Assimilation of Problematic Experiences

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The assimilation model (Stiles et al., 1990) offers an approach to customizing the therapeutic relationship through responsiveness (Stiles, Honos-Webb, & Surko, 1998) to the degree of assimilation of clients' problems. Briefly, the therapist discerns a problem, assesses its assimilation level, and works with the client, using the chosen therapeutic approach, to move the problem from one level to the next.

Definitions

The assimilation model conceptualizes psychotherapy outcome as change in relation to particular *problematic experiences*--memories, wishes, feelings, attitudes, or behaviors that are threatening or painful, destructive relationships, or traumatic incidents--rather than as change in the person as a whole. It suggests that, in successful psychotherapy, clients follow a regular developmental sequence of recognizing, reformulating, understanding, and eventually resolving the problematic experiences that brought them into treatment. The sequence is summarized in the eight stages or levels of the Assimilation of Problematic Experiences Scale (APES, Table 1), numbered 0 to 7: (0) Warded off/dissociated; (1) Unwanted thoughts/active avoidance; (2) Vague awareness/emergence; (3) Problem statement/clarification; (4) Understanding/insight; (5) Application/working through; (6) Resourcefulness/problem solution; and (7) Integration/mastery. The APES uses both cognitive and affective features to characterize each level, which represent anchor points

along a continuum, rather than discrete states. Clients may enter treatment at any point along the APES continuum, and any movement along the continuum might be considered as therapeutic progress.

Table 1

Assimilation of Problematic Experiences Scale (APES)

[APES image by Katerine Osatuke]

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0. Warded off/dissociated. Client is unaware of the problem; the [problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance.

1. Unwanted thoughts/active avoidance. Client prefers not to think about the experience. Problematic voices 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. Problematic voice 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. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.

4. Understanding/insight. The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (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. Voices work together to address problems of living. Affective tone is positive, optimistic.

6. Resourcefulness/problem solution. The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.

7. Integration/mastery. Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

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Note. Assimilation is considered as a continuum, and intermediate levels are allowed, for example, 2.5 represents a level of assimilation half way between vague awareness/emergence (2.0) and problem statement/clarification (3.0).

In assimilation research, we identify problematic experiences, extract multiple passages dealing with them from tapes or transcripts of completed therapies, and study how the expressions of each problem change across sessions. We observe that the problematic experiences change from being feared or unwanted in early sessions to being understood and integrated by the end of successful treatments. As one way to formulate this, following Piaget (1970), we can say the problematic experience is assimilated into a *schema*--a way of thinking and acting that is developed or modified within the therapeutic relationship (accommodation) in order to assimilate the problematic experience (Stiles et al., 1990).

The process of assimilation can also be described using the metaphor of *voice* (Honos-Webb & Stiles, 1998; Stiles, 1997, 1999a, 1999b, 1999c). This metaphor expresses the theoretical tenet that the traces of past experiences are active agents within people and are capable of communication. The traces can act and speak. Dissociated (unassimilated) voices tend to be problems, whereas assimilated voices can be resources--available to be called upon when circumstances call for their capacities and talents. The interlinked traces of experiences that have been assimilated previously can be considered as a community of voices within the person. In successful therapy, a problematic, unwanted voice establishes contact with the community, negotiates an understanding, and is assimilated into the community. For example, in one successful treatment (Stiles, 1999b), Debbie's sudden, uncontrolled angry outbursts (a problem) were gradually assimilated and transformed into a capacity for appropriate assertiveness (a resource). The process of contact between the problematic voice and the community can be described as building a meaning bridge. A meaning bridge is any sign (word, image, gesture, etc.) or system of signs that means the same thing to both the author and addressee of a communication (e.g., the problematic voice and the community). In Debbie's case, an element of the meaning bridge was the concept of a "rejecting" aspect of herself--a complement or shadow to Debbie's predominant experience of being "rejected." This concept was introduced by the therapist as a way of naming the angry outbursts (i.e., the problematic voice). Debbie used the name "rejecting" for talking about and to this problematic aspect of herself as she assimilated it.

Research Review

The assimilation model's description of change has been derived mainly from a series of intensive case studies, in which problematic experiences have been tracked across sessions in tapes or transcripts of completed psychotherapies. The therapies have been

conducted using a variety of approaches, including psychodynamic, interpersonal, cognitive, process-experiential, and client-centered. These studies have used assimilation analysis, a systematic, theoretically-based, qualitative approach to case study (Stiles & Angus, 2001; Stiles et al., 1992) illustrated briefly in the foregoing review of the case of John Jones. The studies have yielded a provisional description of the assimilation sequence, summarized in the APES (Table 1).

Interpretive Studies

Assimilation analyses of cases have yielded a variety of examples of problematic experiences that have been assimilated, to a greater or lesser degree, following the pattern described in the model and the APES. Each case was different and has, in varied proportions, drawn upon, confirmed, modified, and elaborated aspects of the model. There has also been much overlap, and the aggregate offers a substantial basis for confidence in the model. The cases (pseudonyms) and problematic experiences have included the following: (a) John made partial progress in assimilating an angry resentment of people that led to a sense of anxiety or panic in social situations (Stiles et al., 1991). (b) Joan assimilated a feeling of emptiness that seemed to stem from a deep-seated feeling of personal inadequacy (Stiles, et al., 1991). (c) John Jones assimilated his homosexual feelings by accommodating his acceptance-of-others schema to include himself (Stiles et al, 1992). (d) Mrs. M. assimilated a wish to develop her own personal space, which at times meant putting her own needs before those of her children (Shapiro, Barkham, Reynolds, Hardy, & Stiles, 1992). (e) June assimilated a sense of personal vulnerability, which was expressed in anxiety over talking about her feelings (Stiles, Shapiro, & Harper, 1994). (f) Marie assimilated a guilt-producing wish to let go of her mother (Field, Barkham, Shapiro, & Stiles, 1994). (g) Jane Davis assimilated the problematic expression of risky feelings, the avoidance of which had led to use of third-person constructions and other objectifying language in describing her own feelings (Stiles, Shapiro, Harper, & Morrison, 1995). (h) Lisa assimilated her resentment at her husband's gambling (Honos-Webb, Stiles, Greenberg, & Goldman, 1998) and a sense of personal responsibility for other's hurtful behaviors (Honos-Webb, Stiles, Greenberg, & Goldman, in press). (i) George made steps toward assimilating an urge to avoid his wife and run away, though progress stalled, and assimilation was not far advanced by the time treatment ended (Honos-Webb et al., 1998). (j) Jan assimilated problematic voices of neediness and weakness and of rebellion (Honos-Webb, Surko, Stiles, & Greenberg, 1999). (k) Fatima made progress in assimilating the trauma of her infant daughter's death (Varvin & Stiles, 1999). (l) Debbie assimilated her verbal outbursts, which became a resource of appropriate assertiveness (Stiles, 1999b). (m) Vicky assimilated expressions of her sexuality in ways that were related to but somewhat augmented problems in her relationship with her mother (Knobloch, Endres, Stiles, & Silberschatz, 2001). The cited studies include examples of dialogue illustrating each of the APES levels.

Hypothesis-Testing Studies

There have also been a few hypothesis-testing studies bearing on the assimilation model. Two of these have been based on the consideration that clients' *aptitude* for responding to one treatment or another may depend on the APES level of their presenting problems more than their diagnosis or stable aspects of their personality. Theoretically, problems at low APES levels are poorly formulated or dissociated, so that psychodynamic, experiential, or interpersonal approaches, which emphasize exploration, might be most appropriate. On the other hand, problems at intermediate APES levels are relatively well-formulated and might be more efficiently addressed by cognitive or behavioral approaches, which emphasize more prescriptive techniques. The studies supported this suggestion (Stiles, Barkham, Shapiro, & Firth-Cozens, 1992; Stiles, Shankland, Wright, & Field, 1997).

Therapeutic Practices

The assimilation model suggests not only a generic treatment goal--to facilitate the client's progress along the assimilation continuum--but also a series of specific subgoals, corresponding to the APES levels (Table 1). This guidance is not a mechanical prescription, however, but involves appropriate responsiveness to client requirements as they emerge during treatment. As the client changes, the therapeutic relationship changes (or should change) responsively, reflecting the evolving goals, feelings, and behaviors that represent therapeutic progress. Markers of assimilation levels are recognizable types of events in psychotherapy discourse that are empirically and theoretically linked to those levels. Research on finding and describing reliably-recognizable markers has yielded over two dozen candidates (Honos-Webb, Lani, & Stiles, 1999; Honos-Webb, Surko, et al., 1999). Markers of a problem's current level of assimilation, expressed in terms of the APES (Table 1), could guide therapists in facilitating the problem's movement to the next level (Stiles et al., 1995). When an interacting client and therapist are considered jointly, they may reach higher levels on the APES than when the client is considered alone (Leiman & Stiles, 2001). For example, the dyad jointly may be able to formulate a problem (APES level 3) while the client alone would be avoiding the topic (APES level 1). This difference may be understood using a concept drawn from developmental psychology, the zone of proximal development (ZPD; Stetsenko, 1999), defined as "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers" (Vygotsky, 1978, p. 86). Applied to the psychotherapeutic relationship, the ZPD can be understood as the segment of the APES continuum (Table 1) within which a problematic voice can proceed from one level to the next with the therapist's assistance. Therapists using different theoretical approaches appear to use the ZPD differently to facilitate movement through the APES levels. In one pair of assimilation analyses, a client-centered therapist's interventions followed the APES level of client's own descriptions, while the client took the initiative to advance to higher levels (Glick et al., 2000). In contrast, a cognitive-behavioral therapist tended to lead the client in APES terms, in effect challenging her and pulling her along (Osatuke et al., 2000). Graphically, the client-centered case made

smooth but gradual progress along the APES continuum, whereas the cognitive-behavioral case followed a saw-tooth pattern--movement towards greater assimilation through repeated sequences of a rapid advance followed by a falling back to an earlier level. Each "tooth" seemed to represent a different narrow topic or domain, reflecting the therapist's strategy of focusing on issues one by one, actively leading the client to the cutting edge of each issue.

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