An Assimilation Analysis of Psychotherapy: Responsibility for “Being There”

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EDITOR'S INTRODUCTION

With regard to psychotherapy, assimilation is the process of a client coming to acknowledge previously incompatible and thereby problematic experiences. The issues presented at intake resolve as the person integrates these experiences into his or her sense of self. From qualitative studies of psychodynamic, cognitive–behavioral, and process–experiential therapies, Dr. Honos–Webb, along with others, developed the Assimilation of Problematic Experiences Scale (APES) of seven stages of assimilation. In their studies of assimilation with the APES, researchers typically use transcripts of total or substantial segments of a client’s therapy. Dr. Honos–Webb describes the steps of becoming familiar with and indexing the transcripts, and of then identifying themes, extracting relevant passages, and finally assigning ratings of assimilation. As we see in “Lisa’s” case, the evolution of a theme is often the most theoretically and practically intriguing contribution of the analysis.

Two thirds of the chapter is devoted to an assimilation analysis with regard to Lisa’s theme of responsibility. Her presenting issue was depression in the face of life with her gambling-addicted husband. Readers see Lisa gradually coming to terms with her assumed responsibility for her husband’s alcoholism and what she comes to recognize as her choice to remain in the marriage. We witness her coming to own her complexity. Other themes from Lisa’s psychotherapy have been published elsewhere.

Dr. Honos–Webb points out that this qualitative study first relied on quantitative data (aggregated beginning and ending scores on five measures of depression) to select from a database a clearly successful therapy case, which was correctly thought to be most likely to reveal assimilation processes. Moreover, in turn, the qualitative analysis allowed understanding of apparently anomalous changes in some of her depression scale (Beck Depression Inventory [BDI]) responses. In addition, assimilation analysis of the responsibility theme led to an appreciation of Lisa’s seemingly paradoxical increase and decrease in her sense of responsibility for her situation as she significantly resolved her depression. The analysis also led to an appreciation of how two theories of depression (Beck’s self blame and Seligman’s learned helplessness) were both salient, but in more complex ways than usually described. Readers will take away a respect for the complexity of the therapy process. Practicing clinicians note the promise for their work of assimilation analysis, whether formal or informal.

BACKGROUND

The assimilation model describes clients’ incremental assimilation of problematic experiences as they make progress in therapy
Assimilation analysis is a qualitative research method for analyzing tapes or transcripts of psychotherapy cases. In this chapter we present a brief explication of the assimilation model and our method of assimilation analysis. We then describe the case of Lisa (a pseudonym), a 27-year-old woman whose psychotherapy was analyzed. Lisa was treated using an emotion-focused treatment guided by a treatment manual written by Greenberg et al. (1993). Using assimilation analysis, we tracked the theme of responsibility across Lisa’s sessions. Elsewhere, we have reported our tracking of another theme in this case (Honos–Webb et al., 1998). The current results illustrate how Lisa’s depression and its relationship to responsibility were more complex and paradoxical than might be expected from abstract theoretical formulations. Because assimilation analyses are rooted in the client’s immediate experience, the study uncovered contradictions within Lisa’s experience that a more abstract theoretical formulation might have missed.

**THE ASSIMILATION MODEL**

We approached the case of Lisa using the assimilation model (Honos–Webb et al., 2003; Honos–Webb and Stiles, 2002)—a stage model of change that has been examined in treatments from varied theoretical orientations, including integrative approaches (Honos–Webb and Stiles, 2002). The word assimilation refers to a client’s incorporating and integrating a problematic experience into the self. According to this model, clients resolve symptoms in psychotherapy by incrementally assimilating previously unwanted problematic experiences that may be memories of traumatic events, ego–dystonic thoughts or impulses, or uncomfortable feelings. Assimilation has been studied by examining session-to-session changes in clients’ ability to articulate and tolerate awareness of the problematic experience. These qualitative studies of psychodynamic, cognitive–behavioral, and process–experiential therapies have refined a hypothesized sequence of stages, summarized in the Assimilation of Problematic Experiences Scale (APES; Honos–Webb et al., 1998, 1999, 2003). These studies have also supported the association of assimilation with positive outcomes in therapy. For example, in a comparison between a successful and an unsuccessful case (Honos–Webb et al., 1998), the unsuccessful client showed some progress in assimilation, but treatment ended because the research project limited the number of sessions. Because the client had made some progress in gaining awareness of his difficult emotions, he ended therapy with greater awareness of his emotional pain, which he had previously masked. Although he made progress in increasing his awareness, it is not surprising that no improvement in symptom intensity (as determined by self-report measures) occurred. The unsuccessful client made a more authentic connection with his
emotional life during therapy than before he entered therapy, but subjectively this did not make him feel better. In contrast, the successful client entered therapy with high levels of awareness of her emotional pain and was able to work through her pain to a sense of emotional resolution. She experienced alleviation of her depressive symptoms that was maintained at follow-up.

The APES stages range from warded off (stage 0) to mastery (stage 7). At APES stage 0 (warded off), the problematic experience is inaccessible. The uncomfortable and previously warded off material intrudes into awareness and is actively avoided at stage 1 (unwanted thoughts) and emerges more clearly at stage 2 (vague awareness/emergence). Stages 1 and 2 are characterized by negative affect with little understanding. At stage 3 (problem statement/clarification), the experience is more focal in awareness and the client is able to state the problem in words. Movement to stage 4 (understanding/insight) is characterized by “aha” types of experiences and a clearer description of the problematic experience, with a mixture of positive and negative affect. At stage 5 (application/working through), clients report more positive affect and efforts at solving specific problems. During stage 6 (problem solution), the client achieves a successful solution to a specific problem. During the final stage, stage 7 (mastery), affect is more neutral and the client is less likely to focus on the problematic experience because he or she has incorporated the change into daily living.

The progression of problematic experiences across stages has been described theoretically in terms of a self that is considered as a community of voices, rather than a monolithic unity (Honos–Webb and Stiles, 2002; Honos–Webb et al., 1999). Voices are thoughts, feelings, or memories. They encompass what have been called objects in object relations theory, automatic thoughts in cognitive–behavioral therapies, and top dog and underdog in gestalt approaches. The community of voices refers to an inherently multiple self that is multivoiced with smooth and comfortable transitions among voices (rather than fragmentation among voices, as in dissociation). The dominant community of voices represents accepted experiences. Theoretically, voices of unproblematic experiences are easily assimilated into the community, but voices representing trauma, disturbed primary relationships, and other problematic experiences may be avoided, and are therefore nondominant voices. The assimilation model proposes a developmental sequence in which, through psychotherapy, an initially warded-off or unwanted problematic voice finds expression and gains strength until it challenges the dominant community. The sequence of assimilation stages (the APES) represents a changing relationship between these two voices. In successful cases, this leads to mutual accommodation; both the nondominant and the community voices change as they develop an understanding between each other. The formerly nondominant voice joins (is assimilated into) the community and becomes an accepted aspect.
of one’s experience of oneself. Thus, the client moves from experiencing the self as a stable unitary self (e.g., “I am strong”) to experiencing the self as flexible and complex (e.g., “I am strong and needy”).

ASSIMILATION ANALYSIS

Psychotherapeutic assimilation has been studied using a qualitative analytic method that we have come to call assimilation analysis. It is a systematic way to approach the course of whole therapies, or substantial parts of therapies, or other change-oriented discourse.

Although, in principle, assimilation analysis can be applied to any longitudinal sample of a person’s discourse, it has most often been applied to verbatim transcripts or tapes of all (or almost all) of a psychotherapy client’s sessions. Clients’ spontaneous statements as well as responses to the therapist can be rated. The procedure can be considered in four steps.

STEP 1: FAMILIARIZATION AND INDEXING

The goal of this step is to become fully familiar with what is in the transcription and to construct systematic notes (an index) that make it possible to locate passages later concerning particular topics of interest.

In the case of Lisa, transcripts of her 15-session treatment were read and reread, and each topic was listed in sequence, with its session, page, and paragraph numbers to facilitate returning to that passage. Following Stiles et al. (1991), a topic was defined as an attitude expressed toward an object, where “an attitude generally has two aspects—a belief (cognitive aspect) and a feeling or evaluation (affective aspect)—although one or the other of these may be more prominent. An object is the person, thing, event, or situation toward which the attitude is held. An object may be concrete or abstract; simple or compound” (p. 198). An example might be “has given up on” (attitude), “husband” (object), “session 1, 11, 14” (session, page, paragraph).

STEP 2: IDENTIFYING AND CHOOSING A THEME

The goal of this step is to select a theme for analysis. In this context, “theme” refers to some topic that was important or was referred to repeatedly during the therapy. Themes in therapy are presumed likely to represent the client’s work on particular problematic experiences.

In the case of Lisa, we focused on new understandings, or insights (i.e., events in which a problematic experience reaches level 4 on the APES), as a way of finding problematic experiences to track through therapy. Insights are points in therapy when the client understands something in a new
way, suggesting that a problematic experience has been assimilated to a changed schema. "Insight events are affectively charged, and this feature helps to make them salient in the transcript. Often they are marked by process comments, such as ‘I’ve never thought of that before’ or ‘Now this all makes sense’" (Stiles et al., 1992, p. 85). One advantage of starting with new understandings is that they often include a clear, explicit statement by the client of the newly understood problematic experience. Using such clear statements, researchers can track salient new understandings backward and forward through the transcripts.

**STEP 3: EXTRACTING PASSAGES**

The goal of this step is to collect a set of passages dealing with a particular problematic experience. One way to do this is to search the index produced in step 1 for key words related to the new understandings or objects selected in step 2.

In Lisa’s case, the index was used to locate passages indexed by key words related to the selected new understandings. For example, a significant new understanding event occurred within the context of unfinished business to resolve her anger toward her husband, and “anger” was used as a key word. All passages indexed by the key words were read and reread in context (Honos–Webb et al., 1998). As the theme is understood, it may be helpful to narrow the focus to a particular psychological conflict or problematic experience within the broader theme. For example, in Lisa’s case, a conflict between expressing anger and wanting to forgive appeared as a narrower, more specific theme within those passages indexed by “anger.” The index was used to locate all passages related to these narrower themes, and they were excerpted and listed for use in step 4.

**STEP 4: ASSIGNING RATINGS OF ASSIMILATION**

The investigator assigns an assimilation rating to each passage using a scale ranging from 0 to 7 points, guided by an understanding of the problematic experience and knowledge of the passage’s context.

More important, although the APES assessments may be expressed in numbers as well as in words, during a qualitative assimilation analysis they need not be considered as objective ratings corresponding to an independently existing state. Instead, they represent attempts to express the investigators’ perceptions of the level of assimilation precisely. The assessments are guided by a developing understanding of the problematic experience and are made with knowledge of the passage’s context and temporal location within therapy.

Steps 2 to 4 can be repeated any number of times, once for each theme or subtheme that seemed important in each transcription.
Assimilation analysis need not be understood as an attempt to prove that the assimilation model is the only explanation for the outcome in a case. Instead, it can be seen as part of a process of cycling between theory and data meant to refine the model. “It might be argued that this type of theory-guided observation contaminates the data, and that the observations are not ‘pure.’ ... Data out of context of theory are meaningless, however, and there are no ‘pure’ observations” (Safran et al., 1988, p. 7).

Like all qualitative research, assimilation analysis is subject to biases, but because it aims to deepen understanding rather than to predict or control, noninvolvement is not necessarily an appropriate standard. “Replacing objectivity is a concept that may be called permeability, the capacity of theories or interpretations or understandings to be changed by encounters with observations” (Stiles, 1993, p. 602). To reduce bias and encourage permeability, our assimilation analysis of Lisa’s therapy sought to incorporate principles of good practice, including (1) revealing the investigators’ preconceptions and expectations before the research (particularly our understanding of the assimilation model), “meant as orientation for the reader and as an initial anchor point, not as hypotheses to be tested” (Stiles, 1993, p. 600); (2) intensive engagement with the material; (3) iterative cycling between theory and data; and (4) grounding of interpretations in observations.

Iteration is conceived as “an extended ‘dialogue’ with ... texts (tapes, transcripts), which includes reading, conceptualizing, rereading, and reconceptualizing... Interpretations change and evolve as they become infused with the observations” (Stiles, 1993, p. 605). Such engagement promotes the much-called-for contextual understanding of the psychotherapeutic process. “Unlike drugs, psychotherapeutic interventions concern meaning, and hence depend on the active, conscious participation of both patient and therapist, with their idiosyncratic meaning systems... Psychotherapeutic techniques have no meaning apart from their interpersonal (social–symbolic) context” (Stiles and Shapiro, 1989, p. 524).

Reporting the results of any qualitative analysis demands thorough grounding—linking interpretations to specific observations, such as excerpts from the transcripts, to convey the basis for the interpretations (Guba and Lincoln, 1989; Packer and Addison, 1989; Stiles, 1993). To ground our interpretations in the case of Lisa, we present (later) some of the main passages of the therapy on which our interpretations were based. Thus, to some degree, readers can judge for themselves the “validity” of our conclusions.

Unlike traditional case studies, assimilation analyses are grounded in the client’s own words during therapy, rather than in the researcher’s
abstract formulation of the case. Especially during the earlier stages of assimilation, when a client is still struggling to clarify the nature of the problem, there may be a considerable discrepancy between the topics being tracked for assimilation and the themes deemed central by a case formulation. Although a clinical case emphasizes inferences based on a theory of the etiology of pathology, an assimilation analysis is rooted in the transcripts themselves, and therefore ultimately in the client’s self-understandings.

**LISA AND RESPONSIBILITY**

**BACKGROUND**

Lisa was a 27-year-old woman who was married and had two school-age children. Her socioeconomic status was working class. She was not working at the beginning of treatment and found part-time employment before the end of treatment. Lisa was given a diagnosis of major depressive episode. At the onset of treatment, Lisa attributed her depression primarily to her husband’s addiction to gambling.

Lisa presented with depression and a desire to understand why she felt the way she did. She described herself as isolated, trapped, feeling frozen, and “not wanting to move on.” She also described moodiness, which she related to her husband’s gambling, and helplessness because she could not control his behavior. She was involved in a support group for individuals whose spouses were addicted to gambling, which attempted to apply a 12-step program designed to overcome codependency (Alcoholics Anonymous, 2002). Lisa often described her attempts to follow the first step of this program—to admit her powerlessness and acknowledge that she could not control her husband.

Lisa participated in a research project studying the process of change in process–experiential psychotherapy (PEP; Greenberg et al., 1993) and client-centered therapy at an urban university (Greenberg and Watson, 1998). Lisa was randomly assigned to PEP and was seen for 15 sessions. Her therapist was a female doctoral student in clinical psychology. Periodic measurement on the Barrett–Lennard Perceived Empathy Scale (Barrett–Lennard, 1986) and the Working Alliance Inventory (Horvath and Greenberg, 1986) indicated that Lisa maintained a positive alliance throughout treatment (Honos–Webb et al., 1998).

PEP is a hybrid therapy that synthesizes elements of client-centered therapy and gestalt therapy, attempting to balance therapist responsiveness and empathic attunement with therapist direction of process (Greenberg et al., 1993). The foundation of PEP is a therapeutic relationship fostered
by empathy, nonjudgmentalness, and genuineness (Rogers, 1957). PEP assumes that emotional understanding of one’s problems is necessary to long-lasting change, and, at appropriate times, the therapist initiates tasks designed to enhance awareness of the client’s current emotional experience. For example, rather than focusing on a dreaded event in the future, the therapist guides the client to pay attention to the current experience of anxiety. Similarly, rather than talking about past relationship problems (indicating unfinished business), the therapist directs the client to engage in a dialogue with the unforgiven other (empty-chair work) in an attempt to make the emotions come alive in the present. Such in-session facilitation of emotional experiencing is posited to help change the emotional schemes that underlie the presenting problems.

At the end of her 15 sessions of PEP, assessment measures showed large improvements in Lisa’s depression (Table 1-1). Lisa’s case was selected for assimilation analysis from among other PEP clients in the Greenberg and Watson (1998) project for having demonstrated the greatest improvement from intake to end of treatment on four of five standard measures of symptom intensity used in the project: the BDI (Beck et al., 1961), the Symptom Check List-90-Revised (SCL-90-R; Derogatis, 1983), the Inventory for Interpersonal Problems (IIP; Horowitz et al., 1988), and the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965). In addition, Lisa reported feeling much stronger, more independent, in control, and “helped” by therapy. However, Lisa said she was still in pain and that her home situation had not improved. Thus, it was a puzzle how such dramatic psychological changes had occurred despite the intractability of what she perceived as the source of her problems—her husband’s gambling.

**Table 1-1** Lisa’s Assessment Scores

<table>
<thead>
<tr>
<th>Measure</th>
<th>Occasion of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretreatment</td>
</tr>
<tr>
<td>BDI</td>
<td>25</td>
</tr>
<tr>
<td>SCL-90 total score</td>
<td>1.94</td>
</tr>
<tr>
<td>SCL-90 depression</td>
<td>2.75</td>
</tr>
<tr>
<td>IIP</td>
<td>1.97</td>
</tr>
<tr>
<td>RSE</td>
<td>20</td>
</tr>
</tbody>
</table>

Lower scores indicate less symptom intensity on the BDI, SCL-90, and IIP; higher scores indicate greater self-esteem on the RSE. BDI, Beck Depression Inventory; SCL-90, Symptom Checklist 90; IIP, Inventory of Interpersonal Problems; RSE, Rosenberg Self-Esteem Scale.
ANALYTICAL PROCEDURE

All of Lisa’s sessions were audio recorded for use in research, with Lisa’s written permission. Transcripts of 14 of 15 of Lisa’s sessions (one was omitted because of technical problems) were made by professional transcribers, who omitted identifying details (e.g., names of people and places).

The primary qualitative analysis was carried out by the first author, when I was a graduate student in clinical psychology. I followed the four-step assimilation analysis procedure described earlier. I consulted regularly with the second author, who was my research supervisor. Throughout the period of analysis, I kept a progressive subjectivity journal (Guba and Lincoln, 1989), which included personal reactions to the case and the research, evolving formulations of the case and major themes, and preliminary interpretations of patterns and levels of assimilation. The supervisor served as an auditor who reviewed transcripts and other case materials, and assessed my APES ratings and interpretations. Differences in ratings were discussed and, in some instances, changed. Subsequently, the transcripts and other case materials were reviewed by the third and fourth authors, who tended to view the material through the lens of PEP, and their understandings were incorporated into the interpretations presented here. Differences in interpretations were discussed among investigators and were resolved by consensus or by compromises acceptable to all.

Three recurring themes identified in the assimilation analysis included (1) Lisa’s conflict between her anger and her desire to forgive, (2) her growing sense of herself as a separate individual, and (3) her responsibility in her life predicament. In this chapter we present the analysis of the third theme. An analysis of the first theme has been presented in Honos–Webb et al. (1998).

In the following section we present the passages representing the responsibility theme in stanza form, following principles suggested by Gee (1986, 1991; McLeod and Balamoutsou, 1996). Breaking speech into lines and stanzas is meant to convey better our understanding of its rhythm and feeling and to give emphasis to emotional high points and psychologically important thought units. We have identified passages by session number, page number, and paragraph number, based on the printed transcripts, to convey some idea of when the passage occurred. For example, “session 8, 15.9–16.6” means that the passage occurred during session 8, running from paragraph 9 on page 15 to paragraph 6 on page 16. Lisa’s session transcripts averaged about 22 pages long with about 19 paragraphs per page. A line of ellipses (…) indicates material omitted to save space.

OVERVIEW OF THE RESPONSIBILITY THEME

Responsibility was a recurring theme throughout Lisa’s therapy, and we believe she achieved a substantially new understanding of it. It was difficult
to say precisely when the new understanding occurred, because Lisa shifted from an early preoccupation with her responsibility for others’ behavior (particularly her husband’s) to a recognition of her responsibility for her own behavior. This shift was unexpected because it had seemed that her central task would be to relinquish responsibility for her husband’s gambling and to overcome her codependency (although this term was never used).

Lisa spoke frequently about the support she got from her 12-step group at church. She entered therapy reciting the principle of admitting lack of control, as advocated by 12-step groups (Alcoholics Anonymous, 2002): “I understand the disease and the character in him . . . (session 1, 8.13), and “I-I think I’ve given up in that sense; I’ve just kind of let God take over” (session 1, 9.15), and “it’s the disease that, that controls him” (session 1, 11.2), and “Yeah, I can do it. I turn to God and that’s about it” (session 2, 15.18). During the assimilation analysis, it became apparent that these beliefs, for her, were a dysfunctional schema. She did feel a strong sense of responsibility for her husband’s behavior, and this feeling was a problematic experience that was incompatible with the 12-step principles of giving up attempts to control her husband and relinquishing responsibility for his gambling. As the problematic feeling of responsibility emerged into awareness, she clarified her predicament: If she was powerless and he would not change, then she was hopeless.

**TRACKING THE THEME**

Lisa’s intensely painful but vague awareness of her feeling of responsibility was apparent in session 1.

Lisa: Whether it’s giving up—I’ve given up on him—or just-just let it be.
Th: Uh huh.
Lisa: I can’t change him.
Th: Uh huh.
Lisa: What’s the point? But then-then inside, it-it still hurts me, um.
Th: Uh huh.
Lisa: Which doesn’t make sense.
Th: Well, it’s not necessarily a rational thing, right?
Lisa: Yeah. No.
Th: But, but, I guess it’s like, you’re sort of continuing to feel this pain.
Lisa: Yeah, yeah. It’s-it’s always been there.
Th: Yeah, and it’s like it’s not going away.
Lisa: No. No matter how much I believe. It is an illness and, you know, it’s his character.
Th: It’s almost as if you know that and understand that you can’t talk yourself into feeling differently about it. (session 1, 11.14–12.1)
Lisa lacked a clear definition of the problem, as is characteristic of vague awareness/emergence (APES level 2), but she experienced a discrepancy between her actual reaction and her view of an appropriate reaction (“doesn’t make sense”; a problematic reaction point [Greenberg et al., 1993]). Because she believed gambling was a disease, she thought she should not have taken it personally and yet she was still hurt by his behavior. Her feeling of responsibility emerged more explicitly later in the session:

Lisa: It’s almost like, I feel like it’s my fault (crying).
Th: Uh huh. And that’s what sort of feels really painful about this.
Lisa: Yeah.
Th: So much that it rests on you, like.
Lisa: Yeah. And it shouldn’t. I’m not responsible for his actions (crying). (session 1, 20.12–14)

In this passage, the problematic feeling of responsibility appeared intermediate between APES levels 2 and 3 (say, 2.5). Lisa approached a statement of the problem, in that she recognized the schema to be changed (“I’m not responsible for his actions”) in conjunction with the emerging problematic experience (“I feel like it’s my fault”). It was not yet at the level of problem clarification, however, insofar as Lisa was still siding with the dysfunctional schema and was still tentative about the problematic experience (“it’s almost like”).

In session 6 she arrived at a clear statement of the problem (APES level 3). The problematic experience and the schema were both experienced as having merit, bringing to the fore the intensity of the conflict.

Lisa: Yes, as much as I understand, you know, it’s, he’s got to make the change too. I don’t, I guess I get back into the, the depression.” (session 6, 2.7)

Her comment suggests that she identified her belief in her inability to control his behavior as significant in causing her depression. Her words “as much as I understand…” were indicative of greater weight being given to her feeling of responsibility. Her problem statement became more explicit during the following passage also from session 6:

Lisa: Um, well, his gambling. That’s part of it. It’s always been there in my mind. Like it’s something I can’t control. And I guess I, not that. I don’t feel responsible for it anymore, but it, it’s there, [I] can’t really do anything about it.
Th: So it kind of leaves you feeling that. Hopeless.
Lisa: Yeah. Hopeless. Um, yes, and I-I-I can’t reach out to him anymore. I tried, but I’ve given up. I feel I’ve given up on him. (session 6, 11.3–5)

This passage conveyed a sense of being stuck that is characteristic of stage 3, as exemplified by her comment, “I can’t really do anything
about it.” If she was not responsible for her husband, this led to feelings of helplessness. She described her feeling of helplessness using the metaphor of feeling caged in: “These bars that are down and I, I just can’t get out of them” (session 6, 12.14). Her sense of helplessness became even more poignant during the following passage, which occurred later in the session:

Lisa: What if he just never does [change]? You know, that’s his way. And he’s entitled to his way and I’m not going to hold myself responsible anymore.

Th: Yeah and so that’s s-sort of difference now is that, it’s not your fault.

Lisa: No. He has a choice, a choice like we all do. Um, and I don’t want to control him or be responsible.” (session 6, 16.12–14)

Lisa’s questioning about her husband clarified the dilemma she was placed in by her beliefs derived from her 12-step group. If she could not control his behavior and he would not change, she had no hope. Similar to stage 3 in the other themes that were assimilated, this stage was characterized by an insolubility. This conflict set the stage for an insight that would synthesize these opposing tendencies by an accommodation in the schema that allowed for the assimilation of the problematic experience.

In session 8, Lisa achieved a shift in focus that represented an accommodation in her “I am not responsible” schema (a new understanding — APES level 4). In the context of an unfinished business exercise with her husband, the following exchange occurred:

Lisa: I want to face it. I think it’s time that I face it all, and (sigh) it’s not easy. It’s painful.

Th: Tell him [husband, in the empty chair]. About the painful part, about facing it.

Lisa: Um, facing it is scary. It’s putting the blame on myself too. I know I’m responsible for a certain amount of it, um, I want to deny it. I want to be me. I want to, I want to enjoy life for what it is. Not—I’m tired of hiding. And I’m not going to hide for you [husband] anymore. I’m going to see it the way it really is.” (session 8, 14.14–16)

With this new understanding, Lisa seemed to recognize that her belief that she was not responsible may have been maladaptive. Becoming a separate individual required that she accept responsibility for herself. Lisa underlined this point later in the same session:

Lisa: It feels like I have, I have my life to live. I deserve that, um. I’m responsible for myself. I’m responsible.” (session 8, 19.14)

Recognizing the dysfunctional nature of her “I am not responsible” schema opened the way to assimilating the previously problematic experience. Lisa eventually resolved her dilemma by shifting from concern with responsibility for her husband’s behavior to concern with responsibility for her own behavior. Her new understanding was that if she was
responsible for herself, then she had hope, even if she did not attempt to control her husband. By accepting responsibility for her own life, Lisa resolved the sense of helplessness and hopelessness. The content of her responsibility was clarified in the following passages from her final session:

Lisa: I’m still sad, but (crying) I guess that’s, um, my choice. My choice of, um, just being. Being there in this marriage.

Th: Hmm, You’re saying that even though it’s a very hard place to be—

Lisa: Yeah.

Th: And it is hard, that somehow you feel responsible for it.

Lisa: Um, not for all of it. No.

Th: No.

Lisa: But for being in it. And, um, I guess, the commitment I feel. Maybe that’s where I feel responsible.

Th: That you feel responsible to your commitment.

Lisa: Right, right, you know, as a wife and as a mother. . . . That’s why I say, it’d be my choice to be there. (session 15, 22:1–9)

Thus, in Lisa’s reframing, she realized that although she may not have been responsible for the source of the pain (her husband’s gambling) she was responsible for her choice to stay in the painful situation (the marriage). This ability to differentiate which aspects of her pain she was responsible for and which aspects she was not appeared to be the helpful new understanding (APES level 4).

**DISCUSSION**

Lisa’s objective circumstances changed little during her treatment, yet her depression lifted (Table 1-1). Her husband did not stop gambling, but his problems lost some of their power to control her emotional state. At the end of treatment, Lisa marriage remained painful, but the pain was no longer compounded by depression. Thus, a client’s not making bold life changes (e.g., Lisa’s not leaving her husband) need not indicate therapeutic failure. Subtle processes, perhaps involving assimilation of problematic experiences and shifts in perspective, may yield dramatic improvements on measures of symptom intensity.

Of course, as in any study of a single case, we cannot be certain that Lisa’s therapy in general or her changed schema for responsibility in particular was a cause of her improvement. The responsibility theme was only one of several major themes in Lisa’s therapy (cf. Honos–Webb et al., 1998), and the therapy was only one aspect of her life. The case for the contribution of her reframing of her responsibility rests on theoretical and narrative coherence.
The theme of responsibility is central to the etiology of depression in some theories of depression. According to Beck’s (1967) cognitive theory, a primary feature of depression is self-blame—feeling overly responsible for negative events. According to Seligman’s (1975) learned helplessness theory, people become depressed when repeated attempts to control the painful events in their lives fail, and they learn that they are helpless—failing to accept responsibility for events in their lives. Abramson and Sackeim (1977) pointed out that, conjointly, these theories yield a paradox: The merging of Beck’s model and Seligman’s model of depression would result in the paradoxical situation of individuals blaming themselves for outcomes that they believe they neither caused nor controlled (p. 843).

In Lisa’s case, this paradox was not merely theoretical. These contradictory stances toward responsibility appeared to exist simultaneously within her: “I feel like it’s my fault (crying) ... and it shouldn’t. I’m not responsible for his actions (crying)” (session 1, 20.12–14). She felt both responsible for her husband’s gambling and helpless to control it.

Abramson and Sackeim (1977) suggested that “conceptual willingness to assume responsibility and to castigate the self for events beyond personal control signifies a belief in omnipotence” (p. 849). Lisa’s case suggested an alternative account. These two paradoxical aspects of depression appeared to reflect a negation of the self, illustrated by Lisa’s descriptions of herself as “attached to his belly button,” “I was like a twin,” “inside his body,” and “glued to him.” Feeling psychologically fused with her husband, she assumed responsibility and therefore blame for his behavior. Yet she was helpless. Her attempts to stop his gambling repeatedly failed.

Lisa resolved this paradox by differentiating which domains she was responsible for and which struggles she was not responsible for. She both accepted responsibility and learned to hold others responsible. She came to consider herself in control of her life by realizing she had chosen to stay in the marriage. Consistent with learned helplessness theory, although she was still sad, her perception that she was in control of her situation may have alleviated the sense of helplessness and hence the depression.

An abstract theoretical formulation of the “cause and cure” of Lisa’s depression using either of these theories alone would have missed the contradictory and intrinsically paradoxical nature of her sense of responsibility and the relationship of that theme to her depression. She both accepted too much responsibility (for her husband’s gambling) and she didn’t accept enough responsibility (for her choice to stay in the marriage). Her overcoming depression seemed to involve both giving up responsibility and accepting more responsibility.

In addition to illustrating the use of assimilation analysis as a qualitative research method, the case of Lisa illustrates how quantitative data may be
useful in a qualitative research project. This case was drawn from a randomized comparison of the effectiveness of PEP and client-centered therapy (Greenberg and Watson, 1998). In this larger study, the outcome measures were aggregated within each condition to yield an effect size to assess the “effectiveness” of each form of therapy, to permit generalizations about the therapy’s effectiveness across individuals.

Our assimilation analysis used the quantitative data differently, to explicate the context more clearly for the intensive analysis of a single case. The aggregate data located Lisa relative to other cases, allowing us to identify Lisa as the most successful of the PEP clients in terms of reduction in symptom intensity. We chose to study the case of Lisa because we felt that a person who experienced large reductions in symptom intensity would be particularly likely to exemplify successful assimilation. Quantitative data need not be restricted to making abstract generalizations in which the individual is lost.

Conversely, idiographic data from a qualitative analysis can contribute to an understanding of clients’ responses on standard nomothetic measures. As an illustration, we close by considering, speculatively, how Lisa’s responses to an item on the BDI changed across treatment in relation to the responsibility theme. On each of the BDI’s 21 items, the respondent endorses one of four statements, each scored from 0 to 3 points to indicate degree of depression.

Lisa’s responses to BDI item 8, which concerns self-criticism and self-blame, illustrated the complexity of her responsibility theme. During the pretreatment assessment, she endorsed, “I am critical of myself for my weaknesses or mistakes” (score of 1 point). During Mid treatment, she endorsed, “I don’t feel I am any worse than anybody else” (score of 0 points). This improvement may have been attributable to a strengthening of her belief that she was not responsible for others’ behavior. However, post-treatment she again endorsed, “I am critical of myself for my weaknesses or mistakes” (1 point). This was the only BDI item on which she regressed. We speculate that, once she assumed responsibility for her own behavior, she could be critical of her actions. During the final session, referring to her choice to remain in her marriage, she said, “If I decide to go that route it’s okay, and I can, if I make a mistake, then it’s only my fault and nobody else’s” (session 15, 13.13). Although Beck’s (1967) cognitive theory might consider this as a regression to self-blame, Seligman’s (1975) learned helplessness theory could view it as an improvement. Even if she made a poor choice, her perception of control might paradoxically be an improvement over her previous feelings of helplessness and hopelessness. Thus, this pattern of changes on BDI item 8 converges with our interpretation that Lisa’s assimilation of her problematic experience included both a decrease and a paradoxical increase in her sense of responsibility for her position in life.
REFERENCES


**BIOGRAPHICAL BACKGROUNDS**


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