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# Building a Meaning Bridge: Therapeutic Progress From Problem Formulation to Understanding

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Qualitative analyses of 2 clients' psychotherapies (client centered and process-experiential) investigated the developmental progression from formulating a problem to achieving an understanding of it. The results elaborated one segment in the 8-stage Assimilation of Problematic Experiences Sequence (APES), through which problematic parts of a person (described as *voices* to emphasize their active, agentic qualities) are thought to pass during successful psychotherapy, as they become assimilated into the self (described as *a community of voices*). The transition between APES Stage 3 (problem statement/clarification) and APES Stage 4 (understanding/insight) was described as a series of substages. The results highlighted the construction of meaning bridges—semiotic links by which the problematic voice could understand and be understood by voices of the community.

*Keywords:* assimilation model, APES, insight, meaning bridge, case study

There is a particularly satisfying period in many psychotherapies, after a major problem has been identified and formulated, during which clients work hard to understand the what and the why of their distress. The assimilation model (Stiles, 2002) considers this period as the transition between two stages on the eight-stage Assimilation of Problematic Experiences Sequence (APES): Stage 3, *problem statement/clarification*, and Stage 4, *understanding/insight*. In this article, we report our study of this transition in intensive qualitative analyses of two clients' psychotherapies. We observed a sequence of changes that we provisionally describe as substages of the APES. The APES and the proposed substages are shown in Table 1. These new substages represent an elaboration of one segment of the assimilation sequence, offering a more detailed account of how clients make sense of problematic experiences. We suggest that they describe a process familiar to many practitioners and researchers who have no knowledge of assimilation but who have witnessed clients actively struggling with internal conflicts and inching toward insight or a new perspective of their problems. Our aim is to build a better understanding of this process and to show how it fits into a comprehensive account of psychological change.

## THEORY-BUILDING CASE STUDY RESEARCH

Our approach can be described as theory-building case study research (Stiles, 2005a; cf. Fassinger, 2005; Morrow, 2005). Theory-building research begins with a current understanding, which is considered as *permeable*, that is, capable of being infused with and changed by new observations (Stiles, 1993, 2003a). The theory is not considered a rigid treatise to be voted up or down in light of supporting or disconfirming evidence. Rather, theory is a flexible (permeable) account that was constructed as a way of understanding previous observations and now must be elaborated, extended, qualified, and modified to encompass the observations at hand. This constructive process was termed "abduction" by the philosopher Charles Peirce (1965; Rennie, 2001). If the observations do not fit, then the theory has to change so that it incorporates the new observations while still making sense of the past observations upon which it was built. In this way, qualitative case study research can be cumulative (Stiles, 2005a). Theory-building research thus imposes a responsibility on investigators to be informed about the theory and previous research as well as to remain permeable to observations that contradict or go beyond the theory.

Our use of theory-building research assumes a constructivist epistemology within a realist ontology, elsewhere described as the *experiential correspondence* theory of truth (Stiles, 1981, 2005a). This suggests that a statement is true to the extent that the experience of hearing it corresponds to the experience of observing the events it describes. Observations and descriptions of observations, insofar as they represent human experience, are approximate, fallible, and variable across time and people. Nevertheless, within the limits of human communication, changes to theory, such as those developed in this study, must fit coherently into the array of assumptions, terms, mechanisms, and tenets that have evolved from previous research.

Theory-building case studies emphasize broad attention to the rich case material at hand—not just one or a few variables. Instead of trying to assign a firm confidence level to a particular theoretical tenet, as in hypothesis-testing research, the case study strategy examines multiple tenets in one study (Campbell, 1979; Stiles, 2005a). The small change of confidence in many theoretical assertions following a case study may affect confidence in the theory

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Table 1
*Stages and Substages in the Assimilation of Problematic Experiences Sequence*

| Stage number | Stage | Substage | Description |
|---|---|---|---|
| 0 | Warded off/dissociated | | Client seems unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance. Alternatively, problem may appear as somatic symptoms, acting out, or state switches. |
| 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 actively avoided. Affect involves unfocused negative feelings; their connection with the content may be unclear. |
| 2 | Vague awareness/emergence | | Client is aware of the problem but cannot formulate it clearly—can express it but cannot reflect on it. Affect includes intense psychological pain—fear, sadness, anger, disgust—associated with the problematic experience. |
| 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. |
| 3.2 | | Rapid cross fire | The problematic voice addresses dominant community but is abruptly cut off mid-sentence. Rapid cross-triggering of incongruent voices as they fight for possession of the floor. Voices speak for short periods of time with frequent interruptions. |
| 3.4 | | Entitlement | Problematic voice speaks for a longer period of time without disruption from the dominant community. The voice asserts itself forcefully, feels entitled; speaks with a demanding attitude. Affective expression tends to be assertive, angry. |
| 3.6 | | Respect and attention | Voices become more tolerant of each other. They listen to each other without interrupting and are more respectful of the other's position. They each speak for longer and more equal amounts of time. The content is less emotionally charged, and voices are less confrontational. (Voices begin to work toward problem solving.) |
| 3.8 | | Joint search for understanding | Voices work collaboratively and struggle to understand the problem more clearly; connections are made as awareness grows; approximations of insight become evident. Voices begin to blend and sound less distinctive. (They each sound less discrepant and become harder to identify.) |
| 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 with 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). |

as a whole, comparably to the large change in confidence in one or a few statements following a hypothesis-testing study. Observations on multiple cases may strengthen confidence in the theory even though each case is different and bears on somewhat different aspects (Rosenwald, 1988).

## The Assimilation Model

The assimilation model studies psychotherapy outcome by tracking small changes observable in the psychotherapeutic process (Stiles, 2002; Stiles et al., 1990). It describes how problematic experiences—painful or threatening memories, thoughts, feelings—can become integrated (*assimilated*) into the self. The assimilation model is not a treatment approach but a theory of change processes that are common across many approaches. The model helps make sense of the *equivalence paradox*—the observation that theoretically and technically different psychotherapies have similarly good outcomes (Luborsky, Singer, & Luborsky, 1975; Rosenzweig, 1936; Stiles, Shapiro, & Elliott, 1986; Wampold, 2001). Assimilation has been studied in cases of psychodynamic-interpersonal therapy, process-experiential therapy, client-centered therapy, cognitive–behavioral therapy, and family therapy (Field, Barkham, Shapiro, & Stiles, 1994; Honos-Webb, Stiles, & Greenberg, 2003; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Laitila & Aaltonen, 1998; Leiman & Stiles, 2001; Osatuke, Glick, et al., 2005; Osatuke, Gray, Glick, Stiles, & Barkham, 2004; Stiles et al., in press).

The model assumes that people's experiences leave traces (e.g., memories, skills, action tendencies, expectations) that can be reactivated, and it uses the metaphor of *voice* to emphasize the active agency of these traces. That is, the model suggests that experiential traces can speak and take action (Honos-Webb & Stiles, 1998; Stiles, 1997, 1999a). The self is construed as a community of voices, or interlinked traces of experiences. The community thus comprises the predominant perspectives of the client and the voices typically presented in interactions. Insofar as people are composed of voices, the actor is always one of the constituent voices. Having a repertoire of various voices—a diversity of active, agentic experiences—provides resources for dealing with diverse situations.

Voices are considered problematic if they are dissociated or warded off from the community or avoided or rejected by the community. Theoretically, a confrontation between a problematic voice and a dominant community is experienced as negative emotion—fear, anger, sadness, disgust, depression, or some other form of emotional pain (Stiles, Osatuke, Glick, & Mackay, 2004). Typically, the community opposes an emerging problematic voice initially, trying to ward off, suppress, or avoid the voice and the accompanying pain.

In therapeutic discourse, it is often possible to identify not only a distinct voice of the problem (i.e., problematic voice) but also a distinct voice from the community that opposes the problem, referred to as a *dominant* voice. As a caveat, the terms *problematic* and *dominant* refer to internal relationships, not necessarily to the content of a voice. Dominant voices may be interpersonally meek or may be considered dysfunctional, and so-called problematic voices may represent healthy ways of acting. Voices are labeled as problematic because they cause distress for the dominant community.

*Assimilation analysis* (Stiles & Angus, 2001; Stiles et al., 1991), an intensive, qualitative procedure for case study, seeks to identify these opposing internal voices (the problematic voice and the community representative) and track their expressions across sessions using recordings or verbatim transcripts (see Honos-Webb et al., 1999, for an extended example). We use the term *intrapersonal dialogue* to describe the alternating expressions of these opposing voices within a client's speech. The dialogue is not internal—it is actually spoken and observable—but it is spoken by one person and comprises alternating expressions of positions that may be directly contradictory.

The APES (see Table 1; Stiles et al., 1991) describes a sequence of stages through which problematic voices move in successful psychotherapy, from being unwanted and alien to becoming assimilated, useful members of a community. Problems may initially present at any APES stage, and any progress through the stages could be considered as improvement. Advancement to higher stages is associated with a more positive outcome (Detert, Llewelyn, Hardy, Barkham, & Stiles, in press; Stiles, 2002). In Detert et al.'s (in press) comparison of four good and four poor outcome cases, all of the good outcome cases reached APES Stage 4, whereas none of the poor outcome cases did so.

The present description of the eight stages represents a summary drawn primarily from a series of assimilation case studies of clients treated in a variety of psychotherapies (described above). Theoretically, a problematic voice becomes assimilated into the community by building *meaning bridges* to other voices. A meaning bridge is a word, phrase, story, theory, image, gesture, or other expression that has the same meaning for each of the voices it connects. Meaning bridges connect voices through their common understanding, allowing them to empathize and communicate with one another and engage in joint action. Meaning bridges thus allow voices to serve as resources; the voices can be called on when circumstances require their specific talents and capacities. Because meaning bridges are made of *signs*, such as spoken words, they are observable and can be studied empirically by analysis of recordings or transcripts of therapy sessions (Stiles, 1999a; Stiles et al., 2004).

## Voices Formulation of the APES 3-to-4 Transition

The APES, like the rest of the assimilation model, is a work in progress, continually being refined as new cases are analyzed (Stiles, 2003b). Observations in this study led to a substantial refinement: We abduced (in Peirce's, 1965, sense) a series of substages between APES Stage 3 (problem statement/clarification) and APES Stage 4 (understanding/insight), shown in Table 1 (see the *Results: The Case of Margaret* section for examples). The process of constructing meaning bridges is particularly open to analysis during this transition. By Stage 3, the problem is explicitly stated, in contrast to the disguised, distorted, indirect expressions of earlier APES stages (e.g., Varvin & Stiles, 1999).

Theoretically, when a voice is addressed, it seeks to respond. As the problematic voice engages a dominant voice from the community, an expression by one often triggers an opposing expression by the other. Such alternating, seemingly contradictory expressions can be observed as intrapersonal dialogue within sessions. This cross-triggering appears rapid in the early phases of the transition between APES Stages 3 and 4 (*rapid cross fire* and *entitlement* substages) and gradually slows as the voices build meaning bridges that allow them to understand rather than contradict each other (*respect and attention* and *joint search for understanding* substages). We used the decimal notation (3.2, 3.4, 3.6, 3.8) to convey the proposed order of the substages, to integrate the substages into the broader APES, and to try to be precise about our impressions. Though the numbers are equally spaced, we do not claim that the intervals are psychologically equal. Future researchers may rescale them or insert finer gradations (e.g., 3.1, 3.3). In our results, we describe the substages more fully and illustrate each with passages from the transcripts.

## Study Design

We studied the construction of meaning bridges during the transition between APES Stages 3 and 4 in two successful cases of time-limited psychotherapy, drawn from different therapeutic approaches. Each case has been the subject of other studies (Angus & Hardtke, in press; Greenberg & Watson, 1998; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; McLeod & Lynch, 2000; Osatuke, Glick, et al., 2005), but none of these studies focused on the 3-to-4 transition or considered substages.

We used the transcripts and audio recordings to conduct intensive qualitative assimilation analyses (Stiles & Angus, 2001). We decided to write this article when it became apparent that the first (client-centered) case we studied offered a particularly clear example of the transition between APES Stages 3 and 4. We synthesized observations from this first case into the proposed series of substages. We decided to study the second case after the analysis of the first case had been completed to determine whether and how the substages might be manifested in another case, particularly one taking a different therapeutic approach. We chose a process-experiential case that had been studied previously using assimilation analysis (Honos-Webb et al., 1998) and had shown evidence of problems moving from APES Stage 2 to Stage 5, thus including the APES 3-to-4 interval that was of interest. We used the previous study's APES ratings to help us locate the APES 3-to-4 segment in the transcripts and focused on those. We also used a different procedure for analyzing the second case than that used for the first, and we present the cases separately.

## Method

### Clients and Therapists

The two cases were drawn from the York University Depression Project, which compared the effectiveness of brief client-centered (CC) and process-experiential (PE) treatments for depression (Greenberg & Watson, 1998). All 34 participants in this project met the *Diagnostic and Statistical Manual for Mental Disorders* (3rd edition, revised; *DSM–III–R*; American Psychiatric Association, 1987) criteria for major depression, scored at least 50 on the Global Assessment of Functioning Scale (American Psychiatric Association), had experienced fewer than three previous episodes of major depressive disorder, and were not currently in treatment or on medication. The participants gave informed consent for researchers affiliated with the project to analyze session tape recordings and verbatim transcripts (excluding the names of people and places), along with the assessment measures, and to publish the results. They were randomly assigned to either CC or PE treatments, matched on their Symptom Checklist 90—Revised (SCL-90–R; Derogatis, 1983) Depression subscale scores. The therapy was conducted before the therapists had heard of the assimilation model, so neither treatment was explicitly guided by it. We focused on changes in the clients, but in the GENERAL DISCUSSION section, we comment on the therapists' differing approaches in CC and PE therapy.

*Case of Margaret.* The first case was Margaret (a pseudonym), a 58-year-old White woman who entered the project with moderate depression and concerns about her ailing marriage and letting go of her grown children. After her intake assessment, Margaret was randomly assigned to the CC condition and received 17 weekly sessions. Her depressive symptoms improved, and she was considered one of the most successful cases in the project. Her score on the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) went from a raw score of 21 at pretreatment to 11 at a 6-month follow-up, a change score of 1.68 standard deviation units. Over the same time course, her scores moved from 1.30 to 0.42 (0.60 standard deviation units) on the SCL-90–R and from 2.41 to 2.01 (1.00 standard deviation unit) on the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988).

Margaret's therapist was a female doctoral student in clinical psychology who had received 2 years of training in CC therapy prior to the project. She had had 24 weeks of additional training in the project's CC and PE treatment protocols. Therapists in the York project conducted the CC treatment using a manual that focused on Rogers' (1957) necessary and sufficient conditions: empathy, positive regard, and congruence (Greenberg, Rice, & Watson, 1994). In this classically nondirective treatment, therapists attempted to maintain an empathic understanding of their clients, share this understanding, and check whether this understanding fit their experience and was accepted by them.

*Case of Lisa.* The second case was Lisa (also a pseudonym), a 27-year-old White woman who entered the project with moderate depression and concerns about her husband's gambling problem. She was randomly assigned to the PE condition and received 15 sessions. Like Margaret, Lisa was considered one of the most successful cases in the study. Her marked improvement was illustrated by prepost changes of 25 to 3 on the BDI (3.7 standard deviation units). Over the same time course, her scores moved from 1.94 to .22 on the SCL-90–R (1.18 standard deviation units) and from 1.97 to .52 on the IIP (3.63 standard deviation units).

Lisa's therapist, too, was a female doctoral student in clinical psychology who had been trained in both the PE and CC treatment protocols. The PE treatment (Greenberg, Rice, & Elliott, 1993) was grounded in the same humanistic principles and techniques as the CC treatment, but the PE approach added an important *process-directive* element: When the therapist notices certain markers (a *process diagnosis*), he or she may intervene actively to direct the client through specified in-session activities, such as focusing or chair work. For example, Lisa frequently presented *unfinished business* with significant others in her life. Unfinished business is a marker that suggests an *empty chair* intervention. The client is asked to imagine that the significant other is sitting in an empty chair and invited to speak directly to them. At times, the client may also be asked to change chairs and take the part of the other. This enacted dialogue serves to heighten immediacy and emotional intensity.

### Investigators

Meredith Glick Brinegar, the primary investigator, was a White female clinical psychology graduate student in her 20s. She analyzed the Margaret case as part of her master's thesis in clinical psychology. Lisa M. Salvi, a White female clinical psychology graduate student in her 30s, joined the project after the initial analysis of the Margaret case was completed. The case of Lisa was analyzed jointly by Brinegar and Salvi. The other two investigators were White men in their 50s with extensive experience in psychotherapy research. William B. Stiles served as an auditor, reading most of the transcripts and regularly discussing the analyses with Brinegar and Salvi. Leslie S. Greenberg was the principal investigator in the York Depression Project. All authors participated in writing and revising this article.

### The APES

The version of the APES, shown in Table 1, has evolved over the course of many theory-building case studies, including this one (Stiles, 2003b). It represents a summary of our present understanding of therapeutic progress and a vocabulary to communicate investigators' qualitative interpretations precisely—a developmental sequence described in numbers as well as in words. The substages between Stages 3 and 4 were derived from observations of the case of Margaret and then adjusted so that the descriptions could accommodate the case of Lisa as well, consistent with our theory-building approach. Thus, formal reliability analyses were not appropriate in this study, though we made some relevant observations in the case of Lisa, noted later. Previous versions of the APES have been used as formal rating scales with acceptable interrater reliability (e.g., Detert et al., in press; Field et al., 1994; Honos-Webb et al., 2003; Stiles, Shankland, Wright, & Field, 1997).

### Assimilation Analysis of Margaret's Therapy

The primary investigator conducted an assimilation analysis of Margaret's whole treatment first, having regular discussions with the auditor and consulting with other assimilation researchers (Glick, 2002). Assimilation analysis is an intensive, qualitative approach to recordings or transcripts of therapy sessions (Stiles & Angus, 2001) that can be summarized in four steps.

Step 1 was familiarization and cataloguing. The investigator read and reread the case and constructed a sequential catalogue of the topics the client addressed (Stiles et al., 1991). Each entry in the catalogue was a restatement or summary of a *client thought unit* (defined as saying something distinct from the previous thought unit). These entries were indexed by session and line number to make it easier to find passages of interest in later stages of the research.

Step 2 was identifying problematic and dominant voices. Voices were distinguished by their content (what the voice talked about), intentionality (the voice's apparent reason or motivation for speaking), affect (specific emotions associated with the voice), and triggering characteristics (contextual events that seemed to elicit the expression of the voice). Voice characterizations were written to describe each voice and its relationship with the other voices. For example, the ways in which a voice was problematic for other more dominant voices were described. Intervoice conflicts and typical patterns of interacting were noted.

Step 3 was excerpting passages. The catalogue (from Step 1) was searched for words and phrases that represented the voices described in the

voice characterizations (from Step 2). Passages that seemed to represent the voice were located and excerpted. The product of the third step was thus a set of excepted passages representing each of the voices.

Step 4 was describing the process of assimilation represented in the sequence of passages. Each of the passages selected in Step 3 was assigned an APES rating, and the reasoning underlying each rating was noted—indicating how the passage fit into the broader, unfolding assimilation conceptualization. These APES ratings were not blind, independent ratings of separate passages but incorporated knowledge of the context of the case. Ratings were sometimes modified following discussion among investigators. We used the ratings, along with words, to convey our understanding of the process of assimilation as precisely as we could. A major product of Step 4 was the description of substages between APES Stages 3 and 4, as summarized in Table 1 and presented in detail later.

### *Assimilation Analysis Focused on the Substages in the Case of Lisa*

The assimilation analysis of the Lisa case used an iterative, consensual procedure that focused on the proposed substages between APES Stages 3 and 4. The addition of the second investigator and the consensual procedure were meant to enhance the trustworthiness of our interpretations. Periods of independent work by the two investigators alternated with collaborative meetings and meetings with the auditor to share individual results and perceptions. During the meetings, investigators discussed the strengths of each other's results and the criteria used in obtaining them. The iterations offered an opportunity for investigators to incorporate the strengths of each other's contributions and thus tended to facilitate consensus (see Osatuke, Humphreys, et al., 2005, for a more detailed description of the approach).

The earlier assimilation study of Lisa (Honos-Webb et al., 1998) had traced three problematic *themes*. The concept of themes was drawn from an earlier version of the assimilation model (Stiles et al., 1990) and is related to but somewhat different from the concept of voices. Thus, the first task in the Lisa analysis was to translate the previously identified themes into a voices conceptualization. We chose Lisa's primary theme, which involved anger and forgiveness, for our examination of the APES 3-to-4 transition. For this theme, the transition of interest was rated by Honos-Webb et al. as occurring during Sessions 2–8, so we focused on those sessions.

To construct a voices conceptualization, investigators began by working independently. They each read descriptions of the primary theme and then listened to audio recordings and read the transcripts of the seven targeted sessions. Their task was to distinguish salient voices and provide a description of each voice and a few illustrative passages. This represented Steps 1 and 2 of the assimilation analysis procedure, except that it was restricted to previously identified sessions and began with an expected focus on particular voices.

At the first collaborative meeting, the investigators shared their voice conceptualizations and passages. They highlighted the strengths of each conceptualization along with the criteria each had used in distinguishing the voices and selecting the representative passages. There was broad agreement on a dominant and problematic voice (characterized in the *Results: The Case of Margaret* section), with much overlap in descriptions. The investigators used similar words and phrases to describe these different voices, although their initial names for the voices differed. The investigators worked to agree on an accurate label for each voice and to produce a joint voice characterization that encompassed the strengths of the independent conceptualizations.

Investigators then returned to working independently. They excerpted passages that were spoken by or spoke about the dominant and problematic voices and assigned APES ratings, including categorizing the passages (as understood in context) into substages (Steps 3 and 4 of assimilation analysis). They were attentive to the possibility that some passages might not fit any substage. One investigator excerpted 55 passages representing the two voices, and the other excerpted 13. The latter had used a stricter standard, selecting only the most representative passages. Ten of each investigator's independently identified passages matched exactly or substantially overlapped, yielding a combined corpus of 58 passages. The investigators' initial independent substage ratings were identical on 9 of the 10 passages that both identified.

At the next consensus meeting, investigators presented their rated passages along with their rationale for their selections and APES ratings. Their discussions focused on explicit evidence for the substage ratings. They agreed on an APES substage rating between 3 and 4 for 40 of the 58 passages. These included 12 of the 13 passages originally identified by the second investigator, consistent with her use of a stricter standard. Of the 18 remaining passages, the investigators agreed that 5 should be rated in APES Stage 2 (i.e., below the range to which substages could be assigned); 8 passages were within the APES 3-to-4 range but provided insufficient information to judge the substage (interestingly, 5 of these were discussions of family history leading toward the insight); 1 passage was considered to have characteristics of several different substages; and 4 passages were considered as evidence of a substage by one investigator but as unratable by the other because she felt the therapist's direction of PE chair work in these passages left Lisa too little leeway to display a clear APES level. Chair work tends to highlight distinct voices and was involved in 37 of the 58 passages in the corpus, including 24 of the 40 passages with agreed-upon substage ratings.

### *Grounding of Interpretations*

We grounded our interpretations with passages from the transcripts. As Morrow (2005) put it,

> Just as numbers contribute to the persuasive 'power' of a quantitative investigation, the actual words of participants are essential to persuade the reader that the interpretations of the researcher are in fact grounded in the lived experiences of the participants. (p. 256)

The passages supply the multifaceted contact with theory that is essential in theory-building case studies (Campbell, 1979; Stiles, 2005a). Verbatim passages preserve the richness of the phenomenon being studied and honor clients' words (Ponterotto, 2005; Stiles, 1993, 2003a; Taylor & Bogdan, 1998). Line numbers are given to indicate the approximate location of passages within the sessions we studied, which ranged from 913 to 1,342 lines long.

## *Results: The Case of Margaret*

### *Overview: Margaret's Conflicting Voices*

We identified three prominent voices in Margaret's dialogue. We named them *Caretaker*, *Care for Me*, and *Self-Doubt*. In this article, we focus on the first two because their development between APES Stages 3 and 4, which proceeded gradually across approximately 9 of Margaret's 17 sessions, seemed to shed light on the process of building meaning bridges.

The passages we attributed to the Caretaker voice appeared to represent Margaret's dominant community, which guided most of her thoughts, feelings, and behavior. Margaret took pride in being able to skillfully look after her husband, children, and aging parents. She not only viewed her caring actions as implementing her love and affection but also felt a sense of obligation or duty to constantly attend to the needs of others. The Caretaker voice appeared to take up the challenge posed by the problematic Care for Me voice.

The passages we attributed to Margaret's Care for Me voice expressed feeling tired of being the caregiver and wanting others to

start taking care of her. There were complaints that she received little help or acknowledgment for taking so much responsibility for her family's problems, particularly from her husband, and expressions of resentment toward her loved ones for not providing her with reciprocal support. The Care for Me voice was problematic because it represented a part of Margaret that was highly discrepant from the dominant community (represented by the Caretaker voice). For many years, Margaret had suppressed or avoided the experiences of neediness and entitlement that her Care for Me voice embodied.

The Care for Me voice was rated as late in APES Stage 2 (vague awareness) in Session 1, and it gradually became assimilated into Margaret's community of voices, reaching APES Stage 6 (resourcefulness/problem solution) by Session 14. As treatment progressed, the conflicting voices slowly built meaning bridges to each other. We judged that the transition from Stage 3 (in which the voices and problem became clear) to Stage 4 (in which shared understanding was reached) took place between Sessions 3 and 11. Our presentation focuses on these sessions.

During this transition from APES Stage 3 to Stage 4, the Caretaker and Care for Me voices appeared to inch toward a joint understanding. At first, they were equally present and defensively sparring back and forth. The cross fire gradually slowed, and the two voices began to listen to and respect one another. They seemed to consider the other's perspective and eventually reached joint understanding of the problem. Margaret recognized her role in pushing others away by not asking for help and refusing help when it was offered. Throughout this sequence, Margaret first made progress resolving a part of her intrapersonal conflict and then transferred that progress to her interpersonal conflicts (particularly with her husband) outside of therapy.

We constructed a chronological chart listing the parallel changes in four domains, which could be classified as either *intrapersonal* (relations between internal voices, based on her behavior in sessions) or *interpersonal* (relations with other people, particularly her husband, based on her reports) and as concerning either *empathy and understanding* or *self-expression and assertiveness* (see Table 2). The chart shows how, across the APES 3-to-4 transition, Margaret (a) improved the relationship and shared purpose between voices; (b) increased her problematic voice's ability to hold the floor—to speak boldly without interruption in the intrapersonal dialogue and later the ability to engage in joint action; (c) reported increased empathy for others in her life, particularly her husband, and (d) asserted herself more in those relationships—at first abrasively, later more calmly and effectively.

### *APES Stage 3: Problem Statement/Clarification*

By Session 3, Margaret was able to give a clear statement of the problem (i.e., APES = 3), roughly, "I care for others because I love them and because it is my duty, yet I am tired of this and want someone to support *me*." At this point, the opposing voices were distinct in the session dialogue, and they recognized and had started to talk to each other. Although we rated the passage below from Session 1 as late in APES Stage 2 rather than Stage 3, it gives a clear statement of the problem in a relatively self-contained passage.

To highlight our understanding of the dialogue's meaning and emphasis, we present it in stanza form (Gee, 1986; McLeod & Balamoutsou, 1996). In this and subsequent passages, we indicate our interpretation by showing the problematic Care for Me voice (in italics) and the Caretaker voice (the community representative, in bold). Omitted speech within passages is indicated by ellipses points.

*Margaret:* **you know, my husband is a very nice person.**
**He's a very easygoing person you know.**
*But, I mean he's wrapped up in his job,*
*and its just that I-I know I don't understand it enough you know.*
*Like I just sort of feel like*
'hey, I've been giving, giving, giving to kids and the *husband for 30 odd years,*
*when is it going to be my turn*?' (Session 1: Lines 295–299)

### *APES Substage 3.2: Rapid Cross Fire*

APES Substage 3.2 was characterized by self-contradictory speech that we interpreted as a rapid cross-triggering of the opposing voices in the intrapersonal dialogue. The voices seemed to fight for possession of the floor. Expressions by the problematic Care for Me voice seemed to trigger contradictory or qualifying rejoinders from the dominant Caretaker voice, and vice versa. Neither voice spoke for long without being contradicted by the other. This style of interaction occurred primarily in Sessions 3 and 4. The following passage began with a problem statement, from a reported conversation with her husband: "I said, 'You know, I've been nurturing people for 30 odd years,' and I said, 'Isn't it about damn time [someone] started nurturing me?' and shortly thereafter continued:

*Margaret:* **When you've been from my generation,** [Therapist: 'Mm-hm.']
**you know that you've always got your husband's supper.**
**It's very difficult to change,**
**like to say, like,** '*get your own*' (slight laugh), **you know.**
**And, but, I know that he doesn't expect it,**
**because he has said 'If I [come home late?] that's my problem,**
**and if you're in the middle of something . . .',**
**because**
*for a long time,*
*if I was in the middle of something,*
*I did resent it.*
*I felt, well, I had my dinner.*
*He's-he's the one who's ruined the routine,*
*not me.*
*Why should I stop what I'm doing?*

*Therapist:* Right.

*Margaret:* **But I still felt I should do it. (laughs)**
**Because this is my generation, you know.**
**And, um,**
*but I resented doing it.*
**So, I kind of, I'm sort of resolving that as I go along.**
(Session 3: Lines 310–334)

Both intrapersonal and interpersonal empathy were shallow. During this time, Margaret reported that, in her relationship with

Table 2
*Observations in the Case of Margaret at Four Intermediate Substages Between Stage 3 (Problem Statement/Clarification) and Stage 4 (Understanding/Insight) on the Assimilation of Problematic Experiences Sequence (APES)*

| | Domain of observation | | | |
|---|---|---|---|---|
| | Intrapersonal (observations of in-therapy dialogue) | | Interpersonal (reports of behavior outside of therapy) | |
| APES substage | Empathy, understanding | Self-expression, assertiveness | Empathy, understanding | Self-expression, assertiveness |
| 3.2 Rapid cross fire | Awareness of opposing voices without listening. | Constant back and forth.<br>Neither voice could speak for long without qualification. | Shallow empathy for other persons. | Withdrawing care.<br>Assertion of needs to self but not to husband. |
| 3.4 Entitlement | Dominant voice listened but did not fully respect the problematic voice. | Problematic voice held the floor to greater degree.<br>Many fewer qualifications from dominant voice. | Margaret considered that husband may have different perspective. | Problematic voice expressed in a demanding, explosive manner. Pleading for understanding.<br>Margaret expressed anger and asserted needs in frustration. |
| 3.6 Respect and attention | Dominant voice more empathic; listened to and respected problematic voice.<br>Less differentiation between the conflicting voices. | Problematic voice able to hold floor without interruption. | Margaret listened to and respected husband's perspective. | Problematic voice calmer, less abrasive.<br>Margaret expressed needs more confidently in therapy; later shared needs with husband more calmly.<br>Husband started providing emotional support, listening without interruption. |
| 3.8 Joint search for understanding | Understandings had a shared quality, could not be ascribed to one voice.<br>Incongruent voices listened to each other and offered tentative understanding. | No longer relevant; both voices engaged in joint understanding. | Margaret struggled with the role her husband played in their strained relationship as well as her role in keeping him distant. | Interactions with husband were less strained; much less nagging and argumentation with husband.<br>Instead, able to hold fruitful discussions. |

her husband, she started withdrawing her unconditional care. As the passage illustrates, she sometimes refused to cook if he was late returning from work. However, her descriptions were full of verbal cross fire; she would decide to withdraw her care but then hesitate and contradict herself—wanting to do it yet feeling guilty for abandoning her husband's needs. She expressed her needs in therapy in this back-and-forth manner, but she was not yet able to communicate them clearly to her husband.

In the following passage from the middle of Session 4, however, Margaret reported starting to place her husband's perspective alongside hers. She asserted that she had needs too, and, although she still felt guilty, she was becoming more accepting of them:

*Therapist:* So, I don't know,
maybe you haven't actually gone (client blows nose) in and been able to really tell him how you feel about it?

*Margaret:* **No. Not really.**
**So, I think he's caught** [pause]
**he's caught between his job and me. You know, and,**

*Therapist:* Mm-hm.
So, almost when you see it from his perspective maybe he is kind of caught.

*Margaret:* **Yeah. He's caught.**
**I mean he has** [pause] **so much to do right now.**
**And he like he's dealing with people.**
**He's trying to like he's trying to relocate staff and you know relocate jobs and one thing and another. And** [pause]
**I can sympathize** [pause]
*and a few years ago, I might have been able to handle it better.*
*But, I just find that I've because a very*
[pause] *not to myself*
*I'm thinking, well what about me?*

*Therapist:* Yeah.

*Margaret:* You know, and (incomprehensible)
**maybe I'm feeling guilty because of that.**

*Therapist:* So, something has changed for you.

*Margaret:* *Mm-hm.*

*Therapist:* **It's like maybe a few years ago, I could accept this,**
*but now I want something for me.*

*Margaret:* *Mm-hm.* (Session 4: Lines 414–436)

## *APES Substage 3.4: Entitlement*

Across Sessions 4–8, Care for Me became bolder. This voice seemed to feel more entitled to speak, and it did so for longer periods at a time. The Caretaker voice was relatively subdued, slower to insert qualifications or objections. The reduced opposition allowed more opportunity for the Care for Me voice to speak. The community seemed to listen more but not to fully respect the Care for Me voice's position, leading the latter to express itself in a demanding, explosive manner.

*Margaret:* *I became very resentful you know.*
*And I said, 'You just wait a minute. . .*
*I'm your wife,*
*my feelings are important too. . .*
*I just needed you as a sounding board.'*
*He said*, 'don't forget M,'
He said, 'If you want a sounding board,
you have to be prepared for an opinion too . . .'
He said, like, 'you may be wrong.'
*And I said*, '**Well maybe you do have a point'** (laughs).
*But 'at the same time,*
*that's Not Really What I want.'*

*Therapist:* Right.

*Margaret:* *. . . I just want somebody to just sit there and listen.*

*Therapist:* Yeah.

*Margaret:* *Just like I do with you, you know.* (Session 4: Lines 579–592)

As noted in Table 2, Margaret started asserting her needs to others, but usually as a frustrated reaction to perceived mistreatment. She told her husband, "I felt really hurt. I wanted you to listen and you didn't" (Session 4) and proudly noted that this was the first time she had said, "This is what I wanted from you." Nevertheless, she reported that after expressing this to her husband, she dismissed him without giving him the opportunity to respond to her needs. She began to consider that he might have a different perspective, but she did not really empathize with him, just as her internal voices did not fully empathize with each other.

The following passage illustrates Margaret's increased assertiveness and anger toward her husband as told to her therapist:

*Margaret:* *Like he* [husband] *interrupted me* [pause]
*and you know,* [Therapist]
*I don't know what came over me,*
*but you know I just lost it completely.*
*I got so angry* [pause] *and I was (laughing)* [pause]
*I was yelling at him*
*'don't you dare interrupt me.'*
**And it was just, it was stupid.**
**But it was just.**
*I couldn't hold myself in I was so angry and so incensed,*
*that you know that he dared to interrupt me.*
*And he said, 'but Margaret, why didn't you just say "shut up,* [Husband],
*I was talking?"' (laughs)*
*It would have been so simple,*
*but you know,* [Therapist] *I couldn't.*
*I was just, and I don't know whether it was* [pause]
*reaction* [pause] *or what it was.*
*But I was just, I was so angry.*
*I said, 'You know you've been doing this to me'*
*and actually* [Husband] *does have a habit* [pause] *he anticipates what you're going to say.*
*And I said you know 'you've been doing this to me for so long,* [Husband]'
and I said, 'I'm not taking it any more.'
*And I was actually, I was literally screaming at him.*
(Session 7: Lines 162–173)

Margaret probably could not have calmly said "shut up," as her husband had suggested because her dominant Caretaker voice

would not have responded that way. Instead of her usual caretaking response, the Care for Me voice stepped in and exploded in anger.

### *APES Substage 3.6: Respect and Attention*

In Sessions 8 and 9, the Care for Me voice appeared to have gained the right to proceed without interruption. This seemed to reflect the voice's new capacity to speak without being so abrasive and demanding, whereas the Caretaker voice seemed to demonstrate greater empathy or capacity to listen to the opposing experiences. The Care for Me voice no longer had to scream to be heard:

*Margaret:* **This is basically what I'm trying to do** [Husband].
*'I [want to] sound off to you.'*
**But he became so defensive . . .**
**I said, 'It's like this power struggle between us.'**

*Therapist:* Mm-hm.

*Margaret:* '**I'm not trying to start anything.'**
**'I just wanted someone to bounce it off . . .**
**some moral support,**
**that was all.'** (Session 8: Lines 839–847)

The intrapersonal atmosphere of mutual respect and attention led to a calmer, more productive exploration of the conflict in therapy. These intrapersonal changes were echoed by a growing interpersonal respect toward her husband. Margaret reported that she had started sharing her needs with her husband in a calmer, less defensive fashion. She began to listen and consider his perspective. She moved beyond acknowledging that his viewpoint might differ and began to treat it as valid. Her husband responded by providingmore emotional support and listening with fewer interruptions. The following passage is an example of Margaret considering her husband's perspective. The underlined text represents the beginning of a joint understanding:

*Margaret:* . . . I can sympathize with [Husband] in many ways too, and, and yet you sort of find like, when you get his reaction to things,
like, now the other night, what was it?
He started to tell me something,
and then I said [pause]
and I said this sort of half kidding, you know
like 'Ah, come on,' I said, 'these guys are giving you some of baloney' or something like that.
And he said, 'Well, wait until I finish,' you know.
And I thought, I guess I'm doing to him what I used to say.

*Therapist:* Hm.

*Margaret:* You know.
And I said, 'Well, I'm sorry.'
And ah, he said, 'Well, okay.'
And I felt silly.
And then I, you know I thought,
well, instead of thinking of yourself, think of how he felt.
I mean, I must have made him feel sort of stupid
when I said . . .

*Therapist:* Mm-hm.

*Margaret:* 'Oh, come on,'
you know like, I don't believe this you know . . .

*Therapist:* Mm-hm.

*Margaret:* But, I find, our reactions to things are a little different but, um, I can be a little more understanding than I used to be. (Session 9: Lines 1071–1095)

### *APES Substage 3.8: Joint Search for Understanding*

Session 10 was marked by explicit efforts to understand the problem. The two voices seemed to listen intently to one another and to offer tentative understandings. These understandings seemed to be shared; that is, they could not be easily ascribed to one particular voice. In the following passage, we have made separate attributions (shown as italic and bold), but we found this difficult and arbitrary. Portions of this 10-min passage have been omitted:

*Margaret:* *I just nagged him!*
*I was actually looking for things to nag him about.*

*Therapist:* Mm-hm.

*Margaret:* *And I thought, why am I like this?*
*I know I'm contributing to this, sort of,*
*I guess maybe he just gets tired of listening to me and shuts me out* . . . (Lines 458–465)

*Therapist:* And yet, and there are probably things *he's* doing
to contribute to the way they are now,
but you're saying but there are also things *I* do

*Margaret:* M**m-hm** . . . (Lines 473–477)
**he was trying to help me you know** . . . (Lines 596–597)
*it's almost like verbal abuse that I was giving him,*
*and I feel bad* [pause]
but I do it and I can't stop myself . . . (Lines 617–619)
**I think sometimes he shuts me out**
**because I'm sure it's very painful for him too, you know.**
*Maybe this is just his way of coping,*
*he just shuts me out.*
*And then, ofcourse, I become more frustrated.*
(Session 10: Lines 458–797)

As noted in Table 2, Margaret actively struggled with the role her husband played in their marital difficulties as well as her role in keeping him distant. She reported much less nagging and argument; instead, they were able to hold fruitful discussions. In the following passage, Margaret was very close to reaching a full insight:

*Margaret:* I'll admit like, it really was a bad time,
and as I say,
part of it was my fault too,
I guess maybe I pushed [Husband] away in a lot of ways so that he got to the point he thought 'okay, that's the way she feels,
she can, I'm not gonna, you know, try any more.'
Even now he's very careful what he says about my family (laughs).

*Therapist:* So somehow that started this kind of thing
where he was afraid to maybe say,
or get involved?

*Margaret:* Mm-hm.

*Therapist:* It was more like, he thought you wanted him to keep his distance?

*Margaret:* Yeah, I think yeah.
And, and I think,
and then when something like that happens, it leads to other things too, you know,
like quite unwittingly I think people just say,
'Okay fine enough, if that's the way she wants it,' or . . .

*Therapist:* Yeah, maybe he, just kind of,
I can imagine him maybe just getting confused about what you did want.

*Margaret:* Yeah.

*Therapist:* Just kind of feeling like,
maybe you need some space
when it sounds like probably that was the last thing you really wanted.

*Margaret:* Yeah.
I just needed somebody. (Session 11: Lines 941–964)

### *APES Stage 4: Understanding/Insight*

The gradual working toward understanding across the substages led to a classic moment of insight in Session 11, an "aha" experience. The pieces came together; the understanding lost its tentativeness and was expressed with conviction. Both voices felt understood and could understand each other. Empathically taking her husband's perspective, Margaret realized that she had been systematically pushing him away whenever he offered to help. Consequently, he felt alienated. Not knowing that the Care for Me part of her longed for help, he withdrew his support:

*Margaret:* *. . . .I never thought about it this way until now but, maybe, he felt so left out too, maybe!*
*He just felt left out.*

*Therapist:* When . . . [you] were consumed with what was going on with your family. . . maybe he felt, left out
and maybe helpless.

*Margaret:* *Yeah, you know I never looked at it that way before.*
*I just always . . . had this feeling of resentment*
*that my, my sole support* (slight laugh) *wasn't there.*

*Therapist:* Uh-huh, like he should have supported you more.

*Margaret:* *Yeah,*
**and maybe he just felt left out you know that,**
**as I say, I was so consumed with my parents,**
**that maybe I pushed him out of my life? . . .**

*Therapist:* Maybe he didn't know how to help or?

*Margaret:* **Yeah.**

*Therapist:* Maybe he didn't know what you needed at the time

*Margaret:* *. . . yeah, you know, I never thought of it that way, isn't that strange,*
*. . . I guess maybe I was just so angry*
*and so let down and, you know*

*Therapist:* And maybe there was a lot of hurt there that wasn't being expressed, too. (Session 11: Lines 1100–1123)

This understanding was reached jointly, but it can be viewed from the perspective of either voice. The Care for Me voice might have said to the Caretaker, "You felt threatened when your husband tried to help and ended up pushing him away with your need to be caring." The Caretaker could have responded, "Yes, and you never spoke up to let him know that you really needed some emotional support and recognition, so how can we blame him for not helping."

### *Progress in Later Sessions*

As she applied her understanding, Margaret's relationship with her husband improved and she began generalizing this success to other areas of her life. In her final two sessions, Margaret described letting go of her Caretaker role in regard to her daughter's wedding:

*Therapist:* So that was new for you.
To be able to kind of relax and just let it flow.

*Margaret:* **Mm-hm.**
**And I thought, fine.**
**And then I thought, if anything happens, it's not, you know,**
*someone else can worry about it.*
*I just sort of took this attitude, like okay,*
*there's people taking care of things at the church*
*and there's people taking care of things at the hotel,*
*and so what* (laughs).

*Therapist:* So somehow in the past you might have,
I guess, worried or fretted?

*Margaret:* . . . **I know I would have been a wreck.**

*Therapist:* Uh-uh.

*Margaret:* **And actually to be perfectly truthful with you,**
*I really enjoyed myself.*
*I had a good day.* (Session 16: Lines 138–161)

## *Discussion: The Case of Margaret*

The meaning bridge between Margaret's problematic Care for Me voice and the community's representative Caretaker voice seemed to be a shared understanding of how her need to be caring had led her to deny her own needs, to hide them from others, and to push others away when they saw her neediness and tried to respond. In the quoted passage from Session 11, the words began to express an understanding that was shared by both voices (e.g., "I was so consumed with my parents that maybe I pushed him out of my life?"). The understanding appeared to be not merely an intellectual appreciation, but a visceral sense of connection between the two previously separate realms of experience. It allowed each voice access to the experiences represented by the other and

formed a basis for joint action—ways of living that incorporated both caring for others and caring for self.

The process of building this meaning bridge—of reaching this understanding in therapy—seemed well described as a sequence of gradually slowing cross-triggering between two opposing internal voices. At first, each was quick to interrupt and contradict the other, but gradually each voice learned to recognize and more fully understand the other's words, and thus became increasingly effective at conveying the experience of each voice to the other. To summarize the APES 3-to-4 sequence we observed, Margaret's Care for Me and Caretaker voices first (3) explicitly recognized each other (i.e., the problematic experience was expressed and characterized) and (3.2) rapidly fired their opposing views at each other (i.e., Margaret seemed to interrupt and contradict herself in successive utterances). Next (3.4), as the Caretaker voice began to listen rather than interrupt, the Care for Me voice became more assertive and bolder, holding the floor for longer periods of time and expressing entitlement to be heard. After several sessions, this led to (3.6) a period of mutual respect and attention, in which the expressions became less strident as the voices seemed to be trying to understand and be understood by each other. The respect and attention developed into (3.8) an active search for a mutual understanding—acknowledging the other's perspective and trying out new, joint ways of considering events. This culminated in (4) a mutual understanding, or insight. Across this 3-to-4 transition, Margaret's affect became calmer, and her reported encounters with her husband changed in parallel with changes in the in-session expressions of her internal voices (see Table 2).

The therapist's role in facilitating this assimilation of Margaret's problematic voice involved empathic understanding for each voice in turn (see Stiles & Glick, 2002). Thus, the understanding achieved between Margaret's internal voices was largely preceded, step by step, by the therapist's understanding of each expressed position, whether congruent or contradictory to the previous one.

## *Results: The Case of Lisa*

### *Overview: Lisa's Conflicting Voices*

We called Lisa's dominant voice *Empathic Supporter*. She was devoted to filling the needs of others, especially her husband, casting herself as a good and accepting wife. Empathic Supporter always made an effort to accept her loved ones, even when they committed major mistakes or hurt her. Empathic Supporter usually forgave others' mistakes by placing herself in their shoes ("I can understand why he would do that—he was just feeling stressed"). She occasionally felt hurt but told herself, "Just take it. . . it's best just to forgive." This part of Lisa felt unworthy—and often guilty—for not being a good enough wife. Empathic Supporter believed that her husband's gambling problem occurred because she had not taken good enough care of him. Empathic Supporter learned from her parents that it was best to stifle all negative emotions.

*Resentful Fighter* was the problematic voice that emerged in opposition to Empathic Supporter. This voice expressed great anger at being treated unfairly and seemed to wish that those who had hurt her (father, husband) would suffer a similar pain. For example, during an empty chair procedure, she said, "I hope you suffer" in a hurtful and demanding tone. These wishes were kept in check by Empathic Supporter, who was quick to chastise: "It's not right to have such thoughts . . . we're all supposed to forgive. Your role is to support your husband, not criticize him." Resentful Fighter felt more worthy and entitled than did Empathic Supporter and frequently made statements like "I deserve to have my needs met." During therapy, the therapist systematically encouraged the expression of this problematic voice.

Across the 40 passages with agreed ratings, the consensual APES substage was correlated .70 with session number, consistent with assimilation of Resentful Fighter into the community. This correlation was far from perfect, however, and there were many examples of higher substages preceding examples of lower substages. We consider this issue in the *Discussion: The Case of Lisa* section. Passages that best characterized the substages when presented out of context were selected to ground our interpretations in the following sections.

### *APES Stage 3.0: Problem Statement/Clarification*

Of the 40 passages with agreed substage ratings, 7 were rated at 3. These occurred in Sessions 2–6. In the following passage, Lisa described her anger and resentment toward her mother for assigning her so much responsibility as a child. Lisa resented having to care for her younger siblings and felt she missed out on being a child herself. We rated this passage at APES Stage 3 because *Resentful Fighter* (in *italics*) expressed negative feelings about being mistreated as a child, while **Empathic Supporter** (in **bold**) was equally present, advocating forgiveness.

*Therapist:* *So there's this part of you that really feels that, strong resentment toward her*

*Lisa:* *Yeah, yeah,*
**and then the other part wants to just,**
**you know, forgive and carry one** [Therapist: Mm-hm.]

*Therapist:* So, those are likely conflicting forces with you right, like almost like two complete discrepant voices, *that one's saying 'No, no, no, she should pay.'*

*Lisa:* *Yeah,*
**and the other is like, you know,**
**'forgive, she's your mother and she's human,**
**she makes mistakes, too.'** [Therapist: Uh-huh.]
[pause] I feel like I'm caught [pause]
like a yo-yo (laugh). you know,
going back and forth [Therapist: Uh-huh.], um,
[pause] and it feels good to finally let that out. (Session 2: Lines 283–292)

### *APES Substage 3.2: Rapid Cross Fire*

Lisa's conflicting voices were judged to reach stage 3.2 solidly by Session 4, but the 10 passages rated at Stage 3.2 were found in Sessions 2–6. As an example, we chose the following passage from Session 5, although it occurred later in therapy than did our subsequent example of Stage 3.4 because the abrupt shifts between Resentful Fighter and Empathic Supporter are easily understandable out of context. Lisa was discussing her husband's gambling problem:

*Lisa:* **Right, and then I guess sometimes I feel guilty, that I should be, supporting more,** [Therapist: 'Um-hum.'] [pause] *but then what about my needs?*

*Therapist:* Yeah, so then you go back there,
it's like, 'Well, what about me?' Right? (Lisa*: 'Yeah.'*)
What about what I need?

*Lisa:* *That's right, yeah,*
*what, what I feel is comfortable inside me*
*and* [Therapist: 'Um-hum.']*, and for my kids and,*
[Therapist: 'Um-hum.']
*and I deserve this, and* [Therapist: 'Um-hum.']
*I'm a person and I'm going to, uh, look after myself*
[pause] **but, I feel like I'm abandoning him,**
**like, as a wife I shouldn't**.

*Therapist:* [pause] Yeah, but it's just this thing telling you [Lisa: *Um-hum.*] [pause] if you were a good wife you would stick by him

*Lisa:* **Yeah, yeah, it's almost like I would allow him**
[pause] **I should allow him to,**
**to treat me this way,**
**and, and do these things to me [Therapist: Um-hum.]**
**and just be there for him, [Therapist: Um-hum.]**
*and the other side is* [pause]
*you know, I've had enough* [pause]
*that's it . . . I want to, um . . .* [*Therapist: Um-hum.*]
[pause] *I want to fulfill my needs too.* (Session 5: Lines 107–123)

### *APES Substage 3.4: Entitlement*

Resentful Fighter was rated at Substage 3.4 in passages drawn from Sessions 3–8, though the strongest expression appeared in Sessions 4–6. In the next example, from Session 4, Resentful Fighter expressed her resentment toward her husband in a more forceful manner, and Empathic Supporter did not interrupt.

All 11 of the agreed examples of Substage 3.4 in Lisa's therapy were drawn from PE chair work. This example was drawn from an empty chair procedure in which the therapist was directing Lisa to speak to her husband (imagined, in the empty chair):

*Lisa:* *Yeah, you're not* [pause]
*you're just not there for me.*

*Therapist:* Tell him what you feel about that.

*Lisa:* *Um, you're not supportive at home,*
*and it makes me angry, and,*

*Therapist:* Tell him about that anger,
tell him how you're angry,
tell him what you resent,
is it, 'I resent you not being home?'

*Lisa:* *Yeah, yeah. 'I resent you not being*
[pause] *being home* [pause]
*and doing something with me or the children,*
*um, and when you're there, you think you've really put in,*
*you know, your days' work,*
*but really it's nothing*
[pause] *it's not good enough to me or the kids.'*

*Therapist:* So, 'I resent you not,'

*Lisa:* *'Not being there yeah, just* [pause]
*if there's something to do, you just*
[pause] *you don't say*
*I need your help,*
*you just nag about it*
*that I should be taking care of everything*
*and being supermom.* (Session 4: Lines 745–761)

### *APES Substage 3.6: Respect and Attention*

After expressing this demanding (and uninterrupted) resentment for a few sessions, Resentful Fighter began to soften, and Empathic Supporter reentered the picture in a different way. All eight of the passages rated 3.6 were in Sessions 7 and 8. The following example shows a more balanced relationship between the two voices. They appeared to be respectfully listening to one another while discussing Lisa's husband. Lisa simultaneously acknowledged her husband's position (that he had a problem and was likely in pain) and admitted that she was hurting too. This passage, like the last one, was taken from an empty chair procedure:

*Lisa:* *I'm going to go along and hide it.* [Therapist: Uh-huh.]
*I'm not going to do that anymore because*

*Therapist* 'I'm not going to hide it anymore,'
tell him

*Lisa:* *'No, I'm not going to hide it anymore,*
**you may be in pain, and I,**
**I understand that,**
*but so am I* [*Therapist: Uh-huh.*]

*Therapist:* 'I feel this too,
I feel pain too,'

*Lisa:* *'Yeah, I feel pain, too,*
*just like you do.'* (Session 8: Lines 756–765)

### *APES Substage 3.8: Joint Search for Understanding*

As Lisa's conflicting voices listened to each other, they began to tackle the issue of her husband's gambling problem in a more cooperative fashion. The three examples of Substage 3.8 occurred in Sessions 7 and 8. In the following passage, Lisa said she wanted to face her problem instead of denying negative feelings and conflict. Resentful Fighter and Empathic Supporter seemed to be making joint statements, each taking responsibility for part of the problem and agreeing to work through it despite being scared. This passage was drawn from an empty chair exercise and occurred slightly earlier than the example of the preceding substage, though both were in Session 8. The text seemed not clearly attributable to one voice or the other, as both appeared to look at the problem together:

*Therapist:* So, I'm not going to deny it

*Lisa:* No, no, I want to face it, [pause] I think it's time that I,
[pause] I face it all, and (sigh)
it's not easy,
it's painful [Therapist: Mm-hm.].

*Therapist:* Tell him about the painful part,
about facing it.

*Lisa:* 'Um, facing it is scary,
it's putting the blame on myself too
[pause] I know I'm responsible for a certain amount of it
[Therapist: Mm-hm.], um I [don't?] want to deny it,
I want to be me [Therapist: Mm-hm.],
I want to,
I want to enjoy life for what it is not,
I'm tired of hiding [Therapist: Mm-hm.],
and I'm not going to hide for you anymore. [Therapist: Mm-hm.]
I'm going to, going to see it the way it really is' [Therapist: Mm-hm.]. (Session 8: Lines 606–617)

### *APES Stage 4: Understanding/Insight*

By the end of Session 8, Lisa realized that she had accepted more bad treatment in her life than she should have. She saw her own role in maintaining her husband's behavior and accepted partial responsibility. Furthermore, Lisa saw this pattern as an echo of her mother's interactions with her father. Late in the following passage, there is evidence of a new problematic voice expressing a sense of loss and broken dreams, whose emergence seemed facilitated by the resolution of the conflict between Resentful Fighter and Empathic Supporter:

*Lisa:* Yeah, it's a natural pattern (laugh),
it's, it's part of my life,
and yeah, I've accepted,
I guess I've accepted more than what I should have.

*Therapist:* Mm-hm, tell him [pause]
I've accepted much more than I should have.

*Lisa:* Yes, I've accepted much, much more
and put up with a lot more than,
than what I should have
[pause] I should have said put a
should of put a stop to it from the beginning (crying) [Therapist: Mm-hm.],
and, um, um maybe it wouldn't have gone this far (crying) [Therapist: Um-mm.].

*Therapist:* When you say this,
what do you think about?

*Lisa:* Um, I think it's a lot time lost [Therapist: Um-mm.],
um, a lot of time hurting myself.

*Therapist:* Uh huh, and a lot of pain that you felt, right?

*Lisa:* Uh hm, and for not putting the energy into other things.

*Therapist:* Hm, so you have just sort of been locked away
since you know for a long time.

*Lisa:* Yeah, I guess that,
I guess that's what the pain is (crying) [Therapist: Yeah.],
and why,
why have I allowed it (crying) [Therapist: Yeah.]?

*Therapist:* Asking yourself, 'Why did I allow him, to hurt me?'

*Lisa:* [pause] yeah,
and um, um, I,
I know it's probably a pattern from,
um, coming from my mother
because she allowed it,
and I believed that was the only way. (Session 8: Lines 672–697)

### *Discussion: The Case of Lisa*

The meaning bridge between Resentful Fighter and Empathic Supporter appeared to be an understanding of what role Lisa had played in maintaining the poor treatment from her husband, for example, by not standing up to him and making her needs known. Unlike Lisa's previous blaming of herself for her problems (e.g., attributing her husband's gambling problem to not being a good enough wife), this new sense of responsibility represented a more balanced, dynamic view. She acknowledged that her husband was in the wrong but saw how her own behavior had maintained a pattern of misery and discontent for many years. She no longer felt the abuse was entirely her own fault (as she had felt at the beginning of therapy) or entirely her husband's fault (as she felt midtreatment).

Lisa built this meaning bridge by first acknowledging her feelings of anger and resentment (i.e., allowing her problematic voice to emerge and forcefully express its needs; APES Substage 3.2 and 3.4). She then developed an understanding that her failure to stand up to her husband followed a pattern she had learned long ago from her mother. The two prongs of this meaning bridge (accepting an appropriate sense of personal responsibility and placing the problem in historical/familial context) pointed Lisa toward ways to remedy the situation.

We were able to find good illustrations of each of the postulated substages within Lisa's intrapersonal dialogue, and Lisa's progress through the substages appeared broadly similar to Margaret's. The sequence was less clear in Lisa's case, however, as illustrated by the out-of-sequence examples we presented. All of the agreed examples of Substages 3 and 3.2 were in Sessions 2–6, and all those of Substages 3.6, 3.8, and 4 were in Sessions 7–8. However, within those ranges, substages were sometimes out of sequence, and examples of Substage 3.4 were found in Sessions 3–8.

Why were some passages out of the expected sequence? The following possibilities are not mutually exclusive, and several may have contributed to the out-of-sequence manifestations we observed (see also Stiles, 2005b).

Measurement error: The investigators may have misclassified some passages, perhaps because the substages were inadequately described.

Substage recycling: Clients may need to recycle through adjacent substages to deal with closely related threads of a problem. Alternatively, life events may produce setbacks that must be overcome by rehearsing some therapeutic work. Thus, clients' progression may not be strictly linear, as general advancement is accompanied by local recycling.

PE chair work emphases: While providing good examples of voices, PE chair work may exaggerate manifestations of some substages at the expense of others. For example, all 11 agreed

examples of Substage 3.4 (entitlement), but only 2 of the 10 agreed examples of Substage 3.2 (rapid cross fire), were drawn from chair work. Lisa's PE therapist may have directed Lisa to enact entitlement either before or after she would have done so on her own.

Work in the zone of proximal development (ZPD): More generally, directed exercises, such as chair work, may have pushed Lisa ahead so that she achieved higher APES levels than she could have done on her own, an effect that can be considered as a manifestation of the therapeutic ZPD (Leiman & Stiles, 2001; Osatuke, Glick, et al., 2005; Stiles et al., in press). Vygotsky (1978) defined the ZPD 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" (p. 86). Though originally used for understanding children's cognitive development, the ZPD concept has been extended to APES-denominated progress in psychotherapy, "as the segment of the APES continuum within which the client can proceed from one level to the next with the therapist's assistance" (Leiman & Stiles, 2001, p. 315).

Substage conceptualizations: Perhaps our conceptualization of the substages needs modification. For example, combining rapid cross fire (3.2) with entitlement (3.4) and respect and attention (3.6) with joint search for understanding (3.8) yields a simplified set of substages that would fit both of our cases reasonably well.

## GENERAL DISCUSSION

Although the out-of-sequence examples qualify our confidence in the substage descriptions offered in Table 1, our observations of Margaret and Lisa were consistent with the theoretical proposal that assimilation between APES Stages 3 and 4 is characterized by a declining antipathy and growing respect among internal voices. Manifestations in the intrapersonal dialogue included reductions in contradiction and greater respect and reconciliation between positions, moving toward understanding and joint action.

Differences between Margaret's and Lisa's patterns of substage progression may reflect differences in their therapists' approaches. In retrospect, the clarity of the substages in the Margaret case may reflect her CC therapist's relatively less aggressive use of the ZPD. CC therapists aim to stay with the client rather than leading the client. Framed in APES terms, this central principle in CC theory implies that CC interventions should be aimed at the client's current APES stage; clients are trusted to advance at their own pace. We suggest that Margaret's Caretaker and Care for Me voices justified this trust by moving smoothly and steadily (and, for researchers, clearly) across the APES substages toward reconciliation.

By contrast, Lisa's more directive PE therapist used chair work to actively facilitate movement toward higher levels of understanding along relatively narrow threads of the problem, for example, actively encouraging expression of anger and resentment in the passage from Session 4 illustrating Substage 3.4, above. Such advances may be followed by recycling to pick up another thread of the problem at an earlier APES substage. Such repeated recycling can lead to a jagged or saw-toothed pattern of progress through the APES in PE therapy, in contrast to a relatively smooth pattern in CC therapy. A similarly saw-toothed pattern has been observed in a case of cognitive–behavioral therapy, another, perhaps even more directive treatment (Osatuke, Glick, et al., 2005). Insofar as both of these cases could be considered as successful by conventional (symptom intensity) indexes, this account may contribute to an understanding of how contrasting therapeutic approaches can be equivalently effective. We hasten to add that our focus in this study was on common processes of change rather than on the merits of particular treatment approaches.

The APES 3-to-4 transition was neither the beginning nor the end of the assimilation of Margaret's Care for Me voice or Lisa's Resentful Fighter voice. These voices each appeared to be in the painful APES Stage 2 (vague awareness/emergence) when therapy began, and both later progressed beyond Stage 4. In later sessions, each client continued to work through her understanding, making the new meaning bridge more efficient and effective. Our focus on the 3-to-4 transition reflected our taking an opportunity to present a relatively fine-grained exploration of a particular segment of the assimilation continuum. We do not mean to imply that this segment is more important than other segments.

The conflicts between Margaret's Care for Me and Caretaker voices and between Lisa's Resentful Fighter and Empathic Supporter voices appeared to be central issues in these therapies. These conflicts were similar to conflicts observed in other cases of depression (e.g., Honos-Webb et al., 1999; Osatuke et al., 2004). Common features have included a suppression of personal needs or an active denial of personal worth or deservingness, which circumstances had brought into conflict with an overriding sense of duty, responsibility, or obligation to care for others (cf. Stiles, 1999b). Margaret's and Lisa's psychological changes occurred in a cultural context in which women were gradually gaining greater support for finding and expressing their own voice in domestic relationships. Both became more able to assert their needs to their male partners in ways that were closely intertwined with their progress in treatment, as illustrated in Table 2. Margaret and Lisa, like the previously studied cases, also had additional problems that were addressed in therapy but were not the focus of this article.

Elaborating the APES sequence with these substages can be understood as a contribution to the reflexive validity of the assimilation model. *Reflexive validity* refers to whether a theory is changed by the observations it encounters (Lather, 1986; Stiles, 1993, 2003a). A valid theory, according to this concept, can expand to incorporate new ideas as it is applied to new data. A theory that becomes rigid and impermeable to new information cannot support active research. In addition to the new substages, this study elaborated the concepts of meaning bridges and intrapersonal dialogue and the process of achieving insight in psychotherapy. In these ways, observations of Margaret and Lisa have permeated the theory, changing and extending it. Of course, the value of these contributions will have to be assessed in future research. For example, will researchers observe these substages in the intrapersonal dialogue of further cases? Will the substages be recognizable in the intrapersonal dialogue of clients treated for problems other than depression? Can substages be delineated within other APES intervals?

Lisa and Margaret were highly successful cases by conventional criteria, consistent with Detert et al.'s (in press) finding that good-outcome clients (as assessed by BDI change) were more likely than poor-outcome clients to have achieved APES Stage 4 in therapy. In two nominally unimproved cases that have been studied, what appeared as lack of improvement on standard symptom intensity inventories appeared in assimilation analyses as progress that began at a relatively early APES stage and progressed to an intermediate point (APES Stage 2 or Stage 3, characterized by negative affect) by the end of treatment (Glick, 2002; Honos-Webb et al., 1998).

We note that this study represented intensive analysis of only two cases by a small group of investigators with a prior commitment to the theoretical concepts being examined. Although the quoted passages offer readers some direct grounding for our interpretations—and there were other, similar examples in the transcripts—the passages were, nevertheless, selected by us and hence potentially subject to selection biases.

The assimilation model sensitized us to the phenomenon of cross-triggering and to its gradual slowing and abatement over the interval between formulating the problem and reaching an understanding of it. We believe, however, that these phenomena would be recognizable to therapists and researchers whether or not they subscribe to the assimilation model. We hope our observations will attune practitioners to clients contradicting and rebutting themselves or respectfully considering alternative internal viewpoints. Therapists' awareness of such manifestations of internal conflicts may help them facilitate clients' internal communication and the creation of meaning bridges.

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