ABSTRACT

THE PROCESS OF INCLUDING THE OTHER: PATTERNS OF INTERACTION, MEANING- AND DECISION-MAKING OBSERVED ON THE WAY TO IMPROVED RELATIONSHIPS WITH SELF AND OTHERS

by Hugo Josef Schielke

This thesis presents a dialogical theory of change that describes persons as systems of voices in dialogue, and suggests that (1) events are experienced as problematic when relevant voices’ positions are excluded from influence, and that (2) problems are resolved as relevant voices’ positions are increasingly included (i.e., valued, influential) in meaning- and decision-making. This theory represents an elaboration of the assimilation model that emerged out of applying an iterative, team-based approach to theory-building case study research to two successful couple therapies. Observations supported the hypothesis that the processes by which increases in self- and other- understandings develop are isomorphic: in both contexts, self-similar patterns of perception, emotion, intention, communication, and action were observed as once-excluded aspects of experience came to be increasingly included in meaning- and decision-making. These patterns were summarized in the resolution of problematic experiences sequence (RoPES), which appears applicable to tracking intra- and interpersonal therapeutic change.
THE PROCESS OF INCLUDING THE OTHER: PATTERNS OF INTERACTION, MEANING- AND DECISION-MAKING OBSERVED ON THE WAY TO IMPROVED RELATIONSHIPS WITH SELF AND OTHERS

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Dedication

To Myev. Always.
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Introduction

Systems theory (e.g., von Bertalanffy, 1968) has played an influential role in guiding conceptualizations and interventions in couple and family therapies (see e.g., Guerin & Chabot, 1992; Lebow, 2005), and has also been applied to conceptualizing intra-individual relationships (see, e.g., Breunlin, Schwartz, & Mac Kune-Karrer, 1992; Hermans & Kempen, 1992; Pinsof, 2003; Schwartz, 1995; Whelton & Greenberg, 2001). System theory’s ability to help facilitate understanding of both the inter- and intra-personal domains is one of its most attractive features, and is afforded by the systems theory principle of isomorphism (or self-similarity), which suggests that systems display similar patterns of process and organization across their various levels. In regard to people, saying that inter- and intra-personal organization and process are isomorphic implies that formal similarities can be found when looking at relationships between people and at the relationships between different aspects of a person. This, in turn, implies that the process of therapeutic change (and the patterns of relationship observed en route to such change) should also afford curious observers with evidence of self-similarity. That is to say that the process by which relationships between different people improve and the process by which relationships between different aspects of a single person improve should be isomorphic. The present study set out to explore this hypothesis in the context of couple therapy, and to work towards developing a model capable of describing the inter- and intrapersonal change processes observed in successful couple therapies.

Self-similarity and the assimilation model

In what could be construed as implicit support of the aims of this project, the qualitative study of individual therapies has led the elaborators of the assimilation model of therapeutic change (e.g., Brinegar, Salvi, Stiles, & Greenberg, 2006; Brinegar, Salvi, & Stiles, 2008; Honos-Webb & Stiles, 1998; Osatuke et al., 2004; Osatuke & Stiles, 2006; Stiles, 2002; Stiles et al., 1990; Stiles et al., 2006) to adopt interpersonal metaphors (e.g., voices, dialogue) to describe and make sense of the intrapersonal change processes observed in individual therapies. (When first introduced by Stiles and colleagues in 1990, the model was highly influenced by the thought of Piaget, and emphasized the importance of the assimilation and accommodation of information into cognitive schemas. Based on case observations, the model’s primary theoretical grounding has shifted towards a dialogical, Bakhtinian / neo-Vygotskian stance based on a multi-vocal view of the self, a shift that was articulated in Honos-Webb and Stiles, 1998.) This model suggests that the self is akin to a system of voices in dialogue with one another (Brinegar et al., 2008), where each voice represents interconnected traces of experience (Honos-Webb & Stiles, 1998) and can take differing positions in relation to a single situation (e.g., part of a person might feel one way, want to do one thing, and/or hope for one outcome while another part might respond very differently to the same situation; Stiles et al., 2006). In this model, an accepted sense of self (an identity) is likened to a community of voices (Honos-Webb & Stiles, 1998), a metaphor chosen to convey a sense of communal unity and collaboration.

A central aspect of this model is the assimilation of problematic experiences sequence (APES; see Table 1), which describes a series of patterns observed en route to the resolution of problematic experiences. This developmental sequence describes a series of eight stages of progressively increasing self-understanding (Stiles et al., 1990). Building on the metaphor of the multi-voiced self, this sequence also describes the increasing acceptance of voices representing
experiences initially evaluated as problematic (Honos-Webb & Stiles, 1998), and chronicles the process of integrating (e.g., Brinegar et al., 2006, 2008) or including (Osatuke & Stiles, 2006) a voice into the community of voices (sense of self). This process yields more comprehensive and coherent narratives about the self (e.g., Osatuke et al., 2004; Osatuke & Stiles, 2006), an achievement that has, in turn, been linked with psychological well-being (Baerger & McAdams, 1999). This process has also been observed to result in the development of new strengths; the relationships between voices in a client with uncontrolled verbal outbursts, for example, may develop such that the person is able to be appropriately assertive (Stiles, 1999).

The sequence described by the APES has been supported by both quantitative studies (e.g., Field et al., 1994; Detert, Llewelyn, Hardy, Stiles, & Barkham, 2006; Goodridge & Hardy, 2009; Reynolds et al., 1996; Stiles, Barkham, Shapiro, & Firth-Cozens, 1992; Stiles, Shankland, Wright, & Field, 1997) and qualitative research (e.g., Brinegar et al., 2006, 2008; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Humphreys, Rubin, Knudson, & Stiles, 2005; Knobloch, Endres, Stiles, & Silberschatz, 2001; Osatuke et al., 2005, 2007; Stiles et al., 1991; Stiles, Meshot, Anderson, & Sloan, 1992; Varvin & Stiles, 1999) and has been found to be applicable across a number of therapeutic orientations and clinical populations. Prior to the present study, however, the model had not been explicitly elaborated to describe increases in interpersonal understanding.

The present study aimed to assess and extend the model’s ability to describe increases in inter- and intrapersonal understanding in couple therapy. The systems theory principle of isomorphism suggests that formal similarities should be evident in the patterns of intra- and interpersonal dialogues observed en route to therapeutic change, providing encouragement that both levels might be able to be described in a single language system; the model’s already-extant use of interpersonal language to describe intrapersonal process offered additional encouragement that this might be possible. Applying the principle of isomorphism to therapeutic change at intra- and interpersonal levels also suggests that insights about intrapersonal dialogues and relationships (which are not always observable) might be gained by attending to patterns in interpersonal dialogues and relationships (which are far more open to observation). It was with this in mind that this study examined the model in relation to two successful couple therapy cases.

The resolution of problematic experiences in couple relationships

Findings from observational couple research suggest that how partners interact with one another around problematic experiences in their relationships is both highly indicative of marital satisfaction and highly predictive of eventual marital dissolution (e.g., Carrere & Gottman, 1999; Gottman, 1994; Gottman & Levenson, 1999; Gottman, Coan, Carrere, & Swanson, 1998; Gottman, Murray, Swanson, Tyson, & Swanson, 2002; Markman & Hahlweg, 1993; Matthews, Wickrama, & Conger, 1996). Gottman and colleagues’ findings suggest that the problem-solving patterns most highly associated with divorce include: stonewalling (being unwilling to engage in dialogue about the problem), defensiveness (being unwilling to legitimate the other’s point of view), criticism (making globally negative statements about the other’s person, reflecting an inability to see the other’s perspective), and contempt (active rejection of and/or disgust in relation to the other’s perspective and person). These interaction types indicate an avoidance (e.g., stonewalling) and/or increasingly active disregard (e.g., defensiveness, criticism, and contempt) of the positions of the other. Of these, contempt, the stance that is the most
dismissive of the other and their perspective, is most highly predictive of divorce (Gottman, 1994, 1999). In sum, partners’ failure to allow themselves to be influenced by their significant other’s positions is highly problematic for the couple relationship (Gottman, 1994, 1999). Further, it appears that the more the other’s perspective is disregarded and failed to be granted influence (i.e., the more the other’s positions are excluded from influencing a partner’s meaning-and decision-making), the more problematic this is for the relationship.

Therapies informed by this research (e.g., Catherall, 2007; Gottman, 1999; Greenberg & Goldman, 2008) aim to create mutual understanding and reduce the presence of problematic relational patterns by helping couples empathically understand one another’s reactions and learn how to engage one another in ways that are sensitive to each partner’s esteem and relational needs. These therapies encourage the non-defensive sharing of positions that underlie partners’ observable reactions (i.e., each partner is encouraged to share their interpretations of and feelings about the situations in question). As part of this process, each partner is encouraged to be curious about one another’s perspectives, and to try to see their interactions through their partner’s eyes as well as their own. The creation of mutual understanding increases partners’ sense of “we-ness,” (i.e., partners’ sense of identity as a couple and solidarity with one another; Gottman & Levenson, 1999). Increases in partners’ sense of we-ness (couple identity) have, in turn, been found to be associated with reduced indications of couple dissolution risk (Gottman & Levenson, 1999) and increases in partners’ relational satisfaction (Reid, Dalton, Laderoute, Doell, & Nguyen, 2006). Such increases in we-ness have also been associated with increased couple mutuality and increases in the degree to which the other is experienced as being included in a partner’s sense of self (Reid et al., 2006).

Inclusion and the resolution of problematic experiences

This account of successful couple therapies resonates with the description of the resolution of problematic experiences in individual therapies as described by the assimilation model. As noted by Osatuke and Stiles (2006), the APES can be described as providing an account of the increasing inclusion of a voice into a person’s community of voices (sense of self) – a point that converges with Reid and colleagues’ (2006) finding that successful couple therapy results in a increase in the degree to which the other is seen as included in the self.

In the assimilation model’s framework, inclusion is said to reflect a community’s attitude towards a voice ranging from rejecting (in lower APES stages) to embracing a voice as it comes to be increasingly included (as evidenced in higher APES stages; Osatuke & Stiles, 2006). This attitude is indicated by the degree to which a voice “is allowed to participate in affairs of the community (e.g., drawing attention, sharing in the community’s decision-making)” (pg. 300). Put another way, a voice’s influence increases as it becomes increasingly included. As clarified by Stiles et al. (2006), intrapersonal voices (and the relationships between these voices) are identified by attending to voices’ positions, the observable verbal and non-verbal stances a voice adopts “in relation to events, things, other people, and other aspects of self” (pg. 408-409). Each position taken implies a particular interpretation of the meaning and value of the event, thing, person, and/or aspect of self in question, and differing positions imply the presence of differing voices.

Combining the theoretical elaborations presented in the two 2006 articles, the APES might be said to describe the process of including a voice into the community of voices that make up a person’s sense of self, a process that is made observable by attending to the degree to
which a voice’s positions are rejected (i.e., unvalued and excluded from influence) or embraced (i.e., regarded as valued and influential) in that community of voices. Such a framing of the model would encourage those using the model to attend to the relative inclusion of voices’ positions in meaning- and decision-making as a means of determining the relative inclusion of a voice in relation to a particular community of voices (i.e., a sense of self / identity). (Meaning-making here refers to the ways in which clients interpret the implications of their experiences; the results of these processes are observable in clients’ narratives/stories.) This reframing of the model appears to be convergent with the description of the process and outcome of successful couple therapies outlined above, suggesting that this framing could be applicable to describing both intra- and interpersonal problem resolution.

**Methodological framework: Theory-building case study research**

In theory-building case study research (Stiles, 2003, 2005a, 2007, 2009), case material is studied with the intent of assessing and expanding the theory of interest. In this approach, theory is treated as an evolving, logically coherent framework for describing and explaining observations. Statements are subject to ongoing inquiry, and remain tentatively held, open to modification and elaboration based on additional observations.

Theory-building case study involves comparing the statements of a theory with case observations; observations that are not consistent with the theory are seen as indications that the theory requires revision. Central to the success of this qualitative approach is the notion that an invalidation of any aspect of the theory is not regarded as a failure that is to be avoided. Instead, such instances are explicitly sought out and regarded as opportunities to further enhance the theory. In such instances, the theory is refined to account for new observations while maintaining its ability to account for observations made sense of by previous formulations of the theory. It is in this way that observations can be said to permeate the theory (Stiles, 1993, 2003, 2007). Peirce (1958) described this process as that of abduction – responding to an observation that contradicts expectations by introducing or modifying a tenet of theory such that “if the new tenet were the case, then the observation would be expected” (Stiles, 2009, pg. 18).

**Design**

The present study aimed to assess and extend the model’s ability to describe increases in interpersonal understanding by examining the model in relation to two successful couple therapy cases. To increase the likelihood that the implications of case observations would be successfully folded into the theory that emerged out of this work, this study employed an iterative, team-based approach to theory-building case study research, wherein a team of seven co-investigators considered the implications of case observations for the theoretical statements of the evolving theory.

The applicability of the systems theory principle of isomorphism (or self-similarity) to inter- and intra-personal processes in psychotherapy was treated as a hypothesis that could be denied or tentatively supported through this research process. This hypothesis was to be rejected if the study indicated that separate models were required for the intra- and interpersonal levels of description; conversely, tentative support would be considered to have been shown if the results of this effort produced a model capable of simultaneously describing intra- and interpersonal process en route to intra- and interpersonal therapeutic change.
Method

Participants

Cases. The two cases studied were drawn from the Emotional Injury Project (EIP) at the York University Psychotherapy Research Clinic (Greenberg, Warwar, & Malcolm, 2010). The EIP studied the effectiveness of 10-12 sessions of emotion-focused therapy for couples (e.g., Greenberg & Goldman, 2008) for facilitating the resolution of long-standing emotional injuries sustained within their relationship. To qualify for the EIP study, the emotional injury had to have been problematic for at least two years, and at least one of the partners had to identify the injury as actively problematic, causing unresolved hurt or anger. In addition, both partners had to express a desire to remain together, and had to have been cohabiting for a minimum of two years. The screening process excluded potential participants who demonstrated any evidence of partner abuse, substance abuse, suicidal ideation, or severe psychological disturbances (dissociation, psychosis, or narcissistic or borderline personality disorder in either partner). The 20 couples included in the EIP were recruited through newspaper advertisements. All provided informed consent to participate in the study, to have audio and video recordings made of their sessions, and to consistently fill out session process and outcome questionnaires.

The present work studied video recordings and EIP-produced transcripts of two EIP couples’ therapies. To ensure that the present study’s theory-building work was based on observations of successful couple therapies, this project studied two cases that met the EIP’s criteria for having resolved the problem that had brought them to therapy. The EIP designated a couple’s case as resolved when the couple met the project’s criteria for having forgiven each other and become reconciled. This determination was informed by partners’ post-treatment responses on the Enright Forgiveness Inventory (Enright, Rique, & Coyle, 2000) and the Unfinished Business Resolution Scale (Singh, 1994) in conjunction with post-treatment and three-month follow-up interviews. The presence of meaningful therapeutic change in the successful cases was also suggested by the difference between the resolved couples’ pre- and post-treatment Dyadic Adjustment Scale (Spanier, 1976) scores, which reflected a significant reduction in these couples’ levels of marital distress. The couples’ initial and post-treatment scores on these measures are presented in Table 2. Both cases studied consisted of heterosexual, Caucasian couples with children. Partners’ ages ranged from 37-40 years old. All had completed undergraduate degrees; one partner had completed a Master’s degree. One case (referred to as Sarah and Mark) was facilitated by an advanced female doctoral student; the other (referred to as Simone and Daniel) was facilitated by a highly experienced male therapist. Both met for 11 sessions. Detailed descriptions of the cases studied are found in the Results section.

To protect clients’ anonymity, the disclosure of identifying details of the cases has been limited, and some identifying details included in the results section have been modified.

Investigators. Including the principal investigator (PI; Schielke), the research team consisted of seven doctoral psychology students. Four co-investigators were female. Co-investigators’ self-identified primary theoretical orientations were cognitive-behavioral, developmental, existential, humanistic, psychodynamic, systemic, and third-wave feminism. Diversity in gender and theoretical orientation was sought with the intention of increasing the likelihood that salient case information would be identified and attended to; seeking diversity in collaborators’ theoretical orientations was also informed by the finding that the presence of
dissenting positions prior to decision-making leads to better decisions (Schulz-Hardt et al., 2006). Each case was studied by four investigators (three co-investigators and the PI). Co-investigators were assigned such that each case was studied by one female co-investigator with no previous experience with the model and one female and one male co-investigator who had formally studied and/or researched the model.

**Measure: The resolution of problematic experiences sequence (RoPES)**

Partners’ self- and other-understandings were compared to the patterns described in what came to be referred to as the Resolution of Problematic Experiences Sequence (RoPES; see Table 3). The RoPES describes a series of dialogical relationships observed en-route to the resolution of problematic experiences, and represents an elaboration of the APES (Brinegar et al., 2006; Table 1) that emerged through subjecting the APES’ patterns to scrutiny and iterative revision throughout the research process. The RoPES describes the development of increased understanding between voices; each of the eight stages of the RoPES (numbered 0-7) represents an increasing degree of involvement and understanding between the voices in question. Consistent with prior iterations of the model, these descriptions are always specific to the qualities of a relationship between two voices. An elaboration introduced by the RoPES is the RoPES’ description of the relationship to the other’s positions from both voices’ perspectives: each stage offers a brief description of the state of a voice of focus in **bold** followed by a description of that voice’s relationship to another voice’s positions in **italics**. For example, RoPES 2 is **vague awareness / not understood**. (The description in italics describes the relationship from the perspective of the other voice.) A description of the pattern’s qualities follows in plain text.

**Procedure: Iterative abduction**

**Preparing the model document for iterative refinement.** To prepare for the iterative abduction process, I conducted a literature review of the elaborations of the model to date. This literature review included a PsychInfo search on the phrase “assimilation model” as well as a review of a list of relevant publications provided by William B. Stiles (one of the originators of the model, and the researcher most consistently involved in ongoing model research; Stiles, 2006). I used the results of this review to create an electronic document that organized what I viewed as up-to-date statements of the model’s theory into three sections: the model’s view of the person, the model’s conception of therapeutic change, and the sequence of patterns observed en route to the resolution of problematic experiences (i.e., the APES). The citations for each statement were also included. I then tentatively proposed elaborations aimed at describing the process of therapeutic inter- and intrapersonal change in a common theoretical framework. In the interest of transparency, each of these tentative elaborations was indicated as such using the word processing software’s formatting and commenting features. The resulting document (see Appendix A) served as an initial attempt at an account of the process of inter- and intrapersonal change and was designated an elaborated model-in-progress.

**Iterative theory-building process.** The six co-investigators were asked to represent their sense of how the case material disconfirmed, supported, and/or could inform the evolving theory; the onus was on the PI to elaborate theoretical statements that could meet the independent
approval of all co-investigators. In the interest of minimizing confirmation bias (e.g., Nickerson, 1998), collaborators were encouraged to search for theory-disconfirming information. This request was intended to induce a critical norm for the decision-making process; such a norm has been shown to reduce the tendency to ignore disconfirming information in decision-making (Postmes et al., 2001).

Each iteration of this process involved four steps (see Figure 1). For each session, (1) *Each investigator independently reviewed the case data* and was requested to note material that ran contrary to, was currently un- (or under-) described by, or offered confirmation of the theory as elaborated. (2) *Each investigator independently evaluated the current iteration of the elaborated model* based on the case data they had observed. This review process involved rating the descriptive accuracy of each of the model’s theoretical statements in relation to the case material, adding comments and pointing towards case data as necessary to clarify the basis for their ratings. Ratings of each statement were made using a 7-point Likert scale ranging from 0 (the statement was completely invalidated by the co-investigator’s experience of the case material) to 6 (suggesting a perfect correspondence between observed data and the statement in question). Co-investigators were also encouraged to indicate any instances in which they did not feel they had enough data to evaluate a statement. (3) *The PI then reviewed co-investigators’ feedback and met with the team* to ensure that co-investigators’ feedback was accurately understood, as well as to provide an opportunity for the team to explore and address any procedural questions. (4) *The PI then generated the next iteration of the model-in-progress* via the application of the principles of abduction (see “Methodological framework” section of the introduction). The revised model (including reasons for changes and requests for additional feedback) was then submitted for co-investigators’ review alongside the next round of session data.

This iterative process was repeated for each session of case material. Once all sessions had been reviewed, final phrasings of the statements capturing the study’s observations were refined over three additional co-investigator-reviewed iterations of the model; iterations were brought to a close upon the achievement of statements that met the independent validation of each of the six co-investigators.

**Results and Case Discussions**

Co-investigators independently gave each statement included in the final model a Likert rating of 6, suggesting that co-investigators experienced a high correspondence between the final formulations of each theoretical statement and the observed case data. Observations (see below) lent support to the hypothesis that increases in self- and other- understanding would follow similar pathways. In both the inter- and intrapersonal contexts, similar patterns of perception, cognition, emotion, intention, communication, and action were observed en-route to therapeutic change: problematic experiences became resolved as previously excluded aspects of experience came to be increasingly *included* (i.e., valued and influential) in meaning- and decision-making. These observations informed the elaboration of a previous version of the APES (Brinegar et al., 2006; Table 1) to explicitly extend its applicability to include the interpersonal realm, and supported the creation of a model that describes intra- and interpersonal therapeutic change. Patterns observed were encoded into the *resolution of problematic experiences sequence* (RoPES; see Table 3), which appears applicable to tracking intra- and interpersonal therapeutic change.
The primary result of theory-building case study research is a new iteration of a theory, evolved and refined in relation to case observations. Consistent with the prediction based on the systems theory principle of isomorphism, observations supported the elaboration of a single model to describe intra- and interpersonal therapeutic change. The following section presents the formulation of the theory that emerged out of this work; the section thereafter presents qualitative data that informed this work and shows how the theoretical lens resulting from this work makes sense of case observations. Following the presentation of case observations, the discussion highlights the theoretical elaborations that emerged as part of this work.

Final theoretical model

Below follows the final iteration of the theory that emerged from this work. Like the consolidated model assembled at the outset of the project (see Appendix A), this model consists of three sections: the model’s view of persons, the model’s conception of therapeutic change, and the resolution of problematic experiences sequence (or RoPES).

The model’s view of persons

I. The self:

a. The model holds that a person’s self can be described as a system of voices in interrelationship.

   Within this voice system, voices may be differentially influential in regards to meaning- and decision-making processes. Some voices are highly influential; others may not be included in an accepted sense of self, diminishing their direct influence in relevant meaning- and decision-making processes.

b. The model views an identity (an accepted sense of self) as consisting of a community of voices in interrelationship rather than as a monolithic unity.

II. Persons in interrelationship:

a. The sum of all voices in interrelated persons’ voice systems can also be described as a single system of voices (an interpersonal voice system).

b. The model refers to the voices within an interpersonal voice system that mutually include one another’s positions as an interpersonal voice community; this term is chosen to reflect that these voices’ mutual inclusion creates a sense of communal unity and “we-ness.”

III. Voices:

a. Have their origin in and are shaped by interlinked traces of related experiences
b. Represent people, events, and other constellations of experiences

c. Are triggered by *signs* (e.g., words, gestures, or images) and emerge when they are needed / addressed by circumstances that recall their formation

d. Are active and have feelings and motives as well as informational content

e. Take *positions* in relation to events, things, other people, and aspects of self

f. Seek to be *heard* when their positions are relevant to an active meaning- or decision-making process


g. Are linked to one another by shared understandings, or *meaning bridges*

h. Are *included* to varying degrees in influencing a voice community’s meaning- and decision-making processes.

*IV. Positions:*

a. Are stances a voice adopts in relation to events, things, other people, and aspects of self; these are positions an “I” takes in relation to an other.

b. Positions that are made interpersonally observable (e.g., voiced aloud in *intrapersonal dialogue*) are the observable manifestations of the positions of an internal voice.

c. Attending to the positions taken enables one to infer which intrapersonal voice(s) may be active.

d. Failure to include the positions of a voice in relation to relevant meaning- and decision-making processes indicates exclusion; this is true even if the exclusion is unintentional.

*IV. Intrapersonal dialogue:*

a. Is voiced by one person and is composed of alternating expressions of positions that may be directly contradictory.

*V. Problematic voices:*

a. Are voices that represent or trigger experiences that are psychologically threatening, painful, or traumatic.

b. What makes a voice problematic does not reside within the voice itself, but in how it positions a person with regard to self and/or others. A position is problematic when it is experienced as incompatible with positions taken by the voices that comprise a
person’s active accepted sense of self in relation to others.

c. Voices that are experienced as incompatible with the active accepted sense of self tend to become excluded to a degree that reflects their incompatibility; the more incompatible a voice’s positions are, the more it will be excluded. (E.g., a voice whose positions are particularly incompatible may appear to be unheard or ignored.)

VI. Meaning bridges:

a. Can be described as mutually-held positions and/or shared understandings

b. Consist of a set of interconnected signs (e.g., a phrase, story, theory, image) that have come to have the same meaning for each of the voices it connects

c. Connect voices through the common understanding that they enable, allowing them to empathize and communicate with one another, and to engage in joint action.

d. Meaning- and decision-making processes that reflect the lack of a meaning bridge / shared understanding indicate the presence of exclusion.

VII. Relationships between voices and communities:

a. Voices that are simultaneously active create interrelated traces of experience, and so tend to become mutually interlinked to one another into communities of voices.

b. The opposite is also true; that is to say, as one voice excludes another in meaning- and decision-making, voices (and/or voice communities) separate and differentiate from one another.

c. In relation to the community of focus, the voices representing experiences and voice communities may, on a continuum, be more or less included in influencing relevant decision and meaning making processes.

d. Voices that exclude other voices’ positions from having influence in relevant meaning- and decision-making processes can be described as dominant.

e. Voices that are dominant in a community enjoy the explicit or implicit support of a number of other voices; other voices’ perspectives might be “popularly” viewed as invalid, undesirable, or irrelevant. Finally, some voices may be completely ignored by the community, or may not even be recognized as being part of the community.

f. Failing to recognize part of a voice system as part of a voice community indicates the presence of exclusion.

g. Those voices whose positions are unilaterally viewed as irrelevant (i.e., are excluded) by a community make up the set of voices that long to be heard by (and included in)
that community’s meaning- and decision-making processes.

*The model’s conceptualization of therapeutic change*

1. Therapeutic change is observable by attending to changes in the relationships between intra- and interpersonal voices.

2. Therapeutic change occurs through (and is made possible by) dialogue between the voices whose positions are in conflict, and can be described as an observable progression in the qualities and outcomes of voices’ dialogues with one another.

3. This progression reflects a developmental process in the relationships between voices. The model divides this process into a number of identifiable patterns; these patterns reflect increases in involvement and understanding between voices.

4. Observable changes in this progression include changes in perception, cognition, emotion, intention, communication, and action; these indicate changes in meaning- and decision-making.

5. Changes are not necessarily sequential (patterns are sometimes skipped) or linear (voices can return to “earlier” patterns). Observations suggest that getting stuck in or returning to an earlier pattern is an indication that not all relevant voices feel like they have been (or will be) heard. Returning to “earlier” patterns seems particularly prevalent in subpatterns.

6. Voices in “earlier” patterns often shift their relationships in the direction of resolution more slowly than voices in “later” patterns; this is due to voices’ boundaries shifting towards greater permeability (i.e., greater openness) in relation to one another as the dialogical process progresses.

7. Although these patterns can apply to more than two voices at a time, the descriptions are always specific to the quality of the relationship between two voices.

8. These patterns reflect increasing levels of *inclusion*.

   a. Inclusion reflects the degree to which the positions of a voice are *valued* by a voice community, and reflects a community’s attitude towards a voice.

   The degree to which a voice is “valued” can range from seemingly not valued at all (pattern 0), to a spectrum ranging from negatively valued (e.g., patterns 1, 2) to highly valued (e.g., pattern 7).

   Notably, valuing and being curious about the positions of another voice are the conditions that make accurate recognition and empathic understanding possible.

   b. Inclusion is observable by attending to the degree a voice’s positions are influential in a community’s relevant meaning- and decision-making processes, as reflected in behavior
and inter- and intrapersonal dialogue.

c. This varies on a continuum from a voice being completely unheard (fully excluded) to being fully included in relevant dialogue, meaning-, and decision-making (see Table 1, below).

d. As voices are increasingly included, they become increasingly influential in relevant meaning- and decision-making processes, and fluidly transition in and out of activity to the degree that the experiences they represent are recalled by and relevant to the task at hand.

e. Included voices may remain or become psychologically distinct; for example, intrapersonal voices representing an important other (such as the voice of a parent or significant other) may remain or become distinctly recognizable.

f. *Intrapersonally*, inclusion describes the degree to which the positions of a voice are valued by the active sense of self and have influence in a person’s meaning- and decision-making processes.

g. *Interpersonally*, high inclusion represents (a) accurately imagining the positions of another person’s voices in relation to a matter at hand and (b) valuing these positions in one’s own meaning- and decision-making processes (as reflected in dialogue and behavior).

h. *Both inter- and intrapersonally*, inclusion indicates the experiential boundary of a voice community.

The experiential boundary of a community of voices undergoes revision in and through the intra- and interpersonal dialogues that make change possible.

This is observable in attending to which voices’ positions are valued/influential in a community of voices’ processes of meaning- and decision-making.

i. Intrapersonally, these experiential boundaries speak to identity, or what is or is not included within an accepted sense of self (i.e., what is seen as “me” or “I” vs. “not me” or “not I”).

ii. Interpersonally, these boundaries speak to the degree to which there is an experienced “we,” i.e., the degree to which there is a sense of shared experience and mutual inclusion of one another’s positions. (I.e., to what degree is there a sense of “we-ness” vs. the experience of two non-overlapping “I”s?)

The degree to which one includes the positions of another person’s voices in meaning- and decision-making processes provides insight into the degree to which another’s voices are included within one’s own community of voices.
In terms of groups of people, these boundaries also speak to the distinction between “we” or “us” and “they” or “them.”

The Resolution of Problematic Experiences Sequence (RoPES)

Key: **Bold** describes the state of a voice in relation to another voice’s positions / *italic bold* describes the relationship from the perspective of the other voice. A description of the pattern’s qualities follows in plain text.

0. **Unaware / unheard.** Awareness of a problem does not seem to exist. Voices whose positions would challenge this view are unheard or dissociated, and do not seem to influence relevant meaning- or decision-making processes. Affect may be minimal, reflecting effective exclusion of problematic positions. Conflict may become indicated by somatic symptoms, rapid changes in psychological state, or acting out.

1. **Active avoidance, suppression, redefinition / ignored.** Engaging in dialogue with a problematic voice (about a problematic experience) is overwhelmingly painful, and is avoided or suppressed; the other voice is seen as the cause of the problem. Interpersonally, this may be reflected in disengagement and/or non-verbal signs of discomfort. The problem may also be “explained away.” Affect involves unfocused negative feelings (esp. feelings of anxiety and/or depression); their connection with the content may be unclear.

2. **Vague awareness / not understood.** The voice of focus begins to recognize the existence of a problem, and can express a partial understanding of this, but cannot make sense of it. Progress through this state typically becomes accompanied by significant psychological pain (intense fear, sadness, anger, and/or disgust) in relation to the problematic experience. Emerging questions tend to embed accusations (e.g., “what is wrong with,” “how could,” “why would”) that blame the other voice and discourage exploration.

3. **Clarification / increasing recognition.** Voices engage one another in active discussion of their conflicting positions, differentiating and clarifying these such that increasingly refined statements of the problem-- something that can be worked on -- become formulated. As this process progresses, affect shifts from highly negative to manageable as stances shift from opposition towards collaboration. After the other’s hurt becomes experientially available, active curiosity and reflexivity emerge, making recognition possible.

**Observable subpatterns include:**

3.1 **Rapid cross-fire / disputed.** The other voice begins to assert positions, but is abruptly cut-off. Voices fight for possession of the floor, and speak for short periods of time with frequent interruptions.

3.3 **Listening / tolerated, listened-to.** The other voice demands to be heard, feels entitled to differentiate and assert positions, and speaks for longer periods of time; tone may be assertive, demanding, or angry.

3.5 **Attending / respected.** Voices are less defensive, more respectful of each other’s positions, and listen to each other without interrupting. Positions are less oppositional, and a broader range of affect is evident.

3.7 **Softening / opened towards.** The hurt associated with the other voice’s experience of the problem becomes experientially available; the voice of focus opens towards the other’s positions.

3.9 **Exploring / tentatively recognized.** Voices jointly struggle to understand the problem.
more clearly; the voice of focus is actively curious about the other’s positions, and
reflexivity emerges. Connections are made as awareness grows; approximations of insight
become evident. Voices’ positions begin to converge.

4. **Insight / empathically understood.** Voices experience a sense of shared understanding about
the problematic experience -- a meaning bridge has been created. Affect is likely to be
powerful, and may be mixed; there may be some unpleasant recognition of having
contributed to the problem, as well as some pleasant surprise: the problem is experienced as
resolvable.

5. **Working through / applied.** Voices work together to explore and apply implications of hard-
won insight towards problem resolution; alternate courses of action may be considered and
weighed against one another. Affect grows more consistently positive as tangible progress
toward a workable solution is achieved.

6. **Resolution / routinely consulted.** The once-problematic experience is resolved and has
become a resource, and the once-problematic voice is now routinely consulted in relevant
decision-making processes. Voices are flexibly included; some effort is still evident in this
process, however. Related affect is positive, satisfied, reflecting feelings of pride,
accomplishment.

7. **Mutual inclusion / mutually included.** The once-problematic voice is now fully trusted and
automatically included in meaning- and decision-making processes. Voices effortlessly
generalize solutions that are mutually supported. Affect is generally positive or neutral (i.e.,
this is no longer something to get excited about).

**Observations: Sarah and Mark**

Observations from the cases studied follow. This section presents observations from Sarah
and Mark’s therapy, and is dedicated to supporting the model's specific applicability to
interpersonal understanding, providing relevant observations in some detail. The next section
presents observations from Simone and Daniel’s therapy, and emphasizes supporting how
conflicting voices' positions can be tracked across the development of increased intra- and
interpersonal understandings.

Sarah and Mark, married for 12 years, sought counseling in an attempt to address an
emotional injury from an abortion decision that had been made more than 10 years earlier. At the
time of that decision, the couple had a one-year-old daughter and was about to embark on starting
a business. Mark insisted that the couple could not financially support another child, and
expressed the firm opinion that Sarah should have an abortion. Years later, Sarah told Mark that
she’d felt completely powerless to oppose him, and that she felt deeply betrayed by what she
experienced as a unilateral decision. As Sarah put it in the second session, “the abortion seems
to have been, like, Mark’s decision.”

Deeply intertwined with this issue was the fact that Sarah and Mark struggled with a
basic difference in how they approached the world: Mark tended to almost exclusively
emphasize logic in his decision-making; Sarah, on the other hand, placed a great deal of
emphasis on her own and others’ emotions. This mismatch led to a recurring problematic cycle:
Mark would ignore what he might refer to as non-rational context, leaving Sarah feeling
invalidated. This would frequently lead Sarah to attack Mark for his lack of understanding,
which, in turn, would lead Mark to defensively retreat to an intellectualized position, which resulted in Sarah feeling further invalidated, and so on.

Over the course of therapy, Mark took responsibility for having been forcefully insistent about his view; for her part, Sarah recognized that, although she had not been aware of it at the time, she had also played a part in the process. As a couple, both partners came to better understand the reasons for their own behavior, and learned how to engage in dialogue with one another in a way that respected the other’s experience. These changes, in turn, enabled the couple to heal the rift between them that the abortion decision had caused. The observations reported here (from sessions two, three, four, six, seven, 10, and 11) were selected because of their relevance to the abortion decision.

**Session two.**

*Sarah’s description of the problematic experience (RoPES 1).* As noted above, at the time of the abortion decision, Sarah did not feel like she had any say in the matter (“the abortion seems to have been… Mark’s decision”). A statement of Sarah’s from later in session 2 confirms this interpretation: “But at the time I don’t, didn’t feel that I had any options.” (For a discussion of this quote in the context of the therapeutic process, see the sub-section entitled “Sarah’s revelations and a return to rapid cross-fire” below.)

In describing Mark’s stance towards her at the time of the discussion, Sarah said he was “adamant;” she also angrily noted that Mark was “totally detached and cold… logical and cold, feeling-less, you know,” and that her sense of Mark’s reaction to her pain was “‘oh, I saw that you were upset, but I thought that you could get over it.’”

Each of these quotes reflecting Sarah’s memories of the problematic exchange suggests that, at the time of the abortion decision, Sarah experienced her positions as being ignored by Mark. In the language of the model, then, Sarah was experiencing her positions as being excluded from influence in Mark’s meaning- and decision-making processes.

Sarah’s experience of Mark’s retrospectively described behavior fits the description of RoPES stage 1, active avoidance, suppression, redefinition / ignored, where the first part of the description (in this case, active avoidance, suppression, redefinition) refers to the state of the voice of focus (in this case, one of Mark’s voices) in relation to another voices’ positions, while the second (in this case, ignored) describes the relationship from the perspective of the other voice (in this case, one of Sarah’s voices). (Later in the session, Mark would confirm this interpretation of his actions – a point that is highlight in the subsection entitled “Mark’s increasing intrapersonal recognition.”) Also consistent with RoPES stage 1, the source of the problem is defined as located outside the voice of focus; an observation consistent with this distinction is observed in Sarah’s initial problem statement (“the abortion seems to have been… Mark’s decision”).

*Sarah’s increasing intrapersonal awareness (RoPES 2).* The couple’s therapist, a female trainee, adopted a curious stance in response to Sarah’s description of the abortion decision in session 2.

Therapist: So it feels like ‘I didn’t have a choice and, and then, somehow’
Sarah: Not really, no. No. Well – I don’t know, I just, I felt just like, you know
Therapist: Do you remember when you had the conversation with Mark about the abortion?
Sarah: Oh yeah. Yeah.
Therapist: Okay, and do you remember, sort of, what was said?
Sarah: Yeah. Oh yeah! I remember going to that movie (Therapist: right), I remember the bar that we were in, talking about it. Remember? (Therapist: mm-hm) (Mark: mm-hm) Mm. Yeah, I rememb- I don’t remember, I don’t remember any specific (two-second pause) words, but I remember how adamant he was (Therapist: mm-hm) and (inhales) I remember how upset I was. (Therapist: right, yeah)
Therapist: And did you tell him at the time that you were upset? I mean
Sarah: Oh yeah. Well, he could see it, I didn’t think I had to verbalize, I’m sure I did, but (Therapist: mm-hm, mm-hm).

Sarah’s initial answer suggests that her understanding of the situation was beginning to shift. As Sarah reflected on her experience, her description of the situation became less certain. The trailing off of the last line quoted also suggests the introduction of uncertainty into her understanding of the situation (“Well, he could see it, I didn’t think I had to verbalize, I’m sure I did, but”). Such shifts in perception are consistent with the beginning of RoPES stage 2 (vague awareness). Sarah’s impressionistic recollection of the events, her inability to articulate “any specific -- words” that were spoken – that is, the vagueness of her memories – is also broadly consistent with RoPES 2.

An important aspect of this stage is that the positions of a voice associated with a problematic experience are not understood. The pain associated with this inability to understand Mark’s actions at the time of the decision became repeatedly expressed by Sarah. Earlier in the same session, for example, Sarah had plaintively asked “How could someone who you love do something that would hurt you?” The delivery of this question was loaded with a sense of blame towards Mark.

**Mark’s inability to understand Sarah’s response to the abortion decision (RoPES 2).** Curious about Mark’s experience of the exchange, the therapist asked for Mark’s understanding of Sarah’s reactions to the abortion decision.

Mark: Well, I knew she was upset about it (Therapist: yeah) but I didn’t know (Therapist: mm-hm) that she was - that she was – okay, I mean (...) yeah, I mean, (Therapist: yeah) [I knew] that, that, that she was upset that it [the abortion] was going to happen (Therapist: mm-hm) um, but, that’s different from being - um, so adamantly against it that she would say, ‘no I’m, - there’s got to be different, another way.’

In this passage, Mark appeared to be reporting that while he had been aware that Sarah had been upset, he had not understood that she was upset with how he had been interacting with her; instead, he experienced the cause of Sarah’s distress as external to himself and his behavior. Each of these qualities is consistent with RoPES 2 (vague awareness / not understood).
The couple begins to clarify their interpersonal positions (RoPES 3.1 & 3.3). This last statement of Mark’s immediately preceded a shift in the partner’s interactions. Prior to this comment, the partners’ conversation was generally funneled through and facilitated by the therapist. Immediately after this statement, however, the partners began a direct exchange between one another. In this exchange, each partner countered and implicitly and explicitly disputed the validity of the other’s understanding of the situation.

**Mark:** (…) That’s different from being - um, so adamantly against it, that she would say, ‘No I’m, - there’s got to be a different, another way.’ Whatever, I mean, (Therapist: mm-hm) so

**Sarah:** [Incredulous] But there wasn’t another, what was the other way?

**Mark:** Well, I’m, I’m just, well, like you said, you, okay, you said you didn’t feel so strong in the relationship that you could, you know, just had a baby, so if you ah, didn’t have the abortion and I was adamant about it, what would happen to our relationship. (Therapist: mm)

**Sarah:** [Angrily] Yeah, well, that’s a big thing.

**Mark:** Well, you never explored that.

In this exchange, both Sarah and Mark were actively advocating their view of the problem and disputing the other’s account of the situation in question; this is consistent with RoPES stage 3.1 (rapid cross-fire / disputed). (Another way of describing this sub-stage is that, in rapid cross-fire, both voices are fighting to be heard.)

In response to Mark’s last statement (“Well, you never explored that”), Sarah appeared to be both frustrated and taken aback by Mark’s position.

**Sarah:** [Challengingly] What do you mean?

**Mark:** Well, you didn’t say to me, okay if if, if it’s a, you know, that ‘I’m going to leave or, or, or I’m simply not going to have the abortion and you can, you know, decide what you want to do about it’ (two-second pause) I- I mean [trailing off in response to Sarah getting upset and the therapist’s response to this]

Sarah continued to listen to Mark as he stated his positions on the matter (“Well…”), positions that were clearly difficult for Sarah to hear (she became visibly upset as he continued). This kind of exchange is consistent with RoPES 3.3, listening / listened-to, tolerated. The couple’s therapist took note of the degree to which Sarah had become upset, however, and asked Sarah to talk about this.

**Therapist:** So wh- what’s happening, it seems like you’re trying to push down a lot, like when I just, I’ve been looking at you, you were, (Sarah: deep inhale) just, just let the tears come, let’s (10-second pause)

**Sarah:** (Deep inhale, crying) Well, now I feel like a, maybe the onus is b- being put back on me, that maybe, probably, I don’t know, if I’d done something, then I wouldn’t have had the, have had the abortion, but at the time I don’t, didn’t feel that I had any options. (Therapist: mm-hm) So I really am upset that, that I’m trying to be, be made to feel now that I did. (crying) (Therapist: right,
In this quote, Sarah asserted her positions while Mark listened; listening to Sarah required Mark to tolerate hearing Sarah assert a perspective that explicitly challenged his own without challenging her in response. This exchange, too, was consistent with RoPES 3.3, listening/listened-to, tolerated.

**Sarah’s revelations and a return to rapid cross-fire (RoPES 3.1).** Mark continued to assume this stance until Sarah made a statement he could not tolerate. The statement that triggered Mark led to another sequence of rapid cross-fire.

Sarah: What would I, could, what was I going to do? (Therapist: mm-hm) Like, ‘Okay, Mark I’m going to have this other baby without you, (Therapist: mm-hm) but we’re going to live in the same house, and you’ll still have your other son, but I guess you’ll just ignore this child that I’ve decided to have with, you know, that’s, you know, your child, but you’re not going to acknowledge it.’ (Therapist: right). Like wel- (Therapist: mm-hm)

Mark: [Highly frustrated] Well, I mean, you’re, but you’re playing out scenarios that were never even discussed! (Sarah takes a deep breath followed by a three-second pause) ‘Well, we’re going to live in this house, but you’re not going to ackno- (Therapist: right) I mean, I mean, you’re you’re

Sarah: So, yeah, but I’m saying, you didn’t come across that there was any option. (Two-second pause.) (Therapist: mm-hm)

Mark: Okay, so if there’s no option

Sarah: Because I didn’t play out a whole script, (Therapist: mm) (Mark: Okay,) you didn’t get it!

Mark: Okay, at the very least then, if, if it meant more to you than our relationship, then at, at the very least the option was [to talk about it].

Sarah: Oh, but you see, (Therapist: mm-hm) I had to make a choice. (Therapist: mm)

It bears noting that this re-emergence of rapid cross-fire seemed to erupt in response to Mark feeling like his perspective was being ignored (“you’re playing out scenarios that were never even discussed!”). Put another way, the degree to which Sarah was excluding his positions seems to have been too much for him to tolerate. This observation is consistent with the theoretical statement that voices want their positions to be included (i.e., valued and influential) in relevant meaning- and decision-making; it is also consistent with the statement that getting stuck in or returning to an earlier pattern is an indication that not all relevant voices feel like they have been (or will be) heard.

The therapist then intervened by asking Sarah what she had needed at the time.

Sarah: Oh, (8-second pause) I guess it would’ve been nice if we could have discussed options. (Therapist: mm-hm) you know, if it wasn’t so, you know, ‘there are no real options,’ basically, that’s the way I feel. My not mentioning to Mark (Therapist: mm-hm), ‘that’s the way I feel,’ mm, okay, so, it’s like me saying to you, you know, ‘I think this is green, and no matter what you say to me, it’s always going to be green. (Therapist: right) You could talk to me you can tell...
me all your stuff but it’s going to be green and that’s it.’

Here again, the couple was interacting in a way that is consistent with the description of RoPES stage 3.3, **listening / listened-to, tolerated**: Sarah was again asserting her point of view, and Mark was once again able to tolerate and listen to positions that challenged his own perspective.

**Mark’s increasing intrapersonal recognition (RoPES 3.5 – 3.9).** The therapist then refocused the couple’s attention on understanding Mark’s reactions, and asked Mark what happened for him when Sarah got upset.

    Therapist: Wh- what, I’m just wondering, like when you, sort of, see she’s- she is probably upset like at the time, right? (Mark: mm-hm) What happens for you when she’s upset? I know you say it’s hard for you to see that she’s hurt.

Mark’s response to this question did not initially address the question directly. Instead, he first described the couple’s interaction pattern in a way that seemed to be a statement of their typical roles (“she’s emotional… and I’m the one who’s… ‘cold and detached;’”), a way that was respectful (RoPES 3.5) of Sarah’s positions.

Undeterred, the therapist invited him to describe his internal experience again, demonstrating her continued active curiosity around the matter. This time, Mark provided a brief confirmation of the therapist’s earlier statement: “it bothers me,” he confirmed. The therapist then offered a tentative interpretation.

    Therapist: Yeah. And then [there’s] also that, you know, you don’t, sometimes you resent having to take on that role, and sometimes (Mark: right) you’d like to be able to be yourself and express what you’re feeling, and I guess, I’m trying to sort of get a sense of what is happening underneath sort of a, outward, like trying to keep things calm and and rational.

This demonstration of the therapist’s active curiosity and tentative recognition of Mark’s positions is consistent with (RoPES 3.9; exploring / tentatively recognized); after having his positions tentatively recognized (as indicated by Mark’s “right”), Mark acknowledged a function of his focus on logic.

    Mark: (…) obviously it’s a defense, I guess, in some ways it’s a defensive way of, of dealing with stuff, (Therapist: right, yeah) for sure.

The therapist remained actively curious throughout Mark’s answer, and offered Mark signs of tentative recognition (Therapist: “right, yeah”) – both of which are signs of RoPES 3.9. Perhaps as a result, Mark went on to report recognizing a transgenerational pattern.

    Mark: I mean, my father’s like the most, you know, reserved logical engineer. His father’s an engineer; logical, (Therapist: right, right) you know, I mean. And if you, if you lined up my son and me and my father and his father all together at
the same age, we’re indistinguishable, I mean, (Therapist: right) so, you know.

Although still not answering the therapist’s question directly, Mark’s having called attention to his family’s transgenerational pattern can be said to have reflected a respectful (RoPES 3.5 attending / respected) stance in relation to Sarah’s view of him as unemotional (albeit one that remains focused on an “objective,” intellectual understanding of the situation). Perhaps in response to the therapist’s ongoing active curiosity (RoPES 3.9), however, Mark then returned to the original question on his own.

Mark: And, so, I mean, h- how, how do I feel below the surface? (Therapist: right) - (takes deep breath) – uh,

Therapist: Well, actually don’t- what I want, ah, you know, just don’t think about it so much, right? (Mark: yeah) I just, I mean, like when you used to hear her, and you sort of see her sadness around what it was like, I guess I’m wondering what, just, what do you, what happens, yeah, physically, like do you feel anxious, do you feel...

Mark: Well sure, I mean at the ti- at the time, and even now, I mean (Therapist: mm-hm) anxiety, you know, some, some fear even of, of what’s going to happen to the relationship um, um, ah, (four-second pause) guilt, (Therapist: mm-hm) you know.

This response suggested Mark was opening towards (RoPES 3.7) a vulnerable part of himself that both he and Sarah reported was typically excluded from his meaning- and decision-making.

After briefly checking in with Sarah, the couple’s therapist returned the focus to exploring Mark’s understanding of his behavior.

Therapist: I think that, you know, we carry with us, the family stuff (Sarah: Oh yeah! Unintentionally, it’s there!) into other relationships. [You’ve said that] you come from a family where [focusing on logic is] the way you deal with, problems or emotions (...) maybe you could tell me a little bit more about that.

In the passage above, the therapist offered an invitation that included the modeling of a more self-empathic stance for Mark (a modeling that was reinforced by Sarah: “Oh yeah! Unintentionally, it’s there!”). Mark accepted this invitation.

Mark: Well, like when I was a kid, ah (Therapist: mm-hm) if I was in trouble I’d be the pleasing child (Therapist: mm-hm) trying to make light of it, um, be super accommodating. So, you know, I mean, in, in adult life, (Therapist: mm-hm, yeah) when I run into problems, I’m, you know, I try to; I’m not the sort of person who, when I get into a disagreement with someone - states their ground and says, ‘This is it’ like, (Therapist: mm-hm) you know. I’m like, you know, ‘Well, how can we resolve this’ and and so I’m sure it comes across as, um, (four-second pause) logical, because I don’t like, I don’t like confrontation. (Therapist: right) I mean I’m not at, you know, I mean, ah, I don’t like
aggressive behavior. I have a hard time dealing with, with it. And I think, so I think that in a lot of ways I was even more: cold and detached and firm.

Therapist: Sort of ‘I don’t want to get into telling her what I’
Mark: Because I didn’t want to- I wanted to avoid any possible, any (Therapist: mm-hm) chink in my armor would be seen as weakness, and (Therapist: right) they’d, and then I would be
Therapist: attacked somehow into (Mark: right) it, you know
Mark: So, I mean (Therapist: mm-hm) I’m sure that I (…) probably came across as more - cold and detached and firm.

In this passage, Mark began to explore and tentatively recognize (RoPES 3.9) the intrapersonal dynamics that led him to present himself as “cold, detached, and firm.” This tentative self-recognition did not represent an empathic understanding of Sarah’s emotional experience in relation to his behavior; it did, however, lead to increased understanding of his own behavior. (It also confirmed Sarah’s description of him at the time of the abortion discussion: she had described Mark as responding to her in a way that was “totally detached and cold… logical and cold, feeling-less, you know.”)

This process continued throughout the rest of the second session. In exploring other relevant context around the time of the decision, the couple indicated that, at the time, Mark had been preparing to start his own business. Both Sarah and Mark indicated that this was a move that had initially been jointly welcomed. The therapist then asked Mark if he remembered his initial reaction to the news that Sarah was pregnant.

Mark: (Two-second pause) No. (Therapist: mm-hm) I mean I, you know, I could conjecture.
Therapist: Yeah, was there a lot of fear around it at the time?
Mark: Oh sure, yeah, I mean, it must have just been like, oh my God, you know, I could feel, the plan [to start my own business] slipping through my hand, and ‘I’m going to become (Therapist: mm-hm) you know, like my neighbors’ and ugh! You know. (Therapist: mm-hm) I don’t know what. (S: coughing) I’m sure, of some, - I don’t know, yeah.
Therapist: Some, sorry, some- what? There must have been some fear? Is that what your saying?
Mark: Yeah, I mean, I-I’m sure, it was just (Therapist: mm-hm) like, you know, any, plans I had for where life was going to go (Therapist: mm-hm) were attached to the idea of starting the business and I’m sure that, that, - that I was in mortal fear of that, disappearing. (Therapist: mm-hm) For sure, I’m sure, I mean I, that! I remember (Therapist: mm-hm) it was like, you know, ‘no this, this just can’t happen.’

In these turns, Mark increasingly recognized how his own intrapersonal reactions led him to interact with Sarah in the way she’d described. At the end of the session, he was able to state this even more directly.

Therapist: It sounds like there was a lot of stuff that was going on that both of you weren't aware of in the decision-making process. That you didn't talk about
because there was the feeling of ‘this is a choice (Sarah: mm-hm) that has to be made’

Mark: I guess because of my (Therapist: right) reaction and, (Therapist: right) thinking that any discussion would, (Therapist: right) might lead to a decision that I was (Therapist: yeah) uncomfortable with, so, therefore, (Therapist: mm-hm) try to prevent all discussion.

In this turn, Mark openly recognized that he had, in fact, done his best to avoid any extended discussion of the abortion decision. In doing so, he confirmed another aspect of Sarah’s description of him at the time of the abortion discussion (Sarah: “the abortion seems to have been… Mark’s decision”), and indicated that he was beginning to take responsibility for his part in the emotional injury that existed between himself and Sarah. He had not yet, however, understood how much he had hurt Sarah as a result of excluding her from influencing his meaning- and decision-making.

Session three.

Sarah clarifies her experience of the problem while Mark attends (RoPES 3.5). At the beginning of session three, Sarah asked the therapist about the need to take responsibility for her own role in the decision-making process.

Sarah: Do I have to take ownership of the fact that, even though at the time I felt like I didn’t have much of a choice, and – the, I have to take ownership of my choice, that it means I did, it was my decision in the end, right?

The beginning of Sarah’s question implies a not fully welcomed recognition that, regardless of Mark’s actions, she might have responded differently, a position that also reflects an increasing regard for a point Mark had made (i.e., that she hadn’t shared her thoughts on the matter with him). Such a stance is consistent with RoPES 3.5 (attending / respected). It bears noting, however, that Mark’s position here, while true, was also obviously more than a little self-serving; as he admitted, he really hadn’t wanted to hear her perspective.

The last part of Sarah’s question suggests a tendency towards taking on too much responsibility for the decision, however (“it was my decision in the end, right”). This statement suggests that Sarah might have had a tendency towards excluding her own positions; this point would continue to become more salient in the therapeutic process. (The therapist, for her part, deflected the question.)

A bit farther into the session, Sarah returned to the process of clarifying why the experience continued to be painful for her.

Sarah: The whole ordeal is that, you know, his view of it, you know, to this day still is (two-second pause) different than what I wanted to happen. (Therapist: mm-hm) And I guess I just want to understand better why he would be, be so adamant with that (two-second pause) that was the right decision at the time or two years later and two minutes later, or today, whatever.

Therapist: Right. So, would you say that ‘it’s hard for me to forgive that you were so adamant about it?’
Sarah:  (Sigh) Yeah! There has been a point that, at the time there was just, you know; maybe Mark looks back and sees it differently, but I - there was no give. Like I said to him, since that - episode there has never been another instance in our life where he has been so adamant about it, like, you know, about any other major decision

Therapist:  Mm-hm, so (...) this is the one thing that stands out
Sarah:  Yeah, (Therapist: mm-hm) like, everything, well, yeah. I think, well, maybe I’ve changed since then and maybe the reason he doesn’t seem as adamant is because it’s more me than him.

In this exchange, Sarah’s statements suggest that Mark’s continued exclusion of her positions around the abortion decision was what was making the experience an “ordeal.” She also openly indicated that she still did not understand Mark’s responses to her, particularly in light of what she experienced as typical of him. Finally, the last statement quoted also shows an increased sense of her own responsibility in the matter (while again, perhaps, indicating a tendency to take on too much responsibility). Consistent with RoPES 3.5, each of these statements reflect a respect for, though not an empathic understanding of, Mark’s positions.

Shortly thereafter, with the help of the therapist’s ongoing active curiosity (RoPES 3.9), Sarah was able to further clarify what was problematic for her.

Therapist:  What does it mean to you that he was so adamant about the position and he hasn’t, and that’s not his personality, or that’s not, how you find him in your relationship
Sarah:  Well, I guess I’m just trying to understand why! With that he was so - adamant in other things (low talking) that happened he hasn’t been as adamant

With the benefit of the therapist’s tentative recognition of her positions, Sarah continued this exploration.

Therapist:  That’s hard to let go of. How could this person who supports and loves me
Sarah:  Exactly! It always comes back to that. (Therapist: mm-hm) how could, you know – like Mark is the kind of person who I’ll say ‘honey I want to, you know do this’ “we’ll if that’s what you want to do I think that’s great, if that’s what you want to do.” Mark’s never been like, held me back from anything! (Therapist: mm-hm) - but that one thing (two-second pause) so
Therapist:  (Three-second pause) Mm-hm, so when you think about it now, (Sarah: mm-hm) I mean I know that you’re trying to be reasonable and trying to, you know, not to lay blame, but how do you feel: with respect to that towards him. Do you feel angry? Do you feel hurt?
Sarah:  (Six-second pause) Um, well angry, hurt, deceived, yeah.
Therapist:  So what, what, you know, ‘I feel deceived that’ what? That you - ?
Sarah:  (Eight-second pause) Basically, if you really love someone you wouldn’t put them through that, if you saw that (sigh) - the person (Therapist: mm-hm) even of, prior to, during, after would be in so much pain. You just don’t do it. And, like, I’m not sure I can (voice cracks) forgive him for making me do it.
In this exchange, with the aid of the couple’s therapist, Sarah explored her experience of the implications of the abortion decision (RoPES 3.9) and came to the tentative recognition that she wasn’t sure she could forgive Mark.

Therapist: Mm-hm. Can you look at him and say that to him now? (Five-second pause) ‘I can’t forgive you for’ - right now
Sarah: (Three-second pause) Nope.
Therapist: So what happens then, when just now I asked you to look at him
Sarah: Well instead of, instead of getting angry and mad now I’m getting upset. (Crying) (Therapist: mm-hm) It’s easier to get angry and mad.
Therapist: Yeah, yeah, it covers up the hurt that’s underneath (Sarah: Yeah) and you realize it’s part of; (Sarah: sigh) can you say some more about what that anger is covering up inside
Sarah: (Three-second pause) I just wish he could, right now I just wish that he could experience what I experienced, (Therapist: mm-hm) (two-second pause) (sniffles) the whole process
Therapist: Mm-hm. So it’s like ‘I really need you to understand what it was like for me’
Sarah: Well yeah, (Therapist: mm-hm) like, I try to describe it but (sigh) (three-second pause) it’s not the same. (Sniffles) (Therapist: mm-hm)

This exploration process, then, led to a clear statement of the problem – Sarah needed Mark to understand her experience. En route to this problem statement, Sarah also clarified that she had a hard time expressing her concerns around being able to forgive Mark directly to him; Sarah’s difficulty directly expressing such concerns to Mark (and the reasons for this difficulty) would come to be explored in greater detail in session four (see below).

*Mark’s inability to understand (RoPES 3.5 interrupted by exclusion).* Throughout this exchange between Sarah and the therapist, Mark was respectfully attentive (RoPES 3.5), and Sarah’s words had clearly had an impact on him. The couple therapist invited Mark to share his reaction.

Therapist: Mm-hm, so what happens for you when you sort of, like, just right now! What’s happening?
Mark: (Sigh; four-second pause) I, I feel guilty, but I mean, it’s tempered by the fact that (two-second pause) like I said, you know, I feel guilty for the outcome, but not so much for the decision, like when she says
Therapist: Right now
Mark: When she says
Therapist: When you see her, that she’s
Mark: It upsets me for sure, I mean (two-second pause) but it’s such a; I’m so powerless to do anything. So it’s such a frustrating -
Therapist: Right, so it’s like ‘I just don’t know what to do (Mark: yeah) I see that you’re hurting and (…) ‘I feel like there’s nothing that I can do.’ (Mark: mm-hm)
[Turning to Sarah] I mean, given that we can’t, you know, sort of, change bodies around and have him really you know, experience exactly what you experience, I
think it’s important (...) to really go into sort of (...) what it was like for you.

With that, Sarah began to describe a number of thoughts she’d had since the abortion, focusing largely on what might have been if the two had gone through with the pregnancy. Mark remained respectfully attentive throughout.

The therapist then turned to Mark.

Therapist: What sort of happens for you, just, like, at a feeling level, when you hear her?
Mark: Like, it’s just it’s like crazy talk to me (Therapist: yeah) (...) I mean, what it comes down to, it basically is, ah, is, ah, it’s very hard for me to be (two-second pause) have an emotional (Therapist: right) response when someone talks like that because it’s just, it’s they’re speaking a foreign language.
Therapist: Mm-hm, it’s like ‘I can’t relate to it, it feels kind of like, I don’t know, ridiculous or something
Mark: Sure! It, it’s fantasy world, you know, like ‘oh you know it could have been this or it could have been that’

Therapist: Mm-hm, mm-hm. Okay, so what then happens for you [Sarah] when you hear this is his response?
Sarah: Well, like you know (laughs) if it was some statistical data! (Therapist: mm) I’m sure he would be more interested in that sort of thought (laughs)
Therapist: So you feel like
Sarah: Like I have to give him odds or numbers or something but you know, because [if] that’s not the case, then that’s just not the way it works. That’s just not the way it works.

Although Sarah made a joke in response, her delivery made it clear that this was bitter humor. The couple’s therapist encouraged Sarah to share her underlying reaction.

Therapist: Mm-hm, mm-hm. Okay, so what then happens for you [Sarah] when you hear this is his response?
Sarah: Well, like you know (laughs) if it was some statistical data! (Therapist: mm) I’m sure he would be more interested in that sort of thought (laughs)
Therapist: Mm-hm, mm-hm. Okay, so what then happens for you [Sarah] when you hear this is his response?
Sarah: Well, like you know (laughs) if it was some statistical data! (Therapist: mm) I’m sure he would be more interested in that sort of thought (laughs)
Sarah: Condescending, yeah.
Therapist: You feel sort of patronized a little bit
Sarah: Yeah, it’s like I’ve seen it, patronizing, yeah. It’s like ‘oh look the you know, the hysterical female, the emotional female, must be her hormones, you know blah blah blah’

Therapist: Right, right.

Throughout these turns, the couple’s therapist seemed to be trying to keep both members of the couple focused on a non-defensive discussion of the process between them (“So what’s the impact that has on you?”). Mark’s word suggestion along the way could be interpreted in a number of ways: as a brief indication that he was beginning to understand Sarah, as a sign of his perceived intellectual superiority, or, perhaps both.

Mark: I don’t actually say that.
Sarah: No, no. (Therapist: mm-hm) But that’s the impression, that’s, you know, the read between the lines.
Therapist: And so, does that get you sort of more frustrated, or angrier, or what?
Sarah: Well, yeah (Therapist: mm-hm) that’s sort of um – you know, um, what’s the word I’m thinking of? Uh, (sigh) you know, I feel I have a point, and I have a stand that I have, and, and that put me down kind of thing, it makes it seem like I’m being irrational, or my point of view isn’t, uh, um, right (Therapist: mm-hm) or – you know. If there’s me and him in conversation, then you know that that’s going to be the response. (Therapist: right right) Mark will say, you know, ‘Well we haven’t talked about it that much.’ Yeah, well, that’s part of the reason. (Therapist: mm-hm) When I know there’s not going to be any sympathetic ear or understanding – Sometimes, yes, like, Mark, you can’t fix it, but – you know, you can listen without being – condescending.

Therapist: Right. So part of, I guess, this is what you need from him: ‘I need you to listen.’
Sarah: But I don’t think I’m ever going to get that. (Therapist: mm-hm) I mean like (Therapist: right).

In these turns, Sarah can be said to have clarified that she had her own positions that she wanted to be heard (“I feel I have a point”), as well as what kept her from sharing her underlying positions with Mark (his tendency to devalue them and exclude them from his own meaning-making process; i.e., “When I know there’s not going to be any sympathetic ear or understanding”). Through confirming the interpretation offered by the therapist, Sarah offered Mark a statement about what she needed and how he could meet that need (“‘I need you to listen’”). Finally, Sarah also indicated that she was afraid that she might not be able to get that need met. Once again, Mark remained attentive throughout. The therapist then tentatively offered another way of looking at the problem.

Therapist: Maybe this is the impact of your [family of origin experiences]. (Sarah: yeah yeah) like there’s, I mean it has to do with you know, two different styles of, you know, being based on your upbringing and personalities (Sarah: yeah yeah) and um, and so you [Sarah] feel, I mean, underneath all that anger is a lot of hurt that it doesn’t feel like it’s somehow safe to be expressed because ‘what’s the point if it’s not going to be heard?’ And then, um, when you do
express something you [Mark] feel like it’s hard not to feel attacked, and you feel like you need to defend yourself, and then you feel like - frustrated ‘I can’t’ - like what’s the point,’ and you [Sarah] get angry again and then you [Mark] start to go rational and try to figure things out and - I guess the question to ask you [Mark] is, what would you need to feel less blamed in all of this?

Mark: (Eleven second pause) Hmm. I don’t even know if that’s necessarily an issue, like (Therapist: right ok) like, I mean, I’m willing to accept responsibility for it, I’m not saying that I don’t want to necessarily feel blame, I mean sure, (Therapist: right) it would be great if that went away, (Therapist: yeah I guess because) but on the other hand, what would be, what I would feel more relief from would be if there was some sort of getting beyond the point where we’re at now, where I mean, yes, I can understand, like, to sense we don’t talk about it, and we don’t talk about it because of the way that I am, there’s no disagreement I mean, (Therapist: mm-hmm) but on the other hand I don’t think its going happen by – putting up a front of being somewhat (Therapist: no no) not, so I mean, it’s really, it seems extremely complicated to me. (Sarah: Yeah.)

Mark’s response indicated an increasing recognition of the role his interaction style played in perpetuating the problem (“yes, I can understand… [that] we don’t talk about it because of the way I am”). It was also consistent with an approach to problem-solving that devalued emotional experience: put into other words, it was as if he’d said “it doesn’t matter if I feel blamed – what matters is that we keep having this problem, and I don’t want to just pretend it away – I want to fix it.” The couple’s therapist responded as follows.

Therapist: Well, I guess the thing is, is, that what I see is that, she [Sarah], in her frustration, you [Mark] feel blamed, and when you feel blamed, it’s hard for you to be empathic or understanding because you feel like you need to defend yourself; and also, I think when you see her upset, you feel anxious and just (Mark: yah) a little (Mark: I’m sorry yah) And, (Mark: [unintelligible]) I mean when you [Sarah] see someone I mean just that’s (Sarah, reacting to Mark, giggles) that’s defending himself, or you know, saying, ‘well I made the right decision at the time’ it’s really hard to open up - that I understand, I understand that. When you [Mark] feel anxious, it’s sort of hard for you, this is the way that you deal with, um, things that feel out of control, or emotional experience (Mark: right) in your family of origin, that was the issue, so it’s not, you know, to make you feel or say anything that you don’t mean, but it’s just more of a rather than trying to get you to be defensive, getting you to sort of hear what she’s saying, and having her feel comfortable enough and safe enough to feel like she can say it (Mark: mm) that’s sort of what we’re trying to get get past (Mark: right).

As indicated by Mark’s signals of agreement throughout, with this renewed attempt on the therapist’s part, Mark seemed to feel like his positions were reasonably well-recognized (at a
level probably best rated at RoPES 3.9 given what appear to be approximations of insight); he also seemed to take in the therapist’s point.

**Session four.**

**Sarah shares her fear of hurting the relationship (RoPES 3.9).** Sarah’s difficulty in expressing positions that implied a potential threat to the relationship emerged as salient in relation to the abortion decision (she didn’t explicitly share her positions with Mark) and again around her concerns around being able to forgive Mark (she couldn’t tell Mark she was angry at him). This difficulty became directly addressed in session four.

Sarah: I just feel like he, I feel like when I tell him this stuff how I feel it - it’s like tarnishing this relationship, you know, that we have had, or something (voice cracks) ‘I can’t believe you felt that way all these years that I didn’t know’ so it makes him like

Therapist: So what’s the sadness, then, when you say that?

Sarah: Well, ah, (crying) why can’t I just be me! Can I have this and not have to worry that it’s ruining our relationship?

Later in the session, Sarah returned to this point.

Sarah: I guess what I’m really wanting right now is I’m really wanting to just let stuff out (Therapist: mm-hm) and I’m really hoping that Mark is not over-analyzing it (Therapist: mm-hm) and, and just takes it for what it is (…) that’s part of the reason why I was thinking maybe I don’t want to do this. (Therapist: mm-hmm) it’s because I don’t want to (two-second pause) I don’t want to damage a, a good relationship (Therapist: mm-hmm) I want the relationship to go forward and I’m just doing this because I thought it would help, maybe it would help me more than it’s going to help you, Mark, in the end. But then I am the one who had the abortion, so (Mark: mm-hm) you know, so

Therapist: Can you tell him what this relationship means to you then?

Sarah: Everything is our relationship. (Seven second pause,) We’re planning out our future together now, what we’re going to do, and everything. I don’t want to ruin that (voice cracks).

Therapist: ‘I don’t see my life without you’

Sarah: (Crying) No!

In these very moving turns, Sarah made it explicitly clear that she recognized how difficult it might be for Mark to hear how much he’d hurt her (RoPES 3.9), and that, in preparation for this, she wanted him to know just how much she saw him and their relationship as essential parts of her life (“Everything! is our relationship!”). In the language of the model, Sarah was letting Mark know that he was included in her sense of self.
Session six.

Sarah tells Mark about the void, Mark softens and empathically understands (RoPES 3.7 through 4). Two sessions later, Sarah allowed herself to “let [the] stuff out.”

Therapist: Could you tell Mark a little bit about the void? And [to Mark] I just want you to listen, no judgment, and […]to try to put it in your own words, what you think she is feeling. And so [Sarah], can you tell him about the void?
Sarah: (Sigh) um (four second pause) well (two-second pause) sort of, imagine something that you think about everyday (two-second pause) but there is nothing that you can really, can do about it but (crying) it’s
Therapist: ‘So I think about it everyday,’ (Sarah: yeah) Mm-hm
Sarah: (Three-second pause) So
Therapist: Mm-hm, what’s happening for you?
Sarah: (Crying) It's harder than I thought. I thought maybe by not crying that [unintelliglible] (Therapist: mm-hm) [unintelliglible] this feeling would’ve been - but yeah, there’s a lot of pain. (Therapist: yeah)
Therapist: Mm-hm, [and] some frustration that it’s still there (Sarah: yeah) but I think, I don’t expect you; I'm not surprised, right, because you never really dealt with it, but you know, this is what we are trying to do now.
Sarah: I know, but I was equating (Therapist: yeah) dealing with not crying (Therapist: mm-hm) (four-second pause)

In other words, Sarah had been excluding her own feelings (positions) around the abortion, a response that had kept the experience from resolving.

Sarah: Well, because um, the void is just that, that sort of feeling, like, on a daily basis that, you know, to some degree, something is missing (Therapist: mm-hm) (two-second pause) that can't be filled (Therapist: mm-hm) really, truly. - And um, you know, feeling it affects - decisions you make, or the way you react in certain situations that are, I don't know
Therapist: So can you just like, ‘it’s sort of how I react.’
Sarah: Because yeah, it’s not tainted but (two-second pause) tempered by that feeling (two-second pause) you know you might just uh, like I know this is a very simplistic example but you know, just the fact that I get so upset quite often and [our daughter] always wants a friend over, and to me that is a constant reminder that she could have had a sibling but she didn't. (Therapist: yeah) So, obviously, that's not the appropriate reaction (…) but unfortunately it takes that very simple thing.
Therapist: Overreaction to the situation.
Sarah: Overreaction yeah, because uh (two-second pause) because of this ongoing feeling.

Sarah began to describe more of her experience. Clearly moved, Mark then began to show approximations of an empathic understanding of Sarah’s experience (RoPES 3.9).
Sarah: […] and I rehearse] what could I have done differently? What could I have said to Mark (Therapist: mm-hm) that would made the situation differently?

Mark: Even though there is nothing! Everyday you know the answer, (Sarah: yeah) you go through the (Sarah: doesn’t matter) ritual exercise everyday of of, almost re-living it, (Therapist: mm-hm) in a sense…it's not something that you forget about for a week or you know you, sometimes say ‘well you know, - well whatever’ I guess every time you think about it, you think of it in terms of regret, powerlessness, re-living the moment, what could I have done differently? (Therapist: mm-hm) So all the things that, it's a pretty, it's big in a sense that is not something that, you know like

Therapist: Are you saying that about what she is saying?

Mark: Yeah, I didn't really (Therapist: right) imagine that it was such a big thing. I mean, yeah, I know we are here, and we are here to deal with it, (Therapist: right) but somehow, I guess (…) even when I thought it was a big thing before, not a big thing like that! (Therapist: mm-hm) You know? A different kind of big thing. (Therapist: mm-hm) Big in a sense that, like the biggest thing, like this sort of, you know, those kind of - bigger-than-life regrets that people have, (Therapist: right) where they did something, whether it was an accident, (Therapist: mm-hm) or something happened to them. (Therapist: mm-hm) That kind of

Therapist: And do you realize that that's in that category for her?

Mark: (Three-second pause) Just now.

This exchange was first example of Mark expressing what appeared to be approaching an empathic understanding of Sarah’s hurt. When the therapist asked Mark to describe what he was feeling, after a 30-second pause, Mark responded that he felt:

Mark: Well, I guess a, kind of a powerlessness. (Ten second pause.) I feel like, kind of confused right now, (Therapist: mm-hm) just kind of, not really (two-second pause) so I don't know! Yeah shocked almost. I mean I guess (four-second pause) surprised of my own (two-second pause) misunderstanding but sort of lack of, of not really getting it before and then not (Sarah coughs) (four-second pause) not really (two-second pause) guess I just didn't - see the sadness of it because that wasn't what was

Therapist: being presented to you necessarily?

Mark: Yeah, yes.

Mark’s description of this experience indicated that seeing Sarah’s hurt had led him to open toward (RoPES 3.7; softening / opened towards) Sarah’s positions, enabling him to tentatively recognize (RoPES 3.9) and then empathically understand her experience. Consistent with RoPES 4 (insight / empathically understood), Mark’s affect was powerful and mixed, and was accompanied by a recognition of having contributed to the problem.

The therapist then shifted her focus on Sarah.

Therapist: Mm-hm, mm-hm. what is happening for you?
Sarah: Well, I'm trying to figure out what my role was in his misunderstanding. (Therapist: mm-hm)

Seeing Mark soften towards her appeared to lead Sarah to soften towards Mark as well; in the quote above, Sarah began to become reflexive, a move consistent with a shift to RoPES 3.9. The couple’s therapist, however, encouraged Sarah to continue to share more of her experience around the abortion decision directly with Mark.

Sarah: (Sighs) Well, yeah, uh, I feel that, I you know, your actions - were very contrary to, uh, your actions on many other things, that we’ve gone through, or whatever, you know, I, I see them somewhat, like, I know what you said originally, that, you know, this was all very new for you – you were just being a father for the first time, you were starting your career and everything, blah blah blah blah, but I see it all as very self-serving. And I think your choice not to see, I think your, I think you not seeing my pain, even though you say that now, you know, I think it was a choice for you; I think you made a choice not to see it. I think it was always there, I think you chose not to see it.

The therapist quickly interjected herself.

Therapist: So, okay, so I just, I’m going to try [to slow things down] because I think that, this is sort of- we get stuck here sometimes. […] Without getting into attack and defense mode[,] what happens for you [Mark] when you start to hear, some of what she’s saying?

Mark: Well, I think the reason that I didn’t see it as - pain, and sadness, was because I saw it as - anger and, blame, like, they [pain and sadness] were, so overwhelmingly rare, that it [anger] totally masked [them]

Therapist: So, what, in this moment, then, do you feel your walls going up?...

Mark: No, not really.

Therapist: Okay (three-second pause)

Mark: I mean, I’ve (Therapist: mm-hm) heard it (Therapist: right) before, I mean I know, that, now it’s tempered with this kind of, (Therapist: mm-hm) revelation that (two-second pause) so I mean I can understand how she could say, you know, it’s self-serving you did all these other things, you know, you just wanted to look at it this way, well, I could understand why she would think that that’s the case, I mean

Therapist: Can you tell her that you can understand why?

Mark: I could, I can totally see why you would think that - that I was totally harsh and, and didn’t, feel any empathy or sympathy or (Therapist: mm-hm) wasn’t there, I (three-second pause) you know, I

The couple’s therapist’s “Okay” seemed to suggest that she’d been taken off guard by how quickly Mark had seemingly begun to apply (RoPES 5; **working through** / **applied**) his new-found, hard-won understanding – an understanding that, while welcome, was bittersweet for Sarah, as she soon thereafter shared.
Sarah:  Um - (crying) Well, I just wish that we could have, that we shared this like, years ago (...)
Therapist:  So tell him, I need, I needed to, look at him and tell him, ‘I really needed’.
Sarah:  Well, I really needed you back then, Mark, (Therapist: mm-hm) but I’ll take now, as opposed to, nothing (sniffling).

Sarah continued to share long-unexpressed thoughts and feelings with Mark. Asked to comment on the process, Mark noted that he was “more comfortable with this” than the couple’s usual cycle.

Mark:  (…) at the beginning, when you said ‘okay, I want to delve into this’ I’m thinking ‘Oh my god, you know, am I ready for this?’… It’s going to be, you know, (Therapist: mm-hm) ‘you did this, you did this’ (Therapist: mm-hm) and it’s just, totally not what I (Therapist: mm-hm) expected.
Sarah:  It’s totally not what I want; I don’t like being the attacker (Therapist: yeah) and he being the, and that’s, when you describe it that way, it’s very (Therapist: yeah, but I don’t mean it like) right, I know! But it’s okay, I know what you’re saying, I know it’s true, (Therapist: right, mm-hm) but I’m just saying I don’t like the d-d-description. (Therapist: mm-hm) I mean, that’s certainly not something I aspire to in a relationship (Therapist: mm-hm) – And th-that it’s, like, uh, you know, as much as, I was scared that Mark wouldn’t like this part [seemingly referring to her more vulnerable side of herself], (Therapist: right) probably it’s obviously better than the being the defender part.
Therapist:  Mm-hm, so you’re, can you say that, that it’s like some kind of, what? Reassuring to hear you or, I mean, what is it that you’re, what is your experience of hearing her sadness then?
Mark:  (Three-second pause) Well, I guess I never imagined that I could feel - sympathy - to the attacker - part, of the equation, I mean, I can certainly feel sympathy, now to the, to the way you are now, and, how you are affected, and I can only, I can imagine how invalidating it was, because I can imagine what I would have said. I would have said ‘well, it’s all for the best’ but since then, I know that it’s just been like, totally the wrong thing, to have said at the time so but I understand how you, quickly, gave up (Therapist: [incomprehensible]) talking to me about it.

Here, Sarah and Mark each indicated that they share an empathic understanding (have created a meaning bridge) around the problematic cycle they’d been experiencing; in particular, each indicated recognizing how they have been contributing to the problem. Mark also reported recognizing that, in fact, there was something he could do to help in such situations.

Mark:  I’ve always (Therapist: mm-hm) thought there was nothing I could do, (Therapist: right) but now I suddenly realize that, all I had to do was not say things like ‘oh it’s for the best,’ you know, or ‘the child we have will be better off.’ All of the things that that I thought - I guess made me feel better about the decision (Therapist: mm-hm) made you feel, like you, couldn’t even talk
to me about it so, so although I thought it was, maybe worked for me (Therapist: mm-hm) I never really thought ‘oh what works for you’ I mean I guess I never really, I don’t know I guess I’m just shocked at how I (Therapist: mm-hm) completely – missed the boat on that [Sarah laughs].

Sarah: And I feel badly, like, I could see that you really feel badly that I, you know (three-second pause)

Mark: Well, yeah, because it’s such a small, such a small thing, I mean, I can’t take away all of the (Therapist: mm-hm) the, the, the pain and the sadness – (Therapist: mm-hm) but, if all I had to do was (two-second pause) validate her, feelings, then it – (Therapist: mm-hm) seems, I don’t want to use the word selfish, but, it wasn’t something done selfishly, it was just, ignorance, I guess. (Therapist: mm-hm) I just didn’t

Therapist: And I guess you’re sort of also, in saying that, ‘I can understand why you – feel like I, was selfish at times, or.’

Mark: Sure. (Therapist: mm-hm) – well, yeah, I mean, she’s used the word self-centered, so, (Therapist: mm-hm) I can understand why you would think that I was, self-centered around the whole thing because I (three-second pause) (Therapist: mm) (two-second pause) but I, to be honest I, it’s never, you know in all the time that we’ve been coming and we’ve talked about this, none of it’s ever really made any sense to me (Therapist: mm-hm) and now for the very time it’s all (four-second pause)

Sarah: Well, what happened today that made it make sense? (Therapist: mm-hm) what did I say differently? (Three-second pause) Or maybe I didn’t say anything differently?

Mark: Just the way that, you explained that it how it made you feel sad, and you carried the sadness with you every day and it, it affected, you know it was, it was this thing that you, regret, feel powerless all of those things, and it wasn’t about – how, I forced you to, like, the - my usual way of dealing with it is, you know, I forced you into the making the decision, it was an immoral one, you’ve had a hard time with it, um, but mostly because, you’re angry at me for making the decision. Those things are totally different from – feeling sad; being angry and being sad are two things that, to me, are separate. (Therapist: mm-hm) So I didn’t see you as, sad or, it was angry about it. (Therapist: mm-hm) So now I see you as sad about it, and the anger is just, the ab- If you had been able, if we had been able to talk about it, and I hadn’t, um (two-second pause) negated your your – your, feelings about it, (Sarah: then it wouldn’t) then it wouldn’t have transferred into anger and (Sarah sighs) So I see my role in it as different than just being (Therapist: the recipient of the anger) the decision. (Therapist: mm-hm) (…) To me it’s always been the decision that was sort of the, the biggest thing that I did to make it impossible for you to get over it, where as now it’s, it’s (…) how (two-second pause) I guess unsympathetic I was, so, and not that I didn’t (Therapist: mm, so what) not that I didn’t feel sympathy, but just, my inability to express, sympathy in a way that was, helpful to you at all.
The above turns indicate the depth of Mark’s newfound understanding and his ability to apply this. Mark’s clarification of the role of being able to see Sarah’s hurt and pain as instrumental in leading to this is also consistent with RoPES 3.7 (softening).

Sarah’s response to developing a shared understanding (meaning bridge) with Mark (RoPES 4).

Therapist: Mm-hm, well, what, what happens when you hear him?
Sarah: Well, I feel, a sense of relief.
Therapist: Mm-hm, can you tell him, like, what you’re relieved ab-, I’m relieved, or, feel?
Sarah: Well, just, that – (sighs) so, now I can talk to you, and that you won’t say those things again. (Therapist: mm-hm) I mean, I can hear the, logical reasons as to why, it [the abortion] was a good thing (Therapist: mm-hm) – which, like you said, never, really, helped, me – it would help you, but it didn’t help me. (Therapist: mm-hm) So that now, if I want to discuss it with you, and not necessarily, not necessarily [to] say that I’m going to want to discuss it with you, (Mark: mm-hm) but so you know that if I do, that hopefully you will remember that (Mark: mm-hm) and we can just discuss it from the standpoint of, just feeling sad today because (Therapist: mm) whatever.

In this passage, Sarah let Mark know how much it meant to her to have him include her positions in his meaning- and decision-making; these comments also suggest that having her positions included by Mark was leading to feelings of the problem between them becoming resolved. Sarah also indicated how she’d like to see him apply (RoPES 5) his new understanding. With the therapist’s encouragement, she continued in this vein.

Therapist: What else, comes up? What’s happening in just, the focus on your body?
Sarah: (Three-second pause) Well – like a load has been (Therapist: mm-hm) maybe shared, you know, not just carried by me.
Therapist: Mm-hm, (two-second pause) feels, can you tell him like you’re sharing, the load?
Sarah: You can’t begin to understand the sadness and the guilt, or maybe you don’t think it’s appropriate or, I guess not. Now the issue, the issue is that it exists and you know, it’s (Therapist: mm-hm) so it’s well it’s helpful if you, you know, that he could be there for me. That would be good.
Therapist: Yeah, can you tell him, ‘I need you to be there for me’?
Sarah: Yeah
Therapist: Look at him
Sarah: (Crying) So I don’t I feel so alone.
Mark: (Sighs) I’m sorry I haven’t been, all this time.
Sarah: (Three-second pause) I’m sorry too. (Slight laugh.)

Exploring how Mark might apply this understanding to help her not feel alone, the therapist asked Sarah how she would know that he was acknowledging her pain.
Sarah: Well, like maybe holding my hand or something right? (Therapist: mm-hm) so that I would know that he knows (crying).

Therapist: Mm-hm. It’s really important for you to feel, for you to feel like he knows how hard it’s been for you (Sarah: yup) and how you have been carrying this.

Sarah: Mm-hm (crying) and not to devalue it now that he understands it, (Therapist: yeah) you know? (Therapist: mm-hm, yeah) (Crying) That it’s legitimate.

Therapist: Yeah, but say that to him then.

Sarah: Well, you know - you know, now that you know or understand better that perhaps we could you know, use this to go forward and not feel so alone in this issue, when instances arise when it comes up that you know, I can count on you being there in this new way not in the old way (three-second pause) (inhales) It may never come up again, or it may, I don’t know. I can’t think of it never coming up again (Therapist: mm-hm) but (crying) I’m feeling closer about it – because I think in the past, I know the reason why we have avoided it is because it’s always been this thing that’s pulled us apart as opposed to you know, bring us together. (Therapist: right) So hopefully we can turn in around so that even though it was a negative experience it can still have a positive effect on the relationship.

Therapist: Sort of like, as good as the relationship has been, this is something you feel has been between you?

Sarah: It’s always been there, yeah.

Therapist: And it seems like, right now, ‘I’m feeling closer to you.’

Sarah: Mm-hm. (heavy breathing)

Sarah’s statements in these turns continued to reinforce how important it was to her to feel included by Mark, and that Mark’s increasing inclusion had led to an increased sense of interpersonal closeness.

**Session 7: Applying new shared understandings to the everyday (RoPES 5).**

Predictably, the process of applying (RoPES 5) these new shared understandings to everyday situations did not unfold seamlessly. At first, aspects of their interactions would go wrong, re-triggering their problematic cycle. Sarah was the first to recognize that this process was difficult for her.

Sarah: I'm adjusting to the invalidating feeling that Mark may not – in- intentionally make me feel, by- by the way sometimes he reacts to things I say with words or body language that I, that; That's one of my (Therapist: mm-hm) triggers for getting angry, (Therapist: right, okay) and that's something I'm working on.

Mark also admitted struggling to keep their new understandings in mind when Sarah would get triggered.

Mark: The hurt and the sadness just flow so quickly into the anger that I don’t even see it happening, like, I’m not even conscious of it, (Therapist: right) it just
happens like that - automatically.

And when this happened, he also got triggered.

Mark: It's a two way street, but you know, this idea that it’s not her, it's all me, (Therapist: mm-hm) of course I get defensive! And- and this is usually the point where, you know, the conversation's over, because you know, where do you go from here [seemingly referring to the problematic cycle].

When the couple’s problematic cycle did unfold, however, they now talked about it. In addition, Mark began to explicitly talk about his own feelings, as well as how their interactions affected him – something both of them had to get used to.

Mark: (Laughs) It's my turn to explain how I feel, you know?
Sarah: Huh?
Mark: It's my turn to explain how I feel about what you're saying.

Mark’s laugh seemed to suggest that this new way was still somewhat odd for him, and Sarah’s reaction also reflected a sense of not having anticipated Mark’s new response style. In addition, Mark’s attempts to share his feelings were sometimes experienced by Sarah (sometimes fairly, sometimes not) as a rejection of her positions.

Session 10: Early signs of resolution (RoPES 6). The couple’s continued efforts showed signs of paying off by session 10, however.

Mark: I [was] able to get beyond the defensiveness (Therapist: mm-hm) because I didn’t feel defensive, I felt sympathetic, and, and (Therapist: right) we were trying to work through it. So, for the first time, even though you [Sarah] were very angry, (Therapist: mm-hm) I was able to - step outside of my defensive self. And, and we were able to (Sarah: but) talk, (Sarah: I, I) and, and I felt that it was extremely good for both of us.

Sarah: I, also, was able to step outside my angry self, (Mark: exactly, you were) (Therapist: yeah) even though I was still angry when I was talking to you, but I (Mark: that, no, of course, like) I don’t think you got the impression that I was angry at you, (Mark: yeah) like.

Mark: Well, ten minutes later we were talking - calm, cool and collected - and you were sharing how you felt.

Session 11: Termination with resolution (RoPES 6). At termination, both partners’ reports were consistent with RoPES 6 (resolution / routinely consulted): although effort was still evident, exploration of the problematic experience of the abortion decision had led to a shared understanding that had become a resource. Both partners spoke of this with a sense of accomplishment and pride.

Sarah: Because I'm conscious of the difference between anger and hurt and (Therapist: mm-hm) you know, and how it can switch in me - (Therapist:
right) become the other, at least to the outside world, right? I try to tell people now that I'm hurt (Therapist: mm-hm) before it comes out as anger (…) I'm finding that it's working better not only with Mark, but with all relationships.

Mark also indicated that things were different.

Mark: Now we seem to be at a point where we can immediately start discussing what the problem is and how it, I mean - I think that’s one of the (Therapist: yeah) biggest things we’ve accomplished, is (Sarah: yeah) you can be angry and I don’t, sort of, stifle my reaction (Sarah: uh-huh) thinking it’s going to escalate into this huge fight. I can diffuse it by saying ‘Well, you know, that’s that’s not fair’ or whatever and you’re much (three-second pause) I mean it’s funny, the whole issue of – um, the, like, that her emotions are bad or feelings are invalid is tied hand-in-hand with the fact that my reactions are also valid, right?

In other words, the couple’s mutual understanding had been applied, and had served as a resource that led to new strengths – each partner had become more inclusive of one another’s positions – and their own. As a result of this, Mark seemed to be erring on the side of deciding to include references to his emotions in his conversations with Sarah. For example, Mark shared that

I’ve always cared what you think about (sigh) me. So when you are critical it really hurts.

For her part, Sarah acknowledged that

Sometimes I'm not very good at communicating my concerns. I think they come across (two-second pause) (sigh) if I don't get them out they eat away in me inside (…) so I get them out and they come across - I think they mostly come across as criticisms.

Mark also noted that

I think the whole process (…) of being defensive was to avoid further conflict (…) but the ultimate irony in this whole thing seems to be that - if I'm not defensive and I actually [state my positions], it actually (Therapist: mm-hm) produces a dialogue that that works to resolve it. So (…) I don't think I'll be going back to the defensive (Therapist: right) part anytime soon (…) It seems like the benefits of not being defensive are, have become immediately apparent (Therapist: right) and (Therapist: mm-hm) has worked wonders in terms of helping us resolve conflict.

Sarah also shared an ongoing need.
I need to feel, I need to see, I need to see an emotional response at times (…) that indicates that you're moved by, or motivated by, or you care! It, to me, it symbolizes [that] you care (…) that I'm not experiencing whatever this is all by myself.

Turning to the therapist, Mark shared that “I think the whole experience has been quite good for such huge, um, you know, steps in our - in our lives” – a statement that reflected a clear sense of the couple as an us, a “we.” This “we-ness” also appeared to enable both partners to feel safe differentiating their own unique positions.

Mark: Well, like, like Sarah said, you know, um, we don’t have to have a logical (Therapist: right) um, you know, solution to everything - sometimes we’ll just choose to (Therapist: right) disagree.

Therapist: Yeah, so that’s more of your comfort with disagreeing. Doesn’t mean the relationship’s going to end, right?

Mark: Right, yeah. (laughs)

Discussion of observations from Sarah and Mark’s case

Through the dialogues facilitated in couple therapy, Sarah and Mark came to increasingly value aspects of their own and their significant other’s experiences related to the abortion decision. This process led to the resolution of the problematic experience, and to changes in each partner’s sense of self-in-relationship with their significant other. Sarah became aware that she had not been sharing her more vulnerable side with Mark for fear of this creating relational difficulties, and how this stance had actually contributed to problems in their relationship; Mark became aware of how focusing on what he deemed to be logical (with the intent of avoiding problems) devalued Sarah’s emotional experiences had led Sarah to feel ignored and uncared-for, creating significant problems in (and threatening the stability of) their relationship.

This process also led to changes in each partner’s sense of self: Sarah came to increasingly value her more vulnerable side and her need to set boundaries that protect that part of herself; as a result, at the end of therapy she reported that this part of herself had become more influential in her meaning- and decision-making, and was now explicitly represented in her interactions with others (“I try to tell people now that I'm hurt…before it comes out as anger… I'm finding that it's working better not only with Mark, but with all relationships”). Similarly, Mark came to realize that his own emotions were also valuable (“I mean it’s funny, the whole issue of – um, the, like, that her emotions are bad or feelings are invalid is tied hand-in-hand with the fact that my reactions are also valid, right?”).

In addition, this process also led to changes in each partner’s sense of (and representations of) the other. Mark came to realize that Sarah was deeply hurt – something he’d not previously been able to see (in part because she’d not been allowing herself to share it). (Mark: “I just didn't - see the sadness of it because that wasn't what was” Therapist: “being presented to you necessarily?” Mark: “Yeah, yes.”) Once Sarah did explicitly share her hurt, she began to realize that Mark cared deeply about her pain, and no longer saw him as uncaring and unfeeling (Sarah: “he understands”).

In summary, the progressive inclusion of their own previously-excluded positions (i.e., positions that were not valued as an accepted part of themselves, and were therefore “not me” or
“other”) coincided with changes in the boundaries of what each considered to be part of their accepted sense of self (i.e., included in their community of voices). Similarly, the progressive inclusion of the positions of their significant other resulted in a shift in each partner’s sense of the other and an increased sense of interpersonal closeness (Therapist: “I’m feeling closer to you” Sarah: “Hm-hm”) and we-ness (Mark: “we don’t have to have a logical… solution to everything”), a we-ness that is strong enough to allow for disagreement between voices (“sometimes we’ll just choose to…disagree”).

Throughout this process, it was the facilitation of dialogue between voices whose positions were in conflict that led to therapeutic change. On the way to the resolution of the pain associated with the abortion decision, the patterns of interaction in their relationship progressed such that the qualities and outcomes the dialogues each had with one another and “other” parts of themselves improved in an observable way that was consistent with the patterns encoded in the RoPES.

Observations: Simone and Daniel

When they entered therapy, Simone and Daniel had a three-year old son and were common-law spouses who had been living together for over ten years. Four years earlier, while the couple was trying to conceive, Daniel had engaged in an affair, an affair that Simone became aware of by inadvertently hearing Daniel picking up a telephone message from his mistress. Daniel immediately indicated that he wanted to repair the relationship, and ended the affair. (“I wanted to be with her, there was no question in my mind.”) Although distraught, Simone agreed. Despite several prior courses of couple therapy together, however, Daniel’s affair had remained an active, unresolved problematic experience.

Observations from Simone and Daniel’s case are used to support how voices' positions can be tracked across the development of increased intra- and interpersonal understandings, and to illustrate how to attend to conflicting voices’ positions over the course of the development of such understandings. Different font formatting styles (e.g., italics, bold italics, bold, bold underline) are used to identify and differentiate Simone’s and Daniel’s voices' positions en route to their increased understandings of self and other. Representations of others’ positions will be identified using the same formatting as when spoken by the original voice. The observations from sessions one, four, five, and 11 reported here were selected to present the points marking developmental shifts in the relationships between voices related to the affair, the problematic experience that had brought the couple into therapy.

Session one.

Simone’s inability to understand Daniel’s decision to have an affair (RoPES 2).

Inferring the presence of intrapersonal voices by attending to the positions being taken (where each distinct position is taken to imply the presence of an intrapersonal voice), two intrapersonal voices were observed in Simone’s retrospective description of the couple’s relationship at the time of the affair. (The more-included voice is italicized; the less-included [i.e., “other”] intrapersonal voice is indicated by boldface italics):

Simone:  

We had been [living together for several years] and I was sort of feeling that, I wanted to sort of move forward in our relationship, and I knew I wanted to
have kids, and I knew, you know, given my age - I was ready, and, (deep breath) you know, he, said he was ready. (Therapist: mm-hm) (...) I mean, at the time, I mean, even before that, I never felt like (deep breath) we had a-a-a problem relationship; I knew we had issues, but I always, I never felt like

Therapist: So you felt things were going along well
Simone: Yeah! Yeah! And I thought; I had no doubts that I’d even; I thought we’d be together forever (Therapist: Uh-huh.)

Simone had only a vague awareness of Daniel’s positions at the time of the affair (RoPES pattern 2; see Table 3): she had only begun to recognize the existence of problems in their relationship. Sensing Simone’s struggle to make sense of Daniel’s actions, their therapist tentatively voiced an unstated aspect of Simone’s experience. (Recall that representations of others’ positions will be identified using the same formatting as when spoken by the original voice.)

Therapist: And, now; now: there’s a feeling still of ‘how could he have done it then,’ (S: mm-hm) as well as the feeling of (two-second pause) hurt
Simone: Yup, yup.

Seen through the lens provided by the RoPES, Simone had only had a vague awareness (RoPES 2; see Table 2) of problems in their relationship at the time of the affair (“I never felt like we had a-a-a problem relationship; I knew we had issues, but I always, I never felt like...”). In keeping with the description of RoPES 2, Simone had not understood what could have led Daniel to act the way he did. In keeping with the description of RoPES pattern 2, Simone’s response confirmed emerging questions that embedded accusations of blame (“how could he have done it”). In addition, this state is accompanied by psychological pain (“the feeling of hurt”). Throughout this process, Daniel looked like he’d much rather be somewhere else.

Simone then attempted to describe Daniel’s experience at the time of the affair, and became increasingly aware that her understanding was incomplete. (To clearly differentiate Daniel’s positions from Simone’s, Daniel’s positions are indicated by underlined formatting.)

Simone: I used to really lean on him emotionally, and confide in him about stuff that was going on with me, and - - he didn’t feel he could do the same. He wasn’t getting, the emotional (deep breath) he couldn’t tell- he didn’t feel like (two second pause) like, what did you say, like, one time I told you you were my rock, and you tell him, about that

Consistent with RoPES pattern 2, Simone was able to express a partial understanding of positions that had led Daniel to have an affair, but couldn’t make sense of or understand them (“he couldn’t tell- he didn’t feel like”). Simone then invited interpersonal clarification.

Daniel’s clarification of what led him to hide his more vulnerable side (RoPES 3).
Daniel accepted this invitation, and began to clarify his positions.

Daniel: She told me that I was her rock, (Therapist: Right, right) and to me it felt like (two second pause) it meant to me that I couldn’t be vulnerable to her, (Therapist: Alright) that I was steady, and I couldn’t show you any
weaknesses, couldn’t tell her how I felt, my vulnerabilities, uncertainties and problems, you know, if I was feeling hurt, and, I’ve got to be, ah

Therapist: Mr. Strong.
Daniel: Mr. Gladiator. Always strong, always positive spin on everything.
Therapist: Yeah, you couldn’t really be you, (Daniel: Right) or somehow you had to feel more closed so that she wasn’t really close to the real you!
Daniel: Right!

In these turns, Daniel clarified (RoPES 3) that he had been excluding his own positions based on his interpretation of what Simone needed from him (i.e., how he would have to present himself in order to be “her rock”). In other words, Daniel had been excluding his own positions in deference to his intrapersonal representation of Simone’s. Daniel’s vocal tone conveyed that this had been a painful experience for him. Simone leaned away from Daniel and looked uncomfortable as he shared this; this was difficult for her to hear.

Consistent with the theoretical suggestion that inclusion leads to feelings of communal unity, or “we-ness,” whereas exclusion leads to a sense of separation between voices, Daniel’s sense that he had to exclude his own positions created distance between the couple (T: “you [were] more closed so that she wasn’t…close to the real you” D: “Right!”).

**Daniel demands to be heard by Simone (RoPES 3.3).** Later in the session, Daniel described continued difficulty in his attempts to connect with Simone.

Daniel: Since the affair, I’ve really made an effort to communicate to Simone when I’m feeling sad! Or in trouble! Or have issues! (Therapist: Right) And I don’t feel I’ve gotten the support that I’ve needed from her, And we’ve had a series of discussions, saying, “so, when I come home from work, and I’m complaining about something at work, right. (Therapist: Yeah, yeah) what I need from you, occasionally, is support! Not! Any sort of logic! Or definitely don’t need for you to tell me that I’m wrong!”

In this passage, Daniel began to re-demand that his need for emotional support be met while both the therapist and Simone were listening (RoPES 3.3). Daniel’ frustration at not receiving the support he has been asking for supports the assertion that voices want their positions to be included in relevant decision-making, and the pain his words convey reinforces the point that having one’s positions excluded is a psychologically painful experience. Daniel’s narrative also illustrates another explanatory observation made during this study, namely that getting stuck in or returning to an earlier RoPES pattern is an indication that not all relevant voices feel like they have been (or will be) heard (“And we’ve had a series of discussions, saying...”).

**Simone’s respectful acknowledgement of Daniel’s positions (RoPES 3.5).** While hearing this was visibly difficult for Simone, her response was not defensive. Instead, her response acknowledged a need to include Daniel’s positions in her decision-making:

Simone: I think, I think he's, um, um, h-he's right! I think that's something I have to work on. But I'm, (Therapist: mm-hm) much more, I'm trying to be conscious
of, like, it’s almost like, it’s like, being aware of it and thinking through about how I’m going to react to something. Um, I’d say I’m more aware then I was; because something happened recently, and after it – um, you know, he was saying “Oh, you know, you didn’t support me, and I was really upset and hurt” and I thought ‘Oh God, he’s right, I shouldn’t have said that.’

Indicating that she had been becoming aware of how the way she was interacting with Daniel was affecting him, Simone’s response was respectful of Daniel’s positions (RoPES 3.5), even if she wasn’t quite able to include them in her ongoing meaning- and decision-making processes.

**Simone clarifies her reaction to the affair (RoPES 3.1 – 3.3).** When Simone described the emotional impact of the affair, another voice (boldface) joined the conversation.

Simone:  

I wasn’t pregnant at the time when the affair started, so I have a lot of anger around that; I really feel like, um, you know, ah (two second pause; deep sigh) You know? **There was - there was a point at which, we- we may have n-not gone down this road together,** and I would [likely to] have had an opportunity to have a choice in some ways, like, I feel like, you know, **I love him but there’s times when I think, you know, I’m-I’m here partly because I want (two second pause; sigh) I want a family and I want a family to work, and we have a child together** (Therapist: mm-hm) and I and I and I want, **I’m not going to deny that that’s not part of it** (Therapist: uh-huh) you know, and I sort of feel like, you know, **I would have, at least, I might’ve chosen to stick with him and work it out, or not, but I wasn’t given that choice.**

Simone was clarifying (RoPES pattern 3) that Daniel had not only excluded her positions in decisions that were directly relevant to her own well-being, but that, in so doing, he had also made it impossible for her to meaningfully include her own positions in her decision-making processes. Consistent with the theory, Simone experienced this as extremely problematic (“**I have a lot of anger around that**”). Consistent with RoPES pattern 3.1, voices were only able to speak for short periods of time before getting interrupted, and two voices were taking diametrically opposed positions with one another ("**I might’ve chosen to stick with him and work it out, or not**").

The therapist then tentatively offered his sense of Simone’s positions to see if his understanding was accurate.

Therapist: So what’s burning is this issue that – **“he was having an affair before we got pregnant”**

Simone:  **Right.**

Therapist:  And somehow (two-second pause) **he lied and you found out about it later, it’s that it was going on at the time it went on** (Simone: Right!) **that’s the most upsetting to you. (Simone: Right.)** I understand.
Simone: **Right!** Yeah, like, I mean, **just really really selfish, like, really not, um, thinking at all about me. At all!**

Consistent with the theory’s proposition that experiencing an exclusion of relevant positions leads to psychological pain, Simone was deeply upset and hurt by the affair. In addition, consistent with the theory’s suggestion that therapeutic progress is made when relevant voices’ positions are included in meaning- and decision-making, the therapist’s **active curiosity** about and **tentative recognition** of (RoPES pattern 3.9) one of Simone’s voices’ positions seems to have helped that voice progress from RoPES pattern 3.1 to signs of the emergence of RoPES pattern 3.3, where a once-excluded voice begins to differentiate and assert positions, and to speak for longer periods of time (“just really really selfish...”).

**Simone further clarifies her experience (RoPES 3.5).** The therapist continued demonstrating his active curiosity about Simone’s positions, and asked her about the affair’s continuing impact. In response (as seen in the following quote), Simone began to more closely attend to the details of her experience and describe these in an uninterrupted stream: Simone’s **boldface**-indicated voice spoke with fewer interruptions by other voices (RoPES 3.5). In addition, a new voice representing Daniel’s positions (**underlined boldface**) is introduced. Offering support for the explanatory point that voices want to be heard, when asked how Daniel’s affair was currently impacting their relationship, Simone shared that:

Simone: I think, um, the hardest thing, to be honest, is that, um - - I don’t feel like I can talk about my feelings about it with him. Because he doesn’t want, he wants to pretend, it never happened … I can’t talk to him about it because he doesn’t want to hear it!

Simone’s description of Daniel’s **active avoidance** and **suppression** of her feelings about the affair suggests that Daniel was at RoPES 1 in understanding Simone’s perspective. Daniel’s non-verbal signs of discomfort throughout these exchanges were also consistent with such an assessment.

**Daniel’s active avoidance of Simone’s experience of the affair begins to shift (movement from RoPES 1 to RoPES 2).** The therapist next invited Daniel to share what he was experiencing.

Therapist: Okay. Right. How, I mean, **it’s hard hearing that, I imagine**. (Simone: slight laugh)

Daniel: **No! She told me that;** I mean, (Therapist: mm-hm) I was open to that – (Therapist: mm-hm, mm-hm) She did tell me how she felt, **I mean, it’s something I don’t really like hearing, but** – (Therapist: mm-hm, mm-hm) the past - (incomprehensible)

Supported by the therapist’s tentative recognition (RoPES 3.9) (e.g., “it’s hard hearing that, I imagine,”) and encouragement (“mm-hm, mm-hm”) of Daniel’s sharing his positions, Daniel was able to begin to recognize (RoPES 2; “**I mean, it’s something I don’t really like hearing, but**”) his own, previously **actively avoided** (RoPES 1; e.g., “**No!**”) position, a position he
avoided in the conversation above by beginning to *suppress* voices that would indicate otherwise ("No!") and by *redefining* the conversations he’d had with Simone (“I was open to that”). Finally, Daniel’s statement confirmed Simone’s sense of his wanting to avoid hearing about her experience, pointing toward the possibility of a shared formulation of a problem related to the affair.

**Session Four.**

_Simone clarifies her interpersonal positions while Daniel attends (RoPES 3.5)._ In session four, having benefitted from the work in session one and explorations of the influence of each of the partner’s family-of-origin experiences in sessions two and three, Daniel was able to respectfully attend to Simone (RoPES 3.5) while she shared how she felt about the affair and the anguish she had been feeling as a result of his failure to be honest with her when they were trying to conceive. This, she felt, had kept her from being able to make an informed choice about whether to work on the relationship with him before having a child or to leave and try to build a new relationship with someone else:

Simone: I haven’t been able to forgive you yet (Therapist: mm-hm) for (two-second pause) (crying) (sigh) - um, I guess, *not letting, giving me* (sniffles) a choice about what I, a choice about, ah just (Therapist: mm-hm) just choices! and having a chance to have you know, a relationship with some, a good relationship with someone, a family and (exhales) you know, I just, like I; Even if we keep working, I just, I’m so angry! about that one (Therapist: right, right) I’m furious! (crying)

With tears in her eyes, Simone returned to what she had previously referred to as “the hardest part” of the experience.

Simone: I mean, the other thing I’ll get, I mean, ang-. (sigh) Ah, you know, there was this thing early on that, you know, I’m not allowed to talk about my feelings about this. I’m very angry about that, (Therapist: yeah) very angry!

_Daniel’s softening and shift towards empathically understanding Simone’s positions (RoPES 3.7 – 4)._ Moved by his experience of Simone’s emotion, Daniel softened and became *open to* Simone’s positions in his meaning-making (RoPES 3.7).

Daniel: I know how she’s feeling. She’s… justified with that feeling.

Daniel then began to *explore* (RoPES 3.9) their situation from Simone’s perspective; as he did, tears came to his eyes.

Therapist: If you let your tears speak, what would they say? I mean, what do you say?
Daniel: **I’m sorry** (crying) (Therapist: ah-hum) I wish it never happened (Therapist: ah-hm). I wish I’d told you sooner (crying) that; I wish I wasn’t trying so hard - to be (three-second pause) your rock (sniffs), because it wasn’t really that
Exploring Simone’s experience, Daniel began to *empathically understand* Simone’s positions (RoPES 4), both around the affair and around his attempts to include her positions by being her “rock.” In so doing, he began to understand that, despite his intentions, acting like a rock “wasn’t really that helpful” to Simone; instead, Daniel recognized that not sharing his authentic positions (i.e., excluding his own positions in the couple’s dialogues) had led to significant relational problems. In keeping with the description of RoPES 4, Daniel was experiencing some unpleasant recognition of having contributed to the problem, and his affective experience was powerful.

*Simone softens in return, becomes reflexive (RoPES 3.7 – 3.9).* Simone’s reaction to experiencing Daniel as opening towards her positions appears to have encouraged Simone to become reflexive and respond in kind.

Simone:  
*I, I, I, I know that, it isn’t all your fault.*

Feeling heard, and seeing Daniel’s hurt, Simone was able to open towards his positions as well, and became reflexive around her own contributions to the problem (“it isn’t all your fault”), a shift that is consistent with the transition from RoPES 3.7 to 3.9.

**Session five.**

*Beginning to apply hard-won insights towards working through the problem (RoPES 5).* At the beginning of their next session, Daniel reported improvements in their relationship. Asked to clarify what he meant by this, Daniel indicated:

Daniel:  
*I think we, uh, I don't know, I feel like in the past week, I can empatha- empathize with her better, how she's feeling at certain times.*

(Therapist: mm-hm, mm-hm) **And I can, uh, feel, I'm more able to read my own feelings better,** (Therapist: mm-hm, mm-hm) and **gauge my actions or reactions better.**

In the language of the theory, Daniel noticed improved inter- and intrapersonal inclusion (“I can… empathize with her better… and… read my own feelings better and gauge my actions or reactions better”) as a result of the couple’s dialogues.

Simone concurred.

Simone:  
*I think I felt that Daniel had some understanding of why it was important for me to talk about my feelings* (Therapist: yeah) *about it* (Therapist: yeah yeah) **as opposed to up until this time in his mind:** you know, we've had three therapists and they've said it's, you know, non-productive for me to talk about my feelings about this, it's just better to pretend it never happened, at least that was my interpretation.

Therap.:  
*So that feeling of being silenced was so painful for you*
Simone: **Very, very painful, yeah** (Therapist: incomprehensible) **and I was, I was, I was, very angry about that in itself,** (Therapist: yeah yeah yeah) **um, and I think that, that**

Therap.: **That sort of shifted**

Simone: **It has.**

Consistent with RoPES 5, Simone indicated that Daniel had begun to *apply* his empathic understanding of her need to talk about her feelings about the affair (he “had some understanding of why it was important,” i.e., he began to understand her need to be heard). This stood in contrast to the “[v]ery, very painful” experiences she’d had in previous couple therapies in which she’d felt silenced (i.e., where she’d been told it was “non-productive” for her to “talk about her feelings about this”). Having now felt heard, and having had the experience of Daniel including her positions in his meaning- and decision-making, the pain that had been present in their relationship and the problematic experience that had arisen out of her positions being excluded had shifted.

**Simone’s reflexivity applied to working through the couple’s problems (RoPES 5).** Reflecting on how things had changed, Simone described feeling supported by Daniel’s listening to her in this area that he’d previously been unable to, and emphasizing how important it was that they support each other. She then shared the following recognition.

Simone: *He's a better listener than I am. Because that's his big complaint with me* (laughs). *He's talking to me,* (Therapist: mm-hm) *my mind's on - a million and one other things,* (Therapist: yeah) *and then he'll ask me what he just said, and I can't repeat it; but he always can repeat* [what I’ve said].

This exchange can be said to demonstrate the results of Simone having become reflexive about her role in the events surrounding the affair (“it isn’t all your fault”). In this exchange, Simone took full ownership of the complaint Daniel aired in the couple’s very first session (“I don't feel I've gotten the support that I've needed from her”), not being able to listen to and support Daniel as well as he wanted – demonstrating the presence of a shared understanding (*meaning bridge*) that she is now trying to *apply* (RoPES 5) to their problems as they work towards resolving them.

In response to this shift, the therapist then asked Simone and Daniel to share how they were feeling about each other.

Simone: *I feel I'm lucky because he listens to me better than I (laugh), better than - better than I listen to him.* (Therapist: ‘I feel lucky’) *I do, no, I feel lucky. You do listen to me.*

Therapist: How do you feel as you look at her?
Daniel: Ah, I don’t know. *It’s true* (laughs).
Therapist: What do you feel towards her? Can you tell her?
Daniel: (Low voice) I feel really close to you.
Simone: Mm-hm.
Daniel: I love you.
In this exchange, Simone expressed gratitude for Daniel’s ability to listen to and support her within the context of acknowledging her own shortcomings in this area – she has included Daniel’s positions in her meaning-making. In response to this, Daniel reports feeling really close to her and shares a statement of his love for her, behavior that is consistent with the model’s statement that progression towards resolution is associated with (and due to) increases in involvement and understanding between voices, understanding and involvement that leads to a sense of we-ness.

**Session 11: Resolving (RoPES 6).** In the 11th session, having continued to work through the implications of the shared understandings the couple had come to in the first five sessions, the couple reported significant progress around the issues that had brought them in.

Simone: I feel like I'm getting beyond, like, I'm, I'm forgiving, in many ways, and that it's starting to go away. I don't think I'll ever trust him the same way again; (Therapist: mm-hm) I think as time goes on I'll trust him more and more. Um, but it-it's kind of in the background, or, but it's like now, we really are back at what the core issues are, (Therapist: yes, yes) so I think in some ways this has really helped me get past just focusing on the symptom versus the problem.

Saying more about what that meant, Simone offered that

Simone: It just made me realize that there were problems in the in the relationship that I knew were there [e.g., Daniel’s not feeling emotionally supported], see this is, you know (Therapist: yeah) that - but he didn't talk about them, and I let him not talk about them, or maybe I couldn't do anything about it, (Therapist: yeah yeah yeah) but I knew they were there, right? I knew they were there. I can't pretend like they weren't there, and I can't pretend that you know, everything-everything was great.

Therapist: I think that's really realistic… and my sense of it is that's sort of what's happened in this journey together… It's a somehow, it's a shifting for you, right? (Simone: for sure) of the, of the actual meaning of the affair or the sort-of causes of so-and-so maybe there's not as much, sort of, burning hurting anger inside, when you think of it right?

Simone: No - (two second pause) it's (three second pause) resolving.

In these passages, Simone shared how the couple’s relationship had been changing. Consistent with RoPES 6, Simone acknowledged not fully trusting him (in the way that she would in RoPES 7), but also noted that the problem was resolving – and that this had come about in connection with her understanding what had led to the problem, resulting in a change in her meaning-making about the affair.

**Discussion of observations from Simone and Daniel’s case**

Through the dialogues facilitated in this therapy, Simone and Daniel came to increasingly value aspects of their own and their significant other’s experiences related to the affair. This process led to a change in each partner’s relationship to the affair and to the resolution of the
problematic experience; it also led to changes in each partner’s understanding of themselves, one other, and the relationship. Daniel became more acutely aware of how his avoidance of Simone’s emotions around the affair (i.e., his exclusion of her positions in his meaning- and decision-making) had left Simone feeling angry and unsure of her importance to Daniel and his commitment to her. Daniel also came to recognize more deeply just how much his decision to not represent his vulnerable side and unhappiness around how things were going in their relationship in his conversations with Simone (his exclusion of his own positions in the interest of living up to Simone’s sense of him as her “rock”) had precluded both partners from being able to truly get their needs fulfilled. Once Daniel stopped trying to suppress and avoid Simone’s feelings around the affair, he came to realize just how deeply his actions had hurt Simone, leaving him with a better understanding of why it was so important for her to be able to talk about her feelings. For her part, Simone became aware that she had not been providing Daniel with the emotional support and intimacy he had been seeking (i.e., that she had not been sufficiently including his positions in her meaning- and decision-making; Simone: “It just made me realize that there were problems in the relationship that I knew were there”), and how not addressing this had contributed to the problems in their relationship (Simone: “I can't pretend that, you know, everything-everything was great”).

Throughout this process, it was the facilitation of dialogue between voices whose positions were in conflict that led to therapeutic change. Each partner’s progressive inclusion of previously-excluded positions resulted in shifts in each partner’s sense of self and one another, shifts that resulted in an increased sense of interpersonal closeness (Simone: “I feel really close to you”) and a shared understanding of the problem that could be used as a resource in relevant contexts (Simone: “we really are back at what the core issues are, (Therapist: yes, yes) so I think in some ways this has really helped me get past just focusing on the symptom versus the problem”). Finally, the patterns of interaction observed in Simone and Daniel’s relationships with themselves and one another on the way to resolving the pain associated with the affair progressed in a way that was consistent with the patterns encoded in the RoPES.

**General Discussion**

**Theoretical elaborations**

The model that emerged out of this work offers support for the applicability of the systems-theory principle of isomorphism (self-similarity) to inter- and intra-personal processes in psychotherapy. At both levels, therapeutic change appears to be made possible by dialogue between voices whose positions are in conflict, and can be described as an observable progression in the qualities and outcomes of voices’ dialogues with one another. These observations enabled us to elaborate a model that describes intra- and interpersonal change processes within a common theoretical framework.

In the couple therapies studied in this work, dialogue between voices enabled changes in their relationships such that positions that were previously excluded (or were seemingly unheard) came to be empathically understood and included (i.e., valued and influential) in meaning- and decision-making. These changes corresponded with a shift from an essentially competitive relationship between voices, where each voice’s positions were regarded as winning or losing influence, to a collaborative one, where each voice’s positions were influential. In the resulting
collaborative relationship (which becomes consolidated in RoPES pattern 5), voices actively include one another’s positions in meaning- and decision-making.

Further, in the studied therapies, the exclusion of relevant voices’ positions was associated with reports of psychological pain (from Simone and Daniel’s case: “that was so painful for you” Simone: “very, very painful, yeah”), and the inclusion of once-excluded positions was associated with reports of therapeutic gains. Attending to these cases through this lens suggested a clarifying image: voices want to be heard when their positions are relevant to an active meaning- or decision-making process. Put in the language of the theory, voices want their positions to be included (i.e., valued and influential) in relevant meaning- and decision-making processes.

This account suggests a theoretical explanation for problematic experiences and their resolution: events are experienced as problematic when relevant voices’ positions are excluded from influence; problems are resolved as relevant voices’ positions are experienced as included (i.e., valued and influential) in meaning- and decision-making. This theoretical understanding also suggests an explanation for the observation that clients can get stuck at a certain level of therapeutic progress or return to “earlier” patterns (see, e.g., Stiles, 2005b): getting stuck in (e.g., Daniel’s comment about having a “series of discussions” in which he keeps asking for Simone to meet his needs, and her failure to do so) or returning to an earlier pattern (e.g. the return to rapid cross-fire between Sarah and Mark when she seemingly ignores his perspective) appears to be an indication that not all relevant voices feel like they have been (or will be) heard.

In respect to the structure of the RoPES, observations supported the addition (and led to the refinement) of descriptions of both voices’ perspectives throughout the developmental process (e.g., RoPES 4 is titled insight / empathically understood). Observations also led to the identification of a new sub-stage in the clarification stage (stage 3) of the RoPES; this in turn led to a re-numbering of the RoPES 3 sub-stages. The name of the new sub-stage (softening / opened towards, sub-stage 3.7) was inspired by emotion-focused therapy’s terminology for similar observations (e.g., Elliot, Watson, Goldman, & Greenberg, 2004; Greenberg & Goldman, 2008; Greenberg & Johnson, 1988). EFT uses the term softening to refer to a change event marked by an opening towards the perspective (subjective experience) of the other in response to the other making their hurt, vulnerability, or attachment-related concern explicit. Put in the language of the dialogical model presented here, in successful therapies, when the hurt associated with another voice’s experience of the problem becomes experientially available, the voice of focus opens towards the other voice’s positions.

In regard to the theory’s conceptualization of persons, this work produced a dialogically-focused definition of voice communities: voice communities consist of those voices within a voice system that mutually include one another’s positions, resulting in the experience of communal unity and “we-ness” that mutual inclusion creates. Completing the theory’s ability to describe the intra- and interpersonal realms in one language system, this model holds that voices in interrelated persons’ voice systems can also be described as a single system of voices (an interpersonal voice system), and that attending to the inclusion and exclusion of voices’ positions indicates which voices are included in (interpersonal) voice communities. Using the voice system and -community frameworks for both the inter- and intrapersonal realms was further supported by the observation that the distinction between the intra- and interpersonal worlds is not clearly delimitable: representations of others’ positions (and voices) are included in the self, and are influential in both intra- and interpersonal processes. (These representations are not always accurate, however; such situations represent effective exclusion. Examples from the
cases studied include Daniel’s not sharing of his positions due to a sense that that was what it meant to be Simone’s rock and Mark’s not realizing how strongly Sarah disagreed with his views around the abortion decision.)

Finally, consistent with the implications of Stiles et al., 2006, case observations lent support to the theoretical stance that attending to the positions being taken enables one to infer the presence of intrapersonal voices (i.e., each distinct position implies the presence of an intrapersonal voice), and to track these voices’ relationships over the course of therapy – a point that was highlighted in relation to Simone and Daniel’s case.

The dialogical model of therapeutic change that emerged out of this work is an evolving framework, subject to ongoing inquiry and open to modification and elaboration based on additional observations. Although explicitly based upon the study of two couples’ therapies, as an elaboration and extension of the observations described in the assimilation model, this work both rests upon and adds to data accrued in the model to date.

Clinical implications

The presented model proposes that exclusion (or the threat thereof) lies at the root of problematic experiences, and suggests that problems are resolved as voices’ positions are included (valued and influential) in relevant meaning- and decision-making. If correct, this suggests that therapists should be curious about which positions might be being excluded, and facilitate their progressive inclusion. Different theoretical orientations offer differing means of facilitating this process; in the cases observed, this was facilitated through encouraging clients’ curiosity about and empathy with these positions.

The RoPES offers descriptions of a sequence of dialogical relationships observed en route to the resolution of problematic experiences. If these are accurate, comparing clients’ narratives to these patterns may help therapists make sense of clients’ therapeutic tasks relative to the problematic experience in question and be able to predict the trajectory of clients’ therapeutic process. This, in turn, might help therapists be appropriately responsive (Stiles, Honos-Webb, & Surko, 1998).

Finally, the observations that informed this model offer a means of understanding and working with therapeutic impasses in individual and couple therapies. Case observations led to the theoretical suggestion that being stuck in a pattern implies that the positions of at least one voice are not being heard (i.e., are not experienced as influencing meaning- and decision-making), and may be being completely excluded (i.e., this voice’s positions may have remained completely unrepresented in the therapeutic dialogue). If the model is correct in asserting that therapeutic change unfolds through the inclusion of excluded positions, then this suggests that the impasse will persist as long as these positions remain unheard. Clients that fit this description might be invited to engage in interventions aimed at encouraging the recognition, expression, and acceptance of under-included positions.

Resonances with other literature

The dialogical theory of change that emerged out of this work is consistent with calls for a framework that links and facilitates simultaneous consideration of a person’s intra- and interpersonal relationships and a model that offers a means of tracking dyadic interaction (e.g., Guerin & Chabot, 1992). The model’s emphasis on inclusion in dialogue and its description of
therapeutic change being associated with a shift from competitive to collaborative relationships is also found in Fishbane’s (1998) Buber-informed (e.g., 1958, 1965) dialogical approach to couple therapy. As a dialogical theory that offers a narrative description (Osatuke et al., 2004) or meta-story about the process of therapeutic change, the model presented here is also directly linked to two literatures: work on the dialogical / multivoiced self, and the literature on narrative psychology. The model’s focus on inclusion and exclusion as lenses for attending to therapeutic change is consistent with others’ work in both the dialogical and narrative fields. The literature that focuses on the evolution of narratives about the self and meaning-making in therapy makes repeated reference to the therapeutic importance of creating narratives that more comprehensively represent (i.e., include) all aspects of a person’s experience (e.g., Angus & McLeod, 2004; Baerger & McAdams, 1999; McAdams, 1997; McAdams, 2001; McLeod, 1997). In regards to the dialogical / multivoiced self literature (e.g., Dimaggio & Stiles, 2007; Hermans & Kempen, 1993; Hermans & Dimaggio, 2004; Mair, 1977; Rowan, 1990; Rowan & Cooper, 1999), while discussing a series of articles in a special issue of the Journal of Clinical Psychology focused on “Multiplicity of the Self in Psychotherapy” (Volume 63, Issue 2, 2007), Power notes that

All of the therapies [discussed in this special issue] agree on the importance of a formulation and intervention that identifies which aspects of the self are overly dominant and which aspects have been excluded or ignored; that therapy has to be about opening up the individual to being more flexible and less rigid; and that the experience of a variety of emotions provides one of the key ways of broadening the self-concept to be more inclusive of excluded states [italics added] (Power, 2007, pg. 196).

Research on the social psychology construct of interpersonal exclusion can be interpreted as offering support for the present theory’s descriptions at the interpersonal level. For example, like the theory presented here, social psychology research suggests that interpersonal exclusion results in psychological pain (triggering the same areas of the brain as physical pain; Eisenberger et al., 2003; Eisenberger & Lieberman, 2005). Being excluded is associated with anxiety (Baumeister & Tice, 1990), loneliness, depression, and low self-esteem (Leary, 1990). Self-esteem decreases as experienced exclusion increases (Leary et al., 1995). Exclusion negatively impacts self-regulation (Baumeister et al., 2005) and cognitive functioning (Baumeister et al., 2002), and can lead to a state in which self-awareness, meaningful thought, and long-term thinking are reduced (Twenge et al., 2003). Being ignored is experienced as more distressing and more disruptive to a sense of meaningful existence and feelings of belonging, self-esteem, and control than being involved in an argument; being included increases ratings on these same variables (Zadro et al., 2005). Each of these findings is consistent with the implications of the presented model as reflected in the RoPES.

Limitations and suggestions for future research

This work represents a first attempt at elaborating a model that can explain and describe both intra- and interpersonal process en route to the resolution of problematic experiences; it should be treated as such. Although the statements elaborated through this effort rest upon the work to date on the assimilation model, and were intersubjectively found to successfully describe the cases studied, these statements have only been examined in relation to two couple therapy
cases; generalizability is further limited by the many characteristics (e.g., cultural, socio-economic) that these cases had in common.

Although the descriptions in the RoPES may appear to be more readily applied to interpersonal understanding than to self-understanding, the historical accumulation of observations supporting these descriptions suggests otherwise: it is the application of the RoPES to the interpersonal realm that should be more tentatively approached. The elaborations of RoPES stages 0 and 1, while based on case observations, were largely based on clients’ retrospective descriptions, and are therefore possibly impacted by recall distortions.

To increase confidence in the statements elaborated through this effort, observations from a diverse range of cases, and by more (and, preferably, different) researchers are required. Future work examining and extending the model’s ability to describe intra- and interpersonal process should treat the statements of the model as tentative descriptions open to refinement. Further study of the model’s applicability in relation to couple therapies is recommended; studying the model in relation to individual therapies and therapies of more than two persons is also recommended.

As a model elaborated to be experientially resonant with collaborators from varying theoretical backgrounds, it is hoped that this model and the patterns described in the RoPES resonate with personal experience – and that the model continues to be refined to better capture that experience.
References


Table 1

Assimilation of Problematic Experiences Sequence (APES)

0. **Warded off/dissociated.** Client seems unaware of the problem; the problematic voice is silent, unheard, or dissociated. Affect may be minimal, reflecting successful avoidance. Alternatively, problem may appear as somatic symptoms, acting out, or state switches.

1. **Unwanted thoughts/active avoidance.** Client prefers not to think about the experience. Problematic voices that emerge in response to therapist interventions or external circumstances are suppressed or actively avoided. Affect involves unfocused negative feelings; their connection with the content may be unclear.

2. **Vague awareness/emergence.** Client is aware of a problematic voice or experience, and can express it, but cannot reflect on it. Affect includes intense psychological pain—fear, sadness, anger, disgust—associated with the problematic experience.

3. **Problem statement/clarification.** Content includes a clear statement of a problem—something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative, but manageable, not panicky.

   3.2. **Rapid Cross-Fire.** The problematic voice addresses dominant community but is abruptly cut-off mid-sentence. Rapid cross-triggering of incongruent voices as they fight for possession of the floor. Voices speak for short periods of time with frequent interruptions.

   3.4. **Entitlement.** Problematic voice speaks for a longer period of time without disruption from the dominant community. The voice asserts itself forcefully, feels entitled; speaks with a demanding attitude. Affective expression tends to be assertive, angry.

   3.6 **Respect and Attention.** Voices become more tolerant of each other. They listen to each other without interrupting and are more respectful of the other’s position. They each speak for longer, and more equal amounts of time. The content is less emotionally charged and voices are less confrontational. (Voices begin to work towards problem solving?)

   3.8 **Joint Search for Understanding.** Voices work collaboratively and struggle to understand the problem more clearly; connections are made as awareness grows; approximations of insight become evident. Voices begin to blend and sound less distinctive. (They each sound less discrepant and become harder to identify.)

4. **Understanding/insight.** The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.

5. **Application/working through.** The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.

6. **Resourcefulness/problem solution.** The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.

7. **Integration/mastery.** Client automatically generalizes solutions; once-problematic voices now serve as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).
Table 2

Studied Couples’ Outcome Measure Values

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\(^a\)Empathy and Acceptance subscale of the Unfinished Business Resolution Scale
\(^b\)Feelings and Needs subscale of the Unfinished Business
The Resolution of Problematic Experiences Sequence (RoPES)

**Key:** **Bold** describes the state of a voice in relation to another voice’s positions / **italic bold** describes the relationship from the perspective of the other voice. A description of the pattern’s qualities follows in plain text.

0. Unaware / unheard. Awareness of a problem does not seem to exist. Voices whose positions would challenge this view are unheard or dissociated, and do not seem to influence relevant meaning- or decision-making processes. Affect may be minimal, reflecting effective exclusion of problematic positions. Conflict may become indicated by somatic symptoms, rapid changes in psychological state, or acting out.

1. Active avoidance, suppression, redefinition / ignored. Encountering the other voice’s positions about the experience is overwhelmingly threatening; dialogue about these is avoided or suppressed, and the other voice is seen as the cause of the problem. Interpersonally, this may be reflected in disengagement and/or non-verbal signs of discomfort. The problem may also be “explained away.” Affect involves unfocused negative feelings (esp. feelings of anxiety and/or depression); their connection with the content may be unclear.

2. Vague awareness / not understood. The voice of focus begins to recognize the existence of a problem, and can express a partial understanding of this, but cannot make sense of it. Progress through this state typically becomes accompanied by significant psychological pain (intense fear, sadness, anger, and/or disgust) in relation to the problematic experience. Emerging questions tend to embed accusations (e.g., “what is wrong with,” “how could,” “why would”) that blame the other voice and discourage exploration.

3. Clarification / increasing recognition. Voices engage one another in active discussion of their conflicting positions, differentiating and clarifying these such that increasingly refined statements of the problem—something that can be worked on -- become formulated. As this process progresses, affect shifts from highly negative to manageable as stances shift from opposition towards collaboration. After the other’s hurt becomes experientially available, active curiosity and reflexivity emerge, making recognition possible.

*Observable sub-patterns include:*

3.1 Rapid cross-fire / disputed. The other voice begins to assert positions, but is abruptly cut-off. Voices fight for possession of the floor, and speak for short periods of time with frequent interruptions.

3.3 Listening / tolerated, listened-to. The other voice demands to be heard, feels entitled to differentiate and assert positions, and speaks for longer periods of time; tone may be assertive, demanding, or angry.

3.5 Attending / respected. Voices are less defensive, more respectful of each other’s positions, and listen to each other without interrupting. Positions are less oppositional, and a broader range of affect is evident.

3.7 Softening / opened towards. The hurt associated with the other voice’s experience of the problem becomes experientially available; the voice of focus opens towards the other’s positions.

3.9 Exploring / tentatively recognized. Voices jointly struggle to understand the problem more clearly; the voice of focus is actively curious about the other’s positions, and reflexivity emerges. Connections are made as awareness grows; approximations of insight become evident. Voices’ positions begin to converge.

4. Insight / empathically understood. Voices experience a sense of shared understanding about the problematic experience -- a meaning bridge has been created. Affect is likely to be powerful, and may be mixed; there may be some unpleasant recognition of having contributed to the problem, as well as some pleasant surprise: the problem is experienced as resolvable.

5. Working through / applied. Voices work together to explore and apply implications of hard-won insight towards problem resolution; alternate courses of action may be considered and weighed against one another. Affect grows more consistently positive as tangible progress toward a workable solution is achieved.

6. Resolution / routinely consulted. The once-problematic experience is resolved and has become a resource, and the once-problematic voice is now routinely consulted in relevant decision-making processes. Voices are flexibly included; some effort is still evident in this process, however. Related affect is positive, satisfied, reflecting feelings of pride, accomplishment.

7. Mutual inclusion / mutually included. The once-problematic voice is now fully trusted and automatically included in meaning- and decision-making processes. Voices effortlessly generalize solutions that are mutually supported. Affect is generally positive or neutral (i.e., this is no longer something to get excited about).
Figure 1: Iterative abduction process overview.
Appendix: Initial Model

I. The model's metaphor for the self:
   b. Represent “people, events, and other constellations of experiences” (Stiles, Leiman, et al., 2006, pg. 408).
   c. Are “triggered by signs” (Stiles, 1999a) and “emerge when they are needed, addressed by circumstances that recall their formation” (Stiles, Otsuuke, Glick, & Mackay, 2004, pg. 92-93).
   d. Become “stronger as they incorporate more of a person’s experience” (Honos-Webb & Stiles, 1998, pg. 25).
   e. Are “active” and “have feelings and motives as well as informational content” (Honos-Webb & Stiles, 1998, pg. 25).
   f. Take positions “in relation to events, things, other people, and aspects of self” (Stiles, Leiman, et al., 2006, pg. 408-409).
   g. Are linked to one another “by meaning bridges” (Honos-Webb & Stiles, 1998, pg. 25).

II. Voices:
   a. Are “composed of traces of related experiences” (pg. 25).

III. Meaning bridges:
   a. Are “semiotic links by which” a voice can “understand and be understood by [other] voices” (Brinegar, Salvi, Stiles, & Greenberg, 2006, pg. 165).
b. Consist of “a word, phrase, story, theory, image, gesture, or other expression that has the same meaning for each of the voices it connects” (pg. 167).

c. Connect voices “through their common understanding, allowing them to empathize and communicate with one another and engage in joint action” (pg. 167).

d. These connections “allow voices to serve as resources; the voices can be called on when circumstances require their specific talents and capacities” (pg. 167).

e. Finally, “Because meaning bridges are made of signs, such as spoken words, they are observable and can be studied empirically by analysis of recordings or transcripts of therapy sessions” (pg. 167).

IV. Signs:

a. Are “words, gestures, tokens, or pictures” that “point to something besides themselves” (Stiles, 1999b, pg. 1) and are understood by two or more voices.

b. Signs, then, are meaning bridges.

V. Positions:

a. Are the “momentary stances” a voice “adopts in relation to events, things, other people, and aspects of self” (Stiles, Leiman, et al., 2006, pg. 408).

b. Terminology proposal: because positions are always taken from within the experiential perspective of an “I” in relation to an other, I suggest the phenomenologically descriptive term I-other positions.

c. When made interpersonally observable, these are “understood as the observable manifestations of internal voices” (Stiles, Leiman, et al., 2006, pg. 409).
VI. Intrapersonal dialogue:

a. Consists of “alternating expressions of… opposing voices” (Brinegar, Salvi, Stiles, & Greenberg, 2006, pg. 167).

b. Is “spoken by one person and is composed of alternating expressions of positions that may be directly contradictory” (pg. 167).

c. When in the presence of others, intrapersonal dialogues are also interpersonal.

VII. Continuity/benevolence assumption (CBA) voices:

a. “Theoretically, CBA voices arise from positive early experiences of nurturing and care, which involve physical and psychological contact, including holding, feeding, and mutual gazing, along with the fulfilling of physical and psychological needs. Continuity of care allows the traces of different experiences to become linked through the common feature of contact with the mother. This produces a consistent core to which subsequent experiences can adhere. CBA voices are thus a way of thinking about how successful nurturing and care provide a basis for a sense of self that is coherent and continuing and a sense that life is good, I am worthwhile, the world is just, and so forth -- what is sometimes called the will to live” (Stiles, 1999a, pg. 22).

VIII. Problematic voices:

a. …are voices that represent or occasion problematic experiences.

b. “What makes a voice problematic to the a person does not reside within the voice itself but in how it positions the person with regard to self and others. A position is problematic when it is incompatible with positions taken by the voices that comprise the person’s accepted sense of self” (Stiles, Leiman, et al., 2006, pg. 409).
IX. Relationships between voices and communities:

a. Voices that are simultaneously active “leave further, joint traces [of experience] and so tend to become” mutually interlinked to one another; “traces of previous events tend to be linked to traces of newer experiences that are similar or related, forming coherent constellations of mutually linked traces,” such that voices “grow over time” and “become interlinked” into communities of voices (Stiles, Osatuke, Glick, & Mackay, 2004, pg. 92).

b. Observed voices represent community positions: “a specific voice that was previously just a member of the community becomes identifiable and separable (figure instead of ground)” (Honos-Webb & Stiles, 1998, pg. 25).

c. As voices “grow” through repeated activity over time, they come to take on a more significant role in the community (i.e., become more dominant; Honos-Webb & Stiles, 1998, & see below).

d. In cases where experience is too divergent from the existing sense of self (e.g., in the case of traumatic experience violating the positions of CBA voices), new subcommunities (Osatuke & Stiles, 2006) may be formed. Like all voices and communities, subcommunities “can view other voices or each other as problematic” (Osatuke & Stiles, 2006, pg. 297).

e. In relation to the overall community of voices contained within a person, the voices representing experiences and subcommunities may, on a continuum,

1. Be more or less included (Osatuke & Stiles, 2006).

2. Be more or less dominant (i.e., predominant and/or emerging more frequently in relation to experiences) (Osatuke & Stiles, 2006).
3. Be more or less avoided or engaged (Osatuke & Stiles, 2006).

4. Express and/or represent “broader or more limited segments [or scopes] of experience” (Osatuke & Stiles, 2006, pg. 298).

5. Be “processed more or less thoroughly” (Osatuke & Stiles, 2006, pg. 298).

See points f-i for a discussion of each of these dimensions. (Ratings of fit and relevant comments on these dimensions should be made in relation to the points made in items f-i.)

f. Inclusion in a community:

1. Voices and/or subcommunities that are smoothly available and are well-interlinked (mutually interlinked) can be said to be included in the larger community (Osatuke & Stiles, 2006).

2. Intraperonally, inclusion has been said to describe “the clinical manifestation of intra-personal integration” (Osatuke & Stiles, 2006, pg. 300).

3. Both inter- and intrapersonally, inclusion speaks to the experiential boundary of the active community, i.e., which voices are experientially contained within the subjectively defined boundary of the community taking a position. (One person’s community, for example, may include or exclude the perspectives (positions) of another person’s voices in dialogue and/or decision-making processes to varying degrees, demonstrating the degree to which others’ voices are valued by and included within the self.)

4. In interpersonal dialogue, the use of the term inclusion is consistent with Buber’s use of the term - i.e., interpersonally, high inclusion represents accurately...
“imagining the real” subjective reality and held positions of another person’s voices in relation to the matter at hand.

5. Inclusion has been said to reflect “the active dominant community voice’s attitude towards the [other] voice” or subcommunity (pg. 300).

6. Inclusion has also been said to reflect “current levels of rejection-acceptance of unassimilated voices” (pg. 301).

g. Avoidance and engagement between voices

1. “Engagement-avoidance represents meta-processes of the dominant community’s active voices’ decision-making on the extent that the problematic another voice will be attended to or given a chance” (pg. 301).

2. Put another way, this dimension describes “the apparent openness or closedness to hearing and incorporating other, different perspectives” (pg. 301).

3. “This strategic decision depends on gauging gains and costs of assimilation engagement from the dominant perspective” (pg. 301).

4. Engagement “is a mutual process between dominant and problematic voices” (pg. 301).

5. “Avoidance is a unilateral process, exercised by one community voice or community of voices towards [an]other (e.g. the a dominant community maintains its dominance by restricting expression of incompatible views; or the unassimilated a non-dominant community withdraws to protect itself from exposure to the dominant position)” (Osatuke & Stiles, 2006, pg. 301).
h. **Broad versus limited scope of voices**

1. A voice “may appear broad or limited in scope,” reflecting the amount of experiential material from which it speaks, its range of contexts, and how often it is triggered and expressed. This may be evaluated by noticing whether a voice speaks on few versus many or varied topics” (Osatuke & Stiles, 2006, pg. 304).

2. A voice's breadth “reflects the size of its community and hence its wealth of available resources; breadth is thus one of the determining features of dominance” (pg. 304).

i. **Processing of experiences voices' positions**

1. “Processing describes the quality and extent of the links among voices in [relation to] a community or subcommunity” (pg. 305).

2. “Greater complexity of symbolic expression, the presence of metaphors, their originality, and the use of cultural symbols characterize more thoroughly processed experiences” (pg. 306).

3. “Self-reflection represents deeper processing than do reports of sensations” (pg. 306 - 307).

4. “Verbal expression of felt personal experiences--the organizing, meaning-making use of language--reflects deeper processing than does behavioral acting out or somatic symptoms or saying words to fill up space” (pg. 307).

5. “Integration across different experiential modalities, (verbal, behavioral, cognitive, affective) characterizes deeper processing” (pg. 307).
6. “The ability to convey an experience vividly to another person demonstrates its coherence and marks more thorough processing than does an abstract decontextualised description” (pg. 307).

7. “Along with scope, processing reflects a voice’s accessibility: its ability to express itself understandably, coherently, and effectively to internal or external others. Together, these contribute to dominance (a dominant perspective is more extensive and articulated)” (pg. 307).

**Part II: the model’s conceptualization of therapeutic change**

1. Therapeutic change occurs through dialogue between (intra- and interpersonal) voices, and can be described as an observable progression of improvements in the qualities and outcomes of voices’ dialogues with one another.

2. The model describes the progressive improvements in the quality of voices’ dialogues as a continuous sequence of development that it has subdivided into eight larger stages (Stiles et al., 1991).

3. Brinegar, Salvi, Stiles, and Greenberg (2006) identify 4 additional substages (see Table 1).

4. At each level, the experiential boundaries of a system of voices are subjectively defined and undergo revision in and through the intra- and interpersonal dialogues that make therapeutic change possible. Intrapersonally, these experiential boundaries speak to identity, or what is seen as “me” or “I” vs. “not me” / “not I”. Interpersonally, these speak to the distinction between “we” and “us vs. them.”
5. As empathy and understanding are achieved and built upon, voices that were once experienced as problematic (voices that once represented and/or occasioned problematic experiences) come to be valued and included within the experienced boundaries of the system of focus, and relationships that were once problematic become mutually supportive/rewarding.

6. The process described in Table 1 was “written to describe the relation of a problematic voice to a dominant community at each stage, but it could be recast to describe relations between any two voices” (Stiles, Osatuke, Glick, & Mackay, 2004, pg. 93).

**Table 1: The Resolution of Problematic Experiences Sequence**

(The descriptions prior to this project have been exclusively from the perspective of the dominant voices and did not go into much relational detail; Additions below are meant to capture relational aspects and experience of non-dominant, excluded voices as they come to be more included.)

**Key to font style meanings:**
- **Bold** speaks to relationship with positions that are problematic from the perspective of the dominant voices in a system
- **Italic** is experience of “other,” non-dominant voices
- from plain text is description from dominant voice
- **Underline** bold speaks to experience that is shared by the voices in question

0. **Unaware / unheard.** Dominant voices seem unaware that a problem exists; would-be problematic voices are completely excluded, and are unheard or dissociated. Affect may be minimal, reflecting successful domination of would-be problematic voices. Alternatively, signs of conflict may manifest in somatic symptoms, acting out, or state switches.

1. **Actively avoided, suppressed / ignored.** Engaging in dialogue with problematic voices is painful, and is actively avoided or suppressed. Affect involves unfocused negative feelings; their connection with the content may be unclear.

2. **Vague awareness / misunderstood.** Dominant voices are aware of a problem, in relation to a voice or experience, and can express it, but cannot reflect on it. Affect includes intense psychological pain—fear, sadness, anger, disgust—associated with the problematic experience.

3. **Problem statement, clarification / emerging sense of inclusion.** Content includes a clear description of the active dilemma—something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative, but manageable, not panicky.
3.2. **Rapid Cross-Fire.** The problematic voice addresses the dominant community but is abruptly cut-off mid-sentence. Rapid cross-triggering of incongruent voices as they fight for possession of the floor. Voices speak for short periods of time with frequent interruptions.

3.4. **Entitlement.** Problematic voice speaks for a longer period of time without disruption from the dominant community. The voice asserts itself forcefully, feels entitled; speaks with a demanding attitude. Affective expression tends to be assertive, angry.

3.6 **Respect and Attention.** Voices become more tolerant of each other. They listen to each other without interrupting and are more respectful of the other's position. They each speak for longer, and more equal amounts of time. The content is less emotionally charged and voices are less confrontational. (Voices begin to work towards problem solving?)

3.8 **Joint Search for Understanding.** Voices work collaboratively and struggle to understand the problem more clearly; connections are made as awareness grows; approximations of insight become evident. Voices begin to blend and sound less distinctive. (They each sound less disruptive and become harder to identify.)

4. **Insight / empathy / understanding.** The problematic experience is jointly formulated and understood in some way. Voices reach a shared understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.

5. **Application/working through.** The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.

6. **Resourcefulness/problem solution.** The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.

7. **Integration/mastery.** Voices automatically generalize, solutions; once-problematic voices now fully included and serve as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

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**Notes in relation to Table 1:**

7. The description in Table 1 has been referred to as the Assimilation of Problematic Experiences Sequence (APES).

   a. The model has described the process of therapeutic change using the term *assimilation* since its inception (Stiles et al., 1990).

   b. As noted by many (beginning with Piaget), assimilation requires accommodation; in keeping with this, accommodation between voices is “always mutual: both problematic and non-problematic voices change as
they become accessible to each other” and in relation to one another (Osatuke & Stiles, 2006, pg. 292-293).

c. Although the term assimilation may understandably (given contemporary usage) trigger negative images of homogenization, the term assimilation is not meant to imply “homogenisation of dissenting voices;” instead, the model holds that process of therapeutic change “transforms or reconstructs all voices-participants, promoting a community rather than monolithic unity” (Osatuke & Stiles, 2006, pg. 293).

8. “Inclusion reflects the dominant active community's attitude towards the another voice, varying from rejecting to embracing. At intermediate stages (Table 1), non-dominant voices may be owned but not welcomed: e.g., they cause pain (APES 2) or become defined as a problem (APES 3). Inclusion also describes how much the voice is allowed to participate in affairs of the community (e.g., drawing attention, sharing in the community's decision-making). Importantly, included voices nevertheless may remain psychologically distinct; for example, the voice of a parent, though well-assimilated, may remain as a recognizable internal presence” (Osatuke & Stiles, 2006, pg. 300).

The relationships between scope and processing and inclusion:

9. “Scope and processing together reflect the extent of a voice’s assimilation, or its inclusion within its community. They can be tracked by noting how extensively and internally consistently a voice is expressed across a variety of topics and contexts” (Osatuke & Stiles, 2006, pg. 308).
Brief summary of the process of therapeutic change through dialogue between voices:

10. As mutual understanding and empathy are achieved and built upon (through dialogue), voices representing and/or occasioning once-problematic experiences come to be seen as valued or offering valuable information, and become included as a matter of course in relation to the experience at hand.

11. This process represents increases in mutual interlinking between voices (this represents the building and strengthening of relationships between voices) that results in mutual inclusion of voices (and their perspectives/positions) by one another.

12. This applies both intra- and interpersonally.