Author Manuscript
Faculty of Biology and Medicine Publication

This paper has been peer-reviewed but does not include the final publisher proof-corrections or journal pagination.

Published in final edited form as:

serval
serveur académique lausannois

Unil
UNIL | Université de Lausanne
Faculty of Biology and Medicine

CHUV

How psychotherapeutic exchanges become responsive: A theory-building case study in the framework of the Assimilation Model

Claudia Meystre, Ueli Kramer, Yves de Roten, Jean-Nicolas Despland

University of Lausanne

and

William B. Stiles

Miami University

Author note

Claudia Meystre, Institute of Psychotherapy, Lausanne, Switzerland; Ueli Kramer, Institute of Psychotherapy, Lausanne, Switzerland; Yves de Roten, Institute of Psychotherapy, Lausanne, Switzerland; Jean-Nicolas Despland, Institute of Psychotherapy, Lausanne, Switzerland; William B. Stiles, Miami University, Oxford, Ohio, USA.

Correspondence concerning this article should be addressed to Claudia Meystre, Institut Universitaire de Psychothérapie, Avenue de Morges 10, CH-1004 Lausanne, Switzerland.
E-mail: Claudia.Meystre@chuv.ch

Biographical Details

Claudia Meystre is a Ph.D. student at the Centre for Psychotherapy Research at the Institute for Psychotherapy (IUP), Lausanne, Switzerland.

Ueli Kramer, Ph.D., psychotherapist FSP, is a senior researcher and a clinical supervisor at the Centre for Psychotherapy Research at the Institute for Psychotherapy (IUP), Lausanne, Switzerland.

Yves de Roten, Ph.D., is at the head of the Centre for Psychotherapy Research at the Institute for Psychotherapy (IUP), Lausanne, Switzerland.

Jean-Nicolas Despland is Director of the Institute for Psychotherapy (IUP), Lausanne, Switzerland.

William B. Stiles is Professor Emeritus of Psychology, Miami University, Oxford, Ohio, USA.

Abstract

Objectives: The Assimilation of Problematic Experiences Scale (APES) describes eight levels a problematic experience passes through en route to becoming part of the person's self. Theoretically, progress along this continuum may be facilitated by therapist interventions that are appropriately responsive to the problem's current APES level, in the sense that they help the patient move from the current level to the next. This study aimed to investigate links between therapist intervention choice and progress across APES levels. *Design*: A theory-building case study was undertaken to assess and revise hypotheses concerning which therapeutic interventions are optimally responsive at each APES level. *Method:* Therapeutic interventions, measured by the Comprehensive Psychotherapeutic Interventions Rating Scale and assimilation level, measured by the APES, were assessed in 34 session transcripts of a 30-year old woman treated with brief psychodynamic therapy for bouts of weeping and diffuse anxiety. *Results and conclusion:* Results were promising and enabled us to adjust our hypotheses, expanding and elaborating the Assimilation Model. *Implications for practice:* Our case study showed how specific therapist interventions may facilitate assimilation and underlined the dialogical dimension of the therapy process.

Keywords: assimilation; case study; change process; responsiveness

How psychotherapeutic exchanges become responsive: A theory-building case study in the framework of the Assimilation Model

Theory-building case studies offer investigators opportunities to compare detailed clinical observations of the processes of psychotherapy with theoretical statements. The correspondence or lack of correspondence can strengthen or weaken the theory or lead to the theory being elaborated, extended, or refined. In this approach, the theory is seen as a flexible description, continually permeated by new observations (Stiles, 2007, 2009).

In this theory-building case study, we investigated a proposition derived from the Assimilation Model (Stiles, 2002, 2011) suggesting that optimal therapist responsiveness involves systematically different interventions depending on the level to which the patient's focal problem is assimilated (Honos-Webb & Stiles, 2002; Stiles, Shapiro, Harper, & Morrison, 1995).

Assimilation Model

The Assimilation Model conceptualizes how patients progressively integrate their problematic experiences during psychotherapy (Stiles, 2002, 2011). It has been constructed primarily through theory-building case studies, and further case studies continue to extend, elaborate, and refine it (e.g., Brinegar, Salvi, Stiles, & Greenberg, 2006; Caro Gabalda & Stiles, in press; Goldsmith, Mosher, Stiles, & Greenberg, 2008; Kramer & Meystre, 2010 ; Osatuke & Stiles, 2006). The self is seen as made up of different *voices*, centers of experience, interconnected by the sharing of meaning (Honos-Webb & Stiles, 1998). The voice metaphor is used to describe psychological manifestations of neurological traces of previous experiences; voices represent different perspectives individuals have of the world and of themselves, deriving from

their earlier experiences (Stiles, 2011). Each person's internal community of voices--their Self--is characterized by heterogeneity and dynamism. The traces of the person's varied experiences are active agents, reactivated when circumstances somehow recall the original experience.

The concept of problematic voices is used to describe traces of painful or threatening experiences, which are warded off and disconnected from the Self, since they adopt a perspective incompatible with that of the Self (Osatuke & Stiles, 2006). Confrontations between contradictory perspectives generate intense negative affects, and the problematic voices may be suppressed or avoided (Stiles, Osatuke, Glick, & Mackay 2004).

Therapeutic change involves the gradual assimilation of the problematic experiences into the patient's Self, until they become part of the patient's way of thinking and acting and can be used as resources. This process seems to proceed in a regular sequence, described in the Assimilation of Problematic Experiences Scale (APES; Stiles, 2002, 2011). The APES distinguishes eight stages of assimilation representing a developmental progression of the patient's degree of awareness of the problematic voice and cognitive and affective dispositions towards it (see Table 1).

Therapist Responsiveness Can Facilitate Assimilation

The term *responsiveness* refers to "behavior that is affected by emerging context, including emerging perceptions of others' characteristics and behavior" (Stiles, Honos-Webb, & Surko, 1998, p. 439). Human beings are pervasively responsive to each other, as they anticipate each other's responses and orient their discourse to their understanding. They attend to their mutual feedback and react accordingly. In therapy, the therapist tries to do what is required to improve the patient's situation. The

therapist's responsiveness is *appropriate* when the therapeutic response is sensitive to the patient's emerging requirements, difficulties and resources and takes them accurately into account in ways consistent with the therapeutic approach (Stiles et al., 1998).

The formulation that assimilation progress follows a regular series of stages suggests the possibility that systematically different sorts of therapist interventions may be optimally responsive for facilitating progress in different stages (Stiles et al., 1995). That is, promoting awareness and assimilation of problematic experiences responsively may require the therapist to select varying interventions to respond to the patient requirements that change according to the problem's current assimilation level, drawing, perhaps, from different orientations. Using this logic, Honos-Webb and Stiles (2002) listed some patient requirements likely at each APES stage and offered hypothetical examples of appropriately responsive therapeutic interventions, drawn from a variety of therapeutic approaches, to address each of the stage-specific requirements.

Study Purpose and Design

The purpose of this theory-building case study was to deepen our understanding of the therapist's specific role in the increase of their patients' awareness and assimilation. Following Honos-Webb and Stiles's (2002) suggestion that a patient is better able to reach a higher assimilation level if the therapist's intervention is appropriate to the patient's current level, we developed hypotheses concerning responsive therapeutic interventions for each assimilation level.

Influenced by the work of Sachse and colleagues (Sachse, 1992; Sachse & Elliott, 2002) on the role of therapeutic actions in promoting or reducing patient's change processes, we looked at *triples* in the therapeutic dialogue, which are sequences

of patient-therapist-patient responses. We assessed the APES stage of the patients' problem-related talk before and after specific types of therapist interventions. We then noted whether or not the interventions were followed by an advance along the APES. We examined how our hypotheses fared, and then, following a theory-building strategy (Stiles, 2007, 2009), we revised our understanding and our hypotheses in light of what we observed.

Method

The Case of Claire

Claire (a pseudonym) was a young woman about thirty years old who worked in a scientific field. She sought treatment because she had been suffering from high sensitivity, bouts of weeping and diffuse anxiety for several weeks. Whenever she had to make decisions, even in situations without important stakes, she was likely to suffer from anxiety attacks, provoked by the feeling that she had to choose the right solution. She tended to ask other people to make her choices for her and so to depend on them. Claire saw these developments as uncharacteristic of her. She said that usually she behaved assertively and knew what she wanted. She described herself as ambitious, aiming for a successful career.

Claire did not receive a psychiatric diagnosis or show symptoms warranting a diagnosis at intake, discharge or follow-up. On the Global Severity Index (GSI) of the Symptom-Checklist-90 (SCL-90; Derogatis, Lipman, & Covi, 1973), she was rated .41 at intake and .39 at discharge; SCL-90 scores range from 0 (not at all) to 4 (extremely) with a clinical cut-off at .90. The therapeutic alliance was generally positive and followed a positive trend through the therapy. Alliance ruptures and resolutions over the course of Claire's therapy have been described previously (Michel, Kramer, & de Roten, 2011).

Claire's case was taken from a project on the effectiveness of short-term psychodynamic psychotherapy for young adults (Gilliéron, 1997; de Roten, Michel, & Despland, 2005). This approach focuses on the patient's current crisis and conflictual relationship themes. Claire was seen for 34 sessions, from November 2005 to September 2006. The therapy was conducted in French. The therapist was a psychoanalytic psychiatrist and member of the International Psychoanalytical Association (IPA), with more than twenty years of experience as therapist and supervisor. He was not cognizant of the Assimilation Model.

In a companion study, Meystre, Kramer, de Roten, Michel, and Despland (2011) distinguished Claire's two main problematic voices, followed their evolution across psychotherapy, and showed how they were assimilated into Claire's Self. These problematic and avoided experiences were related to dependence: need for others' presence, support, and advice. Claire also showed difficulty in expressing sadness and accepting weakness. Her dominant voices, constituting Claire's Self initially, expressed self-determination, independence and need to have control over her life. In therapy, Claire's Self gained in complexity, reconciling the previously opposed voices. The therapy ended on a positive and pleasant note (Meystre et al., 2011).

Instruments

Assimilation process. Assimilation was evaluated using the Assimilation of Problematic Experiences Scale (APES; Stiles, 2002; see Table 1). The APES is a developmental sequence comprising eight assimilation stages that a problematic experience passes through en route to becoming part of the person's Self. In a refinement study, Brinegar et al. (2006) distinguished four substages describing this transition (see Table 1).

Psychotherapeutic interventions. The Comprehensive Psychotherapeutic Interventions Rating Scale (CPIRS ; Trijsburg et al., 2002) was used to code psychotherapeutic interventions. The CPIRS is designed as an exhaustive classification of interventions in psychotherapy based on a review of empirical studies that used questionnaires or rating scales to assess psychotherapy process. Statistical criteria were used to select the most characteristic interventions for each therapeutic orientation. The latest CPIRS version (Trijsburg et al., 2004) consists of 81 therapeutic interventions, classified by the main therapeutic approaches (experiential, psychoanalytic, psychodynamic, group dynamic, systemic, behavioral and cognitive) or as common factors (coaching, facilitating, structuring, directive process, authoritative support, other interventions). Interrater reliability has been acceptable (Trijsburg et al., 2002). The CPIRS manual is available from this paper's first author.

Procedure

APES rating. As described in the report of the companion study (Meystre et al., 2011), the first and second authors of that--and this--report served as APES raters. They listened to all 34 sessions and formulated characterizations of Claire's two problematic voices, (i) dependence and (ii) difficulty in expressing sadness. Claire's dominant voices expressed her self-determination and sense of independence. The raters then selected eight sessions (numbers 1, 4, 5, 6, 19, 24, 29 and 34) as best representing and illustrating the dominant and problematic voices and the main themes of the therapy.

The entire transcripts of the eight sessions were then analyzed in terms of voices. Using the voice characterizations, the raters extracted every patient-therapist exchange in which they judged that one of the problematic voices seemed to be speaking and which they judged as ratable with the APES. Forty-one coherent and self-contained

patient-therapist exchanges dealt with one or both of the two problematic voices and were retained for further analysis. Each exchange included at least three speaking turns: a patient statement, the therapist's intervention, and the patient's reaction to that intervention. Most of the exchanges included more than three speaking turns to encompass coherent thought units.

The two problematic voices - dependence and difficulty in expressing sadness - were closely interdependent within exchanges. Consequently, in our analyses, we combined exchanges across the two voices into a single data set.

The raters first independently rated each patient speaking turn in the 41 exchanges using the APES. Then they worked to consensus concerning the characterization of the voices, the selection of exchanges, and the assessment of the APES levels, following an iterative procedure in which individual work alternates with group discussions described by Schielke, Fishman, Osatuke, and Stiles (2009). During the meetings, the individual perspectives were presented and discussed in a noncritical way, thus allowing both raters to integrate new relevant ideas and progressively revise his/her understanding. The aim of this approach is a consensual account that incorporates the best elements of initial and emergent conceptualizations. No formal reliability statistics were done on the APES ratings.

CPIRS coding. The first and second authors also independently coded all therapist interventions in the 41 exchanges according the CPIRS, without referring to the earlier APES coding. A meeting was held to discuss CPIRS codes that had been difficult to assess for one of the coders, reaching consensus. During the training process, intercoder reliability assessed on two other cases was excellent with an intraclass coefficient correlation ICC (1, 2) = .99 and ICC (1, 2) =.90.

Data analysis. Aiming to develop a systematic method to study therapist responsiveness, we began with Honos-Webb and Stiles's (2002) list of hypotheses and extended it by using the CPIRS categories, formulating further hypotheses regarding responsive therapeutic interventions for each APES level. The extensions were based on matching the definitions of the CPIRS categories with our theoretical understanding of client requirements at each APES level. The resulting set of initial hypotheses is shown in Table 2.

We then analyzed the 41 exchanges by noting whether each CPIRS-coded therapist intervention was used at the hypothesized APES level shown in Table 2. Then, we compared the APES levels for the patient's statements just before and just after each CPIRS-coded therapist intervention to see which interventions were associated with APES progress or regression at each level.

Armed with these results, we closely examined the 41 exchanges. We noted which hypotheses were confirmed or disconfirmed, and we modified our understanding and expanded our hypotheses to take what we had learned into account. For this article we selected two exchanges to illustrate how therapist and patient jointly contributed to the assimilation process and to show how we confronted the case with our hypotheses.

Results

The 41 exchanges included 69 patient speaking turns assessed with the APES and 92 therapist interventions coded with the CPIRS. The most frequent APES levels were APES-2 (32%) and APES-3.2 (17%). The most frequent CPIRS categories were CPIRS-45 *Subtle guidance* (59%), CPIRS-78 *Asking information and elaboration* (7%), and CPIRS-59 *Interpretation of warded-off wishes, feelings or ideas* (5%). CPIRS-45 was so common because it included the therapist *mm-hm* interventions.

Our hypotheses were confirmed in 7 (17%) of the 41 exchanges. That is, either the therapist's intervention appeared at the APES level we postulated and the patient moved on to a higher APES level (n=3; 7%), or the intervention did not appear at the APES level postulated but stagnation or regression was observed in the assimilation (n=4; 10%). Likewise, our hypotheses were disconfirmed in 7 (17%) of the exchanges, that is, even though the therapist's intervention appeared at an APES level other than the one we postulated, the patient moved on to a higher APES level. The remaining 27 (66%) of the exchanges did not bear directly on our hypotheses, mainly because the therapist's interventions were coded in CPIRS categories not mentioned in our hypotheses.

To show our theory-building results, we first present and discuss two illustrative exchanges as a way of explaining how we confronted the case with our hypotheses. Then we detail the modifications made to our hypotheses in light of what we observed. In addition to adjusting our initial hypotheses, we extend our hypotheses to address the 66% of the exchanges to which our initial hypotheses did not apply.

Illustrative exchanges

The following two illustrative exchanges addressed relationship issues, with the therapist and the boyfriend. Claire's need to be independent, to avoid others' influence, and to have total control over her life were called into question. These exchanges were translated from French for this report by the first author, preserving the original phrasing where the sense was clear. Patient and therapist speaking turns were numbered within exchanges.

The first illustrative exchange was excerpted from session 1. During this session, Claire talked about her difficulty in making choices and her anxiety about making

decisions. Here, Claire said that she wished her difficulties would disappear miraculously, without her making any effort.

1 Pt: The doctor decides which therapeutic action should be taken, while here you say the things but, well, how can I say, you can't press on a button and everything is ok. [APES-2: Vague awareness/emergence]

2 Th: mm hm [CPIRS-45: Subtle guidance]

3 Pt: yes it's-

4 Th: Is it a regret? [CPIRS-55: Drawing attention to unacceptable feelings] [Hypothesis: APES-2 ≠ CPIRS-55]

5 Pt: (laughs) (10-sec pause) *yes I- no!* because I think it's interesting to discuss little by little too and then yes, yes I think that a part [APES-3.2: Rapid cross-fire]

6 Th: but finally I have the feeling that you tell me, maybe there is a regret that I can't blow on [it] and the pain miraculously goes away

7 Pt: yes

8 Th: like when maybe I was a little girl, I could go and someone would blow on the wound

9 Pt: yes

10 Th: and the pain went away. [CPIRS-60: Transference interpretation] [Hypothesis: APES-3.2 ≠ CPIRS-60]

11 Pt: That's true (17-sec pause) I think there could have been this desire of a magic wand or um – but at the same time, I don't know, there is this Taoist idea that it's not only the aim which is important

but also the way, the progression. [APES-3.8: Joint search for

understanding]

Claire's previously warded-off wish that someone else would take charge of her

difficulties emerged in turn 1, expressed in a negative form ("but well, how can I say,

you can't press on a button and everything is ok"), characteristic of APES 2. This was a

contrast with Claire's usually dominant voices - her high awareness, her professional

commitment, and her need to have control over the situation. In turn 4, the therapist

pointed out the unacceptable feeling of regret linked to Claire's warded-off wish

(CPIRS-55). Claire's reaction to this intervention was rapid cross-fire (turn 5). Rapid

cross-fire refers to attempts by problematic voices to speak out, producing abrupt

interruptions by the dominant voices (Brinegar et al., 2006). After ten seconds of

thought, Claire's problematic voice expressed itself by agreeing, but it was abruptly cut

off mid-sentence by the dominant voices underlining the advantages of long hard work

and great commitment. This intrapersonal dialogue was clearly shown by the self-

contradictory speech, which is characteristic of APES 3.2.

In turns 1 to 5, Claire progressed from APES-2 to APES-3.2. According to our

hypotheses, the therapist's intervention *Drawing attention to unacceptable feelings*

(CPIRS-55) was not responsive to APES-2, which is characterized by a vague

awareness of the problem, but would be appropriate to APES-3 when the patient is able

to formulate the problem clearly and work on it. If our hypotheses were confirmed, we

would not have observed an improvement in Claire's assimilation of her problematic

voice. However, judging by the outcome of this exchange, CPIRS-55 may sometimes be

appropriate to APES-2.

In response to the rapid cross-fire, the therapist made a transference interpretation (CPIRS-60; turns 6 8 and 10). He drew attention to Claire's probably unrecognized wish that the therapist would act as her father would have done when she was a little girl, by blowing on her wound to make the pain go away. Interestingly, the therapist used the pronoun "I", as if making her voice his own (cf. Goldsmith et al., 2008). He also continued Claire's metaphor of blowing on a wound to heal it. In turn 11, Claire first agreed with the therapist's interpretation. She had probably hoped that he would have a magic wand. The dominant and problematic voices then talked things over and worked together to gain a better understanding of the problem, as is characteristic of APES-3.8.

Why did Claire not defend herself against the problematic affect by intellectualizing? What might be called a voice of theory (Grossen & Salazar Orvig, 2011) was invoked. Indeed, Claire mentioned Taoist theory; however, this was probably more a pseudo-recognition of the problematic voice than real progress in its assimilation. According to our initial hypotheses (Table 2), we considered that CPIRS-60 is not appropriate to APES-3.2. Transference interpretation may be responsive to higher APES levels, when the patient is already able to put the problem into words. This interpretation category, as well as CPIRS-57 to 59, corresponds to therapeutic interventions more appropriate when trying to link affects and behaviors, past and present reactions, thus when elaborating insight (APES-4).

In the second exchange (session 24), Claire mentioned for the first time that she and her boyfriend saw each other only on weekends and that this situation may have affected her.

   1 Pt: I have an apartment with my boyfriend but he's only here at the

weekends because he works in a different city. During the week I'm

pretty alone; indeed, I have to make appointments to have a social life.

For instance, I was thinking about rowing because I do it in the

evening, and when I go rowing I don't really have people I'm close to

[…] (20-sec pause). [APES-2-3: Vague awareness/emergence-

Problem statement/clarification]

2 Th: Yes, well I was wondering, in fact it's the first time I hear that

your boyfriend lives in a different city and that you

3 Pt: Yeah, that's right, I haven't talked about it before

4 Th: Yes, as it was also the first time that you mentioned perhaps you

missed him and that being alone is not always easy. [CPIRS-55:

Drawing attention to unacceptable feelings] [Hypothesis: APES-2-3 =

CPIRS-55]

5 Pt: Yes, that's right. It's funny that I haven't talked about that before

-- because yeah I don't want to admit that I'm affected. Because yeah

(30-sec pause). […] That's true, it's not easy to be - in some way it's

as if I were single. Half of the time I'm alone. […] I think I would

have preferred that he stayed here. [APES-4: Understanding/insight]

Turn 1 offers an interesting example of problem emergence (APES 2-3). Claire

described her daily life. Her feeling of loneliness was put into words ("I'm pretty alone

indeed", turn 1); otherwise, her description remained factual. Thus, without being

clearly acknowledged, the problematic voice of neediness and dependence progressively

emerged into Claire's awareness through the description of her daily life. In turn 4, the

therapist mentioned the term "miss" and thus explicitly named the feeling of need

resulting from the absence of her boyfriend. This intervention was coded "Drawing

attention to unacceptable feelings" (CPIRS-55). More precisely, the therapist first

repeated what Claire said just before in her description (turn 2). Then he went further

and mentioned the probably unrecognized feeling to make Claire aware of it (turn 4). In

turn 5, Claire agreed the absence of her boyfriend must certainly affect her and that she

most likely had not wanted to admit it before. Her subsequent discourse, however, was

more factual than emotional, with terms like "single", "alone" (vs "lonely") and "stayed

here" (turn 5).

We had hypothesized that the CPIRS-55 was responsive to APES-3, which was

supported in this excerpt. Claire's problematic voice of need and dependence shifted

from APES-3 to APES-4; Claire succeeded in gaining a better and new understanding

of her feelings of need and of dependence on her boyfriend.

Modified Hypotheses

Table 3 lists the modifications made to our original hypotheses as a result of this

case study, all intended to be consistent with the theory and to help account for the

empirical observations. The revision was based on our analysis of all 41 exchanges, not

only on the two illustrative exchanges presented here. Both Tables 2 and 3 include

APES levels and CPIRS categories not observed in this case to show the theoretical

patterns we hypothesize.

We propose three sets of modifications. First, 9 CPIRS categories not addressed

in our original hypotheses were used by the therapist. These accounted for the

therapist's contribution in 66% of the exchanges:

CPIRS-3: Involvement

CPIRS-5: Rapport

CPIRS-10: Supportive encouragement

CPIRS-13: Explicit guidance

CPIRS-15: Advice and guidance

CPIRS-61: Confrontation

CPIRS-78: Asking information or elaboration

CPIRS-79: Clarification, reformulation

CPIRS-81: Using metaphors

As shown in Table 3, we now hypothesize that *Explicit guidance* (CPIRS-13) is responsive to APES 1 and 2, as the patient's confusion may require explicit determination of the content. *Advice and guidance* (CPIRS-15) may be appropriate to APES levels 1 and 2, but also to APES levels 5 and 6, when therapist and patient are directly working on the problem. *Confrontation* (CPIRS-61) also may be responsive to APES levels 2 and 3.

Second, we noticed that some interventions were used, apparently successfully, to encourage, facilitate or clarify communication with Claire. In the same vein, some interventions are used to develop a good relationship and build alliance. We now hypothesize that such facilitative and relationship-building interventions are appropriately responsive throughout the therapy and hence that the corresponding CPIRS categories will be effective at many APES levels (top section of Table 3).

Finally, we would now subdivide the specific CPIRS category, *Subtle guidance* (CPIRS-45). The CPIRS manual defines this as "encouraging the patient to elaborate on something that is implicitly present so that the content or the focus of the conversation can deepen" (CPIRS, 2005, p. 45). It includes *mm-hm* and other expressions used to

communicate attentiveness, support and encourage patients to keep talking. We now hypothesize that *mm-hm* responses, which represented 50% of the therapist's interventions, are appropriate to all APES levels. Other instances of CPIRS-45 are still hypothesized to be responsive to APES levels 1 and 2.

As a post hoc analysis, we recalculated the percentages of exchanges in which our revised set of hypotheses were confirmed or disconfirmed. They were confirmed in 21 (51%) of the exchanges. That is, either the therapist's intervention appeared at the APES level we postulated and the patient moved on to a higher APES level (n=17; 41%), or the intervention did not appear at the APES level postulated but stagnation or regression was observed in the assimilation (n=4; 10%). Our hypotheses were disconfirmed in 19 (46%) of the exchanges: In 17%, the therapist's intervention was at an APES level other than the one our hypothesis suggested as optimal, but the patient moved to a higher APES level. In 12 (29%), the intervention was at the suggested APES level, but stagnation or regression was observed. In one exchange (2%), the result was ambiguous, because the therapist's intervention was coded in a CPIRS category (CPIRS-81 *Using metaphors*) not mentioned in our new hypotheses.

Discussion

Our initial hypotheses concerning responsive therapeutic interventions for each assimilation level (Table 2) obtained a very modest level of corroboration, and many of the therapist's CPIRS-coded interventions were not taken into account. Our analysis of excerpts from the case of Claire enabled us to confront the case with this initial understanding and modify our hypotheses as a result of what we observed, yielding a new, more comprehensive set of hypotheses (Table 3).

In this therapy, Claire succeeded in integrating previously painful ways of being in relation with significant others, related to dependence and losing grip. Focusing on patient-therapist-patient triples made it possible to assess how each participant was influenced by the other. For instance, in the first illustrative exchange, Claire's productive intrapersonal dialogue appeared to be facilitated after the therapist drew attention to and named the unacceptable feelings associated with the problematically dependent voice. By naming Claire's feeling of regret that there wasn't someone who took charge of her difficulties, the therapist drew her attention to this painful feeling. Theoretically, we suggest, intervention was effective because it occurred at the right assimilation level, as Claire progressed from resistance and vague awareness to a rapid cross-fire. The therapist also addressed Claire's problematic dependency by his transference interpretation of her wish to be taken care of, like a little girl by her father (exchange 1, turns 6 and 8). Joining her internal discourse seemed aided by his using the pronoun "I" and metaphors like those Claire had just used. The therapist's "enunciative positioning" towards Claire's voice (Vion, 1998) was neither agreement nor opposition towards the problematic voice; instead, he seemed to question it by pointing to divergences from Claire's original position. He addressed the wish for a magic wand in a neutral way, whereas Claire had offered a negative evaluation of it.

This sequence in the first exchange illustrates Grossen and Salazar Orvig's (2011) contention that the patient's problematic experience is co-constructed by the two protagonists during therapy and not simply put into words. As highlighted by Bakhtine's (1987) dialogical approach, all discourse is shaped by traces of many past discourses (dialogue *in absentia*) but also by what has just been said (dialogue *in praesentia*) and of anticipations of what will said (Salazar Orvig & Grossen, 2008).

Nine types of therapeutic interventions that we initially did not take into account appeared in our analyses of the 41 selected exchanges. These were mostly CPIRS categories related to *Coaching* and *Other interventions*. They may have been systematically overlooked by Honos-Webb and Stiles (2002) because they are not so clearly associated with traditional theories of psychotherapy.

Therapeutic interventions used to encourage, facilitate or clarify communication and those having a relational function appeared to be appropriate for many assimilation levels. Accordingly, we modified our hypotheses by constructing a category of non specific interventions appropriate to many APES levels in our revised hypotheses (see Table 3) and distinguishing *mm-hm* responses from other instances of CPIRS-45.

In our post hoc analyses based on the revised hypotheses (Table 3), the percentage of interventions that had no predictions dropped from 66% to 3% and the percentage that showed the hypothesized increase in APES level rose from 17% to 51%. However, the percentage of interventions followed by a decrease or stagnation in APES level also increased, from 17% to 46%. Our results might have looked even more promising if we considered, less conservatively, that the 29% scored as stagnation may sometimes have been an APES advance that was too small to appear in the ratings.

We will test the revised model in further psychodynamic case studies to see if the alterations are more general and hold up when tested on new sets of data. It will also be important to see if the revised model holds up in psychotherapies from other orientations.

References

Bakhtine, M. (1987). *Esthétique et théorie du roman*. Paris: Gallimard.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53*, 165-180.

Caro Gabalda, I., & Stiles, W. B. (in press). Irregular assimilation progress: Setbacks in the context of Linguistic Therapy of Evaluation. *Psychotherapy Research*.

CPIRS (2005, January). *Comprehensive Psychotherapeutic Interventions Ratings Scale*. Leudsen, Netherlands: Trijsburg, R. W.

De Roten , Y., Michel, L., & Despland, J.-N. (2005). Recherche sur le processus psychothérapique: l'exemple du Modèle de l'Adéquation. *Pour la Recherche, 44*, 11-13.

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale - preliminary report. *Psychopharmacology Bulletin*, 9, 13-27.

Gilliéron, E. (1997). Les psychothérapies brèves. Paris: PUF.

Goldsmith, J. Z., Mosher, J. K, Stiles, W. B., & Greenberg, L. S. (2008). Speaking with the client's voices: How a person-centered therapist used reflections to facilitate assimilation. *Person-Centered and Experiential Psychotherapies, 7*, 155-172.

Grossen, M., & Salazar Orvig, A. (2011). Third parties' voices in a therapeutic interview. *Text & Talk, 31*, 53-76.

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy, 35*, 23-33.

Honos-Webb, L., & Stiles, W. B. (2002). Assimilative Integration and responsive use of the Assimilation Model. *Journal of Psychotherapy Integration, 12*, 406-420.

Kramer, U., & Meystre, C. (2010). Assimilation process in a psychotherapy with a

    client presenting schizoid personality disorder. *Swiss Archives of Neurology and*

    Psychiatry, 161, 128-134.

Meystre, C., Kramer, U., De Roten, Y., Michel, L., & Despland, J.-N. (2011).

    Assimilation des expériences problématiques: Une étude de cas de

    psychothérapie psychodynamique brève. *Santé mentale au Québec, 36,* 181-199.

Michel, L., Kramer, U., & de Roten, Y. (2011). Alliance evolution over the course of

    short-term dynamic psychotherapy: A case study. *Counselling and*

    Psychotherapy Research, 11, 43-54.

Osatuke, K., & Stiles, W. B. (2006). Problematic internal voices in clients with

    borderline feature: An elaboration of the Assimilation Model. *Journal of*

    Constructivist Psychology, 19, 287-319.

Sachse, R. (1992). Differential effects of processing proposals and content references on

    the explication process of clients with different starting conditions.

    Psychotherapy Research, 2, 235-251.

Sachse, R., & Elliott, R. (2002). Process-outcome research on humanistic therapy

    variables. In D. J. Cain & J. Seeman (Eds.), *Humanistic Psychotherapies:*

    Handbook of Research and Practice (pp. 83-115)*. Washington, DC: American*

    Psychological Association.

Salazar Orvig, A., & Grossen, M. (2008). Le dialogisme dans l'entretien clinique.

    Langage et société, 123, 37-52.

Shielke, H. J., Fishman, J., Osatuke, K., & Stiles, W. B. (2009). Creative consensus on

    interpretations of qualitative data: The Ward Method. *Psychotherapy Research,*

    19, 558-565.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357-365). New York: Oxford University Press.

Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research, 7,* 122-127.

Stiles, W. B. (2009). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy, 5,* 9-22.

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21,* 367-384.

Stiles, W. B., Shapiro, D. A., Harper, H., Morrison, L. A. (1995). Therapist contributions to psychotherapeutic assimilation: An alternative to the drug metaphor. *British Journal of Medical Psychology*, *68*, 1-13.

Stiles, W. S., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5*, 439-458.

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H. H. Hermans & G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). New York: Brunner-Routledge.

Trijsburg, R. W., Frederiks, G. C., Gorlee, M., Klouwer, E., den Hollander, A. M., & Duivenvoorden, H. J. (2002). Development of the Comprehensive Psychotherapeutic Interventions Rating Scale (CPIRS). *Psychotherapy Research, 12*, 287-317.

Trijsburg, R. W., Lietaer, G., Colijn, S., Abrahamse, R. M., Joosten, S., & Duivenvoorden, H. J. (2004). Construct of the comprehensive psychotherapeutic interventions rating scale. *Psychotherapy Research, 14*, 346-366.

Vion, R. 1998. De l'instabilité des positionnements énonciatifs dans le discours. In J.

Verschuern (ed.), *Pragmatics in 1998: Selected papers from the 6th*

International Pragmatics Conference, 577–589. Antwerp: International

Pragmatics Association.