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## EMPIRICAL PAPER

# Multiplicity and mutuality in the transition of patient and therapist's self-states: Comparison of good vs. poor outcome groups

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### Abstract

**Objective:** According to the Assimilation Model, the self is consisted of multiple internal voices which are sometimes conflicted, or even dissociated, from one another. Thus, a key therapeutic goal is to create awareness and dialogue between a patient's various internal voices, in order to facilitate positive change. A recent development of this theoretical line suggests that clinically addressing both the patients' and therapists' internal voices, and their mutual influences, contributes significantly to the treatment outcome. Current study aims to examine: (a) Patients' progression throughout treatment in their quality of movement of self-states, from lower levels of dissociation to higher ones of dialectics, and whether this pattern is associated with positive outcomes; (b) temporal congruence in patient-therapist quality of movement of self-states and its association with session outcome. **Method:** Nine good and nine poor-outcome cases of psychodynamic treatment were analyzed ( $N = 18$ ) for both the patient and the therapist using the TPA, an expansion of the assimilation of problematic experiences scale (APES). Patients completed the Outcome Rating Scale (i.e., ORS), a session-by-session measure that assesses overall functioning, and symptomatic pre-and-post treatment measures (BDI). **Results:** A quadratic pattern of change was observed on the TPA of patients from the good-outcome cases: Patients showed more conflict in the beginning, avoidance between self-states in the middle phase, and dialectics towards the end. Additionally, the patient-therapist TPA temporal congruence was significantly related to session outcome of the good-outcome group. **Conclusion:** These findings emphasize the importance of combining an intra-psychoic and inter-psychoic set of lenses when inquiring therapeutic processes.

**Keywords:** congruence; Assimilation Model; multiplicity; two-person psychology; psychotherapy process; response surface analysis

**Clinical or methodological significance of this article:** The two-person analysis developed in the current research design highlights the fundamental nature of therapeutic growth as a nonlinear process of bidirectional self-state negotiation. The Two Person APES (TPA) scale, presented here for the first time, is an innovative way of translating clinical concepts derived from psychodynamic theory into rigorous, empirically definable terms. The nuanced exploration of both patient and therapist self-states as they co-fluctuate in the treatment can contribute significantly to our understanding of the dynamics of therapy and their relationship to session and treatment outcome.

### Introduction

Researchers in the field of psychotherapy are increasingly calling for a combined examination of the intra-personal and interpersonal processes that occur in both patient and therapist in order to better understand the mechanisms of change underpinning the gains achieved during psychotherapeutic treatment

(Castonguay, 2011; Wiseman & Tishby, 2014). Although many prior studies have examined patient variables, research into the interpersonal and intra-personal contribution of *both* partners in the therapeutic dyad has been scarce. An increased focus on interdependent processes that occurs within the patient, within the therapist, and between the two in

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their therapeutic relationship, is beginning to emerge within psychotherapy research (Safran & Muran, 2000; Zilcha-Mano et al., 2016).

The current study suggests a methodology for inquiring into the therapeutic dyad and its influences on changes occurring during and as a result of the therapy process. To do so, our study focuses on two main dimensions: Multiplicity and mutuality; multiplicity addresses one's ability to contain and shift between different aspects of the self, without undermining one's sense of identity (Linville's, 1985), and mutuality focuses on the process through which both sides of the dyad (i.e., patient and therapist) establish an ability to be open and receptive to each other's influence, while maintaining the valuable asymmetry of the therapeutic roles and responsibilities (Jordan, 1986). Thus, multiplicity refers to an intra-psychoic dimension, while mutuality refers to an inter-psychoic aspect of the therapeutic change process. In order to evaluate both the intra-psychoic and the inter-psychoic processes of multiplicity and mutuality, the current research expands The Assimilation Model (Stiles, 2011; Stiles et al., 1991), as a valuable and well-established theoretical and empirical tool. While the Assimilation Model inquires solely into intra-personal processes that occur within the patient during treatment, the current study adds the crucial inter-psychoic perspective.

### **Multiplicity**

#### **The Assimilation Model**

The Assimilation Model (Stiles, 2011; Stiles et al., 1991) views the self as a cohesive yet multiple unit, comprising of numerous—sometimes-contradictory—internal voices or self-states, each representing a constellations of the individual's identity, developmental context and accumulating life experiences. In an adaptive psychic functioning, varying circumstances trigger different voices to emerge and become temporarily dominant, while simultaneously rendering other voices into a background position. However, when some voices or self-states become marked by the psychic as problematic, disavowed, or threatening, they may become silenced and dissociated from the “community of voices.” These “rejected” voices often emerge when the individual is confronted with certain aggravating situations producing major affective symptoms and significant distress.

The Assimilation Model suggests that the therapeutic process gradually develops the possibility for such dissociated voices to become assimilated back into the general community of voices. The model asserts that this change is created through a

“meaning-bridge,” semiotic links by which the problematic voice could understand and be understood by voices of the community. The model offers a way of tracking the intra-psychoic process of this formation, through the use of eight therapeutic stages beginning with warded off/dissociated to integration/mastery of the various voices (Stiles et al., 1991).

Previous investigations using the Assimilation Model supported the hypothesis that as patients move up on the assimilation sequence in a range of treatment types, their symptomatic expressions subside. Most of these studies were in the form of case studies (see Osatuke & Stiles, 2011 for review and references; Stiles, 2006), in-session setbacks analysis (Gabalda, Stiles, & Ruiz, 2016) and single-session measures (Leiman & Stiles, 2001). The first reported statistical analysis between assimilation and psychotherapy outcomes compared the assimilation of problematic experiences in four good versus four poor-outcome cases of short-term psychotherapy (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006). The study showed that the good-outcome cases achieved significantly higher mean levels of assimilation compared to the poor-outcome cases, achieving the level of understanding/insight (level 4 in the APES). Since its development, the Assimilation Model has gained much respectability in the research community, and has been described as trans-theoretical (Leiman & Stiles, 2001).

#### **The Dialectic Approach**

While the Assimilation Model strives for an integration of formerly dissociative voices back into the general community of voices within the psyche, the dialectic approach focuses on the ability to maintain a flexible and reflective dialogue between contrasting self-aspects. Thus, this approach emphasizes the adaptive ability to tolerate intra-psychoic conflicts and multiplicity. The therapeutic importance of the dialectic approach is strongly demonstrated in the Schema Therapy approach (Young, Klosko, & Weishaar, 2003), which emphasizes the need to acknowledge different and even contrasting self-modes within the self. An example of this could be the acknowledgment of both one's “critical-parent” and “vulnerable-child” modes of self as being essential for the functioning of the self, rather than having one of these self-states dissociated and denied existence.

Similarly, theories within the psychodynamic approach share the notion of the self as structured by multiplicity (Mitchell, 1993; Ogden, 1992). These conceptualizations draw attention to the

therapeutic importance of fostering the patient's capacity to negotiate between conflicted or threatening self-states, in order to facilitate greater sense of internal freedom and liveliness. In contrast to the emphasis on self-unification that is denoted by the Assimilation Model, such approach maintains the view that the goal of therapy is to develop an individual's capacity to flexibly move among self-states, to the point of eventually being able to create new self-states (Bromberg, 1998).

To clarify the conceptual differences that exist between the Assimilation Model and the dialectic approach, one might find the following example insightful: Consider working with a patient who deals with an unrelenting perfectionist demand on her various aspects of functioning; the Assimilation-Integration model will aim to impair the dominance of the demanding and criticizing voice by striving to create compassionate and more forgiving voice that will assimilate into the psyche, in the hope that such a process will gradually eliminate the harshly demanding aspect of the self. In contrast, the dialectic approach will aim to provoke and strengthen alternative voices that will then directly oppose the malevolent one, encouraging a conflict to arise. Once such conflict emerges, it can then gradually turn into a bearable dialectical tension between these voices, bearing the tension that exists between the compassionate pole and the ambitious pole of the patient's self. Such line of thought hypothesizes that by fostering greater quality of movement between self-states, the different self-states will exist coincidentally in a more flexible manner within the self, eventually allowing the creation of more adaptive and playful self-states. To date, such assumption has yet to be examined and it is one of the key goals of the current study.

### Mutuality

#### Patient–Therapist Mutual Impact and Congruence

Contemporary two-person psychology approaches such as the relational-intersubjective theory highlight the importance of both the interdependent processes that occur *within* the patient and *within* the therapist, as well as *between* the two members of the dyad (Bromberg, 2012; Mitchell, 1993). Two-Person psychology approaches emphasize that through the process of “ruptures and repairs” occurring within therapy, a negotiation process between the patient's and therapist's self-states is fostered and achieved (Benjamin, 2009). In such moments, therapists' close attunement to patients' shifting self-states, and their clinical ability to acknowledge their own

movement between self-state during the therapeutic encounter, is crucial in order to intensify and accelerate the therapeutic process; Through the recognition of each other's (and each's own) aspects of self that arise and come into action in the interaction, a greater experiential insight of both intra-psychic and intersubjective dimensions is gained (Bromberg, 2012).

Parallel to these theoretical and clinical advancements, recent developments in the area of therapeutic processes research emphasizes the aspect of mutuality, bidirectional involvement, and congruence in the process of therapeutic change (Llewelyn & Hardy, 2001; Safran & Muran, 2000; Wiseman & Tishby, 2014; Zilcha-Mano et al., 2016). Studies investigating the therapeutic relationship found that patient–therapist congruence is associated with better treatment outcomes, across various approaches and treatment variables; congruent expectations between patient and therapist regarding the therapeutic process have been linked to mutually agreed-upon termination of treatment (Reis & Brown, 1999). In addition, congruence in patient and therapist recall of important session events was found to be positively related to patient outcome variables (Kivlighan & Arthur, 2000). Finally, greater congruence in patient–therapist alliance was found to predict better treatment outcomes (Atzil-Slonim et al., 2015; Bachelor, 2013; Zilcha-Mano et al., 2016).

Nonetheless, despite existing research in the field of patient–therapist congruence, to our knowledge no research has yet to explore the congruence between the quality of movement between inner self-states of both the patient and the therapist, in parallel. In addition, prior studies investigating the congruence between patient and therapist have mostly relied on similarity/distance indices and have not used process information models, which look at the pattern of change in congruency throughout therapy, while investigating its relation to treatment outcomes. In an attempt to undertake a complicated and subtle empirical investigation of therapeutic processes occurring during psychodynamic treatment, our study intertwines intra-psychic and inter-psychic dimensions. Multiplicity refers to an intra-psychic perspective, while mutuality refers to an inter-psychic perspective.

#### Introducing the TPA: Two-Person Methodology

To examine the connections between different self-states within an individual, Stiles et al. (1991) developed the assimilation of problematic experiences

scale (i.e., APES). The scale enables the description of self-states as voices, and allows for an examination of the extent to which self-states acknowledge one another. Our current research modifies the APES in order to investigate the therapeutic process through a two-person psychology methodological scale that is termed “TPA” (i.e., Two-Person APES).

TPA encompasses a framework which highlights the importance of exploring the interdependent processes *within* and *between* patient and therapist. In addition, the TPA integrates ideas presented by the dialectic approach, such as the therapeutic significance of achieving and preserving dialectic between patients’ multiple self-states. The TPA measures the quality of movement of self-states, both within the patient and the therapist, as they are inter-related to one another. Moreover, the TPA examines the levels of mutuality or congruency between patient’s and therapist’s quality of movement between self-states (a detailed manual is available in HaCohen, 2016).

Specifically, the TPA conceptualizes five levels of the quality of movement between self-states. These levels range between 0 and 5, going from dissociation (0), active avoidance (1), vague awareness (2), conflict (3), dialectic (4), and mutual co-creation of self-states (5). Notice that the stages 0–3 are similar to the original Assimilation Model, while stages 4–5 were introduced in order to match the dialectic approach, asserting the importance of ongoing negotiation between previously conflicting self-states. An additional dimension of the TPA identifies the level of quality of movement between self-states through the affective experience, ranging from reduced affect and detachment, anxiety, confusion, curiosity, to finally emotional regulation and pleasure. A third dimension regards to the patient–therapist quality of relationship, ranging along a continuum from self-isolation and lack of intersubjective reciprocity to mutual movement (for further illustration, please see Table A1 in the appendix).

In distinction from the TPA levels of the patient, the levels of the therapist’s TPA incorporate both the therapist inter-psychoic congruence to the patient’s transitions; as well as the quality of movement between self-states of the therapist him/herself. Higher levels of the TPA are reached when the therapist pays close attention to his or her own arising and shifting self-states, while simultaneously managing 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. The therapist will receive a higher TPA level when he/she successfully acknowledges the ambivalence regarding the

growing therapeutic change or difficulties within the therapeutic dyad, eventually allowing communicating openly about these processes with the patient (for additional examples, please see Tables A1 and A2 in the appendix).

Therapists’ level of TPA is a delicate issue for investigation, as the therapist’s presence cannot only be referred by his/her verbal accounts (i.e., content variables such as the idea or interpretation given), which are often short and opaque, but also through the moment-to-moment changes in interaction with the patient (i.e., process variables such as the patient’s response to the therapist’s interventions and the affective climate of both the patient and the therapist). The current model thus carefully, empirically, and clinically, observes and rates the therapists’ TPA level.

To conclude, the TPA suggested model is constructed using the following triad: (i) The quality of movement between self-states of both patients’ and therapists’, (ii) Affective characteristics, (iii) level of congruency in the therapeutic relationship as evident by the therapist’s ability to remain attuned to the patient’s shifting TPA levels.

## Research Hypotheses

The current study examines two central processes: (i) the progression in the quality of movement between internal self-states, from lower dissociative levels to higher dialectic levels and; (ii) the mutual effects patient and therapist have on one another’s quality of movement between self-states, over the course of therapeutic treatment. In exploring these goals the current study has formulated the following hypotheses:

Hypothesis 1: We predict a progression in the quality of movement between self-states (as measured by patient TPA levels), from dissociation to dialectic over the course of the treatment in good-outcome cases vs. an absence of such progression in the poor-outcome cases

Hypothesis 2: Temporal congruence between patients’ and their therapists’ TPA levels will be associated with symptomatic relief at the session-by-session level for all participants, regardless of their treatment outcome.

## Method

### Participants and Treatment

**Patients.** Eighteen participants were recruited from an existing pool of 101 patients at a large university outpatient clinic. Patients were selected from the



larger sample to match five criteria: (i) Psychodynamic-oriented treatment, (ii) age range of 25–65, (iii) Beck depression inventory-II (BDI) of between 17 and 40 on the pre-treatment assessment, indicating mild-to-severe depression, (iv) treatments duration of at least 15 sessions, and (v) full data including audio recordings of all sessions and pre-post measurements available for each patient.

Exclusion criteria, based on the M.I.N.I. 6.0 (Sheehan et al., 1998) included severely disturbed patients, either due to a current crisis, severe trauma and accompanying post traumatic stress disorder, psychotic or manic past or present diagnosis and/or current substance abuse. This procedure resulted in 60 patients from which 18 were selected through the formation of the comparison groups.

**Forming comparison groups and cases selection.** In the present study, as in the original statistical examination of the APES (Detert et al., 2006), we used a contrasting-groups design to maximize the difference between good and poor-outcome psychodynamic-oriented treatments. Since many of the patients in our sample were diagnosed with affective disorders, we decided to use the BDI as an exclusion criterion (only patients presenting over 17 points were included), and as the comparison criterion for the creation of the groups. In order to create comparison groups, the reliable change index (RCI) of pre-post change on the BDI was computed for each of the 60 eligible cases, categorizing patients into two subgroups: Those who scored above versus those who scored below the RCI cutoff of 8.46, in addition, in each group, five of the patients were diagnosed with affective disorder. This method has been used in previous studies (Seggar, Lambert, & Hansen, 2002) and was used in the current research to divide the sample posteriori into two extreme subgroups with regard to outcome:  $n = 9$  good-outcome cases and  $n = 9$  poor-outcome cases were sampled. The BDI mean score for the 18 selected cases at pre-treatment was 25.16 ( $SD = 6.55$ ). This mean score indicates mild-to-moderate depressive symptoms. All of the good-outcome patients met the threshold for clinically significant and reliable change (Seggar et al., 2002); their BDI scores dropped from between 17 and 40 at screening assessment to 2 and 21 post treatment. None of the poor-outcome patients showed evidence of reliable change; their BDI scores showed little or no reduction, ranging from 17 to 40 at screening and from 17 to 45 at post treatment. Mean scores on the BDI for good-outcome at pre-treatment were 24.5 and 10 at post treatment. Mean scores on the BDI for poor-outcome at pre-treatment were 25

and 29 at post treatment. The groups displayed significant differences in the change score from pre- to post-therapy; on the Outcome Questionnaire-Self Report (OQ-45.2) that measured wellbeing (Lambert et al., 1996)—(OQ-45;  $M_{\text{poor}} = 7.0$ ,  $SD_{\text{poor}} = 14.7$ ;  $M_{\text{good}} = -14.6$ ,  $SD_{\text{good}} = 14.2$  ( $t(16) = -3.15$ ,  $p = .006$ ); and on the Inventory of Interpersonal Problems (IIP) Personality Questionnaire (Horowitz, 1999) (IIP;  $M_{\text{poor}} = -0.3$ ,  $SD_{\text{poor}} = 0.6$ ;  $M_{\text{good}} = -1.0$ ,  $SD_{\text{good}} = 0.6$  ( $t(16) = -2.44$ ,  $p = .025$ ). These results reinforced the divisions between these groups.

The selected patients were over 25 years old ( $M = 42.66$  years,  $SD = 13.71$ , age range 25–70 years), and the majority were female (12 women and 6 men). Eight of them were single or divorced and 10 were married or in a permanent relationship. Half of them had at least a bachelor's degree and 15 patients were fully or partially employed.

Diagnoses were based on the Axis I Diagnostic and Statistical Manual of Mental Disorders-IV (4th ed., text rev.; DSM-IV-TR; APA, 2000). The clinician conducting intake was not the same as the one who actually provided the treatment. After conducting the intake, the intake operators participated in a discussion group that included two senior clinicians in order to discuss the patients' diagnoses; final diagnoses were determined by consensual agreement of at least 75% of the team members. Ten patients were diagnosed as suffering from affective disorder and three from anxiety disorder, as the primary diagnosis. The rest of the patients reported experiencing relationship problems, academic/occupational stress, or other problems but did not meet the criteria for Axis I diagnosis. According to pre-treatment assessments, the mean Global Assessment of Functioning score for the sample was 69.61 ( $SD = 11.34$ , range = 55–90).

**Therapists.** Sixteen therapists, 13 women and 3 men, participated in the study. Every therapist treated one patient, except two therapists. The patients were assigned to therapists in an ecologically valid manner based on real-world issues such as therapist availability and caseload. The therapists were MA or doctoral student trainees in the university's psychology department training program. Each therapist received 1 hr of individual supervision and 4 hr of group supervision on a weekly basis. All therapy sessions were audiotaped for use in supervision. Supervisors were senior clinicians in psychodynamic psychotherapy. Individual and group supervisions focused heavily on the review of audiotaped case material and technical interventions designed to facilitate the appropriate use of psychodynamic psychotherapy interventions. At the time of

treatment, the therapists were unfamiliar with the TPA scale and the research hypotheses.

**Treatment.** Individual psychotherapy consisted of once or twice weekly sessions of psychodynamic psychotherapy organized, aided, and informed (but not prescribed) by a short-term psychodynamic psychotherapy treatment model (Summers & Barber, 2010). The key features of this model include (i) a focus on affect and the experience and expression of emotions; (ii) exploration of attempts to avoid distressing thoughts and feelings; (iii) identification of recurring themes and patterns; (iv) emphasis on past experiences; (v) focus on interpersonal experiences; (vi) emphasis on the therapeutic relationship; and (vii) exploration of wishes, dreams, or fantasies (Shedler, 2010). Patients were seen once or twice a week for 50 min. Treatment was open-ended in length, limited to 10 months. The mean treatment length was 26.61 sessions ( $SD = 6.47$ , range = 15–43).

### Outcome Measures

**Beck depression inventory-II.** The BDI-II is a 21-item self-report measure of depression that asks respondents to rate the severity of their depressive symptoms during the previous two weeks using a variable Likert scale (i.e., 19 items use a 4-point scale, two items use a 7-point scale). Individual item scores are summed to create a total severity score with a range of 0–63. Total scores can be used to categorize respondents by depressive severity using the following ranges: 0–13 (minimal); 14–19 (mild); 20–28 (moderate); and >28 (severe; Beck, Steer, & Brown, 1996).

**Outcome rating scale (Miller, Duncan, Brown, Sparks, & Claud, 2003).** The outcome rating scale (ORS) is a four-item visual analog scale ranging from 0 to 10, with higher scores indicating better functioning. The ORS was developed as a brief alternative to the OQ-45 and as the OQ-45 it designed to assess change in three areas of patient functioning that are widely considered valid indicators of progress in treatment: Individual (or symptomatic) functioning, interpersonal relationships, and social role performance (work adjustment, quality of life; Lambert & Hill, 1994). The ORS demonstrates strong reliability estimates ( $\alpha = .87-.96$ ) and moderate correlations between the ORS items and the OQ-45 subscale and total scores (ORS total–OQ-45 total:  $r = .59$ ). This correlation meets expectations, given that 45 items were reduced to four (Miller et al., 2003).

The between- and within-person reliabilities for the scale were computed using procedures outlined

by Cranford et al. (2006) for estimating reliabilities for repeated within-person measures, and the reliability levels were considered high in the current study (within = .90, between = .96).

### Process Measures

**Two-person APES.** The TPA is an observer-rated coding system, which examines the patient's and the therapist's transitions between the quality of movement between self-states. The TPA is an extension of the APES (Osatuke & Stiles, 2011). It was developed by the authors of the current study. The TPA scale is coded for the patient and the therapist concurrently (Table A1 in the appendix provides a detailed description of the TPA levels; The TPA manual is available from the authors). The TPA consists of six levels, representing six possible relationships between self-states, identified by three elements: (i) The transition between the quality of movement between multiple self-states; (ii) Affect; and (iii) the patient–therapist relationship Affect. Patients may enter therapy at any level, and any progress through the sequence may be considered as improvement. The development and validation of the TPA included several stages. During the first, we conducted a qualitative pilot research producing several case studies. Then, we conceptualized six key stages that were mostly based on the APES levels but had a relational aims and concerned the intersubjective influences. In the next stage we asked 12 expert clinicians and theoreticians in the relational-psychodynamic field to rate the TPA key stages, presented randomly, in terms of how they believed it reflect an optimal progression of the relational-dialectic approach in therapy regarding the patient and therapist. Their ratings indicated high agreement with the direction of development between levels. In the next stage, inter-rater reliability between two clinical judges for the rating of 48 therapeutic sessions yielding satisfactory results of ICC: Single measures = .91 for patient TPA and .94 for therapist TPA. Construct validity was explored via the calculation of convergent and discriminant validity. The TPA was found to be correlated positively with the Experiencing Scale (EXP; Klein, Mathieu, Gendlin, & Kiesler, 1969) demonstrating convergent validity. Significant weak-to-moderate correlations was also found between the TPA and the coherence coding system (Baerger & McAdams, 1999). In the final stage of development, the TPA extension was approved and supported by Professor William B. Stiles, the primary author of the original APES (Stiles, personal communication, June 2014) and by Professor Philip Bromberg, one of the founders of

the relational-dialectic approach (Bromberg, personal communication, July 2014).

### Raters and TPA Rating Procedure

Two independent experts rated the TPA. The raters were a PhD student and a graduate student in clinical psychology (Masters-level training) with 5 and 2 years of clinical training and therapeutic experience, respectively. Both raters had completed the standard (approximately 40 hr) training, and had extensive experience in applying the TPA in previous research projects. Training entailed weekly 3-hr meetings over a period of 12 weeks in which recordings and transcripts were discussed until agreement was established on the 6-point scale. The intensive training last—until they had reached a satisfactory level of inter-rater reliability (.90) on a sample of 48 sessions, before they began to rate these study sessions. All ratings of the current study sample were done blind to outcome. The total sample of 18 cases, 90 sessions, used in this study, were rated by the first rater, and then 3 out of 5 sessions from each case (60%) were randomly selected and independently rerated in their entirety by a second rater for the purpose of establishing reliability. Independent ratings of the TPA found to demonstrate good inter-rater reliability for the patient TPA (ICC = .87) and for the therapist TPA (ICC = .86).

**Session selection.** From each therapeutic process, five sessions were chosen in even intervals. However, session 1 was excluded because it often might have had the quality of an initial interview. The final therapy session was also excluded because the focus of this session was presumed to be the treatment termination (Crits-Christoph, Gibbons, Temes, Elkin, & Gallop, 2010). For every dyad, five sessions representing five phases were chosen. The intervals between the sessions were proportional to the length of the entire treatment and varied from 2 to 3 sessions in the shortest treatment which lasted 15 sessions, to 9–10 sessions in the longest treatment which lasted 40 sessions. The average interval was spacing of five sessions. In occasions where we were undecided about which particular session should be sampled for the research, we chose the ones which had complete data in terms of questionnaires and with higher audio-recording quality.

**Procedure.** The study was conducted in a university-based outpatient clinic between November 2013 and August 2015. The study procedures were part of the routine battery in the clinic. Patients and therapists were asked to sign consent forms if they agreed to participate in the voluntary study, and

they were told that they could choose to terminate their participation in the study at any time without jeopardizing the treatment. Patients and therapists were also told that their anonymity would be preserved and that data from the patient would not be transferred to the therapist.

The BDI was administered to patients as part of the intake procedure (i.e., at pre-treatment). The session questionnaires were completed by the patients electronically using computers located in the clinic rooms and software that time-stamped their responses. The ORS were completed before each therapy session.

All 90 sessions were audiotaped, transcribed, and then rated, using the TPA scale for both patient and therapist. Each 50-min therapeutic session was divided into consecutive segments of 10 min each. The raters listen to the recordings and read the transcripts of the therapeutic sessions separately by producing a rating that best represents the level of the quality of movement between self-states for each section. In this way, each session receives 5 rating scores for the patient and 5 ratings scores for the therapist. Then, an average was computed to represent overall TPA level. The raters were blind to the treatment stage and outcome at the time of rating.

### Results

No significant group differences were found in the initial measurement of the TPA at the beginning of the treatment process ( $t(16) = 1.01, p = .329$ ). To test the first hypothesis regarding the differential progression on patient's TPA in the good vs. poor-outcome cases groups we ran a 2-level Multi-level analysis (session nested within patients; using SAS proc mixed) with session TPA as the outcome, Time as a level-1 predictor and Group as a level-2 moderator. Since inspection of the observed TPA levels (see Figure 1), revealed a quadratic pattern in the good-cases group, we also included a quadratic term along its interaction with Group as additional predictor in the model. Thus, the mixed multi-level equation in which all effects were considered to be random was:

$$\begin{aligned} \text{TPA}_{ic} = & (\gamma_{00} + \gamma_{01} * \text{Group}_c + u_{0c}) + (\gamma_{10} \\ & + \gamma_{11} * \text{Group}_c + u_{1c}) * \text{Time}_{ic} + (\gamma_{20} \\ & + \gamma_{21} * \text{Group}_c + u_{2c}) * \text{Time}_{ic}^2 + e_{ic}, \% \end{aligned}$$

where the TPA level in time  $t$  of patient  $c$  is predicted by the sample's intercept (i.e., fixed effect;  $\gamma_{00}$ ), the patients' group deviation from the intercept (i.e., fixed effect;  $\gamma_{02}$ ), this patient's deviation from his/her



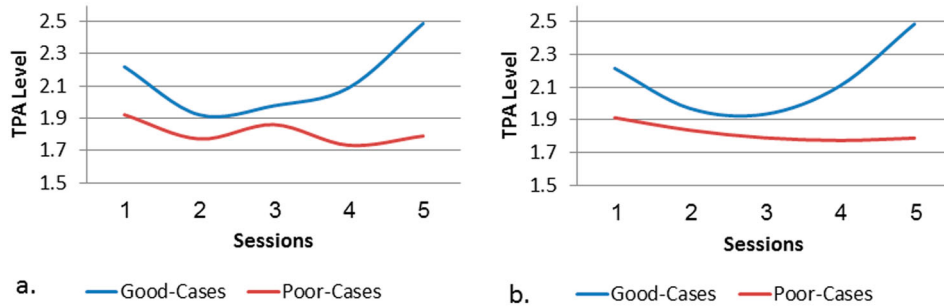


Figure 1 The observed (a) and predicted (b) patient’ TPA levels in the good and poor groups.

group’s intercept (i.e., random effect;  $u_{0c}$ ), the sample’s linear/quadratic effects of time ( $\gamma_{10}/\gamma_{20}$ ), the patients’ group deviation from the linear/quadratic effects ( $\gamma_{11}/\gamma_{21}$ ), this patient’s deviations from his/her group’s linear/quadratic effects ( $u_{1c}/u_{2c}$ ), and a level-1 residual ( $e_{tc}$ ). The time variable was centered on the middle session (i.e., session 3), and group was effect coded ( $-0.5 = \text{poor}, 0.5 = \text{good}$ ); thus, the intercept represents the estimated sample’s average TPA level at the middle session. Finally, the level-1 residual (i.e.,  $e_{tc}$ ) was allowed to differ from session to session, and its first-order autoregressive structure was estimated. As Table I shows, the quadratic term, and the interaction between the quadratic term and group were found to be significant. As Figure 1 shows whereas the good-cases group showed a pattern of quadratic change, the poor-cases group did not show any pattern of change. Importantly, *post hoc* contrasts revealed significant group-difference only in the last session (estimated difference = 0.70, SE = 0.29,  $t(68) = 2.40, p = .019$ ).<sup>1</sup>

To test the second hypothesis regarding the association between the congruence (and incongruence) in therapists’ and patients’ TPA levels and improvement in patients’ functioning at the session level we used the polynomial regression with response surface analysis (PRRSA). We followed the procedure outlined by Shanock and Eisenberger (2006), specifically, we ran a multi-level-model analysis in which the outcome (i.e., reported ORS in session  $t + 1$ ) was predicted by the following five

predictors: (a) Patient’s TPA; (b) therapists’ TPA; (c) a first quadratic term that is formed by squaring patient’s TPA; (d) a cross-product term that is formed by multiplying patient’s and therapist’s TPA; and (e) a second quadratic term that is formed by squaring therapist’s TPA.

Before constructing the quadratic and cross-product terms, the TPA variables were centered. Notably, whereas Shanock and Eisenberger (2006) recommend centering variables around the scale mid-point, we opted for person-mean centering which allows removing between-subject variability, as is recommended when analyzing hierarchically nested data (Raudenbush & Bryk, 2002) for a similar example of centering in PRRSA used with hierarchically nested data. In the context of our analysis, this centering approach means that the effects should be interpreted as changes in outcome associated with variation from the subject’s typical (i.e., average) state of congruence. To test for change in outcome, we also included the outcome level at session  $t$ . To test for different patterns among the study groups, we entered Group as a level-2 moderator of all effects (including the intercept).

Thus, the mixed-level equation in which all effects were considered to be random was:

$$\begin{aligned}
 \text{ORS}_{t+1c} = & (\gamma_{00} + \gamma_{01} * \text{Group}_c + u_{0c}) \\
 & + (\gamma_{10} + \gamma_{11} * \text{Group}_c + u_{1c}) \\
 & \quad * \text{Patient/s TPA}_{tc} \\
 & + (\gamma_{20} + \gamma_{21} * \text{Group}_c + u_{2c}) \\
 & \quad * \text{Therapist/ts TPA}_{tc} \\
 & + (\gamma_{30} + \gamma_{31} * \text{Group}_c + u_{3c}) \\
 & \quad * \text{Patient/s TPA}_{tc}^2 \\
 & + (\gamma_{40} + \gamma_{41} * \text{Group}_c + u_{4c}) \\
 & \quad * \text{Patient/s TPA}_{tc} * \text{Therapist/s TPA}_{tc} \\
 & + (\gamma_{50} + \gamma_{51} * \text{Group}_c + u_{5c}) \\
 & \quad * \text{Therapist/s TPA}_{tc}^2 \\
 & + (\gamma_{60} + u_{6c}) * \text{ORS}_{t+1c} + e_{tc}.
 \end{aligned}$$

Table I. TPA scores predicted by time and group.

	Estimate	SE	t	DF	p
Intercept	1.86	0.13	14.49	16	<.001
Group	0.14	0.26	0.56	16	>.250
Time	0.02	0.04	0.42	68	>.250
Time*Group	0.10	0.09	1.13	68	>.250
Time <sup>2</sup>	0.06	0.02	2.76	68	.007
Time <sup>2</sup> *Group	0.09	0.04	20.6	68	.043

Table II. The response surface parameters for the patient and therapist TPA levels as predictor of ORS in the good and poor groups.

	Good-cases		Poor cases	
	Estimate(SE)	p	Estimate(SE)	p
<i>Predictors:</i>				
Intercept	12.87 (2.91)	<.001	11.51 (2.70)	<.001
C_TPA	2.53 (2.67)	>.250	-4.79 (2.93)	.137
T_TPA	-5.36 (2.40)	.040	0.87 (2.25)	>.250
C_TPA <sup>2</sup>	-5.37 (3.75)	.158	4.93 (4.44)	>.250
C_TPA*T_TPA	13.71 (5.80)	.022	-6.39 (4.40)	.154
T_TPA <sup>2</sup>	7.97 (5.55)	.171	-1.93 (4.50)	>.250
<i>Response surface parameters:</i>				
a <sub>1</sub>	-2.83 (3.34)	>.250	-3.92 (3.02)	.220
a <sub>2</sub>	16.32 (8.20)	.055	-3.39 (5.58)	>.250
a <sub>3</sub>	7.89 (3.82)	.051	-5.66 (4.26)	.200
a <sub>4</sub>	-11.11 (9.01)	.223	9.39 (9.71)	>.250

We then used the fixed coefficients from the multilevel model analysis to calculate test values for four parameters of the response surface (Shanock & Eisenberger, 2006): (i) The linear slope of the line of congruence ( $a_1 = \gamma_{10} + \gamma_{20}$ ); (ii) the curvature along the line of congruence ( $a_2 = \gamma_{30} + \gamma_{40} + \gamma_{50}$ ); (iii) the linear slope of the line of incongruence ( $a_3 = \gamma_{10} - \gamma_{20}$ ); and (iv) the curvature along the line of incongruence ( $a_4 = \gamma_{30} - \gamma_{40} + \gamma_{50}$ ). To obtain different parameters for the study groups, we ran the model twice, once for the poor-cases group (by coding Group as 0 for poor-cases, and 1 for good-cases), and once for the good-cases group (by coding Group as 1 for poor-cases, and 0 for good-cases).

The results of the response surface analysis are presented in Table II (left side for good-cases, right side for poor-cases). As the table shows, none of the

response surface parameters were significant for the poor-cases group, indicating that in this group, neither levels of congruence or levels of incongruence were associated with patient’s functioning. In contrast, both the parameter related to the curvature along the line of congruence ( $a_2$ ) and the parameter related to the linear line along the line of incongruence ( $a_3$ ) approached significance for the good-cases group. As Figure 2 show, the pattern along the line of congruence indicates that patient’s functioning levels were higher following sessions in which both patients and therapist had high TPA levels, or both had low TPA levels than in session in which both had average levels of TPA. In addition the pattern along the line of incongruence indicates that patient’s functioning levels were lower when they had low levels of TPA and their therapist had high levels of TPA (incongruence Therapist > Patient), than when they had high levels of TPA and their therapist had low levels of TPA (incongruence Patient > Therapist).

**Discussion**

Contemporary theory and research regarding psychotherapeutic processes highlight the importance of exploring interdependent processes that occur in both the patient and the therapist (Safran & Muran, 2000; Wiseman & Tishby, 2014; Zilcha-Mano et al., 2016). Nonetheless, most of psychotherapy research remains focused on patient processes; when therapists are examined, it is mainly through the lens of the type of their interventions. Inspired by the dialectic approach and its understanding of the psyche as comprised of multiple self-states, the current study examined the quality of movement between self-states, from lower dissociative levels to higher dialectic levels, and the mutual impact

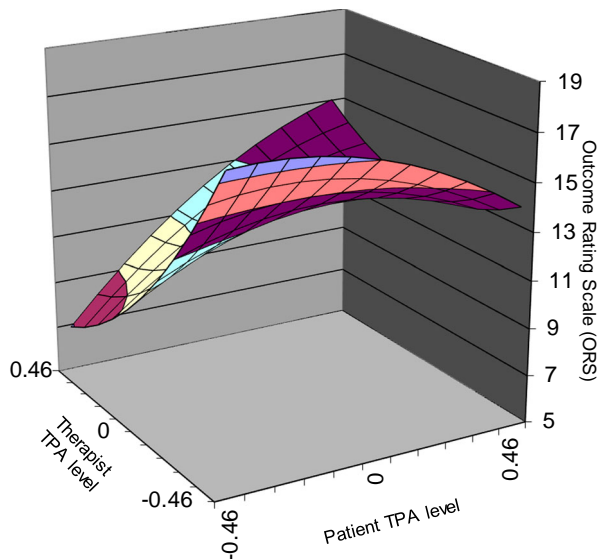


Figure 2 Changes in ORS as predicted by congruence between patient and therapist TPA levels.

patient and therapist exert upon one another over the course of the treatment. We employed intensive repeated measures using the TPA; a complementary approach to Stiles' APES scale (2011) which allowed us to examine in-session processes of both parties of the therapy dyad and the association between these dyadic processes and treatment outcome.

Our analysis supported our first hypothesis that patients in the good-outcome group would demonstrate a progression in their quality of movement between self-states, from dissociation to dialectic, over the course of the treatment, as oppose to the poor-outcome cases. Specifically, whereas the good-cases showed a pattern of quadratic change, the poor-cases did not show any pattern of change. The quadratic TPA pattern of change on the good-outcome cases demonstrates the patient's movement from more openness to conflict between multiple self-states on the beginning, dissociation, and avoidance on the middle phase, followed by high levels of conflict and dialectic at the end of therapy. This finding may suggest that towards the end of treatment patients in the good-outcome group increased their ability to tolerate different self-states and to create an internal meaningful dialogue between them. In contrast, this quality of movement did not characterize the poor-outcome cases that remained on the intermediate levels all along, without neither declining to dissociation nor reaching conflict and dialectics.

These results are in accordance with contemporary relational theories which emphasize the importance of helping patients to tolerate the tension between multiple self-states as a central aim of therapy (Bromberg, 2012). According to these theories, the progression to higher dialectic levels in the quality of movement between self-states is not necessarily linear and may often involve frequent setbacks to lower dissociative levels in the process of healing and growth.

These results are also in line with Detert et al. (2006) work and a series of assimilation studies (Stiles, 2006) which connect between patients level of acknowledgment in their dissociated self-states and their symptoms reduction. It is also consistent with work documenting that frequent setbacks in APES level can be considered as normal and even potentially beneficial in the therapeutic development (Gabalda et al., 2016). From the narrative approach point of view (Adler, Harmeling, & Walder-Biesanz, 2013) the process of the ongoing self-construction, as opposed to the qualities of the self-characteristic, are associated with therapeutic change and wellbeing. These accumulating findings of the quadratic pattern of change highlight the therapeutic importance of fostering an expansion of the range and flexibility

between self-states as previously studied and regarded by other trajectories (Tracey, Sherry, & Albright, 1999).

The results also supported our second hypothesis that temporal congruence in therapist's and patient's TPA levels would be associated with session level outcome. The finding indicated that in the good-outcome group, patient's functioning level increased following sessions with high congruence between patient's and therapist's TPA levels and decreased following sessions with discrepancy between patient's and therapist's TPA levels. In contrast, neither levels of congruence nor levels of incongruence were significantly associated with patient's functioning in the poor-outcome cases.

These results add to several contemporary psychotherapy theories that highlight the importance of patient-therapist congruence in self-states as a key transformational agent towards therapeutic positive change and better treatment outcomes (Bromberg, 2012).

The multiplicity-congruence-outcome association revealed in the data aligns with research regarding other process variables, which shows that congruence between patient and therapist is associated with various positive outcomes (Atzil-Slonim et al., 2015; Bachelor, 2013; Reis & Brown, 1999; Zilcha-Mano et al., 2016). This finding also echoes those of Gabalda et al. (2016) who found that a large majority of setbacks in patients APES levels were after the therapist exceeded the therapeutic zone of proximal development of the patient. It also aligns with previous studies that found that therapist's capacity to recognize rejected/unwanted versions of his/her own self and articulate them with his/her patient already is a predictor of therapeutic change (Elvy, Safran, Muran, & Rubin, 2010; Safran et al., 2014). However, whereas these previous studies tracked either the patient's self-states (Stiles, 2006) or the therapist's self-states (Safran et al., 2014), the current study examined how the patient's self-states interact with the therapist's self-states in the process of change.

The association between patient-therapist congruence and better session outcome that was found only in the good-outcome group may suggest that both congruence and incongruence between patient and therapist self-states are an inherent and significant part of productive therapeutic relationship. This finding echoes the large body of research regarding ruptures and repairs in the therapeutic alliance as an important and inevitable part of the therapeutic relationship establishment, as it calls for an ongoing, mutual and collaborative effort (Safran et al., 2014). Similarly, discrepancy in the patient-therapist levels of self-states may provide an

opportunity to be in touch with tension between self-states together with the therapist, which may lead to greater ability to tolerate this tension and thus to symptomatic relief.

That said, it is important to add that the fact that the poor-outcome cases showed less movement along the TPA levels, must have had some influence on the ability to find links between patient–therapist congruence and session outcome. It is assumed that patient’s fixation on the intermediate levels, inability to acknowledge new dissociated self-states or get to know and deepen the meaning of other conflictual self-states, may also be linked to less patient–therapist meaningful interaction that eventually effects patient’s immediate wellbeing.

There are several limitations in this study. First, the small sample size combined with the fact that the therapists were trainees, render this investigation exploratory and limit its generalizability. Because this investigation is also the first to examine both the patient and therapist transition between inner self-states and the first to use session-by-session data, these associations should be reexamined in future studies. An additional limitation stems from the sampling process, as the comparison groups were created on the basis of the BDI results. It may be feasible to assume that another criterion would have created different groups, possibly modifying our current results. In addition, the dichotomization of the comparison groups may have led to a loss of some variance. That being said, finding statistical significance despite the small sample underlines the magnitude and consistency of the effects found. 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 effect on treatment outcome. Future studies should examine the relationship between the patient–therapist TPA temporal congruence and treatment outcomes above and beyond changes in the therapeutic alliance. In addition, it might be feasible to assume that various co-morbidities affect the pattern of movement between self-states, its correlated symptomology and its influence on the levels of congruence and mutuality between the patient and therapist. Nonetheless, such lines of inquiry did not receive attention in our current research, and might prove to be fertile in future studies. In addition, it will be interesting to see if and how more experienced therapists would impact the pattern of change of the TPA.

Notwithstanding these limitations, the current study initiates a “translation” of core theoretical ideas from relational and two-person psychology theory into empirical variables and inquiry. In addition, the two-person analysis developed in the

current research design highlights the fundamental nature of therapeutic growth as a nonlinear process of bidirectional self-state negotiation.

Furthermore, the statistical approach (i.e., response surface analysis) that was chosen in order to study the impact of the congruence/incongruence between therapist’s and patient’s TPA levels and its correlation to the subsequent session outcomes allows for a greater strength and richness of the conclusions drawn.

Finally, our results have several possible clinical implications. First, they emphasize the importance of continuous progression in the quality of movement along the TPA levels, towards more conflict and dialectics between self-states. Additionally, our results advance the idea that the therapeutic process is not necessarily linear and includes oscillation in dissociative processes and irregular progressions on the way to achieve positive change in the form of vital conflict and dialectic between the patient’s multiple self-states. Third, they suggest that therapists who are attuned to their own shifts in self-states while also tracking their patients’ changing dynamics between self-states may better help their patients gain greater flexibility between self-states and eventually achieve better treatment outcome.

### Note

- <sup>1</sup> We also re-ran our analysis using the BDI change score as a continuous variable (instead of contrasting groups) and found a similar pattern of results.

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## Appendix

Table A1. Two-person APES scale (TPA) with clinical explication.

TPA level	For example
<p><i>Dissociation:</i> Complete disconnection between the “accepted” parts of the self and self-states that must be cut off, being too painful and traumatic. The self is severely threatened from the content contained in the split-off part of the self, causing the psychic to become frozen. All emotions are reduced and avoided, which might result in somatization. The patient is located in an isolated primary mental space, rejecting any feeling of genuine closeness to the therapist.</p> <p><i>Active avoidance:</i> Dissociated self-states are approaching the self-scope but denied and repressed. Anxiety appears, and force and resistance are then applied in order to “push” away “not-me” self-states. At this point, the mind insists on remaining frozen and there is an active effort to distance the therapist.</p> <p><i>Vague awareness:</i> Dissociated self-parts approach the conscious psyche 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. As the mind begins to unfreeze, the therapeutic relationship becomes closer and let cautious, and is now characterized by sensitivity and pausing.</p> <p><i>Conflict:</i> 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 or torture due to the increasing “inner-debate.” The therapeutic relationship becomes more involved and reciprocal movement begins to occur.</p> <p><i>Dialectic:</i> The multiple self-states now begin to value one another’s importance. Even if they remain hostile or oppositional towards one another, there is a fundamental understanding that they depend on one another. As splitting decreases, neither the formerly “good” self-states nor the “bad” ones require idealization/ devaluation. Affect is marked by compassion, acceptance and empathy. The therapeutic relationship is felt as true partnership and there’s a growing sense of owe towards the process.</p> <p><i>Mutual co-creation:</i> A transition to multiplying selves which creates new forms within the multiplicity. 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.</p>	<p>Uncontrollable laughter, losing one’s train of thought, somatization, fatigue, and forgetfulness.</p> <p>Expressing concrete remarks in response to emotional content, negating or giving mechanical and defensive “pseudo-integrative” descriptions.</p> <p>The individual may not know the reason for why things are being said, sensing confused and associative. When this free exploration leads to an upsetting or threatening content, it can be followed by an emotional flooding.</p> <p>The individual moves through multiple view-points, at times feeling or thinking opposing contents. At times, the therapist may first hold/represent one of the patient’s self-state for him/her, allowing the patient to interact with this self-state via the therapeutic dyad. Through this enactment, the patient’s internal conflict gradually becomes more tolerable and dynamic.</p> <p>Using arguments structured as: “I know for a fact that I’m ... but more and more I realize that I have other parts that are not less meaningful. It’s complicated, but it makes me who I am.” Expressions of deep bereavement may arise due to the recognition of the unchangeable past.</p> <p>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.</p>

Table A2. TPA levels with clinical vignettes demonstrating both patient and therapist levels.

TPA level	Patient	Therapist
	Patient: "I wrote and rewrote the text message that I'm sick and may not come to the meeting like a thousand times. You know that I was fired from my last job for being sick all the time, right?" Therapist: "Is it possible that that fear is present in our relationship too?"	
Dissociation	"What does that have to do with it? I want more than anything to be here. I just said that for no reason (laughing). The general vacation here at the clinic is only from August, right? There's some noise from outside ... can I try closing the door better?" <sup>a</sup>	"I didn't get any text message (checks her cell phone). Oh, there is something here from you ... These phones are messed-up, you can't count on them when you need them (starts banging her cell phone on the table)." <sup>a</sup>
Active avoidance	"No, of course not. There's no comparison at all, I wish that at work I had a boss that was as and accepting as you. And I'm not sick anymore, I wrote that text message for no reason."	"But it's not the same as your workplace here, and I can't fire you, so there is nothing to worry about. What matters is that you're here now. What did you want to talk about today?"
Vague awareness	"No. Here I feel safe, most of the time, I think. And of course you would understand if I didn't come. So why is it so hard for me to write these text messages? I have no idea, it doesn't make sense."	"I'm not really sure how to take what you're saying, since this isn't like your workplace. But I still feel that maybe you are trying to tell me something with this. I'm a little bit confused. What exactly happened at work? Why do you think you thought about this here?"
Conflict	"It's possible. On the one hand, of course I know that I'm allowed not to come and that you would understand and accept that. But on the other hand I have this awful thing: I'm scared that if I were to do something for myself, I would lose the people I need. That in the end people will always leave me. I hate it when that happens, and it's awful that it's also happening here with you."	"First of all, of course there isn't that danger here, and it's important that you do what's right for you. But on the other hand, is it possible that somehow I've made you feel that there is? It's hard for me to think of myself in that way, like in some way I'm 'punishing' you for missing a meeting. But I also can't ignore the fear you're bringing up here. Would it be okay if we thought about this together?"
Dialectic	"It's not like at work. I know that you're here for me and that you would understand and would want what's best for me. But especially since I'm so attached to you, which is an amazing thing for me, it also makes it harder. It increases my fear that maybe someday you'll get sick of me, just like has happened so many times before in my life."	"It seems like the fear that I might be mad at you or abandon you if you didn't come is hard for both of us. I'm glad you're telling me this. On the one hand our relationship is so good and close, but perhaps especially because of that, things from the past are floating back, and it's not easy holding this feeling without any fear. And maybe together we will be able to hold both of these parts, although it must be easier to only see the good."
Mutual co-creation	"I feel really safe and protected here. But in relationships I also always have this fear that I will be left, just like I felt when I thought of not coming here today. But when you asked me now about the possibility that you would fire me: that fear felt a little different, a little less scary, because I don't have to hide it since we both know where it's coming from. And also because I know that it scares you too."	"You know, I never thought of therapy as a place that could give a person that feeling, the feeling that if you aren't 100 percent, you will be fired. And here with you I'm discovering that alongside the fact that I hope that I represent for you a place that 'contains' and is supportive, I'm also for the first time encountering places in myself that can abandon and reject. And your sensitivity to those places won't allow us to ignore them. We're going to have to learn about and understand them together."

<sup>a</sup>We are presenting this dialogue here for the purposes of clarifying the example. However, in most cases, from our clinical experience, dissociation would be presented in much more extreme situations, ones which contain material that is especially charged and sensitive for either the patient or the therapist. As a result, the reaction would therefore be externalized and hard to contain.