session within individual clients), the client level (differences between clients within a therapist), and the therapist level (differences between therapists). Although bivariate correlations from cross-sectional data might indicate potential links between different variables, such associations are confounded because one cannot determine whether the observed relationships are due to differences between sessions, differences between clients, or differences between therapists (Li et al., 2021; Zilcha-Mano et al., 2016). In contrast, separating different levels of effects allow us to understand whether and how much the association between various variables is attributed to the therapist-client dyad effects *or* session effects, while keeping the effects at the other level constant (Li et al., 2018). Practically, considering these multilevel distinctions helps us disentangle the contribution of therapist-client dyad effects to session differences (Baldwin & Imel, 2014) and thus lead to important clinical implications for our practice in therapist training and supervision (Li et al., 2018).

The Mediating Effect: Working Alliance as a Mediator

The Relationship between Therapeutic Presence and Working Alliance

Whereas there was theoretical and empirical support for the association between the therapeutic presence and session quality, no published study has explored and investigated the

potential mediating mechanism. One such potential mediator is the working alliance, and the mediation path can be written as: Therapeutic Presence →Working Alliance →Session Quality. Regarding this mediation path, studies indicate that being therapeutically present in session might be an essential precursor to establishing and maintaining a strong therapeutic alliance (Colosimo & Pros, 2015; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011).

For instance, Geller and his colleagues (2010) examined the association between the therapeutic presence and working alliance. Participants included 114 clients from the clinics at York University, Ontario Institute for Studies in Education, and the University of Toronto. All the clients were diagnosed with major depressive disorder before participating in the study and treated with one of the three therapeutic approaches (i.e., EFT, CBT, and CCT). Clients were given the TPI-C immediately after every third session (sessions 3, 6, 9, 12, and 15) to assess their perception of therapeutic presence and a short version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The results showed that clients' ratings of therapeutic presence significantly predicted their ratings of working alliance. In other words, clients tended to feel a more robust working alliance when they sensed their therapist was truly present with and for them. These research findings were consistent with Oghene et al. (2010) and Pos et al. (2011), in which they found that clients' perception of therapeutic presence at the early stage of therapy (i.e., session three) was associated with a stronger and more robust working alliance in later stage (i.e., by session fifteen).

In a study of 200 psychodynamic-oriented therapists in Israel, Goldner (2016) examined the relationship between therapists' perception of working alliance, therapeutic presence, and self-object needs. Therapists were asked to choose one of their clients and report on their therapeutic relationship. Additionally, they completed several assessments: the Self-Object

Needs Inventory (SONI; Banai et al., 2005), the short form of the Working Alliance Inventory (WAI-SR; Horvath & Greenberg, 1989), and the Therapeutic Presence Inventory (Therapist Form, TPI-T; Geller et al., 2010). Results showed that therapeutic presence mediated the relationship between therapists' need for self-object needs, such as approval or admiration for achievements, and the strength of the working alliance. This finding suggested that a therapist's need for validation might impede their ability to remain fully present during therapy sessions, which in turn could weaken their ability to establish a strong therapeutic bond with their clients.

In addition to quantitative research, Granick (2011) conducted a qualitative study to explore the association between clients' experience of therapeutic presence and their perception of working alliance. This study aimed to explore the phenomenological aspects of therapeutic presence from the clients' perspectives. The participants, seven counseling psychology graduate students who had engaged in personal therapy and perceived their therapists as present, were interviewed. The interviews focused on gathering insights about the nature of therapeutic presence and its impact on the therapeutic relationship and psychotherapy outcomes. The qualitative data analysis led to the development of a dual-axis model of perceived therapeutic presence. The X-axis represented a relational dimension, and the Y-axis represented a transcendent dimension. According to participants' perceptions and research findings, the therapist's commitment to being present with the client in therapy affected the client's experience of the therapeutic bond, which enhanced the quality of the connection, including a sense of mutual transcendence

The Relationship between Working Alliance and Session Quality

In addition, the working alliance has repeatedly been found to be a strong predictor of positive outcomes in psychotherapy (e.g., Horvath & Bedi, 2002; Kivlighan et al., 2014;

Flückiger et al., 2018). For example, in a recent meta-analysis summarizing 295 published studies with more than 30,000 clients over approximately 40 years, Flückiger et al. (2018) found that working alliance consistently and stably predicted various forms of psychotherapy outcome with a moderate effect size (aggregated correlation coefficient r = .28). The existing literature reviewed above indicated that therapeutic presence was positively related to working alliance (Colosimo & Pros, 2015; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011). Given the meta-analytical findings establishing working alliance as a robust predictor of positive outcomes in psychotherapy, including session quality (Flückiger et al., 2018), it seems feasible to propose the mediation path (therapeutic presence→working alliance→session quality) in which higher therapeutic presence would lead to a higher therapist-client working alliance, which would, in turn, predict a higher level of session quality.

However, it is worthwhile to point out that although there is theoretical and empirical support for the effect of therapeutic presence on working alliance, these studies tended to apply a cross-sectional design, and the reverse direction has not been examined. Therefore, before exploring the potential mediating effect of working alliance, I would like to adopt the Random Intercept Cross-Lagged Panel Model (RI-CLPM; Hamaker et al., 2015) to further clarify the relationship between therapeutic presence and working alliance and, more importantly, the direction of influence.

Critique of the Existing Literature

Among the studies exploring the relationship between therapeutic presence and working alliance (e.g., Oghene et al., 2010; Pos et al., 2011; Geller & Greenberg; 2010), researchers tended to adopt a cross-sectional study design, which prevented us from inferring a causal relationship and determining the direction of causality between these two constructs. The focus

of the contemporary psychotherapy literature has been centered on the role of the therapist-client relationship and working alliance in facilitating positive changes in clients (e.g., Flückiger et al., 2018; Horvath & Greenberg, 1986; Norcross & Lambert, 2019; Watson & Greenberg, 2015). However, a gap in knowledge of which variables contribute to the establishment and development of therapeutic presence still exists (Horvath, 1994; Geller & Greenberg, 2022) Therapeutic presence has been theorized as a precursor to a positive strong working alliance because, according to Geller & Greenberg (2010), it helps build a therapeutic bond between the client and the therapist and provides the therapist with an opportunity to actively listen to, reflect on, and respond to clients' experiences, which further enhances the development of treatment goals and the agreement of the necessary tasks in therapy that grow out of clients' deepest needs. Despite the theoretical propositions, however, the existing studies could only reveal that therapeutic presence is positively *correlated with* the therapeutic alliance (Colosimo & Pros, 2015; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011) without clarifying the *directionality* between these two constructs; Thus, therapeutic presence cannot be truly identified as a contributor to working alliance. Therefore, this study aims to further clarify the relationship between therapeutic presence and working alliance and empirically test whether therapeutic presence temporally leads to working alliance across therapy sessions.

The Dyadic Nature of Psychotherapy Process

The psychotherapy process is dyadic and dynamic in nature (Barkham & Castonguay, 2021). That being said, the complex interactions and mutual influences between the therapist and the client and their role in the therapeutic change process cannot be thoroughly understood if we simply consider one of the two perspectives (Barkham & Castonguay, 2021). The therapy dynamics are defined as the patterns of the mutual influences between therapists and clients

(Lichtenberg & Semon, 1986) that cause changes in their respective perceptions of the psychotherapy process and behaviors over the course of the treatment (Li & Kivlighan, 2019). One example of a dynamic process can be the therapist's perception of therapeutic presence may temporally affect the changes in the client's ratings of therapeutic presence. As Geller and Greenberg (2022) argued, the more therapeutically present the therapist is, the more likely the client can be present with and accepting of themselves, and the more present the client becomes, the greater the therapeutic presence the therapist develops and maintains in session.

Review of the Dyadic Process Based on Therapist-Client Shared Perceptions

The dyadic nature of psychotherapy has also been recognized in contemporary psychotherapy research. There are an increasing number of studies examining the dyadic patterns between therapists and clients using various advanced statistical methods (Li, 2021). These studies typically focus on dyadic congruence, correspondence, and synchrony to explore the interactive patterns between therapists and clients (Atzil-Slonim et al., 2015; Kivlighan et al., 2017; Marmarosh & Kivlighan, 2012; Ramseyer & Tschacher, 2011; Schoenherr et al., 2019; Zilcha-Mano et al., 2017). This line of research on the congruency and discrepancy in therapist-client perceptions contributed to our understanding of the dyadic nature of the psychotherapy process, the more nuanced interactions between therapists' and clients' perspectives, and its effects on treatment outcomes. However, these incongruence/congruence-based methods failed to precisely capture the therapist-client shared perception of the psychotherapy process that are distinct from each party's unique or respective views within a dyadic therapeutic relationship. Unfortunately, few studies have adopted the relevant approach that accurately measured the therapist-client shared perception, making it relatively difficult to conclude the relational variables-outcome association from a joint, communal, and collective perspective shared by both

the client and the therapist. Two exceptions to this general trend are from Kivlighan (2007) and Li et al. (2021), who focused on both individual and shared perceptions of working alliance and session evaluation to model and describe the dyadic psychotherapy process from a different perspective.

For example, Kivlighan (2007) examined the dyadic associations between therapists' and clients' ratings of working alliance and session quality. Participants in the study consisted of 53 therapist-client dyads from counseling centers at two Midwestern universities. Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the Depth and Smoothness scales of the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984) were adopted to assess the working alliance and session quality, respectively. Both the client and the therapist were given the WAI and SEQ to complete independently right after their third therapy session, and the common fate model was applied to analyze the dyad ratings. Results indicated that when the therapist and the client jointly possessed a positive perception of working alliance, they tended to agree on the session being smoother and more profound. Furthermore, even after accounting for the effects of a "shared" perception of the working alliance, the data indicated that each party's "individual" positive view of the working alliance was linked to their respective higher ratings of session smoothness. These findings suggested that clients and therapists had a shared sense of relationship variables (e.g., working alliance) and session quality besides individual perspectives. This shared perception of the working alliance was positively associated with the therapist-client dyad's shared sense of session depth and quality.

Li et al. (2021) addressed the limitations in Kivlighan's (2007) study, which used cross-sectional data to explore shared perceptions of working alliance and session evaluation. They replicated this earlier study in a longitudinal framework, so that the data were able to be

disaggregated into three different levels: between sessions, between therapists, and between clients. The participants were 44 doctoral student therapists and their 284 clients, who together participated in a total of 8,188 therapy sessions at a therapy clinic in a mid-Atlantic university. The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) and the Session Evaluation Scale (SES; Hill & Kellems, 2002) were administered to measure the therapist' and the client's ratings of working alliance and their perception of session quality, respectively. At the end of each session, the therapist and the client independently completed the working alliance and session quality measures. Similar to Kivlighan (2007), the common fate model was applied to examine the dyad-level and individual-level covariance in working alliance and session quality ratings. Li et al. (2021) found a significant positive relationship between therapist-client shared perceptions of working alliance and session quality at all three levels. In contrast, therapists' individual perception of the working alliance was associated with their individual perception of session quality only at the between-session and between-therapist levels; clients' individual perception of working alliance only predicted their individual perception of session quality at the between-session and between-client levels (Li et al., 2021). These research findings further stressed the importance of modeling and assessing the collective, shared, and joint views between the client and the therapist regarding the psychotherapy process.

Critique of the Existing Literature

Research on the dyadic nature of psychotherapy using multilevel modeling is on the increase but remains relatively rare, and the predominant process examined thus far is the therapeutic alliance (Barkham & Castonguay, 2021). However, the research on other relational constructs, such as therapeutic presence, is very limited. To the best of our knowledge, there was only one empirical study on therapeutic presence considering both therapist' and the client's

perceptions (Bernhardt et al., 2021). More specifically, in a dyadic case study, Bernhardt and his colleagues (2021) conducted four qualitative interviews with one therapist and one interview with the therapist's client over a period of four years, aiming at exploring how the therapist's particular way of presence and the client's perception of the therapist's presence in session might contribute to the therapeutic change process. They utilized the interpretative phenomenological method to analyze the data from the semi-structured interviews and found that the therapist's presence, as perceived by both the client and the therapist, was communicated at a superordinate level by means of "embodied listening," which enhanced the therapy efficacy and was rooted in the therapist's personal history (Bernhardt et al., 2021). According to the authors, this study was interested in examining the therapeutic presence as a dyadic construct in psychotherapy (Bernhardt et al., 2021). However, researchers did not pay equal attention to the therapist' and client's perspectives. They tended to de-emphasize the client's experience, which hindered a deeper and more nuanced understanding of therapeutic presence as a dyadic construct. Furthermore, this dyadic case study failed to capture the shared perceptions of therapeutic presence but instead focus on their respective perspectives. The inability to examine the combined effects of their perception of therapeutic presence on therapeutic changes was perhaps caused by the methodologies adopted in this study.

Therefore, my study will focus on therapeutic presence and partly aims at uncovering the relationship between therapists' and clients' shared perceptions of the therapeutic presence, working alliance, and session quality using common fate model within a multilevel framework. Based on the existing research on the association between therapeutic presence, working alliance, and session quality, I attempt to conduct a more extensive examination of the subtle and nuanced relationships between these three constructs while addressing their dyadic

interdependence (i.e., individual vs. shared perspectives on the therapeutic presence and session quality in CFM). Specifically, I plan to use longitudinal data to explore the shared perceptions of therapeutic presence and session quality at both the between- session and therapist-client dyad levels (Zilcha-Mano et al., 2016). Lastly, I will examine the mediating effect of the shared working alliance on the association between shared therapeutic presence and session quality at the between-session level.

Chapter Three: Methods

Participants

A de-identified archival dataset will be used in this study, where participating therapist trainees and clients are drawn from a longitudinal psychotherapist training research project conducted at a university in Northern China. Master's level counseling trainees in this study enrolled in their first practicum at a community mental health clinic housed within the counseling psychology department. As they were in the early stages of training, many have not yet developed an established theoretical orientation. However, they typically received training based on Clara Hill's three-stage model (2020), which includes facilitating exploration, insight, and action. For this research project, counseling trainees completed longitudinal measures assessing their professional development and clinical work with clients. Additionally, these trainees' clients responded to surveys assessing their perceptions of the counseling process and treatment outcomes.

Therapists. The full sample contains a total number of 409 therapist trainees participating in this study. Trainees' ages ranged from 22 to 54 (M = 30.82, SD = 7.041). For gender, 29 identified as cisgender male (7.1%), 139 identified as cisgender female (34.0%), 5 identified as other (1.2%), and 236 did not report gender identity (57.7%); for sexual orientation, 116 trainees identified as heterosexual (28.4%), 9 as sexual minority (2.2%), 15 selected "prefer not to disclose" *or* skipped the question (3.7%), and 269 had missing values (65.8%); regarding race/ethnicity, 159 trainees (38.9%) identified as Han (the majority ethnic group in China), 14 identified as various minority ethnic groups (3.4%), and 236 had missing values (57.7%).

Clients. The full sample contains a total number of 2242 clients participating in this study, who worked with the aforementioned 409 therapist trainees. Clients' ages ranged from 9

to 59 (M = 27.25, SD = 6.631). Among them, 302 identified as cisgender male (13.5%), 1180 identified as cisgender female (52.6%), 6 identified as others (0.3%), 8 selected "prefer not to disclose" (0.4%), and 746 did not report gender identity (33.3%); with respect to sexual orientation, 1156 reported heterosexual (51.6%), 79 reported sexual minority (3.5%), 108 selected "prefer not to disclose" (4.8%), and 899 did not report sexual orientation (40.1%); regarding ethnicity, 1406 clients identified as Han (62.7%), 90 identified as different ethnic minority groups (4.0%), and 746 did not report ethnicity (33.3%). The most common presenting concerns for these clients included emotional distress (mostly depressive *or* anxious mood), family issues, and general interpersonal relationship issues.

Measures

The Therapeutic Presence Inventory-Therapist-Brief (TPI-T-Brief; Zhao et al., 2022). The TPI-T-Brief measures the therapists' perception of their level of presence with their clients in therapy sessions. Zhao et al. (2022) shortened the 21-item TPI-T (Geller et al., 2010) into the 6-item TPI-T-Brief in a Chinese sample, with 3 being positively worded and 3 negatively worded (reverse coded for subscale scoring). Response to each item is selected from a 7-point Likert scale ranging from 1 (*not at all*) to 7 (*completely*), with higher score representing a higher level of therapeutic presence perceived by the therapist. For instance, Item #6 (positively worded) is "I felt in synchronicity with my client in such a way that allowed me to sense what he/she was experiencing"; and Item #3 (negatively worded) reads "I found it difficult to listen to my clients." Zhao et al. (2022) reported an omega coefficient of .85 for the full TPI-T-Brief scale to support its reliability. With respect to validity, researchers ran an M-CFA with a general loading on all 6 items, and the results revealed that the model fit was excellent. Specifically, they observed that RMSEA=.01, CFI=1.00, TLI = .99, $SRMR_{within}$=.02, $SRMR_{between}$=.01. These

findings provided the preliminary empirical support for the structural validity of TPI-T-Brief in the Chinese context. Additionally, they found strong associations between the total scores of TPI-T-Brief and its original scale, TPI-T, to support its convergent validity. Furthermore, Zhao et al. (2022) also observed that the total score of TPI-T-Brief was significantly correlated to four criterion variables, including both the therapist' and client's ratings of working alliance and session quality, which evidenced the concurrent validity of TPI-T-Brief.

The Therapeutic Presence Inventory-Client (TPI-C; Geller et al., 2010). The TPI-C assesses the clients' experience of therapist presence *or* absence. Responses to each item were selected from a 7-point Likert scale ranging from 1 (*not at all*) to 7 (*completely*), with higher scores representing a higher level of therapeutic presence perceived by the clients. For example, Item #1 is "My therapist was fully there in the moment with me"; and Item #2 reads "My therapist's responses were really in tune with what I was experiencing in the moment." Geller et al. (2010) found a Cronbach's $\alpha = .94$ for the full TPI-T scale to support its reliability. In addition, they also found that the client's rating on TPI-C scale was significantly associated with their ratings on measures of working alliance and session outcome, which provided preliminary empirical support for the predictive validity of TPI-C. Because there is no TPI-C used in the Chinese cultural context available to this study, the research team translated the English scale into Chinese following the standard translation and back-translation procedures recommended by Brislin (1970). Graduate students and faculty members from counseling psychology programs in both China and U.S. who were proficient in both Mandarin and English completed translation, back-translation, comparison, and revision.

Brief Working Alliance Inventory (WAI-B3; Li et al., 2023) was adopted to measure clients' and therapists' perceptions of the working alliance during therapy. This 3-item self-

report inventory inquiries about three dimensions of working alliance, including the agreements on tasks, goals, and emotional bonds. Items were rated on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores on the WAI-B3 indicate a better working alliance. This study will use the translated and validated Chinese versions of the WAI-B3 in Li et al. (2023), which demonstrated an omega coefficient of .86 for the therapist and .92 for the client form in a Chinese sample to support its reliability. Regarding validity, researchers found that all three items significantly loaded on the working alliance factor at both the between-person and within-person levels, which provided the preliminary empirical support for the structural validity of the WAI-B3 in the Chinese context. Moreover, Li et al. (2023) found strong associations between the total scores of WAI-B3 and its original 12-item WAI at the session, client, and therapist levels in a Chinese sample, which evidenced its convergent validity.

The Session Evaluation Scale (SES; Hill & Kellems, 2002) measures therapist and client perceptions of the quality of the session. A 5-item version of the SES (Lent et al., 2006) was used in this study, with each item anchored on a 5-point Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. A higher total average score represents a higher quality of the session. This study will use the translated and validated Chinese version of the therapist and client forms of SES in Li et al. (2021), where the researchers reported an internal consistency of $\alpha = .85$ for the therapist form and .72 for the client form. Regarding validity, Li et al. (2021) conducted CFA using the assessment of SES in the first session. The results revealed that the model fit was adequate. Specifically, for the therapist form, they obtained that $\chi 2 = 3.98$, $p = .408$; RMSEA = .021, CFA = .989, TLI = .976, SRMR = .009. For the client form, they found that $\chi 2 = 16.55$, $p = .002$; RMSEA = .061, CFA = .968, TLI = .920, SRMR = .020. These findings provided the preliminary empirical support for the structural validity of both the

therapist and client forms of SES in the Chinese context. Additionally, Li (2021) found that at the session level, therapist trainees' and clients' SES scores were significantly associated with therapists' and clients' ratings of working alliance in a Chinese sample, which also offered evidence to support the concurrent validity of the translated Chinese version of SES.

Procedures

The Training Program. The Chinese counseling trainees participating in the study were from a master's level clinical mental health counseling program at a university located in Northern China. In this training program, therapist trainees were first required to complete foundational counseling courses such as counseling theories, helping skills, and ethics. All the counseling trainees then engaged in supervised counseling practicum as an essential part of their training experience required by the program. The therapist trainees were placed at a community mental health clinic housed within the counseling psychology department. Throughout the practicum internship, trainees offered free, time-limited counseling services for clients, which was commonly capped at 12 sessions with a possible extension after consulting with the trainee's licensed supervisor. The clinic screened potential clients for their eligibility. More specifically, clients with suicidal *or* psychotic tendencies *or* with mental health diagnoses *or* symptomatic levels inappropriate for beginning therapists were referred to a community provider outside the university for seeking professional psychotherapy *or* psychiatric evaluation. Eligible clients were admitted to the clinic and assigned to therapist trainees. All the trainees were required to receive weekly individual and group supervision provided by credentialed supervisors in China as a part of their training.

The Data Collection. The research project was approved by the governing ethics board in the department of the university. Before engaging in counseling practice, both the trainee and

the client were informed of the study and given their respective consent forms for signature if they agreed to participate. All therapist and client identifiers were replaced with unique code numbers to ensure anonymity.

At the beginning of the practicum, therapist trainees participating in the study were administered a demographic information survey. In addition, clients' demographic information (e.g., age, gender) and presenting concerns were routinely collected when they reached out to the clinic for an intake appointment. Upon consent, at the end of each session, the therapist forms of WAI-SR, TPI-T, and SES were administered to the trainee, and the client forms of WAI-SR, TPI-C, and SES were distributed to the client. Counseling trainees and clients independently completed the measures through an online survey platform. Notedly, the research team in charge of collecting the data for the project was different than the site supervisors. Due to this, supervisors could not directly access trainees' research data, and trainees did not have access to their clients' research data either.

The data collection is a cumulative ongoing process without a fixed starting and ending date, depending on every trainee's individual practicum process. The dataset utilized in the current study consisted of trainees participating in the practicum between June 2022 and January 2023.

Plan of Data Analysis

Data Inspection and Preliminary Data Analysis

All item scores will first be averaged to obtain the total score for each scale. Descriptive statistics of all six variables of interest, including therapist-rated therapeutic presence (TPI-T), client-rated therapeutic presence (TPI-C), therapist-rated working alliance (TWA), client-rated working alliance (CWA), and therapist-rated session quality (TSQ), and client-rated session

quality (CSQ), will be calculated and reported. Data inspections will include missing value analysis and data distribution analysis. Specifically, suppose the missing percentage of the variables of interest exceeds the negligible missingness threshold of 5% (Hair et al., 2006), and I will then investigate the missing value patterns to determine the most appropriate way to deal with it. For example, I will run a Little's Missing Completely at Random (MCAR) test to inspect the missing data patterns in these six core variables. If the test results are not significant, it means that the missing data pattern is completely at random. If the results of the Little's MCAR test is significant, it means that the missing data patterns are either missing at random (MAR) *or* missing not at random (MNAR). In this case, I will further investigate the missing patterns by running separate *t* tests to compare the average values of each of the six variables central to this study across the groups of "missing" versus "not missing" on another variable. If the missing pattern is most likely MCAR or MAR, I will adopt the Full Information Maximum Likelihood (FIML) estimation to deal with the missing data on relevant items within the analysis model, which may handle MCAR and MAR well and is recommended over the pairwise deletion method (Enders, 2010; Savalei & Bentler, 2005).

For data distribution analysis, I plan to investigate the univariate and multivariate normality by inspecting the univariate and multivariate skewness and kurtosis of the six core variables. Specifically, if their univariate skewness and kurtosis estimates all fall within the -2 to 2 range (George & Mallery, 2010), these six core variables will be viewed to have a normal univariate distribution. Similarly, I plan to employ the FIML estimator which is argued to be robust against data non-normality (Enders, 2010; Savalei & Bentler, 2005). IBM SPSS 23.0 (IBM Corp, 2015) and Mplus 8.0 (Muthen & Muthen, 2017) will be used for all data analyses, and the primary analyses include two parts specifically explained below.

Main Analysis Part 1

In the first part of data analysis, I attempt to use the RI-CLPM to investigate how therapeutic presence may temporally predict working alliance across therapy sessions, while accounting for the autoregressive effects of both variables. To approach this research question, I will follow the procedures described in Hamaker et al. (2015) to build the RI-CLPM for this study (As previously shown in Figure 1). According to Hamaker et al. (2015), the RI-CLPM requires at least three waves (i.e., sessions in the current study) of data. I will use the data from the first six sessions because the therapist-client dyads have an average number of 6.75 therapy sessions. That being said, I will select therapist-client dyads that have had at least 6 sessions in total. For the initial part of the data analysis, I will use data from their first 6 therapy sessions. This data, currently in long format where each session is a row, will then be converted to wide format, with each session as a variable. This results in the retainment of 1112 clients seen by 180 trainees.

Since I am interested in assessing the mean autoregressive and cross-lagged effects across therapy sessions, I will first compare the RI-CLPM (Model 1) with all corresponding autoregressive, cross-lagged, concurrent residual correlations fixed to be equal across various time points based on the stationarity assumption in CLPM (Kearney, 2017), versus the alternative Model 2, which allows all these correlations to be freely estimated, thus assuming time-variant associations. If there is no significant difference in model fit between the more parsimonious Model 1 and the more complex Model 2, I will conclude that the associations were time-invariant and proceed to interpret the path coefficients of Model 1. Otherwise, Model 2 assuming that the associations were time variant will be adopted and its path coefficients will be interpreted accordingly.

Lastly, I will handle the level-3 data nesting (the client nested within the trainee) by introducing the TYPE = COMPLEX command in Mplus, which applies the Huber-White procedure to adjust the standard error estimation due to data nesting (Muthen & Muthen, 2017). In this way, the "between" part of the RI-CLPM model represents between trainee-client dyads after adjusting the trainee level nesting, and the "within" part of the model stands for the temporal dynamic relationship between therapeutic presence and working alliance, which is the main focus of the study.

Meaning of the Model Parameters. As previously shown in Figure 1, the two autoregressive paths (i.e., *aT, aW*) indicate the within-person, carry-over effects in the therapeutic presence and working alliance at each assessed time point and are all constrained to be equal based on the stationarity assumption. A significant autoregressive path in this study means that therapists and clients with an increased level of perception of therapeutic presence or working alliance in one therapy session would be more likely to experience a higher level of therapeutic presence or working alliance in the next therapy session.

Two cross-lagged paths (i.e., *W2T, T2W*) reflect the temporal dynamic relationship between therapeutic presence and working alliance, which is of primary interest in this study. For example, if *T2W* is significant and *W2T* is not, it suggests that therapeutic presence temporally predicts subsequent working alliance but working alliance does not predict subsequent therapeutic presence; in other words, therapeutic presence temporally precedes working alliance which is consistent with the theoretical proposition (Geller, 2020) that therapeutic presence is a precursor in the development of working alliance. However, if *W2T* is significant and *T2W* is not, it indicates that working alliance temporally leads to therapeutic presence, but therapeutic presence does not lead to subsequent working alliance; in other words, working alliance

temporally precedes therapeutic presence, suggesting that a strong working alliance is the precondition for the therapist to be more present. Lastly, if both *W2T* and *T2W* are significant, it means that there is a significant bidirectional relationship between therapeutic presence and working alliance where higher ratings of therapeutic presence contribute to a stronger subsequent working alliance while a stronger working alliance also contributes to higher subsequent ratings of therapeutic presence.

The concurrent correlations (i.e., *rTW*) represent to what degree deviations from the person-specific mean in one variable (e.g., therapeutic presence) are related to that in the other variable (e.g., working alliance) at the same session. A significant *rTW* means that there is a significant relationship between the residuals in therapeutic presence and working alliance at the same therapy session. In other words, a higher level of residuals in therapeutic presence tends to lead to a higher level of residuals in working alliance in the same session. Lastly, to separate within-person from between-person associations between therapeutic presence and working alliance, two between-person latent random intercepts were specified: one for therapeutic presence (RITP) and one for working alliance (RIWA), as previously shown in Figure 1. In the RI-CLPM model, the path coefficients from these intercepts to all observed scores were fixed at one. A significant correlation between the RITP and RIWA means that the between-person differences in therapeutic presence are significantly correlated with the between-person differences in working alliance. In other words, if a therapist-client dyad on average reports higher therapeutic presence, they also tend to report higher working alliance.

Main Analysis Part 2

In the second part of the data analysis, I will adopt the Common Fate Model (CFM; Ledermann & Kenny, 2012) to further explore the relationship between therapeutic presence,

working alliance, and session quality. The CFM model can differentiate and model the "individual perceptions" and "shared perceptions" of both members of a dyad (Kivlighan 2007; Li et al., 2021). More specifically, the CFM posits that the ratings given by two members of a dyad on a particular relational construct are influenced by a "dyadic" or "shared" latent variable (Ledermann & Kenny, 2012; Li et al., 2021).

Hypothesized Model. If the RI-CLPM produces results consistent with the main hypotheses of this study that therapeutic presence precedes working alliance, I proceed to examine the specific CFM model at the between-session level, as previously depicted in Figure 2. In this CFM, the therapist and client ratings of therapeutic presence, working alliance, and session quality are predicted by a latent variable of their "shared perception" of therapeutic presence, working alliance, and session quality. The factor loadings from the latent shared variable onto the individual ratings of the therapist and the client are fixed to be one to statistically identify the model (Ledermann & Kenny, 2012; Li et al., 2021). Regression paths between the dyadic latent variables of "shared perceptions" (Li et al., 2021) are then specified to examine whether the therapists' and clients' "shared perception" of therapeutic presence is predictive of their "shared perception" of session quality, with the "shared perceptions" of working alliance as a potential mediator.

Moreover, the residual covariances between the variables reported by the same party (either the client *or* therapist) represent the link between variables of research at the "individual perception" (Li et al., 2021). For instance, I calculate the residual terms between therapists' ratings of therapeutic presence and session quality and again between clients' ratings of therapeutic presence and session quality, which represents the association between therapists' and clients' individual (respective) perceptions of therapeutic presence and session quality after

their “shared perceptions” have been accounted and controlled in the latent dyadic factor regressions (Li et al., 2021).

In addition, longitudinal data will be used to investigate the relationship between shared perception of therapeutic presence, working alliance, and session quality at the between-session and between therapist-client dyad levels. At the between-session level, this study investigates whether, in sessions where both the trainee and client report a higher than average rating of therapeutic presence within the same therapist-client dyad, they also tend to jointly experience a higher session quality compared to their other sessions. At the between therapist-client dyads level, I will explore variations across different groupings. This investigation aims to uncover broader patterns, revealing whether therapist-client dyads that, on average, report higher levels of shared therapeutic presence also tend to report higher levels of shared session quality compared to those with lower levels of shared therapeutic presence. Furthermore, this study aims to examine whether the shared perception of the working alliance between the therapist and client mediates the relationship between their shared perception of therapeutic presence and session quality at the between-session level. More specifically, within the same therapist-client dyad, I will explore whether, in sessions where both the trainee and the client report a higher-than-average rating of therapeutic presence, this joint perception correlates with a stronger shared working alliance, which further leads to higher shared session quality compared to their other sessions.

Alternative Models. Two alternative models will be examined based on the results from the Main Analysis Part 1, if they do not conform to the hypothesized temporal association between therapeutic presence and working alliance where therapeutic presence precedes working alliance. If the findings from RI-CLPM indicate that working alliance temporally predicts

therapeutic presence across therapy sessions rather than the other way around, I will examine whether shared perception of therapeutic presence mediates the association between the shared perception of working alliance and session quality. This alternative model is previously depicted in Figure 4. Furthermore, if RI-CLPM reveals bidirectional relations between therapeutic presence and working alliance, I will test the alternative model, as previously depicted in Figure 5.

Chapter Four: Analysis and Results

Data Inspection and Preliminary Analyses

All item scores were first averaged to obtain the total score for each scale. Given that Part I and Part II of the main analysis have different analytical requirements, the complete dataset comprising 15,145 cases/sessions was reorganized. It is now divided into Dataset D1and its subsets (D1_T, D1_C) for the first part of the main analyses, and into the Dataset D2 for the second part. The variables of interest include therapist-rated therapeutic presence (TTP), client-rated therapeutic presence (CTP), therapist-rated working alliance (TWA), client-rated working alliance (CWA), therapist-rated session quality (TSQ), and client-rated session quality (CSQ). Descriptive statistics for all these six variables were calculated and reported in Table 1. Data inspections included missing value analysis and data distribution analysis.

Table 1

Descriptive Statistics of All Investigated Variables

Variable	*Minimum*	*Maximum*	*M*	*SD*	*Skewness*	*Kurtosis*
Data Set D1						
TWA_S1	1.33	5.00	4.0803	.68219	-.593	.286
TWA_S2	2.00	5.00	4.1031	.66443	-.439	-.239
TWA_S3	1.67	5.00	4.1648	.65647	-.545	.153
TWA_S4	2.00	5.00	4.2119	.63357	-.583	.043
TWA_S5	2.00	5.00	4.2338	.63776	-.531	-.265
TWA_S6	1.33	5.00	4.2462	.64034	-.591	.171
TTP_S1	2.50	7.00	6.1183	.75628	-1.306	1.909
TTP_S2	2.33	7.00	6.1378	.77454	-1.539	3.020
TTP_S3	2.83	7.00	6.1728	.73143	-1.286	1.789
TTP_S4	2.83	7.00	6.2182	.73796	-1.563	2.986
TTP_S5	2.33	7.00	6.2363	.74305	-1.655	3.858
TTP_S6	1.50	7.00	6.2645	.75898	-1.928	5.354
CWA_S1	1.00	5.00	4.2109	.69463	-.605	-.010
CWA_S2	1.67	5.00	4.2404	.63409	-.518	-.169
CWA_S3	1.00	5.00	4.3222	.63522	-.728	.317
CWA_S4	1.00	5.00	4.3748	.64119	-.916	.747
CWA_S5	2.00	5.00	4.4141	.61655	-.838	.101
CWA_S6	1.33	5.00	4.4670	.61178	-1.015	.735
CTP_S1	2.33	7.00	6.1733	.79474	-1.000	.864

Table 1 (Continued)

Variable	*Minimum*	*Maximum*	*M*	*SD*	*Skewness*	*Kurtosis*
CTP_S2	2.33	7.00	6.2155	.80513	-1.006	.601
CTP_S3	2.33	7.00	6.2952	.78756	-1.180	.933
CTP_S4	2.67	7.00	6.3475	.76962	-1.216	.825
CTP_S5	3.67	7.00	6.4004	.74255	-1.289	.937
CTP_S6	3.00	7.00	6.4450	.73755	-1.432	1.429
Data Set D2						
CWA	1.00	5.00	4.3624	.66774	-1.019	.314
CTP	2.33	7.00	6.3565	.77776	-1.419	1.471
CSQ	2.33	6.33	5.7171	.69505	-1.268	.855
TWA	1.33	5.00	4.1890	.66023	-.590	-.013
TTP	1.00	7.00	6.2466	.70186	-1.672	4.473
TSQ	1.00	6.33	5.0324	.77704	-.494	.485

Note. CWA = client working alliance; CTP = client therapeutic presence; CSQ = client session quality; TWA = therapist working alliance; TTP = therapist therapeutic presence; TSQ = therapist session quality; mindfulness. "_S1" indicates the variable measured at Session 1, same for other notations.

Missing Value Analysis

RI-CLPM. According to Hamaker et al. (2015), the RI-CLPM requires at least 3 waves (i.e., sessions in the current study) of data. Thus, for the first part of the main analysis, I selected from the complete dataset therapist-client dyads who had 6 or more therapy sessions in total, as the therapist-client dyads have an average number of 6.75 sessions. Additionally, I utilized the data from the initial six sessions, which resulted in a dataset consisting of 1112 clients who were seen by 180 therapist trainees for 6672 sessions. This data set has been labeled D1. Since Dataset D1 contains both therapists' and clients' ratings of therapeutic presence and working alliance from the first six sessions, I further divided it into two subsets: Dataset D1_C, which includes only client data, and Dataset D1_T, which includes only therapist data. As a result, I was able to examine how therapeutic presence temporally predicts the working alliance from the perspectives of both therapists and clients.

Given the requirement of the RI-CLPM, Datasets D1_T and D1_C were restructured from the long format, where each session was a row, to the wide format, where each session was a variable, respectively. As a result, both D1_T and D1_C have 1112 cases and 12 core variables. For example, D1_T contains six therapist-rated therapeutic presence scores from Session 1 to Session 6, as well as six therapist-rated working alliance scores from Session 1 to Session 6. Similarly, D1_C contains six client-rated therapeutic presence scores and six client-rated working alliance scores, each spanning from Session 1 to Session 6. For Dataset D1_C, Little's MCAR test indicated that the pattern of missing values occurred completely at random ($\chi 2$= 33.073, df = 30, p = .319). However, the test indicated that the pattern of missing values in Dataset D1_T was not completely random ($\chi 2$=52.707, df = 30, p = .006). That being said, the missing data in Dataset D1_T was either missing at random (MAR) or missing not at random (MNAR).

Consequently, to further investigate the missing data patterns in Dataset D1_T, I conducted separate *t* tests (pairwise mean value difference tests) to compare the average values of each of the core variables central to this study across the groups of "missing" versus "not missing" on another variable. Results are presented in Table 2. Several observations are noteworthy from this missing pattern analysis. First, one reasonable scenario for MNAR is that therapists or clients tend to not fill out the WA measure when they perceive the WA to be low. However, this was not the case with the data in this study. Specifically, the results in Table 2 suggested that the group with non-missing Therapist WA at Session 3 (TWA1 *mean* = 4.05) had significantly lower (t = -2.1) average Therapist WA at Session 1 than the group with missing Therapist WA at Session 3 (TWA1 *mean* =4.19), showing evidence of MAR.

Table 2.

Separate Variance t Tests

		TWA.1	TWA.2	TWA.3	TWA.4	TWA.5	TWA.6	TTP.1	TTP.2	TTP.3	TTP.4	TTP.5	TTP.6
TWA.1	t	.	.	.	.	.	.	.	.	.	.	.	.
	df	.	.	.	.	.	.	.	.	.	.	.	.
	# Present	751	682	625	579	529	482	751	682	625	579	529	482
	# Missing	0	0	0	0	0	0	0	0	0	0	0	0
	Mean(Present)	4.0803	4.1031	4.1648	4.2119	4.2338	4.2462	6.1183	6.1378	6.1728	6.2182	6.2363	6.2645
	Mean(Missing)	.	.	.	.	.	.	.	.	.	.	.	.
TWA.2	t	-1.7	.	.	.	.	.	-.6	.	.	.	.	.
	df	82.1	.	.	.	.	.	79.6	.	.	.	.	.
	# Present	682	682	625	579	529	482	682	682	625	579	529	482
	# Missing	69	0	0	0	0	0	69	0	0	0	0	0
	Mean(Present)	4.0665	4.1031	4.1648	4.2119	4.2338	4.2462	6.1129	6.1378	6.1728	6.2182	6.2363	6.2645
	Mean(Missing)	4.2174	.	.	.	.	.	6.1715	.	.	.	.	.
TWA.3	t	-2.1	.0	.	.	.	.	-1.5	-2.2	.	.	.	.
	df	184.9	66.4	.	.	.	.	180.7	73.1	.	.	.	.
	# Present	625	625	625	579	529	482	625	625	625	579	529	482
	# Missing	126	57	0	0	0	0	126	57	0	0	0	0
	Mean(Present)	4.0576	4.1035	4.1648	4.2119	4.2338	4.2462	6.0997	6.1216	6.1728	6.2182	6.2363	6.2645
	Mean(Missing)	4.1931	4.0994	.	.	.	.	6.2103	6.3158	.	.	.	.
TWA.4	t	-1.9	-.5	-.5	.	.	.	-1.1	-2.4	-.4	.	.	.
	df	281.8	135.0	49.9	.	.	.	273.3	156.5	50.3	.	.	.
	# Present	579	579	579	579	529	482	579	579	579	579	529	482
	# Missing	172	103	46	0	0	0	172	103	46	0	0	0
	Mean(Present)	4.0541	4.0973	4.1606	4.2119	4.2338	4.2462	6.1010	6.1111	6.1693	6.2182	6.2363	6.2645
	Mean(Missing)	4.1686	4.1359	4.2174	.	.	.	6.1764	6.2880	6.2174	.	.	.
TWA.5	t	-2.5	-.6	-.6	-.5	.	.	-.9	.0	.0	1.3	.	.
	df	427.5	234.5	122.0	58.1	.	.	416.9	227.9	125.9	57.1	.	.
	# Present	529	529	529	529	529	482	529	529	529	529	529	482
	# Missing	222	153	96	50	0	0	222	153	96	50	0	0
	Mean(Present)	4.0403	4.0951	4.1575	4.2079	4.2338	4.2462	6.1021	6.1383	6.1723	6.2313	6.2363	6.2645
	Mean(Missing)	4.1757	4.1307	4.2049	4.2533	.	.	6.1569	6.1362	6.1753	6.0800	.	.
TWA.6	t	-2.4	-.1	-.5	1.0	.5	.	-.8	-.2	.6	2.7	1.8	.
	df	573.2	359.3	208.3	123.1	52.4	.	553.1	346.8	210.7	123.1	51.2	.
	# Present	482	482	482	482	482	482	482	482	482	482	482	482
	# Missing	269	200	143	97	47	0	269	200	143	97	47	0
	Mean(Present)	4.0360	4.1010	4.1577	4.2248	4.2386	4.2462	6.1024	6.1331	6.1826	6.2604	6.2590	6.2645
	Mean(Missing)	4.1599	4.1083	4.1888	4.1478	4.1844	.	6.1468	6.1492	6.1399	6.0086	6.0035	.

Table 2 (Continued)

		TWA.1	TWA.2	TWA.3	TWA.4	TWA.5	TWA.6	TTP.1	TTP.2	TTP.3	TTP.4	TTP.5	TTP.6
TTP.1	t	.	.	.	.	.	.	.	.	.	.	.	.
	df	.	.	.	.	.	.	.	.	.	.	.	.
	# Present	751	682	625	579	529	482	751	682	625	579	529	482
	# Missing	0	0	0	0	0	0	0	0	0	0	0	0
	Mean(Present)	4.0803	4.1031	4.1648	4.2119	4.2338	4.2462	6.1183	6.1378	6.1728	6.2182	6.2363	6.2645
	Mean(Missing)	.	.	.	.	.	.	.	.	.	.	.	.
TTP.2	t	-1.7	.	.	.	.	.	-.6	.	.	.	.	.
	df	82.1	.	.	.	.	.	79.6	.	.	.	.	.
	# Present	682	682	625	579	529	482	682	682	625	579	529	482
	# Missing	69	0	0	0	0	0	69	0	0	0	0	0
	Mean(Present)	4.0665	4.1031	4.1648	4.2119	4.2338	4.2462	6.1129	6.1378	6.1728	6.2182	6.2363	6.2645
	Mean(Missing)	4.2174	.	.	.	.	.	6.1715	.	.	.	.	.
TTP.3	t	-2.1	.0	.	.	.	.	-1.5	-2.2	.	.	.	.
	df	184.9	66.4	.	.	.	.	180.7	73.1	.	.	.	.
	# Present	625	625	625	579	529	482	625	625	625	579	529	482
	# Missing	126	57	0	0	0	0	126	57	0	0	0	0
	Mean(Present)	4.0576	4.1035	4.1648	4.2119	4.2338	4.2462	6.0997	6.1216	6.1728	6.2182	6.2363	6.2645
	Mean(Missing)	4.1931	4.0994	.	.	.	.	6.2103	6.3158	.	.	.	.
TTP.4	t	-1.9	-.5	-.5	.	.	.	-1.1	-2.4	-.4	.	.	.
	df	281.8	135.0	49.9	.	.	.	273.3	156.5	50.3	.	.	.
	# Present	579	579	579	579	529	482	579	579	579	579	529	482
	# Missing	172	103	46	0	0	0	172	103	46	0	0	0
	Mean(Present)	4.0541	4.0973	4.1606	4.2119	4.2338	4.2462	6.1010	6.1111	6.1693	6.2182	6.2363	6.2645
	Mean(Missing)	4.1686	4.1359	4.2174	.	.	.	6.1764	6.2880	6.2174	.	.	.
TTP.5	t	-2.5	-.6	-.6	-.5	.	.	-.9	.0	.0	1.3	.	.
	df	427.5	234.5	122.0	58.1	.	.	416.9	227.9	125.9	57.1	.	.
	# Present	529	529	529	529	529	482	529	529	529	529	529	482
	# Missing	222	153	96	50	0	0	222	153	96	50	0	0
	Mean(Present)	4.0403	4.0951	4.1575	4.2079	4.2338	4.2462	6.1021	6.1383	6.1723	6.2313	6.2363	6.2645
	Mean(Missing)	4.1757	4.1307	4.2049	4.2533	.	.	6.1569	6.1362	6.1753	6.0800	.	.
TTP.6	t	-2.4	-.1	-.5	1.0	.5	.	-.8	-.2	.6	2.7	1.8	.
	df	573.2	359.3	208.3	123.1	52.4	.	553.1	346.8	210.7	123.1	51.2	.
	# Present	482	482	482	482	482	482	482	482	482	482	482	482
	# Missing	269	200	143	97	47	0	269	200	143	97	47	0
	Mean(Present)	4.0360	4.1010	4.1577	4.2248	4.2386	4.2462	6.1024	6.1331	6.1826	6.2604	6.2590	6.2645
	Mean(Missing)	4.1599	4.1083	4.1888	4.1478	4.1844	.	6.1468	6.1492	6.1399	6.0086	6.0035	.

Similarly, the group with non-missing Therapist WA at Session 5 (TWA1 *mean* = 4.04) had significantly lower (t = -2.5) average Therapist WA at Session 1 than the group with missing Therapist WA at Session 5 (TWA1 *mean* =4.18). These results meant that therapists were less likely to omit the WA measure when initial ratings were lower, suggesting that missing data at later sessions could be due to reasons unrelated to low WA, thus providing evidence against MNAR but for MAR. Moreover, while directly testing for data that is MNAR is not feasible without obtaining extra information on the missing cases, the aforementioned scenario for MNAR (that participants have missing values due to low scores on that variable) is unlikely because the surveys used in the study are low-stake self-reports, and their scores were not utilized to evaluate therapist trainees' performance in therapy. These findings and reasoning indicated a greater likelihood that the Dataset D1_T was MAR instead of MNAR.

According to statistical literature (Enders, 2010; Schafer & Graham, 2002), the Full Information Maximum Likelihood (FIML) estimator is robust against biases in estimation when the data are missing completely at random (MCAR) or missing at random (MAR). However, it may produce biased estimates if the data are missing not at random (MNAR). Considering that the missing data in Datasets D1_T was most likely MAR than MNAR, I retained all cases in these datasets and adopted the FIML estimation to address the missing data on relevant items in the first part of the main analysis.

CFM. In the second part of the main analysis, I first inspected the overall dataset for missing values in the six variables of interest, including therapist-rated therapeutic presence (TTP), client-rated therapeutic presence (CTP), therapist-rated working alliance (TWA), client-rated working alliance (CWA), therapist-rated session quality (TSQ), and client-rated session quality (CSQ). I then excluded cases from the analysis if they lacked any data on the core

variables from either therapist trainees or clients. Specifically, if a case/session in the overall dataset had all trainee variables (TTP, TWA, TSQ) missing, or if there was a complete absence of client data (CTP, CWA, CSQ), that case was not included in the subsequent analyses. Notably, the cases excluded from this part of the analysis were retained in the overall dataset because of their inclusion of demographic information or data on variables unrelated to this study.

From the total of 15145 cases in the overall dataset, we excluded 9717 cases in the step described above and retained 5428 cases. This refined dataset, labeled Dataset D2, was used for the second part of the main analysis to test the associations between therapist-client shared perceptions of therapeutic presence, working alliance, and session quality. Further missing value analysis of the retained 5,428 cases in Dataset 2 indicated that the percentage of missing values for TTP, TWA, TSQ, CTP, CWA, and CSQ was 0%, signifying complete data for these core variables. Consequently, all 5,428 cases were retained in the second part of the main analysis.

Data Distribution Inspection

RI-CLPM. For Dataset D1_T and D1_C, I also assessed the normality of the distribution for the average scale scores, respectively. Applying the criteria that skewness and kurtosis values between -2 and 2 indicate univariate normality (George & Mallery, 2010), all variables in Dataset D1_C were determined to exhibit a normal distribution. However, in Dataset D1_T, although all six therapist working alliance scores from Sessions 1 to 6 exhibited univariate normality, four of the total six therapist therapeutic presence scores for Sessions 2, 4, 5, and 6 displayed a non-normal distribution, with kurtosis values ranging from 2.986 to 5.354. Given these findings, I decided to manage the non-normality of the variables in D1_T by utilizing the FIML estimator (Enders, 2001).

CFM. Additionally, for Dataset D2, aside from therapist TP (skewness =-1.695, kurtosis =4.473), all other core variables for the second part of the study (TWA, TSQ, CTP, CWA, and CSQ) were found to exhibit a normal distribution, with skewness and kurtosis estimates ranging between -2 and 2. Based on these findings, I once again employed the FIML estimator (Enders, 2001) to handle the non-normal therapist TP distribution.

Main Analyses

RI-CLPM

As aforementioned, both therapists and clients filled out the measures on therapeutic presence and working alliance. To comprehensively grasp the nature of the relationship between therapeutic presence and working alliance, I examined how therapeutic presence temporally predicts the working alliance from the respective perspectives of therapists and clients. Therefore, the RI-CLPM, as previously depicted in Figure 1, was run separately for the datasets: D1_T and D1_C. As noted previously, for each dataset, two models were evaluated: Model 1, a more parsimonious time-invariant model where the corresponding effects across various time points were fixed to be equal based on the stationarity assumption in CLPM (Kearney, 2017); and Model 2, a more complex, time-variant model allowing corresponding associations to vary without constraints across different time waves. Upon comparing Model 1 and Model 2, I made a decision on which model to adopt moving forward. Specifically, in cases where there was no significant difference between the two models, I opted for the simpler and more parsimonious Model 1, and its path coefficients were the focus of my interpretation.

Relating Client Therapeutic Presence to Client Working Alliance Using RI-CLPM. First, I employed Dataset D1_C to conduct the RI- CLPM analysis, which was aimed at

examining the temporal association between client-rated therapeutic presence and the client-rated working alliance. Parameter estimation results of the RI-CLPM are reported in Table 3.

Table 3
Model Fit Indices for the RI-CLPM Analysis

		χ^2 (df, p)	CFI	TLI	RMSEA	SRMR
Client rating	Model 1	199.853 (66, p<.001)	0.973	0.973	0.043	0.077
	Model 2	85.498 (37, p<.001)	0.990	0.983	0.035	0.049
Therapist rating	Model 1	75.815 (66, p=0.191)	0.997	0.997	0.014	0.066
	Model 2	49.064 (37, p=0.089)	0.996	0.993	0.021	0.073

Specifically, for Model 1, the fit indices were as follows: $\chi2(66) = 199.853$, $p = .000$; RMSEA = .043; CFI = .973; TLI = .973; SRMR = .077. For Model 2, the fit indices were: $\chi2(37) = 85.498$, p = .000; RMSEA = .035; CFI = .990; TLI = .983; SRMR = .049. Both models demonstrated good overall model fit according to Wang & Wang (2020). Additionally, when comparing Model 1 with Model 2, the scaled $\chi2$ difference test was first employed, taking into account the scaling correction factor as estimated by Mplus (Satorra & Bentler, 2010). The test result showed that corrected $\Delta\chi2 = 144.355$, $\Delta df = 29$, $p < .001$, which indicated that there was a significant difference between Model 1 and Model 2. However, considering the scaled $\chi2$ difference test is sensitive to sample size and minor nuisance differences would lead to significant results (Putnick et al., 2016), I proceeded to compare Model 1 and Model 2 using additional model fit indices as recommended by Rutkowski & Svetina (2014), ΔCFI = -.017, and ΔRMSEA = .008. Given that the criteria for a significant difference between two models are $\Delta CFI \leq -.02$ and $\Delta RMSEA \geq .03$ (Rutkowski & Svetina, 2014), it was concluded that there was no significant difference in model fit between Model 1 and Model 2. Thus, I chose the more parsimonious, time-invariant Model 1 and proceeded to interpret its specific path coefficients.

In Model 1, at the between-person level, the analysis showed a significant correlation between the random intercepts of client-rated therapeutic presence and client-rated working

alliance (estimate = .209, *SE* = .012, $p < .001$). Specifically, it suggested that clients who tended to rate therapeutic presence highly also tended to report a stronger working alliance consistently over time.

At the within-person level, for the autoregressive effects, a client's perception of therapeutic presence at the end of a session significantly predicted itself at the end of the next session (aCTP = .181, *SE* = .025, $p < .001$). Similarly, a client's perception of the working alliance at the end of a session significantly predicted itself at the end of the next session (aCWA = .153, *SE* = .023, $p = <.001$). Regarding the cross-lagged effects, a client's perception of therapeutic presence at the end of one session significantly predicted their perception of the working alliance at the end of the following session (T2W = .057, *SE* = .012, $p < .001$); however, client ratings of working alliance at the end of a session did not significantly predict their ratings of therapeutic presence at the end of the subsequent session (W2T = .019, *SE* = .022, $p = .376$). Lastly, the concurrent residual correlations were significant (rTW = .047, *SE* = .005, $p < .001$), which suggested when clients reported a higher-than-average rating of therapeutic presence for a particular session, they also tended to have a higher-than-average working alliance rating for that same session, after accounting for their overall average levels (i.e., the random intercepts). Estimation results are shown in Table 4. In conclusion, from the clients' perspectives, these findings were consistent with the Hypothesis 1, indicating that therapeutic presence temporally predicted subsequent working alliance over the course of the treatment in that higher therapeutic presence at one time point leads to greater working alliance at the subsequent time point, but higher working alliance at one time point did not temporally lead to higher therapeutic presence at the subsequent time point.

Table 4

Summary of Results of Client CLPM

Path	Coefficient	*S.E.*	*Est./S.E.*	*p*
Client				
Autoregressive paths				
CWA_S1 → CWA_S2	0.153***	0.023	6.612	<.001
CWA_S2 → CWA_S3	0.153***	0.023	6.612	<.001
CWA_S3 → CWA_S4	0.153***	0.023	6.612	<.001
CWA_S4 → CWA_S5	0.153***	0.023	6.612	<.001
CWA_S5 → CWA_S6	0.153***	0.023	6.612	<.001
CTP_S1 → CTP_S2	0.181***	0.025	7.287	<.001
CTP_S2 → CTP_S3	0.181***	0.025	7.287	<.001
CTP_S3 → CTP_S4	0.181***	0.025	7.287	<.001
CTP_S4 → CTP_S5	0.181***	0.025	7.287	<.001
CTP_S5 → CTP_S6	0.181***	0.025	7.287	<.001
Cross-lagged paths				
CTP_S1 → CWA_S2	0.057***	0.012	4.648	<.001
CTP_S2 → CWA_S3	0.057***	0.012	4.648	<.001
CTP_S3 → CWA_S4	0.057***	0.012	4.648	<.001
CTP_S4 → CWA_S5	0.057***	0.012	4.648	<.001
CTP_S5 → CWA_S6	0.057***	0.012	4.648	<.001
CWA_S1 → CTP_S2	0.019	0.022	0.886	0.376
CWA_S2 → CTP_S3	0.019	0.022	0.886	0.376
CWA_S3 → CTP_S4	0.019	0.022	0.886	0.376
CWA_S4 → CTP_S5	0.019	0.022	0.886	0.376
CWA_S5 → CTP_S6	0.019	0.022	0.886	0.376

Relating Therapist Therapeutic Presence to Therapist Working Alliance at the Session Level. Second, I utilized Dataset D1_T to perform the RI-CLPM analysis, focusing on exploring how therapist-rated therapeutic presence predicts the therapist-rated working alliance over time. Table 3 presents the parameter estimates from the RI-CLPM, previously introduced. Specifically, for Model 1, the fit indices were as follows: $\chi 2(66) = 75.815$, $p = .191$; RMSEA = .014; CFI = .997; TLI = .997; SRMR = .066. For Model 2, the fit indices were: $\chi 2(37) = 49.064$, p = .089; RMSEA = .021; CFI = .996; TLI = .993; SRMR = .073. Both models demonstrated excellent overall model fit based on Wang & Wang (2020). Moreover, when comparing Model 1 and Model 2, it appears that the Model 1 not only is more parsimonious but

also exhibits slightly better fit indices than the more complex Model 2. Thus, I chose the more parsimonious, time-invariant Model 1 and proceeded to interpret its specific path coefficients.

In Model 1, at the between-person level, the analysis showed a significant correlation between the random intercepts of therapist-rated therapeutic presence and therapist-rated working alliance (estimate = .152, *SE* = .025, *p* = .000). Essentially, it indicates that therapists who consistently reported a higher level of therapeutic presence with a client also tended to report a higher level of working alliance with that client over therapy sessions.

At the within-person level, regarding the autoregressive effects, a therapist's perception of therapeutic presence at the end of a session significantly predicted their perception at the end of the next session (aTTP = .116, *SE* = .043, *p* =.007). Similarly, a therapist's perception of the working alliance at the end of a session significantly predicted their perception of working alliance at the end of the next session (aTWA = .153, *SE* = .036, $p < .001$). Regarding the cross-lagged effects, a therapist's perception of therapeutic presence at the end of one session significantly predicted their perception of the working alliance at the end of the following session (T2W = .053, *SE* = .023, *p* = .022); however, therapist ratings of working alliance at the end of a session did not significantly predict their ratings of therapeutic presence at the end of the subsequent session (W2T = .039, *SE* = .039, *p* = .314). Lastly, the concurrent residual correlations were also significant (rTW = .08, *SE* = .009, $p < .001$), which indicated that when therapists had a higher-than-average rating of therapeutic presence for a particular session, they also tended to have a higher-than-average working alliance rating for that same session, after accounting for their overall average levels (i.e., the random intercepts). Estimation results are shown in Table 5. In summary, from the therapists' perspectives, these results also supported the

Hypothesis 1 in that therapeutic presence temporally predicted the working alliance over the course of treatment, rather than the reverse.

Table 5
Summary of Results of Therapist CLPM

Path	Coefficient	*S.E.*	*Est./S.E.*	*p*
Therapist				
Autoregressive paths				
TWA_S1 → TWA_S2	0.153***	0.036	4.283	<.001
TWA_S2 → TWA_S3	0.153***	0.036	4.283	<.001
TWA_S3 → TWA_S4	0.153***	0.036	4.283	<.001
TWA_S4 → TWA_S5	0.153***	0.036	4.283	<.001
TWA_S5 → TWA_S6	0.153***	0.036	4.283	<.001
TTP_S1 → TTP_S2	0.116**	0.043	2.683	0.007
TTP_S2 → TTP_S3	0.116**	0.043	2.683	0.007
TTP_S3 → TTP_S4	0.116**	0.043	2.683	0.007
TTP_S4 → TTP_S5	0.116**	0.043	2.683	0.007
TTP_S5 → TTP_S6	0.116**	0.043	2.683	0.007
Cross-lagged paths				
TTP_S1 → TWA_S2	0.053*	0.023	2.291	0.022
TTP_S2 → TWA_S3	0.053*	0.023	2.291	0.022
TTP_S3 → TWA_S4	0.053*	0.023	2.291	0.022
TTP_S4 → TWA_S5	0.053*	0.023	2.291	0.022
TTP_S5 → TWA_S6	0.053*	0.023	2.291	0.022
TWA_S1 → TTP_S2	0.039	0.039	1.007	0.314
TWA_S2 → TTP_3	0.039	0.039	1.007	0.314

CFM

Building on the insights from the first part of analysis, I applied the CFM model to further investigate the relationship among therapeutic presence, working alliance, and session quality. The CFM enabled me to distinguish between and model the "individual perceptions" and "shared perceptions" of both members of a dyad (Kivlighan, 2007; Li et al., 2021). Thus, in the second part of analysis, I first examined how shared therapist-client perceptions of therapeutic presence were associated with their shared perceptions of session quality at the between-session (within -client) and between therapist-client dyads level, respectively. Additionally, I assessed how their individual perception of therapeutic presence predicts their individual perceptions of

session quality at the aforementioned two levels. Lastly, since the first part of analysis revealed that therapeutic presence preceded working alliance, I investigated the mediating effect of therapist-client shared perception of working alliance on the relationship between their shared perception of therapeutic presence and session quality. This examination at the between-session level aimed to explore how the client's and therapist's perceptions and interactions vary from one session to another within the context of their therapeutic relationship.

Relating Therapeutic Presence to Session Quality. A two-level CFM was constructed to account for the nested data structure: sessions within client-therapist dyads. Because clients were also nested within therapists, the Huber-White sandwich method was used to adjust for the standard error estimation bias due to clients nesting within therapists (Muthen & Muthen, 2017). This was done by employing the TYPE=COMPLEX command in Mplus. At the between-session (within-client) level, two latent variables, representing shared therapeutic presence and shared session quality, were specified, using the therapeutic presence and session quality ratings from both clients and therapists as their respective indicators. The loadings for both therapists and clients were fixed at 1, and the model allowed for the residual variances of the therapeutic presence and session quality ratings from the same raters to correlate without restriction. The latent factor representing session quality was regressed on the latent factor representing therapeutic presence. Additionally, the observed indicators for therapist and client therapeutic presence and session quality were not centered, as their intercepts would be analyzed at the higher level. Consequently, at the between therapist-client dyads level, the intercepts obtained from the first level were used and the latent constructs of shared therapeutic presence and shared session quality were similarly defined, with therapist and client ratings serving as indicators.

This level captures variations across different therapist-client dyads, providing insights into the overall patterns of therapeutic interaction and session efficacy.

Mplus 8.3 (Muthén & Muthén, 2017) was used to estimate the two-level Common Fate Model (CFM), and the parameter estimates are presented in Table 6. The model demonstrated good overall fit: $\chi^2(2) = 34.82$, $p < .001$; RMSEA = .055; CFI = .976; TLI = .854; SRMR (between sessions) = .014; SRMR (between dyads) = .059.

Table 6

Model Fit Indices for the Common Fate Model

		χ^2 (df, p)	CFI	TLI	RMSEA	SRMR
Relating TP to SQ	Between-session	34.820 (2, p<0.001)	0.976	0.854	0.055	0.014
	Between-dyad	34.820 (2, p<0.001)	0.976	0.854	0.055	0.059

Note. TP = therapist-client shared perception of therapeutic presence; SQ = therapist-client shared perception of session quality

Estimation results for the CFM examining therapist–client shared perception of therapeutic presence are presented in Table 7. Frist, at the between-session level, the results indicated that therapist-client shared perception of therapeutic presence was a significant predictor of their shared perception of session quality ($B = 1.507$, $p < .001$). In other words, sessions characterized by a higher shared perception of the therapeutic presence were also associated with a higher shared session quality; specifically, a one-unit increase in shared therapeutic presence was associated with a 1.507-unit increase in shared session quality.

Table 7

Summary of Results of CFM with Shared TP and SQ

	Coefficient	*S.E.*	*Est./S.E.*	*p*
Shared perception				
Between-session level				
TP1→SQ1	1.507***	0.348	4.335	<0.001
Between therapist-client dyad level				
TP2→SQ2	1.428***	0.363	3.928	<0.001
Individual perception				
Between-session level				
CTP ↔ CSQ	0.044***	0.006	9.248	<0.001
TTP ↔ TSQ	0.092***	0.010	3.751	<0.001
Between therapist-client dyad level				
CTP ↔ CSQ	0.203***	0.022	9.290	<0.001
TTP ↔ TSQ	0.118***	0.033	3.586	<0.001

Note. TP1 = therapist-client shared perception of therapeutic presence at the between-session level; SQ1 = therapist-client shared perception of session quality at the between-session level; TP2 = therapist-client shared perception of therapeutic presence at the between therapist-client dyad level; SQ2 = therapist-client shared perception of session quality at between therapist-client dyad level

In addition, at the between-session level, both clients' and therapists' individual perceptions of therapeutic presence are positively related to their respective senses of session quality, after accounting for the association between their shared perceptions of therapeutic presence and session quality. For example, from the individual perspective of therapists, a one-unit increase in therapeutic presence corresponded to a 0.092-unit increase in perceived session quality ($p < .001$). Moreover, from the individual perspective of clients, a one-unit increase in their perceived therapeutic presence was associated with a .044-unit increase in their perception of session quality ($p < .001$). Therefore, when a client's (or therapist's) individual perceptions of the therapeutic presence were higher in one session compared to other sessions, their individual perception of session quality tended to be similarly higher in that particular session.

Second, at the between therapist-client dyad level, it was found that therapist-client shared perception of therapeutic presence significantly predicted their shared perception of

session quality across different dyads ($B = 1.428$, $p < .001$). In other words, therapist-client dyads that, on average, reported higher levels of therapeutic presence also reported higher levels of session quality compared to dyads with lower levels of therapeutic presence—specifically, across different therapist-client dyads, as the shared perception of therapeutic presence increases by one unit, the shared perception of session quality is predicted to increase by 1.428 units.

Moreover, at the between therapist-client dyad level, therapists' and clients' individual perceptions of therapeutic presence and session quality were also significantly correlated, after accounting for the association between their shared perceptions of therapeutic presence and session quality. For instance, from the individual perspective of a client, for each unit increase in client therapeutic presence, there's an expected increase of .203 units in client session quality ($p<.001$). Similarly, from the individual perspective of a therapist, for each unit increase in therapist therapeutic presence, there's an expected increase of .118 units in therapist session quality ($p<.001$). Therefore, clients (or therapists) who generally reported higher levels of therapeutic presence also tended to report higher overall session quality.

Mediating Effects of Working Alliance on Therapeutic Presence and Session Quality. Based on the two-level CFM model built to explore the impact of shared therapist-client perceptions of therapeutic presence on session quality in the last step, I introduced a third latent variable representing their mutual perception of working alliance at the between-session (within-client) level to assess its mediating effect. Similar to therapeutic presence and session quality, ratings of working alliance from both clients and therapists served as indicators of the working alliance latent variable. The loadings for both therapists and clients were fixed at 1, and the model allowed for the residual variances of the therapeutic presence, session quality, and working alliance ratings from the same raters to correlate without restriction. In addition, the

model was constructed to include paths for mediation analysis. Specifically, it was posited that the therapist-client shared therapeutic presence latent variable predicts the shared working alliance latent variable, which in turn predicts the shared session quality latent variable. A direct path from therapeutic presence to session quality was also included, allowing for assessing the direct and indirect effects of therapeutic presence on session quality through the working alliance. Moreover, as I was interested in examining the dynamic processes that occur within individuals over time, as opposed to the more static characteristics that differ between dyads (i.e., the therapist-client dyads level), the main focus of the model was on the between-session (within-client) level. However, to maintain the integrity of the two-level structure, similar covariances between therapists' and clients' respective ratings of therapeutic presence, working alliance, and session quality were specified at the between therapist-client dyads level.

Parameter estimation results of the CFM mediation model are reported in Table 8. The model fit indices of the model indicated an overall good fit: $\chi^2 = 132.372$, $df = 12$, $p < .001$; RMSEA = .043, CFI = .968, TLI = .921; SRMR for between-session level = .017, and between therapist-client dyad level = .151. It's worth noting that while the SRMR for the between therapist-client dyad level was higher than the generally accepted threshold of .08, it was believed to be nonessential given the main focus of the current study. As mentioned earlier, my primary interest was in examining variations within clients across therapy sessions in. Although the therapist-client dyads level was established to account for the hierarchical data structure, it did not serve as the main focus of the study. Instead, my analysis concentrated on interpreting the results for the mediation effect at the between-session (within-client) level.

Table 8.
Model Fit Indices for the Mediation Model

		χ^2 (df, p)	CFI	TLI	RMSEA	SRMR
Mediating model between TP, WA, and SQ	Between session	132.372 (12, $p < .001$)	0.968	0.921	0.043	0.017
	Between Dyad	132.372 (12, $p < .001$)	0.968	0.921	0.043	0.151

Note. TP = therapist-client shared perception of therapeutic presence; SQ = therapist-client shared perception of session quality; WA = therapist-client shared perception of working alliance

Lastly, the mediation effects are reported in Table 9. The current study revealed that the total effect is significant (estimate = 1.513, *SE* = 0.348, $p < .001$), which indicated that therapist-client shared perception of therapeutic presence was significantly associated with their shared perception of session quality. In other words, sessions characterized by a higher shared perception of the therapeutic presence were also associated with a higher shared session quality. Regardless of the total effect being significant, the indirect effect via the shared working alliance was not statistically significant (estimate = 0.612, *SE* = 0.944, p=.517). This finding suggested that although shared therapeutic presence significantly predicted shared session quality, the working alliance did not significantly mediate this relationship.

Table 9.
The mediation effect through shared perception of WA

	Coefficient	*S.E.*	*Est./S.E.*	*p*
Shared perception				
Between-session level				
WA1→SQ1	0.534	0.921	0.580	0.562
TP1→SQ1	0.901	1.242	0.726	0.468
TP1→WA1	1.146***	0.281	4.085	<0.001
Mediation Path				
Indirect effect	0.612	0.944	0.648	0.517
Total effect	1.513***	0.348	4.342	<0.001

Note. TP1 = therapist-client shared perception of therapeutic presence at the between-session level; SQ1 = therapist-client shared perception of session quality at the between-session level; WA2 = therapist-client shared perception of working alliance at the between-session level

Chapter Five: Discussion

This study sought to explore how therapeutic presence contributed to the development of the working alliance and session quality. Although empirical evidence preliminarily supports positive relationships between therapeutic presence and working alliance across various theoretical orientations, the majority of studies in this field were limited by their cross-sectional design. Consequently, they failed to explore the directionality between therapeutic presence and working alliance. To bridge this gap in the literature, I examined how therapeutic presence temporally predicted working alliance across therapy sessions using Random Intercept Cross-Lagged Panel Models (RI-CLPM; Hamaker et al., 2015). Additionally, upon clarifying the directionality between therapeutic presence and working alliance, I investigated the associations between therapeutic presence, working alliance, and session quality while taking into account the perspectives of both therapists and clients using Common Fate Model (CFM; Ledermann & Kenny, 2012). Furthermore, to overcome the significant limitation of relying solely on cross-sectional data in previous research, I utilized longitudinal data to examine the shared perception of these three variables across session and therapist-client dyads levels of analysis (Zilcha-Mano et al., 2016). In summary, the findings were anticipated to:1) establish the directionality between therapeutic presence and working alliance, and 2) provide a deeper insight into the dyadic nature of the psychotherapy process, as well as into the complex multilevel relationships between therapists' and clients' shared perceptions of therapeutic presence, working alliance, and session quality.

RI-CLPM

In the first part of the main analysis, I examined how therapeutic presence temporally predicted the working alliance, considering the separate perspectives of therapists and clients.

More specifically, the RI-CLPM analysis revealed that a client's perception of therapeutic presence in one session significantly predicted their perception of the working alliance in the following session, after accounting for the autoregressive effects, the correlation between the random intercepts of these two variables, and the concurrent residual correlations. Similarly, a therapist's perception of therapeutic presence in one session was a significant predictor of their perceived working alliance in the subsequent session after accounting for the autoregressive effects, the correlation between the random intercepts of these two variables, and the concurrent residual correlations. However, the analysis of both therapists' and clients' data in my study suggested that the level of working alliance in the current session was not associated with the level of therapeutic presence in the next session. Taken together, the findings from both therapists and clients corroborated my Hypothesis 1, demonstrating that a higher level of therapeutic presence in one session temporally led to a stronger working alliance in the subsequent session rather than the reverse.

The first part of the main analyses regarding Hypothesis 1 was consistent with the existing literature, indicating that therapeutic presence may act as a precursor to the development of a strong working alliance and a positive therapeutic relationship (e.g., Allison & Rossouw, 2013; Dunn et al., 2013; Hayes & Vinca, 2017; Pos et al., 2011). However, my findings may enhance the existing literature by enabling us to establish the directionality between these two constructs, considering both therapists' and clients' perspectives. From a therapist's perspective, being therapeutically present with and for clients enables the therapist to be more sensitive to the here-and-now aspects of the therapy process and fosters the formation of a strong therapeutic bond (Geller & Greenberg, 2002; Geller & Greenberg; 2022). Additionally, therapeutic presence allows therapists to actively listen to, reflect on, and effectively respond to their clients'

experiences and provide more attuned and responsive feedback (Geller & Greenberg, 2010). This engagement not only strengthens the bond therapists feel with their clients but enables them to perceive that they are able to collaboratively establish treatment goals and reach an agreement on necessary therapy tasks that emerge from clients' deepest needs and concerns. Furthermore, from a client's perspective, perceiving their therapists as fully present and engaged and thereby demonstrating profound empathy and understanding encourages them to invest in the therapeutic process (Shepherd et al., 1972). This fosters a view of therapy as a shared journey rather than a one-sided effort. In other words, clients who feel their therapists are fully present may experience a profound connection and a strong therapeutic bond, which enhances their perception of effective collaboration with their therapists and thus enable them to work more effectively to tackle and progress toward their treatment goals and concerns.

CFM

Relating Therapeutic Presence to Session Quality

In the second part of the analysis, I first examined the influence of shared therapist-client perceptions of therapeutic presence on their shared perceptions of session quality at the between therapist-client dyad and between-session levels, respectively. Additionally, I assessed how their individual perceptions of therapeutic presence predicted their individual perceptions of session quality at these two levels after accounting for the associations of their shared perception.

Therapists’ and clients’ shared perception of therapeutic presence was significantly and positively associated with their shared perception of session quality both at the between-session and between therapist-client dyad level, which was consistent with my hypothesis 2. At the between-session level, these findings suggested that sessions characterized by a higher shared perception of the therapeutic presence were also associated with a higher shared session quality.

Therefore, in a particular session where the therapist and the client feel in synchronicity with each other and perceive their interactions as flowing and rhythmic in which both parties were able to immerse in the client's experiences at a deep and profound level, they may jointly feel satisfied with that session and believe that it benefits the client in that session. However, rather than concentrating on micro-level dynamics, the analysis at the between therapist-client dyads level explored variations across different groupings. It aimed to uncover broader patterns, revealing a consistently positive relationship where dyads, on average, reported higher levels of therapeutic presence also tended to report higher levels of session quality, compared to those with lower levels of therapeutic presence. In other words, this shared perception highlighted the universal significance of therapeutic presence in fostering positive therapeutic outcomes and underscores its relevance across diverse therapeutic relationships, regardless of specific therapist-client dynamics.

Furthermore, these findings also deepened our understanding of the dyadic and dynamic nature of psychotherapy through modeling and assessing the joint, collective, and shared perceptions between the therapist and the client about the therapy process. The existing theoretical and empirical evidence suggested that therapeutic presence, as a common factor, is transtheoretical (Geller & Greenberg, 2022) and therefore has been a significant predictor of the effectiveness of various therapy approaches (Furrow et al, 2012; Geller et al., 2010; Goldner, 2016; Kanter et al. 2009). However, most of these studies focused either on the client's experience of the therapist, or the therapist' experience of themselves, which failed to accurately capture the "two-person" nature of the relational aspect of this construct. By employing the CFM model, we were able to more closely quantify the "consensual" and "reciprocal" aspects that are pivotal in what Schmid (2002) conceptualized as 'coexperiencing' or 'joint experiencing' in

therapeutic presence. For example, when the therapist perceives that they are effectively present with the client's pain, and the client feels this presence is clearly expressed and communicated by the therapist, both parties become increasingly attuned to the depth and variety of their experiences. In other words, the shared perception of therapeutic presence modeled in CFM is rooted in the synchronized psychological and emotional journey between therapist and client. With each encounter, both members were completely attuned to each other's feelings and become increasingly open to hearing and sensing the client's experiences at a deeper level (Geller & Greenberg, 2022). Therefore, in line with the suggestions of Kivlighan (2007) and Li et al. (2021), the CFM model is recommended as a viable analytic method when examining how therapists and clients engage and evolve through therapy together in future research.

In terms of the therapists' and clients' individual perception of therapeutic presence and working alliance, the results displayed a similar pattern, aligning with Hypothesis 3. Based on how the CFM was developed, the correlation between individual perceptions refers to "residual correlations" after shared perception are patriated out. Individual perceptions of therapeutic presence and session quality were found to be significantly correlated at the between-session and therapist-client dayd level, for both therapists and clients. Specifically, at the between-session level, when a client's or therapist's individual perceptions of the therapeutic presence were higher in one session compared to other sessions, their individual perception of session quality tended to be similarly higher in that particular session. These findings indicated that, in additional to the shared perception, the unique viewpoints of therapists and clients also play an important role in the therapy process. Throughout therapy, due to differences in their roles, both the therapist and the client can bring unique viewpoints to the understanding of their therapeutic relationship and the quality of their sessions (Li at al., 2021). For instance, based on how the

concept therapeutic presence was constructed, from the therapist's individual perspective, a high rating of therapeutic presence in a specific session may not only result from attunement with the client but also from the therapist's ability to maintain deep contact with and listen to their inner self, including their body, emotions, and reactions to the client (Geller & Greenberg, 2022). Therefore, when therapists are well aware of their own internal flow of experiences during a session—experiences that are not shared with the client—they may individually perceive the session as beneficial for the client and accordingly report a high session quality rating.

Similarly, the client can also have unique perceptions that are not shared with therapists about the therapy process. For instance, clients enter therapy with their own expectations, beliefs, and understandings about what constitutes effective therapy (Wang et al., 2022). These views can be shaped by various factors such as cultural background, life experience, personality, personal values, or even past experience with therapy (Caine et al., 1973; Robitschek & Hershberger, 2005). Therefore, in a particular session, when the therapist manages to meet the client's unique expectations and makes them feel heard and understood, the client may perceive a heightened level of therapeutic presence and thus feel satisfied with that session. However, in this case, there can be a discrepancy between the therapist and the client, where the client senses a high level of therapeutic presence because of their unique needs and understanding of the therapy process, while the therapist does not necessarily perceive it in the same way due to their own evaluation of how engaged they feel in the session.

Finally, at the between therapist-client dyad level, a significantly positive correlation between therapists' and clients' respective perception of therapeutic presence and session quality indicated that dyads where clients or therapists, on average, exhibited a high rating of therapeutic presence are also the dyads in which clients or therapists, on average, reported higher session

quality. Compared to the analysis at the between-session level, which focused on relationships between therapists' and clients' individual perceptions within each dyad over time—after partitioning out their shared perceptions—the findings at the between therapist-client dyad level revealed a general pattern across multiple dyads. Given that similar patterns were once again observed at both levels, this further strengthens the argument that certain common factors, such as therapeutic presence, are universally beneficial across different client-therapist pairs.

Mediating Effects of Working Alliance on Therapeutic Presence and Session Quality

Drawing on the findings from the RI-CLPM and the two-level CFM model in the current study and considering the established link between working alliance and session quality in previous research (Colosimo & Pros, 2015; Flückiger et al., 2018; Geller et al., 2010; Hayes & Vinca, 2011, 2017; Pos et al., 2011; Zhao et al., 2022), we explored whether the shared perception of working alliance between the therapist and the client mediated the relationship between their shared perception of therapeutic presence and session quality at the between-session level. The study is among the first to investigate the potential mediating role of working alliance in this context, and our findings revealed that the direct path from shared therapeutic presence to shared session quality was significant, while the mediated path through shared working alliance was not, indicating that the primary contribution of shared therapeutic presence to shared session quality does not depend on the shared working alliance.

These findings did not support the Hypothesis 4, and one possible explanation for the absence of mediation could be the distinct contributions of shared therapeutic presence and shared working alliance to shared session quality. Specifically, Geller et al. (2010) proposed that therapist presence captures the unique aspects of the therapy process that extend beyond the contribution of working alliance. Building on this assertion and utilizing the CFM model, Zhao

et al. (2022) found that at the between-session level, therapist ratings of therapeutic presence significantly predicted therapist-client shared session quality, above and beyond the shared working alliance. The current study further suggested that the therapist-client shared perception of therapeutic presence might have its own unique, direct impact, which did not operate through the shared working alliance. For instance, in a specific session, the direct effects of shared therapeutic presence—such as strong attunement to the multiplicity of experiences—are potent enough to independently enhance the shared perception of session quality of that session, regardless of the shared working alliance strength, such as whether the therapist and client have agreed on necessary tasks that will be used to achieve the therapy goals. Further studies are needed to validate these findings in different therapeutic settings and populations. Additionally, it would also be beneficial to investigate other potential mediators that could affect the dynamic between therapeutic presence, working alliance, and session quality.

Limitations and Future Directions.

Several limitations should be noted in the current study. First, while this research included more participants and therapy sessions than many existing studies on psychotherapy processes and outcomes (e.g., Kivlighan et al., 2015; Markin et al., 2014), each therapist-client dyad had a mean of 6 to 7 sessions, and the RI-CLPM developed for this study utilized data exclusively from the first 6 sessions. This is typically considered an early stage in the context of long-term psychotherapy, which might not fully capture the dynamics of later phases of treatment. Therefore, the session-level findings regarding the relationship between therapeutic presence and working alliance might differ if more sessions were included in this study. In addition, this study did not assess within-session moment-to-moment variations, which can be a significant limitation. More specifically, while therapeutic presence and working alliance may

fluctuate within a session, relying on overall session-level ratings of therapeutic presence and working alliance may overlook the within-session variations and nuances. Moreover, although this study explored variations in therapeutic presence and working alliance across different sessions, the time intervals between sessions present another limitation. We could not control or account for external influences that affect the participants outside of therapy sessions. Therefore, this gap might lead to an incomplete understanding of how these external factors impact the therapeutic process over time.

Furthermore, this study focused on assessing the experiences of Chinese therapist trainees and their adult clients in the community, so the results may not be able to generalize to other more experienced therapists and their clients in other settings *or* cultural contexts. Given these limitations, I recommend that future studies can use a larger sample to assess within-session moment-to-moment variations in the therapeutic presence and working alliance where the therapists and clients are from different cultural backgrounds and engage in longer-term treatment in a different setting to examine if the findings of this study can be replicated.

Lastly, the scales of therapeutic presence, working alliance, and session quality applied in this study were all developed from an individual perspective. They, thus, might not be the ideal measures to capture and model the dyadic nature of the therapeutic relationship and psychotherapy process. For example, the therapeutic presence, working alliance, and session quality measures include items with a mix of "I" and "we" wording and, therefore, may not fully communicate the relational *or* dyadic aspects of the psychotherapy process. Since the existing studies have demonstrated that therapist and client shared perceptions of the working alliance were more predictive of the session quality than their respective perspectives were, emphasizing the necessity of a collective and consensual approach to assessing relational variables, future

studies can focus on developing measures of dyadic constructs from a more collective perspective rather than individual perspectives.

Conclusion and Clinical Implications

The findings from the first part of the study using the RI-CLPM revealed essential dynamics in the psychotherapy process, particularly highlighting the critical role of perceived therapeutic presence on the development of working alliance from both the clients' and therapists' perspectives. Consequently, it was observed that both parties acknowledge that therapeutic presence contributes to strengthening the working alliance. These insights may offer several clinical implications that could enhance therapeutic practices, training, and interventions. First, given the significant impact of therapeutic presence on the working alliance, training programs should aim to assist and motivate novice therapists in developing skills that enhance their therapeutic presence. This may include mindfulness-based practices, active listening skills, and additional techniques that foster emotional and cognitive engagement with clients during sessions (Geller & Greenberg, 2022). Second, during supervision, supervisors can offer more direct feedback on trainees' therapeutic presence by helping them reflect on session recordings and focusing on non-verbal cues. This approach may help therapists-in-training to become more aware of their level of presence during sessions and motivate them to practice presence-enhancing exercises. Third, therapist trainees should be encouraged to engage in regular self-care activities, such as meditation, physical exercise, and adequate rest to manage stress and maintain emotional resilience. Since a therapist's ability to be present in therapy sessions can be influenced by their own mental and emotional state (Geller & Greenberg, 2022), self-care may play an essential role in sustaining this capacity. Lastly, considering the study shows a cross-session influence, it emphasizes the importance of therapists being therapeutically present for

their clients from the very early stage of therapy. Establishing therapeutic presence early on may create a positive trajectory for the working alliance and the overall therapy outcome.

Additionally, the findings from the second part of the study using the CFM model highlighted the importance of therapist-client shared perceptions, in addition to their individual perceptions, of psychotherapy process and treatment effectiveness. Significant associations were found between shared perceptions of therapeutic presence and session quality, both at the between-session and between therapist-client dyad levels. This result supports the idea that relational constructs, such as therapeutic presence, are jointly experienced by both therapists and clients, underscoring that the perspectives of both parties contribute to the treatment outcome. These findings suggest that therapists should concentrate on the dyadic nature and consensual aspects of therapy. For instance, therapists can invite their clients to share their perceptions of the relationship and the therapy process in therapy. Concurrently, therapists should engage in active listening to deeply understand clients' perspectives, feelings, and experiences. Such practices are crucial for resolving potential misunderstandings and discrepancies between them. Moreover, therapists and clients may collaboratively complete and discuss the therapeutic presence and session quality measures to ensure they are aligned in their understanding and perception of the therapy process.

References

Allison, K. L., & Rossouw, P. J. (2013). The therapeutic alliance: Exploring the concept of "safety" from a neuropsychotherapeutic perspective. *International Journal of Neuropsychotherapy*, *1*(1), 21–29. https://doi.org/10.12744/ijnpt.2013.0021-0029

Atzil-Slonim, D., Bar-Kalifa, E., Rafaeli, E., Lutz, W., Rubel, J., Schiefele, A. K., & Peri, T. (2015). Therapeutic bond judgments: Congruence and incongruence. *Journal of Consulting and Clinical Psychology, 83*(4), 773–784. https://doi.org/10.1037/ccp0000015

Baldwin, M. (2000). Interview with Carl Rogers on the use of the self in therapy. In M. Baldwin (Ed.), *The use of self in therapy* (2nd ed., pp. 29–38). The Haworth Press.

Baldwin, M. (2013). *The use of self in therapy*. New York: Routledge.

Baldwin, S. A., Imel, Z. E., Braithwaite, S. R., & Atkins, D. C. (2014). Analyzing multiple outcomes in clinical research using multivariate multilevel models. *Journal of Consulting and Clinical Psychology, 82,* 920–930. https://doi.org/10.1037/a0035628

Banai, E., Mikulincer, M., & Shaver, P. R. (2005). "Selfobject" Needs in Kohut's Self Psychology: Links with Attachment, Self-Cohesion, Affect Regulation, and Adjustment. *Psychoanalytic Psychology, 22*(2), 224–260. https://doi.org/10.1037/0736-9735.22.2.224

Barkham, M., Lutz, W., & Castonguay, L. G. (2021). *Bergin and Garfield's Handbook of psychotherapy and behavior change*. John Wiley & Sons, Inc.

Barrett-Lennard, G. T. (1973). *Relationship inventory* [Unpublished manuscript]. University of Waterloo, Ontario, Canada.

Bernhardt Stange, I., Nissen-Lie, H. A., and Råbu, M. (2021). The embodied listener: A dyadic case study of how therapist and patient reflect on the significance of therapist's personal

presence for the therapeutic change process. *Psychotherapy. 31*, 682–694. https://doi.org/10.1080/10503307.2020.1808728

Bergin, A. E., & Garfield, S. L. (2021). *Handbook of psychotherapy and behavior change: An empirical analysis.* John Wiley.

Bourgault, M., & Dionne, F. (2018). Therapeutic Presence and Mindfulness: Mediating Role of Self-Compassion and Psychological Distress among Psychologists. *Mindfulness, 10*, 650-656. https://doi.org/10.1007/s12671-018-1015-z

Brislin, R. W. (1970). Back-translation for cross-cultural research. *Journal of Cross-Cultural Psychology, 1*(3), 185–216. https://doi.org/10.1177/135910457000100301

Brodley, B. T. (2000). Personal presence in client-centered therapy. *The Person-Centered Journal*, *7*(2), 139–149.

Buber, M. (1958). *I and Thou* (2nd ed.). Scribner.

Buber, M. (1966). The way of response. In N. N. Glatzer (Ed.), *Selections from his writings*. Schocken Books.

Bugental, J. F. T. (1978). *Psychotherapy and process*. Addison-Wesley.

Bugental, J. F. T. (1983). The one absolute necessity in psychotherapy. *The Script*, *13*, 1–2.

Bugental, J. F. T. (1987). *The art of the psychotherapist*. W. W. Norton & Company.

Campbell, J. C., & Christopher, J. C. (2012). Teaching mindfulness to create effective counselors. *Journal of Mental Health Counseling, 34*(3), 213–226. https://doi.org/10.17744/mehc.34.3.j756585201572581

Caine, T. M., Wijesinghe, B., & Wood, R. R. (1973). Personality and psychiatric treatment expectancies. *The British journal of psychiatry: the journal of mental science*, *122*(566), 87–88. https://doi.org/10.1192/bjp.122.1.87

Clarkson, P. (1997). Variations on I and Thou. *Gestalt Review*, *1*, 56–70.

Coles, A. (2014). "Being time": An exploration of personal experiences of time and implications for art psychotherapy practice. *International Journal of Art Therapy*, *19*(2), 71–81. https://doi.org/10.1080/17454832.2013.844184

Colosimo, K. A., & Pos, A. W. (2015). A rational model of expressed therapeutic presence. *Journal of Psychotherapy Integration*, *25*(2), 100–114. https://doi.org/10.1037/a0038879

Crane-Okada, R. (2012). The concept of presence in group psychotherapy: An operational definition. *Perspectives in Psychiatric Care*, *48*(3), 156–164. https://doi.org/10.1111/j.1744-6163.2011.00320.x

Crenshaw, D. A., & Kenney-Noziska, S. (2014). Therapeutic presence in play therapy. *International Journal of Play Therapy*, *23*(1), 31–43. https://doi.org/10.1037/a0035480

Craig, P. E. (1986). Sanctuary and presence: An existential view of the therapist's contribution. *The Humanistic Psychologist, 14*(1), 22–28. https://doi.org/10.1080/08873267.1986.9976749

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy (2nd ed.)*. Washington, DC: American Psychological Association.

Dunn, R., Callahan, J. L., Swift, J. K., & Ivanovic, M. (2013). Effects of pre-session centering for therapists on session presence and effectiveness. *Psychotherapy Research*, *23*(1), 78–85. https://doi.org/10.1080/10503307.2012.731713

Enders, C. K. (2001). The impact of non-normality on full information maximum-likelihood estimation for structural equation models with missing data. *Psychological methods*, *6*(4), 352–370. https://doi.org/10.1037/1082-989X.6.4.352

Enders, C. K. (2010). *Applied missing data analysis.* Guilford Press.

Epstein, M. (2007). Psychotherapy without the self: A Buddhist perspective. Yale University Press.

Feuerman, M. L. (2018). Therapeutic presence in emotionally focused couple's therapy. *Journal of Experiential Psychotherapy*, *21*(3), 22–32.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316–340. https://doi.org/10.1037/pst0000172

Fraelich, C. B. (1989). A phenomenological investigation of the psychotherapist's experience of presence. *Dissertation Abstracts International*, *50*(4), 1643B.

Furrow, J. L., Edwards, S. A., Choi, Y., & Bradley, B. (2012). Therapist presence in emotionally focused couple therapy blamer softening events: Promoting change through emotional experience. *Journal of Marital and Family Therapy*, *38*(1, Suppl. 1), 39–49. https://doi.org/10.1111/j.1752-0606.2012.00293.x

Gelso, C. J. (2011). *The real relationship in psychotherapy: The hidden foundation of change.* American Psychological Association. https://doi.org/10.1037/12349-000

Geller, S. M. (2001). *Therapeutic presence: The development of a model and a measure* [Unpublished doctoral dissertation]. York University.

Geller, S. M., & Greenberg, L. S. (2002). Therapeutic presence: Therapists' experience of presence in the psychotherapy encounter. *Person-Centered and Experiential Psychotherapies, 1*(1-2), 71–86. https://doi.org/10.1080/14779757.2002.9688279

Geller, S. M. (2010). *Clearing the path of therapeutic presence to emerge: Therapeutic rhythm and mindfulness practices* [Unpublished manuscript]. York University.

Geller, S. M., Greenberg, L. S., & Watson, J. C. (2010). Therapist and client perceptions of therapeutic presence: The development of a measure. *Psychotherapy Research*, *20*(5), 599–610. https://doi.org/10.1080/10503307.2010.495957

Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic presence: A mindful approach to effective therapy.* American Psychological Association. https://doi.org/10.1037/13485-000

Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration*, *24*(3), 178–192. https://doi.org/10.1037/a0037511

Geller, S. M. (2017). *A practical guide to cultivating therapeutic presence*. American Psychological Association. https://doi.org/10.1037/0000025-000

Geller, S. M. (2019). Therapeutic presence: The foundation for effective emotion- focused therapy. In L. S. Greenberg & R. N. Goldman (Eds.), *Clinical handbook of emotion-focused therapy* (pp. 129–145). American Psychological Association. https://doi.org/10.1037/0000112-006

Geller, S. (2020). Cultivating online therapeutic presence: Strengthening therapeutic relationships in teletherapy sessions. *Counselling Psychology Quarterly, 34*(3-4), 687–703. https://doi.org/10.1080/09515070.2020.1787348

Geller, S. M., & Greenberg, L. S. (2022). *Therapeutic presence: A mindful approach to effective therapeutic relationships* (2nd ed.). American Psychological

George, D., & Mallery, P. (2010). SPSS for Windows step by step. A simple study guide and reference. *Pearson Education, Inc*.

Goldner, L. (2016). Therapists' self-perception, attachment, and relationship: The role of selfobject needs. *Psychoanalytic Psychology*, *33*(4), 535–553. https://doi.org/10.1037/pap0000049

Gonzalez, R., & Griffin, D. (2002). Modeling the personality of Dyads and groups. *Journal of Personality*, *70*(6), 901–924. https://doi.org/10.1111/1467-6494.05027

Granick, J. (2011). *Transpersonal aspects of therapists' presence: What do clients experience?* (dissertation). ProQuest LLC, Ann Arbor, MI.

Greenberg, L. S. (2015). *Emotion-focused therapy: Coaching clients to work through their feelings* (2nd ed.). American Psychological Association. https://doi.org/10.1037/14692-000

Hair, J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. L. (2006). *Multivariate data analysis* (6th ed.). Upper Saddle River, NJ: Pearson University Press

Hamaker, E. L., Kuiper, R. M., & Grasman, R. P. (2015). A critique of the cross-lagged panel model. *Psychological methods*, *20*(1), 102–116. https://doi.org/10.1037/a0038889

Haley, M. R. (2014). *The quality of presence: An essential component of therapeutic work* [Unpublished thesis]. University of Arkansas. http://scholarworks.uark.edu/etd/2209

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16,* 12–25. http://dx.doi.org/10.1080/10503300500352500

Hayes, J. A., & Vinca, M. (2017). Therapist presence, absence, and extraordinary presence. In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others: Understanding therapist effects* (pp. 85–99). American Psychological Association. https://doi.org/10.1037/0000034-006

Hill, C. E. (2020). Helping skills: Facilitating exploration, insight, and action. American Psychological Association.

Hill, C. E., & Kellems, I. S. (2002). Development and use of the helping skills measure to assess client perceptions of the effects of training and of helping skills in sessions. *Journal of Counseling Psychology, 49,* 264–272. http://dx.doi.org/10.1037/0022-0167.49.2.264

Holtforth, M. G., & Castonguay, L. G. (2005). Relationship and techniques in cognitive-behavioral therapy--A motivational approach. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 443–455. https://doi.org/10.1037/0033-3204.42.4.443

Horvath, A. O., & Greenberg, L. (1986). The development of the Working Alliance Inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). Guilford Press.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*(2), 223–233. https://doi.org/10.1037/0022-0167.36.2.223

Horvath, A. O. (1994). Empirical validation of Bordin's pan-theoretical model of the alliance: The working alliance inventory perspective. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 109– 128). John Wiley & Sons.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37–69). Oxford University Press.

Hycner, R. (1993). *Between person and person: Toward a dialogical psychotherapy*. Gestalt Journal Press.

Hycner, R., & Jacobs, L. (1995). *The healing relationship in gestalt therapy: A dialogical/self-psychology approach*. Gestalt Journal Press.

Kanter, J. W., Rusch, L. C., Landes, S. J., Holman, G. I., Whiteside, U., & Sedivy, S. K. (2009). The use and nature of present-focused interventions in cognitive and behavioral therapies for depression. *Psychotherapy: Theory, Research, & Practice*, *46*(2), 220–232. https://doi.org/10.1037/a0016083

Kearney, M. W. (2017). Cross legged panel analysis. In M. R. Allen (Ed.), *Sage Encyclopedia of communication research methods*. Sage.

Kelly, S. W., & Papps, F. A. (2021). 'Really caring, really curious, and really there': A qualitative exploration of therapeutic presence from a Hakomi therapy perspective. *Body, Movement and Dance in Psychotherapy*, *17*(2), 150–165. https://doi.org/10.1080/17432979.2021.1939162

Kivlighan, D. M., Jr. (2007). Where is the relationship in research on the alliance? Two methods for analyzing dyadic data. *Journal of Counseling Psychology, 54*(4), 423–433. https://doi.org/10.1037/0022-0167.54.4.423

Kivlighan, D. M., Jr., Hill, C. E., Gelso, C. J., & Baumann, E. (2016). Working alliance, real relationship, session quality, and client improvement in psychodynamic psychotherapy: A longitudinal actor partner interdependence model. *Journal of Counseling Psychology, 63*(2), 149–161. https://doi.org/10.1037/cou0000134

Kivlighan, D. M., Marmarosh, C. L., & Hilsenroth, M. J. (2014). Client and therapist Therapeutic Alliance, session evaluation, and client reliable change: A moderated actor–partner interdependence model. *Journal of Counseling Psychology*, *61*(1), 15–23. https://doi.org/10.1037/a0034939

Kivlighan, D. M., Jr., Gelso, C. J., Ain, S., Hummel, A. M., & Markin, R. D. (2015). The therapist, the client, and the real relationship: An actor–partner interdependence analysis of treatment outcome. *Journal of Counseling Psychology, 62*(2), 314-320. https://doi.org/10.1037/cou0000012

Kivlighan, D. M., Jr., Lo Coco, G., Oieni, V., Gullo, S., Pazzagli, C., & Mazzeschi, C. (2017). All bonds are not the same: A response surface analysis of the perceptions of positive bonding relationships in therapy groups. *Group Dynamics: Theory, Research, and Practice, 21*(3), 159–177. https://doi.org/10.1037/gdn0000071

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Sage Publications.

Ledermann, T., & Kenny, D. A. (2012). The common fate model for dyadic data: Variations of a theoretically important but underutilized model. *Journal of Family Psychology, 26*(1), 140–148. https://doi.org/10.1037/a0026624

Lent, R. W., Hoffman, M. A., Hill, C. E., Treistman, D., Mount, M., & Singley, D. (2006). Client-specific counselor self-efficacy in novice counselors: Relation to perceptions of session quality. *Journal of Counseling Psychology, 53*(4), 453–463. https://doi.org/10.1037/0022-0167.53.4.453

Leszcz, M. (2018). The evidence-based group psychotherapist. *Psychoanalytic Inquiry*, *38*(4), 285–298. https://doi.org/10.1080/07351690.2018.1444853

Levinas, E. (1985). *Ethics and infinity, conversations with Philippe Nemo* (R. A. Cohen, Trans.). Duquesne University Press.

Lingiardi, V., Colli, A., Gentile, D., & Tanzilli, A. (2011). Exploration of session process: relationship to depth and alliance. *Psychotherapy (Chicago, Ill.)*, *48*(4), 391–400. https://doi.org/10.1037/a0025248

Li, X., Kivlighan, D. M., Jr., Hill, C. E., Hou, Z.-J., & Xu, M. (2018). Helping skills, working alliance, and session depth in China: A multilevel analysis. *The Counseling Psychologist, 46*(3), 379–405. https://doi.org/10.1177/0011000018763965

Li, X., & Kivlighan, D. M., Jr (2019). Examining therapy dynamics and session outcome using differential equations model and multilevel data disaggregation. *Psychotherapy research: journal of the Society for Psychotherapy Research*, *30*(5), 604–621. https://doi.org/10.1080/10503307.2019.1649730

Li, X., O'Connor, S., Kivlighan, D. M., Jr., & Hill, C. E. (2021). “Where is the relationship” revisited: Using actor-partner interdependence modeling and common fate model in examining dyadic working alliance and session quality. *Journal of Counseling Psychology, 68*(2), 194–207. https://doi.org/10.1037/cou0000677 (Retraction published 2023, Journal of Counseling Psychology, 70[4], 449)

Li X. (2021). The "dyadic dance": Exploring therapist-client dynamics and client symptom change using actor-partner interdependence modeling and multilevel mixture modeling. *Journal of counseling psychology*, *69*(4), 474–489. https://psycnet.apa.org/doi/10.1037/cou0000599

Li, X., Zhao, H., Wu, M., Li, F., & Hill, C. E. (2023). The development of a Brief Working Alliance Inventory for clients and therapists using multilevel factor analysis and item response theory in the United States and China. *Journal of counseling psychology*, *70*(2), 172–188. https://psycnet.apa.org/doi/10.1037/cou0000655

Lichtenberg, J. W., & Semon, D. A. (1986). *A study of the dynamics of social influence in counseling.* Paper presented at the 94th Annual Convention of the American Psychological Association, Washington, DC.

Liu, Y., Zemke, R., Liang, L., & McLaughlin Gray, J. (2021). Model of occupational harmony: A Chinese perspective on occupational balance. *Annals of International Occupational Therapy*, *4*(4). https://doi.org/10.3928/24761222-20210601-08

Markin, R. D., Kivlighan, D. M., Jr., Gelso, C. J., Hummel, A. M., & Spiegel, E. B. (2014). Clients’ and therapists’ real relationship and session quality in brief therapy: An actor partner interdependence analysis. *Psychotherapy, 51*(3), 413–423. https://doi.org/10.1037/a0036069

Marmarosh, C. L., & Kivlighan Jr, D. M. (2012). Relationships among client and counselor agreement about the working alliance, session evaluations, and change in client symptoms using response surface analysis. *Journal of Counseling Psychology, 59*(3), 352–367. https://psycnet.apa.org/doi/10.1037/a0028907

McAuliffe, G., & Eriksen, K. (2011). *Handbook of counselor preparation: Constructivist, developmental, and experiential approaches*. Sage Publications.

Merleau-Ponty, M. (1962). *Phenomenology o perception,* (C. Smith, Trans.). London: Routledge & Kegan Paul.

Moustakas, C. (1969). *Personal growth*. Howard A. Doyle.

Moustakas, C. (1985). *A conceptual-methodological model of existential Dasein analytical psychotherapy* [Unpublished manuscript].

Muthen, L. K. & Muthen, B. O. (2017). *Mplus: User's Guide* (8th Edition). Los Angeles, CA: Muthen & Muthen.

Myhra, L. L., Gone, J. P., Barry, D. T., Cutter, C. J., Faria, A. B., & Beitel, M. (2023). Session quality and impact in psychotherapy with American Indian clients. *Psychological Services, 20*(Suppl 1), 86–93. https://doi.org/10.1037/ser0000634

Norcross, J. C., & Lambert, M. J. (Eds.). (2019). *Psychotherapy relationships that work: Vol. 1. Evidence-based therapist contributions*. Oxford University Press.

Oghene, J. E., Pos, A. E., & Geller, S. M. (2010). *Therapist presence, empathy and the alliance in experiential treatment for depression* [Unpublished honors thesis]. York University.

Pesale, F. P., Hilsenroth, M. J., & Owen, J. J. (2012). Patient early session experience and treatment outcome. *Psychotherapy research: journal of the Society for Psychotherapy Research*, *22*(4), 417–425. https://doi.org/10.1080/10503307.2012.662607

Pemberton, B. (1977). *The presence of the therapist* [Unpublished doctoral dissertation]. School of Education, Georgia State University.

Phelon, C. (2001). Healing presence: An intuitive inquiry into the presence of the psychotherapist (UMI No. 3011298) [Doctoral dissertation, Institute of Transpersonal Psychology]. *Dissertation Abstracts International, 62*(04), 2074B.

Phelon, C. R. (2004). Healing Presence in the Psychotherapist. *The Humanistic Psychologist, 32*(4), 342–356. https://doi.org/10.1080/08873267.2004.9961759

Pos, A., Geller, S., & Oghene, J. (2011, July). Therapist presence, empathy, and the working alliance in experiential treatment for depression. Proceedings from SPR '11: *The 42nd Annual Meeting for Society for Psychotherapy Research.* Bern, Switzerland.

Putnick, D. L., & Bornstein, M. H. (2016). Measurement Invariance Conventions and Reporting: The State of the Art and Future Directions for Psychological Research. *Developmental review: DR*, *41*, 71–90. https://doi.org/10.1016/j.dr.2016.06.004

Ramseyer, F., & Tschacher, W. (2011). Nonverbal synchrony in psychotherapy: Coordinated body movement reflects relationship quality and outcome. *Journal of Consulting and Clinical Psychology, 79*(3), 284–295. https://psycnet.apa.org/doi/10.1037/a0023419

Robitschek, C., & Hershberger, A. R. (2005). Predicting expectations about counseling: Psychological factors and gender implications. Journal of Counseling & Development, 83(4), 457–469. https://doi.org/10.1002/j.1556-6678.2005.tb00367.x

Reik, T. (1948). *Listening with the third ear*. Farrar Straus.

Robbins, A. (Ed.). (1998). *Therapeutic presence: Bridging expression and form*. Jessica Kingsley.

Rogers, C. R. (1951). *Client-centered therapy; its current practice, implications, and theory.* Houghton Mifflin.

Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.

Rogers, C. R. (1986). Client-centered therapy. In I. L. Kutash & A. Wolf (Eds.), *Psychotherapist's casebook: Theory and technique in the practice of modern therapies* (pp. 197–208). Jossey-Bass.

Rutkowski, L., & Svetina, D. (2014). Assessing the hypothesis of measurement invariance in the context of large-scale international surveys. *Educational and Psychological Measurement, 74*(1), 31–57. https://doi.org/10.1177/0013164413498257

Satorra, A., & Bentler, P. M. (2010). Ensuring positiveness of the scaled difference chi-square test statistic. Psychometrika, 75(2), 243–248. https:// doi.org/10.1007/s11336-009-9135-y

Savalei, V., & Bentler, P. M. (2005). A Statistically Justified Pairwise ML Method for Incomplete Nonnormal Data: A Comparison with Direct ML and Pairwise ADF. *Structural Equation Modeling, 12*(2), 183–214. https://doi.org/10.1207/s15328007sem1202_1

Schafer, J. L., & Graham, J. W. (2002). Missing data: Our view of the state of the art. Psychological methods, 7(2), 147-177.

Schmid, P. F. (1998). "Face to face": The art of encounter. In B. Thorne & E. Lambers (Eds.), *Person-centered therapy: A European perspective* (pp. 74–90). Sage Publications.

Schmid, P. F. (2002). Presence—Immediate co-experiencing and co-responding. Phenomenological, dialogical and ethical perspectives on contact and perception in person-centered therapy and beyond. In G. Wyatt & P. Sanders (Eds.), *Contact and perception* (pp. 182–203). PCCS Books.

Schneider, K. J., & May, R. (1995). *The psychology of existence. An integrative, clinical perspective*. McGraw-Hill. Schwarz, N., Snir, S., & Regev, D. (2018). The therapeutic presence of the art therapist. *Art Therapy: Journal of the American Art Therapy Association*, *35*(1), 11–18. https://doi.org/10.1080/07421656.2018.1459115

Schoenherr, D., Paulick, J., Strauss, B. M., Deisenhofer, A.-K., Schwartz, B., Rubel, J. A., Lutz, W., Stangier, U., & Altmann, U. (2019). Nonverbal synchrony predicts premature termination of psychotherapy for social anxiety disorder. *Psychotherapy, 56*(4), 503–513. https://doi.org/10.1037/pst0000216

Shafran, N., Kivlighan, D. M., Gelso, C. J., Bhatia, A., & Hill, C. E. (2017). Therapist immediacy: The association with working alliance, real relationship, session quality, and time in psychotherapy. *Psychotherapy research: journal of the Society for Psychotherapy Research*, *27*(6), 737–748. https://doi.org/10.1080/10503307.2016.1158884

Shepherd, I., Brown, E., & Greaves, G. (1972). Three-on-oneness (presence). *Voices*, *8*, 70–77.

Spiegelman, J. M. (1996). *Psychotherapy as a mutual process*. New Falcon Publications.

Stern, D. (2004). *The present moment in psychotherapy and everyday life*. W. W. Norton & Company.

Stiles, W. B., Shapiro, D. A., & Firth-Cozens, J. A. (1990). Correlations of session evaluations with treatment outcome. *British Journal of Clinical Psychology, 29*(1), 13–21. https://doi.org/10.1111/j.2044-8260.1990.tb00844.x

Stiles, W. B., & Snow, J. S. (1984). Dimensions of psychotherapy session impact across sessions and across clients. *British Journal of Clinical Psychology, 23*(1), 59–63. https://doi.org/10.1111/j.2044-8260.1984.tb00627.x

Sun, X., Nancekivell, S., Gelman, S. A., & Shah, P. (2021). Growth Mindset and academic outcomes: A comparison of US and Chinese students. *Npj Science of Learning*, *6*(1). https://doi.org/10.1038/s41539-021-00100-z

Tannen, T., & Daniels, M. H. (2010). Counsellor presence: Bridging the gap between wisdom and new knowledge. *British Journal of Guidance & Counselling, 38*(1), 1–15. https://doi.org/10.1080/03069880903408661

Wang, K., Chung, H., Stuart-Maver, S. L., Schreier, B., Galligan, P., Davis, H., & Kivlighan, D. M. (2022). The relationship between clients' expectation of therapist support and challenge and treatment outcome: A response surface analysis. *Psychotherapy (Chicago, Ill.)*, *59*(3), 481–486. https://doi.org/10.1037/pst0000440

Wang, J., & Wang, X. (2020). Structural equation modeling: Applications using Mplus (2nd ed.). Wiley.

Watson, J. C., Shein, J., & McMullen, E. (2010). An examination of clients' in-session changes and their relationship to the working alliance and outcome. *Psychotherapy Research*, *20*(2), 224–233. https://doi.org/10.1080/10503300903311285

Watson, J., Timulak, L., & Greenberg, L. S. (2019). Emotion-focused therapy for generalized anxiety disorder. In L. S. Greenberg & R. N. Goldman (Eds.), *Clinical handbook of emotion-focused therapy* (pp. 315–336). American Psychological Association. https://doi.org/10.1037/0000112-014

Webster, M. (1998). Blue suede shoes: The therapist's presence. *Australian and New Zealand Journal of Family Therapy*, *19*(4), 184–189. https://doi.org/10.1002/j.1467-8438.1998.tb00336.x

Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books.

Yontef, G., & Fuhr, R. (Eds.) (2005). *Gestalt therapy theory of change*. SAGE Publications, Inc., https://doi.org/10.4135/9781452225661.n5

Zhao, H., Li, X., & Chen, S. (2022). Development of a brief therapist presence inventory in China using multilevel factor analysis and item response theory. *Psychotherapy research: journal of the Society for Psychotherapy Research*, 1–16. Advance online publication. https://doi.org/10.1080/10503307.2022.2143301

Zilcha-Mano, S., Muran, J. C., Hungr, C., Eubanks, C. F., Safran, J. D., & Winston, A. (2016). The relationship between alliance and outcome: Analysis of a two-person perspective on alliance and session outcome. *Journal of Consulting and Clinical Psychology, 84*(6), 484–496. https://doi.org/10.1037/ccp0000058

Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist, 72*(4), 311–325. https://doi.org/10.1037/a0040435