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THE ASSIMILATION PROCESS OF PROBLEMATIC EXPERIENCES AND LONG-TERM OUTCOMES IN PSYCHOTHERAPY FOR DEPRESSION: COMPARING A RELAPSED AND A NON-RELAPSED CASE

Beatriz Viana[1,2], Ricardo Machado[1,2], William B. Stiles[3,4,5] João Salgado[1,2], Patrícia Pinheiro[1,2], & Isabel Basto[1,2]

[1]*University Institute of Maia (Portugal)*
[2]*Center of Psychology, University of Porto (Portugal)*
[3]*Department of Psychology, Miami University, Oxford, Ohio (USA)*
[4]*Appalachian State University, Boone, North Carolina (USA)*
[5]*Metanoia Institute, London (UK)*

Abstract

Over the years, research has demonstrated that psychotherapy is an effective treatment in different psychopathological conditions. However, which are the mechanisms or processes involved in therapeutic change that could explain its efficacy are not yet clear. The Assimilation of Problematic Experiences Model describes change in therapy as a process that occurs through the gradual assimilation of problematic experiences in the self – higher levels of assimilation seem to be associated with a better outcome at the end of therapy. However, little is known about the contribution of this process to the maintenance of therapeutic gains after the end of therapy. In the current study we aimed to explore how the level of assimilation achieved throughout therapy is associated with relapse prevention after treatment. We analyzed two good outcome cases of Emotion-Focused Therapy, previously diagnosed with depression: one case that remained asymptomatic and another that relapsed one year and a half after the end of therapy. The Assimilation of Problematic Experiences (APES) was used to assess the assimilation levels achieved and the Beck Depression Inventory-II (BDI-II) was used to assess the intensity of depressive symptoms. Five therapeutic sessions and three follow-up sessions were rated using the APES. The results showed that higher APES levels were associated with lower intensity of symptoms at the end and after therapy termination, being associated with relapse prevention in depression. These results suggest that a complete assimilation of the problematic experiences may help clients to maintain therapeutic gains reducing the probability of relapsing in depression.

Keywords: *Depression, assimilation of problematic experiences, change.*

1. Introduction

The Assimilation Model of Problematic Experiences has been used in an attempt to explain how change occurs throughout the therapeutic process (Stiles, 2001, 2011). According to this model, change occurs through the integration of problematic experiences into the self, over eight stages, measured using the Assimilation of Problematic Experiences Scale (APES; Caro-Gabalda & Stiles, 2009). Previous studies demonstrated the relation between success in therapy and an increase in terms of assimilation of problematic experiences (Basto et al., 2018; Stiles, Shapiro, Harper & Morrison, 1995), but there are few studies analyzing the relation between assimilation and relapse prevention. In this sense, we aimed to understand how assimilation grows during and after the therapeutic process and consequently, to explore what is the relation between this therapeutic process and the maintenance of gains after the end of the therapy.

The Assimilation Model argues that self is composed by a community of voices that emerge as representative of the experiences lived by people throughout their lives (Stiles, 2001). Dominant voices from the self-community are assumed as habitual ways of being and thinking, guiding the people's behavior (Honos-Webb, Surko, Stiles & Greenberg, 1999). Experiences associated with uncomfortable or painful episodes arising from life events may result in the emergence of problematic voices, inconsistent with self-community dominant voices (Stiles, 2002). The emergence of problematic voices into the self is associated with the creation of an internal conflict between problematic and dominant self-voices, where

the problematic voice is rejected and ignored by the self (Honos-Webb et al., 1999). The inability to integrate these problematic experiences or voices into the self generates psychological suffering and, in some cases, psychopathological conditions, such as depression (Stiles et al., 1990).

To track the gradual assimilation of problematic voices into the self-community of voices, the APES was developed. This 8-points scale allows the moment-by-moment identification of the clients' assimilation level during psychotherapeutic sessions (Caro-Gabalda & Stiles, 2009; Stiles, 2001).

Across different therapeutic approaches and psychopathological conditions process-outcome research has pointed out a relationship between therapeutic outcome and the growth in terms of APES levels (Honos-Webb et al., 1999; Stiles et al., 1995). Specifically, with regard to Major Depressive Disorder cases (Basto, Pinheiro, Stiles, Rijo & Salgado, 2016; Basto et al., 2017), empirical studies highlight the association between higher levels of assimilation and positive therapeutic change. In this sense, the assimilation of problematic experiences has been proposed as a common factor for change in psychotherapy (Detert, Llewelyn, Hardy, Barkham & Stiles, 2006).

2. Method

2.1. Aims

The present study aimed to investigate the potential role of clients' assimilation of problematic experiences in preventing relapse in depression. Specifically, we investigated how assimilation level grows during and after the therapeutic process and what was the relation between such growth and the maintenance of gains after the end of therapy

2.2. Participants

The participants were part of the project "ISMAI Depression Study", which aimed to compare the effectiveness of Cognitive-Behavioral Therapy (CBT) and Emotion-Focused Therapy (EFT) on depression (Salgado, 2019). The two cases included in the current study were selected from the EFT good-outcome cases (N = 18). Cases were selected based on their therapist (same therapist, N= 6) and relapse status at 18 months follow-up assessment according to BDI-II scores (BDI-II > 13; BDI-II < 13). These were the only two cases that fitted such criteria: Elizabeth (non-relapsed case) and Helen (relapsed case). Both clients received 16 sessions of therapy and 6 follow up sessions. Elizabeth was diagnosed with a mild Major Depressive Disorder, moderate episode, recurrent. The client showed major difficulties managing her role as a mother and as a woman after her divorce. Helen was diagnosed with a single, moderate episode of Major Depression. The client suffered with pressure and guilt associated to the management of professional and familiar demands.

The therapist was a Portuguese woman in her early thirties. She was a PhD clinical psychologist with 9 years of clinical experience and 4 years of experience in Emotion-Focused Therapy.

2.3. Instruments

The BDI-II (Beck, Steer & Brown, 1996) is a self-reported questionnaire composed of 21 items to assess the intensity and severity of depressive symptoms. Each item is answered in a Likert scale from 0 to 3 points. The total score results from the sum of all items response, ranging from 0 to 63 points. Higher scores represent more severe symptoms. The adaptation to the Portuguese population by Coelho, Martins, and Barros (2002) has a good internal consistency (Crohnbach's Alpha = 0.89).

The APES (Caro-Gabalda & Stiles, 2009; Stiles, 1999) is composed by eight stages representative of the assimilation of problematic experiences. These stages are numbered from 0 a 7, where 0 corresponds to the total avoidance of the problematic experience, and 7 corresponds to its complete integration into the self-community of voices (Stiles, 2001; Basto et al., 2017). When clients moved up to a higher APES level it is considered to be advance, while when they moved back to a lower level it was considered a setback (Stiles, 2001).

2.4. Procedures

BDI-II was used at the beginning of all therapeutic sessions. Three follow-up sessions were selected: 1, 6 and 18 months after therapeutic termination. These therapeutic and follow-up sessions were transcribed according to Mergenthaler and Stinson recommendations (1992).

Training (Basto et al., 2017; 2018) on the APES procedures lasted approximately four months, with weekly meetings of approximately one hour each. First, papers about the assimilation model were analyzed, as well as the coding manual. Then, training cases were independently coded until a good inter-judge agreement has been reached (ICC > 0.65; Cicchetti, 1994). After finishing the training period, the PhD researcher and the Master' students coded APES in each case, following the procedures described by Stiles and Angus (2001). The discrepancies between coders were solved by discussion until consensus

was reached. The agreement level was calculated using the Intraclass Correlation Coefficient (ICC). The ICC Elizabeth case was 0.973 (ICC [2, 3]), and in the Helen case it was 0.887 (ICC [2, 2]), both being considered good levels of inter-rater agreement (Cicchetti, 1994).

The longitudinal association between the client's assimilation levels and the intensity of clinical symptoms was computed using the Simulation Modeling Analysis Software (SMA; Borckardt & Nash, 2014). To explore multiple temporal associations between variables we computed Pearson rho tests based on SMA cross correlation models. On the other hand, to obtain mean APES level for each session, we averaged APES ratings across passages of themes within each session.

2.5. Results

In Elizabeth's case (non-relapsed case) was possible to identify a dominant voice that presents itself as self-demanding – "I have to live up to my idealization as a mother and woman" and a problematic voice – "My difficulties as a mother and woman". In an initial phase (session 1), lower levels of assimilation were identified (APES 2 and 3). Throughout the working phase of therapy (sessions 4, 8 and 12) higher levels of assimilation were identified: APES 3 to 6. In the final phase (session 16) the most frequent APES level was 5. After the end of the therapeutic process it was possible to verify the maintenance of the gains acquired during the therapy, namely Elizabeth maintained higher levels of assimilation of understanding regarding the problem and the strategies used to solve it. Throughout the follow-up sessions, the assimilation levels have increased to APES 6 and 7. In the last the follow-up (18 months), the most frequent APES level corresponded to 6, although, excerpts encoded with APES 7 were identified in this session. Elizabeth demonstrated a total resolution of the problem.

In Helen's case (relapsed case) it was possible to identify a recriminating and demanding voice (dominant voice) related to the need to be perfect – "I have to do everything perfect" – as well as a problematic voice that directly contacts the failure and that makes her feel vulnerable – "I'm a failure". In an initial phase (session 1) lower levels of assimilation were identified (APES 2). In the working phase of therapy (sessions 4, 8 and 12) there were several improvements to higher assimilation levels (APES 4 and 5), although the most frequent level corresponds to APES 2. In the final phase of the process (session 16) there was an improvement in assimilation level, being the most frequent level coded the APES level 4. After the end of the therapeutic process it was possible to verify a several advances and setbacks. Throughout follow-up sessions, the most frequent levels were APES 3 and 5. In the last follow-up (18 months), there was a sharp setback in terms of gains, although the problem was recognized. Despite the fact that problematic voice was heard, the dominant voice drowned outits expression. The client's needs were expressed but the gains are not consolidated and there was still a need to work on the problem.

In both cases it was possible to identify a significant negative relationship between assimilation levels and depressive symptoms: Rho = -.71, p = .05 (Elizabeths's) and SMA Rho = -.92, p = .002 (Helens's; Borckardt & Nash, 2014). In the Elizabeth's case it was possible to see a gradual increase of depressive symptoms along with a decrease in the APES levels. The analysis of the follow up sessions showed that the assimilation levels remained high (average values above 5), with a slight increase over time, while the depressive symptoms intensity remained low. In the Helen's case, during the acute phase of treatment, as well as in the follow-up sessions, the increase in assimilation levels appears accompanied by a decrease in depressive symptoms. Helen started the process with lower levels of assimilation (around APES 2), showing a vague awareness of problematic experiences. Throughout the process, it was possible to identify a growth in terms of assimilation. After the end of the process, it was possible to observe a growth to average levels (APES 3 and 4), followed by a setback in the last follow-up (18 months).

2.6. Discussion

Elizabeth presented a gradual positive growth through the therapeutic process, as well as in the follow-up sessions. There was a more linear growth reaching higher levels (APES 5 and 6). The existence of these levels (APES 6) during the final phase and, subsequently, throughout the follow-up sessions seems to be an indicator of change realization, as well as of the consolidation of the gains acquired during the therapy. This result is congruent with the assimilation model: as the experience is assimilated into the existing community it no longer has as much impact on the client's life, leading to a decrease in depressive symptoms. The stability founded in the final phase appears to be indicative of the problem resolution. Although there was some reticence, initially, in confronting the dominant voice, the client managed to do it successfully, having evidenced a constant effort to achieve and maintain a solution to the problem she brought to the therapy. After the end of the therapeutic process it was possible to see the gains obtained throughout the process. Elizabeth showed higher assimilation levels over the 18 months after the end of therapy, reaching a total resolution of the problem (APES 7). This means that the problematic voice has been integrated into the community.

Helen showed a growth in terms of assimilation and symptomatologic improvement resulting from the work on the problem and the awareness of it. Despite achieving higher assimilation levels, APES 6 weren't achieved, neither during the acute phase of treatment or after the end of process. In her case, a set of setbacks were evident throughout the assimilation process. This may indicate the existence of new understandings and some application of these in daily life, but not a structured and sustained change that would be evident in the presence of higher levels (APES 6 and 7) of assimilation. In general, it was possible to verify that as the experience is worked on and integrated, the depressive symptoms decrease. On the other hand, it was evident that the presence of setbacks in assimilation appears to be associated with increased intensity of depressive symptoms. Subsequently, it was possible to verify the presence of average levels of assimilation (APES 4) in the final phase of the process, as well as throughout the first follow-ups, in which the client remains with depressive symptoms below the cut-off point. Despite this, the analysis of the last follow-up session showed the presence of lower assimilation levels, accompanied by an increase in symptomatology, with a therapeutic setback.

Comparing the two cases, it was possible to verify the existence of a negative relationship between the intensity of depressive symptoms and the APES levels identified. The association of results in terms of assimilation of problematic voices in the self with the reduction of depressive symptoms confirms the existing studies (Basto et al., 2016; Leiman & Stiles 2001). In this sense, it is possible to affirm that the gradual integration of the problematic voice with the community of voices appears to be directly associated with the reduction of clinical symptoms and consequently with the return of psychological well-being. On the other hand, both cases showed improvements and setbacks throughout the process, although these were more significant in Helen. This may indicate that, in her case, the change process was still in an active phase of the assimilation process, that is, the complete assimilation of the problematic voice with the existing community has not yet been achieved. These are consistent with previous studies confirming the irregularities throughout any therapeutic process. Despite this, they don't imply therapeutic failure (Caro-Gabalda & Stiles, 2009), as can be seen in this study, both cases were therapeutic successes. The setbacks seem to corroborate this idea: the client appears to be in a change phase, where the problematic voice assimilation and consequent reorganization of the community of voices has not yet been finalized. The setbacks arise as a result of the voices confrontation and it doesn't result as a problem for the process, indicating that the client is in the active phase of the assimilation process (Basto et al., 2018; Caro-Gabalda & Stiles, 2016).

Levels equal to or greater than APES 4 seem to be related to therapeutic success and to a decrease in terms of symptoms (Goodridge & Hardy, 2009). Our results are consistent with this idea, once both cases reached levels equal to or higher than APES 4, being possible to relate the assimilation progression with change in therapy. Despite this, only Elizabeth managed to reach levels above APES 5 during the acute phase of treatment. On the other hand, in Helen's case, the maximum levels identified correspond to APES 5. Elizabeth corresponds to a successful case during and after the end of therapy, having APES 6 levels have been identified either in the acute phase of treatment or during follow-up sessions. This may indicate that APES 6 may be associated with a more structural and sustained change, as reflected by the maintenance of gains after the end of the therapeutic process (Basto et al., 2017, 2018). An explanatory hypothesis for the present results may be related to the fact that reaching level 6 in terms of assimilation can act as an important mark in preventing relapse and allowing the maintenance of gains. This seems more evident when, after the end of the therapy, APES 7 is achieved, synonymous with a complete integration of the problematic experience, as in Elizabeth.

In Elizabeth's case, there was a complete resolution of the problem, resulting from the implementation of concrete resolution strategies. Thus, level 7 seems to be associated with therapeutic success, in cases where the client can fully assimilate the problem and use it as a resource. At the same time, this means that the problematic voice is fully integrated within the community of voices, being accepted in the self.

3. Conclusions and limitations

The main conclusions are essentially related to: 1) any therapeutic process presents advances and setbacks, in terms of APES levels and symptoms; 2) higher APES levels appear associated with lower intensity of symptoms; 3) assimilation is characterized as a gradual process; and 3) levels equal to or greater than APES 4 appear to be associated with a good prognosis regarding the outcome at the end of therapy; 4) levels equal to or higher than APES 6 may be related to a good prognosis in terms of maintaining the therapeutic gains and preventing relapse.

This study presents as main limitation the impossibility of analyzing all sessions of both cases. Despite this, this study contributed to the enrichment of the assimilation model.

Regarding clinical practice, the identification of specific levels associated with therapeutic success may act as a facilitator in terms of preventing relapse. The identification of specific APES levels can act as a facilitator for the process, as well as for the therapist, to move their interventions in order to make it possible to obtain these same levels.

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