

Assimilation process in a psychotherapy with a client presenting schizoid personality disorder

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Summary

The assimilation of problematic experiences has been studied as change processes in psychotherapies of different client populations. Several theory-building case studies using the assimilation model have shown how important a meaning bridge is in such change processes. In a client presenting schizoid personality disorder the creation of meaning as an affect-evoking process may be a particularly important stage in the change process. The present case study aims to apply the assimilation model to a psychotherapy process with a highly disturbed client and focuses on the creation of a meaning bridge in the process. Moreover, the assimilation analysis focuses on the effect of an external person, i.e. the partner or the therapist, when responding to the client's unassimilated problematic experiences. Their effects on the client's assimilation processes are discussed.

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Understanding symptomatic change processes over the course of treatments is a major task in psychotherapy research. The dose-effect model by Howard, Kopta, Krause and Orlinsky [1] refers to the number of sessions spent on a client as a predictor of the possible outcome: a negatively accelerated curve is assumed [2]. Although there is some evidence for this hypothesis (e.g. [3]), Stiles et al. [4] have pointed out the limits of the drug metaphor of therapeutic effects. If the research relies on establishing the relation between therapist interventions and outcome on the global level, i.e. session-level, as is the case in many psychotherapy studies, in-session moment-by-moment micro-processes are overlooked. In such processes the therapist may be responsive to the patient's utterances, which, in turn, may have an impact on the therapist and influence subsequent therapist intervention. In fact, this moment-by-moment interrelatedness between client and therapist is not taken into account in the aforementioned statistical change models [5]. A recent case study illustrates the limits of the drug metaphor and shows that the therapist's responsive attitude tends to produce a positive outcome without neces-

sarily adhering to a manual [6]. Theory-building case studies [7, 8] have developed solid theoretical grounds and methods for the moment-by-moment analysis of therapeutic change in clients over the course of treatment. In particular, Stiles [9] put forward the integrative conceptual framework of the assimilation model. This model enables the researcher to analyse psychotherapy processes, using session transcripts as a basis, from the specific vantage point of therapeutic change as an assimilation process of problematic experiences in the client.

Assimilation model

The assimilation model [9, 10] provides a means to understand change processes in clients undergoing psychotherapy. Traces of previously problematic experiences, represented as internal "voices" by the model [9, 11], are transformed in the course of therapy by being assimilated into integrated unproblematic schemata aspects of the self. These may then function as resources for the client. In total, eight levels, or stages, of assimilation of problematic voices have been identified (see table 1); four intermediate substages have been defined between levels 3 and 4. The concept of multiplicity of the self has been reviewed by Osatuke [12] and Osatuke and Stiles [11]. In particular, it is important for clients presenting long-standing personality disorders to understand the therapeutic process in terms of shifting dominance within aspects of the self – i.e. communities of voices – aiming at a progressive assimilation of problematic and in many cases traumatic experiences. A key moment in such developments is the presence of a meaning-bridge [13], taking place between the stages of problem formulation and of the individual's understanding.

What is the therapist's role in the client's assimilation process? Stiles et al. ([4], see example on p. 7 on "Jane") showed that the therapist is likely to have a positive effect on the client's specific assimilation processes. However, assimilation processes may also be hindered by the presence of a third party, e.g. someone playing a significant role in the client's life (e.g. in couple therapy, see [14]) or even, though unwillingly, the therapist. Theoretically this would mean that the client's partner (or the therapist) affiliates with a particular voice, i.e. the expression of a specific problematic experience on the client's part. Even if the third party's intention may be acceptable, we would consider the specific affiliation to a particular voice potentially problematic for the assimilation process.

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Table 1 Assimilation of problematic experiences scale (APES) ([22], p. 1443).

Warded off. Client is unaware of the problem. Affect may be minimal, reflecting successful avoidance.
Unwanted thoughts. Client prefers not to think about the experience; topics are raised by therapist or external circumstances. Affect involves unfocused negative feelings; their connection with the content may be unclear.
Vague awareness/emergence. Client is aware of a problematic experience but cannot formulate the problem clearly. Affect includes acute psychological pain or panic associated with the problematic experience.
Problem statement/clarification. Content includes a clear statement of a problem – something that could be or is being worked on. Affect is negative but manageable, not panicky.
3.2. Rapid Cross Fire ¹
3.4. Entitlement
3.6. Respect and Attention
3.8. Joint Search for Understanding
Understanding/insight. The problematic experience is formulated and understood in some way. Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.
Application/working through. The understanding is used to work on a problem. Affective tone is positive, optimistic.
Problem solution. Client achieves a successful solution for a specific problem. Affect is positive, satisfied.
Mastery. Client automatically generalises solutions. Affect is positive or neutral (i.e. this is no longer something to get excited about).

Note. The APES stages are understood as representing an underlying continuum of assimilation, and intermediate ratings are permitted (e.g. 2.5 midway between vague awareness/emergence and problem statement/clarification).

¹ Intermediate steps between APES level 3 and 4 according to Brinegar et al. (2006).

So far, only a few studies have investigated long-term psychotherapeutic processes of clients with personality disorder by using the assimilation model [11]. The purpose of the current case study is to use the model to understand tentatively the psychotherapy process in a client presenting schizoid personality disorder with several co-morbidities. We aim to show that the assimilation model enables (1) identification of the effects of a third party on the assimilation process, i.e. when the partner takes sides within the communities of unassimilated voices, or the effects of the therapist's interventions, and (2) confirmation of the importance of a meaning bridge in the treatment of a highly disturbed client.

Specificities in the treatment of schizoid personality disorder

Gaebel and Falkai [15] have pointed out that at the beginning of the treatment of a client presenting schizoid personality disorder, emphasis is laid upon the development of a particularly solid therapeutic relationship, since the pathology implies a high level of affective retreat and difficulties in expressing and experiencing his/her inner (affective) life, which also applies to affects related to close relationships. According to Sachse [16], the core relationship stakes in these clients are distanciation from other people and self-protection. Affects related to these stakes need to be experienced in the therapeutic relationship and addressed in psychotherapy. These are the main clinical goals in such treatments.

In terms of assimilation processes, parts of the treatment focus on the low level of assimilation, i.e. on problem statement and on moving the patient toward problem clarification. As suggested above, it may be hypothesised that meaning bridges play a particularly important role. A meaning bridge is defined as “a word, phrase, story, theory, image, gesture, or other expression that has the same meaning for each of the voices it connects” ([13], p. 167). In

terms of APES, meaning bridges occur between APES stages 3 and 4. Affective involvement of the client seems required in order to pass from problem clarification to understanding. As suggested by the scale anchors, intensity of affect diminishes between stages 3 and 4, leading to a more mixed affective state (positive and negative intertwined). In the case of a client with schizoid personality disorder for whom, per definition, the expression of affect is highly difficult, we may hypothesise that the actuation of affect-laden verbal conflicts within the therapeutic relationship would suggest a positive sign of change. We may even say that the emergence of negative affect within the therapeutic relationship, its clarification and progressive integration with other affective and cognitive elements would therefore be one of the core elements in such therapeutic processes.

Method

The client and the therapeutic process

Paul, a Caucasian male, 24 years old, was seeking therapy for multiple and severe symptoms, i.e. schizoid personality disorder, obsessive-compulsive disorder (OCD) and alcoholism. In particular, the OCD were described by the client as the “most bothering at the moment, because it causes conflicts in the relationship with Christine” (the client's girlfriend). Schizoid personality disorder was diagnosed by using the SCID-II [17]. OCD was assessed by using the Yale-Brown Obsessive Compulsive Scale [18].

The client enters therapy in a distant, affect-less mode of interaction which may be summarised under the label of schizoid personality disorder. Regular alcohol consumption is another coping strategy to alleviate major anxieties in this client, i.e. fear of being abandoned, fear of being different, fear of being neglected and feelings of inferiority. When Paul first drank alcohol at the age of 16, he felt he was as outgoing as everyone else, that alcohol provided “absolute security”. Finally, the compulsive symptoms represent a strategy to

cope with the stress associated with social interaction. While controlling aspects of his apartment (i.e. by compulsive checking of locks), Paul avoids any stressful encounters and remains “in his own world”, so he says.

The treatment, integrative cognitive-behavioural, was a combination of cognitive-behavioral therapy (CBT) of OCD [19] among other symptoms and clarification-oriented therapeutic interventions (COP [20]). Thus, it was not dictated by the assimilation model. In total, 90 psychotherapy sessions were conducted with this client. The process may be broken down into six phases: (1) Psychotherapeutic assessment (5 sessions); (2) CBT of OCD (10 sessions); (3) Treatment of alcohol dependency (16 sessions); (4) Supportive and crisis intervention; (9 sessions); (5) Clarification of motives and affect (25 sessions) (6) Coping enhancement (25). In the first part of the treatment, Paul’s girlfriend Christine, attended 9 sessions, because the client expressed the wish to do so. Therapy ended with an assessment: symptomatic assessment revealed highly successful therapy; there was no longer any diagnosis on axis II of DSM-IV [17], nor any OCD symptoms according to Y-BOCS test [18] administered at the end of the therapy. In addition, he had stopped drinking alcohol and was actively seeking an affective relationship and new professional training.

Procedure

This client was chosen on the basis of two criteria: (1) the high number of partner sessions embedded within an individual psychotherapy, enabling us to investigate our first research question; (2) the importance of affect actuation for the reduction of the symptoms related to schizoid personality disorder (see second research question). The data analysed consisted of the clinical notes taken by the therapist and first author. As mentioned, assimilation analysis needs to be based on transcript analyses. However, in this specific case, no transcripts as such were available but the case was part of the therapist’s accreditation process, which implies extremely detailed note-taking. Parts of the notes were taken in session, others immediately after the therapeutic sessions. Even if memory is not infallible, the details in these partly transcribed sessions were sufficient in our view to rate the concepts related to the assimilation model for this particular case. Two raters analysed the therapist’s notes separately in terms of voices and stages of the assimilation model (APES). One rater was the therapist (UK), the second a co-worker (CM); assimilation analyses took place three years after the end of therapy, and it can thus be supposed that the raters both had the same basic material to rate; in addition, the therapist had some complementary information on this case. Afterwards, a consensus meeting was held and the consensus is reported here. Consensus was established according to the Ward method in qualitative psychotherapy research [21], in collaboration with the author of the assimilation model (WBS).

Voices identification followed the procedure described by Osatuke, Glick, Stiles, Greenberg, Shapiro and Barkham ([12], p. 99). The choice of 11 sessions (out of 90) to be analysed thoroughly is based on the feasibility criteria and responded to a top-down principle: after identification of

the main voices in the patient, the raters went back to the session notes and identified key sessions with regard to the change in the previously identified voices.

Results

Assimilation model account

Based on the therapist’s session notes and the raters’ extensive notes, four communities of voices were identified in this client. Multiple voices and communities of voices is an observation in accordance with Humphreys et al. [22], who described assimilation processes in patients with borderline and dissociative symptoms. For our client the communities may be named according to the major motive underlying the community: (I) Looking for help (this is the dominant community, which, collaborating most fully in therapy, implies the search for autonomy); (II) Relationship control (by using self-defeating behaviours or other means of relationship control); (III) Impulse (or self-) control; (IV) Dependency (this community aims to remain in the relationship). Moreover, an independent self-critical voice may appear (e.g. attacking community II of relationship control by saying “You shouldn’t present yourself as self-defeating, this is disgusting”). We may hypothesise that non-integration of the four communities of voices, along with the self-critical voice, contributes to producing the cited symptoms, i.e. alcohol dependency to feel safe and to control impulses, compulsive disorder to control impulses and be in control of the relationship with his partner (to avoid finding himself definitively alone).

Next, key sessions were identified, based on the process description outlined above. Analysis of these sessions enables us to apply the APES and, consequently, to identify to what point the communities of voices had integrated. In the first section and in line with one of our main focuses, our interest concerns the partner’s responsiveness to the client’s processes, in particular how Christine, the partner, takes sides in the client’s communities of voices. To what extent did Christine precipitate the crisis or to what extent did she, unwittingly, contribute to the client’s favourable evolution by breaking off their relationship? In addition, the therapist’s responsiveness to the assimilation process is investigated (sessions 3, 5, 6, 11, 12, 16, 18, 24). In the second section of the therapy, we are particularly interested in identifying the occurrence of a meaning bridge (sessions 43, 45, 51) occurring between APES-levels 3 and 4. In total, we analysed 11 sessions (out of 90); sessions 6, 11 and 43 were identified as key sessions with regard to assimilation processes and were analysed more thoroughly on a moment-to-moment basis.

Assimilation process

The client starts off (session 3) on APES-level 0 when he says in a detached manner, without actually referring to his inner experience: “I am afraid of losing control, when I’m acting aggressively or when I’m drunk.” According to Honos-Webb et al. [23], this sequence remains on level 0

of a non-integrated, loose juxtaposition of the description of affective experiences. The client is not always in control of such experiences, as suggested by the content of the quotation. This result is in line with the diagnosis of schizoid personality disorder, implying a detached way of speaking and an absence of awareness of the problematic affective experience contributing to the client's suffering.

In the next session (6), the client is accompanied by Christine, his partner. The assimilation analysis focuses on the partner's (and therapist's) responsiveness to the client's processes. It becomes apparent that the partner's presence in the sessions elicits conflictual affective reactions within the client: (1) The client feels supported by his girlfriend; (2) The client resents Christine's presence as intrusive to the process. The latter part of the conflict arouses frustration and anger in the patient. In this situation, the therapist addresses the client's affective reaction to the fact that the partner has agreed to come to the session. The client, in his response, is unable to perceive the conflictual aspect of his inner affective life and adheres to the dependency community (IV), while denying the conflict; this reaction is situated on APES-level 0. The client adds that he is angry, but wonders why (APES-level 2). The following excerpt illustrates our comments:

- Th: "So how do you feel, Paul, about Christine coming to the session?"
- Paul: "I guess, that's fine, this helps (...; *adheres to the dependency community IV; APES 0*). At home, I feel more relieved than before and I can tell my partner more clearly if something is wrong (...) I wonder why I am so angry, I don't know" (*APES 2*).

Next, the partner's responsiveness to the client's communities of voices was analysed. In this session, the therapist asks what Paul's partner thinks about his progress in therapy. Christine's reply shows that she takes sides within the communities of voices; from the point of view of Paul's assimilation process, she affiliates with the self-critical voice in the client. It becomes apparent that Paul experiences this affiliation as difficult. In order to enhance the client's introspective capacity, the therapist therefore suggests that the client does a role-play, where the client has to convince his own self-critical voice, in the presence of his partner. The actuation of the self-critical voice in the therapeutic process enables the client to progress momentarily on the APES-scales, by the emergence of contradictory voices (*APES 3.2., Rapid Cross-Fire*) and, straight afterwards, the formulation of a possible motive behind the client's apparent behaviour in a joint search for understanding (*APES 3.8.*). The excerpt:

- Th: "How do you, Christine, see Paul's progress in therapy?"
- Christine: "I think, he does not do anything for therapy at all." (*Partner affiliates with the self-critical voice in the client.*)

The therapist identifies the self-critical voice in the client, here expressed by the partner, and proposes the role-play where Paul needs to convince his own self-critical voice that he did well this week as regards the therapy homework.

- Paul: "I am a bit nervous about doing this, but, ehm, ... I can do it (...; *APES 3.2.*) actually, this is so problematic, because I don't want to get angry at Christine" (*APES 3.8.*).

Finally, this session ends on individual-based work on the client's anger, turned this time towards the client's brother. The client is able to identify intellectually his emotion, but does not manifest anything in the situation and does not state this as a problem. Thus, we may hypothesise that the assimilation process drops to APES-level 2 (Vague awareness).

- Paul (speaking about his fear of becoming angry): "(...) I gave a CD to my brother, expecting it back a couple of weeks later. The CD was completely scratched, it was not possible to do anything with it anymore, it was ruined. For my brother, this was just fine. For me, it wasn't, but I didn't say anything (*APES-level 2*), I was too afraid of getting angry at him. (...) Later, I got really angry at him and told him that he doesn't care about me at all. I was really mad at him. I was like that for approximately 10 minutes (*APES-level 2*)."

In session 11, the therapist focuses on the OCD symptoms. In the previous session (10), he suggested that the client should tell his partner when he feels a compulsive urge coming on. Our hypothesis is that if the client does so, his dependency community of voices (IV) will be actualised and usable in the therapy process. By telling Christine when the urge was starting, the client may feel the necessity of Christine's presence when he was doing the compulsive behaviour, in accordance with the hypothesis of the interpersonal origins of the disorder in this particular client. This might have an impact on the assimilation process of the voices related to dependency. In order to increase empathy between the couple, the therapist addresses the partner's position. This time, Christine expresses her own affective experience, without affiliating or responding to the client's communities of voices. The therapist re-focuses on the client's affective experience in this exercise, in order to deepen it: the client oscillates between APES-level 0 (afraid of myself, fear of losing control, [23]) and APES-level 2 (vague awareness of a problematic experience). Finally, in another attempt to reinforce empathy in the couple, the therapist re-focuses on the partner's affective reaction to the client's description: the partner is now able to show more empathic understanding of the client's situation and no longer affiliates with the critical voice within the client's community of voices.

In the next session (12), however, the level of symptoms undergoes an increase, this time due to heavier alcohol consumption. The client drinks in order to feel, so he says, "completely safe in such moments". It can be hypothesised that the reduction in compulsive behaviour led to the client's becoming aware of diffuse *pain* needing to be contained by the community of self-control (III). Since this community is not integrated with the dominant one (Looking for help; I), it may be said that the client's functioning remains on APES-level 2 in this session; there is some awareness of the problematic impulses (i.e. diffuse pain). Again, in session 16, the partner, herself an ex-alcoholic, takes sides in this process and intervenes by judging the client and by putting forward alternative ways of coping with the alcohol consumption. As a result, she enters into competition with the therapy and shows an almost missionary attitude towards the client. Again, we would assume that her taking sides does not assist the assimilation process in the client, as it does not

strengthen the dominant community of voices (i.e. looking for help). On the contrary, it activates several marginal voices, related to the communities of dependency, self-control and relationship-control. In session 18, the therapist once again uses the presence of the partner and stages a role-play based on the described situation where the client begs the partner for more money, so that he can buy some alcoholic drinks (due to the client's heavy drinking, it is his partner who is in charge of the couple's finances, implying that the client is financially dependent on his partner). His partner plays the role of the client begging for money, while the client plays the partner, firmly refusing these requests. By means of this exchange of roles, the client gains initial awareness of one of his communities of voices (Community II: Control over his partner by appearing weak, by "manipulating" the partner). This emergence of awareness can be rated as APES-level 2. In session 24, while working on the reduction of alcohol consumption, the client talks about a traumatic experience in his adolescence (see excerpt of session 43). At that time, he tended to wear only black clothes. His colleagues made fun of him by saying "You are behaving as if you were gay!" which made him feel unsure of himself. It appears that the dominant community is "Looking for help"; the client entering a more stable therapeutic alliance with the therapist.

The couple broke up a few sessions later; the client committed self-mutilations implying APES-levels 1 or 2, where the client is flooded with the affect related to the marginal community of voices of dependency. His realisation that he is now completely alone needed to be contained by impulsive, self-destructive behaviours. Thus, this period and the following crisis intervention represent a backlash in the client's assimilation process. However, it also carries great potential for change, if the voice related to the help-seeking is not completely inundated by the affect related to the crisis. In fact, although this seemed to be the case in many sessions, the client continued coming to the sessions, whereas he stopped all his other activities at this point (work, support group, medical consultation). As a result, the therapy remains the only occasion for him of obtaining structured help.

The client did not give up therapy and the therapeutic alliance continued to strengthen. In session 43, a thrust in terms of the assimilation of problematic experiences takes place. Paul starts the session by formulating a problem statement (APES-level 3): he puts off anything difficult, such as calling in when ill. The therapist addresses the beliefs behind this problem statement and focuses on the most challenging belief. The client is becoming more precise in the way he formulates the problem. He starts linking the current problem situation to a past problematic where the same belief occurred: he expects the other person not to take him seriously and laughs at him by saying "You only played truant!". While he is telling this story, some Rapid Cross-Fire appears within the conflictual voices (one voice was the one of the peers, one of his self in the situation; APES-level 3.2.). The client realises the current problem is related to a traumatic situation in his adolescence - the shower episode - and identifies the similar affect of shame in the past situation (APES-level 3.4.: Entitlement): the hidden voice full of shame comes

out and takes centre stage. The therapist finally addresses the common underlying affect and the client identifies the same affect in all these situations: shame, along with the self-perception of defectiveness. Then, by using the metaphor of a breakdown, he makes a major thrust into his understanding of himself (APES-level 4: Understanding/insight). The metaphor of the "breakdown" may in this case be understood as a meaning bridge, enabling the client to access a broader insight into his own functioning [13]. This work on shame is the continuation of session 24 when he first started to be aware of his insecurity in social situations, i.e. wearing black clothing and the related mockery he suffered. Here the affect of shame, or the idea of a defective invalid self, is the link between various episodes and contributes to more coherent understanding of Paul's current problematic experience. The excerpt:

- Paul: "I am worried that my colleagues will tell me that I am unreliable, but perhaps nobody can count on me (APES-level 3: Problem-statement)."
- Th: "Hmh, what else?"
- Paul: "That people do not believe what I say. The worst would be that my colleagues tell me that I very often miss work."
- Th: "What is so difficult about imagining your colleagues telling you you miss work very often?"
Paul: "Life would be completely unsafe, and my reaction is that I want to stay home, when I think about being threatened so much (...; APES-level 3: more precise problem-statement). It is the same situation as at school. I didn't have any friends when I was at school. When I went back after being sick, my colleagues laughed at me and told me: 'Oh, you only played truant!' They were working, I wasn't; I am nothing" ... (APES-level 3.2.: Rapid Cross Fire).

The client goes on to relate the shower episode: When he was 12, his schoolmates made fun of him after a sports class by putting him under the shower fully clothed.

- Paul: "I was so humiliated. I had to sit in the classroom afterwards in completely wet clothing; that was the worst moment in my life (APES-level 3.4.: Entitlement); at that point, they made fun of me even more. It was so humiliating."
- Th: "Can you say in what way this situation is similar to the one at the current workplace?"
- Paul: "I feel humiliated in both situations. Or ashamed. As if there is no security in my life; everything breaks down and I feel ashamed (APES-level 4: Understanding/Insight)."

The presence of a meaning bridge implies the first of any communication between the communities of voices, here between the self-critical voice (internalised peers: "You only played truant") and the dependency community of voices aiming at remaining in relationship with the peers (or the collaborators). The "breakdown" is a metaphor for the social retreat behavior, in accordance with the affect of shame. The fact that the client talks about a "breakdown" – representing his social retreat behaviour – may imply that the dominant community (which is looking for help, trying to collaborate with the therapist in order to get better) communicates now with the dependency community (which agrees to be

dependent of the therapist in order to get better), as well as with the self-critical voice. In that sense, we understand the quoted excerpt as a meaning bridge leading the patient to a new insight over his functioning.

In session 45, the client extends the aforementioned meaning bridge to the therapeutic relationship (rated on APES-level 4). The client did not come to the previous session, did not offer any excuse to the therapist and conveyed fear and shame at the beginning of session 45. He said that, at the time he should have been at his appointment, he was wondering: "Is the therapist now waiting for me and thinking I don't want to come, does he think that I believe therapy is not important for me?" (see also above). The therapist responds in an empathic way, by linking the expressed fear to the previously expressed affects, in particular shame (session 43). In session 51, the client works through the shame he feels when obliged to call his medical doctor for an appointment which is overdue. The client extends his new understanding of his problematic experience and applies it to a current problematic situation. Thus, this interaction was rated on APES-level 5; experiences which were previously traumatic have become a resource for this client. In the remaining sessions, the client applies the insight gained throughout therapy to contacting several key persons who may potentially be helpful. The therapy ends with the client in tears in front of the therapist. He says that generally he would avoid weeping when someone else is watching, and that it feels "unexpectedly good". Thus, the last section of the therapy remained constantly high in terms of assimilation processes, on APES-level 4, 5 and 6.

Discussion

This case study had two objectives: (1) to confirm the importance of a meaning-bridge in the treatment of a highly disturbed client presenting with schizoid personality disorder, and (2) to identify the effects of a third-party (i.e. the intimate partner or the therapist) when responding to the communities of unassimilated voices on the client's assimilation process. We were able to confirm the relevance of the meaning bridge notion in the case of Paul. In the second part of the therapy, in particular in sessions 43 and 45, the client becomes fully aware of the problematic experience and starts integrating into his mental structure several difficult experiences related to the affect of shame. The full experiencing of the latter becomes the pivotal point of the whole treatment, since it will a) on the content level imply better understanding of the way he functions and why, and b) on the process level imply a novel affective experience that contradicts the distancing-affect strategy apparent at the beginning of treatment. Evidence of this affective change appears in the client's utterances at the end of the therapy, when he is connected with his inner emotional experience. He weeps before the therapist, yet comments on this in a positive way. In this process, in session 43 as documented, the role of a meaning bridge (in this case the metaphor of the breakdown) helped the client to reach more elaborate levels of assimilation [13]. As postulated, the meaning bridge implied in this client presenting with schizoid personality

disorder is important in session affect actuation. Affect distanciation being a major diagnostic feature of this client, the emergence of affect in particular in sessions 43 and 45, around the elaboration on the metaphor of the "breakdown", becomes the pivotal point of the therapy. After that, the client was able to connect more fully with his inner emotional experience, which would not have been possible earlier in the process (see also [22]). This case study also shows that long-term therapy is needed if these highly-disturbed clients are to benefit from therapeutic interventions aiming at producing meaning in the person of the client.

To what extent does an external person's responding to a complex, partially non-integrated community of voices assist the assimilation process? Some data hint at the hypothesis that taking sides is not helpful for the client, particularly if the relationship with this person is conflict-laden (see session 6). In such cases, we may be facing what Osatuke et al. [24] called the voice's limited breadth. In fact, a partner supporting marginal voices unilaterally (without supporting the other communities of voices, as Christine did in session 6) does not encourage assimilation, but tends to trigger only the specific voice. However, if used well, external persons may contribute greatly to progress made in the assimilation process, such as illustrated by the role-play staged by the therapist with the partners exchanging roles (sessions 11 and 18); this therapist intervention enabled mutual empathic understanding between both partners of the couple, as well as tending to assimilate to some (limited) degree different unassimilated voices in the client. By experiencing the functioning of the partner, which was hitherto defended against within the marital conflict, the client reaches some insight into the partner's and his own functioning, in particular with regard to the community of voices related to dependency (III). Later, by accepting the break with the partner, the client starts integrating this community more fully into his functioning, to the point that he was able, at the end of therapy, to use it as a means of looking for help (see session 45 where the patient regularly returns, even if negative emotions are aroused towards the therapist). Dependency becomes a resource in this client over the course of therapy in the form of a strengthened therapeutic alliance. It will help the client to solve problems at hand, but also solve new problems. This client benefited from the therapeutic interventions (see above) parallel to his emotional involvement in therapy and the strengthening of the therapeutic alliance over time.

Responsiveness to the client's functioning is adequately taken into account in the assimilation model. The moment-by-moment anchor of the arguments enables the researcher to track the degree of integration of the voices over the course of psychotherapy, but also, as shown in the case of Paul, how the client benefits from the external person's – either the intimate partner's or the therapist's – presence. These external persons may represent real-world representatives of inner voices, such as the critical voice staged by the intimate partner, or may encourage progressive integration of the non-integrated voices in the client, such as the role-play staged by the therapist. Future research needs to focus on the necessary conditions in the client, in the external person and the

characteristics of their relationship, if the client is to benefit from responsiveness to his functioning.

Case studies are designs with $N = 1$ with limited generalisability. However, the use of a widely-discussed and empirically-proven methodology and theoretical framework (the assimilation analysis and model) strengthens the conclusions of the case study (for a methodological discussion, see [5, 7, 8]). Our research questions may also be investigated using a statistical approach where the number of observations per case is limited, but where the total N of cases meets the requirements of quantitative research designs [7]; such research into the variables of third party, i.e. therapist, responsiveness and affect integration processes in psychotherapy is sorely needed.

Several limitations of this case study must be acknowledged. We did not, as is usually the case in assimilation analyses, use session transcripts of the entire psychotherapy. Feasibility constraints obliged us to use only detailed therapist session notes, which are prone to biases. However, these notes were particularly detailed and reliable and were not taken with the present assimilation analyses in mind but for accreditation purposes; thus, in this case, the quality of the material was acceptable. Without detailed session notes or transcripts moment-by-moment analysis of the process is simply not feasible and would yield speculations at best. Focusing on only eleven sessions out of 90 is prone to bias. To account at micro-level for the change process in this long-term therapy, time constraints obliged us to prioritise and make an empirically-based selection. We may have ignored important moments in other sessions and the results of the present case study may have been different. These biases were reasonably limited by the use of a specific iterative consensus procedure [21].

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