

ASSIMILATION OF PROBLEMATIC EXPERIENCES BY CLIENTS IN PSYCHOTHERAPY

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In successful psychotherapy, problematic experiences (threatening or painful thoughts, feelings, memories, etc.) are gradually assimilated into schemata that are introduced by the therapist or developed in the therapist-client interaction by modification of old schemata. As it is assimilated, a problematic experience passes through predictable stages. The client moves from being oblivious, to experiencing the content as acutely painful, then as less distressing, merely puzzling, then understood, and finally as confidently mastered.

In this article, we present an integrative model of a central aspect of change in psychotherapy. According to the assimilation model, clients in successful psychotherapy follow a regular sequence

in processing their problematic or painful experiences as these are assimilated into schemata developed in the therapeutic interaction.

The assimilation of problematic experiences is a common change mechanism, a component of many or all psychotherapies. It encompasses a wide range of phenomena, including cognitive and affective features of client behavior. The model is integrative, drawing concepts from psychodynamic, experiential, cognitive-behavioral, and personal construct theories, as well as from cognitive and developmental psychology.

We have sought to extract a concise, internally consistent, researchable model from a variety of sources, identifying common change processes and articulating systematic differences among approaches. The model appears to complement current work by several other investigators (e.g., Grawe et al., 1988; Russell & van den Broek, 1988; Silberschatz et al., 1989).

The model is not prescriptive; that is, it does not recommend a particular therapeutic approach or method to produce the hypothesized sequence of change. If the sequence can be measured and verified, it can provide a reference point for evaluating the effectiveness of alternative techniques.

Terms and Concepts

Our model's principal concepts include (a) schema, (b) problematic experience, and (c) the

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complementary processes of assimilation and accommodation.

A *schema* is a familiar pattern of ideas, a way of thinking to which new experiences can become assimilated. Recognizing that “schema” has been used in diverse contexts in developmental and cognitive theory (e.g., Piaget, 1962, 1970; Rumelhart & Norman, 1978), with considerable variation in meaning, we use it broadly and inclusively. It is a generic term that may refer to a tightly organized theory, a metaphor, a narrative or script, or a more loosely organized network of associations, incorporating both mental content and patterns of action.

The ideas that make up a schema are associated with, and tend to evoke, each other. Frequently, therapists and clients develop words or phrases that bring to mind a constellation of concepts or memories, that is, re-evolve useful schemata. A schema must apply to the client’s personal experience and behavior; it cannot be a purely abstract construction. It may be the active or working end of a client’s self-concept, and much therapeutic work may be seen as changing (accommodating) the self-concept to permit the assimilation of problematic experiences.

A *problematic experience* is a perception, intention, impulse, attitude, wish, fantasy, or idea that causes psychological discomfort when brought to awareness or put into action. (Unassimilated experiences are not necessarily problematic; we are considering only those that are. We do not attempt to account for the etiology of problematic experiences.)

Experiences are the raw “stuff” of our mental life, while schemata are the cognitive structures that contain them. Problematic experiences, then, are experiences that are not adequately contained by the available schemata. Consequently, one cannot speak or think clearly about them. They are disequilibrating, inconsistent, incongruent, “not me.” They cause the person psychological pain or perplexity, or they lead to behavior that impairs relationships with others. The accompanying sense of discrepancy may reflect a lack of schemata to contain the experience or put it into words (“I don’t know what this is about”), a contradiction of current schemata (“This is not like me”), or an invocation of rejected schemata (“I can’t stand this about me”).

Such inchoate, atypical, ego-dystonic, or conflicting experiences typically involve self-perceptions (e.g., observations about one’s own feelings

or behavior) or perceptions of the self’s relation to significant others that are discrepant from current self-schemata and so cannot be assimilated. For example, if one considers oneself as unfailingly generous, recalling a selfish act will be painful and avoided. Or, if one sees oneself as incompetent, positive evidence of one’s abilities may be distorted and felt as puzzling or confusing.

A schema may be considered as an organized constellation of many interconnected experiences, as an abstraction from experience, or as a repeating pattern or category of experience. In contrast, problematic experiences are smaller and separate from the self or other large constellations. However, they, like schemata, also may have multiple associated elements.

Our notion of problematic experience dovetails with the experiential notion of felt referent, i.e., something that is only dimly or vaguely appreciated and is often psychologically painful (Gendlin, 1964, 1978); with Rice’s (1983) notion of problematic reaction point, a puzzling or disturbing personal response to a situation; with the psychoanalytic notion of warded-off content or conflictual ideas (cf. Horowitz et al., 1975); with object-relational notions of experiences that are split off from awareness to maintain a sense of self-coherence and connection with an idealized internal object; and with interpersonal notions of “not-me” experiences that are selectively inattended to in an attempt to avoid anxiety. Similarly, according to Personal Construct theory (Kelly, 1955), anxiety is experienced by a person when events occur which fall beyond the range of convenience of his or her construct system.

Assimilation is a concept borrowed from developmental cognitive theory (e.g., Piaget, 1962, 1970). In assimilating a new experience, a schema “takes it in”—integrates it, explains it, incorporates it into a system of associations. Wholly unassimilated experiences may be described as obscured, warded-off, denied, or repressed. Partially unassimilated experiences may be distorted, confused, vague, or ephemeral. After being assimilated, however, the formerly problematic experience is part of the schema; thus, a schema comes to consist partly of the personal insights achieved during therapy.

The complementary process, *accommodation*, takes place simultaneously with assimilation. Accommodation refers to changes both within a schema and within an experience that are required for the two to become associated (i.e., for the

schema to take in new material and for the experience to be incorporated). Thus, as a problematic experience becomes assimilated, both the experience and the schema must change to accommodate each other. Assimilation and accommodation occur simultaneously and inseparably during psychotherapy, and we intend each use of either term to imply the joint activity of both processes. We emphasize assimilation and use the term in this article's title to focus on the end state.

According to the model, assimilation of an experience to a schema requires bringing their common elements to awareness, so that they can become interconnected. Unlike new experiences assimilated in ordinary learning, the problematic experiences assimilated in psychotherapy involve a discrepancy from or an inability to be contained by the client's current schemata. The associated psychological pain leads the client to organize his or her life and thinking to avoid these experiences. Consequently, the therapeutic relationship and context must work against resistance to hold and focus the client's attention.

Stages of Assimilation

Affective Reactions

Our model proposes that unassimilated problematic experiences, unless completely warded

off, are felt as painful and negative. Partially assimilated experiences are felt as problematic or puzzling. Fully assimilated experiences are felt as psychologically accepted, even when they concern apparently unpleasant matters. Successful application of a schema to a new domain yields feelings of mastery and satisfaction (Figure 1).

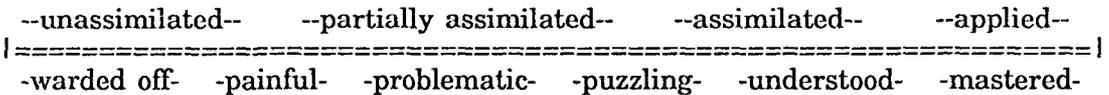
The model thus implies that successful therapeutic work yields a predictable sequence of attitudes toward a problematic experience, moving from left to right in Figure 1. Extremely problematic experiences emerge from their oblivion accompanied by distress. These painful perceptions become more focused and felt as explicitly problematic, then as puzzling, then as understood and emotionally accepted, and finally as constructive components of daily life.

Since problematic experiences invariably concern affectively potent material, full assimilation must be emotional and behavioral as well as intellectual (cf. Greenberg & Safran, 1987). However, incomplete assimilation may be manifested as an isolation of cognitive and affective aspects: a client may understand a connection intellectually without integrating it into his or her life.

Immediate Therapeutic Impacts

Although assimilation can occur gradually, inside or outside therapy sessions, some events within

--- Assimilation of experience ---



--- Affective reaction ---

Associated therapeutic impacts:

Unwanted thoughts --->

-----> Awareness ----->

---> Problem clarification --->

-----> Insight ----->

---> Problem solution --->

Figure 1. Continuum of assimilation of problematic experience, affective reactions, and associated therapeutic impacts.

sessions produce sudden, dramatic increases in assimilation. These increases give rise to strong affective reactions (positive or negative), and to distinctive *immediate therapeutic impacts*, which differ, depending on the segment of the assimilation continuum involved. These impacts can be classified according to a taxonomy developed empirically from clients' descriptions of events they found particularly helpful or unhelpful in brief counseling interviews (Elliott, 1985; Elliott et al., 1985). Five of these impacts are shown in Figure 1 in relation to the assimilation continuum (definitions are from Elliott et al., 1985, pp. 622-623):

1. *Unwanted thoughts* The client describes feeling discomfort from being forced or stimulated to confront unpleasant experiences, facts, or memories. (Theoretically, the movement of previously warded-off experiences into vague awareness is the first stage in the productive process of assimilation, but clients may rate the impact as unhelpful at the time because of the increased psychological pain.)

2. *Awareness* The client describes approaching uncomfortable experiences, including lessening or overcoming blocks to experiencing of uncomfortable thoughts, feelings, perceptions. (Theoretically, awareness impacts reflect movement from painful, unassimilated, and hence poorly articulated experience to a realization what one is feeling. Accommodation may change the salience of important elements of the client's schemata, leading to greater ability to put the experience into words.)

3. *Problem clarification* The client describes becoming clearer about the definition of his or her problems, tasks, or goals. (Theoretically, problem-clarification impacts reflect movement from an uncomfortable awareness of a problem to the development of clearer ideas about what must be changed or worked toward, transforming the problem into a puzzle that is potentially solvable using schemata developed in therapy.)

4. *Personal insight/new perspective* The client describes realizing something new about self, including gaining cognitive insight or seeing new connections about self or about self in relationship to others. (Theoretically, personal insight impacts involve changes in connections and the solution of personal puzzles. Such impacts reflect movement from recognition of a problem to comprehension of experiences in terms of schemata developed in therapy.)

5. *Problem solution* The client describes progress toward a plan of action, including specification of alternatives, selection of a course of action, or learning how to cope with situations outside of therapy. (Theoretically, problem-solution impacts reflect application of the assimilated material and extension of insights or principles into daily life.)

Parallel Movement of Linked Aspects of an Experience

At any given time during the therapeutic process, different aspects of a problematic experience may be at different points in the sequence shown in Figure 1. Because all aspects are closely associated, they tend to move in parallel. Therefore, while relatively obscured aspects are moving from being confusingly problematic to being puzzling-but-solvable, more assimilated aspects may be newly applied to daily life. For example, in the first clinical event described below, (a) Mark experienced remorse while clarifying (without solving) the problem that he behaved in a way (i.e., bullying) that he strongly disliked. This aspect appears to be about one-third of the way along the continuum as drawn in Figure 1. Simultaneously, (b) Mark began to understand that his not liking himself was, in part, attributable to his own controlling behavior (roughly two-thirds of the way along the continuum), and this realization led to feelings of positive accomplishment. Because (a) his bully-like behavior and (b) his felt need to control were associatively linked, a single therapeutic event precipitated parallel changes in both. The (less assimilated) bully-like behavior moved from a vague awareness to a clear problem, while the need to control, already recognized as a problem, became better understood as a source of his not liking himself.

Clinical Case Illustrations

The following two illustrations are drawn from the Sheffield Psychotherapy Project (Shapiro & Firth, 1987), which studied Exploratory Therapy, an interpersonal/psychodynamic treatment, and Prescriptive Therapy, a cognitive-behavioral treatment. Assimilation takes place in both forms of treatment. Each illustration presents a significant event early in therapy for which *personal insight* was an important helpful impact, according to the client's postsession Helpful Aspects of Therapy form (Elliott et al., 1987; Llewelyn, 1988; Llewelyn

et al., 1988). The first illustration is from an *exploratory* session; the second is from a *prescriptive* session.

Mark, Session 3 (Exploratory)

Mark was a 37-year-old teacher who described his difficulties as including "loss of self confidence; always wanting to impress people; aggressive interaction with colleagues; anger and frustration toward most people." He was a short, neat man, with a military bearing and a noticeable but minor physical handicap. He had become highly sensitive to "bullying," overreacting (in his view) to bullying behavior by others. Nevertheless, his own behavior toward his wife and child, and toward the therapist, could be described as domineering or bullying at times. Later in therapy, it emerged that he had felt bullied by his father and his schoolmates as a child.

Mark began his third session by describing a difficult week, feeling "pretty angry and fed up" because of "people dumping on me." He described a childhood incident in which he thrashed a school bully and a recent episode in which he became incensed upon seeing a film about child abuse.

Midway through this session, he described his angry reaction anticipating the arrival at the boarding school where he worked of a "lad [described by others as] an out-and-out bully." He continued, "I had to take that away and get hold of that and do something straightaway because I, I know unless I controlled my feelings about that I could very well turn round and do some bullying myself. And that wouldn't be the proper thing to do." The therapist summarized, "I think recently you've seen [some of your behavior] as bullying in some way, [and] you've not liked yourself at all." Mark responded first by producing a corroborating example of his "bullying" one of his charges, then by remorseful crying, and then by asking rhetorically, "Why must I control all the time?" On his post-session Helpful Aspects of Therapy form, he cited this event as the most helpful in the session.

Theoretical Analysis

By the third session of Mark's therapy, "bullying" had become a central theme and a symbolic way of expressing his growing understanding of his relationship difficulties. This constellation of understandings (the schema) drew on Mark's past experience, but was elaborated and explored systematically by the therapist, who used the term "bully" from time to time, ensuring that new experiences became assimilated to it. The contents of the unassimilated self-perceptions (the problematic experiences) that gave rise to Mark's "anger and frustration" and "loss of self-confidence" appeared to include a previously unspoken identification with the bullying characteristics he so despised in others. His partial appreciation of this connection is indicated by his saying that he could "do some bullying" himself. During this event, his assimilation of his experience (recognition of his own bullying behavior and his need to control)

to the bullying constellation clearly increased, enriching the schema and making it more useful for further work. He became more aware of his own bullying propensities, clarified but did not solve the puzzle that he behaved in a way he despised, and saw that some of his pain (not liking himself) was attributable to this internal conflict. He left feeling much helped.

Louise, Session 4 (Prescriptive)

Louise was a 37-year-old, twice-divorced teacher with three children. She presented with anxiety, depression, fears of breaking down, and inferiority feelings. She attributed her problems to stress at work, where she felt very anxious on account of poor relationships with colleagues, whom she saw as critical. She tended to blame herself and yet to see herself as a victim.

Louise spent much of her fourth session unburdening herself of the week's events. She recounted a car accident the previous day in which she had been hit from behind when innocently waiting to turn. She described her fear of blame in this situation as rendering her passive and unable to assert herself. The therapist asked her for evidence for or against "this idea that everything you do may be wrong," to which she offered her accident-free record. He then suggested she take credit for this record. The client said this was a new idea and proceeded jokingly to attribute her record to chance ("I've just been lucky"). The therapist seized this opportunity to point out Louise's attributional bias: "When things go well, it's luck, and when things go wrong, it's your fault."

Louise listened attentively and acknowledged her bias in the case of her driving and this accident. (On her post-session Helpful Aspects of Therapy form, she wrote, "Recalled car accident yesterday. Saw how clearly it emphasized my tendency to blame myself for bad things and put good occurrences down to luck.") Then, with active prompting from the therapist, and after some resistance, she came up with blaming herself for the breakdown of her marriages as a further example of her general attributional bias against herself.

Theoretical Analysis

The therapist's interpretation of an attributional bias invoked a schema—a principle that Louise already accepted intellectually: She blamed herself inordinately and failed to take deserved credit. The problematic, inappropriate self-blame for the accident was not fully assimilated to this schema prior to the interpretation. Her failure to apply the principle in everyday life is shown by her passively sitting in her damaged car awaiting the angry reproach of the other driver, as well as by her joking suggestion that her accident-free record reflected no credit on her skill and judgment at the wheel. Her difficulty in applying the schema to other situations is further evidence of the incomplete assimilation of the idea. However, the therapist's persistence in advancing the schema

was rewarded by Louise's productive application of it to her marriages.

During this episode, the client's reactions changed from seeing the experience as problematic (e.g., jokingly acknowledged), to understood (e.g., "I've never even thought about it like that," followed by attentive processing of the therapist's interpretation), and then to partially mastered (e.g., her more reflective tone when reviewing her self-blaming reaction to her mother's recrimination about her failed marriages). Thus, whereas Mark's work on "bullying" centered on relatively unassimilated experiences (in the left part of Figure 1), Louise's work on equitable distribution of blame and credit centered on relatively, if still incompletely, assimilated experiences (in the right part of Figure 1), even though both events included elements of personal insight.

The Assimilation Model as an Integrative Framework

Generality of the Assimilation Concept

The assimilation model is meant to integrate and supplement major therapeutic approaches, not to replace them. Almost all theories of psychotherapy directly or indirectly acknowledge the process of constructing schemata to assimilate problematic experiences. Most colleagues and reviewers who have read earlier versions of this article have suggested further writers whose work touches on the assimilation model (e.g., Bugental, 1978; Oatley & Johnson-Laird, 1987). The following examples illustrate assimilation-like concepts in major theories and are not exhaustive.

Frank (1973) saw all successful psychotherapy as involving a change in the assumptions (in our term, schemata) people make about themselves and the world. In his view, as in ours, changes in assumptions are necessarily coordinated with emotional and behavioral changes. Similarly, according to Orlinsky and Howard's (1986, 1987) "generic model" of psychotherapy, "micro-outcomes should gradually accumulate over the course of therapy and be synthesized by the patient to change the habitual, problematic assumptive systems (schemata, scripts, programs) used in dealing with self and others" (1986, p. 367).

In psychoanalytic theory, the dictum, "where id was, there shall ego be" suggests an increasing process of assimilation of unconscious wishes and instinctual drives within conscious awareness. Most psychodynamic theories see "insight" as centrally

important and consider it not as a moment but as a process—proceeding from a gradual assimilation into consciousness of longstanding conflicts and leading to a need for action.

Gendlin (1964, 1978) has described a process resembling our conception of assimilation from an experiential viewpoint: In his model, "focusing" attention on a "felt referent"—an unarticulated but bodily felt experience, usually related to puzzling, problematic, or painful content—promotes a process of labeling or symbolization (assimilation into some schema), with concomitant relief and "carrying forward" into action.

For personal construct theorists (Bannister, 1975; Kelly, 1955), assimilation is the result of active elaboration of the construct system. Such reconstructing initially causes anxiety (parallel to "unwanted thoughts"), which is proportional to the centrality of the changed constructs in the system.

The assimilation of experiences through "contact" with the environment is a central element in gestalt therapy theory (Daldrup et al., 1988; Perls et al., 1951). The assimilation process is seen as an active, "destructive" process, analogous to the ingestion and digestion of food, involving the sometimes painful tearing down of old gestalten and the creative formation of new gestalten, changing both self and environment. When experiences are introjected without being properly reworked (assimilated), the flexible harmony and flow of the organism-environment field is disturbed.

From a more cognitive-behavioral viewpoint, Lazarus (1984) has argued for the importance of cognitive contents or meanings in shaping each kind of emotional reaction. Applying cognitive and behavioral principles requires the same sorts of accommodation and assimilation as does psychoanalytic "working through."

Assimilation as a Way of Understanding Theoretical Similarities and Differences

The model specifies three broad similarities among therapies with respect to assimilation. First, all therapies offer a forum in which prolonged attention can be brought to bear on painful or puzzling experiences. Second, all involve the elaboration of coherent schemata—frameworks in which the problematic experiences can be understood. Finally, because the continuum of assimilation and the typology of impacts associated with change in each segment of the continuum (Figure 1) are inherent to the mental organization of the client, this process occurs in all therapies.

A more fine-grained analysis suggests two major ways in which therapies differ: First, they differ in the point or points along the assimilation continuum (Figure 1) that they focus upon. Second, they differ in the source and content of the schemata they typically elaborate.

Experiential and psychodynamic therapies generally emphasize the left portion of the assimilation continuum (Figure 1); they foster the emergence of warded-off content, the formulation of problems, and movement toward insight (e.g., Gendlin, 1964; Wallerstein, 1983). By contrast, cognitive and behavioral therapies appear to emphasize the right portion: gaining understanding of specific problems brought to therapy and applying that understanding to daily life (e.g., Barber & DeRubeis, 1988; Beck et al., 1979; Beck & Young, 1985). These emphases are not absolute; most therapies give some attention to all phases. Nevertheless, these therapies' relative emphases can be illustrated by the theoretical place they give problem clarification and insight, which are in middle of the assimilation continuum in Figure 1. Experiential and psychodynamic therapies tend to see awareness and insight as the culmination of treatment, whereas cognitive and behavioral therapies tend to see this (i.e., formulation of problems and understanding them in new, rational, objective ways) as the beginning, a point of departure for designing and effecting behavioral change.

In concert with their preferred segments of the assimilation continuum, different approaches draw their schemata from different sources. Client-centered and experiential therapies (Gendlin, 1964; Mahrer, 1983; Perls et al., 1951; Rogers, 1951, 1959) seek a unique frame of reference for each client, by testing and elaborating the self-understanding that he or she brings to therapy. The therapist focuses attention on unappreciated bodily sensation, unwanted thoughts, and vaguely-defined felt referents, while more adaptive schemata are constructed by accommodation of old schemata.

Psychodynamic approaches draw schemata from detailed theories of intrapsychic processes, which clients can adopt by using their own experiences as referents. Areas of interpersonal and intrapsychic conflict with roots in childhood are often expressed in concrete metaphors about bodily situations. For example, a client might describe being unable to speak by saying, "I've dried up," a metaphor that might refer to early deprivation, specifically problems in weaning (Freeman-Sharpe, 1940). Interpretation would give access to (and permit assim-

ilation of) the warded-off infantile experiences that generate the anxiety and the symptom.

In behavioral and in cognitive therapies, more-or-less standard schemata are often given to clients (i.e., ways of thinking are taught by therapists). Behavioral therapies use more externally oriented principles that often focus on versions of reinforcement and classical conditioning principles. For example, clients may learn to describe aspects of their problems in terms of their degree of tension or relaxation, and excessive tension then can be dealt with by applying skills in progressive relaxation. Cognitive therapies (e.g., Beck et al., 1979) focus on identifying specific self-defeating "irrational" thoughts (e.g., "I'm a failure") and underlying dysfunctional attitudes (e.g., "Angry people aren't loved"). Theoretical labels (e.g., catastrophizing) are applied to these thought patterns, and corrective exercises are prescribed (i.e., the theoretically imposed schemata are applied in practical situations).

Our studies of insight events in interpersonal/psychodynamic and cognitive-behavioral treatments (the clinical cases above and Elliott et al., 1987) illustrated the contrasting sources and contents of schemata. The interpersonal/psychodynamic (Exploratory) schemata were symbolic themes (e.g., Mark's fears of bullying and being bullied) that connected to many aspects of clients' lives and (for the therapist) to psychodynamic theoretical conceptions, especially to repeating conflict themes (Luborsky, 1984; Luborsky et al., 1986). The cognitive-behavioral (Prescriptive) schemata included formulas for rational living (e.g., rational and even-handed attribution of blame and credit for Louise), and they also connected to cognitive theoretical conceptions (e.g., role of attribution processes).

Implications of the Assimilation Model

Assimilation and Research

The assimilation model offers particular advantages for research. It points to specific elements in the therapy process—schemata and problematic experiences—that are empirically identifiable within therapeutic discourse at a modest level of inference. To be effective, a schema must be prominent, well-elaborated, and accepted by the client to some extent. Thus, preliminary versions of the schema should be clearly identifiable in the therapeutic discourse prior to assimilation. The content of a problematic experience may be

vague, obscured, or distorted at first, but its affective consequences (psychological pain or puzzlement, somatic manifestations or symptoms, rigidity or defensiveness, or a sense of discrepancy or ego-alienation) should be apparent.

The process of assimilation—and concomitant accommodation—can be studied directly, as it takes place within sessions, as in the events paradigm (Greenberg, 1984, 1986; Rice & Greenberg, 1984) and in comprehensive process analysis (Elliott, 1983, 1984, 1989). Alternatively, assimilation can be inferred by assessing a client's way of thinking about particular problematic content at multiple points in time and comparing these to demonstrate changes. For example, researchers can track particular themes or content areas across sessions and rate changes in degree of assimilation (cf. Luborsky et al., 1986; Stiles et al., 1990, in press). Because assimilation is a subtle, small-scale phenomenon, microanalytic process approaches seem particularly appropriate. These include discourse analysis (Labov & Fanshell, 1977) and tape-assisted recall (Elliott, 1984, 1986; Kagan, 1975).

The assimilation model addresses the need for a short-term conceptualization of psychotherapy outcome (Safran et al., 1988). In most psychotherapy process-outcome research, processes (such as therapist interventions) are assessed within sessions, on a time scale of minutes, whereas outcomes are assessed on a time scale of months or years. The assimilation model describes in-session outcomes concerning a limited topic or domain rather than the whole complex person. Thus, the scale of assimilation outcomes is better matched to the scale of psychotherapeutic interventions and process measures.

Assimilation and Practice

The assimilation model offers several advantages to practicing clinicians. It conceptualizes change processes on a small scale, it suggests an optimal ordering of psychodynamic and behavioral interventions, and it provides a way of understanding the needs of different clients.

Because the model conceptualizes change processes on a relatively small scale, it may draw attention to significant processes and events within the day-to-day practice of psychotherapy. This can provide both therapist and client with a needed sense of progress.

A number of studies have described or discussed the complementary use of behavioral and psychodynamic therapies (e.g., Birk, 1973; Birk &

Brinkley-Birk, 1974). Often, one treatment has been used adventitiously when progress in the other appeared impeded in some way. However, responding to day-to-day client needs can justify imposition of therapists' quirks and biases and can allow avoidance of difficult issues, leading some (e.g., Luborsky, 1984; Messer, 1986) to argue that treatment purity is essential. This suggests that, if multiple treatments are to be used in a case, each should maintain its own integrity, and the sequence should be planned.

Therefore it is reasonable to ask which therapy should be used first (Marmor, 1979). In terms of the assimilation model, doing exploratory or evocative work first allows clients to move across the assimilation continuum (Figure 1) from left to right, whereas doing problem-solving work before exploration forces clients backwards (presumably toward new material) when they are already some way along the path. Our clinical experience using interpersonal/psychodynamic and cognitive-behavioral treatments in both sequences supports the exploratory-problem solving ordering (Firth et al., 1986; Parry et al., 1986; Shapiro & Firth, 1987).

Regardless of which treatment they enter, clients who come with a formulated problem and the limited goal of solving it may suitably begin work in the middle of the assimilation continuum (cf. Figure 1). Clients who come with unformulated or poorly formulated problems, or who seek deeper changes, may need to begin work farther to the left. More broadly, the assimilation continuum concept can replace the older distinction between psychological adjustment and growth (or between crisis management and existential transformation) as a way of understanding different therapeutic tasks (i.e., growth involves the left side of the continuum, adjustment involves the right).

Finally, in any approach, choosing the best therapeutic intervention at a given moment in treatment requires the therapist to judge where the client is along the the assimilation continuum with regard to the issue at hand. For example, within a psychodynamic approach, evocative techniques may be more appropriate for warded-off, unassimilated material, whereas probing or confronting techniques may be more appropriate in areas already clearly delineated as problematic.

Assimilation and the Therapeutic Relationship

The assimilation model focuses on the "task" aspects of therapy, as opposed to the social and emotional aspects of the therapist-client rela-

tionship. This focus is not, however, meant to deny the crucial importance of the relationship. We assume that progress in the assimilation of problematic experiences is fostered by a positive alliance between client and therapist (Alexander & Luborsky, 1986; Bordin, 1979; Luborsky, 1976; Marmar et al., 1986; Marziali, 1984). A strong relationship is required to hold the client's attention on problematic material (Rice, 1983), a prerequisite for assimilation. Conversely, progress along the assimilation continuum strengthens the therapeutic relationship (Luborsky, 1984).

To a client in therapy, the relationship that makes assimilation possible may be more salient than the process of assimilation itself (Llewelyn, 1988; Llewelyn & Hume, 1979; Strupp et al., 1964). The therapeutic relationship may have its own systematic developmental sequence (Stiles, 1979), which offers complementary therapeutic impacts while serving as a vehicle for assimilation.

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