

What does the first exchange tell? Dialogical sequence analysis and assimilation in very brief therapy

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Abstract

The authors applied dialogical sequence analysis, a microanalytic method for tracing recurring maladaptive patterns, to study assimilation in the psychotherapy of a woman treated for mild depression in two weekly sessions plus a 3-month follow-up session. The very first exchange (four speaking turns each by client and therapist) enacted a pattern in which the client responded to her own potential vulnerability by adopting a controlling caretaker position. Subsequent therapeutic work delineated component positions in this pattern, which was recurrent and maladaptive, leading to an insight reached midway through the second session. From the client's reports, it appeared that she used her new understanding to assimilate her problematic controlling side, giving her greater flexibility in her relationships and greater scope for meeting her own needs for care. She seemed to progress across three of the eight developmental stages postulated by the assimilation model: problem statement–clarification, understanding–insight, and application–working through.

Researchers as well as clinical lore have suggested that clients' central problems are manifested in their very earliest therapeutic contacts (e.g., Benjamin, 1996; Greenson, 1967; Hobson, 1985; Salzberger-Wittenberg, 1970). Even if clients cannot specify their problems, they may reveal them in their utterances and expressions and in patterns of interaction with the therapist. Our study aimed to elucidate this process in terms of the assimilation model (Stiles, 2002; Stiles et al., 1990). We analyzed therapeutic dialogue to identify possible manifestations of problems in an opening exchange. We then followed the course of a pattern we identified and traced its manifestations in the client's eventual understanding, which she reached over a course of very brief psychodynamic–interpersonal psychotherapy.

Problematic positions and the assimilation model

According to the assimilation model, people's experiences (i.e., their awareness and activity in the moment) leave traces, which may later be reactivated. Traces of experience have been called *voices*, reflecting the observation that they are not passive

parcels of information but agentic parts of the person, able to act and speak (Honos-Webb & Stiles, 1998; Osatuke, Gray, Glick, Stiles, & Barkham, 2004; Osatuke et al., 2005; Stiles, 1997, 1999). Thus, a person's personality is understood as a community of voices representing significant people, events, and other constellations of experiences. Normally, experiences are assimilated, unproblematically linked together, so that they are smoothly accessible and can serve as resources in daily living. Voices of problematic experiences, however, may remain dissociated or at least partially separated from the rest of the person's experiences, being held apart by the negative affect engendered by encounters between them (Stiles, 2002; Stiles, Osatuke, Glick, & Mackay, 2004). The problematic voices may be addressed and reactivated by circumstances that recall the conditions under which they were formed.

A new aspect to the assimilation model is added by postulating that voices are positioned (Harré & van Langenhowe, 1999; Leiman, 2002, 2004; Madill, Sermpezis, & Barkham, 2005; Shotter, 1993); that is, voices are manifested as momentary stances that the person adopts in relation to events, things, other

people, and aspects of self. Conversely, the positions a person takes are understood as the observable manifestations of internal voices.

When people encounter the circumstances that trigger problematic voices, they may suddenly reenact the problematic patterns, adopting positions that resemble those they were forced into during the prior problematic events or adopted as an immediate response to such events. Unlike normal, appropriate changes of personal stance to things and events, which are accomplished smoothly, comfortably, and voluntarily, shifts to problematic positions and patterns tend to be sudden, unexpected, and involuntary. Attempts to integrate the problematic positions with the currently acceptable self, which is also positioned, can be acutely distressing.

What makes a voice problematic to the person does not reside within the voice itself but in how it positions the person with regard to self and others. A position is problematic when it is incompatible with positions taken by the voices that comprise the person's accepted sense of self. For example, an enraged, murderous position may be frightening from the perspective of a docile, peacemaking voice that dominates the person's sense of self. It is also an awkward position in relation with others. The incompatibility is manifested by emotional distress and discontinuity in interaction patterns: abrupt shifts under triggering conditions or, in the extreme, complete dissociation.

By contrast, after problematic voices have been assimilated, as in successful psychotherapy, they become flexible and adaptable to the circumstances rather than unavailable or rigidly reenacted when triggered unexpectedly by life events. They no longer have to be warded off or escaped. Assimilation of a problematic experience makes possible new intermediate or combined positions and thereby allows moderate rather than extreme responses.

Theoretically, assimilation involves developing meaning bridges (i.e., words or other signs that can represent, link, and encompass the previously separated voices and thereby form a new configuration). Thus, the work of therapy involves gaining useful access to formerly problematic experiences and turning them into resources. The main observable part of this therapeutic process of assimilation consists of the semiotic mediators: the words and nonverbal expressions used to name, describe, and enact the changing patterns. These meaning bridges or potential meaning bridges form initially between client and therapist and then may become internally available to the client. The therapist participates by serving alternately as addressee, observer, and alter ego as clients enact and modify versions of their habitual patterns.

In successful psychotherapy, clients appear to follow a regular developmental sequence of recognizing, formulating, understanding, and, eventually, resolving the problematic experiences that brought them into treatment. A series of intensive case studies (e.g., Brinegar, Salvi, Stiles, & Greenberg, 2006; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Knobloch, Endres, Stiles, & Silberschatz, 2001; Leiman & Stiles, 2001; Osatuke et al., 2004, 2005; Shapiro, Barkham, Reynolds, Hardy, & Stiles, 1992; Stiles, Meshot, Anderson, & Sloan, 1992; Stiles, Morrison, Haw, Harper, Shapiro, & Firth-Cozens, 1991; Stiles, Shapiro, & Harper, 1994; Stiles, Shapiro, Harper, & Morrison, 1995; Varvin & Stiles, 1999) has yielded a provisional description of this sequence: the eight stages or levels of the Assimilation of Problematic Experiences Sequence (APES; Table I). The APES levels represent anchor points along a continuum of the relation of the problematic content to a self (construed as an interlinked community of internal voices), ranging from being warded off to being fully integrated.

Clients may enter treatment with problems at any point on the APES, and any movement along the continuum may be considered therapeutic progress. The therapist's task may be construed as assessing a problem's level of assimilation and facilitating movement to the next level, using interventions appropriate within that treatment approach (Leiman & Stiles, 2001; Stiles et al., 1995).

Effective therapists tend to work within a therapeutic zone of proximal development (ZPD), construed in terms of the APES (Leiman & Stiles, 2001). The ZPD is a concept widely used in developmental psychology and drawn from the work of Vygotsky (1978), who defined it as the distance between a child's actual developmental level as assessed by independent problem solving and the level of potential development as assessed by problem solving with adult guidance. As applied to psychotherapy, the ZPD can be understood as a region between the current APES level and the level the client can manifest in collaboration with the therapist, which may be ahead of what the client could exhibit independently (Leiman & Stiles, 2001). Thus, the ZPD links the joint work by therapist and client with the client's internal development as formulated by the assimilation model. Therapists probably learn implicitly to observe their clients' responses and shape their formulations responsively to stay within clients' ZPD. The jointly generated formulations serve as building blocks for the meaning bridges that underlie successful assimilation. This appropriate clinical responsiveness has been discussed previously in terms of timing, tact, or

Table I. Assimilation of Problematic Experiences Sequence (APES).

Level	Description
0. Warded off–dissociated	Client is unaware of the problem; the problem is silent or dissociated. Affect may be minimal, reflecting successful avoidance.
1. Unwanted thoughts–active avoidance	Client prefers not to think about the experience. Problems emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect is intensely negative but episodic and unfocused; the connection with the content may be unclear.
2. Vague awareness–emergence	Client is aware of a problematic experience but cannot formulate the problem clearly. The problem emerges into sustained awareness. Affect includes acute psychological pain or panic associated with the problematic material.
3. Problem statement–clarification	Content includes a clear statement of a problem, something that can be worked on. The client can take alternative or opposing perspectives with respect to the problems. Affect is negative but manageable, not panicky.
4. Understanding–insight	The problematic experience is formulated and understood in some way. An understanding is reached that incorporates or gives access to the problematic experience (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.
5. Application–working through	The understanding is used to work on a problem, considering implications and ramifications. Client seeks to apply the understanding in daily living. Affective tone is positive, optimistic.
6. Resourcefulness–problem solution	The formerly problematic experience has become a resource, used for solving problems. The formerly problematic experience can be drawn upon and used flexibly. Affect is positive, satisfied.
7. Integration–mastery	Client automatically generalizes solutions. The formerly problematic experience is fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

judgment (Benjamin, 1996; Greenson, 1967; Hardy et al., 1999; Hobson, 1985; Salzberger-Wittenberg, 1970; Stiles, Honos-Webb, & Surko, 1998). Our application of the ZPD concept to therapy offers a formal account of the clinical wisdom that a therapist should ascertain the client's tolerance for depth and risk and should not push the client too far, suggesting there is an APES-denominated zone that describes the client's limits.

Study design

In this case study, we identified and tracked one woman's assimilation of her problematic tendency to take controlling care of others at the expense of meeting her own needs for care. We first examined the opening exchange for evidence of potentially problematic positions. Then, having identified a candidate pattern, we traced it across the sessions, seeking to understand how it was formulated jointly by therapist and client and how it progressed along the APES continuum.

The case was chosen to explore the use of dialogical sequence analysis (DSA), a microanalytic tool for understanding interpersonal patterns (Leiman, 2002, 2004; Leiman & Stiles, 2001) in order to study therapeutic assimilation. DSA focuses on identifying and describing problematic positions and patterns as they emerge in therapeutic dialogue. According to DSA, any utterance positions the person both with regard to the referential content, or topic, and in relation to the person to whom the utterance is addressed. These positions can be inferred from the composition of the utterance: the

words used, the intonation, the timing, and so forth. DSA offers an empirical approach that can glean useful information regarding key concepts of the assimilation model from relatively small segments of therapy dialogue, making it possible to study assimilation on a finer scale than previously done.

Like most case studies, ours did not address a specific research question or test a specific hypothesis. In contrast to statistical hypothesis-testing studies, which bring many observations to bear on one or a few aspects of a theory (represented by research questions or hypotheses), case studies bring relatively few observations to bear on relatively many aspects of a theory. We concur with Campbell's (1979) suggestion that observations on multiple aspects of theory are analogous to multiple degrees of freedom, so that a successful case study may justifiably impact confidence in the underlying theory as much as a successful hypothesis-testing study (Stiles, 2003, 2005). We report theoretically relevant observations on many aspects of the rich clinical material in this case.

Method

We selected a case from a previously reported comparative clinical trial of two very brief psychotherapies for mild to moderate depression: the two-plus-one project (2+1; Barkham, Shapiro, Hardy, & Rees, 1999). In the 2+1 project, clients whose screening measures (sent by mail) suggested mild to moderate depression were first assessed and then randomly assigned to either cognitive-behavioral

vioral or psychodynamic–interpersonal therapy and to one of the participating therapists. Clients in the 2+1 study received two treatment sessions 1 week apart and a follow-up (“+1”) session approximately 3 months later. Additional assessments were conducted during and after the treatments (see Barkham et al., 1999, for further details). All sessions were recorded on audiotape. The project was approved by the local ethics committee, and informed consent procedures were followed.

Client and Therapist

The client, whom we shall call Karen, was a 36-year-old White woman who was treated in the psychodynamic–interpersonal therapy condition of the 2+1 project. This approach was based on Hobson’s (1985) conversational model of therapy, which was manualized in a brief version for the 2+1 project (Barkham et al., 1999). The DSA and assimilation concepts were not an explicit part of the therapist’s approach to conducting the treatment. The therapist was a White male clinical psychologist in his 40s with 19 years of clinical experience.

Karen was selected from a subset of the 2+1 clients whose first two sessions had been previously transcribed as part of another project (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006). The availability of the transcripts and the limited number of sessions made these convenient cases in which to explore the use of DSA in assimilation research. The results of this, the first such case we studied, were interesting enough to stimulate our writing of this article.

Investigators

William B. Stiles and Mikael Leiman were the primary DSA analysts, as described later. The other five authors served as auditors. Each of the auditors had had prior involvement with this case and had participated in research on the 2+1 project involving this case (Barkham et al., 1999, 2002; Detert et al., 2006). Some had played multiple roles. David A. Shapiro was the therapist. Gillian E. Hardy and Michael Barkham were also therapists in the 2+1 project and participated in the peer supervision of this case. Niels Detert and Gillian E. Hardy oversaw transcription of one or more of the sessions. Michael Barkham was director of the 2+1 research project. In an earlier project (Detert et al., 2006), Niels Detert and Susan P. Llewelyn read the transcripts and formulated descriptions of this clients’ opposed dominant and nondominant voices, and Niels Detert supervised a group of APES raters who rated passages from this case.

DSA

DSA is a fine-grained qualitative approach for distinguishing and describing dialogical positions (i.e., positions taken in dialogue) and interpersonal patterns that can be observed in psychotherapy and elsewhere (Leiman, 2004; Leiman & Stiles, 2001). Derived from cognitive–analytic therapy (Ryle, 1990, 1997), DSA assumes that all mental actions are dialogically structured.

DSA is not a standardized procedure but rather a set of theoretical concepts used for making sense of patterns embedded in sequences of utterances. DSA distinguishes three structural aspects in any utterance: the referential content, the author, and the addressee. The analyst asks what, by whom, and to whom. DSA then seeks to describe how speakers simultaneously position themselves with regard to both the object of their utterance and the addressee. Clients speak about something to somebody, and the way they speak about that something is affected by the addressee’s anticipated response (see Leiman, 2004, for a detailed description and an example of DSA). Taking a position places the addressee in a complementary counterposition; for example, taking a needy, vulnerable position may place the addressee in a controlling caretaker counterposition. DSA uses both therapist and client utterances to identify dialogical patterns (characteristic positions and counterpositions) and sequences of patterns.

These and other analytic concepts of DSA, such as personal stance to the object or to the other and responsive understanding, are offspring, although not direct derivations, of Bakhtin’s theory of utterance (Bakhtin, 1981, 1984, 1986; Leiman, 1992; Voloshinov, 1928/1986). Because the concepts articulate relational configurations rather than particular features or elements, it is not possible to generate simple rules or procedures that can be followed in all cases.

DSA encourages early formulation of explicit hypotheses regarding problematic positions and dialogical patterns, drawing on investigators’ clinical acumen. It then demands that these hypotheses be checked and revised in light of later observations. The DSA analyst examines and reexamines the semiotic material, including clients’ interactions with their therapists and clients’ narratives about their lives, seeking to apply the analytic concepts to describe the observed dialogical patterns. In this way, DSA offers an approach to systematizing clinical inference.

Procedure

Karen’s three sessions were transcribed verbatim for analysis. Applying DSA, the first two authors began

by reading and discussing the opening sequence and characterizing the positions that Karen adopted. They then read and reread the remainder of the first session. After further discussion, they read the second session and, later, the third session. Hypotheses regarding Karen's positions and patterns were formulated and refined at each stage. Thus, the interpretation of each segment incorporated accumulated knowledge of the other segments. On the basis of their understanding, the first two authors wrote the first draft of the results. This and subsequent drafts were circulated among all seven authors through several iterations. The transcripts and other case materials were reviewed as required by each author.

Although the seven authors lived in several different countries and did not all meet together, they had extensive e-mail exchanges, and subgroups discussed the case face to face when they met at conferences and when one visited others' institutions. All co-authors reviewed multiple drafts of this report and responded to the interpretations with substantive elaborations, skepticism, alterations, or justifications as well as editorial comments. Some of their changes and additions drew explicitly on their prior involvement with the case. For example, two coauthors' previously written characterizations of the opposed dominant and nondominant voices and the session notes by the therapist were incorporated into the results. All coauthors were satisfied with the final product. Thus, the results and discussion may be considered as a consensual account among seven authors who had had varied but substantial contact with the case material.

Results

Each of the three sessions had a distinctive character, and we consider each in turn. In the first session, Karen and her therapist worked mainly on formulating the problematic positions (characteristic of APES Level 3). In the second session, they worked toward, achieved, and explored a new understanding (characteristic of APES Level 4). In the third, follow-up session, Karen reported a process of working through and applying that understanding (characteristic of APES Level 5). In the passages we report, identifying details have been omitted or disguised. Speaking turns (as divided by our transcribers) have been numbered sequentially within sessions (185 in the first session, 150 in the second session, and 173 in the follow-up session). We begin with a close look at the reciprocal positioning between client and therapist in the opening sequence.

The First Exchange: Enacting a Dialogical Pattern

In the first exchange between Karen (C) and her therapist (T), Karen simultaneously positioned herself with regard to both the object of her utterance (her voice) and the addressee (the therapist).

C1: My voice is a bit croaky at the moment.

T2: Have you got a bug or something?

C3: I don't know what it is actually, if it's the change in the climate since I've been back from holiday; it might just be that I've picked something up.

T4: Oh right.

C5: Hope it's short lived anyway.

T6: Mm. Yes, we're into the season now where we give people fans because it's . . .

C7: Yeah, do you want that off actually?

T8: No, it's fine, it's fine, it's up to you, it's comfortable.

At C1, Karen commented on her croaky voice, as if apologizing. The therapist was thus called into an understanding, considerate counterposition; DSA principles suggest that the comment anticipated the response of the addressee. Her croaky voice, the referential object, was a sign with layers of meaning, we supposed, accumulated from previous experiences of physical illness and vulnerability, and it served as a mediator in the reciprocal positioning of the speaker and the addressee.

At T2, the therapist responded to Karen's vulnerability, focusing on the croaky voice and highlighting its socially shared meaning as a symptom of a cold. Karen next offered a plausible explanation for the (possible) bug (C3) and expressed a blended stance toward it (C5). "Hope it's short lived anyway" may be considered a way of reassuring herself. Alternatively, it may represent a dismissive position concerning her own potential vulnerability, as if to say "Stop complaining!", or it may have been a continuation of her excuse for being ill, meaning "Let us not be bothered by this slight inconvenience." All of these meanings may have been involved. Karen seemed to put an end to her concern by that utterance. However, the therapist attended to her discomfort by referring to the electric fan (T6). He did this somewhat indirectly, perhaps slightly apologetically, by referring to the season (it was summer,

and the room could get hot). That is, he adopted a caring position, albeit framed in terms of clinic practice.

Karen's response to the therapist's act of concern was surprising. Instead of indicating her own wish, she briefly acknowledged the therapist's concern ("yeah") and then expressed her concern about the therapist's comfort (C7), in effect reversing roles to adopt a considerate position toward him. That is, she seemed to make an abrupt shift from her potentially vulnerable position to a stronger, more controlling caretaker position.

The First Session: Identifying the Problematic Patterns and Beginning Work in the ZPD

During the remainder of the first session, Karen offered at least 16 instances in various domains of her life, past and present, illustrating elements of a sequence in which she normally took a strong caretaker position in relation to her family, friends, and co-workers, whereas becoming vulnerable led to being dismissed.

Example of the problematic pattern. At C27 Karen gave her first longer account of her recent experiences with those close to her. Its central theme seemed to be "When I'm weak and not able to cope with others' problems, I am dismissed." There was also an indirect statement about the strong, caring person she normally had been. We have labeled her references to the vulnerable, dismissed, and caretaking positions.

T24: [...] The other thing you say is you had relationship counseling.

C25: Yes.

T26: Could you tell me a bit about that?

C27: That was, 3 years ago, just after my father had died [T: Uh huh]. He was terminally ill and my, me and my Mum, we had an excellent relationship, more of a friend rather than mother and daughter, and I don't know if it was a result of my father or whatever [**vulnerable**] but, during that time my brother didn't speak to me, and I was like my brother's idol, my Mum fell out with me, and me and my boyfriend split up [**dismissed**]. And I started to question was it actually something that was the matter with me [T: Mhm] or was it just the people that were going through a lot of problems, that, I was weak 'cuz I was emotionally drained [T: Mm, mm] obviously [**vulnerable**]. But I wasn't able to cope with their problems like I

normally did [**previously strong, caretaking**], and I, that was what came out of the counseling, that in actual fact there was nothing the matter with me but I was struggling with some things to deal with [**vulnerable**], and the people that were so dependent upon me in the end couldn't cope with the person that they were seeing [**dismissed**].

T28: Mm. Mm.

This alternation of positions has been described within the assimilation model as rapid cross fire between internal voices and appears to represent a process of problem clarification characteristic of APES Level 3 (Brinegar et al., 2006).

Formulating the controlling caretaker and vulnerable positions. The following passage represents the therapist's early attempts to work toward a joint understanding of Karen's need to stay in control and be a caretaker. He invited Karen to consider the nature of her predicament, asking what might be similar in the episodes that she had told so far. Karen saw her problem as a recurring position in her relationships. She gave an elaborate account of some past uneven relationships (passages omitted). The therapist asked her to focus on the strong caretaker position.

T42: Yes, sure. Let's, let's try and get into what it feels like to be taking someone's problems on board. What's that like?

C43: I feel a bit like initially, always initially, "Oh don't worry, it's [T: "Don't worry, I can ..."] help you.

T44: "I can help you." There's a kind of feeling inside that you want to reach out and help. You want to?

C45: Oh yeah, I mean, I'm a very ... I think 'cuz I always feel strong, that when somebody else is feeling that they can't cope, I feel I've got enough strength for them to lean on me. And I allow them to lean and sometimes too far, to the point that I start to topple.

T46: So this business about being strong feels like it's something that you, you're not sure about. You're not sure how strong you really are inside, underneath.

C47: I think I've discovered I'm probably not as strong as I'd like to be, unfortunately [T: Hmm].

The therapist tentatively suggested that this position might be a response to something not yet directly available for exploration. In effect, he was testing the limits of Karen's ZPD and moving toward an understanding (i.e., moving along the continuum from APES Level 3 to Level 4). He introduced the term "inside" (T44) and used it again in combination with "underneath" (T46). Karen accepted his suggestion of vulnerability as the underlying alternative to strength but emphasized that she was not happy about it.

Signaling the success of the therapist's probing, Karen then expanded, using examples of her excessive caring for others' needs.

C47: But, say for instance like a financial problem, or, somebody's not quite happy in their career, I mean I might go to the extremes of helping them find the right places, to the point that you end up actually filling the application form in. Do you understand?

T48: Yeah, yeah, you're doing it for them.

C49: Exactly.

T50: You're doing it for them.

C51: When it's them that need to do it.

T52: And you who don't. Who ever did anything for you?

C53: True. Probably, I've been a very independent child since probably about 9 years old.

The therapist clarified Karen's habitual adopting strong caretaking toward others who are needy and then, in effect, used the counterposition to frame a pointed question, "Who ever did anything for you?" (T52). This produced an important disclosure that the pattern had existed since Karen was a child (C53).

Working in the ZPD (i.e., slightly in advance of Karen's APES level), the therapist further clarified the pattern by suggesting that Karen was giving the care she never had received. (T54). This was the therapist's straightforward formulation of the pattern of being dismissed when in the needy position. Karen confirmed it by elaborating with several stories, the first of which is shown as C55.

T54: You're giving them the help you never had yourself.

C55: And I still feel I don't get it when I, when I ask for it I don't get it. Even like [T: Yeah] at the time I probably needed the most help, when my husband died [T: Mm, sure] and my family were the ones I didn't want because I, I was living abroad and I went abroad and my friends, and even like my boss at the time she said, "You're just coping far too well."

An alternative to the controlling position. Toward the end of the session, the therapist addressed the possibility of an alternative to the controlling caretaker position. He summarized the repetitive need for being strong and in charge by naming it as "being stuck." He then contrasted this by prompting for an alternative, in a sense pushing their joint exploration in the ZPD beyond merely understanding (APES Level 4) toward application (APES Level 5):

T150: You're stuck with being who you are. Would you like it to be different sometimes?

C151: [pause]

T152: It's about sh-, there's something about sharing here. Something about being effective working on your own but working in a team is hard. Sharing, sharing power.

C153: I haven't actually found it, as I say, in the last, 3 months. I mean I've enjoyed who I've been working with but I, initially I was being like orientated and I just took all the responsibility [T: Mm] and gradually kept it.

Encouraged by the therapist's suggestion, Karen told of some recent changes at work that had made the team relationships more sharing and even. This had reduced her stress and made her feel better during the previous weeks. Karen ended her reflections about the new relationships in her team by recognizing the more mutual relationships that had developed.

C163: So maybe they can accept, just like myself and maybe I have put myself on too high a pedestal really to be achievable all the time.

T164: But there is a thing about, about accepting yourself, allowing yourself to just go with the flow but not push yourself, you know, or not take on everything you're asked to do. Which feels like something about accepting who you are, accepting your limitations.

C165: I think that's something I've never, never done, is just, you know, take each day as it comes [T: No] or each year. I've always had to have a plan.

The therapist went one step further to characterize an alternative to being strong and in charge: "Just go with the flow but not push yourself." This was clearly more than just sharing power. Karen admitted having never done it, but the therapist's invitation was strong enough to generate a benign and peaceful tone in the room. Thus, an alternative to the controlling caretaker position was both explored and briefly enacted at the end of the first session.

The therapist's session notes indicated much uncertainty (belying the seemingly skillful work in the ZPD), but they nevertheless converged with the DSA with respect to central themes: "A chaotic session—little to get hold of—power and control. Giving to others to retain strength, deny weakness, or identifies with the recipient as the helpless, needy child (???—no idea whether these formulations have any validity!)." The formulation of the characteristic opposed positions of dominant and nondominant voices, prepared to guide APES raters in the Detert et al. (2006) study, were also highly convergent: dominant: "I must be independent, dominant, and keep control over my life, relationships and environment"; nondominant: "I can be dependent on someone else, show vulnerability, and be a 'partner' rather than having to control people."

The Second Session: Constructing an Understanding

Karen began her second session by continuing to clarify aspects of the problem (APES late Level 3). Early in the session, Karen took up the topic of the demanding way she expressed her wishes. This had happened in an incident with the boyfriend.

C4: I'd like to be able to negotiate better [T: Mm-hm] and put my feelings across without being forceful and demanding [T: Mm, mm]. And an incident occurred this week where I just wanted to do that and it didn't come across, it came across as though I was being condescending! That's what the person I was speaking to said, that it, I was being condescending. And it wasn't. Rather than con-, being angry I was trying to control it and discuss it.

In joint exploration, Karen brought more examples in which she felt she was "making ultimatums" when she did not want to seem demanding. This led

to a renewed consideration of the pattern, identified in the first session, of adopting the strong and controlling role toward others and not getting her own needs met. Her frequently repeated solution to this imbalance had been to withdraw from relationships that had been important to her.

Discussion of Karen's illustrations of this cycle led to a straightforward formulation by the therapist, which opened the key passage of the second session (T81–C100), during which Karen reached a new understanding that could be characterized as an insight (APES Level 4). We present most sections of this key passage, beginning with the therapist's formulation, which repeated Karen's description of the caring position.

T81: But what you call give, give, give, you said that you give, give all the time, you know, that's really, isn't that actually giving out being strong and it's actually strong, isn't it.

C82: Yeah.

T83: It's not, not being in touch with your own needs. So it's a form, in a way it's a lie, it's deceiving yourself perhaps.

C84: But that's something that I, I've been trying to do, and let, you know, of late, and I think this is why I'm having the problems, is to be honest with myself and say [T: Mm-hm] "I do need this and I do want that" and that is where the conflict comes [T: mm] with me and how I've been for so long [T: Mm].

T85: You're trying to get out of that pretense, which, that pretense at not being needy.

Karen responded by describing her wish to be able relax control and be more dependent in her close relationships. The therapist's interventions seemed to stay slightly ahead of Karen in APES terms while remaining in the ZPD:

C86: Yeah, and I've, I've explained that to my boyfriend, I've said to him, like this, this is the first honest relationship that I've ever had, openly honest, that I feel that I can be me, I, I can be dependent or I can be independent, I can be what I want [T: Mm], I don't have to be, I can say that I want to have a life with someone else and share [T: Mm], where it's always been a very much of a weakness before to admit to that.

T87: Mm. But somehow saying that doesn't make it happen.

C88: No, not always, no!

T89: That's the way you're heading, maybe, you know, maybe that's the direction you're heading but you haven't arrived yet.

C90: No.

T91: Something like that.

C92: Probably.

T93: Do you see what I mean? Based on where you've been before.

C94: Yeah. I've always wanted to take control of relationships before and where we're going and what we're doing.

This led shortly into a joint formulation that seemed to resonate deeply for Karen:

T97: Mm. Mm. There's, you've got other ways of, yeah, you've got, you've got a very well-developed repertoire of controlling, dominant, quite a pattern, which you can always fall back on in moments of frustration.

C98: But I don't like the results that come.

T99: No, no, you don't want to do that, but you can't help it.

C100: No, and that's what I'm trying, you've hit the nail on the head probably there. Not realizing it myself it probably is, it's, it's trying to be a partnership [T: Mm-hm], trying to be a relationship, and yet for a lifetime I've been fighting that [T: Mm-hm, mm-hm].

The expression "you've hit the nail on the head" in C100 appeared to mark an insight (APES Level 4). This meaning bridge centered on recognizing that her strong, controlling caretaker position was triggered maladaptively by her own feelings of neediness and vulnerability. We note that this precisely describes the pattern that was enacted in the very first exchange. The therapist repeated and elaborated Karen's conclusion, apparently seeking to consolidate the gain:

T101: So the, so the pattern you're striving to accomplish of being more give and take, less controlling, less dominant is one which is constantly at risk because things only have to go a little bit wrong, just you experience a bit of frustration, a bit of uncertainty, a bit of, a bit of hurt, and you go back

to your old pattern [C: Mm], which is so deeply ingrained that it's ready to pop out at the slightest. Karen responded with a fresh example from her current relationship. The therapist advanced the topic within the ZPD, elaborating the insight by prompting her to link the present pattern to her history. In APES terms, this is the work needed to move from Level 4 (understanding) to Level 5 (application)

T103: So you're hoping, you're hoping for a different sort of relationship?

C104: Mm.

T105: [omitted text] So it's coming to terms with your own power, your own forcefulness and your own, your own history. And the fights, the battles that you're fighting, you know, that forceful you is fighting earlier battles I guess.

C106: Oh yeah definitely!

T107: It's going back to the story of your life.

C108: Yeah, yeah, from as long, well as long as I can remember.

T109: How awful that you need to be in control, you need to be . . .

C110: And I think that's why I've been very singular minded, even though I have been in a marriage, I've been very independent [T: Mm] and very self-centered I suppose, without even knowing that that's what I was.

The remainder of the session dealt with ramifications of the new understanding. The therapist sought to relate Karen's history to her difficulty in adopting the needy position. Karen affirmed and elaborated this link with a detailed account of her childhood, in which, as the eldest in an overstressed family, she had major responsibility managing the home and caring for her younger siblings, thus elaborating and strengthening the meaning bridge with historical material. In C116 she summarized, "From a very early age I would say I was very grown up, very adult." The joint clarification of Karen's repetitive cycle in relationships affirmed the alternative to the controlling position that was introduced at the end of the first session: Relationships can be about partnership and sharing.

Toward the end of Session 2, the therapist sought a summary of the main discoveries, and Karen singled out the passage presented above (T81–C100), repeating the insight marker:

T125: So can you say where we've got to, can you say what you think you may have learned today?

C126: Well I think, like I said, you probably hit the nail on the head in the fact that I've been fighting a lifetime, I think, with not being dependent upon someone else. I've always been striving to be independent and, I'm, I'm trying to make habits go away of, of accepting that this, I'm happy in what I'm doing, being together. And accepting that sometimes it's, I can't move things at my pace! They need to move. The therapist's session notes reflected the sense of movement: "A bit better for focus —wants to move from dominant, controlling to more equal relationships in which she can acknowledge her needs."

The Follow-up Session

Evidence of application and working through. Karen had had some difficulty in making the 3-month follow-up appointment because she had been away studying. This was briefly discussed before the therapist took up the main theme:

T7: Right. Right. Well I'm glad you made it (laughs) yeah. It's so long ago I'm just going to have to remind myself what things I... I scribbled down. How have you been in this time?

C8: Um... a lot of things that you said, I actually took away [T: Mm hm] and I feel that that worked really [T: Mm hm, mm hm] and [inaudible] great but.

T9: [inaudible] Tell me about that. Just tell me what you were doing and what...

C10: Well things... one of the things that is that I like to be in control [T: Mm hm] and [inaudible] control others [T: Mm hm] rather than let... and always trying to... make people see what I see rather than allowing them to see it themselves [T: Mm], letting course go along. [T: Mm hm] So being a little bit more patient [T: Mm hm, mm hm] and... and allowing others to make their mistakes and see that for themselves.

Karen thus reviewed her problematic shifts to the controlling position and her growing ability to let it go in her close relationships. She then gave a long account of difficult situations at work that she had handled much better because she had asked for help and expressed her vulnerability in an appropriate way. The understanding she had achieved—that she slipped into a pattern of caretaking when she felt

vulnerable or uncertain—served as a meaning bridge, allowing her to cross back from the controlling caretaker position to a more spontaneous, authentically sharing position. She did not lose her considerable capacity for self-assertion but could use it with greater discretion: "I wasn't afraid to confront because I'd know I could do it without anger. And I feel I've achieved that again. Something like approaching the director of the company was a difficult time, but I knew I could do it because I wasn't angry" (C36). From an assimilation model perspective, her narratives could be understood as descriptions of applying and working through the new understanding (APES Level 5).

Comments on the process of therapy. The therapist introduced the question of how the changes had actually happened and the contribution of the two sessions of therapy. Karen first cited the sense of safety that she had felt in the therapeutic relationship, which allowed her to experience her vulnerability more fully. A second response focused on the role of conscious self-reflection and the joint exploration of her habitual ways of acting in relationships:

C50: If anything... it's actually enabled me to just [T: Mm] look at... at me. Rather than situations. It was me that I was looking at, not what happened. It was how I was feeling at the time, how I reacted, how I expressed myself, not [T: mm hm] rather at... what I tended to do was look at it as that that situation makes me behave like that rather than I behave like this to that situation. [T: Mm, mm] So now when the situations come, I don't think, "Well, that's going to make me get..." I think, "I... I have a choice. [T: Mm hm] I can behave (a) or I can behave (b)." [T: Mm hm, mm hm] It isn't the situation that makes you behave. [T: Mm] It... whether [T: Mm] it's that, feeling good about myself like if something happens then I would say, I have a right to feel angry, I have a right to be upset. I have a right to feel the way I have [T: Mm hm, mm] or... you know, I... well before I would say that, "You've no right to make me feel that way." (laughing)

This account of greater personal resources reveals an important new development in which Karen could look at herself as an object in relationships. This metacognitive advance required a meaning bridge—an understanding of self, presumably built on her experience of therapy—across which Karen could smoothly move between an experiencing position and an observer position.

The therapist's session notes emphasized robust positive changes: "A good example of (surprisingly)

effective 2+1—she was just ready for it! Reports major changes in relationship pattern based on insight from last session—less controlling, more open. Less ego-invested.”

Discussion

Karen’s first exchange illustrated how an unassimilated voice can be triggered and interfere with relationships. Karen moved suddenly and unexpectedly from a position of vulnerable care receiver to that of a controlling caregiver, seeking to make the therapist comfortable in his own therapy room. This DSA-identified sequence appeared to enact, on a small scale, a pattern that had been problematic for Karen in many areas of her life. For example, her problematic issuing of ultimatums could be similarly understood as an attempt to control while appearing to give freedom. When placed in a powerless and vulnerable position, she seemed to become frightened and acted to take control. Adopting the strong caretaker position avoided the possibility that her needs would be dismissed, but it also interfered with getting her needs met. Arguably, this was the problem that brought her to treatment. The therapy, then, consisted of building and using a meaning bridge to (i.e., assimilating) the strong controlling voice, so that Karen could use it volitionally rather than automatically.

Much of the first session involved joint work in the ZPD formulating the component positions of the problematic pattern. Later parts of the first session and early parts of the second explored how these positions had been enacted in Karen’s life and considered alternative responses. Throughout this work, the therapist tended to stay slightly ahead of Karen on the APES continuum (Table I) but attuned to her response, so as not to exceed the ZPD. The insight Karen reached midway in the second session involved a recognition that events triggered her caretaker voice involuntarily, even when it was contrary to her interests. As summarized succinctly by the therapist in T99, “You don’t want to do that, but you can’t help it.”

This insight, elaborated in subsequent work, seemed to serve as a meaning bridge between the hitherto separated needy and strong caretaker positions, a semiotic glue that connected the parts of the pattern in a way that was emotionally meaningful for Karen. She could use this understanding to recognize the avoidant function of suddenly taking control and move into a more relaxed, accepting position that was ultimately more fulfilling. This insight also described precisely what Karen had done in the opening exchange.

The joint work in later parts of the second session seemed to consolidate the new understanding, and the session ended with a hint of a new position, in which Karen relinquished her usual control. In the third, follow-up session, Karen reported that she had maintained the new understanding and was applying it in her life. This was manifested as a new-found sense of freedom and an ability to tolerate give-and-take in her personal and professional relationships. Importantly, she had not lost her ability to act authoritatively; that is, the strong, controlling position was not suppressed. On the contrary, she reported a greater capacity for confrontation when it was called for (e.g., confronting the director of her company), presumably because her access to the controlling position was more flexible and moderated.

Karen’s progress can be understood as comprising three of the eight APES stages (Table I). By the end of the first session, she could state her problem clearly (APES Level 3. problem statement–clarification). Through the first and second sessions, she worked on the issue in a focused way, making constructive use of the therapist’s empathy and direction (but cf. Madill & Doherty, 1994). The meaning bridge achieved in the second session seemed a classic illustration of APES Level 4 (understanding–insight). The understanding was foreshadowed by joint formulations (i.e., within the ZPD; Leiman & Stiles, 2001) as early as the middle of Session 1. In the follow-up session, Karen’s reports of applying her understanding in varied life domains seemed to illustrate APES Level 5 (application–working through).

Karen entered treatment ready for focused joint work. Her good progress suggests that her ZPD was fairly wide. That is, she was able to use the offered resources to make rapid therapeutic progress. In the two allotted working sessions, she and the therapist quickly formulated the opposing positions and found an understanding that embraced both in an emotionally satisfying way. The follow-up session dialogue indicated that she was applying her new understanding to achieve more successful outcomes in her life. Clients who begin therapy with problems at earlier APES levels or who have fewer personal resources may not progress so quickly in such very brief treatment as that offered in the 2+1 project.

Of course, like any story, this is a simplification. To focus on what we considered most relevant, we have selected and omitted details and themes, although we believe the omitted details were consistent with our interpretation. As in much psychotherapy outcome assessment, it is possible that Karen was performing for the therapist, exaggerating her progress. We can say only that the session

dialogue seemed convincing to the therapist at the time and to the current authors, who read the transcripts. The consensus among the current authors, representing a variety of different types of intensive contact with the case, offers some assurance to readers of its trustworthiness, but, of course, we cannot entirely rule out observer bias.

This study's contributions to the assimilation model included an elaboration of the concept of position as a manifestation of voice and a demonstration of how DSA methodology can expose problematic patterns of interaction in very brief segments of therapeutic dialogue. This study showed how unassimilated problems may be enacted in microcosm from the very first moments of treatment. It also directed attention to a way a skillful therapist may work responsively in the ZPD, pressing ahead (in APES terms) on both process and content while monitoring the client and modulating when the client was not following. In addition, it demonstrated the possibility of productive assimilation in very brief psychotherapy.

When problems are warded off or present mainly as symptomatic experiences and unwanted thoughts, the therapist's ability to make sense of client expression and formulate problematic patterns becomes a demanding task. Conceptual tools drawn from the assimilation model and DSA may help sensitize therapists to the ways problems appear in early exchanges. Therapists who recognize these manifestations can more quickly help clients understand and resolve the problems they bring to treatment.

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References

- Bakhtin, M. M. (1981). Discourse in the novel. In M. M. Bakhtin (Ed.), *The dialogic imagination. Four essays by M. M. Bakhtin* (pp. 259–422). Austin: University of Texas Press.
- Bakhtin, M. M. (1984). *Problems of Dostoevsky's poetics*. Manchester, UK: Manchester University Press.
- Bakhtin, M. M. (1986). The problem of text in linguistics, philology, and the human sciences: An experiment in philosophical analysis. In M. M. Bakhtin (Ed.), *Speech genres and other late essays* (pp. 103–113). Austin: University of Texas Press.
- Barkham, M., Rees, A., Stiles, W. B., Hardy, G. E., & Shapiro, D. A. (2002). Dose-effect relations for psychotherapy of mild depression: A quasi-experimental comparison of effects of 2, 8, and 16 sessions. *Psychotherapy Research, 12*, 263–274.
- Barkham, M., Shapiro, D. A., Hardy, G. E., & Rees, A. (1999). Psychotherapy in two-plus-one sessions: Outcomes of a randomized controlled trial of cognitive-behavioral and psychodynamic-interpersonal therapy for subsyndromal depression. *Journal of Consulting and Clinical Psychology, 67*, 201–211.
- Benjamin, L. S. (1996). *Interpersonal diagnosis and treatment of personality disorders* (2nd ed). New York: Guilford Press.
- 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.
- Campbell, D. T. (1979). "Degrees of freedom" and the case study. In T. D. Cook & C. S. Reichardt (Eds), *Qualitative and quantitative methods in evaluation research* (pp. 49–67). Beverly Hills, CA: Sage.
- Detert, N. B., Llewelyn, S. P., Hardy, G. E., Barkham, M., & Stiles, W. B. (2006). Assimilation in good- and poor-outcome cases of very brief psychotherapy for mild depression. *Psychotherapy Research, 16*, 393–407.
- Greenson, R. R. (1967). *The technique and practice of psychoanalysis: Volume 1*. New York: International Universities Press.
- Hardy, G. E., Aldridge, J., Davidson, C., Rowe, C., Reilly, S., & Shapiro, D. A. (1999). Therapist responsiveness to client attachment styles and issues observed in client-identified significant events in psychodynamic-interpersonal psychotherapy. *Psychotherapy Research, 9*, 36–53.
- Harré, R., & van Langenhove, L. (1999). *Positioning theory. Moral contexts of intentional action*. Oxford, UK: Blackwell.
- Hobson, R. F. (1985). *Forms of feeling: The heart of psychotherapy*. London: Tavistock Press.
- 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., Greenberg, L. S., & Goldman, R. (1998). Assimilation analysis of process-experiential psychotherapy: A comparison of two cases. *Psychotherapy Research, 8*, 264–286.
- Honos-Webb, L., Surko, M., Stiles, W. B., & Greenberg, L. S. (1999). Assimilation of voices in psychotherapy: The case of Jan. *Journal of Counseling Psychology, 46*, 448–460.
- Knobloch, L. M., Endres, L. M., Stiles, W. B., & Silberschatz, G. (2001). Convergence and divergence of themes in successful psychotherapy: An assimilation analysis. *Psychotherapy, 38*, 31–39.
- Leiman, M. (1992). The concept of sign in the work of Vygotsky, Winnicott and Bakhtin: Further integration of object relations theory and activity theory. *British Journal of Medical Psychology, 65*, 209–221.
- Leiman, M. (2002). Toward semiotic dialogism. *Theory and Psychology, 12*, 221–235.
- Leiman, M. (2004). Dialogical sequence analysis. In H. H. Hermans & G. Dimaggio (Eds), *The dialogical self in psychotherapy* (pp. 255–269). London: Brunner-Routledge.
- Leiman, M., & Stiles, W. B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research, 11*, 311–330.
- Madill, A., & Doherty, K. (1994). "So you did what you wanted then": Discourse analysis, personal agency, and psychotherapy. *Journal of Community & Applied Social Psychology, 4*, 261–273.
- Madill, A., Sermppezis, C., & Barkham, M. (2005). Interactional positioning and narrative self-construction in the first session of psychodynamic-interpersonal psychotherapy. *Psychotherapy Research, 15*, 420–432.
- Osatuke, K., Gray, M. A., Glick, M. J., Stiles, W. B., & Barkham, M. (2004). Hearing voices: Methodological issues in measuring internal multiplicity. In H. H. Hermans & G. Dimaggio (Eds), *The dialogical self in psychotherapy* (pp. 237–254). London: Brunner-Routledge.
- Osatuke, K., Humphreys, C. L., Glick, M. J., Graff-Reed, R. L., Mack, L. M., & Stiles, W. B. (2005). Vocal manifestations of

- internal multiplicity: Mary's voices. *Psychology and Psychotherapy: Theory, Research and Practice*, 75, 21–44.
- Ryle, A. (1990). *Cognitive analytic therapy: Active participation in change. A new integration in brief psychotherapy*. Chichester, UK: Wiley.
- Ryle, A. (1997). *Cognitive analytic therapy and borderline personality disorder*. Chichester, UK: Wiley.
- Salzberger-Wittenberg, I. (1970). *Psycho-analytic insight and relationship: A Kleinian approach*. London: Routledge.
- Shapiro, D. A., Barkham, M., Reynolds, S., Hardy, G., & Stiles, W. B. (1992). Prescriptive and exploratory psychotherapies: Toward an integration based on the assimilation model. *Journal of Psychotherapy Integration*, 2, 253–272.
- Shotter, J. (1993). Bakhtin and Vygotsky: Internalization as a boundary phenomenon. *New Ideas in Psychology*, 11, 379–390.
- Stiles, W. B. (1997). Signs and voices: Joining a conversation in progress. *British Journal of Medical Psychology*, 70, 169–176.
- Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research*, 9, 1–21.
- 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. (2003). Qualitative research: Evaluating the process and the product. In S. P. Llewelyn & P. Kennedy (Eds.), *Handbook of clinical health psychology* (pp. 477–499). London: Wiley.
- Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 57–64). Washington, DC: American Psychological Association.
- Stiles, W. B., Elliott, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy*, 27, 411–420.
- Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, 5, 439–458.
- Stiles, W. B., Meshot, C. M., Anderson, T. M., & Sloan, W. W., Jr. (1992). Assimilation of problematic experiences: The case of John Jones. *Psychotherapy Research*, 2, 81–101.
- Stiles, W. B., Morrison, L. A., Haw, S. K., Harper, H., Shapiro, D. A., & Firth-Cozens, J. (1991). Longitudinal study of assimilation in exploratory psychotherapy. *Psychotherapy*, 28, 195–206.
- 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). London: Brunner-Routledge.
- Stiles, W. B., Shapiro, D. A., & Harper, H. (1994). Finding the way from process to outcome: Blind alleys and unmarked trails. In R. L. Russell (Ed.), *Reassessing psychotherapy research* (pp. 36–64). New York: Guilford Press.
- 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.
- Varvin, S., & Stiles, W. B. (1999). Emergence of severe traumatic experiences: An assimilation analysis of psychoanalytic therapy with a political refugee. *Psychotherapy Research*, 9, 381–404.
- Voloshinov, V. N. (1986). *Marxism and the philosophy of language*. Cambridge, MA: Harvard University Press. (Original work published 1928)
- Vygotsky, L. (1978). *Mind in society: The development of higher psychological processes* (M. Cole, V. John-Steiner, S. Scribner, &

E. Souberman, Eds.). Cambridge, MA: Harvard University Press.

Zusammenfassung

Was besagt der erste Austausch? Eine Sequenzanalyse des Dialogs und Assimilation in sehr kurzer Therapie

Die Autoren haben Sequenzanalyse auf den Dialog angewendet, eine mikroanalytische Methode um wiederkehrende Fehleranpassungsmuster aufzuspüren und um Assimilation während der Psychotherapie einer Frau, die anlässlich einer leichten Depression mit zwei Sitzungen in einer Woche und einer Katamnese nach drei Monaten behandelt wurde, zu erfassen. Der allererste Austausch (jeweils vier Sprechabfolgen von Klient und Therapeut) führte zu einem Muster, in dem die Klientin dadurch auf ihre potentielle Verwundbarkeit reagierte, dass sie die Rolle des kontrollierenden Versorgers annahm. Daran anschließende therapeutische Arbeit zeigte weitere Komponenten dieses Musters auf, das wiederkehrend und fehlangepasst war. Das führte zu einer Einsicht, die in der Mitte der zweiten Sitzung erreicht wurde. Aus den Äußerungen der Klientin lässt sich schlussfolgern, dass sie ihre neu erworbene Einsicht benutzte, um ihre problematische, kontrollierende Haltungen zu assimilieren. Das gab ihre größere Flexibilität in ihren Beziehungen und eine weitere Bandbreite, um ihre Versorgungsbedürfnisse zu erfüllen. Sie schien einen Fortschritt über drei der acht Entwicklungsstadien, die das Assimilationsmodell postuliert, gemacht zu haben: Problemverdeutlichung, -erkennung; Verständnis, Einsicht, und Anwendung, Durcharbeiten.

Résumé

Les premiers échanges: que disent-ils? L'analyse des séquences de dialogue et l'assimilation dans la thérapie très brève.

Les auteurs ont appliqué l'analyse des séquences de dialogue, une méthode micro-analytique pour identifier des patterns inadaptés récurrents, pour étudier l'assimilation dans la psychothérapie d'une femme traitée pour une dépression légère par deux séances hebdomadaires plus une séance de catamnèse après trois mois. Le tout premier échange (quatre tournures de paroles par patiente et thérapeute) mis en évidence un pattern par lequel la cliente répond à sa propre vulnérabilité potentielle en adoptant une position de soignante contrôlée. Le travail thérapeutique consécutif a tracé les positions composantes de ce pattern qui était récurrent et inadapté, résultant en une prise de conscience au milieu de la deuxième séance. Le rapport de la cliente suggérait qu'elle a pu utiliser sa compréhension toute fraîche pour assimiler son côté contrôleur problématique, ce qui la rendait plus flexible dans ses relations et plus apte à s'occuper de ses propres besoins de soins. Son progrès semblait atteindre trois des huit stages de développement postulés par le modèle d'assimilation: définition du problème – clarification, compréhension – insight et application – perlaboration.

Resumen

¿Qué Transmite El Primer Intercambio? Análisis de la secuencia dialógica y asimilación en la terapia muy breve.

Los autores aplicaron un análisis de secuencia dialógica, un método microanalítico para identificar pautas recurrentes de mala adaptación, para estudiar la asimilación de la psicoterapia en una mujer tratada por depresión leve en dos sesiones semanales más una sesión de seguimiento a los 3 meses. El primer intercambio (cuatro turnos de habla por cliente y terapeuta) describieron una pauta en la que la cliente respondió a su propia vulnerabilidad potencial adoptando una posición de cuidadora controladora. El trabajo terapéutico subsiguiente delineó posiciones componentes en esta pauta, que fue recurrente y maladaptada, lo que llevó a un insight logrado a mediados de la segunda sesión. De acuerdo con los informes de la cliente, resultó que ella usó su nueva comprensión para asimilar su lado controlador problemático, lo que le dio mayor flexibilidad en sus relaciones y mayor horizonte para lograr sus propias necesidades de cuidado. Pareció progresar a lo largo de tres de las ocho etapas de desarrollo postuladas por la asimilación del modelo: enunciación del problema-clarificación, comprensión-insight y aplicación-elaboración.

Resumo

O que nos diz a primeira interação? Análises de Sequências Dialógicas e a Assimilação em Terapia muito breve

Os autores aplicaram análises de sequências dialógicas, um método micro-analítico para seguir padrões mal adaptativos recorrentes, para estudar a assimilação numa mulher em psicoterapia para depressão leve em duas sessões semanais mais uma sessão de seguimento aos 3 meses. A primeira de todas as interações (quatro turnos de diálogo do cliente e do terapeuta) desencadeou um padrão com o qual o cliente respondeu à sua potencial vulnerabilidade adoptando uma posição de prestador de cuidados controlador. O trabalho terapêutico subsequente delineou componentes de posição neste padrão, recorrente e mal adaptativa, conduzindo a um insight a meio da segunda sessão. Partindo dos relatos da cliente, parece que ela usou a nova compreensão para assimilar o seu lado de controlador problemático, ganhando uma maior flexibilidade

nas suas relações e mais oportunidades para alcançar as suas necessidades de ajuda. Ela pareceu progredir através de três de oito estádios desenvolvimentais do modelo de assimilação: clarificação / formulação do problema, compreensão-insight e aplicação-prática.

Sommario

Che cosa si dice nel primo scambio? Analisi dialogica di sequenza e assimilazione nella terapia breve.

Gli autori hanno applicato l'analisi dialogica di sequenza, un metodo microanalitico per seguire i patterns maladattativi, per studiare l'assimilazione nella psicoterapia di una donna curata per una lieve depressione in due sedute settimanali più una seduta di follow-up a tre mesi. Il primissimo scambio ha illustrato un modello in cui il cliente ha risposto alla sua vulnerabilità potenziale adottando una posizione di sorvegliante. Il lavoro terapeutico successivo ha delineato le posizioni in questo pattern, che erano ricorrenti e maladattative, conducente ad un insight a metà della seconda sessione. Dalle relazioni della cliente, è sembrato che ella usasse la sua nuova comprensione per assimilare il suo lato di controllo problematico, procurandole una maggior flessibilità nei suoi rapporti e maggiori capacità per incontrare i suoi bisogni di cura. Ella è sembrata progredire attraverso tre delle otto fasi inerenti lo sviluppo postulate dal modello di assimilazione: esposizione del problema - chiarimento, comprensione-insight, ed applicazione-funzionamento.

第一個交換說明了什麼？極短期治療的對話序列分析與同化

摘要

作者以對話序列分析法，此係一種追蹤重複出現的不適應組型的一種微觀分析法，針對一位被診斷為輕度憂鬱症的婦女，在持續接受每兩週一次的心理治療與三個月的追蹤之後，探討其同化的歷程。第一個交換（治療師和案主的四句對談交換之後）呈現的是案主以一種控制型的照顧者姿態來面對自己的脆弱無助。接下來的治療工作亦勾勒出此種型態的姿態，此姿態是重複出現且適應不良的，案主在第二次治療的中途有所頓悟。從案主的報告中發現，案主將她的新發現同化至有問題的控制型那邊去，讓她對自己的人際關係有更大的彈性，以及可以從較寬廣的角度滿足其自身需要照顧別人的需求。案主似乎可以從同化模式的八個發展階段進展三個階段，亦即問題陳述—澄清、瞭解—頓悟，以及運用—修通。