DEPATHOLOGIZING DIAGNOSTIC COMMUNICATION IN PSYCHOTHERAPY: A QUALITATIVE EXPLORATORY STUDY IN THE CONTEXT OF INTERNAL FAMILY SYSTEMS

Carolina Ratjen (MSH Medical School Hamburg), Ann-Katrin Bockmann (University of Hildesheim), Tamara Thomsen (HAWK Hildesheim), Germany

Aims

Communicating a mental health diagnosis can have negative consequences for the person affected [1]. The present study represents a first attempt to investigate whether diagnoses communicated through the IFS model can have a depathologizing effect. The long-term goal is to contribute to making the psychotherapeutic space a safe place where those affected feel seen and experience relief.

Abstract

The communication of mental health diagnoses is indispensable in psychotherapeutic practice, yet simultaneously involves risks [1]. This is the first study to examine how the Internal Family Systems (IFS) model (Schwartz [2]) can shape diagnostic communication in a depathologizing way. Two sub-studies were conducted and analyzed using qualitative content analysis (Mayring [8]): A focus group discussion with eight IFS-trained therapists (Sub-study 1) and two semi-structured individual interviews with individuals who had experienced diagnostic communication in both non-IFS-based and IFS-based therapy (Sub-study 2).

The findings suggest that replacing diagnostic labels by mapping inner part dynamics that emerged within a person's life context can be experienced as comprehensible, relieving, and depathologizing. A curious and compassionate stance of the treating clinician was described as significant in both sub-studies. Due to the exploratory design and small sample size, the findings should be understood as preliminary indicators.

Introduction & Theory

- Diagnostic communication is…
  - legally required [3]
  - indispensable in clinical care [4]
  - the foundation for Shared Decision Making [5]
- Problem: Categorical diagnostics are deficit-oriented → Risk of maladaptive processing of diagnostic communication [1].
- Status quo: Psychotherapists bear considerable communicative responsibility — so far without structured guidance or established concepts [1].
- Diagnostic communication should strengthen all three components of the sense of coherence (comprehensibility, manageability, meaningfulness) [6] and Shared Decision Making [5]
- The Internal Family Systems model [2] offers depathologizing language for diagnostic communication: Symptoms = contextually developed protective efforts of inner parts → no bad parts; a healthy Self at the core of every person; the consistent separation of person and symptom prevents over-identification with the diagnosis.
- Empirical studies on diagnostic communication in the IFS context are currently lacking.

Contact:
Carolina Ratjen: carolina.ratjen@student.medicalschool-hamburg.de
Dr. Ann-Katrin Bockmann: Bockmann@uni-hildesheim.de
Prof. Dr. Tamara Thomsen: tamara.thomsen@hawk.de

Research Questions & Methods

Overarching Research Question:
How can the Internal Family Systems (IFS) model, as a depathologizing approach, support the design of diagnostic communication in psychotherapeutic practice?

Sub-study 1 Therapist Perspective

Sub-Research Question 1 (SRQ1): How has the understanding and practice of diagnostic communication changed through IFS training compared to previous psychotherapy training?

SRQ2: How is diagnostic communication currently structured in IFS-based therapeutic practice, and which linguistic or conceptual elements of the IFS model are used?

- Focus Group Discussion
- 8 IFS-trained therapists
- Semi-structured interview guide

Sub-study 2 Patient Perspective

SRQ1: How did interview participants (IPs) experience the communication of their mental health diagnosis — first in non-IFS-based, then in IFS-based therapy?

SRQ2: What impact does diagnostic communication in IFS-based therapeutic practice have on self-concept and the quality of the diagnostic conversation?

- Individual Interviews
- 2 interview participants
- Semi-structured interview guide

Analysis:
- Structuring Qualitative Content Analysis [8]
- Deductive-inductive category system
- software-assisted (MAXQDA)

Results & Discussion

Sub-study 1 Therapist Perspective, SRQ1: Changes through IFS Training

Pre-IFS	Change
• Alternative framings / direct communication • Varied, depending on training background • Skepticism / Uncertainty	→ • Parts language • Self-leadership as a stance • Dual fluency (IFS and medical language)

Discussion: Changes in diagnostic communication appear independent of prior training background. IFS training appears to lead to a more consistent approach.

Sub-study 1 Therapist Perspective, SRQ2: Current Design and Elements

- Parts language as a tool → destigmatizing, countering a logic that fixes people in a static state
- Self-led communication as a central design feature → leveraging positive effects of communicative competencies

Discussion:
Parts language separates person and symptom and appears to directly address the risk of stigmatization in practice [7]. Positive effects of communicative competencies such as compassion are put to use.

Sub-study 2 Patient Perspective, SRQ1: Experience of Diagnostic Communication

	Pre-IFS	IFS-based Therapy
IP1 IP2	(Self-)Stigmatization & Lack of Understanding	Relief & Understanding

Discussion:
No coherent understanding beforehand → consistent with the findings of prior research [1].
Experiences of appreciation and normalization in IFS-based diagnostic communication → align with the core assumptions of Schwartz [2].

Sub-study 2 Patient Perspective, SRQ2: Impact on self-concept and the quality of the diagnostic conversation

- IFS-based diagnostic communication appears to strengthen all three components of the sense of coherence [6].
- IPs report disidentification with the diagnosis

Discussion:
Convergence of both perspectives: therapeutic stance as the decisive quality factor; the IFS model implies equal footing, aligning with the ideal of Shared Decision Making [5].
Disidentification with the diagnosis suggests that IFS can counter self-stigmatization [7].

Conclusions

IFS supports depathologizing diagnostic communication through…

1. Parts Language	**2. Functional Processing / Strengthening of the Sense of Coherence**
3. A Self-Led Stance	**4. Instilling Hope**

"Within IFS there is always hope, because the Self exists." (IP2, para. 56)

Practical Implications:
Design Principles for Diagnostic Communication in IFS Practice

Normalize
- Frame symptoms as meaningful responses to stress within their context of origin
- Offer biological/polyvagal explanations
- Be transparent about the institutional framework & clinical care function of diagnoses

Account for Neurodiversity
- Conceptual distinction: Hardware (neurobiological foundations) vs. Software (parts)
- Open up perspectives for change without downplaying neurological realities.
- Further research is needed here.

Empowerment & Equal Footing
- Convey Confidence
- Enable participation [5]. IFS positions the
- person's inner wisdom as the primary resource [2].

Adjust Pace
- Adjust the pace so that Self can be experienced

Future Research:
- Replication with larger, representative samples in routine care settings
- Examine self-leadership as a cross-modality factor
- Investigate whether IFS can be experienced without prior cognitive understanding
- Empirically investigate diagnostic communication in neurodiversity contexts

References

[1] Schnell, T. (2019). Folgen subjektiver Verarbeitung von psychiatrischen Diagnosen [in German]. *Psychotherapeutenjournal, 18*(1), 11–16.
[2] Schwartz, R. C. (2021). No bad parts: Healing trauma and restoring wholeness with the Internal Family Systems model. Sounds True.
[3] Gemeinsamer Bundesausschuss. (2025). *Psychotherapie-Richtlinie [in German]*. https://www.g-ba.de/richtlinien/20/
[4] Schneider, F. (2016). *Klinikmanual Psychiatrie, Psychosomatik und Psychotherapie [in German]*. Springer. https://doi.org/10.1007/978-3-642-54571-9
[5] Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., Cording, E., Tomson, D., Dodd, C., Rollnick, S., Edwards, A., & Barry, M. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine, 27*(10), 1361–1367. https://doi.org/10.1007/s11606-012-2077-6
[6] Antonovsky, A. (1997). *Salutogenese: Zur Entmystifizierung der Gesundheit [in German]* (A. Franke, Ed.; Vol. 36). DGVT-Verlag.
[7] Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 35–53. https://doi.org/10.1093/clipsy.9.1.35
[8] Mayring, P. (2015). *Qualitative Inhaltsanalyse: Grundlagen und Techniken [in German]* (12th ed.). Beltz.

Detecting Therapeutic Progress in IFS Therapy from Session Transcripts

Adam Taylor — Parts Companion (Evolve Labs) · adam@evolve.org · partscompanion.org/research

Philanthropically backed
Evolve.org · Evolve Labs — supporting the evolution in consciousness

10,344 recorded sessions
the largest known collection of real IFS therapy recordings

Recruiting collaborators
to label IFS process · client progress — from real session transcripts

Why We Are Doing This Research

Evolve.org: a philanthropic org. with a mission to support the evolution of consciousness. Experience supporting clinical rsch. in psychedelic therapy.

Evolve Labs: R&D arm supporting *inner technologies* like parts work.

Parts Companion: our recording and analysis platform for IFS.

IFS has earned the practice. Not yet the evidence.

2
randomized controlled trials, ever

0
major guideline or EST-list appearances

27
peer-reviewed studies (2025 scoping review)

0
validated observer-rated process measures

The bottleneck is measurement. Unblending, Self-energy, unburdening — invisible to every validated instrument. Fields move when measurement arrives: MI's MITI, automated CBT coding. IFS deserves the same.

What We Bring

10,344
transcribed, client-linked sessions

1,382
clients, in real courses of therapy

139
long arcs — ≥10 sessions over ≥6 months

3 + 1
event tracks + a separated safety pathway

Plus a working annotation portal — clinicians verify, reject, or add turn-anchored events — and LLM detectors for every candidate signal.

Data ethics: client consent or HIPAA Safe Harbor de-identification only · safety content never scored as progress · therapy transcripts treated as the sensitive data they are.

The Research Question

Can client progress be measured from transcripts?

Four studies in sequence. Each is a requirement for the next.

STUDY 1
Human reliability
Do trained clinicians agree on the IFS process events and signs of client progress?

STUDY 2
AI rater vs. clinicians
Can an LLM label with consensus with the human experts?

STUDY 3
Trajectories
Is client progress observable over time?

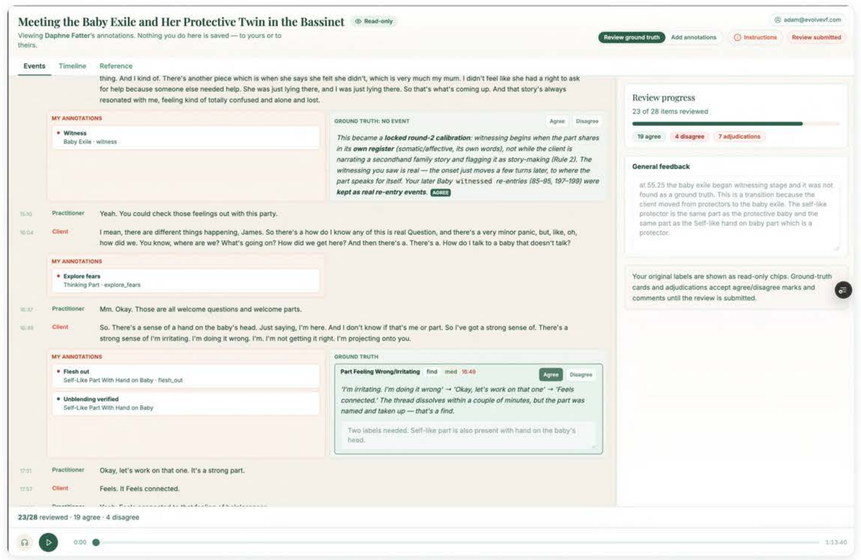
STUDY 4
Outcomes
Your trial, your IRB, your outcome data

Pre-registered on OSF · blind human ground truth · sealed holdouts · insiders excluded

What we label and measure

In-session: IFS Process & Ratings
Blending & unblending, unburdenings, 6Fs; client agency, somatic access

Longitudinal: Outcomes & Durability
self-reported symptoms, enacted life change, deepening experiential contact



The annotation portal: clinicians label events and verify or reject events labeled by an AI annotator

Researchers Wanted. Is this you?

- **IFS clinicians** — trained rater roles. Paid; co-authorship eligible.
- **Researchers** — co-develop, co-publish, replicate independently.
- **Trial teams** — session-level process coding for your recorded sessions.
- **Funders & field bodies** — protocol and dossier open for review.

partscompanion.org/research
adam@evolve.org · full protocol on request

Hypothesis-generating findings

six-client, 104-session pilot — not validation

Quiet in-session signals matched later life change
In session: growing somatic access, sustained experiential depth, client-initiated unblending. **Sessions later, in clients' own reports:** boundaries held, protector strategies gone quiet, change that lasted. ***Dramatic in-session "breakthroughs" produced no such echo.***

Negative finding examples we keep
Of 7 unburdening candidates: 4 disconfirmed, 3 uncorroborated. "Self-energy %" inflated for fluent clients.

Conclusions

We claim no validated measure — and will not, until these studies are done.

Next: rater recruitment → OSF pre-registration → Study 1 → sealed AI-rater comparison.

For research groups: adopt the instrument in your trial — even as exploratory endpoints. Your IRB, your outcomes: the criterion validity the field lacks.

In the therapy room: session-level feedback in IFS's own terms. The quiet signals of progress, made visible. The measurement base IFS trials need.

Naperville Trauma Institute

Evaluating Clinician Transformation Through IFS Level 2 Trainings Facilitated By Cece Sykes

Lauren Brdecka, LCPC • Olivia Lewis, PhD • Cece Sykes, LCSW • OSU IRB HE-2026-2421 • Naperville Trauma Institute & Oregon State University

Why We Are Doing This Research

The purpose of this study is to quantitatively examine clinicians' self-reported perceived change in Self-energy and related Internal Family Systems (IFS) capacities following completion of an IFS Level 2 Intensive Training focused on addictive processes, eating disorders, and high-consequence behaviors lead by Cece Sykes. The addictive processes being evaluated could be in a client, a loved one, or within the therapist, personally.

Addictive processes, eating disorders, and other high-consequence behaviors are among the most stigmatized presentations therapists meet. When the clinician is frightened, moralizing, or locked into "stop the behavior first," protective parts often tighten - clients hide, families polarize, and therapists leave sessions feeling harsh, or more troubling feelings, toward the systems they hope to help.

Abstract

This independent outcomes study evaluates clinician-reported development after IFS Level 2 training on addictive processes, eating disorders, and high-consequence behaviors. Using one anonymous THEN/NOW questionnaire, it describes perceived change in Self-leadership, compassion, stigma, systems awareness, curiosity, readiness, and intervention confidence. OSU provides IRB oversight (HE-2026-2421); NTI sponsors and stewards data; IFSI is educational partner only. Findings will inform curriculum and training research without claiming causal efficacy.

Introduction

IFS frames high-consequence behaviors as protective, not merely pathological. Training volume has outpaced independent research on what Level 2 education changes in clinicians. Typical evaluations measure satisfaction, not Self-leadership, stigma, curiosity, readiness, or confidence with polarized systems. This study addresses that gap with a theoretically mapped, vendor-independent THEN/NOW design.

Research Question

RQ1: To what extent do clinicians report increased Self-energy (Self-leadership) from "BEFORE the training" (retrospective pretest/then rating) to "NOW" (post-training rating) after completing the IFS Level 2 Training?

Secondary: Self-leadership; compassion toward protective systems; reduced stigma; internal systems awareness; therapeutic curiosity; clinical readiness; confidence with advanced IFS interventions (unblending, polarization, Circle/Table). Exploratory: views of clients, loved ones, and the clinician's own system.

Methods

Design: cross-sectional, single-arm retrospective pretest–posttest after IFS L2 Addictive Processes, Eating Disorders, and High-Consequence Behaviors. Sample: adult MH professionals who completed that training; convenience; no incentive. Flow: IRB-approved QR/anonymous Qualtrics link → e-consent → demographics → Structured Study Questionnaire (~20–25 min). Analysis: paired t or Wilcoxon by domain; Cohen's dz; exploratory contrasts. No causal claims. Exempt Cat. 2 requested.

Results

Results are not yet available (application unsubmitted as of 8-6-2026). Planned: sample description; THEN vs. NOW means across seven a priori domains; effect sizes with 95% CIs; exploratory items on clients, loved ones, own system, and Circle/Table. Report aggregate only; small cells suppressed.

Discussion

THEN vs. NOW patterns will be read as participant-reported development, not proof the training "works." Retrospective ratings reduce response-shift bias once clinicians have language for Self and parts. Limits: no comparison group, no prospective baseline, convenience sample, self-report. Governance (OSU ethics; NTI data stewardship; IFSI educational partner only) keeps interpretation independent of the training vendor.

Conclusions

Next steps: multi-cohort replication, a prospective pretest arm, and linking clinician-reported change to de-identified practice indicators. Other groups can reuse this independent-evaluation model for additional Level 2 specialties.

In the therapy room: a less stigmatizing stance toward addictive and ED protectors may reduce shame-driven escalation. In life: clinicians who stay Self-led with high-consequence systems are better able to offer curiosity instead of control with themselves, clients, and loved ones.

References

Anderson, Sweezy, & Schwartz (2017). IFS Skills Manual.

Belmont Report (1979). 45 CFR 46.

Cook & Campbell (1979). Quasi-experimentation

Howard, Ralph, et al. (1979). Retrospective pretests. Appl. Psychol. Meas.

Schwartz & Sweezy (2021). IFS Therapy (2nd ed.).

Sykes, Sweezy, & Schwartz (2023). IFS Therapy for Addictions; Trauma-Informed, Compassion-Based Interventions for Substance Use, Eating, Gambling and More

HEALING THE INNER SYSTEM: A PILOT STUDY OF INTERNAL FAMILY SYSTEMS (IFS) THERAPY FOR MEDICAL TRAUMA IN ADULTS WITH CYSTIC FIBROSIS

Veronica Grosse-Cardinale, PsyD, Samantha Allen, LICSW, Carolyn Snell, PhD, Ahmet Uluer, DO
Boston Children's Hospital

Background

Cystic fibrosis (CF) is a progressive, multi-system genetic disorder that can affect people of every racial and ethnic group. CF is caused by variants in the cystic fibrosis transmembrane conductance regulator(CFTR) gene. These variants impair chloride ion transport across epithelial cells, leading to thick, sticky secretions that most notably affect the respiratory and gastrointestinal systems. Diagnosis is confirmed by sweat chloride testing and genetic testing.

Many adults with cystic fibrosis (CF) have experienced repeated hospitalizations, invasive procedures, prolonged isolation, and delayed care, which may contribute to medical trauma and persistent psychological and somatic responses to healthcare experiences (Cuneo et al, 2023). These experiences can impair trust in providers, adherence to treatment, and overall quality of life (Shulka, Schilt-Solberg & Gibson-Scipio, 2025).

Internal Family Systems (IFS) is an emerging evidence-based therapeutic modality that provides an alternative approach to established cognitive and behavioral models that have been researched for the CF community, with a particular focus on medical trauma. To date, while behavioral interventions such as CBT and ACT have been studied and disseminated in people with CF (pwCF), there has been less emphasis on insight-oriented approaches such as IFS.

IFS has been shown to be a promising modality for the treatment of trauma (Hodgdon et al., 2022). IFS has also been shown to reduce overall pain experiences, improve physical functioning, and increase self-efficacy immediately after treatment for people with rheumatoid arthritis (Shadick et al., 2013). Findings suggest that IFS may improve psychological adjustment to chronic illnesses, even without changing underlying disease pathology. However, this approach has not yet been studied in pwCF, a population uniquely affected by lifelong treatment burden, recurrent procedures, and high rates of medical trauma. With recent advances in CFTR modulator therapies substantially extending life expectancy for many pwCF, optimizing quality of life and psychological coping has become increasingly important as adults with CF face age-related medical and psychosocial challenges that were historically seldom encountered.

Study Overview

This study aims to evaluate the feasibility, acceptability, and preliminary outcomes of an Internal Family Systems intervention for adults with cystic fibrosis who have experienced medical trauma. By targeting the mind–body connection, this approach will explore potential changes in PTSD-like symptoms, physiological stress markers, treatment adherence, and provider trust.

Adults with CF represent a clinically relevant pilot population due to early and repeated exposure to invasive medical care, complex treatment regimens, and elevated rates of psychological distress (Quittner, Saez-Flores & Barton, 2016). Findings from this pilot may inform future research on integrating trauma-informed psychotherapies, including IFS, into care models for medically complex populations such as individuals with autoimmune conditions, transplant history, long COVID, or other chronic illnesses often associated with healthcare-related trauma.

Objectives

Primary Aim:
To evaluate the feasibility and acceptability of delivering IFS therapy to pwCF age 18 and older, who report symptoms consistent with medical trauma.

Secondary and Exploratory Aims:
To explore changes in mental health symptoms, including symptoms of post-traumatic stress, anxiety and depression; health-related quality of life/ illness-related stress, and physiological stress markers.

Methods

Type: Mixed-methods, single-arm pilot study
Sample Size: 12-16 adults with CF
Duration: 16 weeks of intervention to occur across no greater than a 32-week period + 6-month post-intervention follow-up.
Setting: CF clinic at Boston Children's Hospital, with virtual IFS sessions led by trained therapists

Intervention

16-week IFS Intervention

- Weekly 60-minute virtual IFS therapy sessions
- Focus on identifying and unburdening parts of the self related to trauma (e.g., protector parts, vulnerable parts impacted by difficult medical procedures, isolation, shame, or loss)
- Integration with participants' CF care as appropriate (e.g., medical and mental health team coordination with therapist if patient consents)

Hypotheses

Primary

H1: IFS will be feasible to implement among adults with CF and symptoms consistent with medical trauma, demonstrated by successful recruitment, retention, and treatment completion .
Benchmark re: Treatment completion: We expect at least 80% of participants to complete 12 out of the 16 sessions.
H2: Participants will report high levels of treatment acceptability and satisfaction with the intervention, as evidenced by scores on the Acceptability of Intervention Measure (AIM) and qualitative interviews.

Secondary

H3: Participants will demonstrate improvements in trauma-related symptoms from baseline to post-treatment, as demonstrated by the PCL-5.
H4: Participants will demonstrate improvements in CF-related quality of life from baseline to post-treatment.
H5: Participants will demonstrate improvements in symptoms of depression and anxiety from baseline to post-treatment.

Exploratory outcomes include sleep, pain, physiological data, and qualitative themes relevant to participants' experiences of the intervention . Therapeutic alliance will be evaluated as a process measure to explore potential associations with intervention outcomes.

Outcome Measures

Quantitative Measures will Assess:

- Feasibility and Acceptability: Recruitment, attendance, and completion rates, Acceptability of Intervention Measure (AIM)
- Mental Health: PTSD Checklist for DSM-5 (PCL-5), Generalized Anxiety Disorder-7 (GAD-7), Patient Health Questionnaire-8 (PHQ-8)
- Health Related Quality of Life and Illness-Specific Measures: Cystic Fibrosis Questionnaire-Revised, Adult Version (CFQ-R), Cystic Fibrosis Stress Questionnaire (CFSQ)

Qualitative Component

Semi-structured interviews will be conducted at two timepoints: Week 1 (baseline) and Week 16 (post-intervention). The use of semi-structured interviews allows participants to describe their experiences in their own words while ensuring that key domains relevant to medical trauma and treatment engagement are explored.

Data Analysis Plan

- This study will utilize a mixed-methods approach, combining quantitative and qualitative data to evaluate changes in psychological outcomes and other study outcomes over the course of intervention
- Feasibility metrics: % enrolled, session attendance, treatment completion, retention
- Quantitative outcomes will be examined using within-subject comparisons across applicable study timepoints. For outcomes assessed at baseline and post-intervention, paired t-tests or Wilcoxon signed-rank tests will be used, as appropriate.
- Outcomes assessed at additional timepoints will be examined across their specified assessment periods.
- Retrospective clinical and wearable data will be summarized descriptively when available. Data from the pre-intervention, intervention, and post-intervention periods will be examined, and within-participant change will be explored when comparable data are available across time periods. Wearable data will be considered exploratory and will be analyzed only for participants who provide available wearable data.
- Qualitative interviews: Thematic analysis using NVivo or similar software

Next Steps if Feasible

If pilot outcomes suggest feasibility and positive trends, pursue:

- Broader application to other medical trauma populations (e.g., congenital heart disease, spina bifida, transplant, sickle cell, long-COVID)
- A randomized controlled trial
- Integration with other trauma-informed care approaches in CF
- Exploration of adaptations for adolescents or caregivers
- Improved adherence and cost outcomes - reduced emergency visits, hospitalizations, etc.

References

Cuneo, A. A., Outram, S., Marsac, M. L., Vendlinski, S., Heyman, M. B., Ly, N., von Scheven, E., & Perito, E. R. (2023). Medical traumatic stress in cystic fibrosis: A qualitative analysis. Journal of Cystic Fibrosis, 22(4), 763–771. https://doi.org/10.1016/j.jcf.2022.12.008

Hodgdon, H. B., Anderson, F. G., Southwell, E., Hrubec, W., & Schwartz, R. (2022). Internal Family Systems (IFS) therapy for posttraumatic stress disorder (PTSD) among survivors of multiple childhood trauma: A pilot effectiveness study. Journal of Aggression, Maltreatment & Trauma, 31(1), 22–43. https://doi.org/10.1080/10926771.2021.2013375

Shadick, N. A., Sowell, N. F., Frits, M. L., Hoffman, S. M., Hartz, S. A., Booth, F. D., Sweezy, M., Rogers, P. R., Dubin, R. L., Atkinson, J. C., Friedman, A. L., Augusto, F., Iannaccone, C. K., Fossel, A. H., Quinn, G., Cui, J., Losina, E., & Schwartz, R. C. (2013). A randomized controlled trial of an internal family systems-based psychotherapeutic intervention on outcomes in rheumatoid arthritis: A proof-of-concept study. The Journal of Rheumatology, 40(11), 1831–1841. https://doi.org/10.3899/jrheum.121465

Quittner, A. L., Sáez-Flores, E., & Barton, J. D. (2016). The psychological burden of cystic fibrosis. Current Opinion in Pulmonary Medicine, 22(2), 187–191. https://doi.org/10.1097/MCP.0000000000000244

BRIGHAM AND WOMEN'S HOSPITAL | The Lung Center |

Boston Children's Hospital
Where the world comes for answers

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Faculty of Social Work and Health Hildesheim

POSTER PRESENTATION | IFS ANNUAL CONFERENCE | VIRTUAL | OCTOBER 15 – 16, 2026

Mental Health in Professional Interactions in Social Work

A qualification program with elements of IFS and PAUSE

Katharina Maaske & Tamara Thomsen

Abstract

Social work involves emotionally demanding professional interactions that can affect well-being and mental health. The current longitudinal study looks at a qualification program with elements of Internal Family System (IFS; Schwartz, 2023) and the PAUSE model (Curry-Sartori, 2025) for social work professionals during their recognition year. Participants are assessed at three measurement points as well as through daily process monitoring. This poster report presents the current sample and preliminary results of the program evaluation. These first results show a high level of acceptance and perceived usefulness as rated by participants, while the longitudinal analyses on mental health and individual resources are still ongoing. The comparison with the control group is also still pending. Additionally, another training group will start in winter 2026.

Why We Are Doing This Research & Introduction

Professional social work can have a significant impact on the occupational well-being, physical health, and mental health of practitioners (Groen et al., 2024). The profession is associated with a high risk of stress-related outcomes, such as burnout and emotional exhaustion, particularly among early-career social workers (e.g. Hollederer, 2023; Kahl & Bauknecht, 2023). High emotional demands in client interactions increase vulnerability to mental health problems (Kinman & Grant, 2020; Winter, 2019) and require professionals to manage complex emotional processes, including their own and clients' emotions (Jansson, 2024). At the same time, relational practice is widely considered the foundation of social work (Cleece et al., 2025; Lamph et al., 2023), making emotionally demanding relational work a central focus for understanding both risks and protective factors in the field.

Research Question

To what extent does participation in the qualification program play a role in mental health and the development of resources in dealing with oneself and others during the state recognition year in social work?

Study Objectives

- Evaluation of the adapted qualification program
- Assess changes in mental health and individual resources
- Identify factors predicting the change process
- Develop practical recommendations for supporting social work professionals

Brief description of the qualification program

Participants completed a six-session, practice-based training over ten weeks, combining the PAUSE model with parts work based on IFS. Through theoretical input, experiential exercises, and between-session transfer tasks, participants learned to recognize and reflect on their own internal reactions, regulate these more consciously, and consider the internal processes of others to support professional relationship-building.

Methods

Design: 3-month longitudinal study with three measurement points plus daily monitoring.
Groups: Training group (qualification program) and control group (supervision offer)
Randomization: Not possible due to organizational constraints

Data Collection

1. Personal data: age, gender, experience level and work context
2. Standardized questionnaires: mental health and individual resources
3. Process monitoring: brief daily assessments of wellbeing and resources
4. Program evaluation: perceived usefulness and training evaluation
„TEI: Training Evaluations Inventar" (Ritzmann et. al, 2020)

Current Sample

	Training group (n = 9)	Control group (n = 18)
Age in years, *M*	27.9	29.2
Months in state recognition year, *M*	4.3	4.1
Working days per week, *M*	4.9	5.0
Working hours per week, *M*	36.3	36.9

Results

Training evaluation (mean scores (*M*) on 5-point TEI scales):

Note. Training evaluation data were available from *n* = 8 participants; the training group originally included *n* = 9 participants (dropout: *n* = 1).

Training evaluation was further assessed using study-specific items rated on 0–10 scales (0 = *not at all/not useful*, 10 = *very/very useful*). Results show high participant ratings for the seminar overall (M = 9.71), theory–practice balance (M = 9.38), and usefulness for professional practice and private life (both M = 8.38).

Qualitative Evaluation:
Most frequently coded aspects in open responses were practical exercises and perceived private-life usefulness (9 codings each), relationship building (6 codings), and self-reflection and professional usefulness (5 codings each). Participants also mentioned requests for more practical work and more exchange. These findings describe participant experiences and do not establish program effectiveness.

Discussion

The first evaluation suggests high acceptability of the training and perceived usefulness for professional and private contexts. The pattern is consistent with the earlier pilot study, where participants highlighted understanding own and others' reactions, client work, conflict handling and reflection on interactions. However, the current findings are preliminary and descriptive. The study is not randomized, the sample is still developing, and longitudinal analyses of mental health, individual resources and process dynamics are ongoing.

Conclusions

The qualification program is currently being well received by the participating social professionals. Preliminary evaluation data support further examination of its feasibility and perceived usefulness. Another training group is still pending. The planned longitudinal and process-oriented analyses will show whether participation over time is associated with changes in mental health and individual resources.

References

Cleece, K., Cheneler, B., Harrison, J. & Hill , James Edward (2025). Relational practice, a critical component for successful social work, *Cogent Social Sciences*, *11*(1), 2492402, DOI: 10.1080/23311886.2025.2492402
Curry-Sartori, J. (2025). *The self-led educator: An IFS-inspired guide to create calm, compassionate, and confident learning communities*. PESI.
Groen, G., Weidtmann, K., Vaudt, S., & Ansen, H. (2024). *Selbstfürsorge in psychosozialen Berufen*. UTB.
Hollederer, A. (2023). Wer leidet in der Sozialen Arbeit an Erschöpfung? Ergebnisse einer Repräsentativerhebung. *Soziale Passagen*, *15*(1), 233–250. https://doi.org/10.1007/s12592-023-00463-7
Jansson, P., & Gunnarsson, N. (2024). Working with emotions in social work practice. A pride-building model for institutional care of young people. *Children and Youth Services Review, 161*. 10.1016/j.childyouth.2024.107610.
Kahl, Y., & Bauknecht, J. (2023). Psychische und emotionale Erschöpfung von Fachkräften der Sozialen Arbeit: Entwicklung, Ausmaß und die Rolle von Belastungs- und Resilienzfaktoren. *Soziale Passagen*, *15*(1), 213–232. https://doi.org/10.1007/s12592-023-00448-6
Kinman, G. & Grant, L. (2020). Emotional demands, compassion and mental health in social workers. *Occupational medicine*, *70*. 10.1093/occmed/kqz144.
Lamph, G., Nowland, R., Boland, P. et al. (2023). Relational practice in health, education, criminal justice, and social care: a scoping review. *Systematic Reviews*, *12*(194). https://doi.org/10.1186/s13643-023-02344-9
Ritzmann, S., Hagemann, V. & Kluge, A. (2020). TEI. Training Evaluations Inventar [Verfahrensdokumentation, Inventar deutsch und englisch]. In Leibniz-Institut für Psychologie (ZPID) (Hrsg.), *Open Test Archive*. ZPID. https://doi.org/10.23668/psycharchives.4493Informed Consent
Schwartz, R. C. (2023). *Introduction to internal family systems* (2nd ed.). Sounds True.
Winter, K. (2019). Relational social work. In M. Payne, & E. Reith Hall (Eds.), *Routledge Handbook of Social Work Theory* (pp. 1-10). Routledge.

HOCHSCHULE FÜR ANGEWANDTE WISSENSCHAFT UND KUNST Hildesheim/Holzminden/Göttingen
University of Applied Sciences and Arts

Katharina Maaske katharina.maaske@hawk.de
Prof. Dr. Tamara Thomsen tamara.thomsen@hawk.de

www.hawk.de/en/s

How Mental Health Professionals in the United Kingdom Decide to Integrate IFS Therapy: A Constructivist Grounded Theory Study

Dr. Oliver Beaumont[1], Dr. Maike Klein[1*] & Emma E. Redfern[2]

[1]Division of Health Research | Lancaster University | Lancaster, UK
[2] Emma E. Redfern Online Psychotherapy Services | Honiton, UK
[*] Corresponding author: Dr Maike Klein | E-mail: m.klein@lancaster.ac.uk

Introduction

Mental health professionals in the UK are supporting an increasing number of adults who experience psychological distress, many of whom have histories of trauma (National Health Service [NHS] England, 2025). UK clinical guidelines currently recommend trauma-focused cognitive behavioural therapy and eye movement desensitisation and reprocessing for post-traumatic stress disorder (PTSD; NICE, 2018). Although these interventions have substantial empirical support, some clients do not seem to benefit or even discontinue treatment (e.g. Semmlinger et al., 2024; Yunitri et al., 2023). The heterogeneous presentations of PTSD and complex PTSD have also prompted interest in approaches that can be adapted to clients' differing needs, including difficulties involving identity, relationships and emotional regulation (Burback et al., 2025; Zilberstein, 2022).

Internal Family Systems (IFS) therapy is one such approach and is being increasingly incorporated into trauma-focused practice (Earleywine et al., 2025). However, literature on IFS integration consists largely of case studies and conceptual accounts, predominantly from outside the UK. This literature illustrates possible combinations of therapeutic approaches but provides limited empirical understanding of how professionals decide whether, when and how to integrate IFS in routine practice.

Addressing this evidence gap is particularly relevant for the UK context, where NHS mental health services are currently facing substantial demand and resource constraints, which can restrict interventions and professionals' flexibility in responding to complex presentations (Care Quality Commission, 2025; Iliffe & Manthorpe, 2019; NHS Digital, 2026).

Research Questions

The study therefore addressed the following two research questions:

1. What is the process of deciding to integrate internal family systems therapy into practice among UK-based mental health professionals?

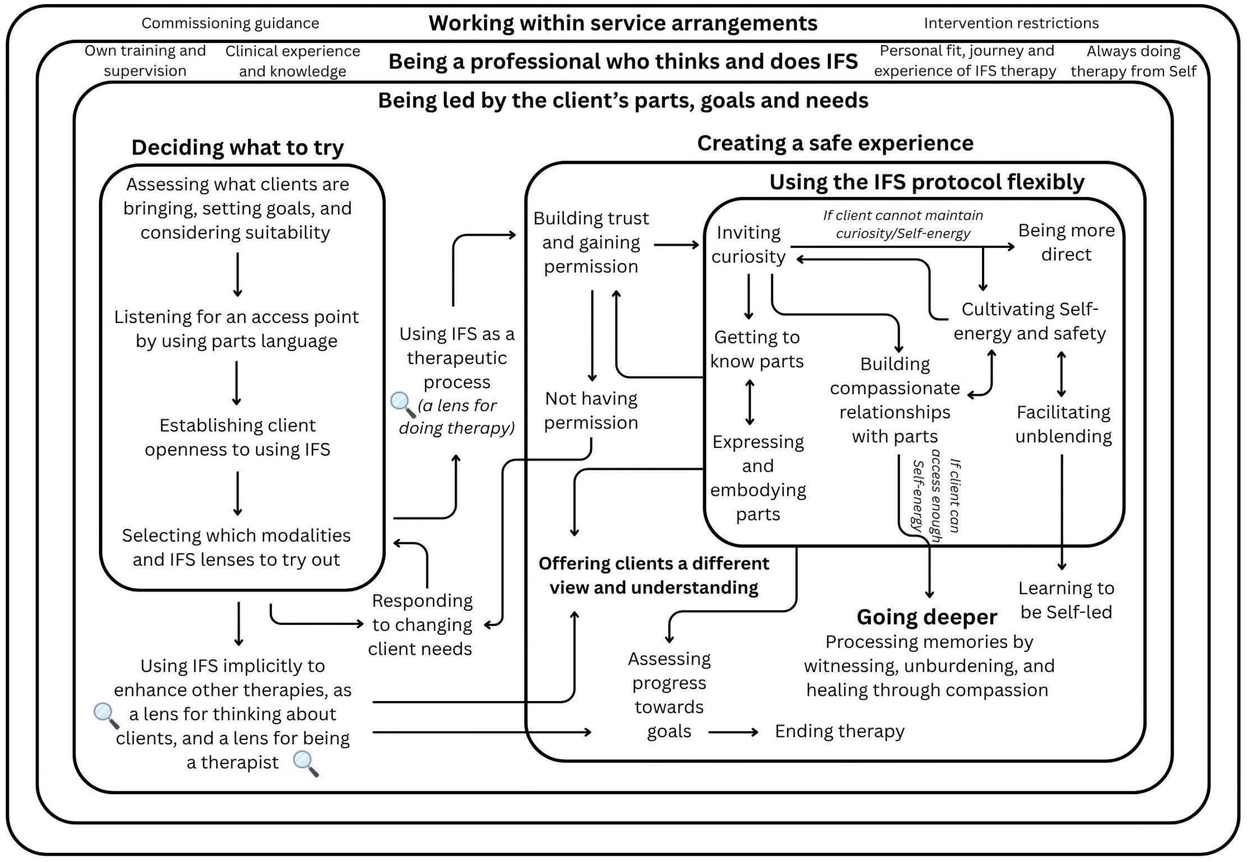
2. Which factors influence their decision-making?

Methods

This study employed constructivist grounded theory (Charmaz, 2024). Online qualitative interviews were conducted with 13 UK-based qualified mental health professionals, with iterative cycles of data collection and analysis. Recruited purposively, participants were from varied professional backgrounds. Eight worked solely in private practice, while five worked with adults across NHS mental health services, four of whom also practised privately. Participants had varying levels of IFS training and integrated IFS with different therapeutic approaches.

Results

Figure 1 presents the constructed grounded theory, with factors influencing professionals' decisions arranged in concentric layers. At its core, participants described being led by clients' parts, goals and needs. However, client-ledness operated within professional and organisational contexts that shaped which approaches participants considered appropriate and feasible. The middle layer represents professionals' training, experiences and therapeutic orientations, which influenced how they understood and integrated IFS. The outer layer represents service arrangements, which could further constrain clinical choices. The central flowchart in Figure 1 depicts the process of how professionals described deciding to integrate IFS with other modalities. Professionals consistently stated that throughout this process, they focused on being alongside clients and going with the flow. Participants described initially exploring clients' needs, goals, access to Self-energy and openness to IFS, with client responses informing whether professionals offered the full IFS process, integrated selected concepts into other approaches, or used another modality. If using IFS explicitly appeared less suitable, professionals described still drawing on IFS as a lens for thinking and being. Decisions on how to use IFS were reassessed as therapy progressed, in response to clients' needs, goals, and treatment responses.



Discussion

This study offers a novel conceptual model of the relationship between client-led decisions, professional influences and service arrangements in the integration of IFS in the UK. The study also offers a distinction between IFS as a lens for thinking, a way of being a therapist and a therapeutic process for doing therapy. Although these dimensions appear in existing IFS literature, the present study clarifies their different roles in IFS integration. Findings relating to professional influences on decision-making are highly consistent with existing research. Moreover, the centrality of flexibility and client-ledness within the novel model of IFS integration is strongly echoed in conceptualisations of integrative psychotherapy processes from other research contexts (e.g. Oddli & McLeod, 2017; de-Paula-Ravagnani et al., 2022). Ultimately, the present study's conceptual model extends existing descriptions of the different possibilities for IFS integration by offering a process-based representation of how professionals might select among these possibilities in an individualised, responsive, trauma-informed manner.

Conclusions

This study conceptualises UK-based mental health professionals as negotiating client-led decisions about IFS integration within professional and service-level constraints and describes how IFS can inform their clinical thinking and therapeutic presence even when it is not delivered as an explicit intervention. The conceptual model offers a framework for readers to reflect on how they decide to integrate IFS within their own practice and how they might continuously reflect on this throughout therapy, while holding in mind a client's emotional safety. It is hoped that such reflection might help therapists who work within approaches, evidence bases and service structures, yet find the people in front of them to not fit neatly into any one of these, to navigate this understandable tension in their practice. It is also hoped that if this does lead to a more responsive, trauma-informed, person-centred practice, that this would ultimately have a positive impact on the lives of clients.

Further research directions include:

1. Further grounded theory research to examine integration of IFS with specific therapeutic approaches.
2. Research incorporating session observations and client perspectives to examine how collaboration, permission-seeking and flexible integration of IFS concepts and techniques are experienced by clients.
3. Controlled trials and longitudinal studies are needed to establish the effectiveness and longer-term outcomes of IFS-integrated interventions.
4. Research into whether IFS as a lens for thinking (e.g. parts-informed formulation) can improve client experiences or outcomes in shorter-term therapy without the full IFS protocol needing to be implemented.

References

Burback, L., Winkler, O., Jetly, R., Swainson, J., Zhang, Y., Bhat, V., & Vermetten, E. (2025). Evolving psychotherapeutic approaches for PTSD: Beyond the fear- based model. Psychiatry and Clinical Psychopharmacology, 35(1), 152–167. https://doi.org/10.5152/pcp.2025.241019

Care Quality Commission. (October 2025). The state of health care and adult social care in England 2024/25. https://www.cqc.org.uk/publications/major-report/state- care/2024-2025/access/mh

Charmaz, K. (2024). Constructing grounded theory (3rd ed.). SAGE Publications.

de Paula-Ravagnani, G. S., Sundet, E. R., & Guanaes-Lorenzi, C. (2022). Learning from within: Therapists' actions in daily clinical practice. Family Process, 62(1), 94–107. https://doi.org/10.1111/famp.12840

Earleywine, M., Oliva, A. B., de Leo, J. A., & Banks, R. (2025). An examination of internal family systems interventions for trauma with implications for ethical psychedelic-assisted treatment. Journal of Psychedelic Studies, 9(1), 51–58. https://doi.org/10.1556/2054.2024.00265

Iliffe, S., & Manthorpe, J. (2019). Job dissatisfaction, 'burnout' and alienation of labour: undercurrents in England's NHS. Journal of the Royal Society of Medicine, 112(9), 370–377. https://doi.org/10.1177/0141076819855956

National Institute for Health and Care Excellence. (2018). Post-traumatic stress disorder [NICE Guideline No. 116]. https://www.nice.org.uk/guidance/ng116

NHS Digital. (January 2026). Mental health services monthly statistics, performance November 2024. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly- statistics/performance-november-2025

NHS England. (November 2025). Adult psychiatric morbidity survey: Survey of mental health and wellbeing, England, 2023/4. https://digital.nhs.uk/data-and- information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of- mental-health-and-wellbeing-england-2023-24/posttraumatic-stress-disorder

Oddli, H. W., & McLeod, J. (2017). Knowing-in-relation: How experienced therapists integrate different sources of knowledge in actual clinical practice. Journal of Psychotherapy Integration, 27(1), 107–119. https://doi.org/10.1037/int0000045

Semmlinger, V., Leithner, C., Klöck, L. M., Ranftl, L., Ehring, T., & Schreckenbach, M. (2024). Prevalence and predictors of nonresponse to psychological treatment for PTSD: A meta-analysis. Depression and Anxiety. https://doi.org/10.1155/2024/9899034

Yunitri, N., Chu, H., Kang, X. L., Wiratama, B. S., Lee, T. Y., Chang, L. F., Liu, D., Kustanti, C. Y., Chiang, K. J., Chen, R., Tseng, P., & Chou, K. R. (2023). Comparative effectiveness of psychotherapies in adults with posttraumatic stress disorder: a network meta-analysis of randomised controlled trials. Psychological Medicine, 53(13), 6376–6388. https://doi.org/10.1017/S0033291722003737

Zilberstein, K. (2022). Trauma in context: An integrative treatment model. Journal of Child and Adolescent Trauma, 15(2), 487–500. https://doi.org/10.1007/s40653- 021-00416-3

Efficacy of an Online, Group-Based Internal Family Systems (IFS) Intervention on PTSD Symptom Clusters

Laure Tobiasz Veltz[1], Dilara Ally[1,2], Zev Schuman-Olivier[1,2]
[1]Center for Mindfulness and Compassion, Department of Psychiatry, Cambridge Health Alliance, [2]Department of Psychiatry, Harvard Medical School, Harvard University

Why This Research?

- **Posttraumatic stress disorder (PTSD) is a debilitating condition** that often follows exposure to traumatic experiences
- Symptoms are defined in the Diagnostic & Statistics Manual, 5th edition, text revision (DSM-5-TR)[1] and organized by specific criteria:
  - **Intrusion Criterion B,**
  - **Avoidance Criterion C,**
  - **Negative Cognition Criterion D,**
  - **Hyperarousal Criterion E**
- **Internal Family Systems (IFS)** is an innovative intervention that has gained popularity since its inception forty years ago
- Preliminary studies[3,4,5,6] suggest it has **potential for alleviating symptoms of traumatic stress**
- Evidence of its efficacy for PTSD remains to be definitively established
- This individual participant data (IPD) meta-analysis aims to **scrutinize the efficacy of an online, group-based IFS intervention on PTSD symptom clusters**
- It postulates that overall PTSD symptoms will improve, with greatest reductions seen in intrusion (Criterion B) and avoidance (Criterion C) symptoms

Methods

- **Four studies**[3,4,5,6] (*N* = 76 participants) were included in this IPD meta-analysis (**Table 1**)
- All involved an online, group-based IFS intervention for PTSD paired with individual IFS therapy sessions
- **Pre-/post-intervention PTSD CheckList for DSM-5** (PCL-5)[2] data were collected via self-reported surveys
- The primary aim of this work is to **assess the efficacy of the IFS intervention by cluster of PTSD symptoms** as defined by the DSM-5-TR[1]. A **two-stage individual participant data (IPD) meta-analysis with random effects, measuring differences in effect sizes** followed by meta-regressions with and without moderating variables were performed

Results

- Overall, the **IFS intervention showed significant efficacy in reducing overall PTSD severity**
  - g = -1.13, p<=0.05, p_{HB} < 0.05, 95% *CI* [-1.50; -0.76]
  - PCL-5 median scores pre-/post-intervention showed notable reductions for all clusters (**Figure 1**)
- Even though **efficacy was not linear** across PTSD clusters, **no cluster significantly differed in terms of effect sizes**
- The meta-analysis by cluster showed **large negative effect sizes for all symptom clusters**:
  - **g_B= -1.17**,
  - **g_D= -1.12**,
  - **g_C= -1.04**,
  - **g_E= -0.80**,
  - p<0.05, p_{HB} < 0.05 (**Figure 2**)
- Yet with low certainty around the estimates (wide 95% CIs)
- Heterogeneity statistics did not reveal any between-study variability, indicative of consistent study protocols and intervention designs
- While intrusion (Criterion B) and negative cognition (Criterion D) appeared to have markedly higher effect sizes, a meta-regression using clusters as a moderator, disproved the significance of the effect size differences (p>0.05, p_{HB} > 0.05)
- Hence, we did **not** find evidence to support that IFS had a **significantly preferential impact on different clusters of PTSD symptoms**

Figure 2. Meta-analysis by symptom cluster

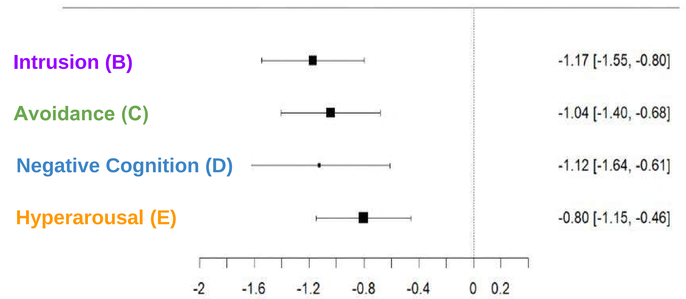
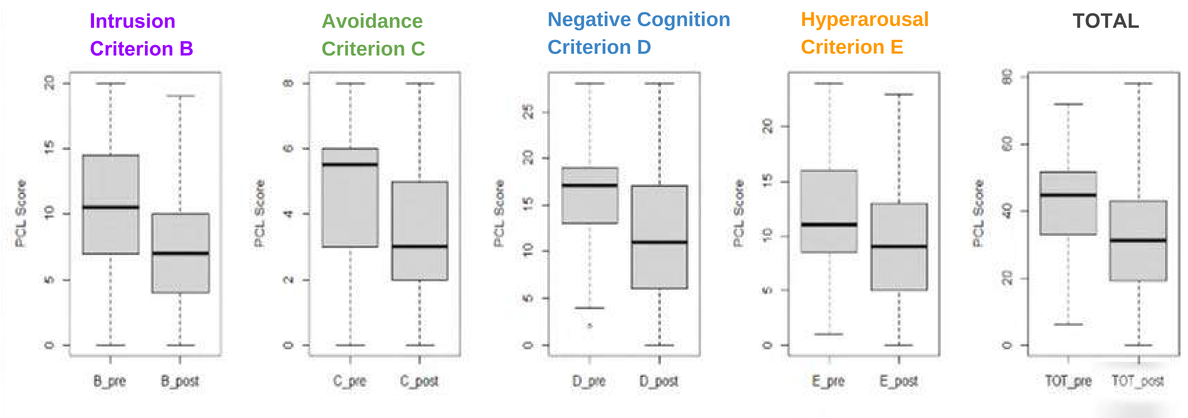


Table 1. Studies overview

Study	Sample size	Non-male	Non-white	Condition	Intervention type
PARTS Pilot[3]	*n* = 15	87%	40%	PTSD	PARTS 16-wk
PARTS RCT[5]	*n* = 30	83%	47%	PTSD	PARTS 16-wk
PARTS SUD[4]	*n* = 10	60%	40%	PTSD + SUD	PARTS 12-wk
PARTS CPP[6]	*n* = 21	81%	33%	PTSD	PARTS 16-wk

Figure 1. Boxplot of pre-/post-intervention PCL-5 scores by symptom cluster (median)



Discussion

- This IPD meta-analysis adds to the emerging research **showing the efficacy of IFS as a modality of psychotherapy to alleviate PTSD**
- **Findings did not demonstrate a differential or heterogeneous impact of IFS on PTSD symptom clusters**, though larger studies are needed to definitively determine whether IFS reduces symptoms of PTSD homogeneously across symptom clusters
- The results align with empirical findings from the existing literature regarding other PTSD treatment modalities (including CBT and EMDR), which show a lack of differentiation in efficacy amongst PTSD symptom clusters
- All in all, **IFS is a promising treatment for reducing PTSD symptoms with evidence from four trials**[3,4,5,6] **consistently reporting a large effect size reduction**

Acknowledgments & References

- Scan for full reference list and additional data:
- The studies included in this meta-analysis were supported by the following grants:
  - PARTS Pilot Study: Foundation for Self Leadership (Grant R050120-CHA) to ZSO
  - PARTS RCT Study: Foundation for Self Leadership (Grant R050120-CHA) awarded to ZSO, National Center for Complementary and Integrative Health, National Institutes of Health (Grant 3R01AT011002-04S1)
  - PARTS CPP Study: departmental funding for the PARTS Service in the Cambridge Health Alliance Center for Mindfulness and Compassion directed by ZSO, Richard C. Schwartz fellowship grant from the Foundation for Self Leadership (Award No. R082523 CHA) to ZSO through the Foundation for Self Leadership, Harvard Medical School Livingston Fellowship awarded to DA
  - PARTS SUD Study: Foundation for Self Leadership grant (Award No. R050120-CHA) to ZSO
- The PI's and authors of these studies were supported by the following fellowships:
  - Dr. Dilara Ally: Richard C. Schwartz Research Fellowship (Award No. R082523 CHA), Harvard Medical School Livingston Fellowship
  - Dr. Diane Joss: Richard C. Schwartz Research Fellowship from the Foundation for Self Leadership
  - Dr. Joseph Rosansky: T32 fellowship from the National Center for Complementary and Integrative Health, National Institutes of Health (Grant T32AT000051)

RELATING TO THE SELF:
A RELATIONAL FRAME THEORY (RFT) ANALYSIS OF CHANGE PROCESSES IN IFS THERAPY

Alex Tsarev, PhD. *South Korea*. An Independent Researcher ORCID: 0000-0002-4716-0808

Why This Analysis

IFS has clinical support (Buys, 2025) but limited account of HOW change happens.

RFT is the behavior-analytic science behind ACT, with an established experimental base and a mature clinical translation.

Sits within process-based therapy (PBT): mapping transdiagnostic mechanisms across modalities (Ciarrochi et al., 2024), organized within the Extended Evolutionary Metamodel (EEMM).

Goal: to generate precise, falsifiable hypotheses about IFS mechanisms, not replace language of IFS.

Theoretical analysis: hypotheses proposed.

What Is RFT?

Derived relational responding: we derive relations never directly trained: train A→B, then B→A follows.

Transformation of stimulus functions: relating one event to another transfers psychological weight onto it

Cognitive fusion: verbal functions override direct contingencies.

Deictic (I-Here-Now) + hierarchical framing: the perspective FROM which content is held, not the content itself.

The Core Translation

Blending = cognitive fusion: the part's network takes over the whole experiential field.

Unblending = defusion + deictic re-anchoring: I-Here-Now & a hierarchical reframe; the part becomes one member of a system you contain.

Self / Observing Self = the stable deictic-hierarchical perspective-locus. Contentless: nothing can threaten it.

Witnessing = active acceptance: holding content without avoidance (not agreement!).

Unburdening = hypothesized contextual recontextualization: sustained compassionate presence changes the context the network was learned in.

The network isn't erased; its functions shift.

Structural Correspondences

Unit of analysis: verbal event → internal part

Source of suffering: cognitive fusion → blending

Mechanism of change: defusion → unblending

Perspective construct: observing self → Self (8 Cs)

Avoided content: acceptance → witnessing

Direction: chosen values → Self-leadership

Resolution: contextual control → unburdening

Grounding: explicit (RFT) → implicit (phenomenological)

Where It Holds — Where It Strains

Convergence is mechanistic (not verbal): different vocabularies, same underlying operations.

But: ACT's observing self is contentless by definition.

IFS Self is content-rich: the 8 Cs.

One reading: the Cs emerge FROM stable deictic-hierarchical framing.

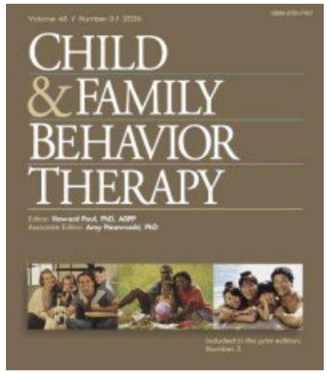
Witnessing also diverges: IFS treats the part as responsive to HOW it's witnessed.

A bidirectional relational encounter current RFT doesn't fully model.

What IFS Still Explains

Three things a single-network RFT account doesn't predict on its own:

1. Sequencing: why accessing an exile before a firefighter gives 'permission' reliably backfires.
2. Multiplicity: polarized parts, alliances, conflict between whole networks.
3. Being fully seen: parts appear to update differently depending on the QUALITY of witnessing, not just contextual exposure.



Clinical Implications

ACT-style defusion may work as PREP when high fusion blocks initial unblending.

IFS's embodied, relational procedures may build deictic framing more effectively than ACT's cognitive defusion exercises.

Firefighters activate too fast for real-time reframing. Retrospective deictic anchoring—reviewing episodes after the fact—may open a door live intervention can't reach.

A clinically integrated approach could draw on both ACT & IFS strategically: matched to the functional demand of the moment, not the diagnosis.

Research Directions

- Adapt the Cognitive Fusion Questionnaire to part-specific fusion.
- Test unburdening via implicit-association or physiological threat measures: did stimulus functions actually shift?
- IFS processes are likely equisyncratic (Ciarrochi et al., 2024): need idionomic, within-person designs, not group means.
- Map parts as nodes in a process-based network to guide sequencing decisions.

References

Buys, M. E. (2025). Exploring the evidence for Internal Family Systems therapy: A scoping review of current research, gaps, and future directions. *Clinical Psychologist, 29*(3), 241–260. https://doi.org/10.1080/13284207.2025.2533127

Ciarrochi, J., Hernández, C., Hill, D., Ong, C., Gloster, A. T., Levin, M. E., Yap, K., Fraser, M. I., Sahdra, B. K., Hofmann, S. G., & Hayes, S. C. (2024). Process-based therapy: A common ground for understanding and utilizing therapeutic practices. *Journal of Psychotherapy Integration, 34*(3), 265–290. https://doi.org/10.1037/int0000348

Gillanders, D. T., Bolderston, H., Bond, F. W., Dempster, M., Flaxman, P. E., Campbell, L., Kerr, S., Tansey, L., Noel, P., Ferenbach, C., Masley, S., Roach, L., Lloyd, J., May, L., Clarke, S., & Remington, B. (2014). The development and initial validation of the Cognitive Fusion Questionnaire. *Behavior Therapy, 45*(1), 83–101. https://doi.org/10.1016/j.beth.2013.09.001

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (Eds.). (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. Springer. https://doi.org/10.1007/b108413

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). Guilford Press.

Schwartz, R.C., & Sweezy, M. (2020). *Internal family systems therapy* (2nd ed.). Guilford Press.

Villatte, M., Villatte, J. L., & Hayes, S. C. (2016). *Mastering the clinical conversation: Language as intervention*. Guilford Press.

SELF-COMPASSION, DECENTERING, TRAUMA, AND INTERNAL FAMILY SYSTEMS MEDITATION

Rakhel N. Shapiro, PhD, Kevin B. Meehan, PhD, Sara C. Haden, PhD, and Nicholas Papouchis, Phd
Department of Psychology, PhD Program in Clinical Psychology, Long Island University - Brooklyn

Why We Are Doing This Research

- Exposure to potentially traumatic events (PTEs) is highly prevalent.
- Exposure to PTEs is costly to mental health.
- However, not everyone who is exposed to a PTE develops posttraumatic symptoms.
- This indicates risk factors and protective factors that support a person to be more or less resilient in the face of PTEs.
- Internal Family Systems (IFS) is a promising trauma treatment.
- IFS meditation is used widely in the field, but empirical research has yet to be published on it, let alone with a trauma-exposed sample.
- It would be useful to investigate what these protective factors in the face of PTEs are, and if IFS meditation is one practice than can develop them.

Abstract

Prior research establishes the prevalence of exposure to PTEs (Morris et al., 2012). Prior research also indicates the presence and level of posttraumatic symptoms varies from person to person following PTEs (Amstadter et al., 2009). Individual differences in trauma responses indicate the presence of protective factors that buffer some individuals from posttraumatic symptoms. IFS is a promising intervention, often regarded as an intervention for trauma (Germer & Neff, 2015). In the field, the IFS model is often practiced in the form of guided meditation. However, no research has been conducted on IFS meditation, or on IFS meditation with a trauma exposed sample. In a sample of 168 English speaking adults, all of whom have experienced at least one PTE, this study found the trait self-compassion subscale of self kindness significantly moderated the relationship between childhood and lifetime trauma exposure, and posttraumatic symptoms. This study also found the trait self-compassion subscale of mindfulness significantly moderated the relationship between lifetime trauma exposure and posttraumatic symptoms. This study also established that IFS meditation is efficacious for a trauma exposed sample, and significantly increased state self-compassion and state decentering, with changes in state decentering mediating changes in state self-compassion.

Introduction

- Epidemiological research indicates 82% of Americans experience at least one PTE in their lifetime (Morris et al., 2012).
- Two most prevalent sequelae of PTEs are posttraumatic stress disorder (PTSD), with approximately 18% of those exposed to a PTE developing PTSD; and major depressive disorder (MDD), with approximately 7-9% developing MDD (Morris et al., 2012). Anxiety-related difficulties are also common following PTEs (Amstadter et al., 2009; Gavrilovic et al., 2005).
- Trait self-compassion has been found to be a protective factor, yielding lower trauma symptoms following PTEs (Zeller, 2015).
- Brief meditation inductions using multiple meditation techniques, including self-directed lovingkindness, compassionate body scan, and positive excitement have all been found to increase state self-compassion (Kirschner et al., 2019).
- IFS is a promising intervention with preliminary research supporting its effecacy in decreasing symptoms of PTSD, depression, and anxiety — common sequelae of PTEs — and increasing trait self-compassion (Hodgdon et al., 2022; Shadick et al., 2013).
- Components of the IFS process mirror the construct of decentering.
- State decentering has been found to be present in effective processing of traumatic events (Hayes et al., 2017), and trait decentering has been found to protect against relapse in major depressive disorder (Baer, 2010).
- State decentering has also been found to increase following brief mindfulness inductions (Hanley et al., 2020).
- In addition to IFS being offered in the field via individual and group therapy, IFS is also practiced in the field via guided meditations.
- However, empirical research has yet to be published on IFS meditation.
- Empirical research has also yet to investigate the efficacy of IFS meditation in increasing self-compassion and decentering in a trauma exposed sample

Research Questions

- Is self-compassion a protective factor in the trauma process?
- Is decentering a protective factor in the trauma process?
- Is IFS meditation one method for increasing self-compassion and decentering in a trauma-exposed sample?
- What's the relationship between decentering and self-compassion?
- Is IFS meditation acceptable and efficacious for a trauma-exposed sample?

Methods

- Participants were N = 168 adults aged 18 and over who were fluent in English and had experienced at least one PTE in their lifetime.
- Recruitment took place via Long Island University (LIU) - Brooklyn's student body, and IFS and meditation-related listservs and social media groups.
- Institutional Review Board (IRB) approval was obtained via the LIU - Brooklyn IRB.
- Participation took place via Zoom. Responses were collected via Qualtrics and a structured interview with the investigator.
- Participants were briefed to the study, then directed to complete measures of childhood trauma exposure, lifetime trauma exposure, posttraumatic symptoms, trait self-compassion, trait decentering, and social desirability.
- Participants were then prompted to reflect on a situation they currently found painful or difficult or evoked feelings of inadequacy, in keeping with the self-compassion induction protocol outlined in Neff et al. 2021.
- Participants then completed measures of state self-compassion and state decentering.
- Participants were then directed to complete the recorded IFS meditation induction that comprised the study's intervention (by Dr. Richard Schwartz, entitled Internal Family Systems Meditation, Insight Timer, n.d.).
- After completing the meditation, participants were prompted once again to complete measures of state self-compassion and state decentering.
- Each participant then completed a structured interview with the investigator on their subjective experience of the study as a whole, and the meditation practice specifically.
- Participants were then debriefed. Following participation, they received an email with mental health resources.

Results

- The trait self-compassion subscale of self-kindness was found to significantly moderate the effect of childhood trauma exposure on posttraumatic symptoms (b = -0.67, SE = 0.27, t = -2.52, p = .013).
- The trait self-compassion subscales of trait self-kindness (b = -1.67, SE = 0.65, t = -2.59, p = .011) and trait mindfulness (b = -1.65, SE = 0.63, t = -2.61, p = .011) were found to significantly moderate the effect of lifetime trauma exposure on posttraumatic symptoms.
- There was a significant increase in state self-compassion from pre- to post-intervention (see *Figure 1).*
- There was a significant increase in state decentering from pre- to post-intervention (see *Figure 1).*
- Changes in state decentering significantly mediated changes in state self-compassion from pre- to post-intervention (see *Figure 2).*

Figure 1.

Paired Samples t-Test Results for Pre- and Post-Intervention Scores (n = 155)

Measure	Mean (SD) Pre	Mean (SD) Post	95% CI of the Difference SE	LL	UL	t	df	p	Cohen's d
State Self-Compassion	3.02 (0.84)	3.83 (0.72)	0.05	-0.91	-0.70	-15.32	154	<.001**	-1.23
State Decentering	8.97 (2.98)	10.63 (2.98)	0.19	-2.03	-1.28	-8.75	154	<.001**	-0.70

Note. State Self-Compassion = State Self-Compassion Scale (Neff et al., 2021); State Decentering = Metacognitive Processes of Decentering Scale - State (Hanley et al., 2020); CI = confidence interval; SD = standard deviation; SE = standard error mean of paired differences; t = t statistic; df = degrees of freedom; p = significance level. Cohen's d reflects the effect size based on the paired differences. *$p \leq .05$, **$p \leq .01$.

Figure 2.

Results of Mediation Analysis Examining the Change in State Decentering as a Mediator in the Change in State Self-Compassion from Pre-Intervention to Post-Intervention (n = 155)

Path	Description	B	SE	t	p	95% CI LL	UL
a	Condition ➔ Change in State Decentering	-1.66	0.19	-8.75	<.001*	-2.03	-1.28
b	Change in State Decentering ➔ Change in State Self-Compassion	0.14	0.02	-7.53	<.001*	0.11	0.18
c	Total Effect	-0.80	0.05	-15.32	<.001*	-0.91	-0.70
c'	Direct Effect	-0.67	0.06	-10.25	<.001*	-0.67	-0.46.
a x b	Indirect Effect	-0.24	0.04			-0.33	-0.16

Note. B = unstandardized beta; *SE* = standard error of unstandardized beta; t = t-test statistic; p = significance; CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; *$p < .001$.

Discussion

- A negativistic view of self can be one facet of posttraumatic symptoms, which is a view of self in direct opposition to that of the self-kindness facet of self-compassion. This may be one explanation for why self-kindness was found to moderate the relationship between trauma exposure and post-traumatic symptoms.
- Posttraumatic symptoms also sometimes include re-experiencing, which is in direct opposition to the presence and perspective characteristic of the mindfulness facet of self-compassion. This may be one reason mindfulness was found to moderate the relationship between lifetime trauma exposure and posttraumatic symptoms.
- Mindfulness may also provide some exposure-like benefits, pairing titrated exposure with the qualities of curiosity and openness.
- This is first study to find the efficacy of meditation as a delivery mechanism for the IFS model, and to do so in a trauma exposed sample.
- This is the first study to find IFS meditation to increase state self-compassion and decentering, indicating it may be a promising avenue for increasing these protective factors in the trauma process.
- This study also strengthens the empirical links between the IFS model and the constructs of self-compassion and decentering, including finding decentering to facilitate self-compassion as in the IFS model.

Conclusions

- This study's initial findings on the capacity of one brief IFS meditation to increase state self-compassion and state decentering call for future longitudinal research on the capacity of IFS meditation to facilitate increases in trait self-compassion and decentering as a result of long-term practice.
- This study investigated the efficacy of IFS meditation in facilitating increases in the potentially beneficial states of self-compassion and decentering. It would be useful for future research to investigate the efficacy of IFS meditation in decreasing posttraumatic symptoms.
- This study strengthened the empirical links between the IFS model and the constructs of self-compassion and decentering, via IFS meditation. Future research should continue to investigate self-compassion and decentering as mechanisms of the efficacy of IFS therapy as well as meditation.
- The findings of this study imply that IFS practitioners in the field would do well to focus on self-kindness and mindfulness in their application of the IFS model with trauma exposed individuals.
- It is the aspiration of this research to bring us a small step closer to a world in which all people receive the care they need before, during, and after the trauma exposure most will experience at some point in the course of their lives. And, it is the aspiration of this research that these findings — and the act of facing the realities and prevalence of trauma exposure in and of itself — can be part of bringing about a world in which fewer and fewer of these harms ever take place at all.

Selected References

Amstadter, A. B., Broman-Fulks, J., Zinzow, H., Ruggiero, K. J., & Cercone, J. (2009). Internet-based interventions for traumatic stress-related mental health problems: a review and suggestion for future research. *Clinical Psychology Review*, *29*(5), 410-420.
Baer, R. (Ed.). (2010). *Assessing mindfulness and acceptance processes in clients: Illuminating the theory and practice of change.* New Harbinger Publications.
Bremner, J. D., Bolus, R., & Mayer, E. A. (2007). Psychometric properties of the Early Trauma Inventory-Self Report. The Journal of nervous and mental *disease*, *195*(3), 211–218. https://doi.org/10.1097/01.nmd.0000243824.84651.6c
Germer, C. K., & Neff, K. D. (2015). Cultivating self-compassion in trauma survivors. In Follette, V. M., Briere, J., Rozelle, D., Hopper, J. W., & Rome, D. I. (Eds.), Mindfulness-Oriented interventions for Trauma: Integrating contemplative practices (pp. 43-58). Guilford.
Hanley, A. W., Bernstein, A., Nakamura, Y., Hadash, Y., Rojas, J., Tennant, K. E., ... & Garland, E. L. (2020). The Metacognitive Processes of Decentering Scale: Development and initial validation of trait and state versions. *Psychological* assessment, 32(10), 956.
Hayes, A. M., Yasinski, C., Grasso, D., Ready, C. B., Alpert, E., McCauley, T., ... & Deblinger, E. (2017). Constructive and unproductive processing of traumatic experiences in trauma-focused cognitive-behavioral therapy for youth. *Behavior therapy*, *48*(2), 166-181.
Hodgdon, H. B., Anderson, F. G., Southwell, E., Hrubec, W., & Schwartz, R. (2022). Internal Family Systems (IFS) Therapy for Posttraumatic Stress Disorder (PTSD) among Survivors of Multiple Childhood Trauma: A Pilot Effectiveness Study. Journal of Aggression, Maltreatment & Trauma, 1-22.
Insight Timer (n.d.). *Dr. Richard Schwartz.* Insight Timer. https://insighttimer.com/drrichardschwartz
Kirschner, H., Kuyken, W., Wright, K., Roberts, H., Brejcha, C., & Karl, A. (2019). Soothing your heart and feeling connected: A new experimental paradigm to study the benefits of self-compassion. *Clinical Psychological Science*, *7*(3), 545-565.
Morris M.C., Compas B.E., Garber J. (2012) Relations among posttraumatic stress disorder, comorbid major depression, and HPA function: a systematic review and meta-analysis. Clinical Psychology Review. 32(4):301–315. doi:10.1016/j.cpr.2012.02.002
Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. Self and Identity, 2(3), 223-250.
Neff, K. D., Tóth-Király, I., Knox, M. C., Kuchar, A., & Davidson, O. (2021). The development and validation of the state self-compassion scale (long-and short form). *Mindfulness*, *12*(1), 121-140.
Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M (2013). The Life Events Checklist for DSM-5 (LEC-5). Instrument available from the National Center for PTSD at www.ptsd.va.gov
Shadick, N. A., Sowell, N. F., Frits, M. L., Hoffman, S. M., Hartz, S. A., Booth, F. D., ...& Schwartz, R. C. (2013). A randomized controlled trial of an internal family systems-based psychotherapeutic intervention on outcomes in rheumatoid arthritis: a proof-of-concept study. *The Journal of Rheumatology*, *40*(11), 1831-1841.
Zeller, M., Yuval, K., Nitzan-Assayag, Y., & Bernstein, A. (2015). Self-compassion in recovery following potentially traumatic stress: Longitudinal study of at-risk youth. *Journal of Abnormal Child Psychology*, *43*(4), 645-653.

Toward a Neurobiological Framework of Parts: Integrating Deep Brain Reorienting and Network Neuroscience

Laura Patryas, PhD, IFS L3 certified Therapist, Family and Systemic Practitioner | Carys Bannister Building, The University of Manchester

Why We Are Doing This Research

IFS is increasingly used in trauma treatment, but its parts remain primarily phenomenological. This inquiry asks how IFS phenomenology might be investigated using contemporary trauma neuroscience without treating parts as one-to-one neural entities. The aim is a clinically useful, falsifiable multi-level framework linking bodily states, subcortical systems and large-scale networks.

Abstract

This theoretical framework proposes that IFS parts are recurrent, distributed configurations of psychological and neurobiological processes. Exiles are framed as shock–affect–memory configurations, Firefighters as acute defensive configurations, Managers as anticipatory regulatory configurations and Self as a flexible embodied integrative mode.
A pre-affective shock phase is proposed as an early organizing transition linking orienting/arousal to later affective, defensive and autobiographical processes. These are testable hypotheses, not established neural correlates.

Introduction

IFS describes psychological life as interacting parts coordinated by an intrinsic Self.
Trauma may increase rigidity, polarization or compartmentalization. Contemporary PTSD research emphasizes distributed network alterations rather than a single fear circuit. This creates an opportunity to connect IFS language with multi-level models spanning subcortical affective/defensive systems and large-scale cortical networks.

Research Questions

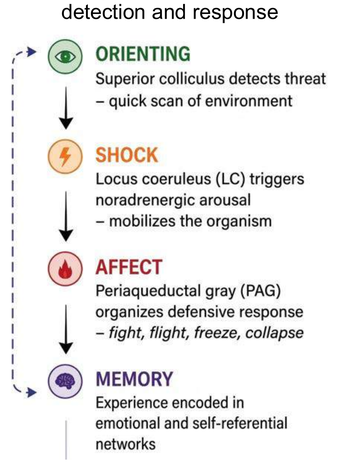
1. How might neuroscience help us think about IFS parts without reducing them to single brain regions?
2. Could an early response (pre-affective shock) precede a clearly felt emotion and lead to subsequent formation of burdened parts?
3. What might this mean for the pace and focus of therapeutic witnessing?

Approach

Conceptual synthesis of four layers:

1. IFS phenomenology (Exiles, Firefighters, Managers, Self)
2. Established trauma neuroscience (distributed networks, LC, PAG and dissociation-related connectivity)
3. DBR theory (orienting–shock–affect temporal architecture, see image)
4. New hypotheses (how these levels may interact over time and affect clinical practice).

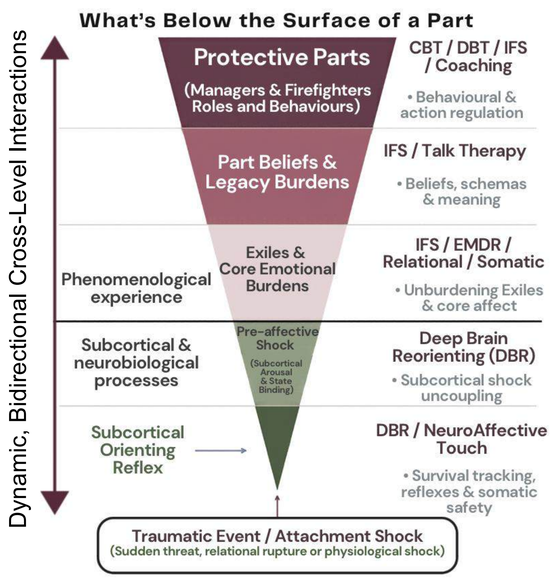
No new data were generated or analyzed.



Disruption at any stage may lead to trauma and formation of burdened parts

Framework

- Exiles: subcortical affective states coupled over time with Default Mode Network (DMN) autobiographical self-meaning.
- Firefighters: acute defensive autonomic and Salience Network (SN) changes, with active vs. passive profiles.
- Managers: heightened predictive control and rigid Central Executive Network (CEN) engagement, with reduced flexibility.
- Self-leadership: greater cross-network flexibility, physiological stabilization and reduced automatic defensive coupling.

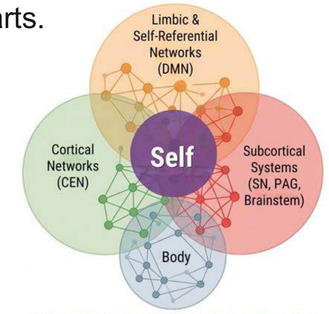


pre-affective shock
↓
influences how later affective,
defensive, bodily, autobiographical and self-related processes become coupled
↓
repeated reactivation stabilizes these couplings
↓
burdened parts emerge

Discussion

- Parts are understood here as recurring patterns across body, emotion, memory and meaning, not discrete brain regions.
- Large-scale brain networks may help shape attention, self-related meaning and regulation.
- These links are a conceptual framework, not proven neural explanations of IFS parts.

Exiles may not necessarily be the deepest accessible layer of traumatic organization. They may sometimes be the first psychologically differentiated layer that becomes accessible to conscious witnessing.



SELF-LEADERSHIP:
An Embodied Integrative Process
Embodied Integration: Emerges from continuous bottom-up somatic/autonomic feedback and top-down network coordination. Associated with feelings of calm, clarity, curiosity, compassion, and connectedness.

Conclusions

The framework bridges IFS phenomenology with trauma neuroscience while avoiding one-to-one neural mapping. Its central hypothesis is that early orienting and pre-affective arousal may organize later affective, defensive, somatosensory and autobiographical coupling.

Potential Implications for IFS Practice:

- Exiles need not be assumed to be the deepest accessible layer of traumatic organization.
- The trailhead may sometimes be followed into increasingly pre-affective bodily phenomena.
- Therapeutic witnessing might therefore be slowed substantially to detect subtle orienting/shock-related phenomena before they consolidate into recognizable affect or defensive action.
- Any subsequent change should be observed rather than prescribed as a particular form of 'discharge'.

Selected References

- Patryas L. (in press) Toward a Multi-Level Framework of Internal Family Systems Parts: Integrating Deep Brain Reorienting and Network Neuroscience.
- Schwartz & Sweezy (2020). Internal Family Systems Therapy (2nd ed.).
- Corrigan & Christie-Sands (2020). Medical Hypotheses, 136, 109502.
- Lanius et al. (2018). Current Psychiatry Reports, 20, 118.
- Menon (2011). Trends in Cognitive Sciences, 15, 483–506.

Tracking Internal System Reconfiguration and Therapeutic Change in IFS-informed Psychotherapy

A Dynamic Systems Case-Series Study Protocol Integrating Microgenetic Session Analysis and SNS Monitoring

Polina Roussou[1], **Tamara Thomsen**[2] & **Günter Schiepek**[3]

[1]Private Practice [2]HAWK University of Applied Sciences and Arts [3]Paracelsus Medical Private University

Why This Research

This research project is born out of the curiosity to systematically observe and document the processes of internal system reconfiguration and change that unfold during Internal Family Systems (IFS) therapy, within the naturalistic setting of long-term individual psychotherapy. The study aims to translate what IFS therapists intuitively know and routinely bear witness to into a systematic, empirically grounded account based on real-world clinical data, while also illuminating change processes that currently elude our understanding.

A central expected contribution is the identification of the IFS interventions most strongly associated with positive shifts in clients' internal systems, both within the therapy room and in their everyday lives.

Abstract

Internal Family Systems (IFS) is a multiplicity-informed psychotherapy model that views the mind as a system of interacting parts led by a compassionate core Self. Despite its growing popularity, the IFS evidence base remains limited and requires more rigorous research. This doctoral study aims to capture how clients' internal systems reconfigure during long-term IFS-informed individual psychotherapy and to identify interventions that support positive change. Using a naturalistic mixed-methods case series design, 4–5 clients will be followed for 12 months, combining thematic narrative analysis of therapy sessions with high-frequency monitoring via the Synergetic Navigation System (SNS). Within- and cross-case analyses will be performed and presented as timelines and sequences. The study aims to advance IFS process research and develop an integrative methodology for examining non-linear change in psychotherapy. This poster presents the research protocol and illustrative qualitative findings from the ongoing pilot study which is at the stage of operationalizing IFS concepts.

Introduction

The Internal Family Systems (IFS) model (Schwartz, 1987) views the psyche as a system of parts that coexist in dialogical and often conflicting relationships with one another, and therapy aims to restore internal harmony by cultivating compassionate Self-leadership (Schwartz & Sweezy, 2020). IFS was recognized by the former SAMHSA-NREPP in 2015 following a proof-of-concept randomized controlled trial (RCT) with rheumatoid arthritis patients (Shadick et al., 2013), and subsequent studies show promising results for depression, anxiety, PTSD and chronic pain, as well as gains in self-compassion, self-awareness and self-forgiveness (Buys, 2025). A more recent RCT of an online group IFS protocol for PTSD showed higher acceptability and feasibility compared to the control condition (Joss et al., 2026).

Despite these early encouraging results, little is known about the fine-grained processes through which IFS brings about change. Existing qualitative studies rely on small samples, few sessions, clinical vignettes or isolated aspects of the model (Buys, 2025), and, to our knowledge, no study has tracked in-session micro-processes alongside non-linear change dynamics over time (Schiepek, 2003; Schiepek et al., 2016, 2017).

This doctoral project addresses these gaps by applying a dynamic complex systems framework (Schiepek, 2003) to the intensive study of clients in IFS-informed psychotherapy. Data collection will follow a design based on a continuous flow of data, combining session recordings with daily self-reports to capture each client's lived experience beyond the confines of the therapy room. This design offers a unique opportunity to examine how what unfolds in therapy spills over into, transfers to and interacts with daily life, and vice versa, and how these complex interactions give rise to change.

Research Questions

Main research question

How do clients' internal systems reconfigure and which IFS therapeutic processes appear to support this reconfiguration during long-term IFS-informed psychotherapy, when examined through microgenetic session narrative analysis and daily monitoring via the SNS?

Study objectives

- How clients' internal systems reconfigure, self-organize and evolve over time.
- Which IFS interventions link to positive therapeutic shifts both at the microlevel (within the session) and at the macrolevel (over time).
- How to systematically capture the above by combining thematic narrative analysis of therapy sessions via an adapted Viou & Georgaca (2024) qualitative methodology and high-frequency monitoring via the Synergetic Navigation System (SNS) (Schiepek, 2003; Schiepek et al., 2016, 2017).

Methods

Design. Naturalistic, longitudinal, mixed-methods multiple-case study integrating qualitative microgenetic session analysis with SNS daily and monthly monitoring.

Participants & sampling. Approximately 4–5 adult clients receiving long-term IFS-informed psychotherapy, purposively recruited from the researcher's clientele.

Data collection. Participants followed for approximately 12 months through audio-recorded psychotherapy sessions, idiographic daily SNS questionnaires and monthly standardized questionnaires.

Analysis

Qualitative strand

Thematic narrative analysis · adapted Viou & Georgaca (2024)

- ~12 strategically selected sessions per case; 50–60 sessions overall
- Operationalizing IFS interventions and devising a codebook for coding sessions (two independent coders)
- Mapping of parts & Self presence
- Frequency & dominance of parts / Self
- Grouping into Managers, Firefighters, Exiles & Self
- Timelines & sequences of parts and Self presence in relation to IFS interventions
- Changes in frequency & quality of parts over time

Quantitative strand

High-frequency SNS monitoring (Schiepek, 2003)

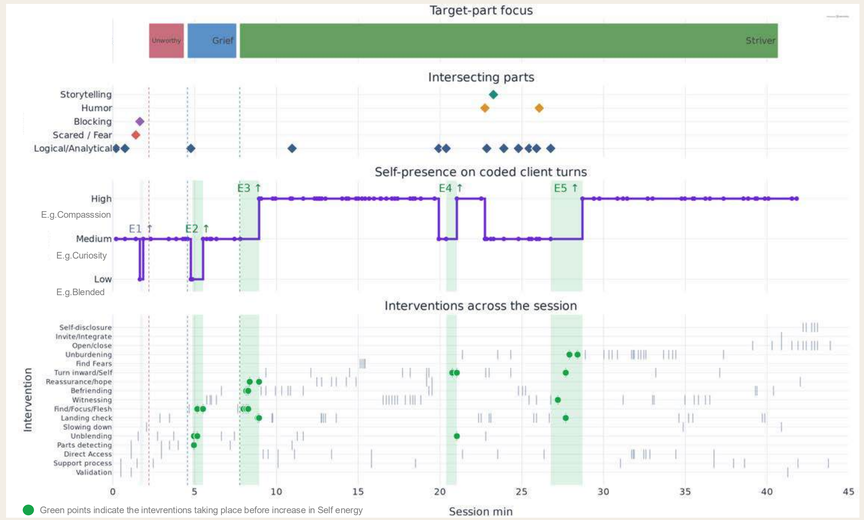
- **Idiographic interview** and formulation of personalized questionnaires coupled with standardized questionnaires
- **Time-series plots** of single items, with sessions and major interventions marked
- **Raw data resonance diagrams**
- **Complexity resonance diagrams** to identify transition periods and zoom in on preceding sessions
- **Inter-item correlation plots** across early, middle and late therapy
- **Recurrence plots** to visualize recurrent and transient states and order transitions

Integration

Qualitative session coding and SNS items will mostly share the same idiographic labels, ensuring a continuous flow of data and direct comparability between fine-grained narrative analyses and high-frequency time series. Results will be synthesized through within-case and cross-case comparisons.

Illustrative Results from Coding of One Session

Within Session Change and Intervention Timing



Results & Discussion

The graph presents a legacy unburdening session (Schwartz & Sweezy, 2020), fully coded using a codebook developed by the first author, illustrating the dynamics and intricacies of the IFS therapeutic process. It shows how parts enter the therapeutic scene, some taking center stage as target parts ('Unworthy', 'Grief', 'Striving'), and others assuming protective roles in the moment (e.g., 'Blocking', 'Logical/Analytic', 'Humor' and 'Storytelling'). It also traces how Self-energy fluctuates and mediates the relationships among these parts, until the session culminates in an unburdening accompanied by sustained high levels of Self-energy. The therapeutic interventions most closely associated with increases in Self-energy, and with the initiation and completion of the unburdening ritual, were: find/focus/flesh out; inviting the client to turn inward; unblending statements; landing checks; befriending; detecting parts; offering hope and reassurance; and inviting witnessing and unburdening (Pastor & Gauvain, 2020). Because these interventions generally occurred in clusters, their individual contributions cannot be isolated. As this is a single-session illustration, these findings are not generalizable, but demonstrate the method's potential for studying microprocesses and the unfolding of therapeutic change.

Conclusions

As this study is in its early stage, no firm conclusions can yet be drawn beyond the method's potential for capturing microprocesses in psychotherapy. Adding high-frequency monitoring is expected to offer deeper insight into change processes in IFS therapy. A future direction relevant to this study and other research groups is integrating large language models (LLMs) into coding, which could make it possible to analyze more sessions and produce larger, richer datasets.

References

Buys, M. E. (2025). Exploring the evidence for Internal Family Systems therapy: A scoping review. Clin Psychol, 29(3), 241–260.

Joss, D., et al. (2026). A randomized controlled trial of an online group-based internal family systems treatment for PTSD: The PARTS study. Psychol Trauma. Advance online publication.

Pastor, M., & Gauvain, J. (2020). Internal Family Systems Institute Level I training manual. Trailhead Publications.

Schiepek, G. (2003). A dynamic systems approach to clinical case formulation. Eur J Psychol Assess, 19(3), 175–184.

Schiepek, G. K., et al. (2016). Systemic case formulation, individualized process monitoring, and state dynamics in a case of dissociative identity disorder. Front Psychol, 7, 1545.

Schiepek, G., Aichhorn, W., & Schöller, H. (2017). Monitoring change dynamics: A nonlinear approach to psychotherapy feedback. Chaos Complex Lett, 11(3), 355–375.

Schwartz, R. C. (1987). Our multiple selves: Applying systems thinking to the inner family. Fam Ther Netw, 11, 24–31.

Schwartz, R. C., & Sweezy, M. (2020). Internal family systems therapy (2nd ed.). Guilford Press.

Shadick, N. A., et al. (2013). A randomized controlled trial of an IFS-based intervention in rheumatoid arthritis. J Rheumatol, 40(11), 1831–1841.

Viou, M., & Georgaca, E. (2024). Tracking change in group psychotherapy: Systematic methodological steps to record the development of clients' voices. In Routledge international handbook of innovative qualitative psychological research (pp. 215–228). Routledge.

Polina Roussou, MSc, ECP
Independent Researcher, Psychologist and Psychotherapist | Private Practice | Greece
info@polinaroussou.gr

Prof. Dr. Tamara Thomsen
Faculty of Social Work and Health, HAWK University of Applied Sciences and Arts | Germany
tamara.thomsen@hawk.de ORCID 0009-0002-4450-9960

Univ.-Prof. Dr. Dr. Günter Schiepek
Institute of Synergetics and Psychotherapy Research, Paracelsus Medical Private University | Austria
guenter.schiepek@ccsys.de ORCID 0000-0003-3482-801X