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Investigating the Mutual Changing of Patient’s and Therapist’s Self-States: An Integrative Clinical Research Study of a Single Case

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CITATION

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The current study presents an integrative mixed-method examination of a single case using the TPA, or the Two-Person Assimilation of Problematic Experiences Scale (APES). Stemming from the Assimilation Model (Stiles, 2011; Stiles et al., 1991), the TPA integrates relational-psychodynamic thought with an empirical analysis to create a clinical tool that simultaneously tracks and codes change-processes in psychotherapy. The TPA expands the APES by following changes in the quality of movement between self-states, in a continuum ranging from dissociation to dialectic, within both the patient and the therapist. Thus, it allows for an observation of complex intrapsychic and intersubjective processes occurring in therapy, and a simultaneous relating of these processes to symptomatic outcome variables and process variables. The current theory-building case study investigated 26 therapy sessions of a 30-year-old woman who received an evidence-informed psychodynamic-oriented treatment for depression. Sessions were coded quantitatively and then qualitatively analyzed by clinical judges, using the TPA tracking and rating procedure. An improvement in the quality of movement between self-states, as the therapeutic process progressed, was found. In addition, mutual changing (i.e., temporal congruence) between patient’s and therapist’s quality of movement between self-states increased during the last third of the treatment. Results of the study have clinical and empirical implications for an understanding of how therapeutic change is generated, as a process occurring both intrapsychically and in the context of a dyadic intersubjective relationship.

Keywords: relational-psychodynamic approach, psychotherapy research, self-states, therapeutic relationship, theory-building case study

Prominent researchers in the field of relational-psychodynamic psychotherapy have increasingly called for an examination of the intraper-

sonal and interpersonal processes that occur in both patient and therapist during the treatment process (Castonguay, 2011; Castonguay, Eubanks, Goldfried, Muran, & Lutz, 2015; Castonguay & Muran, 2015; Kazdin, 2008; Llewellyn & Hardy, 2001; Norcross, 2002; Stricker, 2010; Wachtel, 1997, 2010). These inquiries aim to offer a better understanding of the mechanisms of changes achieved in the course of treatment. Although contemporary relational theory emphasizes the importance of the intersubjective therapeutic relationship in generating intrapsychic change, research into the interpersonal and intrapersonal contribution of both partners in the therapeutic dyad has been scarce.
In attempting to narrow the existing gap in the field, the present case study joins a new evidence-informed movement which calls for the construction of integrative and inventive methodological measurements (Barber, Muran, McCarthy, & Keefe, 2013; Goldfried, 2010; Kazdin, 2009; Stiles, Hill, & Elliott, 2015; Stricker, 2010; Wachtel, 2010). To offer a rich, in-depth examination of the presented clinical and empirical material, the current study focused on a single case using a mixed-method methodology (Fishman, 2013; Fishman & Messer, 2005, 2013; Stiles et al., 2015). Such a theory-building case study has the potential to inform and deepen the issue of progression in self-multiplicity and intersubjective mutuality and congruency over the course of therapy (Stiles, 2005, 2007; Stiles et al., 2015).

Intrapsychic Multiplicity and Interpsychic Mutuality in Psychotherapy

The notion that a person’s identity consists of multiple perspectives has been investigated within various psychological approaches in recent years. Narrative theory, for example, posits that individuals can switch between different, and even conflicting, self-narratives that are contained within a single, total, and not always coherent, narrative (Bamberg, 2006; Gergen, 1984, 1994). Metacognition theories conceive of psychotherapy processes in terms of multiple self-aspects that achieve reflection (Dimaggio, Hermans, & Lysaker, 2010). For its part, dialogical self theory seeks to foster dialogue among an individual’s inner-self voices (Hermans & Dimaggio, 2004). Similarly, the assimilation model views the self as multifaceted and inhabited by several, sometimes contradictory, “self-voices” that may be regarded as a community (Honos-Webb & Stiles, 1998).

Within the relational-psychodynamic approach, self-states, a similar term to self-voices, is used to address different aspects of the self. Self-multiplicity is regarded as one’s ability to contain and shift between these self-states, without undermining one’s sense of cohesive identity (Bromberg, 1991, 1998, 2004; Mitchell, 1993). This notion emphasizes that when adaptive psychic functioning takes place, varying circumstances trigger different self-states to flexibly and temporarily emerge and become dominant, while simultaneously pushing other self-states into a background position. However, self-states that are marked by the psyche as too-threatening to endure, may become silenced, disavowed, projected, and ultimately dissociated. From such a perspective, an inherent objective of the therapeutic process is to stimulate and renew mental movement between self-states, while addressing the various impending factors that have contributed to the blockage of this movement (Mitchell, 1993; Stern, 2004). Thus, the therapeutic process is directed toward achieving acknowledgment, conflict, and dialectic between the inner self-states that were previously dissociated (Stern, 2004; Bromberg, 1998; Davies, 1996).

The relational approach sees the therapeutic relationship as the central tool in fostering change (Bromberg, 1998; Mitchell, 1993). The therapist is considered to be emotionally and mentally activated in the course of the therapeutic change process, while required to maintain his therapeutic stance (Aron, 1990; Binder & Strupp, 1997; Safran & Muran, 2000). From this theoretical and clinical perspective, the term “mutuality” refers to the process through which both sides of the therapeutic dyad (i.e., patient and therapist) establish an ability to be open and receptive to each other’s influences, while preserving the valuable therapeutic asymmetry stemming from their distinct roles and responsibilities (Aron, 1990; Bromberg, 2012; Hill, 2005; Mitchell, 1993). Wiseman and Tishby (2011) stressed that both the interpersonal process that is undergone by the therapist during therapy and his or her ability to reflect on this process with the patient are crucial to understanding what works in therapy. In a similar vein, Safran and Muran (2000) indicated that the success of an individual’s therapy is closely related to the therapist’s capacity to recognize rejected/unwanted versions of his or her own self and to articulate them with the patient.

Studying Changes in Self-Multiplicity and Mutuality: The Development of a Relational-Empirical Tool

To examine the relationship between different self-voices according to the Assimilation Model, Stiles, Meshot, Anderson, and Sloan
(1992) developed the Assimilation of Problematic Experiences Scale (APES; Osatuke & Stiles, 2011; Stiles & Angus, 2001; Stiles et al., 1991). This measure provides empirical tools that allow for the identification of self-voices, thus enabling an examination of the extent to which one self-voice is recognized by another. The level of assimilation relates to the relationship between the voices, ranging along a developmental continuum from denial to mutual acceptance to integration. In recent years, numerous studies of the assimilation model have demonstrated that growth in therapy is associated with a progression toward higher assimilation levels in which formerly dissociated voices become increasingly integrated (for a review, see Stiles, 2011).

Although the lower levels of the APES (i.e., dissociation, active avoidance, and vague awareness) appear to be commensurate with the relational-psychodynamic approach, the higher levels essentially diverge from it. This divergence stems from two main reasons: First, the Assimilation Model’s emphasizes resolution and integration as the ultimate goals of therapy, whereas the relational theory views the ability to handle conflict and dialectic as the objectives of the therapeutic process. Second, the relational-psychodynamic approach emphasizes the intersubjective aspect of the therapeutic process, thus calling to consider the mutual interaction between patient and therapist as a key aspect of progression in self-multiplicity, whereas the Assimilation Model focuses solely on the patient’s internal processes.

To address these differences and to enable an examination of therapeutic processes through a relational-psychodynamic model, the Two-Person APES (TPA; HaCohen, 2016; HaCohen et al., 2017) was developed. The TPA is a relational-empirical revision of the APES that facilitates the identification of the relationship between self-states in such a way that it evinces their patterns of movement as the treatment progresses. The revised scale the titled Two-Person APES to emphasize the therapeutic relationship. In addition, Stiles’ “self-voice” terminology was replaced with the term self-state, which is more commonly used by the relational approach.

The scale is based on the dimensions of the therapeutic process that are known to emphasize internal conflict and dialectic: the transition between self-states and patient-therapist mutual impact and change. As such, progression is measured along a continuum from dissociation (0), to active avoidance (1), to vague awareness (2), to conflict (3), to dialectic (4), and finally to mutual cocreation of self-states (5). The continuum also takes into account two additional dimensions: (a) the affective state that ranges from emotional reduction, to felt-anxiety, to regulation and finally to curiosity and pleasure, and (b) the patient–therapist relationship, ranging from defensiveness to mutual movement and creation (for elaboration, see Table 1).

Therapists’ level of TPA is a delicate issue for investigation, as the therapist’s presence needs to be evaluated not only by his or her verbal accounts (i.e., content variables such as the idea or interpretation given), which are often short and opaque, but also by the moment-to-moment changes in interactions with the patient (i.e., process variables such as the patient’s response to the therapist’s interventions and the affective climate surrounding both the patient and the therapist). As distinct from the TPA levels of the patient, the levels of the therapist’s TPA incorporate both the therapist’s congruence with the patient’s transitions as well as the quality of movement between the self-states of the therapist him/herself. Thus, in the case of the therapist’s rating, higher levels of the TPA are reached when the therapist pays close attention to his or her own emerging and shifting self-states, while he or she simultaneously manages to remain oriented to what the patient is experiencing. For example, when the therapist does not make any reference to an awakening and evident self-state of the patient that was formerly dissociated, the therapist will be rated at a lower TPA level. Conversely, the therapist will receive a higher TPA level when he or she successfully acknowledges the ambivalence regarding the growing therapeutic change or the difficulties within the therapeutic dyad, and eventually communicates openly about these processes with the patient.

To sum, TPA is a recently developed integrative methodology for inquiring into the therapeutic dyad and its influence on changes that occur during and as a result of the therapeutic process. It is a clinically based empirical coding instrument which enables the tapping of the two main therapeutic change mechanisms—self-multiplicity and mutuality. As such, the TPA
Table 1
Two-Person Assimilation of Problematic Experiences Scale (TPA) Levels of the Quality of Movement Between Self-States

<table>
<thead>
<tr>
<th>TPA Level</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0) Dissociation</td>
<td>Complete disconnection between the “accepted” parts of the self and disavowed self-states. The self is severely threatened from the content contained by the split-off part of the self. All emotions are reduced and avoided. The patient is located in an isolated and frozen mental space, unable to feel genuine closeness to the therapist. Uncontrollable laughter, losing one’s line of thought or inability to speak coherently, somatization, fatigue.</td>
</tr>
<tr>
<td>(1) Active avoidance</td>
<td>Dissociated self-states are approaching the self-scope but are denied and repressed. Anxiety appears, activating resistance to ‘push away’ threatening self-states. At this point, the patient is rigid and is actively distancing the therapist. Concrete verbalizations that are inconsistent with the emotional state or content, negations, rationalizations and “pseudo-integrative” descriptions.</td>
</tr>
<tr>
<td>(2) Vague awareness</td>
<td>Dissociated self-parts approach mind but are still unable to be “owned” and contained. Affective lability and confusion arise, while there is a growing ability to tolerate ambiguity within the therapeutic process. The therapeutic relationship becomes closer and less cautious and is now characterized by sensitivity and pausing. The individual may be sensing confused and associative. Emotional flooding may occur.</td>
</tr>
<tr>
<td>(3) Conflict</td>
<td>Previously dissociated self-states become gradually acknowledged as part of the tapestry of one’s self. Self-states begin to reflect, negotiate and “argue” with one another. Affect is more regulated, with less anxiety and confusion present. Nonetheless, there might be a sense of worriedness due to the increasing “inner-debate.” The therapeutic relationship becomes more involved and reciprocal movement begins to occur. The individual moves through multiple view-points, at times feeling or thinking opposing contents. The therapist may represent one of the patient’s self-state, allowing the patient to interact with this self-state via the therapeutic dyad.</td>
</tr>
<tr>
<td>(4) Dialectic</td>
<td>Self-states now begin to value one another’s importance and inter-dependency. Affect is marked by compassion, acceptance and empathy. The therapeutic relationship is felt as true partnership and there’s a growing sense of awe towards the process. Expressions of self-acceptance and bereavement arise due to the recognition of the unchangeable past and the unavoidable imperfections of the self and the other.</td>
</tr>
<tr>
<td>(5) Mutual Cocreation</td>
<td>A transition to multiplying selves which creates new forms within the self. The ability to develop and be born anew from the movement and from the contact of self-states with one another, and with the outside. Affect is curious, creative, lively, and open. The relationship becomes deeply reciprocal, as both patient and therapist move together to new internal and intersubjective scopes. Expressions of surprise and excitement arise. There might be a continuing of the bereavement process which has begun by the dialectic phase, with the addition of hope and new perspective on the self.</td>
</tr>
</tbody>
</table>

The model encompasses a framework which highlights the importance of exploring the interdependent processes within and between patient and therapist. In addition, the TPA emphasizes the therapeutic importance of achieving and preserving conflict and dialectic between multiple self-states. This line of thought suggests that by fostering greater quality of movement between self-states, the different self-states will coexist in a more flexible manner within the self, eventually allowing for the creation of more adaptive and playful self-states (for an
elaboration of the TPA, see HaCohen, 2016; HaCohen et al., 2017).

The Study

The current theory-building case study presents an integrative perspective for researching psychotherapy change processes, using an extensive analysis of one treatment based on a mixed-method analysis (Fishman, 2013; Stiles, 2011; Stiles et al., 2015). It presents this perspective by implementing the TPA (HaCohen et al., 2017).

Research Questions and Hypotheses

The first objective of the study was to explore the patient’s TPA patterns of change in a successful-outcome treatment to examine the hypothesis that TPA levels would progress throughout the course of treatment, from lower dissociative levels to higher dialectic levels between the inner self-states.

The second objective was to explore the extent to which therapist and patient TPA levels were temporally congruent from session to session. We hypothesized that in a successful treatment, the therapist’s TPA levels would become temporally congruent with patient’s TPA levels on a session-by-session basis.

As a theory-building case study, an additional objective of the current study was to strengthen the clinical relevancy of the TPA and its relational conceptualization (Stiles, 2005, 2007; Stiles et al., 2015). Such an in-depth qualitative examination would allow for a demonstration of the delicate and nuanced coding procedure that the TPA entails. For this purpose, we chose a clinical case which had the potential of informing and deepening the issue of progression in self-multiplicity and intersubjective mutuality and congruency over the course of therapy.

Method

Case Context

One dyad was selected from an existing pool \((N = 121)\) at the Bar-Ilan University Research-Based Psychology Clinic. Treatments at the clinic are provided by graduate students from the clinical psychology program who receive weekly individual and group clinical supervision from senior clinicians. Treatment length aligns with the academic calendar and is of 6–8 months in duration (25–35 weeks). Individual psychotherapy at the clinic consists of one weekly 50-min session of psychodynamic psychotherapy informed by a time-limited psychodynamic psychotherapy treatment model (Levenson, 2003, 2012). The key features of this model include (a) a focus on one’s experience of self; (b) a focus on one’s experience of others; (c) an identification of recurring interpersonal themes and patterns; (d) an emphasis on the therapeutic relationship; and (e) an exploration of emotions, therapeutic ruptures, and corrective experiences (Levenson, 2003).

Upon arrival at the clinic, patients are briefed about the empirical setting of the academic clinic and are required to sign a written consent form agreeing to the following: (a) anonymously participating in ongoing data collection; (b) filling out questionnaires at pre-, mid-, and posttreatment; and (c) allowing their sessions to be audiotaped and used for supervision and empirical purposes.

At intake, patients complete the Beck Depression Inventory, or the BDI-2 (Beck, Steer, & Brown, 1996) and the Outcome Questionnaire Self-Report, or the OQ-45.2 (Beckstead et al., 2003; Lambert et al., 1996). In addition, patients are diagnosed at intake using the Axis I Diagnostic and Statistical Manual of Mental Disorders-IV (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association [APA], 2000), initially formed using the M.I.N.I. 6.0 structured interview (Sheehan et al., 1998). The intake coordinator is not the individual that provides the treatment. The diagnosis procedure is supervised and confirmed by a senior clinician.

Case Selection

Upon case-selection, it was ensured that (a) both patient and therapist had fully participated in the ongoing data collection of pre-mid-post ratings of all submitted questionnaires, (b) a full audiotaped and transcribed documentation of sessions had been obtained, and (c) informed-consent forms had been signed by both parties.

Based on the Axis I DSM-IV-TR, the patient in the selected case was diagnosed at intake with recurrent major depressive disorder without other Axis I or Axis II disorders (GAF = 60). The selected case was considered to have
had a “positive outcome;” it was ranked as having achieved among the five highest percentages in terms of improvement in outcome measurements, in both the BDI-2 and the OQ-45.2. The patient began her treatment with a BDI-2 = 19 (i.e., mild depression) and an OQ-45 = 90 (i.e., clinically significant distress), that were sustained until the middle stage of treatment (BDI = 21, OQ-45 = 90). Toward the final stage of treatment, her scores significantly decreased to reach the normative range (BDI-2 = 6, OQ-45 = 58). These positive changes persisted beyond the termination of treatment, as indicated after four months, in the posttreatment assessment (BDI-2 = 12, OQ-45 = 58).

The Patient and Case Formulation

Amy (a pseudonym) was a 30-year-old married woman who worked as a bookkeeper. She sought treatment because of difficulties she was experiencing in interpersonal relationships. During the intake session, Amy reported that her father had physically abused her when she was a child. When she was in her twenties, her parents divorced. At the time of the intake, she was not in contact with her father. In addition, her mother had suffered from depressive episodes during Amy’s childhood, and Amy had been tasked with caring for and parenting her mother. Determined not to show weakness and to be strong at all costs, she eventually suffered a depressive episode while serving as an officer in the army. After a month-long hospitalization for depression, she received no support from those around her and felt abandoned. During the years preceding this intake, she had switched jobs several times as the result of interpersonal problems, such as difficulties maintaining boundaries with her colleagues. She described her relationship with her husband as supportive. Nonetheless, marital tensions related to financial problems and subfertility may have diminished her already shaky self-esteem.

The emotional absence and withdrawal of her parents had left Amy fearful of separation, of abandoning the parental role she had assumed as a child toward her mother, and of developing independence. The role reversal had forced Amy during childhood to deny her needs for dependency and to assume an autonomous role far beyond her developmental maturity. Amy’s strategy for managing her emotions included “bottling them up” to protect herself from painful feelings of inadequacy and shame and to avoid rejection. Amy’s relationship patterns were characterized by a denial of her own needs. Such denial created a vicious cycle in which she felt that she received no support, the lack of which caused her to feel increasingly lonely, helpless, and disappointed in others.

Presenting the Therapist and Treatment

The therapist, a young woman in her late 20s, was a graduate student in the clinical psychology program and a trainee at the university clinic. She met with Amy weekly over a period of approximately eight months, resulting in a total of 26 sessions.

According to the treatment’s concluding documents written by the therapist and the supervisor, the therapist’s treatment of Amy was psychodynamic-oriented psychotherapy. The main goals of this therapy were as follows: (a) to create a safe environment in which Amy could explore her real and internalized relationships for the purpose of opening up new ways of experiencing herself and others and of allowing herself to be supported by others with less self-criticism; (b) to help Amy tolerate and regulate her emotions for the purpose of better integrating the disavowed parts of herself that were typically experienced only during breakdowns; and (c) to help Amy face life challenges with greater flexibility and freedom.

At the time of Amy’s treatment, the therapist was unfamiliar with the current research hypotheses and the utilization of the TPA. Moreover, the therapist didn’t receive any feedback report from the researchers regarding the progression of treatment. It is important to note that although the psychodynamic orientation of the therapist and the supervisor was not relational per se, examining the intersubjective interaction using the TPA is considered to be possible, because interpsychic processes occur and are assumed to be researchable in any therapeutic setting, disregarding the therapeutic orientation of the therapist.

Procedure

The 26 sessions were separately rated by two graduate students of clinical psychology using the TPA. Prior to the rating of the current case sessions, both raters had undergone TPA train-
ing and until they reached a satisfactory level of interrater reliability (.90) on a sample of 48 sessions. Each 50-min therapeutic session was divided into consecutive segments lasting 10 min. The raters listened to the recordings and read the transcripts of the therapeutic sessions to provide a rating that best represented the quality of movement between self-states in each segment. In this manner, each session received five rating scores for the patient and five rating scores for the therapist. At the time of the rating, the raters were blind to the treatment outcome. Current interrater reliability was examined over all 26 sessions to obtain satisfactory results of the Intraclass Correlation Coefficient (ICC); single measures .91 for patient TPA and .94 for therapist TPA.

Following the quantitative TPA rating procedure, a qualitative in-depth analysis of four sessions from Amy’s treatment was conducted. These four passages were chosen to illustrate the internal and intersubjective change processes, as they present notable changes in TPA levels. Such progressions evinced clear shifts in the quality of movements between self-states of both Amy and her therapist. The sessions were chosen from different time points along the treatment process. That way, the qualitative analysis enabled delicate and nuanced clinical conceptualization of the dyadic mutual therapeutic process of this case. As both the patient’s and therapist’s process of change is a phenomenon that is contextual, intersubjective, and meaning-laden, the investigators based their understandings on listening to and reading whole sessions.

The qualitative research team consisted of four researchers with varying levels of clinical and empirical experience. Among the team were a senior relational clinical psychologist, two graduate students and one intern of clinical psychology, all of whom were familiar, theoretically and clinically, with the relational approach and the TPA’s development process and rationale. Also, Nehama HaCohen had obtained training and research experience in qualitative analysis (HaCohen, Amir, & Wiseman, 2018), and the research supervisor was a senior clinician and had in-depth knowledge regarding qualitative research and coding qualitative data (Lieblich, Tuval-Mashiach, & Zilber, 1998; Tuval-Mashiach, 2006, 2017; Zilber, Tuval-Mashiach, & Lieblich, 2008).

Each member of the team listened, individually, to the recordings, read the transcripts of the four selected sessions and defined and tracked the patient’s and therapist’s current quality of movement between self-states, as it is defined by the TPA index (see Table 1). Next, the team members clinically conceptualized the interpersonal and intrasubjective process going on within and between the patient and therapist. Finally, the team members met to present their individual and independent ratings and conceptualizations. Their presentations enhanced a mutually facilitated discussion (see Osatuke et al., 2005, for a more detailed description of the approach). The qualitative team reached consensus in describing the case material and then chose an exemplifying passage from each of the four sessions that best illustrated the change processes. These segments were chosen because they presented notable changes in TPA levels which evinced clear shifts in the quality of movements between self-states.

### Results

**Pattern of Change in the Patient’s TPA**

To test the patterns of change in the quality of movement between self-states, as evidenced by the patient’s TPA levels, we ran a regression analysis in which the TPA was the outcome, and the linear, quadratic and cubic effects of time were the predictors. Two models were implemented: In the first model, the outcome was the average level of TPA in each session; in the second model, the outcome was the maximum level of TPA in each session. In the maximal model, the patient’s TPA was operationalized as the maximum level she attained during each session. We chose to include the maximum level of TPA in our analysis because the theory assumes that patients will experience low and high levels of tension between various self-states during advanced stages of treatment. Because the regression errors in time series data are frequently auto-correlated, we used the AUTOREG procedure (SAS Institute Inc, 2003) to run an autoregressive error correction regression (with a first-order autoregressive error).

In the first model, in which the patient’s session average-level of TPA was the outcome, we observed a significant and positive quadratic effect (estimate = 0.006, \(\text{SE} = 0.001\), \(p <\)
The linear effect (estimate $= 0.033$, $SE = 0.025$, $p = .192$) and the cubic effect (estimate $= 0.000$, $SE = 0.0002$, $p = .686$) were not significant. The observed and predicted estimates of the model (which explained 45% of the variance) are presented in Figure 1. The TPA quadratic pattern of change demonstrates the beginning phase of therapy with high quality of movement between self-states, reaching Level 3 of conflict; then a decrease toward low level (avoidance) during the middle phase; and then an increase toward a higher quality of movement between self-states, reaching Level 4 of dialectic, during the final phase of treatment.

In the second model, in which the patient’s session maximum-level of TPA was the outcome, we observed a significant and positive linear effect (estimate $= 0.092$, $SE = 0.040$, $p = .031$). The quadratic effect (estimate $= 0.004$, $SE = 0.003$, $p = .112$) and the cubic effect (estimate $= 0.000$, $SE = 0.0004$, $p = .257$) were not significant. The observed and predicted estimates of the model (which explained 45% of the variance) are presented in Figure 2. These results indicate that Amy was able to experience higher levels of TPA (i.e., conflict and dialectic).

**Patient–Therapist Temporal Congruence**

Temporal congruence can be defined as the mutual changing of the patient and therapist. As such, it refers to the correlation between two persons’ ratings as they fluctuate over time (e.g., the correlation between the patient’s and the therapists’ ratings of their emotions as they co-fluctuate from session to session). To test the temporal congruence between the patient’s TPA levels and the therapist’s TPA levels, we ran a regression analysis in which the patient’s TPA was the outcome and the therapist’s TPA was the predictor. To estimate the levels of congruence at the beginning (Sessions 1–8), middle (9–16), and final stages (17–26) of the treatment, we used a piecewise regression using three indicator variables (one indicator variable for each stage), which were set to 1 for observation within a stage, and to 0 for observation outside a stage. Because we used time series data, we used the AUTOREG procedure (SAS Institute Inc, 2003) to run an autoregressive error correction regression (with a first-order autoregressive error). Note that the choice to treat the patient’s TPA as the outcome and the therapist’s TPA as the predictor was admittedly

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**Figure 1.** Progression in TPA average levels during the course of treatment. See the online article for the color version of this figure.
random. In essence, we are interested in estimating correlative relationship (vs. causative relationship) between the two variables and thus it has no substantive meaning which of the two is treated as the outcome versus the predictor.

Although the congruence during the beginning and middle stages of treatment was not significant (estimate = 0.205, SE = 0.122, p = .095; estimate = 0.035, SE = 0.110, p = .753, respectively), the congruence during the final stage of treatment was positive and significant (estimate = 0.366, SE = 0.110, p = .001). Thus, the patient and the therapist became more congruent in their TPA levels as treatment progressed (see Figure 3).

**Clinical Illustration**

Transformations in the quality of movement between self-states of both the patient and therapist occur within and between sessions and can produce sudden and significant increases toward improvement. Four passages from Amy’s treatment were chosen to illustrate the internal and intersubjective change processes. These four segments were chosen because they (a)
offer vivid exemplifications of TPA levels; (b) taken together, present a notable change process of TPA levels which evinced clear shifts in the quality of movements between self-states, from active avoidance, to dissociation, to vague awareness and conflict, finally reaching dialectic; and (c) demonstrate the gradual achievement of therapeutic congruence over the course of treatment.

Example 1: Session No. 7—Patient’s Active Avoidance

A: After giving a prolonged and detailed description of her economic problems, and the debt she and her husband were having a hard time paying off, thus leading them to consider taking an additional loan. It’s not that I’m neglecting things and it’s not that I do not care.

T: I know, but all the things you are saying now do not make me any less worried.

A: No, but you see, it’s not that I do not care, everything that comes in and goes out financially, I go over, I see, I know. I really do not neglect it. I didn’t miss anything.

T: I know, but I think exactly because of this, and I’m deliberately interrupting you for a moment, because maybe what I said could have sounded like criticism, but it was not my intention. I understand how it could have sounded like one.

A: No, but I’m also really afraid of what you are saying, you know? I . . . So what should I do? The problem is this. I know now if I do not have a car, I cannot get to work.

T: Let’s try to think together, to be with this fear you’re experiencing. You know I’m not a financial advisor, but . . .

A: I know (starts to cry).

T: I’m trying to think what we can do here, how to be here for you. I suggest that you take this anxiety, really, take it with both your hands.

A: You know what? Maybe after the call with the financial aid organization I’ll text you, so you’ll be calm, because I see you’re stressed. Sorry for making you worry about me (crying).

In this initial segment, the therapist encourages Amy to get in touch with a very frightening self-state although Amy disavows this self-state and rushes to seek definitive answers, asking the therapist to tell her what to do, as if she is trying to avoid feeling pain and helplessness. She repeats the details of her financial situation and seems to rapidly shift from trying to convince the therapist that she is in control toward seeking concrete direction from the omnipotent and experienced therapist. While actively blocking herself and her therapist from addressing and relating to her emotional distress, Amy’s tears indicate her sense of suffering.

Thus, the dimensions of the relationship between self-states, the affective dimension, and the relationship between Amy and her therapist are all indicative of active avoidance (= 1) on the patient’s TPA. The therapist is engaged, emotionally responsive and is dedicated to seeking ways to help Amy in her distress, while also acknowledging her own momentary state of hopelessness. Thus, she demonstrates an ability for dialectics (= 4) on the therapist’s TPA. At this point, the patient and therapist are demonstrating a significant gap in TPA levels, suggesting a reduced ability for congruence.

Example 2: Session No. 14—Patient’s Ongoing Avoidance and Dissociation

A: Yesterday, I had a feedback talk at work and my boss said, “You talk too much Amy, and it is hard for us.” So I said, “However, I’ve changed, right?” All my intimate talk exhausts them . . . when you carry the kind of baggage I do and you need someone who will be there for you, it is hard to just come and work. But now I stopped. I do not talk anymore. I arrive in the morning and start to work, and that’s it. From time to time, I ask dumb questions. I do not understand where they come
from, it’s like . . . I’m just trying to communicate and I do not know how.

T: Do you know what’s going through my mind? We recently started by talking about your family.

A: They do not deserve it.

T: Do not jump to conclusions. I have this feeling . . .

A: How messed up I am.

T: No. Now that you are telling me a little bit about what’s happening at work, I feel like there are many things that are very similar. I feel that in both places there are these coalitions and that you feel that you are not a part of them.

A: Totally. I really want to be, and I feel like I’m being pushed out.

T: So this is why I’m telling you. You always say, “It’s fine, it doesn’t matter, it’s fine, it doesn’t matter.” However, I think maybe I’m also hearing something different from you. Like you are saying, “It’s fine, it doesn’t matter,” but inside you’re saying, “I’m angry. It’s painful. This hurts. I’m sad and I’m frustrated.” And I hear many more things too. However, it’s easier now for you to say, “It’s fine, it doesn’t matter,” and not let it get to you.

A: Right now I do not care.

T: It doesn’t really seem that way.

A: (starts to cry) I’m in a place that all I really care about is my work and school and my husband (coughing). I think I’m getting sick. We’ll have to finish earlier today.

In this session, the therapist encourages Amy to recognize and own her dissociated, disavowed self-states, as distasteful as they may be, while enduring the conflict between them (implying therapist TPA Level 3). Despite the therapist’s efforts, and although Amy can recognize the self-states that the therapist is trying to reveal to her, she seems to refuse to own them. In this manner, Amy may be able to avoid painful ambivalent self-states while experiencing the therapist as an external deterrent judge (implying patient TPA Levels 1): a witness looking in from the outside. Amy may feel that she is being pushed too hard by the therapist at this stage, taking her to places that she cannot bear, and this feeling reflects the gap between the patient’s and therapist’s TPA levels. The reason Amy is so afraid of criticism and not being accepted and loved—feelings that are manifested in her tearful reaction to the therapist—may be that she cannot afford to experience dependency at this point.

The therapist, on the other hand, seems unable to recognize Amy’s anxiety. Thus, in a similar and even parallel process to what happens to Amy in her relationships with family members and coworkers, she seems to perceive the therapist as judging and threatening. The therapist may also be experiencing difficulties in facing her own self-parts or, more specifically, her rejecting and abandoning self-states. Her insistence on reflecting Amy’s conflict without engaging in a parallel process results in an ineffective intervention.

At the end, Amy begins to cry, indicating that she is overwhelmed and suffering from both a lack of emotional regulation and rigid control. She seems to feel isolated and unable to allow the therapist’s words to penetrate (which implies patient TPA Level 0). The quality of movement between self-states, the relationship between the patient and the therapist, and the patient’s affect indicate Levels 0–1 on the patient’s TPA scale. Therefore, there is still a significant gap between the patient and the therapist at this point.

Example 3: Session No. 20—the Mutual Changing From Vague Awareness to Conflict Between Self-States

A: I decided that I will not speak to my husband about how I feel depressed because anyway there is plenty of mess and stress and bullshit. Anyways . . . (crying).

T: I’m thinking about the message you sent me today to make sure that I had room for you. Maybe given all
this instability, you were looking for a place that would stay stable.

A: One island in all this mess (takes a deep breath).

T: I have to tell you that I want to do the same thing: take a deep breath.

A: I feel like I’m choking from all the mess. I feel like I have to float above the water and I cannot.

T: It sort of feels that way—that you’re drowning a little.

A: I said to my husband, “I’m nervous,” so he told me that I do not look nervous. Of course not! Because I do not cry next to him and I do not do anything next to him because I do not want to pressure him. However, I’m so nervous! I’m nervous! I really try to calm myself, and I try to be optimistic and think positive. I get up in the morning and force myself to sing happy songs and say thank you for what I have. I really try so much and I do everything for me and for everyone around me, everything. However, it’s hard! This is endless work! And I need it, seriously, let me be. Let me be. Give me this time and space.

In the beginning of this segment, Amy seems to be flooded with emotions (Level 2 of patient’s TPA), and the therapist is sensitive enough to hear her longing for a place where she will not feel rejected. The therapist joins Amy’s sense of flooding by seeming to connect to her own self-state of feeling flooded (which demonstrates therapist’s TPA Level 2). At this point, the therapist can refrain from challenging Amy because she seems not to be afraid of experiencing her own helplessness. She seems to be able to accept the fact that she does not know what to do or say.

In a mutual cycle, Amy manages to discuss the parts of herself that she does not want to see and generally tries to hide (patient’s TPA Level 3), enabling her to address her conflict. Amy seems to be beginning to acknowledge her fear of being dependent on her husband. She describes how she typically tries to cope by ignoring this need, but her helpless and dependent self-state then begins to appear. In this interaction, Amy and her therapist are moving and changing together in an open, honest, and painful place.

At this point, Amy seems to experience the therapist as a subject with whom she can share the process and as someone with whom she is more comfortable. New self-states arise that may have initially been experienced as confusing and somewhat torturous as they begin to reveal contained meanings, suggesting that patient and therapist have arrived at TPA Levels 2 and 3; vague awareness and a growing ability to tolerate conflict.

Example 4: Session No. 26—Moving Toward the Capacity for Conflict and Dialectic Between Self-States

In the final meeting of the therapeutic process (the 26th session), the therapist continues her efforts to prepare Amy for their approaching separation. She invites her to think about what might help get her through the upcoming period:

T: It’s funny what happened here now: you are telling me that I can be calm while I try to get you to a point where you’ll feel that you can reach out and ask for help if you need it.

A: Yes (laughs at herself). I bring things up because I want to tell you, “Look, I know that my condition might not be the best,” but I also want to give you time for your vacation, for everything you need. However, I do not want to do something that would be wrong for either you or for me. On the other hand, I’m also trying to think of solutions that I know that I’ve used in the past and that will be right for me, this framework, and for our relationship. I’m not trying to hide, or God forbid, say that certain things will not occur, or to reassure you and the clinic, like, “I’ll be fine, don’t worry about me.” I’m here because I need this place and I need you. I know how much you and the treatment have helped me and what a different place I’m in today than
when I started. I look back and frequently examine things and understand. I’m aware of things and the changes in me. And still, I also know that it will not be easy for me.

At this point in the process, the therapist discusses the intersubjective dynamic. She seems to feel more comfortable now in trying to understand with Amy what is occurring in the room. She refers to the conflict within both of them: the therapist’s need to worry about Amy and Amy’s need to assure the therapist that she will be fine. It is the same dynamic that emerged in Session 14. The difference is that both of them seem to be able to distinctly view themselves and work together with the dynamic between them: The therapist reflects on her fears of rejecting and abandoning, which made her push Amy toward owning her self-states before she was ready to do so, while Amy reflects on her need to disavow her neediness (strongly associated with her fear of rejection and abandonment) and pretend that everything is under control.

In this final meeting, Amy and the therapist seem to be much more relaxed and not hesitant to experience their emotions, despite the pain of separation. They seem not to need to repress painful or vulnerable self-states or to compensate by bringing forward their strong and independent self-states. Instead, they seem able to reflect humorously about themselves in a playful manner, a demonstration of their ability to tolerate conflict and even achieve an ability for dialectic (exemplifying patient’s and therapist’s TPA Levels 3 and 4).

Throughout the treatment, both Amy and her therapist learn to reflect on the processes taking place within and between them. Thus, they create a safer place in which Amy and her therapist are better able to experience their dissociative inner self-states, sustain the conflicted parts, and eventually move more flexibly among the states.

Discussion

Clinical experience, wisdom, novel hypotheses, and knowledge are often lost because they are not in a form that we codify and accumulate. We are letting knowledge from practice drip through the holes of a colander. We can plug up those holes to retain critical information, and we can feed this information into research designed to test hypotheses and add further support for what seems to be true from the data gathered in practice. (Kazdin, 2008)

The presented theory-building case study aimed to explore how the quality of movement between inner self-states develops within the patient and the therapist mutually and influences them throughout the psychotherapeutic process. In investigating these delicate and implicit clinical processes, we used the TPA. Our empirical and clinical integration was implemented by modifying Stiles’ (2011) APES into a relational empirical instrument. By doing so, we were able to examine the quality of movement between self-states of both parties of the therapy dyad.

Consistent with our expectations, and in line with a former TPA investigation (HaCohen et al., 2017), the patient achieved higher levels of quality of movement between self-states as treatment progressed. The results showed a quadratic TPA pattern of change on the patient session average-level: more conflict between self-states at the beginning, avoidance in the middle phase, and higher levels of conflict and even dialectic between self-states at the end of treatment. The highest levels of TPA that were achieved during the sessions were not consistently sustained. It can be assumed that when the patient was characterized by a lower quality of movement between self-states (lower TPA levels) she was addressing aspects of her multiplicity that had still not been processed and metabolized in treatment. Such irregular nonlinear progress within sessions has previously been noted in a few assimilation studies and has previously been found to be related to symptomatic improvement (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006; Leiman & Stiles, 2001).

Although a positive change process was yielded by the treatment, the patient did not achieve a TPA level of 5, representing a mutual and newly cocreated self-state that arises within the significant therapeutic relationship. One way of interpreting this finding is that although the treatment was meaningful and positive according to the outcome variables, its short duration did not allow for a full establishment of cofacilitated, dyadic development. An alternative explanation could be that the level of mutual cocreation is harder to identify and code, as it represents a subtle yet meaningful expansion.
in both the patient’s and the therapist’s self-states’ dynamic. A deeper exploration of this stage should be sought in future studies, such as in the case of longer treatments, and also in considering possible relations with additional empirical constructs examining cofacilitated changes occurring between patients and therapists.

The results also support our second hypothesis: As therapy progressed, the quality of movement between patient’s and therapist’s self-states grew more and more congruent. Thus, therapist’s TPA levels were temporally congruent with patient TPA levels, as measured session by session, only at the last stage of treatment. During the beginning and middle stages of treatment, the patient’s and therapist’s quality of movement between self-states reflected a discrepancy, as exemplified by a large gap between the therapist’s dialectic level and the patient’s actively avoidant and dissociative levels. As treatment progressed, the therapist and the patient became more congruent in their TPA levels. As demonstrated in Session No. 20, the therapist allowed herself to introduce new, vague, or disconnected self-states, which then accompanied the patient’s progression from dissociation to dialectic.

This finding may suggest that the therapist was able to achieve increased attunement with the patient’s internal movement, while the patient herself became freer, more confident, and more willing to move between different self-states. Such an interpretation aligns with previous studies emphasizing the importance of mutual impact and change, which are facilitated and codeveloped by both patient and therapist in the therapeutic process (HaCohen et al., 2017; Safran & Muran, 2000). An additional explanation for this finding is that the mutually developing ability to negotiate the gaps and misattunements within the therapeutic relationship assisted the progression in congruency. Such a progression may have occurred when misattunements “awakened” the patient’s most disavowed and threatening self-states while promoting the therapist’s ability to contain and adequately respond to them to create greater therapeutic safety and facilitate positive change.

The above-mentioned studies emphasize the importance of the therapist’s attendance to the limits of the patient’s therapeutic TZPD to avoid setbacks occurring as a result of a momentary problem in therapeutic communication (Gabalda & Stiles, 2017). Such findings suggest the possibility that congruence in the mutual changing process may serve as an important marker and clinical platform for the creation of an effective transition into a higher level of the TPA, when considered and adjusted properly by the therapist.

Our findings may also suggest that symptom alleviation occurs only during the final stage of treatment, when the therapist is more congruent with the patient. Previous studies have suggested that patient’s-therapist’s congruent perspectives regarding the treatment’s goals and progression are associated with better outcomes across various approaches and treatment vari-
ables (Atzil-Slonim et al., 2015; Bachelor, 2013; Kivlighan & Arthur, 2000; Tryon, Blackwell, & Hammel, 2007; Zilcha-Mano et al., 2016). Our current results align with these studies and additional case studies (Dimaggio, 2006; Honos-Webb & Stiles, 1998; Kramer, Meystre, Imesch, & Kolly, 2016; Ryle & Fawkes, 2007; Smith & Greenberg, 2007; Stiles, 2005, 2007; Stiles et al., 1992) that have linked assimilation of problematic self-voices with symptomatic improvement, and in this case with the relational version of this model.

Our results have several possible clinical implications. First, they emphasize the dynamics of continuous movement between patient’s self-states, which in a positive process gradually shift toward dialectic. Our findings thus support notions regarding the importance of working with nonlinear oscillating dissociative processes and irregular progressions, to create fertile ground for psychological development and growth. Second, our results highlight the importance of understanding that meaningful treatment processes rely on a dyadic movement toward mutual congruency. Moreover, change seems to occur by allowing dissociated self-states to be acknowledged and negotiated in the relational therapeutic context. Therefore, a key element in achieving effective psychotherapeutic treatment may be the consideration and evaluation of processes occurring between patient and therapist (Barber et al., 2013; Bromberg, 1998; Safran & Muran, 2000).

In addition, our current theory-building case study aimed to offer a valuable understanding of change mechanisms that are related to the emergence of self-states, shedding light on ways in which new patterns are formed throughout treatment. Such a nuanced and evidence-informed exploration of the quality of movement between self-states of both the patient and the therapist, as they co- fluctuate during treatment, may greatly contribute to contemporary clinicians’ understanding of the dynamics of various therapeutic modalities. Thus, as an integrative-clinical measure, the TPA can be used in a wide range of psychotherapy research and may enable a translation of core change mechanisms into an empirical language of analyzable variables. To address different approaches and modalities of the psychotherapeutic processes using the TPA, future studies are needed.

It is important to note, however, that great caution must be exercised in generalizing from our findings, as they are based on only one case from one research clinic. Thus, a replication in other settings is much needed (Stiles, 2005). Likewise, insofar as the researchers are fallible, and inevitably have their own biases, it is likely that at least some aspects of the case would have been interpreted otherwise by different observers of varying levels of clinical experience and judgment. Moreover, when considering group decision-making processes, we consider that some hierarchical dynamics were unavoidable, albeit ongoing reflexivity and transparency, as the research team consisted of individuals with varying roles and experience. We tried to address some of these issues by presenting the readers with verbatim material to allow individual independent impressions to be formed, although we had to take space limitations into consideration. Without undermining these limitations, we hope the team of multiple investigators contributed the case with some validation for the interpretations provided in the current study. A future comprehensive qualitative analysis would shed light on additional patterns in which dissociative processes operate and formulate throughout psychotherapy.

In addition, there is a notable limitation to the rating and subsequent qualitative analysis of the therapist, when relying solely on audiotaped and transcribed data. As therapists’ level of TPA is a delicate issue for investigation, due to his or her often short and opaque statements, rating and qualitative interpretations are mostly inferred. It may prove beneficial to investigate such nuanced data using videotaped therapeutic sessions, while also considering using additional innovative tools for evaluating implicit intrapsychic processes.

Another limitation of this study is that we did not examine the association between changes in TPA and other process variables, such as the therapeutic alliance, that are known to have an effect on treatment outcome. Future studies should examine the relation between the patient-therapist TPA temporal congruence and treatment outcomes above and beyond changes in the therapeutic alliance. In addition, it is reasonable to assume that various comorbidities affect the pattern of movement between self-states, their correlated symptomology, and their influence on the levels of congruence and mu-
tuality between the patient and therapist. Nonetheless, such lines of inquiry did not receive attention in our current research and might prove to be fertile grounds for further research. In addition, it would be interesting to see if and how more experienced therapists would impact the TPA pattern of change.

References


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