ABSTRACT

CLIENTS’ ASSIMILATION OF THE VOICE OF THEIR THERAPIST

By James K. Mosher

This study is a theory building investigation of clients’ assimilation of their therapist. The assimilation model posits that individuals accumulate and organize threads of experience into constellations around central people, events, or experiences. These constellations may be expressed as voices. In particular, the therapist may form a center around which the client’s in-session experiences are associated and organized into a voice—called the voice of the therapist. Five interviews with former psychotherapy clients about their experiences with their therapists were analyzed using a modified form of the qualitative method of assimilation analysis. Based on case observations, a tentative theory of how clients assimilate the voice of their therapist was articulated as the Assimilation of the Therapist Sequence.
CLIENTS’ ASSIMILATION OF THE VOICE OF THEIR THERAPIST

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Introduction

For many clients, therapy may be a profound and significant life event that stands apart from all others. Clients may associate their experience in therapy with the resolution of a personal issue, the achievement of more satisfying interpersonal relationships, or a time of personal exploration and enhanced self-understanding. These significant events experienced in therapy may be inextricably linked to the other person—the therapist—with whom they were shared.

Considering the potential personal significance of therapy, clients accordingly often report having thoughts, feelings, or fantasies about their therapists and therapy both between-sessions and following termination (Geller, Cooley, & Hartley, 1981). Often, clients say such imaginal experiences of the therapist are helpful and comforting (e.g., Arnold, Farber, & Geller, 2000; Knox, Goldberg, Woodhouse, & Hill, 1999; Rosenzweig, Farber, & Geller, 1996). Indicating the clinical importance of these events, some theorists (e.g., Edelson, 1963; Singer & Pope, 1978) have posited that such internalization of aspects of the therapist and the therapeutic relationship by the client are key components in successful therapy.

The assimilation model is a description of psychological change in therapy (Stiles, 1992, 2002; Stiles et al., 1990, 1992) which posits that experiences come to be represented as voices (Honos-Webb & Stiles, 1998). This study suggests, in particular, that a client’s experiences with their therapist may be organized into a coherent internal voice—the voice of the therapist. This thesis offers a theoretical account of how clients internalize their therapists and assimilate their experiences with them, thereby extending the assimilation model (Stiles, 1992, 2002). The Assimilation of the Therapist Sequence (ATS)—adapted from the Assimilation of Problematic Experiences Sequence (APES; Stiles et al., 1992; Stiles, 2002)—is an articulation of this theory, describing changes observed in clients as the voice of the therapist is assimilated.

The Assimilation Model

The assimilation model is an account of psychological change in therapy (Stiles et al., 1990, 1992; Honos-Webb & Stiles, 1998) describing clients’ progress as they work through the problematic experiences that compelled them to seek treatment. Drawing upon Hermans’ (2004; Hermans, Kempen, & van Loon, 1992, Hermans, Rijks, &
Kempen, 1993) concept of internal multiplicity, the assimilation model posits that individuals are comprised of multiple voices. A voice is a constellation of associated experiences. Conceptually, at the center of a voice is a significant person, event, or experience and organized around this nucleus are threads of associated experiences. When an individual encounters a situation, cognition, or emotion similar to an experiential thread contained within the constellation, the voice is addressed. That is, the voice of the experience may emerge and speak (Honos-Webb & Stiles, 1998).

When a voice speaks, it is said to be positioned. A position is observable as a real-world stance—such as an opinion, action, behavior, statement, or feeling—taken by a person in response to an object, situation, person, or aspect of the self. Thus, positions are understood as observable manifestations of voices. People typically take characteristic positions, and the observation of such repeated positions allows for the inference of a voice’s presence (Stiles et al., in press).

Normally, voices are assimilated; that is, coherent and fluid links exist between them. This network of connected voices is said to form a community of voices. The community defines the individual’s center of experience, sense of self, or personality. Assimilated voices contained within the community may act as flexible resources for the individual, to be called upon or to emerge as needed. For example, a man’s experience and memories of being nurtured by his parents may guide his future behaviors, thoughts, and feelings when caring for his own children. However, some voices represent experiences, events, or people that were in some way troubling, painful, or traumatic (Stiles, 1992; 2002). Conversely, one’s experience and memories of being humiliated by his parents as a child may later emerge as a voice that assumes positions similar to that of his parents. Encounters between this problematic voice and community voices may generate painful emotions such as shame and self-loathing. Accordingly, this voice may then be warded off or avoided by the community.

Despite such defenses, problematic voices tend to speak when experiences contained within them are addressed. That is, experiences recalling aspects of a problematic voice may prompt it to emerge and take a position. When a problematic voice emerges, however, it conflicts with the positions of voices within the dominant community of voices. It is these conflictual encounters between voices (i.e., problematic
and community) that generate psychological pain, as the positions of problematic voices are experienced as being incompatible with the individual’s normal sense of self. As in the previous example of the man humiliated by his parents, the voice of that experience may be incompatible with the community voice believing he is a worthwhile person. Because of the dysphoria associated with these encounters, problematic voices are typically disconnected from the community and remain unassimilated.

When voices are able to communicate, however, they may come to understand and accept one another. This change in the nature of their relationship is achieved through the creation of meaning bridges (Brinegar, Salvi, Stiles, & Greenberg, 2006; Honos-Webb & Stiles, 1998; Osatuke, Humphreys et al., 2005). A meaning bridge is a sign—a word, phrase, action, or idea—that provides voices with a means of communicating about shared experiences. Through the creation of meaning bridges, voices that were once dissociated may begin to speak and resolve their differences. For example, in the case of Margaret, a needy care for me voice was incompatible with the dominant caretaker voice that demanded she always care for others. Thus, the emergence of the care for me voice and encounters between it and the caretaker voice were experienced as problematic. A meaning bridge was represented by a phrase from session 11 (i.e., “I was so consumed with my parents that maybe I pushed him out of my life?”), marking a shift in intellectual and experiential understanding, as Margaret recognized her tendency to prevent others from caring for her and to push them away when they tried to do so (Brinegar et al., 2006).

As problematic voices talk with the community, the experiences they represent then become accessible to it as well. In so doing, these experiences may become community resources. Returning to the example of the man humiliated by his parents, his awareness of that experience and his ability to access it may allow him to treat and respect his own children appropriately. In assimilation, clients advance through a sequence of stages whereby a warded off voice is encountered and emerges, it becomes understood through the creation of a meaning bridge, the new understanding is applied to the problematic voice, the client resolves and gains mastery over it, and the voice becomes a resource (Stiles et al., 1990, 1992). The APES (see Table 1; Honos-Webb & Stiles, 1998, Stiles et al., 1992; Stiles, 2002) depicts this sequence of change.
Theory Building Research

A theory is a series of logically constructed statements that attempts to describe or account for a real-world phenomenon (Stiles, 1981). The statements contained within a theory, however, do not provide truth. Instead, the truth of a theory may be evaluated by the correspondence of its words and statements with the observations that are brought to bear on it. The common denominator in evaluating this relationship, then, is *experience*. That is, both the words of a theory and the observations are experienced by someone. The degree to which the experience of each (i.e., words in a theory and observations) corresponds may indicate the degree to which the theory is true. Such an epistemological perspective is called the *experiential correspondence theory of truth* (Stiles, 1981, 2005).

In theory-building psychological research, theories are said to be *permeable* (Stiles, 1993, 2003). Within this paradigm, a theory is considered a series of flexible and tentative statements. The challenge to the researcher is to incorporate new observations into the theory, while simultaneously respecting, elaborating, or reinterpreting old observations. In so doing, the statements and words of a theory may be reconciled with observations, so as to offer a better approximation of observed events. Thus, a theory may be adjusted and changed to enhance its correspondence with observations.

A multiple case study approach (Rosenwald, 1988) to theory-building psychological research provides a means of collecting observations from many perspectives on a particular phenomenon. Because of challenges such as selective sampling and low power, confidence in the generalizability of any isolated statement may be low. However, by using multiple cases many observations may be collected and brought to bear on many theoretical statements. In so doing, a series of cases may adjust how a theory accounts for a phenomenon, thereby increasing confidence in it as a whole (Campbell, 1979; Stiles, 1993, 2003).

The permeability of theory building research rests upon the researchers’ infusion of new observations into the theory. A multiple iterative method of analysis (Ward, 1987) encourages a hermeneutic discourse between theory and observation. A hermeneutic stance recognizes there isn’t a definitive version of the truth. Instead, there are only further iterations of understanding in an ongoing process of understanding (Bontekoe, 1996; Stiles, 1993). A natural cycling between observation and theory as a case is read,
interpreted, reread, and reinterpreted may allow for the understanding of each (i.e., observation and theory) to develop simultaneously. In so doing, hermeneutics facilitates the integration of observation into theory.

Previously, assimilation model research has used a theory building multiple case study approach. Prior papers have examined cases of post-traumatic stress disorder (Varvin & Stiles, 1999), dissociative identity disorder (Humphreys, Rubin, Knudson, & Stiles, 2005), childhood sexual abuse (Salvi, Glick, Gray, & Stiles, 2006), and generalized anxiety disorder (Gray et al., 2006, April) to elaborate and refine the model’s tentative theory of change in psychotherapy. Multiple case studies have also been used to expand the model theoretically, and account for the assimilation of cultural voices (Henry, Stiles, & Biran, 2005), divorce experiences (Fishman, 2006, April), and elaborating sub-stages within the APES (Brinegar et al., 2006). Similarly, this study uses observations from multiple cases to extend the assimilation model and provide a tentative theoretical explanation of clients’ assimilation of the voice of the therapist.

The Voice of the Therapist

A number of different theories of psychology offer accounts of how people internally experience their relationships with others. For example, attachment theory (Bowlby, 1969, 1973) was originally formulated to explain the behavioral and emotional mechanisms that maintain proximity between young children and their primary caregivers. An important study in attachment was conducted by Ainsworth, Blehar, Waters, and Well (1978) that described different types of attachment patterns between children and their caregivers. It is thought that relationships with attachment figures come to be internalized and are experienced by the individual as working models (Bowlby, 1979). Working models influence one’s beliefs about the self, as well as expectancies of how others will treat them (i.e., responsive, neglectful, helpful, hurtful, etc.). In this way, relationships with significant others come to be represented internally.

Similar to attachment theory’s concept of a working model, is the term internal representation from object relations theory (Fairbairn, 1954; Guntrip, 1969). Like attachment theory, this theory described the relationship between the child and caregiver (Klein, 1932) and understood interpersonal relationships as being the result of one’s internal relationship with an external object. Under this framework, then, internal
representations are defined as “ideational events that are open to conscious introspection and self-report but, unlike perceptions, do not require...the support of immediate sensory input” (Orlinsky, Geller, Tarragona, & Farber, 1993; p. 596).

Alternatively, this study uses the assimilation model, specifically, as its theoretical framework in building a theory that describes how clients come to experience their relationship with their therapist internally. The assimilation model conceives the individual as being comprised of a community of voices—each voice representing a configuration of associated experiences. Central to the construction of a voice is a significant person, event, or situation. The assimilation model, then, suggests that experiences with other people may come to be represented as a voice and speak. The metaphor of voice stresses the agency and action of experiences, as voices speak to one another, and motivate the actions, behaviors, thoughts, and feelings of the individual.

In therapy, because the client's experiences with the therapist center on a unique person, a particular kind of relationship, and likely a powerful emotional experience, they may form a new internal voice. We conceive that at the center of the voice of the therapist is the client’s experience of the relationship with the therapist. Configured around this center are the threads of many therapeutic experiences that are associated with the therapist. These threads of experience may be based upon real-world or imaginal interactions with the therapist occurring both within- and between-session.

Accordingly, when a client encounters situations, events, or inner-experiences that are similar to or that address the threads forming the voice of the therapist, it may emerge and speak. For example, an encounter with a problematic experience may address the voice of the therapist because the threads contained within it may be of experiences from therapy of talking about the problematic experience. Therefore, when the voice of the therapist is addressed it may then speak with community or problematic voices. Primarily, changes in the relationship between the voice of the therapist and the client’s community voices may indicate changes in assimilation of the voice of the therapist into that community.

In this study, then, the assimilation model suggests that when clients talk about their therapists and their experiences in therapy—in this case in the context of an interview—threads contained within the voice of the therapist may sometimes be
addressed, thus prompting it to speak. In so doing, inferences may be made about the
voice of the therapist and its assimilation based on these observations. Similarly, clients
may be able to directly recall their experiencing of the voice of the therapist and describe
it. Such accounts may provide additional and direct observations of the voice of the
therapist and its assimilation.

Thus far, much of the assimilation literature has focused on elaborating the APES
description of change as warded off problematic voices move towards becoming
assimilated resources (e.g., Brinegar et al., 2006; Honos-Webb, Surko, Stiles, &
Greenberg, 1999; Osatuke, Glick et al., 2005, Osatuke, Humphreys et al., 2005; Stiles,
Meshot, Anderson, & Sloan, 1992). However, although this study uses the assimilation
model as a conceptual framework, it is not an examination of problematic voices. Instead,
it is a theory building study that offers a tentative explanation of the assimilation of a
different type of voice—the voice of the therapist. Certainly, in some instances the
therapist and therapy may actually be a problematic experience, insofar as not all
therapists and therapies are helpful and some are actually harmful. However, the theory
of assimilation being developed provides an account of how clients assimilate
experiences with their therapists in non-problematic instances. That is, this is an
examination of instances in which the voice of the therapist is not warded off or avoided
by the community because encounters with it are psychologically painful.

A Theory Describing the Assimilation of the Voice of the Therapist

Articulated in this section is a series of theoretical statements describing the voice
of the therapist and its assimilation. The theory presented here is the version refined and
modified by the case observations made during the study. The statements contained
within the theory are an articulation of the current understanding of the phenomenon,
derived from the research and theories of the assimilation model and developed over the
course of the study based on case observations and interview analysis (see Table 3 for the
original formulation of the ATS; see Appendix B for an informal description of my a
priori thoughts on the model).

The reasons for presenting the current refined version of the theory describing the
assimilation of the voice of the therapist, rather than the original, are twofold. First,
presenting the modified version of the theory reduces cognitive demands on the reader, as
there is substantially less material to read and remember when considering the cases. Second, it is our intent to reduce confusion between the two theories (i.e., original and modified) and which aspects presented are modified or original, as features of each theory both overlap and differ. Instead, in the discussion section, aspects of the refined version of the theory and the ATS will be considered specifically, in light of the case observations that are presented in the results section.

*The voice of the therapist may exhibit several levels of assimilation.* In the original formulation of the assimilation model (Stiles et al., 1990, 1992), the assimilation of single experiences was tracked across sessions of therapy. However, in the reformulation of the model (Honos-Webb & Stiles, 1998), experiences were conceived as being organized into voices. Thus, in the reformulation, a voice represented multiple experiences rather than a single one, as in the original formulation. Because voices represented multiple experiences, then, they were sometimes observed as being assimilated unevenly because not all experiences are assimilated equally. To help describe this phenomenon, the metaphor of *threads of experience* came to be used. This metaphor was an attempt to describe the relationship between experiences that comprise a voice. For example, when there is a tightly woven configuration of threads, a voice may appear to be coherent and evenly assimilated. However, in a loosely woven configuration of threads, a voice may be less coherent and the assimilation more uneven and scattered.

Similarly, the voice of the therapist is also comprised of multiple threads of experience. And, because each thread forming the voice of the therapist represents an experience to be understood and integrated by the community of voices, each may be assimilated by the community somewhat differently. Accordingly, the voice of the therapist may have varying degrees of coherency, based on the relationship between the threads comprising it. In instances in which the threads are tightly woven, the voice of the therapist may be a coherent voice, likely characterized by a particular level of assimilation. However, in instances in which the threads are loosely woven, the voice of the therapist may exhibit several levels of assimilation, and appear less coherent, with disparate levels of assimilation observed between threads. This phenomenon of *uneven assimilation* was observed in several cases in this study. Despite appearing contradictory,
such instances of uneven assimilation may be expected, and have been observed in other studies (e.g., Brinegar et al., 2006; Osatuke, Glick et al, 2005), as well.

**Early in assimilation, the voice of the therapist is outside of the community of voices.** Similar to warded off problematic voices, at low stages of assimilation the voice of the therapist may exist outside of the community of voices. Because it represents a collection of new experiences with a new person, the voice of the therapist may be unfamiliar to the community. Therefore, early in assimilation the community of voices may not recognize the voice of the therapist, may not communicate with it, and may be unable call upon it. However, despite it existing outside of the community, the voice of the therapist is still conceived as a constellation of experiences contained within the client. Therefore, it may be addressed by the experiences, events, and situations encountered by the client and emerge and speak. Other researchers have observed (Geller et al., 1981) that therapist representations sometimes seem to occur spontaneously. In assimilation terms, it may be that because the voice of the therapist is not a community member early in assimilation, its activity is beyond the community’s awareness or control.

**The voice of the therapist may introduce different positions to the community.** In therapy, the role of the therapist may be to introduce different positions—such as new or different ways of considering, thinking, or talking about old problems—to the client. For example, cognitive-behavioral therapy uses terms such as schema and mind-reading to encourage clients to gather evidence and evaluate their cognitions (e.g., Leahy, 2003; Young, Klosko, & Weishaar, 2006). In so doing, new positions for problematic voices may be considered: a client learns to challenge his belief (problematic voice) that people talk about him, by gathering evidence. As a result, he may begin to take new positions (i.e., confidence) in the place of old ones (i.e., self-blame and doubt).

Accordingly, some of the threads forming the voice of the therapist are experiences of the client talking about, realizing, observing, and considering different positions with the therapist. Thus, when one of these threads is addressed, the voice of the therapist may speak from the position of the respective thread. That is, from a position that may be new or different from usual community positions, relative to problematic
voices. Because these positions taken by the voice of the therapist may be different, the voice of the therapist may be a useful voice throughout assimilation.

*Meaning bridges allow community voices to call upon the voice of the therapist.* Meaning bridges formed between voices (i.e., therapist and community) allow community voices to purposefully address and talk to the voice of the therapist. Prior to the creation of meaning bridges, the voice of the therapist may emerge of its own accord and clients—if they are aware of its presence—may simply note or observe it. However, with the creation of meaning bridges, voices are able to communicate about shared experiences. In so doing, community voices may begin to purposefully address the voice of the therapist and call upon it to consider its positions, discuss new positions, or to seek support. In this study, clients described *learning* to use the voice of the therapist, or knowing how to use it. Consistent with this observation, some research (Geller et al., 1981) has indicated clients may deliberately evoke representations of the therapist. In assimilation model terms, these descriptions would suggest the presence of meaning bridges between voices (i.e., therapist, community, and problematic).

*The client may perceive a shift in personal agency, from the voice of the therapist to the self.* As meaning bridges are created between voices (i.e., therapist and community) and communication between them increases, the voice of the therapist may be recognized by the client’s community of voices as a member within it. Clients’ may describe a *shift*, whereby they begin to associate change in therapy with themselves, rather than with the therapist. In this study, some clients described this as the voice becoming their own, or taking aspects of the therapist’s personality. We understood such accounts as being consistent with the assimilation model’s theory of multivoicedness: the community of voices forms the client’s center of experience and sense of self. Therefore, when a voice formerly perceived as being outside of that community becomes a new member within it, the client may experience this as becoming part of the self. This sense of shifting corresponds with Singer and Pope’s (1978) suggestion that over the course of therapy and extending beyond termination, “the image of the therapist should gradually fade and the function of self-examination [may] become much more automatic and ego-syntonic” (p. 21).
The voice of the therapist may emerge as a community representative and resource. As community voices learn to talk with the voice of the therapist and it is perceived as becoming part of the self, the client may come to experience therapy as being self-contained. This may be the internal continuation of therapy that Edelson (1963) described. Accordingly, many of the experiences of therapy (e.g., self-reflection and analysis, enhanced self-awareness, or learned coping skills and strategies) may now be available to the community through the voice of the therapist. Now, the client’s community of voices may be able to call upon the voice of the therapist deliberately as a resource. Similarly, the voice of the therapist, when addressed, may emerge in response to encountered situations, events, or aspects of the self and speak as a representative for the community. As the voice of the therapist becomes an available resource, some clients may describe there is a sense that therapy continues in the physical absence of the therapist.

As assimilation increases, client descriptions of the voice of the therapist and therapy experience may become more detailed, nuanced, and sophisticated. Because the voice of the therapist is formed from multiple threads of experience, it may be that a client’s capacity to talk about and describe the therapist and therapy experience is indicative of the voice’s assimilation. That is, as the client accumulates experiences with the therapist, the threads contained within the voice of the therapist may come to represent increasingly nuanced and subtle experiences of the therapist. It may be, then, that the clarity, complexity, and consistency of a client’s description may indicate the detailed nature of the threads that represent their real-world experience with the therapist. Thus, as community voices come to talk with the voice of the therapist and it is increasingly assimilated, client descriptions of the therapist may correspondingly become more sophisticated, nuanced, and detailed, reflecting access to and familiarity with the experiences contained within the voice of the therapist.

The Assimilation of the Therapist Sequence

The ATS (see Table 2) organizes the theory being built in this study into a sequence describing observable changes in clients as they assimilate the voice of the therapist. The stages of the ATS were formulated based on the theories of the assimilation model and internal representations, as well as observations that emerged
from the analysis of interview transcripts with people about their experiences in therapy. The version of the ATS presented is different from the original version (see Table 3), as it has been modified based on the case observations of this study. Thus, the presented version has the theory-building benefits of this study. However, the ATS and the theory that underlies it are both considered works in progress; each is tentative and may be elaborated, refined, and modified by further observations. Briefly, the ATS describes the assimilation of the voice of the therapist as the client’s community of voices becomes aware of it, forms meaning bridges and talks with it, the voice of the therapist becomes a community member, and the community draws upon it as a resource.

**Study Design**

For this study, a tentative theory was constructed explaining how clients assimilate their experiences with their therapists in therapy. Originally conceived using the theories of the assimilation model and clients’ internal representations of the therapist, this new theory was examined and modified using a multiple case study approach (Rosenwald, 1988). Interviews were conducted with five former clients about their therapists and their experiences in therapy. These interviews were then analyzed using a modified form of assimilation analysis (Stiles & Osatuke, 2001), an intensive method of qualitative inquiry. Case observations from these analyses were then brought to bear on the originally conceived theory and were used to refine, elaborate, and alter aspects of it. The modified, yet still tentative, theory of clients’ assimilation of the voice of the therapist was then articulated in the ATS, an eight stage sequence describing changes observed in clients as the voice of the therapist is assimilated.

**Method**

**Participants**

Five former therapy clients participated in this study. Participants’ length of treatment ranged from two months to eight years ($M = 3.03$, $Mdn = 2$). Two male and three female participants were interviewed; their ages ranging from 18 to 34 ($M = 23.4$, $Mdn = 21$).
Investigators

Two groups of investigators were assembled. The first group analyzed two cases (pseudonyms: Tom and Emily) and was comprised of the principal investigator (myself—a twenty-eight year old White male second year clinical psychology graduate student) and two clinical psychology graduate student co-investigators (i.e., a thirty-five year old Hispanic/White male second year student and a twenty-five year old White Jewish male first year student).

The second group also analyzed two cases (pseudonyms: Jackie and Bernice) and was comprised of the principal investigator, one clinical psychology graduate student co-investigator (i.e., a twenty-five year old White female first year student), and one social psychology graduate student co-investigator (i.e., a twenty-four year old White Jewish male first year student).

The fifth case, Jay, was analyzed by me and overseen by the participant himself. Jay, a graduate student in clinical psychology, was also a co-investigator in the first research group. For his own case, Jay served as a consultant, reviewing my analyses, interpretations and clarifying case materials, as needed. An auditor (a clinical psychology faculty member) oversaw the study and advised on analyses, theoretical interpretations, and methodological issues.

Measure

The Assimilation of the Therapist Sequence (ATS; see Table 2) is an eight-stage description of changes observed in clients as they assimilate the voice of the therapist. Briefly, the assimilation of the voice of the therapist is marked by clients initially being unaware of it (Stage 0; Silent therapist), it emerging and becoming tentatively describable (Stage 1; Emerging therapist), it responding to other problematic voices (Stage 2; Responsive therapist), it becoming a recognized and sustained internal presence (Stage 3; Differentiated therapist), it forming meaning bridges with other internal voices (Stage 4; Understood therapist); it being called upon and consulted by other internal voices (Stage 5; Applied therapist), it switching to the client and fading (Stage 6; Voice of the client), and it becoming an internal resource of support and problem solving (Stage 7; Community resource).
The ATS was conceived as a rating scale for assessing a client’s level of assimilation of the voice of the therapist. The numbering of the ATS (i.e., 0 – 7) represents a continuum in the assimilation of the voice of the therapist. Thus, ratings may be assigned using whole numbers (e.g., 3), indicating the observed features are described by the aspects of a particular stage of assimilation; rational numbers (e.g., 3.5), indicating the observed features are points on the ATS continuum in transition between stages; or a combination of both (e.g., 1.0 & 2.5), which indicates that several observed features may be at different levels of assimilation simultaneously.

Procedure

Recruiting participants. All participants were former therapy clients and were not in therapy at the time of the study. Three participants were recruited from the undergraduate subject pool at a moderately sized Midwestern university. An example of the recruitment bulletin may be found in Appendix C. Two participants were recruited by word of mouth within the graduate student body of the psychology department of the same university. Students recruited from the undergraduate subject pool received either course credit for their time or $10, and graduate student participants received $10 for each interview they participated in.

Interview details. All interviews were conducted by me—the principal investigator—in a reserved room at the psychology clinic of a Midwestern university, and lasted between 40 and 90 minutes. I obtained the informed consent of each participant prior to beginning the interview, and each was provided a copy of the consent form to keep. Upon completion of all interviews, a debriefing sheet containing counseling referrals and the contact information for myself and the auditor was also provided. Examples of the consent form and debriefing sheet can be found in Appendices D and E, respectively.

All participants were informed that their contact information would be maintained for six months after the interview, in the event they needed to be consulted or re-interviewed if aspects of the interview required clarification or elaboration. One participant (i.e., Jay) was contacted for a follow-up interview. An example of the participant information form used to gather basic identifying and demographic information may be found in Appendix F.
Interview guidelines. Presented in Table 4 is a brief list of questions that I used as an interview guideline for the study. These questions were neither a strict protocol to be followed nor a checklist to be posed to each participant. Instead, the questions were a flexible interview guideline, providing multiple reference points for differing lines of inquiry. In some instances, I asked only a few of these questions; in other instances I asked many. These questions reflect my *a priori* thinking on how to best elicit and understand participants’ experience of the voice of the therapist. In compiling this list of questions, I gathered the input of a research group comprised of seven clinical psychology graduate students (i.e., the Assimilation Research Group), as well as that of the auditor.

Conducting the interviews. My aim in each interview was to encourage participants to tell their story of their experiences with their therapist, both within- and between-sessions of therapy. Questions posed of the participants were intended to be open-ended and to encourage their elaboration of the interview topic using their own frame of reference, rather than mine. Facilitative responses and active listening techniques (e.g., paraphrasing, reflecting, clarifying, etc.) were used to encourage participants to describe their experience of the voice of the therapist in their own words, while communicating my tentative understanding of their story. These techniques may have increased the reliability of the data somewhat, as participants were able to accept, reject, or clarify my understanding of their story. Table 5 provides brief examples of some of my actual responses, questions, and speaking turns during the interviews.

Interview recording and transcription. All interviews were electronically recorded. Due to time limitations one interview was not transcribed—the follow-up interview in the case of Jay. All other interviews were transcribed. For each transcribed interview, speaking turns between me and the participant were numbered. For the one non-transcribed interview, the location of the excerpt within the interview was indicated using minutes and seconds.

Assimilation Analysis

The analysis of the interview transcripts was informed by a modified version of the qualitative method of assimilation analysis (Stiles & Osatuke, 2000). The modified form was a five-step methodology involving the familiarization and selection of
passages; the extraction and assembling of relevant passages; the drafting of a consensual
document; ATS revision; and description of assimilation, as described below. An
adaptation of a method devised by Ward (1987) for structuring group process served as a
framework for conducting the final three steps of assimilation analysis.

Ward’s method—originally formulated to structure group work in the design of
architectural projects—has subsequently been adapted by a number of psychological
researchers (e.g., Henry, Stiles, & Biran, 2005; Osatuke, Humphreys et al., 2005; Stiles,
Shankland, Wright, & Field, 1997). According to the method, group members perform an
assigned task independently, meet and provide strengths-focused feedback, and then
redraft their documents incorporating the strengths of their documents—as well as other
group members—into the revisions. In particular, during the revision process group
members are encouraged to liberally incorporate the aspects of the other members’
product they prefer. This focus on strengths and flexible sharing of materials and ideas
between group members allows weaknesses to fall out, while encouraging collaboration.

1. Familiarization and selection of passages. Each group analyzed one transcript
at a time, completing the analysis before proceeding to the next transcript. During
familiarization, investigators systematically read the interview transcript and in some
instances listened to the corresponding interview tape, taking notes throughout the
process. Based upon the holistic understanding of the transcript gained, each investigator
independently identified relevant passages. General examples of passages identified as
being relevant include instances in which the participant was speaking about or
describing the therapist, recalling aspects of the therapy experience, or discussing
instances of the voice of the therapist emerging in daily-life.

2. Extracting and assembling relevant passages. In the second step, each
investigator extracted and assembled the passages they individually identified in the first
step into an assimilation case formulation. In this step, as well as all subsequent steps,
Ward’s iterative method for consensual group work (1987) served as a guideline for
conducting analyses and group process.

When drafting the assimilation case formulations, investigators were instructed
devise their own method for organizing and talking about the interview. In so doing, each
investigator devised a unique method for accomplishing the task and a great diversity in
organizational methods was noted between documents. For instance, some documents were chronological indices of important excerpts from the interview, interspersed with thoughts, reactions, and commentary from the author. Other drafts were organized into themes of excerpts, with some discussion preceding each excerpt grouping. Still, others were discussions of themes or important aspects of the interview, with only a handful of excerpts accompanying them or, in some instances, with the time in which the statement occurred in the audiotape marked.

Generally, in each group the first interview took several document drafts, as the investigators established norms for conducting group process, discussing the case, and organizing the papers. In accordance with the Ward method, investigators were encouraged to identify aspects of the others’ methods they liked and incorporate them into their own drafts. In so doing, the organization and structuring of documents tended to converge over time. Typically, investigators organized excerpts into headings and provided several paragraphs per heading, noting observations and discussing their relevance to the case.

3. Drafting a consensual assimilation case formulation. Each group of investigators generally met for 90 minutes to discuss a case. Each investigator presented his or her selected excerpts and conceptualization of the case individually, usually taking between 15 and 20 minutes. These conceptualizations tended to focus on passages that were interpreted as evidence of the presence of the voice of the therapist, its level of assimilation, and the clients use or understanding of it. Generally, feedback and comments from other investigators were held until the speaking member had finished presenting their document. This process continued until all investigators had presented their conceptualization. There was then a general discussion of the case, aspects of each draft, and the assimilation model.

During these discussions, the assimilation model, rather than the originally proposed version of the ATS (see Table 3), provided the theoretical framework for understanding the formulation and assimilation of a voice, and was used to guide case observations and interpretations. Following meetings, investigators redrafted their assimilation case formulations individually, freely incorporating strengths of the other documents. In some instances, excerpts of documents were cut-and-pasted into the
revised drafts. In other instances, new material was written to articulate ideas expressed during the group discussions.

This iterative process of assimilation analysis continued until investigators had reached a consensual understanding the features of the case, the voice of the therapist, and its assimilation. A *consensual assimilation case formulation* was then written by the principal investigator—culled from all previous and redrafted assimilation case formulations—which reflected the investigative group’s collective understanding of the case. Each investigator reviewed the consensual document and provided changes, interpretations, and feedback. This process of revising the consensual assimilation case formulation continued until all investigators had agreed upon its final content. To enhance each group’s understanding of the assimilation of the voice of the therapist, consensual assimilation case formulations were then shared between groups, so that each could benefit from the knowledge of the other. In so doing, investigators were able to identify and observe differences and similarities in the assimilation of the voice of the therapist between participants.

4. *ATS revision.* In this step, the principal investigator wrote the final case analyses presented in this study, drawing upon specific content, interpretations, and observations from the consensual ATS documents. The observations contained in the final case analyses were then used to revise the ATS’ description of the assimilation of the voice of the therapist. The co-investigators then reviewed the revised version of the ATS and offered feedback, comments, and changes. This process continued until the current version of the ATS (see Table 2) was consensually agreed upon.

5. *Describing the process of assimilation.* In the final step, ratings were then assigned to the cases using the revised version of the ATS, and the co-investigators reviewed the final analyses and ratings. Feedback and revisions of analyses and ratings were given to the primary investigator, until all investigators had reached a consensus.

**Results**

*Organizing Case Observations*

Case observations that emerged from the assimilation analysis of the interview transcripts were organized under four headings: clarity of the description of the therapist,
carrying the therapist as an internal presence, source of therapeutic change, and Change through therapeutic contact. These headings reflected recurring themes expressed by participants across multiple interviews, and they provided a method for organizing observed similarities and differences between cases. The case observations were then used to revise and modify the originally proposed version of the ATS. As presented here, each topic draws upon general case examples for purposes of illustration, although specific examples will be presented during the assimilation analysis of each case interview.

**Clarity of the description of the therapist.** This heading contains observations of the process of how participants described their therapists, and what participants talked about when describing their therapists. It was noted that some participants had clear, cohesive, and certain descriptions, while others were uncertain, vague, and contradictory. It was also observed that some clients described concrete and tangible qualities of the therapist (i.e., hair color, gender, age) and others focused on the personality of the therapist (i.e., funny, compassionate, edgy) or features of the relationship they shared (i.e., safe, trusting, supportive). We interpreted these observations as indicating the experiential composition of the voice of the therapist, as well as participants’ familiarity with it. Theoretically, it may be that increased familiarity with the voice of the therapist and an enhanced capacity to talk about are indicative of advanced assimilation, as community voices talk with it and become familiar with its positions as a new internal presence.

**Carrying the therapist as an internal presence.** Material under this heading organizes observations of the participant’s perception of his or her therapist as a carried internal presence. Some participants described having general thoughts of the therapist and others identified instances in which the voice of the therapist emerged. Some talked about the voice of the therapist as a carried presence and others said its presence had faded. We interpreted these observations as indicating communication between community voices and the voice of the therapist through meaning bridges.

**Source of therapeutic change.** This heading organizes observations of the participant’s perception of the source of therapeutic influence and change. Some participants described the changes associated with therapy as being the result of what the
therapist did for them. However, others described an internalized sense of the voice of the therapist as the source of change, or a feeling that the source of change had switched to them. Theoretically, these observations may indicate the recognition of the voice of the therapist as a member by the community and the community’s ability to communicate with the voice of the therapist.

*Change through therapeutic contact.* Observations contained under this heading tried to capture the degree to which the client felt contact with the therapist was needed or wanted in order to make therapeutic progress. Some participants said any changes that had occurred ceased upon the termination of therapy, while others said therapy was no longer a particularly useful or needed experience. We interpreted these observations as indicating the voice of the therapist becoming a purposeful and intentional community resource.

*Assimilation Analysis of the Case Interviews*

Each case interview presented here represents content from the consensual assimilation case formulations written by the investigators while conducting assimilation analyses. A brief introduction to each case is provided that includes background information about the participant and a description of the interview process. In the first two cases, special interviewing issues are also considered. The main results of the case are then presented. These include an assimilation formulation of the case and the presentation of the observed threads with ATS ratings, followed by the case observations that led to the rating. Case observations have been organized under headings (i.e., clarity of the description of the therapist, carrying the therapist as an internal presence, etc.), although not every case contained observations that pertained to every heading. Therefore, in some cases not every heading is reviewed.

Additionally, it is our intent to present all of the case observations and assimilation ratings in a very tentative fashion. The ATS is considered a work in progress and still requires further revision, elaboration, and modification based on additional case observations. The ATS represents an attempt to logically construct and organize the current case observations of this study into a coherent continuum that describes the assimilation of the voice of the therapist. However, we acknowledge that the ATS is constructed by the very same cases it describes, which is why we stress the tentativeness
of our interpretations. As with much qualitative research, it is the duty of the researcher to control for and reduce the likelihood of confirmation biases and self-fulfilling prophecies.

One aim of the consensual group method (Ward, 1983) used to analyze these cases and construct the ATS, then, is to minimize such validity threats through the use of multiple investigators and consensus. Accordingly, a number of perspectives and opinions emerged during the assimilation analysis and served as a means of checks and balances between researchers on each case.

In all interview excerpts, interviewer speaking turns are indicated by the letter "I" and participant speaking turns by the initial of the participant’s assigned pseudonym. The number accompanying each excerpt indicates its location in the interview, by speaking turn or by minutes and seconds (for the one non-transcribed interview).

**The Case of Jay**

**Overview.** Jay was a Hispanic male in his mid-thirties in a clinical psychology graduate program at a Midwestern university. Jay had received three years of psychoanalysis, terminating approximately 18 months prior to being interviewed. Jay did not specify his reasons for seeking treatment, but did say that he had discussed issues such as anxiety about relationships and school, and his tendency to avoid problems. Despite acknowledging sometimes feeling frustrated during therapy, Jay indicated he felt it was a very successful treatment.

Jay’s interview was the first conducted in the study and was conceived as a pilot interview. Jay participated in a total of two interviews. The first lasted about an hour and a half. Transcribed it was 33 pages long with a total of 369 speaking turns. The second interview lasted 55 minutes, but was not transcribed due to time constraints. Speaking turns from the second interview were indicated by the minutes and seconds in which they occurred.

**Process of the interview.** Rapport during both interviews seemed good, as Jay was forthcoming and appeared comfortable. Jay disclosed personal information about his experience in therapy that I hadn’t known prior to the interview through our relationship as students within the same department, and I interpreted that as a positive indication of
his comfort. Generally, I thought Jay was open, honest, and frank with me in talking about his experience. Generally, Jay’s interview was an easy one. That is, he tended to require little prompting and spoke at great length about his experience in therapy and his thoughts and feelings about his therapist. Essentially, it appeared that Jay had much to say about the subject. I felt that because of his frankness and verbosity, his interview was one of the richest, capturing many facets of his experience of the voice of the therapist. Jay’s interview was the longest in both time and transcription length (33 pages) and in the first 12 speaking turns alone he did most of the talking, speaking 655 words (92%). Generally, he required very little prompting or questioning. In almost every way, talking about the voice of the therapist seemed intuitive for Jay.

Special case considerations. What distinguished Jay’s case was that he was also a co-investigator on two other cases (Tom and Emily). Prior to the study, he had been identified as a good candidate for a pilot interview based on his long-term psychotherapy and due to his expressed interest in the research topic. To avoid confounding Jay’s involvement on the study with his participation in it, both of Jay’s interviews were conducted before he served as an investigator on any of the other cases. Regarding the analysis of his own interview, Jay expressed concerns about other people reading it and didn’t want to expose its personal content. Because of this, I analyzed Jay’s case and assigned the ATS ratings independently.

Jay then reviewed all of the excerpts I had chosen, as well as my analysis. I insisted that Jay do this because I wanted to minimize the possibility of Jay’s participation because of coercion. That is, I did not want Jay to feel obligated to consent to my use of his results because of our dual-relationship (i.e., interviewer and participant; graduate students in the same department). By allowing him to review the material to assure his comfort, and offering multiple opportunities for him to decline to be used as a case study, I thought the risk of coercion was minimal and the Jay was freely cooperating, rather than doing so out of feelings of guilt or obligation. In reviewing my analysis and ratings, Jay said that he was comfortable with the material that had been included. As a result, no interview content was removed from the analysis.
When analyzing the case of Jay, I identified a number of observations that I interpreted as indicating the presence of the voice of the therapist and its level of assimilation. These threads included: (a) Jay’s complex description of the therapist, (b) his description of learning to use the voice of the therapist, (c) his ability to purposefully call upon the voice of the therapist, (d) his description of personal agency shifting from the voice of the therapist to himself, and (e) his return to therapy and subsequent discovery that he felt an internal sense of “having [therapy] within [him].” Based on these observations, detailed below, I thought Jay’s case best described ATS level 6.5 (Shifting agency/Community resource).

Generally, I thought that Jay’s description of his therapist was quite sophisticated, entailing emotional and relational aspects of the experience as well as physical features of the therapist. In describing him, Jay talked about the pleasant and unpleasant aspects of his experience, specific therapeutic moments, and his therapist’s personality. In theoretical terms, I interpreted Jay’s ability to provide such a sophisticated and nuanced description as being indicative of the complexity of the voice of the therapist’s experiential composition and the community’s familiarity with facets of it.

Jay described learning to talk to the voice of the therapist and “knowing how make use of it.” I thought this observation described ATS stage 4.0 (Understood therapist), because it suggested that community voices were able to engage the voice of the therapist in a sustained and goal-oriented dialogue. Implicit to this would be the presence of meaning bridges. Jay also said that at one point in his life, he called upon memories of specific moments from therapy to help him. I thought this described ATS level 5.0 (Applied therapist), because community voices were purposefully calling the voice of the therapist and communicating with it (i.e., therapist and community). I also thought this was a more advanced form of communication between voices than seen in ATS stage 4.0, because it indicated collaboration between voices (i.e., the memories helped him).

Jay talked about taking parts of his therapist’s personality and carrying his therapist with him. I thought this observation described ATS stage 5.5 (Applied therapist) because the voice of the therapist seemed to be moving towards recognition by the client’s community voices and membership within the community. It seemed logical that the
sense of carrying the therapist would precede Jay’s sense of personal agency shifting from the therapist to the self. Jay talked about this shift, describing it as coming to associate change with himself rather than the therapist, as well as his need to recall specific memories of therapy fading. I thought Jay’s account described ATS stage 6.0 (Shifting agency), because it suggested that the voice of the therapist was recognized by the community and the experiences contained within it were thus becoming available to the community via the voice of the therapist, as well.

In the first interview, Jay talked about wanting to return to therapy and prior to the follow-up interview he did so, having ten sessions with a new therapist. However, he subsequently discovered a pleasant surprise: he felt he no longer needed therapy or that there was nothing further to be gained from it, at the moment. In describing this, Jay said that his “first therapy was still hanging around” and that he “had it [therapy] within [himself].” I interpreted Jay’s description as possibly describing the upper stages of the ATS. In Jay’s case, the voice of the therapist had become an assimilated and accessible community resource, containing many of the needed elements associated with Jay’s therapist and therapy experience. Accordingly, he discontinued therapy because he felt therapy was continuing within him. Because the voice of the thread seemed to be a resource for Jay, I thought this thread described ATS stage of 7.0 (Community resource).

*Clarity of the description of the therapist.* During the interview, Jay offered a rich and multifaceted description of his experience in therapy. Here, he discussed immediately being interested in his therapist, and respecting him:

8. J: And, like I said he was a psychoanalyst, so…it was, uh, it was cool because I really…I sort of respected him even though I didn’t know him. And, I was interested in psychoanalysis from my first therapist who was sort of psychodynamically oriented and at the time the time I had just been doing my own reading. And so, um, there was kind of a thing like, “Oh, I respect this guy.” Or something, and so I went and saw him and, uh, he was just…I was really impressed with him…
He also discussed feeling challenged by his therapist. In this excerpt, Jay talked specifically about feeling challenged by his therapist’s intelligence:

69. J: …He was really smart. And, I felt like I was smart, but like, it sounds weird, but he was smarter than me. [laughs] And, um, and so, so there’s a couple of things. So, there’s a challenge there from him that through hanging in there with him I actually got smarter—by hanging in there with somebody that was going to challenge me that way…

Jay later elaborated upon his therapist’s role in challenging him, using the metaphor of a martial arts sensei:

313. J: …I always felt like with him, it was almost like I felt…it was almost like this martial arts thing or something, like where you’re with the guy and you’re trying to keep up with him and it’s really tough and you have to work hard, and, uh…and so like, I can remember my consciousness, my mind, being much more acute. Like, trying to keep up with everything going on.

Collectively, I thought these passages indicated the voice of the therapist was comprised of a number of experiential threads, to include Jay’s experience of respecting his therapist, his intellect, being challenged, and learning from him. Furthermore, I interpreted Jay’s ability to talk about this experience as being indicative of the community of voice’s familiarity with the threads of experience contained within the voice of the therapist.

Jay’s description also included feelings of anger and frustration, experiences which were not discussed by any of the other participants. In this excerpt, Jay talked about how his therapist’s challenges would sometimes anger him:

315. J: …And, I always kind of felt like it was out of reach and it always made me mad. And like, and he would just keep it there, and I hated him for it…but
I learned through it. Um, and I kind of knew I could do it, and yeah, we used to talk about it in terms of like, woodwork or something…like, you’re doing a beveled edge or something…

Although Jay tended to focus on describing emotional and relational aspects of his experience, it seems that physical features of his therapist were also important to him. In this excerpt, he described a dream of his therapist:

188. J: The dreams were…I remember this one dream I had and I saw his face, which is strange too because in analysis it’s not like that, but I saw his face and I saw his face, like, so clear. Like, I remember just seeing the etches in his face in this dream, and just being like, “There he is.” And, um, there was kind of a cool feeling, like, seeing his face.

As Jay’s dream seemed to indicate, the therapist’s physical characteristics may have been in some ways salient for him, also.

In describing his therapist, Jay gave a complex and detailed description that included the emotional, the relational, the physical, and the pleasant and unpleasant aspects of his experience. I understood the comprehensiveness of his description of the therapist as indicating the nuanced and experientially complex composition of the voice of the therapist. That is, this voice seemed to be comprised of many threads of experience and Jay was able to articulate them. Implicit in this ability to articulate the experiences may have been the presence of meaning bridges: because community voices talk with the voice of the therapist they may be familiar with the threads of experiences contained within it.

Carrying the therapist as an internal presence. During the interview, Jay talked about how he felt some parts of his therapist had stayed with him:

92. J: …there was something about his personal style or something about some sense of his personality that I intuited or had a sense of through my work with him that I felt stayed with me. And, like a keen kind of intelligence or
kind of, um, ability to be reflective. And, um, that I feel like there’s a core…and I think too in that experience of analysis there was a really quiet—it’s hard to describe—a real quiet and a silence. Like, so there’s that anxious part of the silence but then there were also moments where there was a real deep kind of quiet…  

93. I: Mm hm.  
94. J: …experience that I had in there with him. And I feel like sometimes I can access that sense of calm that I had with him and I think it helps me to feel clearer, sometimes like if I’m speaking or my, in my thinking, or just my understanding that I’ve carried with me.

I thought that the aspects of his therapist’s personality that Jay felt he had taken—intelligence, reflection, and quietness—may have been new positions the voice of the therapist brought to Jay’s community of voices. That is, these features of his therapist were first experienced by Jay in therapy as being helpful or different in some way. They were then later addressed by situations he encountered and emerged in response. I interpreted Jay’s description of “accessing” to imply the presence of meaning bridges between voices (i.e., therapist and community), as the voice of the therapist could be purposefully addressed by the community.

However, Jay also described the fading of his memories for specific moments or events with his therapist:

175. J: …In a way, the things he said were secondary, in a way. As strange as that sounds. Although, what he said was obviously helpful, too. And I remember, it’s strange now, back then I remember crystal clear the things he would say and I find that now my memory is fading for the specific things he said, but, having more of a clear sense of what the experience does for me, the whole experience.  
176. I: Okay. So now it’s more of, a vague, um, sensation or feeling about the experience as a whole rather than like specific things that might have happened or occurred to you.
178. I: Okay.
179. J: At that time, I needed to call on specific memories of things he said.
  Whereas now, I don’t quite feel the need to refer back to specific things he
  said, um, because they’re now kind of in me.

I interpreted Jay’s description of needing to maintain specific thoughts, moments, and
memories of therapy as indicating that the voice of the therapist was outside of the
community of voices. However, I understood his description of these specific memories
fading and coming to be contained inside of him as being indicative of the voice of the
therapist’s movement towards community membership. That is, as the voice of the
therapist became a community member, the community no longer had to maintain
memories for such specific moments, as they were now contained within it and available
to it via the voice of the therapist.

*Source of therapeutic change.* Jay talked about the changes he experienced in
therapy coming to be associated with what *he* had done, rather than anything his therapist
had done to him. Here, Jay described this:

115. J: And so, rather than going to another person to give me that experience, I
  tried to consolidate what I’d learned with him. And so, like I say, I didn’t
  know for a whole year, like it didn’t make sense—most of the time it didn’t. Some of the times it did. I didn’t make, I mean, in the sense of
  internalizing the support…
116. I: Mm hm.
117. J: …I didn’t quite have a grasp of it. But, over time, like now I feel like I’m
  getting more of that.
118. I: You, you…
119. J: More of an internalized source of support. Like I’m really internalizing
  him, and realizing that it’s not him that it’s…all the work was something
  that was deepening in me. So, for awhile the process was associating all of
  the change that happened with him… and as it’s deepened, it was more
he’s going away more. And now, it’s my own understanding through the experience with him.

Jay indicated that rather than turning to someone else for support, he wanted to instead hang on to his old therapist. In so doing he articulated a change in perspective: where he had once associated his change with his therapy, he had come to feel that it was something that he was now doing himself. This description was consistent with Jay’s earlier account of specific memories of therapy now being “kind of in me” (line 179).

We observed this switch in the association of change from the therapist to the self in two other cases (e.g., Jackie and Tom) and called it *shifting*. This term is an attempt to capture the participants’ described experience, whereby they come to feel their capacity to change comes from the self rather than from the therapist. This shift may mark a point in assimilation whereby the voice of the therapist moves from being held outside of the community to be assimilated and recognized as a community member.

Jay elaborated upon this, when he talked about how he learned to “make use” of the voice of the therapist:

130. J: And I would have a lot of dreams about him and there was still a sense of putting him on a pedestal as the mentor, or the ‘one who taught me,’ and needing that.

131. I: Mm hm.

132. J: He still represented that. But then, there was a fading of that into internalizing more of, like, I gained strength through my association and my collaboration with him. It wasn’t that he was just sitting there from on high, like, you providing these interpretations that made me understand…

133. I: Sure, like, “Casting down knowledge from his soapbox.”

134. J: Yeah. Right. Exactly. It wasn’t whatever he was saying and it wasn’t just him being smart, but it was actually me knowing how to make use of that experience and realizing that now I can internalize it. But that took a long time…
As we observed in another case (Tom), it may be that necessary to Jay’s assimilation of the voice of the therapist was his *learning* to use it. Specifically, he described this experience as “knowing how to make use of [therapy].” I interpreted that implicit to his understanding how to use the voice of the therapist was an ability to communicate with it in a sustained and goal-oriented fashion. I thought that Jay’s selection of words (i.e., “make use of”) implied a relationship between voices (i.e., therapist and community), as one was able to address and talk to the other.

*Change through therapeutic contact.* In the first interview, Jay talked a great deal about missing his therapist, and wanting to return to therapy. These desires were despite his growing sense of self-reliance, and the feeling that he had consolidated his gains from therapy within himself. In this passage, Jay talked about terminating therapy and some of his struggles post-termination:

110. J: …he didn’t offer me any promises…like, “You’re going to go out and everything’s going to be great.” He said, you know the very last time we—our very last session—you know, “It’s going to be hard for awhile. And, expect it to be.”

111. I: Mm hm.

112. J: And there was a lot of times where I wanted the support of a therapist during the first year, but I said, “No.” Because there was a way in which I wanted to hold onto him, and what I’d learned with him.

Perhaps most prominent in this excerpt was that it indicated the centrality of the *person* in the composition of the voice of the therapist. That is, Jay didn’t want the support of any therapist—he also wanted the support of his specific therapist whom he had seen for three years. However, despite the voice of the therapist’s strength and presence within the community, Jay’s desire to return to therapy suggested that something remained to be gained from it.

Approximately two months after the initial interview, Jay participated in one follow-up interview. In the second interview, Jay talked extensively about having subsequently returned to therapy and what he learned from that experience:
1:07 J: I gained a lot from my old therapist that I’d talked about…
    I: Yeah, you didn’t want to step on his toes, in some ways.
    J: Yeah, or replace it, or something to that effect. And so, but anyway, I
        think it’s probably important to say that I did go back…
    I: Mm hm.
    J: …in December, I guess.
    I: Mm hm.
    J: …and interestingly, what I found out through going through that
        experience was that, um…Actually, I just decided that I’m going to stop.
    I: You’re going to stop the therapy.
    J: And, I guess the main thought I had was, “There’s no therapy here.
        There’s not a therapy to be had for me.”
    I: Huh.
    J: Um, I realized that in the process…I was distressed and I went back and, I
        realized that my old, first therapy was still hanging around and is still kind
        of a resource for me.

Jay indicated that despite feeling distressed and having a desire to be in therapy, he found
that returning to it was not the solution for him. As suggested within the previous excerpt,
Jay found that the voice of his previous therapist was still a resource available to him. Jay
continued:

2:24 J: There was nothing more for me to really learn from therapy, like, I
    realized that I had it within me. But, I was looking for it outside of myself.
    So, it was kind of like I was testing the waters in a way. And seeing is—
    you know—therapy going to be helpful for me now? And I realized at this
    point in my life, it’s not…it was surprising for me. It was something I
    discovered in the process.
In this excerpt, Jay said that in returning to therapy, he sought support and help. However, in so doing, he discovered that what he was seeking was already contained within him. I understood Jay’s description of the first therapist “still hanging around” as “kind of a resource” as being indicative of the voice of the therapist being an available and accessible community resource.

I thought Jay’s description captured aspects of the last stage in assimilation: when the voice of the therapist becomes fully assimilated, it may serve as a therapeutic resource for the client. That is, a client may perceive therapy as being self-contained and self-perpetuating, in the therapist’s absence. Accordingly, it seems that Jay terminated his therapy because he felt that therapy was within him. In his words, “there was nothing more for me to really learn from therapy, like, I realized I had it within me.” In assimilation terms, I understood this as meaning that the voice of the therapist was an adequate and available resource to the voice community. Perhaps in some cases in which the voice of the therapist is completely assimilated, clients may feel that therapy is no longer desired or needed, as it previously had been.

**The Case of Bernice**

**Overview.** Bernice was a White female in her mid-twenties in a clinical psychology graduate program at a Midwestern college. She had been in therapy for approximately two months, attending a total of eight sessions. She sought treatment because she was having difficulty getting along with her roommate and said she wanted outside support, validation, and perspective. Bernice terminated therapy when she moved into a different living space, away from the roommate. Despite the brevity of the treatment, Bernice was very enthusiastic and positive about therapy and mentioned several times that she wanted to return to therapy at some point, saying, “I really enjoyed being in there and I want to engage in that relationship again.” Bernice’s was the shortest of all the interviews, lasting just under 40 minutes. Transcribed it was 17 pages long and contained 277 speaking turns.

**Process of the interview.** Like Jay’s interview, Bernice’s was also conceived as a pilot. In contrast to Jay, however, Bernice did not seem to talk about her experience in therapy or her therapist in an easy or intuitive fashion. Generally, her responses were brief, to-the-point, and without elaboration. At times, she seemed to struggle to answer
questions, or to elaborate upon those she offered. In other interviews, discussing a sense of a carried or continued therapist presence seemed intuitive for the participant. Although Bernice appeared to understand the phenomenon intellectually, she seemed to lack any experiential recognition of the process. In short, it appeared that Bernice had little to say about the voice of the therapist. However, during the interview rapport seemed good. Unprompted, Bernice disclosed to me why she went to therapy, as well as some of its specifics, and these were interpreted as positive indicators of her comfort level.

Special case considerations. In considering the observations of Bernice’s case, we think it is important to consider the context of the interview: Bernice was talking to a fellow graduate student, in the same psychology department as herself, about her experiences in therapy. During the interview, I generally perceived her as being comfortable: we made small talk both before and after the interview, and she seemed generally relaxed. However, she did seem to struggle with some of the questions I asked her. At one point, she commented on my style of questioning with a laugh, “I hate that this is so open!” Such an exclamation may have signaled that Bernice felt uncomfortable or uneasy during the interview. However, this was not my interpretation of her statement. Essentially, during the much of the interview Bernice had little to say, and often, it seemed as though she did not know what to say. Therefore, I interpreted her response as indicative of her frustration with the silence in the room and not being asked straight forward, close-ended questions.

Later, Bernice also seemed frustrated with the quality of her interview, at one point commenting laughingly, “I’m not helping you!” Bernice’s response may have indicated she felt guilty about not giving a helpful interview, or providing me with adequate and useful information. However, I didn’t have a sense that Bernice was simply trying to give me the answers she thought I wanted to hear. In many instances, she clearly said no to my questions. Again, I perceived Bernice’s frustration as stemming from her having relatively little to say about the phenomenon. I felt that her interview was an honest and frank one, but also a sparse one.

Theoretical Case Interpretations: The Case of Bernice

In analyzing Bernice’s case, we decided not to describe her assimilation with a cumulative ATS rating. Instead, each thread was rated individually. In the case of Jay,
although we thought some observed threads were described by different ATS stages, the threads tended to be woven in a coherent fashion and were characterized by a high level of assimilation. Thus, we were able to assign a cumulative ATS rating that we thought described his assimilation. However, with Bernice the voice of the therapist did not seem to be as coherent and well-formed as it was with Jay. In Bernice’s case, we interpreted the differences between some of the observed threads as being indicative of quite different levels of assimilation. Such uneven assimilation has been observed in other studies (e.g., Brinegar et al., 2006; Henry et al., 2005; Osatuke, Glick et al., 2005), as well as other cases (e.g., Jackie) within this study.

Some of the observations we identified from Bernice’s case included (a) her sparse description of the therapist, (b) her report of the emergence of the voice of the therapist, and (c) her indication of the absence of the voice of the therapist upon terminating therapy. We interpreted these threads as describing a low level of assimilation. However, there were other observed threads that suggested a somewhat higher level of assimilation, such as (d) Bernice’s clear and consistent description of the therapist and (e) her account of it emerging in instances beyond therapy and unrelated to her problematic situation.

We observed that Bernice’s description of the therapist was brief, vague, and with little detail. Essentially, it appeared as if she had very little to talk about. We thought her sparse description described ATS stage 1.0 (Emerging therapist): considering the brevity of her therapy it was likely there was little material to be assimilated and thus little for her to talk about. However, in contrast to the brevity of her description of the therapist, Bernice did talk about her therapist in a consistent and clear manner. We thought this described ATS stage 3.0 (Differentiated therapist), because her clear and consistent description may have indicated an awareness of and familiarity with some of the experiential threads comprising the voice of the therapist.

In Bernice’s case we found evidence to suggest the presence of two distinct threads, each centering on the therapist, and each representing different experiences. The first, called the problematic voice thread, was conceived as being responsive to Bernice’s encounters with her problematic living situation. Bernice said that thoughts of her therapist would emerge when she encountered or thought about issues concerning her
living situation. We thought this described ATS stage 2.0 (Responsive therapist), because it did not suggest the presence of dialogue between voices (i.e., therapist and community), as Bernice simply reported the occurrence of the events. However, there was also evidence to suggest that the assimilation of this voice thread regressed, as Bernice reported the voice of the therapist ceased emerging when her living situation was resolved and she terminated therapy. We thought this cessation of the emergence of the voice of the therapist described ATS stage 0.0 (Silent therapist).

The other distinct voice thread was conceived as responsive to her struggles as a beginning therapist, and was called the beginning therapist thread. We based our conceptualization on Bernice’s description of thinking of her therapist post-termination, in response to her experiences as a beginning therapist. We thought this voice thread described ATS stage 4.0 (Understood therapist) because her description of its emergence implied the presence of meaning bridges and suggested that she was talking to the voice of the therapist by asking it questions.

Cumulatively, we interpreted Bernice’s description as indicating uneven assimilation of the voice of the therapist. For example, some aspects of her story suggested that particular threads described higher levels of assimilation (i.e., beginning therapist thread, clear and consistent description) than others (i.e., problematic voice thread, brevity of description). To make sense of these inconsistencies, we conceived of Bernice’s case as being one of loosely woven threads of experience, each assimilated to a somewhat different degree. However, because of the disparities in the observed threads, no single ATS stage adequately described the assimilation of the voice of the therapist, as Bernice experienced it. It may be that in the absence of the therapist and continued experiences to be assimilated, perhaps this voice had become, metaphorically speaking, somewhat unwoven.

Clarity of the description of the therapist. Considering Bernice’s relatively brief experience in psychotherapy, what was striking about her description was her consistency and clarity. Bernice was enthusiastic and positive, talking about aspects of her therapy experience that she valued:
10. B: …like, what she thought about this. I really enjoyed that. She wasn’t advice giving, but she helped me to really see the differences, and point out things that I was avoiding, instead of narrowly focusing on the issues I was talking about. She helped to broaden that out.

18. B: She was very warm. She was very engaging. She liked to take a stand, and I really liked that. She wasn’t neutral or anything. [inaudible] I really felt like she was on my side. [inaudible] …that made me feel comfortable. She didn’t criticize me or tell me I was wrong.

22. B: And when I was wrong, she was able to point that out without, you know, being critical.

23. I: So, she challenged you, but it was in a way that…

24. B: It was in a warm, empathic way. [laughs]

These excerpts indicated both the clarity and consistency of Bernice’s description, as well its brevity. Relative to all other interviews, Bernice seemed to have the least to say as her interview was the shortest in time. Theoretically, we thought her brevity indicated there were few threads of experience contained in the voice of the therapist. Essentially, she had very little to talk about because there was little experiential material that had been assimilated.

However, her clarity and consistency indicated some recognition of the voice of the therapist and the experiences that comprised it. As detailed later in the interview, for a brief while, the voice of the therapist was a frequently emerging voice. Accordingly, it likely may have been a somewhat salient voice as well. Therefore, although there may not have been many threads contained within the voice of the therapist, Bernice seemed to be able to describe the few experiences she had with clarity and certainty.

Carrying the therapist as an internal presence. Here, Bernice said the voice of the therapist emerged when she would encounter problems with her roommate in daily situations:
41. B: [inaudible] The issues that I was dealing with in therapy were very prevalent in my day-to-day life.

42. I: Mm hm.

43. B: So, I did think about her a lot.

44. I: So, when these things kind of surfaced for you, you found yourself referring back to that?

45. B: Mm hm.

46. I: Can you explain that, or describe it at all?

47. B: I can think of instances where I would do something and I would think, “Ah. Sandy says you do that.”

48. I: Okay.

49. B: Or like, she would point out things that I then see in myself or see in a situation that we talked about in therapy. [inaudible] And it would be like, “You were right!” [laughs] Or [inaudible] “I didn’t, but I think you did.”

Bernice indicated that when she dealt with issues concerning her roommate, she would think about her therapist. We labeled this thread of the voice of the therapist—responsive to this specific and troubling situation—the problematic voice thread. Bernice indicated that encounters with the problematic situation cued her to reflect on moments from therapy, such as things her therapist had said to her.

However, at several points during the interview, Bernice said she thought of her therapist in some situations unrelated to her presenting problem. Specifically, in her experiences as a beginning therapist:

8. B: Well I have really positive thoughts about my therapist. I really enjoyed my relationship with her. Um, it actually helped me a lot with my own ‘being a therapist.’ Being on that side of that chair, what was okay to feel, what was not okay to feel. Because, I felt like as a therapist I felt that I would be really concerned about saying too much in therapy, and I felt like my therapist actually said a lot and I really liked that. She was very
directive, and it worked well, but she was very directive and she would tell me things…

As Bernice indicated, part of her experience of being in therapy was thinking about what she would do as a therapist one day, herself. It appeared that her experience as a client—what she did and did not like about her therapist, for example—may have emerged later as she learned to become a therapist. Thus, encounters as a beginning therapist recalled another thread that formed part of the voice of the therapist, and we called this the beginning therapist thread. Here, she described this further:

98. B: …A lot of what I took away from it—when we ended therapy—I feel like [thoughts of the therapist] ended with the problem that I was having. So, I haven’t really thought much about that since then, since that was dealt with. But, more in my own life as a therapist.

99. I: Okay.

100. B: I do think of her a lot when I’m struggling in the therapist role, in my experience. “What would I have wanted to hear from her?” So, I do kind of channel that in that way.

Bernice said that thoughts of her therapist ended when her problematic living situation was resolved. We thought this cessation was indicative of a diminished level of assimilation of this voice thread. Relative to her earlier description, then, this account suggested that the problematic voice thread actually regressed in its assimilation. That is, in the absence of continued contact with the therapist, additional experiential material to assimilate, and a problematic voice to respond to, the thread may have stopped being assimilated.

However, Bernice indicated the beginning therapist thread later emerged when her encounters addressed her own experiences of being a client. We interpreted her description of asking herself “What would I have wanted to hear from her?” as suggesting beginning dialogue between voices (i.e., therapist and community) and indicating the presence of a meaning bridge. We interpreted Bernice’s account as
suggesting she considered positions demonstrated by her therapist (i.e., being directive, being talkative) and was able to draw upon them to evaluate her own therapeutic decision-making.

Change through therapeutic contact. Throughout the interview, Bernice’s enthusiasm and appreciation for therapy were evident—as she consistently expressed a desire to return to therapy:

32. B: Um, I find myself thinking that I want to go back to therapy.

36. B: Because I felt that I probably wouldn’t [inaudible] I do think about her because I want to go back.

132. B: I think it’s now. Well, both. Now, I’m thinking about her because I want to go back.

Bernice indicated that she terminated therapy for financial and insurance reasons, and because the sessions had become “chit chatty.” However, she said the termination of therapy coincided with the resolution of the problem that she went to therapy for:

117. I: So, it seems like it [the emergence of the voice of the therapist] was kind of brief. Like, just when you were in therapy, and it was specific to what you were talking about.
118. B: Yes, it was very situational…
119. I: …situational…
120. B: …and the situation resolved itself shortly after I left therapy…
121. I: Mm hm.
122. B: So…
123. I: Okay, that makes sense. So, and then it was situational and then these cues and pieces didn’t really come up anymore.
124. B: Exactly. Like I was no longer needing it.
In Bernice’s case, she sought therapy for a very specific purpose—support, perspective, and validation to help her cope with issues she was having with a roommate. Once she moved out, however, the problem was resolved and Bernice felt she no longer had any need for therapy. Accordingly, the problematic voice thread that was responsive to the problematic situation ceased emerging. Theoretically, it may be the specificity of her presenting problem precluded the extension of this particular thread beyond the problematic situation. However, the beginning therapist thread did emerge beyond termination and was a voice that Bernice’s community voices did talk to. While both threads seemed to be centered around Bernice’s experiences with her therapist, both emerged and responded differentially based on the experiences that addressed them (i.e., living situation versus beginning therapist circumstances).

The Case of Jackie

Overview. Jackie was a White female 18 year-old psychology major at a Midwestern college campus. She said she had been in therapy for “a couple of years” for depression, continuing to return occasionally while at home and on breaks from school. Jackie was positive about her experience in therapy, saying that it had been useful because she learned different ways of coping with her feelings of depression that she thought were effective. Jackie said that her depressive episodes continued to recur for her at school, but she was better able to cope with them and they were less frequent than when she had started going to therapy. Jackie’s last session with her therapist had been approximately four months prior to being interviewed. Her interview lasted about one hour. Transcribed it was 28 pages long with a total of 411 speaking turns.

Process of the interview. During the interview, Jackie generally appeared comfortable and forthcoming. Unprompted, she disclosed why she had sought treatment, as well as the specifics of some of her bouts of depression. She tended to require little prompting during the interview and was able to speak to the phenomenon of the voice of the therapist with a certain degree of ease. Generally, her description of her experience in therapy was detailed and well-articulated. Although some elements of the interview seemed somewhat contradictory, Jackie recognized these contradictions and tried to reconcile them.

Theoretical Case Interpretations: The Case of Jackie
In the case of Jackie, we thought that a single ATS rating did not accurately describe the assimilation of the voice of the therapist. As in the case of Bernice, we thought the threads each described a different ATS stage but that they did not indicate a coherent and single level of assimilation. The threads that we identified included (a) Jackie’s account of being aware of and noticing the voice of the therapist, but not calling on it or talking to it directly, (b) her articulation of two well-defined threads contained in the voice of the therapist, and (c) her description of the voice of the therapist switching to herself.

In describing her experience in therapy, Jackie said it was like a “preventative shell” against depression. We thought this described ATS stage 2.0 (Responsive therapist) because her description indicated an awareness of the voice of the therapist, but not the presence of a speaking therapist voice or communication between voices (i.e., therapist and community). Jackie also described the voice of the therapist as being beyond her control. That is, it would pop up, rather than be called upon, and Jackie tended to simply note its presence. Similarly, she said she found herself acting like a therapist when she listened to the problems of friends. We thought these accounts both described ATS stage 3.0 (Differentiated therapist) because in both instances, Jackie did not describe the presence of dialogue between voices. Instead, she simply described its emergence.

A prominent aspect of Jackie’s case that we identified was the presence of two well-defined threads contained within the voice of the therapist. Jackie gave a detailed and nuanced description of these different facets of her therapy experience. We conceived one as representing her experiences with her therapist as someone who was an expert and non-family member and called it the expert therapist thread; we conceived the other as representing her experiences with her therapist as someone who was like a family member and called it the familial therapist thread. Understanding between these two threads was signified by the term mentor, which seemed to symbolize a person with expertise but also a close relationship.

Jackie also talked about purposefully using what the therapist had taught her and becoming self-reliant in the absence of the therapist. She talked about this as realizing she could deal with her depression “on [her] own.” We interpreted Jackie’s account as being
like the shift in agency that was described in the case of Jay: where Jackie had once relied upon her therapist to help her, she had come to find she was able to help herself in some ways, as well. We thought this thread described ATS stage 6.0 (Shifting agency). However, this thread was in contradiction with the earlier threads that suggested only that Jackie was aware of the voice of the therapist, not that community voices communicated with it and called upon it specifically. In trying to understand this inconsistency, we thought that there may indeed have been dialogue between voices, but that it simply was not articulated by Jackie in the interview, and thus not observed by us.

Clarity of the description of the therapist. Early in the interview, Jackie talked about how her therapist had been unlike a family member, and the ways in which this was important to her:

14. J: …I wanted to go. It was something important to me, because I knew that I wanted to talk to someone and as much as I could talk to my parents or—I have three brothers—as much as I could to them or talk to my friends or anyone, it wasn’t the same as talking to someone who sees patients everyday going through the same thing. So, I knew I wanted to see someone who’s seen this the whole time. I mean, once I started going I realized that like, something that I wanted to keep doing, like even if I’m feeling well I like going back for appointments…

15. I: Mm hm.

16. J: …just talking to someone is nice. Having someone to talk to that doesn’t have opinions like my mom does or someone like that.

It was important to Jackie to see someone with experience in treating psychological complaints. She also talked about the importance of speaking to someone who was removed from her family.

However, in this excerpt, Jackie likened her therapist to being similar to a family member:
123. J: Yeah. She was, um, she was really soft-spoken and, um, I don’t know, she kind of reminded me of my mom a lot. But, just the fact that I guess we aren’t related, really helped me talk to her. Um, but she was really soft-spoken and she was really sweet and like, seems like part of my family now.

We interpreted these excerpts as indicating the presence of a thread that represented Jackie’s experience of her therapist as an expert who was separate from her family. This thread was called the expert therapist thread. The somewhat contradictory statement in line 123, in which Jackie compares her therapist to being like a family member after saying they weren’t related, may have indicated Jackie’s struggle to describe this experience to me. We thought this spoke to the multifaceted nature of her experience, in that it could not be adequately captured by the expert therapist thread.

In the next excerpt, in contrast to the expert therapist thread, Jackie talked about her therapist being like a family member and the importance of their relationship. This description seemed to capture the part of her experience not represented by the expert therapist thread:

340. J: Um, she’s not…I mean it’s not like, I wouldn’t say she was just an expert because that doesn’t seem like I have a relationship with her. I would say she’s like, um, I don’t know, she just seems like a mentor. Like a mother, but…
341. I: Hm.
342. J: But, she’s not my mother. I don’t know.
343. I: Okay.
344. J: She’s a mother to someone else, so that’s comforting. She, you know, she has her own kids and everything, um. I don’t know. I don’t feel like as close to her as I do to my mom or anything, but I feel like…I feel like I can talk to her about more things than I can with my mom because some things with my mom are embarrassing, or, um…just, mostly embarrassing, I guess (laughs).
Thus, Jackie articulated a second thread of the therapist voice, which we called the *familial therapist thread*. We conceived this thread as representing Jackie’s relational and intimate experiences with her therapist, which she perceived as similar to her familial relationships. We thought this thread may have described aspects of her experience not captured by the expert therapist thread. We thought the word “mentor” formed a meaning bridge in two ways. First, we thought it signified understanding between threads, as the term recognized the salient features of both the familial therapist (i.e., like a mother, cared for, comforted) and the expert therapist (i.e., knowledge, safety in confidentiality) threads. However, we thought the term mentor also formed a meaning bridge between Jackie and me, as it helped me to more fully understand her experience, than was possible by understanding a single thread.

*Carrying the therapist as an internal presence.* During the interview, Jackie clearly described her therapist as a carried presence using the image of a “preventative shell” in the back of her mind that helped to prevent her depression:

315. J: It’s [therapy] a preventative shell so that I don’t get depressed again, or so that when I get depressed I’ll get over it quicker. We talked about that, um. But that’s what I think it does when I’m not actually depressed.

316. I: I think that’s interesting. So, it’s support for you in that it’s protective, “Like I’m doing something that I know will work.”

317. J: Yeah, like it’s in the back of my mind so that I don’t get depressed.

Here, Jackie indicated the therapy was with her even when she was not depressed, helping to prevent future depression. According to the assimilation model, depression was the position that Jackie took when the problematic voice emerged. Jackie’s description implied that the voice of the therapist was able to prevent the depression, in someway. However, we were unable to infer how this process occurred, based upon the description Jackie provided. Although her description of the voice of the therapist suggested that she was aware of it and could articulate it, she was able to only vaguely describe it.
Jackie talked about another instance in which the voice of the therapist was with her—when counseling friends:

259. J: Yeah, I think so. Um, I’ve learned…being a person who has experienced things, and I mean I feel like when I talk to my friends I’m on Sheila’s side. Like, I’m doing what she does. I’m more of a listener, not, you know, I’m more of like the therapist, not the patient, I guess.

As in the case of Bernice, the voice of the therapist may have emerged when Jackie listened to the problems of others. That is, her experiences of her therapist as a speaker may have guided her actions when she was in the position of listening. Again, Jackie’s account only suggested an awareness of the emergence of the voice of the therapist retrospectively. That is, she didn’t indicate that she was able to communicate with the voice of the therapist or purposefully call upon it. Instead, she was simply aware of it and could articulate its presence. However, this is not to say that communication didn’t exist between voices. Only that it was not observed in this instance.

*Source of therapeutic change.* Jackie also talked about becoming more self-reliant:

182. J: Um, well I said it’s been like a collaborative thing, but now that I don’t have my therapist here, I’m more independent. I just kind of took what she taught me and now I can do it on my own.

This passage suggested that, in the absence of her therapist, Jackie had to become more independent and self-reliant. We interpreted Jackie’s description as being similar to Jay’s: both may have indicated a shift in agency, as the client assumed some of the responsibility for effecting change. However, what distinguished the shift observed in the case of Jackie was that it was not the result of natural shift or progression, but rather seemed to be out of necessity. This is elaborated in the following excerpt. Here, Jackie talked about encountering problems addressed in therapy after moving to college and being without her therapist:
195. I: So, I want to understand when these things happen to you—when you find yourself thinking about your therapist, thinking about therapy—what it’s like.

196. J: Yeah. Okay. Well, it was, I mean, it was reassuring for me…it was like, I mean, I was sad because I was thinking, “What would Sheila do?” And I was wishing, “I wish she was here. I wish I could talk to her right now. I wish I could call her right now.” And my mom would be like, “Well, they’re not working right now. You can’t just call them. You can’t just do that.” And I would, you know, I did want her to be here but then I realized that she’s not here and I can do this on my own.

It seemed that some challenges encountered by Jackie elicited a desire for the physical presence of the therapist. However, it may be specifically that not having access to the therapist actually facilitated the establishment of communication between voices and the shift of personal agency from the therapist to Jackie. That is, the physical absence of Jackie’s therapist coupled with her desire for therapeutic contact may have forced community voices to establish communication with the voice of the therapist and precipitated their assumption of responsibility for change.

The Case of Tom

Overview. Tom was a White male 19 year-old freshman psychology major at a small Midwestern college. Tom said he had sought treatment for drug use and antisocial behavior (i.e., getting into trouble, strong feelings of anger). Tom spoke of therapy in an entirely positive tone, and indicated that he felt it had been very successful, as he no longer used drugs and had a more satisfying relationship with his family. Tom said he had been in therapy for two years, terminating approximately 3 months prior to being interviewed. His interview was about 50 minutes long, and transcribe it was 18 pages long and contained 287 speaking turns.

Process of the interview. Throughout the interview, Tom appeared to have a high degree of enthusiasm, comfort, and openness in talking about his experience in therapy. Unprompted, Tom said his therapist was like a “voice in my head” (speaking turn 24) and...
talked about internalizing his therapist. We thought that Tom’s spontaneous use of these terms indicated his intuitive understanding of the phenomenon and familiarity with it. Tom was enthusiastic when talking about therapy, noting that it was one of the “quickest hours of my week” (speaking turn 4) and said that thinking about it would “soak up my entire drive home” (speaking turn 14). He said therapy was “definitely, definitely…it was definitely a good thing. Um, definitely a good thing” (speaking turn 16) and as for his therapist, he said, “I was more close to him than to anybody I’ve ever been in my life” (speaking turn 112).

In describing his experience, Tom was straightforward and confident. The interview could have been concluded within the first 30 minutes, as Tom seemed to know precisely what he wanted to say, as well as how he wanted to say it. The only reason it wasn’t concluded more quickly was because as an interviewer, I felt compelled to make it last longer, ask more questions, and get more information. However, it seemed that Tom said what he had to say almost immediately and without my prompting or questioning. Thus, the details that emerged from this case, much like Jay’s, did not seem to be so much a result of my questioning as they were product of Tom’s intuitive and familiar understanding of the interview topic.

**Theoretical Case Interpretations: The Case of Tom**

The observations that we identified as indicating Tom’s level of assimilation of the voice of the therapist included (a) the evidence of meaning bridges and dialogue between voices, (b) his description of learning to use the voice of the therapist, (c) his description of the voice of the therapist shifting and becoming his own, and (d) his description. Based on these observations, Tom was assigned a cumulative ATS rating of 6.5 (Shifting agency/Community resource).

Tom described several instances of being able to dialogue with the voice of the therapist. Tom talked about learning to use the voice of the therapist by mimicking or imitating what he had learned in therapy. That is, he “broke it down like he [the therapist] had broken it down for me originally.” We thought this statement described ATS stage 4.0 (Understood therapist/Applied therapist) because it implied the presence of meaning bridges between voices and an advanced level of communication as Tom tried to imitate and learn from the voice of the therapist. Tom also described purposefully using the voice
of the therapist as a reference point to evaluate his own behaviors. We thought this described ATS stage 5.0 (Applied therapist) and interpreted it as evidence of community voices calling upon the voice of the therapist. In describing how the voice of the therapist had shifted, Tom said, “maybe that used to be his voice, and now it’s mine.” We thought this statement described ATS stage 6.0 (Shifting agency) because it suggested the membership of the voice of the therapist within the community. Finally, Tom talked about the voice of the therapist emerging and speaking on the behalf of the community and taking a position of abstinence towards peer-pressured drug use. Although he said he could argue with the voice, he also said that he chose not to. We thought this described ATS stage 7.0 (Understood therapist) because the voice of the therapist was interpreted as emerging as a community representative and speaking for it when confronting a problematic voice.

Carrying the therapist as an internal presence. Here, Tom provided an example of the voice of the therapist emerging and speaking:

23. I: So, it seems like when you kind of see things in the real world—not actually in therapy—when that would kind of come up, it would be different somehow for you?
24. T: Mm hm. I could kind of hear his like voice in my head.
25. I: Hm.
26. T: Just in day-to-day activities. Not when I was in therapy ever. Like, something he had talked about… I would like repeat a behavior that he would talk about. Like, “This is what…how you acted. Why did you act this way?” Then, I would like perform that behavior in like a day-to-day situation and would look back on it and say, “You know what? I was at fault in that situation.” When normally, my…complete denial…
27. I: Mm hm.
28. T: …uh, I would definitely have a different perspective on my behavior. Like, a third person perspective, more of like, without the…my own bias. And, so I definitely thought that was a big improvement on myself.
We thought that Tom’s description suggested his community voices were able to use the voice of the therapist as a reference point for evaluating positions and would communicate with it by responding to its questions. Also, Tom’s account of the voice of the therapist as a “third person perspective” may have been an anecdotal description of the ATS’ conceptualization of the voice of the therapist being an entity outside of the client’s community of voices early in assimilation.

Tom later described the voice of the therapist as taking an active role in effecting behavioral change within him. Here, he indicated the nature of the relationship between the voice of the therapist and his community voices:

151. I: I guess I don’t want to lead you so I’m trying to be kind of vague…would you…would you talk with the voice? Would it just say stuff?
152. T: No, it wasn’t like, it wasn’t something, it wasn’t…the…I’m trying to word this right. Um, like, when I heard that voice telling me not to do it, it wasn’t something I could, um, persuade a different way. It was just, like uh, it was just defined. It was set in stone.
153. I: It just…
154. T: …Like, as soon as I brought it up, it wasn’t like I was going to be like, you know, “I’m going to do it today and like I won’t do it again for a week.” It was just set in stone, “I’m not going to do it.” Um, and…
155. I: So, the decision was pretty final.
156. T: Yeah. And I had it set in my mind that I didn’t want to do it, no matter like the pressure that was going to come up. So, as soon as that voice came up and just, like, “You don’t want to do this.” It was, “Alright, I’m not going to do it.” It wasn’t like, um, like I was trying to get around it or anything like that…

In this passage, Tom described the voice of the therapist responding to the problematic voice and insisting upon a very definite position—abstinence from drugs. Tom said that he didn’t try to dissuade or bargain with the voice of the therapist, and we interpreted his description as depicting the emergence of the therapist as a community representative.
Although Tom indicated that he could argue with the voice of the therapist if he wanted to, it seemed that he chose not to. When the voice of the therapist assumed its hard-line position, then, it seemed the community voices simply complied.

*Source of therapeutic change.* Tom also said that over time the role of the voice of the therapist may have changed somewhat:

141. I: So, when somebody offers you a joint or something, like, you would kind of check off…

142. T: Yeah, there would be a voice in the back of my head saying, you know…the urge is still there, like, you know, you want to be socially accepted, um, but the reason I haven’t been is because, you know, probably because that voice…

143. I: Mm hm.

144. T: …is helping me to do that. That, maybe that used to be his voice, and now it’s mine, like that’s one way I’ve internalized, like he’s told me…

In this example, Tom again indicated specifically that the voice of the therapist responded to a problematic voice that pressured him to take drugs for social purposes. He said it was like “that voice used to be his, and now it’s mine.” We interpreted Tom’s account as being an anecdotal description of the phenomenology of the assimilation of the voice of the therapist: the voice of the therapist is initially held outside of the community—here Tom perceived it as a “third person perspective”—and as it is assimilated it shifts to being felt as part of the self.

As shown previously, the voice of the therapist emerged in response to problematic situations and would help Tom, guide him, or tell him what to do. Over time, these interactions resulted in lasting change. Here, Tom’s description may have indicated some of the processes underlying this change:

182. T: Um, um, I think it was…it would happen like post- a behavior that has already happened, um, and in it was always…usually in retrospect when I looked at it I could break it down, um, and I broke it down like he had
broken it down for me originally, um, and, um, like kind of gave me the ability for me to think for myself like in a psychological way. Um, and the way, yeah, once again, like the way he had always broken down my behavior, um, I kind of did the same thing or did my best to do it. That’s how I would describe it.

Thus, Tom indicated he learned how to use the voice of the therapist. It appeared he did this by imitating or mimicking his experience in therapy. In theoretical terms, Tom may have practiced assuming the positions of the voice of the therapist when he encountered problematic experiences. It also may be that these exercises helped form meaning bridges between voices (i.e., therapist and community), as practicing using the positions of the voice of the therapist may have facilitated communication and the sharing of experiences between voices.

*Change through therapeutic contact.* Tom was enthusiastic about therapy, saying he would recommend it to anyone and that he wanted to continue it himself. In this excerpt, he talked about missing his therapist and wanting to continue seeing him:

124. T: I’ve emailed him and said I want to start up again during breaks. I think that that’s, like, always going to be a part of my life, like, wanting to do that again. It was just, like, just from my persp…it was just so successful that like, you know, why not continue it?
125. I: Yeah.
126. T: Definitely be with me for a long time. And I wouldn’t say it’s done now, like, I don’t think it’s ever really done.

Clearly, Tom valued and wanted to continue therapy. Throughout his interview, there was evidence of the therapist as a continuing resource for Tom. He was able to call upon it and talk to it to help solve problems and the voice of the therapist would emerge as a community representative to speak on his behalf (e.g., when being offered drugs). Thus, although we thought that features of both Jay and Tom’s interviews described aspects of ATS stage 7.0, what differentiated Tom from Jay was that Tom wanted to continue
therapy. We interpreted this difference as being indicative of the subtle and nuanced nature of assimilation: while different cases may share similar features of assimilation, the expression of these features may be somewhat different.

The Case of Emily

Overview. Emily was a White female 20 year-old freshman philosophy and English major at a Midwestern college. During the interview, Emily did not indicate why she had been in therapy. In terms of describing the outcome of therapy, she was positive about her experience in therapy, but did not talk about the degree to which therapy was a success or failure. Emily said she had been in therapy for eight years with a psychologist, while concurrently seeing a psychiatrist for the previous four years. Her interview lasted about an hour. Transcribed it was 29 pages long with 521 speaking turns.

Process of the interview. This excerpt captured the general tone of the interview interactions: I would paraphrase what Emily had said or ask her a question, she would actively listen to me, and then she would elaborate:

179. I: So, when something comes up in life that you kind of see that you made the change in for the better…
180. E: Right.
181. I: …and you’re doing something good that you’re happy about…
182. E: Yeah.
183. I: …it kind of brings them up.
184. E: Yeah. I mean, I think about that…I wouldn’t be able to do that were it not for their help in that situation. So, those are probably the two…two most frequent occurrences of when I think about them.

As illustrated here, Emily appeared to listen to me attentively and was responsive. While some of her responses were brief and succinct, as seen in other interviews, what distinguished Emily was that she would often extensively elaborate on material, as well. Thus, her brief “Yes” and “No” responses were not wholly answers to my questions or comments, but instead appeared to be acknowledgements that she was listening to what I
was saying, trying to understand me, and then responding as she saw fit. I perceived Emily as being very focused during the interview.

*Theoretical Case Interpretations: The Case of Emily*

We identified several case observations that we thought described Emily’s assimilation of the voice of the therapist. These included (a) her sophisticated description of her psychiatrist and psychologist and (b) her account of the voice of the therapist emerging rather than being called upon. Cumulatively, Emily was assigned an ATS rating of 3.0 (Differentiated therapist). However, there was evidence to suggest she may have held the potential for a higher level of assimilation. This was indicated by (c) her description of the voice of the therapist as a “lifeline” or “textbook” that she could call upon, which we thought may have indicated the presence of meaning bridges and communication between voices. However, as will be detailed in the case analysis, there was evidence to suggest that a community or problematic voice may have inhibited her ability to assimilate the voice of the therapist.

Emily’s case was unique in that she talked about two concurrent therapy experiences: eight years with her psychologist and four years with her psychiatrist. Although she did describe each individually, she didn’t distinguish between them when talking about instances of the emergence of the voice of the therapist. Therefore, we conceptualized her experiences with each person as being contained within one voice and her individual descriptions of them being separate threads within that voice. In describing both her psychologist and psychiatrist, Emily included features of the relationship, physical characteristics, and qualities of their personalities. We thought this described ATS stage 3.0 (Differentiated therapist) because her detailed and clear descriptions may have indicated the sophistication of the experiences contained within the voice of the therapist, as well as her familiarity with them. Emily also described the voice of the therapist as emerging on its own. We thought this described ATS stage 3.0 (Differentiated therapist) because she tended to observe or watch the voice, rather than to actively engage and talk with it.

However, we also observed a voice that seemed to conflict with the voice of the therapist, potentially inhibiting its assimilation. This voice was inferred by the positions of resistance it took towards therapy. We thought that Emily may have had potential for
greater assimilation, as she talked about being able to use the voice of the therapist as a “lifeline” if she needed to. We thought this thread described a potential for ATS stage 5.0 (Applied therapist) because of Emily’s ability to actively evoke the voice of the therapist when needed. However, it seemed that the conflicting voice seemed to inhibit assimilation, as Emily said she usually simply chose not to use the voice of the therapist.

*Clarity of the description of the therapist.* Emily offered detailed descriptions of her experiences with both her psychologist and psychiatrist. Here, she talked about her psychologist:

2. E: Okay, um, she is a middle-aged, single woman. Um, very intelligent. Very funny. And, kind of straight forward. Like, real. You know? No crap. Just doesn’t, I don’t know…she jokes around in a way that’s not, um, you know, she’s not afraid to hurt anyone’s feelings, I guess…

3. I: Mm hm.

4. E: Like she’s not insensitive either. Um, so it was just a very, like, real experience. You know? I didn’t have to worry about thinking you know like, “Was she thinking of me?” Or this or that, or things like that. So, I felt pretty confident that she was on the level with me.

Emily’s description indicated aspects of the experiential composition of the voice of the psychologist, including intelligence, age, marital status, her forthrightness, and her sense of humor.

In regards to the power dynamic of the relationship, Emily said, “You don’t want to have a parent-child relationship. You want to have, you know, like maybe a colleague relationship where you’re equal to her and she sees that” (speaking turn 29). In this example, Emily gave a description that seemed to capture this nature of their relationship:

10. E: She, um, I would also consider her to be—I guess a friend, in a way. You know, because once you start to reveal so much information about yourself to somebody else, it’s kind of hard for you not to be connected.

11. I: Mm hm.
12. E: So, I would consider her a friend. You know, I’m not going to invite her to some gig or anything, but, um, she and I were close because, you know, I’ve known her for a really long time and she was also really familiar with my parents—which was the source of some of my problems. So, it was easy to relate to what we were talking about. Yeah, she was nice…she was a nice, like, friendly person.

Generally, we thought these voice threads seemed to be well-developed, as they encompassed aspects of their relationship and the psychologist’s personality. They seemed to indicate a nuanced understanding and familiarity with the therapist. Furthermore, the threads seemed to be salient and familiar to Emily, as she was able to articulate them in detail.

Initially, when describing her psychiatrist Emily contrasted him with the psychologist. Here, she talked about him:

107. I: So, well I guess let’s start with the psychiatrist a little bit. Um, you felt that he was very interested, and enthusiastic maybe.

108. E: Yeah. I think why, um, the reason I, um, felt that was because he was much more forthright with me about me. Instead of, okay, the psychologist was upfront with things that I was doing, but not me as a person, as an individual, as a whole. Um, the psychiatrist within one or two days of my first meeting, I knew that he liked me as a person. I mean, as a person. You know, like he’d almost pick me to be a friend outside.

109. I: You felt really accepted.

110. E: Yeah. And, I didn’t not feel that in the other one, but, um, it was just a different feeling. I felt like the other one was almost a lot more necessary. Like, “I’m here because I have to be.” And, when I saw my psychiatrist I felt like, um, I always felt like he was really excited to see me. Like, when he saw me when I was scheduled he was like, “Yes! Emily is here.” You know? So…which was funny but it just makes you feel like, “Okay. I can
handle this. It’s not as intimidating…the whole environment.” So, that’s…sums it up pretty well.

Relative to the psychologist, Emily indicated the psychiatrist seemed happy to see her and she felt more comfortable, accepted, and appreciated with him. It seemed that the psychiatrist provided a contrast to the psychologist, as up until that point in the interview, Emily had characterized the psychologist in entirely positive terms. Emily later described the psychiatrist further:

118. E: Um, really short. Bushy white beard and eyebrows and hair…white hair. Um, and really fit looking…like very healthy looking. He was Greek. Um, so, I think that also has something to do with the fact that he’s a male. Um, I mean if you go—I guess—on a few theories why I think that, but, one of them is that just having the person be of the opposite sex, you make an immediate connection with them. Um, especially as maybe a surrogate father. Like, some sort of a father figure. My father is still very much around and in my life, but, there was a point in time where he wasn’t. So, I would say that I am automatically, I guess, emotionally attracted to men more than women. So, I think making that connection was almost instantaneous, versus trying to work at it with my psychologist.

Emily’s description of the psychiatrist was dense and sophisticated. Like the psychologist, we interpreted this as being theoretically indicative of a complex experiential composition to the voice, with threads representing his physical and relational features, as well as her experience of him as a father figure. We interpreted Emily’s sophisticated description of each indicative of the experiential complexity to the threads and her familiarity with them.

Carrying the therapist as an internal presence. Here, Emily talked about an instance in which the voice of the therapist emerged:

94. I: When you’re brought back, what happens?
95. E: Um, I just start thinking about them. You just go on a train of thought…you know, maybe, a funny moment that we had or a connection that was made or just a comfortable image, you know, just like a happy place or something…it’s not what I would pick. It’s just something that came up.

96. I: So, what would be an example of a comfortable image?

97. E: Um, sitting there in the chair having small-talk with my therapist.

98. I: Okay, so you actually kind of have an image of seeing from your perspective in her office?

99. E: Right. Something that has probably already happened. Like, an image of a thing or event or just a certain time that has already happened.

100. I: Um, you would have a conversation, or what would happen?

101. E: Um, I never really put myself in that image. I see it so I’m like the third party viewing myself and the therapist. Um, and usually I am picturing…just looking at it like it’s almost a movie. But, there are other times when I almost put myself in the same seat and I’m looking at my therapist and wondering what they’re thinking or, um, I mean, with my psychiatrist I was even more open with him that I was with my psychologist.

Emily’s description suggested that the voice of the therapist would emerge rather than be called upon and we thought this suggested there weren’t meaning bridges between voices. That is, Emily’s community voices seemed to passively observe the voice of the therapist, rather than actively engage it by talking to it. Emily also indicated her experience of the voice of the therapist was visual, taking the form of an image she saw from a third-person perspective. Again, we thought this description suggested Emily’s role in these interactions was that of a passive observer, rather than an active participant.

However, a brief while later in the interview, we interpreted Emily’s description of the voice of the therapist as being somewhat contradictory to her earlier account. Here, she talked about being reminded of her therapists when seeing someone else struggling:
184. E: …it brings me back to almost thinking, like, “Well, I wonder what they would say about that.” Or, “I wonder…” You know, like you…they kind of become a reference. Like a source for you to turn back to and use as…I don’t want to say like a textbook, but, a dictionary or something. You know, if you want to know something about it and you know that they would know something about it.

185. I: So, you kind of flip through the pages and reference the relevant part…

186. E: Yeah, like, if you’re on “Who wants to be a millionaire” and you need a lifeline you call them.

Emily gave a sophisticated description of how she was able to purposefully access and call upon the voice of the therapist, using the metaphors of a textbook and a lifeline. We inferred the existence of meaning bridges between voices through this excerpt, as the purposeful addressing of the voice of the therapist implied their presence. However, this was in clear contradiction to her earlier description, in which she said the voice of the therapist emerged of its own accord and she passively experienced it.

In this excerpt, Emily may have demystified the contradiction somewhat:

347. E: Yeah. Well, because if they’re popping up they’re obviously not there. You know? I mean, there’s something…for me, I guess there’s always something that triggers them to be thought of. Whereas if I was carrying them around, I could go get them anytime I wanted.

348. I: Okay.

349. E: Um, but because I don’t do that…I mean, I can go get them. You know? Like go back in my head and think, like, “Such and such.” But, I don’t ever do that. So, I guess that’s why I say I don’t carry them around.

Thus, it seemed that Emily may have been able to access the voice of the therapist, but that she chose not to do so. In light of this, we thought the contradictory nature of her earlier descriptions, then, seemed less problematic. Because Emily could call upon the voice of the therapist but chose not to do so, when it did emerge it was of its own accord.
Later observations in the case led us to believe that Emily’s position of choosing not to access the voice of the therapist may have been because there was a community or problematic voice that was in conflict with the voice of the therapist. This voice will be detailed under the next heading.

*Source of therapeutic change.* Emily was clear in stating that any progress stemming from therapy was contingent upon her being in therapy. That is, without exposure to her therapists and active maintenance of her work in therapy, progress ceased. In this example, she talked about her reliance upon the therapist:

218. E: Like, I can go back every week or however it was…however often it was that I saw them. Go back and kind of check off things, like, “Okay. I’m okay here.” Or like, “I need to work on this a little bit more and do that.” And, I think I could do that by myself, but, you know…

219. I: That’s my question.

220. E: I’m going to hesitate to do that on my own. *(laughs)*

Later, Emily explicitly stated the cessation of progress upon termination:

238. E: Well, no, I just, I don’t…um, I would say that as soon as I stopped seeing them, my progress simultaneously stopped. I mean, there might be a few inklings of my mental and emotional development without them, but it just doesn’t seem as significant, um, then it was when I was working with them.

Emily’s description suggested that the progress she made in therapy was contingent on her exposure to her therapists. That is, in the absence of her therapists, change ceased. We thought this was surprising considering her length of treatment (i.e., eight years with the psychologist and four years with the psychiatrist). Thus, unlike in other cases (e.g., Jay, Jackie, and Tom), Emily did not seem to experience a shift of agency from the therapist to herself. Instead, the therapist seemed to remain the agent of change.
However, we thought we later identified a voice that may have specifically inhibited her assimilation of the voice of the therapist.

We think this passage provides evidence of the voice. We believe this voice emerged when Emily talked about her difficulty in not continuing therapeutic work on her own:

240. E: So, I mean, it’s just, I can think about it, but I don’t ever really act on it too much. You know, like, something that maybe I learned in therapy that I want to, you know, I mean there were certain—I don’t want to say homework—but there were certain tasks that, um, my psychologist would say, “Okay, here’s the three things you’re going to do for this week.” And, usually I wouldn’t do them. (laughs) Um, it’s not because I was being belligerent or just stomping my foot, saying like, “No.” You know? I wasn’t being…I wasn’t trying to refuse. But, honestly, I just don’t think about it that often. Like, you just don’t think about certain things unless it was something that was a monkey on my back that was really like beating me down every single day. I didn’t go back to what I needed to do. So, there’s not much for me to think why I would do it without them if I didn’t do it with them. (laughs)

We thought this excerpt was evidence of a voice that assumed a position that was in some way unmotivated to work in therapy, or resistant to it. This position could be seen in Emily’s statement, “So, there’s not much for me to think why I would do it without them if I didn’t do it with them.” Through the observation of this position, then, we inferred the presence of a voice—called the resistant therapy voice. The position of this voice seemed to conflict with some threads of experience contained within the voice of the therapist. Conceptually, these threads may have been the aspects of her experience that recalled her active involvement and engagement in her therapy. However, we thought the resistant position of this voice may have actually inhibited the assimilation of the voice of the therapist by the community.
Discussion

Building a Theory of Assimilation of the Voice of the Therapist

In this study, we used the assimilation model to conceptualize client experiences in therapy as coming to be represented by an internal voice, called the voice of the therapist. Based on the analysis of case observations, we have tried to build a theory describing the assimilation of this voice. However, the theory presented in this paper remains tentative, and is viewed by us as being only the first step in understanding this phenomenon. Although it is the intent of this study to construct a preliminary understanding of the phenomenon, it is recognized that further research and observations are needed to modify and refine its description of assimilation. Thus, our confidence in the statements contained herein is also tentative, and the statements themselves are considered to be flexible and open to the infusion of new observations. In its current form, the statements of the theory come from the speculative extension of the theory of the assimilation model and the direct infusion of case observations. We will now discuss how the case observations came to inform the theoretical statements describing the assimilation of the voice of the therapist, previously presented in the introduction of this study.

The voice of the therapist may exhibit several levels of assimilation. As was described initially, the voices formulation of the assimilation model (Honoes-Webb & Stiles, 1998) conceives of a voice as representing multiple experiences, in contrast to the original formulation of the assimilation model (Stiles et al., 1990, 1992) which tracked the assimilation of single problematic experiences. The metaphor of thread, then, describes the relationship between the experiences contained within a voice: a cohesive voice that may be described by a particular stage of assimilation may be composed of tightly woven threads, whereas a non-cohesive voice that appears to be at several levels of assimilation may be composed of loosely woven threads.

In the assimilation analysis of the case interviews, we thought that the cases of Jay (e.g., ATS stage 6.5; Shifting agency/Community resource), Tom (e.g., ATS stage 6.5; Shifting agency/Community resource), and Emily (e.g., ATS stage 3.0; Differentiated therapist) were examples of cases in which the threads comprising the voice of the therapist were tightly woven. Although we thought some case observations
described different levels of assimilation and these observations were infused into the ATS, generally the voice of the therapist in these cases was understood as being characterized by a particular level of assimilation.

However, we thought that the cases of Bernice and Jackie were instances in which voice threads were loosely woven, and the voice of the therapist could not be described by a single ATS stage. For example, in the case of Bernice, we identified a thread that we called the problematic voice thread. We thought that Bernice’s account of the thread emerging in response to encounters with her problematic living situation described ATS stage 2.0 (Responsive therapist). However, we thought her account of the cessation of this voice upon the resolution of her problem indicated the loss of assimilation, and described ATS stage 0.0 (Silent therapist). Within this same case, we also identified a beginning therapist thread that we thought described ATS stage 4.0 (Understood therapist), as it continued to emerge beyond therapy and talked with community voices. Both threads seemed to be centered on the person of the therapist, but both also exhibited different levels of assimilation, simultaneously.

Thus, in the example of Bernice, the voice of the therapist did not seem to be coherent. Instead, we thought the observed threads were unevenly assimilated. Theoretically, this observation may suggest that the threads of experience contained within the voice may have been loosely associated and were being assimilated at different rates. Therefore, although these threads seemed to center on the same voice, their uneven assimilation seemed to suggest the voice may have not been progressing in assimilation in a cohesive fashion.

Early in assimilation, the voice of the therapist is outside of the community of voices. The assimilation model conceptualizes the individual as being made up of many voices, comprising a community of voices. This community of voices may define one’s sense of self, center of experience, or personality. According to the assimilation model, warded off problematic voices are held outside of the community of voices and are inaccessible to it. Conceptually, their assimilation is marked by the recognition of these voices by the community.

Similar to problematic experiences, we conceived the voice of the therapist as being held outside of the community. We did not think this was because it was warded
off or avoided by the community. Instead, we thought this was because it was a new voice, and thus was unfamiliar to the community and unrecognized by it. In some cases, we thought this lack of familiarity between voices (i.e., therapist and community) was observed in the participants’ descriptions. For example, in the case of Jackie, she described her experience in therapy as being like a “preventative shell” against depression. We thought that Jackie did not elaborate upon this description because her community voices had not yet begun to talk with the voice of the therapist. Instead, they only seemed aware of its existence and were therefore unable to elaborate on its quality or function.

Similarly, Tom described the voice of the therapist as being like a “third person perspective.” We thought this description indicated the position of the voice of the therapist relative to the community of voices: it was held outside of the community and thus provided an outside perspective. We thought this interpretation was consistent with the assimilation model’s theory of internal multiplicity, which suggests that the community of voices defines one’s sense of self, center of experience, or personality. Therefore, that Tom described the voice of the therapist as being a third person perspective suggested that it was a perspective separate from his own, and therefore separate from, or outside of, the community of voices.

The voice of the therapist may introduce different positions to the community. The assimilation model suggests that when a voice emerges, the person takes a position that is observable in the real-world. It is the observation of the positions a person takes that allows us to infer the presence of a voice. For example, in depression a person may have a voice that represents her experience of being teased as a child, and tells her she is worthless as an adult. The collective statements, actions, and behaviors this person takes may be described as depression—and we infer the presence of a problematic voice through her positions.

In a very practical sense, then, we conceive one way that therapy helps people is by considering old positions and introducing new or different positions. In therapy, then, we thought that the individual’s experience of talking about and trying new positions would be associated with the voice of the therapist. In this study, we interpreted some of
our observations as being evidence of the voice of the therapist bringing new positions to the community of voices.

For example, in the case of Jay, he talked about being able to access a sense of calm that he experienced with his therapist. Based on Jay’s description of feelings of anxiety and worry, we thought this sense of calm may have been a new position his community took. In a very practical sense, the position of calmness was based in his experience in therapy, and we therefore conceptualized it as being a part of the voice of the therapist. Similarly, in the case of Tom, he talked about the voice of the therapist telling him not to do drugs, saying this mandate was “set in stone.” We interpreted this observation as indicating a position of abstinence towards drug use. It seemed clear that Tom experienced this stance as coming from the voice of the therapist, rather than himself. That Tom said that part of his therapy addressed issues of drug abuse seemed to suggest that this position of abstinence did emerge from his experience in therapy.

*Meaning bridges allow community voices to call upon the voice of the therapist.* This statement remains largely theoretical and tentative. Essentially, it is an extension of assimilation model theory. The assimilation model suggests that as unassimilated voices move towards assimilation, they begin to talk to community voices and reach a mutual understanding. Similarly, it was observed that some participants simply described the voice of the therapist and others described talking to the voice of the therapist and calling upon it. Although we did not observe meaning bridges between voices (i.e., therapist and community) in this study, based on the assimilation model we inferred their presence in some instances.

In the case of Tom, he described having conversations with the voice of the therapist. In the example Tom provided, he said the voice would ask him, “Why did you act this way?” and he would respond, “You know what? I was at fault in that situation.” (e.g., Tom; line 26) We thought Tom’s description provided a good example of communication between the voice of the therapist and a community voice. By extending the assimilation model’s theory of voice relationship, we interpreted the communication between these voices as implying the presence of a meaning bridge.

Jay and Tom also talked about learning to use the voice of the therapist. In the case of Jay, he described “knowing how to make use of” his experience in therapy. In the
case of Tom, he talked about imitating what his therapist had done and mimicking what he had learned in therapy—he “broke it down” the way the therapist had for him originally. In both of these instances, we interpreted these descriptions as being indicative of goal-oriented communication between the voice of the therapist in a fashion and community voices. We interpreted the presence of an advanced level of communication such as this, as also implying the presence of meaning bridges.

The client may perceive a shift in personal agency, from the voice of the therapist to the self. In three cases (e.g., Jay, Jackie, and Tom), we observed participants describe the voice of the therapist shifting to the self. In the case of Jay, he described this as coming to associate his change in therapy with himself, rather than the therapist. In the case of Jackie, she talked about taking what her therapist taught her and using it herself. And, in the case of Tom, he said he attributed his change to the voice of the therapist, but that what changed him “used to be his [the therapist’s] voice, and now it’s mine.” In each of these examples, we thought the participants indicated a shift in personal agency: they assumed responsibility for change and came to have a sense of ownership over the changes that had occurred.

We thought the description of these shifts may have marked an important stage in assimilation, as the voice of the therapist came to be recognized as a community member. We thought the participants’ experience of this shift may have described the phenomenology of assimilation: if the community of voices is experienced as one’s sense of self, personality, or center of experience, then the membership of new voices within this community may be perceived as becoming part of the self. Jay described that his memories of therapy had faded and he now felt them as “within me.” For him, this was in contrast to an earlier time he was able to recall, in which he felt he needed to purposefully hang on to these thoughts. We interpreted Jay’s description of these memories being within him as an indication of the assimilation of the voice of the therapist into Jay’s community: because the memories were threads within the voice of the therapist and that voice was now a member of Jay’s community, he had a corresponding sense that the memories were now within him and available to him via the voice of the therapist. Thus, he no longer had to purposefully maintain them.
The voice of the therapist may emerge as a community representative and resource. The assimilation model suggests that as unassimilated voices become assimilated into the voice community, they may become accessible as resources for it. We conceived the assimilation of the voice of the therapist as operating similarly: as the voice of the therapist became a community member, it could also be used as a resource by the community or emerge as a representative for the community. In the case of Jay, we thought the voice of the therapist had become a community resource, as Jay described his therapist as being a resource for him and that he had therapy “within” him. We interpreted Jay’s description as suggesting that therapy was, in some way, accessible to him through the voice of the therapist. It may be that, theoretically, the threads of experience contained within this voice represented the features of therapy that were important to Jay.

Alternatively, in the case of Tom, we thought we observed an instance in which the voice of the therapist emerged as a representative for his community. Tom said that when he had encountered peer pressure to take drugs in order to be accepted, the voice of the therapist had stepped forward and insisted on abstinence. Tom said this voice was “set in stone” and he wouldn’t try to persuade it or bargain with it. As Tom described it, it sounded almost as if he let the voice of the therapist handle the situation for him.

However, the complete assimilation of the voice of the therapist and its emergence as a community resource or representative does not imply that therapy is no longer needed or desired. Jay terminated therapy because he felt there was nothing more to be gained at the moment, but he still talked about wanting the support of his original therapist, specifically. Similarly, Tom had a continued desire to see his therapist, saying that he had emailed him and wanted to “start up again during breaks.” However, in contrast to Jay, Tom said, “I don’t think [therapy is] ever really done.” Thus, despite the voice of the therapist seeming to function as a community representative, it seemed that Tom still felt he had much to gain from continued therapy.

We also want to stress that we do not suggest the voice of the therapist can serve as an equal substitute for the person and experiences it represents. Even in the healthiest of mother and child relationships, it is to be expected that the child wants to see her
mother, to talk to her, to hold her, and vice versa. Similarly, we suggest the same feelings may extend from client to therapist, even at this high level of assimilation.

As assimilation increases, client descriptions of the voice of the therapist and therapy experience may become more detailed, nuanced, and sophisticated. We noted that some participants’ descriptions of the therapist and therapy experience were more detailed and complex than others. Theoretically, it may be that as the voice of the therapist is assimilated, the client’s familiarity with that voice and the threads of experience contained within it may also increase. Accordingly, we thought client descriptions might be indicative of the level of assimilation of the voice of the therapist, as their ability to talk about these experiences may represent the community’s familiarity with them. However, these statements remain almost entirely theoretical and need further observations to modify and change them. While some participants certainly described the voice of the therapist differently (i.e., detailed, consistent, and clear as opposed to brief, uncertain, and confusing), we could not ascertain if these differences were because of the assimilation of the voice of the therapist or simply personality and character differences (i.e., psychological mindedness, interviewer relationship, intelligence, age, etc.) between the participants.

Expanding the Assimilation Model

In building a tentative theory of how clients assimilate the voice of their therapist, observations emerged that allowed the assimilation model’s description of voice construction and activity to be expanded. Like any other voice, we conceived the voice of the therapist as an organization of many different associated threads of experience. However, in examining the voice of the therapist it was observed that the same voice sometimes held different levels of assimilation simultaneously, and that threads of experience contained within this voice could sometimes be in conflict. These differences were understood as the result of uneven assimilation of the threads of experience that formed the voice of the therapist. When experiences, encounters, or aspects of the self addressed these threads, the voice of the therapist would emerge and be observed as speaking from a position or level of assimilation indicative of the thread that was addressed.
Conceiving voices as being composed of differentially assimilated threads may provide a tentative alternative explanation for how one voice may demonstrate out-of-sequence assimilation between-sessions (e.g., Brinegar et al., 2006), or a saw-toothed pattern of assimilation within-session (Osatuke, Glick et al., 2005). In these prior cases, it was postulated that differential levels of assimilation may have been the result of the theoretical orientation of the therapist in conjunction with the therapist’s ability to adjust the intervention so as to appropriately address voices within the client’s zone of proximal development (ZPD; Vygotsky, 1978; Leiman & Stiles, 2001)—defined as the section of the APES continuum along which the client is able to make progress with the therapist’s help. Alternatively, this study suggests that differences observed in the assimilation of a particular voice both within- and between-sessions may be the result of differently assimilated threads of experience contained within the same voice being addressed.

The notion of multiple threads forming a voice—each potentially speaking from a different position and being differentially assimilated relative to the other—may also suggest the experiential-structure of a voice is in some ways similar to the voice-structure of the individual. That is, like voices, threads of experiences contained within a voice may have different levels of assimilation, be in conflict, and form meaning bridges. This phenomenon was observed in the case of Jackie, whereby the expert therapist thread and the familial therapist thread formed a meaning bridge using the sign mentor. This meaning bridge seemed to acknowledge the respective position of each thread (i.e., expertise and intimacy). Theoretically, the creation of a meaning bridge between conflicting threads of experience contained within a voice may facilitate advances in its assimilation. For instance, in the case of Jackie, it may be that if the meaning bridge had not been created, the voice threads may have continued to emerge and demonstrate different levels of assimilation. However, because the meaning bridge was created, it may now be that when the threads are addressed and the voice speaks, both show the same level of assimilation.

Clinical Implications

Some research has indicated there is a positive relationship between the client’s internalization of the therapist and treatment outcome (Geller & Farber, 1993; Orlinsky et al., 1993). We think that the current model, then, may provide a way for clinicians to
conceptualize and monitor the client’s ability to make use of the therapy experience between sessions. In so doing, therapists may be able to use this phenomenon therapeutically. For example, a therapist could encourage her client to talk to her voice and problem solve when encountering problems between sessions. Similarly, therapists might encourage clients to evoke their voices as resources for support, comfort, and consolation. This may be particularly beneficial in instances where clients may have pervasive suicidal ideation or self-injurious behaviors.

Limitations and Directions for Future Research

The theory and model built in this study describing clients’ assimilation of the voice of the therapist is tentative and is bounded by the experiences of the participant in the sample, the experiences of the investigators, and the corresponding case observations. Therefore, it is important that later studies address some of the shortcomings of the current study. In so doing, observations may continue to be infused into the theory describing the assimilation of the voice of the therapist, and elaborate, refine, and modify its statements.

One limitation of this study may be that participants’ intelligence, verbal ability, and psychological mindedness may have acted as confounds in understanding assimilation. It may be that individual’s who are more intelligent, have better verbal skills, and are psychologically minded may talk about their experience in a way that suggests higher levels of assimilation. Conversely, it may also be that investigators are more likely to rate these types of participants as being high in assimilation. For example, in the case of Jay, we perceived his ability to talk about his experience in therapy as being sophisticated and complex. However, he was also a graduate student studying clinical psychology. Therefore, his ability to describe his experience may speak more to his intelligence, verbal ability, and knowledge of psychology, than to the level of assimilation of the therapist. Similarly, Tom appeared to be confident, intelligent, and to have a grasp of some psychological concepts—for instance, when he spontaneously used the term *internalization* and described his therapist as being like a “voice” in his head. Therefore, our understanding of Tom’s case as being one at a high ATS stage may have been partially a result of his intelligence and his psychological knowledge. This issue—parsing out intelligence and psychological mindedness—is something we have
encountered in other studies (e.g., Henry et al., 2004), and needs to be addressed in future research.

One limitation of this study is that none of the participants were in therapy at the time of the interview. In future studies, it may be useful to recruit participants who are currently receiving therapy. It may be that participants in therapy describe the voice of the therapist or articulate their experiences in therapy differently than those who discuss them retrospectively. More detailed articulations of the voice of the therapist, experiences of it emerging, and dialogue with it may allow for a more nuanced description of the process of change as clients assimilate this voice. It may also be that the passage of time—in this instance, between terminating therapy and being interviewed—may affect one’s ability to talk about the voice of the therapist or alter the course of its assimilation, in general. For example, in the case of Bernice, the assimilation of one thread (i.e., problematic voice thread) of the voice of the therapist seemed to actually regress, in the absence of her therapist. Alternatively, a different thread (i.e., beginning therapist thread) seemed to reemerge later, at a high level of assimilation. Further research will be needed to understand how passage of time may influence the assimilation of the voice of the therapist.

Another limitation of this study is that no information was gathered about the presenting problems of the client. When examining the assimilation of the voice of the therapist, it may be important to consider the client’s presenting problems for two reasons. First, examining the assimilation of the voice of the therapist relative to the assimilation of a problematic voice may indicate how the voice of the therapist interacts with other voices. For example, as suggested by Emily’s case observations, problematic or community voices may interfere with the assimilation of the voice of the therapist. Therefore, it may be important to consider the idiosyncratic role other voices play in the assimilation of the voice of the therapist, in order to properly contextualize and qualify case interpretations. Second, prior research has shown that some clients—based on their clinical diagnoses—have differential capacities to internalize and make use of their relationship with their therapist (Bender et al., 2003). For example, it has been noted that in instances of severe pathology, such as with personality disorders, the client’s ability to form a strong alliance with the therapist may be impeded (Muran, Safran, Samstag, &
Accordingly, it may be important to consider the client’s presenting problem when examining her ability to assimilate the therapy experience. It may be that some clinical diagnoses or problematic experiences present characteristic limitations or challenges to assimilating the voice of the therapist. As Sullivan (1956) suggested, it may be selective inattention to important others that may be the root of psychological problems. Thus, it may be such inattentions that inhibit one’s ability to assimilate experiences with an important other, such as a therapist.

Future researchers may also want to address the theoretical orientation of the therapist. Different therapies stress the importance of the relationship between the client and therapist differently, in examining and treating client problems. For example, in cognitive-behavioral treatment, the therapist may focus on the therapeutic relationship to encourage the completion of homework (Beck, 1995; Dunn, Morrison, & Bentall, 2006) or facilitate a client’s motivation to change (Holtforth & Castonguay, 2005). Conversely, in interpersonal theory, the therapist may collaboratively examine the therapeutic process to understand problematic relational patterns and to facilitate the creation of new ones (Teyber, 2000). Accordingly, the client’s valuing of the therapeutic relationship and the associated experiences, as well as his capacity to assimilate them, may vary per the theoretical orientation of the therapist.

Additionally, a final limitation of this study is that, demographically, there appeared to be little variance within the sample. In this study, four participants were 25 years old or younger, four had majored in psychology in college, four were White, and all participants were college students in either a graduate or undergraduate capacity. Accordingly, it may be that observed similarities between cases were not characteristic of a particular stage of assimilation and instead simply reflected similarities between participants. Thus, because of homogeneity in the age, race, socioeconomic background, and the cognitive capacities of the participants, many experiences common to other groups may not have been represented within the sample and were therefore not able to be observed and incorporated into the ATS.
References


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Appendix A.

Table 1. Assimilation of Problematic Experiences Sequence (APES)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Warded off/dissociated</td>
<td>Client is unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance.</td>
</tr>
<tr>
<td>1. Unwanted thoughts/active avoidance</td>
<td>Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect is intensely negative but episodic and unfocused; the connection with the content may be unclear.</td>
</tr>
<tr>
<td>2. Vague awareness/emergence</td>
<td>Client is aware of a problematic experience but cannot formulate the problem clearly. Problematic voice emerges into sustained awareness. Affect includes acute psychological pain or panic associated with the problematic material.</td>
</tr>
<tr>
<td>3. Problem statement/clarification</td>
<td>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.</td>
</tr>
<tr>
<td>4. Understanding/insight</td>
<td>The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.</td>
</tr>
<tr>
<td>5. Application/working through</td>
<td>The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.</td>
</tr>
<tr>
<td>6. Resourcefulness/problem solution</td>
<td>The formerly problematic experience has become a resource, used for solving problems. Voices can be used flexibly. Affect is positive, satisfied.</td>
</tr>
</tbody>
</table>
7. **Integration/mastery.** Client automatically generalizes solutions; voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (e.g., this is no longer something to get excited about), (Stiles, 2002).
Table 2. Assimilation of the Therapist Sequence (ATS)

0. Silent therapist. The client may appear ambivalent about the therapist and therapy, and may report having no thoughts of either. The client may require a great deal of prompting and may have little to talk about.

1. Emerging therapist. Client descriptions of the therapist and therapy may be uncertain, tentative, and sparse. The client may report having thoughts of the therapist, but there may be little exposition of these.

2. Responsive therapist. The client may be aware of the voice of the therapist responding to problematic voices. The client may begin to view the voice of the therapist as a useful presence.

3. Differentiated therapist. The client may be able to articulate the voice of the therapist as a presence. The client may report that the voice of the therapist emerges, and is beyond their control. Descriptions of the therapist may be certain, clear, and consistent.

4. Understood therapist. Through the creation of meaning bridges, the client and the voice of the therapist reach a mutual understanding. The client may begin addressing the voice of the therapist and describe a sense of learning to talk to it or use it.

5. Applied therapist. The client may begin deliberately calling upon or consulting the voice of the therapist. The client may describe having conversations with it. The client may describe a sense of carrying their therapist with them.

6. Shifting agency. The client may perceive a shift whereby they come to associate their change in therapy with themselves and not the therapist. The client may describe the voice of the therapist as fading.

7. Community resource. The voice of the therapist has become a therapeutic resource for the client. Accordingly, the client may be able to purposefully call upon the therapist as a resource, when needed, or the voice of the therapist may emerge as a community representative.
Table 3. Original Formulation of the Assimilation of the Therapist Scale (ATS)

0. **Silent therapist.** The voice of the therapist will be unassimilated. The client may describe the therapist and therapy in very concrete terms (e.g., homework, specific conversations, and objects in the therapy room). Clients may report not having thoughts of therapy or the therapist.

1. **Emerging therapist.** The voice of the therapist may emerge and may be connected to specific thoughts or themes from therapy. Specifically, the voice of the therapist may respond to negative feeling states of the client that correspond to the presence of problematic voices. The client may only subtly perceive the presence of the voice of the therapist and it may be described in vague terms, and undistinguished as being connected to therapy or the therapist.

2. **Vague dialogue.** The client may be aware of the voice of the therapist as it responds to the strong negative feelings associated with emerging problematic experiences and describe the voice as being connected to therapy, or belonging to the therapist, in some way. The client may perceive the voice as more frequently present. The client may begin to articulate the voice and its presence.

3. **Differentiated therapist.** The client is aware of the presence of the voice of the therapist, can define its activity, and articulate it as separate. This voice is a sustained presence, functioning independent of the client. It is still experienced as occurring or being activated by themes, rather than called upon by the client.

4. **Engaged therapist.** The client begins engaging the voice of the therapist and imaginally interacting with it. Through the creation of *meaning bridges*, the client and the voice of the therapist reach a mutual understanding. As problematic voices occur, this voice may offer the client support and advice.

5. **Applied therapist.** The client may begin actively referring to the voice of the therapist, and purposefully evoking it, for general problems or negative feelings. The client’s awareness of this voice may begin declining, as the deliberate processes of consulting and applying it may be increasingly intuitive and automatic.
6. **Resource/solution generation.** The client may automatically consult the voice of the therapist, and the two generalize solutions together. The client may stop describing this activity in terms of two voices, and refer to it as a process that happens automatically. The client may perceive a shift whereby they experience the presence and function of the voice of the therapist transferring to themselves.

7. **Voice of the client.** The client no longer feels the voice of the therapist is present, although they may be able to articulate it once was. The client’s self-talk may assume the former function of the voice of the therapist and reflect characteristics of it. The client may be able to articulate this assumption of the characteristics of the voice of the therapist, as well as being able to describe the voice of the therapist as having switched to themselves.
Table 4. Interviewer Guideline

Introduction

- Thank you for coming to the interview today. What I’m researching is how and what you think of your therapist when you’re not in therapy. For example, some people report that they have pretend conversations, thoughts, or images of their therapist when they aren’t in therapy…and that these things are helpful for them.
- The questions I am going to ask you today will help me to understand what your imaginary experience of your therapist is like.
- I want to stress that this interview is about how and what you think of your therapist outside of therapy and NOT about the content of your actual therapy.
- Before beginning, do you have any questions for me?

Questions

Description of the therapist and therapy experience:

- Can you describe your therapist?
- What can you tell me about your therapist?
  - What is he/she like?
- How is your therapist different from you?
- How is your therapist similar?
- Could you describe your relationship with your therapist?
- When you think of your therapist, what comes to mind?
  - Thoughts, images, sounds, feelings, etc.?
  - What purposes have these served for you?

Experiencing the therapist:

- Can you imagine a time when you thought of your therapist?
  - Can you describe this for me?
- Have you had dreams about your therapist?
  - Could you talk about these?
- Could you tell me about times that stand out for you, when you thought of your therapist or therapy?
  - What happened?
  - Where were you?
o Why do you think you thought of him/her?

**Taking pieces of therapy:**

- In what ways did your therapist or therapy influence you?
- In what ways do you see your experience in therapy influencing you now?
  - In the past?
- Have you carried things out of therapy with you?
  - What have you taken?
  - How have you used these things?

**Miscellanea:**

- Is there anything else that you would like to talk about, that you feel is important, or that I may have missed?
Table 5. Examples of Interviewer Speaking Turns

- I: Okay. So now it's more of, a vague, um, sensation or feeling about the experience as a whole rather than like specific things that might have happened or occurred to you.
- I: So, you said you were closer to him than anyone you’ve ever known in your life.
- I: Okay, um, can you talk about your therapist a little bit?
- I: So, you said you see this difference in yourself between when you were in and when you were out. How was it different? Can you describe that?
- I: So, a big part…you said earlier…it seems like a big part of being in there was silence. And, at times this was almost anxiety provoking for you.
- I: So you said, “Knowing to make use of.”
- I: So, it seems like, uh, salient features of the therapist for you were that you felt very challenged…and, at first, it seemed like relative to your other therapist, he wasn’t supportive, but over time your idea of support changed?
- I: So, you could kind of see things differently, a different perspective maybe and you would analyze and you would see yourself – rather than just reacting – looking from a perspective more critically.
- I: You thought about it a lot.
- I: So, I guess I want to begin with just asking you to kind of describe your therapist.
- I: So, what would be an example of a comfortable image?
Appendix B.

“How I got here”

Inception of the idea. I’ve included, per Bill’s suggestion, an informal account of how this project came to be what it is. Hopefully this will address some of the concerns that have surfaced in response to this paper, regarding the methodology, theory building aspect, and case analyses and interpretations. Essentially, the idea behind this paper stemmed from a video I viewed in one of Margaret’s interpersonal modules, in which we saw a client talk about her experience in therapy. In this account, she specifically described a few instances in which she would ‘talk’ to her therapist when not in therapy. I thought this would be an interesting phenomenon to investigate from the perspective of Bill’s assimilation model, considering its description of experiences represented as voices, multivoicedness, and the dialogical self.

My history as a client and therapist: How my experiences may have informed the model formulation. Something which Margaret asked about in her feedback on this document was my history as a client and therapist. I’ll detail these here, as briefly as I can. I’ve been in therapy at three points in my life: once when I was 18 and dealing with drug problems and self-esteem issues (for about 5 months), once when I was 21 and dealing with relationship problems (for about 8 months), and currently, as I deal with the pressures of graduate school and trying to achieve more satisfying relationships (for about 15 months). How would I rate my ATS level on any of these experiences? Well, surprisingly, not particularly high. Although I feel like in all three instances I’ve had very successful therapy and a strong bond with my therapist, I never really find myself thinking of my therapists frequently, having imaginary conversations with them, or anything like that. My two earliest therapists are distant and largely inaccessible memories to me. However, I do feel that these experiences do indeed speak through me…there is an automaticity and assumption of what I learned from them, that I think has resulted in lasting changes within me.

In terms of how I think about therapy, at most, I find myself thinking of the ideas and problems that I talk about in therapy during the week more frequently than
if I were not in therapy—rather than having thoughts of my therapist, specifically. Thoughts of my therapist are usually in terms of, “How am in the room with him? What is our process like? What emotions do I experience towards him? How can I learn about myself and experiences with other people, based on the answers to these questions?” However, in terms of thinking of my problems, I think that for me being in therapy serves as a cue and reminder to be more mindful of myself, reflective on my actions, etc. If anything, when not in therapy the issues that I may want to work on or the aspects of my life that I find dissatisfying tend to fall to the back of my mind, rather than being at its forefront, and thus go unaddressed.

To some degree, then, my own experiences in therapy informed my understanding of the phenomenon. This is something that Roger readily identified and that I had not been completely aware of until he pointed it out: self-contained individualism. In my own experience as a client, I have found that as I felt I was becoming ready to terminate therapy, it was marked by a feeling of increased self-reliance. The best way that I can describe this is as it was articulated by Jay: I found that I wanted to begin trying to do things on my own, without the help of the therapist—I wanted to face my problems by myself to see how I fared. I wanted to experiment, and challenge myself. Reflecting on it, I used the therapist as a touchstone or guidepost of sorts. It certainly conjures up images, at least for me, of the young child who explores the far side of the room while his mother sits in the corner, and then returns to her for validation, support, guidance, counsel, or comfort.

This is not to say, however, that my motions towards becoming independent from my therapist stemmed from an aversion to dependence upon the therapist, or shame in needing the therapist. Except my first few months in therapy as an 18 year old, I wasn’t really ashamed to be in therapy. I came to take a very practical view towards therapy: if your car is broken, you go to a mechanic. If your arm hurts, you see a doctor. Accordingly, if you’re feeling sad, depressed, angry, etc., why not see a therapist? In going through these experiences in therapy then, I found myself pleasantly surprised as I began to face some of my fears, finding that maybe they weren’t as scary, terrible, or overwhelming as I’d once thought, or that I would probably be okay at the least and at best I could indeed handle them. These
discoveries were often in the presence of bi-weekly appointments, as I gradually weaned myself from my therapist. Beyond termination, I came to find a great deal of satisfaction in learning to face my fears and problems, rather than avoiding or burying them, as I had done in the past. I would credit this ability to my therapist.

As a clinician, I’ve had only one brief year of experience, in which I saw three clients for more than only a handful of sessions (6, 10, and 24 sessions each, approximately). With one of my clients, he would sometimes talk about thinking of me during the week, what we had talked about, or questions I may have posed him. Certainly, I could assign him some rating on the ATS, but I don’t think that this experience informed my formulation of the model in any particularly powerful way that I can see. I remember that my thoughts in response to his disclosure were something along the lines of, “It seems that therapy has had at least some sort of impact on him, in that it has initiated a process of self-reflection or thinking about his old problems in a new way. That seems to be a good thing.” In these instances, I viewed his descriptions of thinking of me and therapy as being positive, in that I seemed to have some influence on him as his therapist that seemed to be helpful, and also that some of the work of therapy was being continued outside of the room.

Original theoretical underpinnings of the ATS. However, the theoretical basis from my early thoughts and ideas contained in the original version of the ATS (see Table 3) came from my readings of previous research on internal representations of the therapist, as well as my speculation and projective thinking of the phenomenon based on my knowledge of the assimilation model. In terms of internal representations, my thoughts stemmed largely from my readings of Geller (and his correspondingly vast body of research), Edelson, and Singer and Pope about clients coming to function as their own therapists in a way, and hanging onto the therapist beyond the termination of therapy. These ideas can be seen in my initial conceptualization of the higher stages of the ATS. Additionally, the substantial body of research based on Geller’s Therapist Representation Inventory (i.e., TRI) served to reassure me that the phenomenon I was researching did indeed exist. That is, according to this research clients experienced representations as felt, heard, and
visualized experiences with which they would interact. This seemed to correspond with how I conceived the phenomenon from an assimilation model perspective.

In terms of the assimilation model specifically, it helped to formulate my understanding of the phenomenon in that I conceived these interactions as being based in the client’s real-world experiences with the therapist. When these experiences were triggered, or were addressed, the voice of the therapist might speak. Accordingly, the client’s interactions with this voice could be understood in terms of dialogue between experiences with the therapist and the other experiences—or voices—that formed their internal world (i.e., personality, psyche, sense of self, or center of experience).

Originally, the vast bulk of the ATS and its stages were based on a paper written by Stiles, Osatuke, Glick and Mackay (2004), in which the assimilation of problematic experiences was described along three curves: salience, feeling, and valence. The original formulation of the ATS, then, was based upon three corresponding domains: voice salience, voice activity, and theme generality—the first two domains corresponding to the respective curves of Stiles et al. (2004). In this paper, salience was a bell-shaped curve—early in assimilation clients’ problematic experiences are warded off and the client is largely unaware of them. As the problematic experiences are encountered, their salience rises and peaks, followed by the diminishishment of the salience as the problems are understood, mastered and become resources. My original thinking was that the voice of the therapist would similarly rise, peak, and diminish in its salience as the client was unaware of it, recognized it, and it came to be an assumed aspect of the self, per Singer and Pope. This was reflected in the domain of ‘voice salience.’

The domain of voice activity suggested that the voice of the therapist would be responsive to the feelings states of the client. The assimilation model suggested that early in assimilation affect was neutral, as problematic voices were avoided (voice activity low). As they emerged, affect became negative (voice activity increased and high). As the voice became understood and resolved, affect became positive (voice activity diminished), and as the client mastered the problem, affect
returned to neutral (voice activity low). The voice activity of the therapist was thought to be responsive to these feelings states.

The domain of theme generality suggested that the voice of the therapist would be associated with specific themes, or problematic voices, early in therapy. However, as the client amassed experiences with the therapist, I thought that there would be a correspondingly larger number of experiences that the client might encounter that might then recall or address the voice of the therapist. Thus, my thinking was that early in assimilation the voice of the therapist would emerge in response to very specific experiences, stimuli, voices, etc. and over time would be generalized and responsive to a much larger range of experiences.

Revising the model based on observation. However, once I had analyzed the cases and reviewed the observations, I realized that none of them really fit with any of these three domains. In fact, I felt that the domains and my early thinking, speculations, and projections were basically wrong. Initially, I did try to understand or interpret the observations of the cases from the perspective of these three domains, but that really seemed like I was forcing the interpretations and trying to fit a square peg into a round hole. Thus, I sadly discarded all of this material and started basically from scratch, in a theoretical sense. Because of this, most of the material contained in the theory that informs and underlies the ATS is completely new and different from the original, reflecting my new, and altered, understanding of the phenomenon.

However, this is not to say that there wasn’t some pleasant surprise and correspondence between my early thinking and my observations. Several participants did perceive a switch (as I called it) of the voice of the therapist becoming their own, in a sense what Edelson had described. Similarly, Jay talked extensively about becoming more self-reliant and wanting to ‘try things on his own.’ The notion of the voice of the therapist becoming a complete therapeutic resource for the client—and the subsequent client feeling of wanting to terminate therapy—while corresponding with my own experience, hadn’t occurred to me until Jay’s second interview, when he talked about it. I thought this was a neat idea that seemed logical in an assimilation sense: if assimilation is progression towards a community resource, then it seemed likely that assimilation of the voice of the therapist would be a therapeutic resource.
and clients may have a corresponding diminished desire or sense of dependency or need for therapy. Perhaps this is what preceded my own forays and explorations into the world, in the absence of my therapist, in my prior terminations of therapy.
Appendix C.

Recruitment Flyer

A study about people and their therapists

What is this study about?
I want to understand how, and in what ways, people think about their therapist between sessions of therapy

What do I have to do?
I will interview you for about an hour and we will talk about how and what you think of your therapist. When you think of your therapist, what is it like? How do you imagine them?

- You will not be asked to talk about your actual therapy
- Your identity will be concealed

Why might I want to participate?
Your participation may help therapists to better understand how therapy works, possibly providing improved services in the future.

How can I participate?
If you want to participate, you must:

- Be at least 18 years of age
- No longer be in therapy

Simply contact me, Jim Mosher, at:

E-mail: mosherjk@muohio.edu
Phone: 513-461-1587

This study has been approved by the Miami University IRB (05-014 PSY).
Appendix D.

Consent Form

**Project Title:** Clients’ Assimilation of the Voice of the Therapist

**Experimenter:** James K. Mosher, Clinical psychology graduate student

William B. Stiles, Ph. D.

I, __________________________ (please print), hereby authorize and direct James K. Mosher and associates or assistants of his choosing, to perform the activities listed here.

A. **Description of the Research.** This study will investigate how and what people think of their therapists outside of therapy. For example, what kinds of thoughts do they have? How often do they think about their therapist? Are these thoughts helpful or not?

B. **Research Procedures.** You will be interviewed, and asked to discuss and describe the thoughts you have about your therapist outside of therapy, their frequency, their usefulness, and other questions of this nature.

C. **Time Required for Participation.** You will be interviewed for approximately one hour, although some people may need more or less time.

D. **Risks.** The risks of this study are minimal and should not be any greater than those experienced during everyday life. Some individuals may experience some distress. If you do, please let me know immediately and I will address any questions or concerns you may have. Counseling resources will also be made available to you upon request.

E. **Benefits.** Through participating in this study, you may gain insight into how therapy helps you, the effects your therapist has on you, and how change in you occurs outside of therapy. Research such as this will help advance psychologist’s understanding of the ways in which they may or may not help their clients, and how to increase their efficacy.

F. **Confidentiality.** An audio recording of this interview will be made, and a written transcription of that recording will be produced. Researchers will read the
transcription for purposes of analysis. Researchers may also listen to the audio recording of the interview. The only form of identification on either document will be an identification number and a false name. Your real name will not be attached to either document in any way. Additionally, passages from the interview may be published or cited in future research. Again, a false name will be used in conjunction with any excerpts, so that no one will be able to identify you. All identifying documents and materials will be stored in a locked cabinet in Benton Hall.

G. Voluntary Participation. Your participation is completely voluntary and you may withdraw at any time for any reason without consequence. You may refuse to answer any question you wish. It is possible that I may try to contact you up to six months after today, in the event that I need to clarify aspects of this interview. Again, if this occurs you may refuse to participate for any reason, without any consequence.

H. Questions about the Study. Do you have any questions that you would like to ask me? Do you need me to clarify any of the above information? If any questions should arise after the interview is complete, you can contact me using the information provided at the end of this form.

I. Questions about Rights of Subjects. You may contact the Office for the Advancement of Research and Scholarship (513-529-3734) or humansubjects@muohio.edu if you have any questions or concerns about your rights as a participant in this study.

Research Participant’s Statement of Consent

By signing your name below, you are indicating that you understand the following statements:

- My participation today is in a study entitled “Clients’ Assimilation of the Voice of the Therapist.”
- The purpose of this study is to investigate how and what people think of their therapists outside of therapy. I understand that I will be asked about my therapist
and the nature of my thoughts of him/her outside of therapy. I understand that I will not be asked about the content of my therapy sessions.

- I understand that I may be contacted up to six months after today, if the interviewer needs to clarify aspects of this interview. I may refuse to participate for any reason, now or later, without consequence.

- I have been informed of the research I am going to participate in today, its procedures, its risks, and its benefits.

- I understand that only the interviewer will be able to identify me. I understand that this interview will be electronically recorded, and that a transcript of that audio recording will also be made. I understand that other researchers may read this transcript, hear the recording, that some of its contents may be published for research purposes, and that my identity will be concealed through the use of a false name.

- I will be paid $10 for my time.

- I understand that if I have any further questions about the study or its results, I may contact James K. Mosher (mosherjk@muohio.edu; 513-529-2452) or Dr. William B. Stiles (stileswb@muohio.edu; 513-529-2405).

- I understand that if I experience any negative psychological distress as a consequence of participating in this study, I may contact any of the three following sources:

  **Student Counseling Service**  
  195 Health Services Bldg.  
  Miami University  
  529-4643

  **Psychology Clinic**  
  18 Benton Hall  
  Miami University  
  529-2423

  **24-Hour Crisis Hotline**  
  523-4146

- I verify that my participation in this study is voluntary, my responses and identity will be concealed, and I am at least 18 years of age.

________________________  ___________________  ____________________  ___________________
(Signature of participant)  (Date)  (Signature of witness)  (Date)
Appendix E.

Debriefing Form

Thank you for participating in this study. A greater understanding of how therapists affect their clients outside of therapy may be helpful for both clients and therapists, in several ways:

- For clients, a deeper understanding of how they utilize their therapist between sessions may increase their bond with their therapist both away from them and while in their presence, as well increase their capacity to transfer the gains and benefits of therapy to their day-to-day lives.

- For therapists, a greater understanding of how they affect their clients outside of therapy and the ways that they are most helpful may allow them to focus on these areas and increase their usefulness to their clients.

If you have any questions, please contact me, Jim Mosher (e-mail: mosherjk@muohio.edu; phone: 513-529-2452) or Dr. William B. Stiles (stileswb@muohio.edu; 513-529-2405).

If after participating in this study you would like to talk about any issues the study brought up for you, please contact any of the following resources:

**Student Counseling Service**  
195 Health Services Bldg.  
Miami University  
529-4643

**Psychology Clinic**  
18 Benton Hall  
Miami University  
529-2423

**24-Hour Crisis Hotline**  
513-523-4146
Appendix F.

Participant Information Form:
Name: ___________________________ Student ID: ___________________________
Address: ________________________________________________________________
Phone number: __________________________________________________________
E-mail: ________________________________________________________________
Date of Birth: ___________________________ Age: ___________________________
Race: ___________________________ Occupation: ___________________________
Marital Status: ___________________________ No. of Children: ____________________
Educational Level: ________________________________________________________
Are you currently in psychotherapy?: _________________________________
   If yes, for how long?: ______________________________________________________
   If yes, for how long? ____________________________________________________
Were you formerly in psychotherapy?: _________________________________
   If yes, for how long did you see your therapist?: ______________________________
   If yes, how long ago since you were in psychotherapy?: ________________________
Pseudonym and ID #: _____________________________________________________